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The AIDS Pandemic in the 21st Century

The Demographic Impact in Developing Countries

by

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Paper prepared for presentation at the XIIIth International AIDS Conference, Durban, South Africa, 9-14 July 2000. Excerpts from US Census Bureau's World Population Profile 2000 focus chapter, to be published 2000.

The AIDS pandemic in the 21st century continues to have its greatest impact in the developing world.

The overwhelming majority of people with HIV, 95 percent of the global total, live in the developing world. The Joint United Nations Programme on HIV/AIDS (UNAIDS) expects that this proportion will continue to rise in countries where poverty, poor health systems and limited resources for prevention and care fuel the spread of the virus.¹

An estimated 71 percent of the global total of HIV-positive people, 24.5 million out of 34.3 million, live in sub-Saharan Africa. Sub-Saharan Africa contains only 11 percent of the global population. Over eight percent (8.6%) of all adults in sub-Saharan Africa are HIV positive compared to 0.6 percent of Americans. Since the beginning of the epidemic, 14.8 million Africans have died from AIDS; 2.2 million AIDS deaths occurred in 1999.

Southern and eastern Africa have been the most severely affected regions. Seven countries now have an estimated² adult HIV prevalence of 20 percent or greater: Botswana, Lesotho, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe. In these countries, all in southern Africa, at least one adult in five is living with HIV. An additional 9 countries have adult HIV prevalence levels higher than 10 percent.

In comparison, HIV prevalence levels in Asia are relatively low. Adult HIV prevalence exceeds 1 percent in only three countries: Burma, Cambodia, and Thailand. In other countries, the prevalence rate is much lower.

In Latin America and the Caribbean, the HIV/AIDS epidemics vary from those that are concentrated among IV drug users and men who have sex with men to epidemics that seem to be mostly driven by heterosexual transmission. These include The Bahamas, Haiti, and Guyana, the countries with the highest adult HIV prevalence rates in the region.

In sub-Saharan Africa, more women than men are HIV positive.

At the end of 1999, UNAIDS estimated that 55 percent of all HIV infections in sub-Saharan Africa were among women. Peak HIV prevalence among women occurs at a younger age than among men. Among women, HIV prevalence tends to peak around 25 years of age. Peak HIV prevalence among men occurs 10 to 15 years later and generally at lower levels.

Several studies³ comparing data from antenatal clinic with community based studies have shown that HIV prevalence among antenatal clinic (ANC) women still gives a reasonable overall estimate of HIV prevalence in the general adult population. ANC prevalence tends to underestimate the prevalence among women but overestimates HIV prevalence among men.

Mortality patterns are driven by HIV prevalence patterns.

Median survival with HIV/AIDS is estimated to be around 10 years. In South Africa, by 2020, mortality for adults ages 20 to 45 will be much higher than it would have been without AIDS. Mortality for women will peak during the ages of 30-34, earlier than the peak seen for men during the ages of 40-44.

¹ AIDS epidemic update: December 1999, @ UNAIDS December 1999.

² Report on the Global HIV/AIDS Epidemic, June 2000, @ UNAIDS.

³ Fylkenes, Musonda, Sichone, *et al*, 1999.

At the beginning of the 21st century the growth rate in Zimbabwe has been reduced to nearly zero due to AIDS mortality.⁴

Other countries with sharply reduced growth rates include several other southern African countries: Botswana, Malawi, Namibia, South Africa, Swaziland, and Zambia.

The negative population growth seen in Guyana in 2000, is the impact of AIDS mortality compounded by out-migration. The underlying growth rate for Guyana is 0.1. with AIDS, the growth rate for Guyana is -0.1.

In Asia, AIDS mortality results in slightly lower growth rates in Burma, Cambodia and Thailand.

By the year 2003, Botswana, South Africa and Zimbabwe will be experiencing negative population growth.

By 2010, the growth rate for these countries will be around a -1 percent. This negative population growth is due to the high levels of HIV prevalence in these countries and relatively low fertility. This is the first time the Census Bureau is estimating negative population growth due to AIDS for any country. Previously, HIV/AIDS experts never expected HIV prevalence rates to reach such high levels, nationally, in any country. By the end of 1999, adult HIV prevalence had reached an estimated 36 percent in Botswana, 20 percent in South Africa, and 25 percent in Zimbabwe.⁵

Other countries in southern Africa will be experiencing a growth rate of nearly 0 including Lesotho, Malawi, Mozambique, Namibia, and Swaziland. Without AIDS, these countries would have been experiencing a growth rate of 2 percent or greater.

In Latin America and the Caribbean, The Bahamas and Guyana will be experiencing the greatest impact on their growth rates. Growth rates will be reduced from 1 percent to 0.4 percent.

In Asia, growth rates will be slightly reduced for Burma, Thailand, and Cambodia.

AIDS mortality will produce population pyramids that have never been seen before.

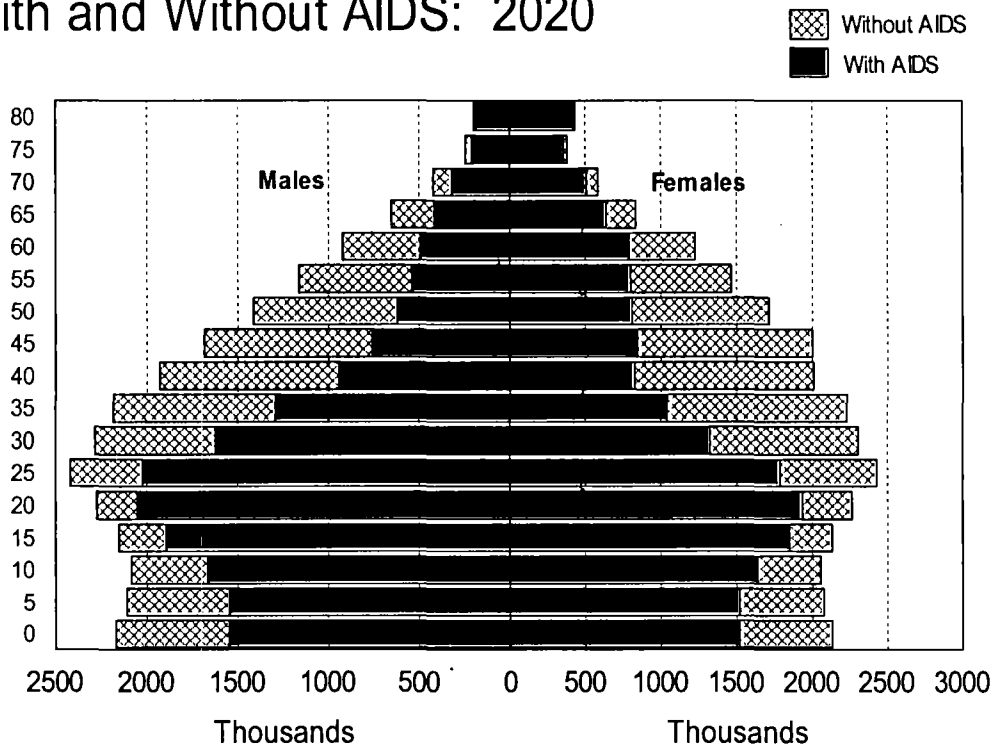
Particularly in those countries with projected negative population growth, Botswana, South Africa and Zimbabwe, population pyramids will have a new shape. At the population chimney. (See figure below). The implications of this new population structure are not clear. By 2020, between the ages of 15 and 44, there are more men than women in each of the 5-year-age cohorts which may push men to seek partners in younger and younger age cohorts. This factor in turn may increase HIV infection rates among younger women. Current evidence⁶ indicates that older men are infecting younger women, who then go on to infect their partners, particularly through marriage. This vicious cycle could result in even higher HIV infection levels.

⁴Refer to appendix tables for country specific indicators.

⁵Report on the Global HIV/AIDS Epidemic, June 2000*, UNAIDS

⁶Multicentre Study on Factors Determining the Differential Spread of HIV in 4 African Towns. Buve, A., R. Musonda, M. Carael, *et al.* XI International Conference on AIDS and STDs in Africa, Lusaka, Zambia, Late Breaker Session, 1999.

Population of South Africa, With and Without AIDS: 2020



In countries with moderate epidemics, AIDS mortality will have less of an effect on the population structure.

For example, in Uganda, the greatest relative differences in future population size by cohort are evident in the youngest age groups and in those 30 to 50 years of age. However, the population pyramid still continues to maintain its traditional shape.

AIDS mortality is resulting in falling life expectancies.

Already, life expectancies have fallen in many countries in sub-Saharan Africa from levels they would have been without AIDS. In Botswana, life expectancy is now 39 instead of 71. In Zimbabwe, life expectancy is 38 instead of 70. In fact, six countries in sub-Saharan Africa: Botswana, Malawi, Mozambique, Rwanda, Zambia, and Zimbabwe have life expectancies below 40 years of age. They would have been 50 years or greater without AIDS.

In Latin America and the Caribbean, the impact on life expectancy is not as great as in sub-Saharan Africa because of lower HIV prevalence levels. However, they are still lower than they would have been without AIDS. In The Bahamas, life expectancy is now 71 instead of 80. And in Haiti, life expectancy is now 49 instead of 57.

In Asia, Thailand, Cambodia, and Burma have lost three years of life expectancy.

In ten years time, 2010, many countries in southern Africa will see life expectancies falling to near 30 years of age, levels not seen since the beginning of the 20th century.

In a region that would have expected life expectancies to reach 70 years of age by 2010, many will see life

expectancies falling to around 30:

\$ Botswana^{B29}
 \$ Namibia^{B33}
 \$ Swaziland^{B30}
 \$ Zimbabwe^{B33}

Many other countries will see life expectancies falling to 30-40 years of age instead of 50-60 years.

AIDS mortality will continue to result in falling life expectancies in Latin America, the Caribbean and Asia. In Latin America and the Caribbean, life expectancy will be 14-15 years lower in The Bahamas and Guyana than they would have been without AIDS. In Asia, life expectancies will be two years lower in Thailand and 4 years lower in Cambodia and Burma.

The most direct impact of AIDS is to increase the number of deaths in populations affected.

Crude death rates, the number of people dying per 1,000 population, have already been affected by AIDS.

In Africa, HIV epidemics have had their greatest impact in eastern and the southern regions. Adult HIV prevalence is 20 percent or higher in 7 countries and an additional 9 countries have HIV prevalence rates between 10 and 20 percent. In many of these countries, reports indicate the presence of the HIV virus since the early 1980s.

As a result of these long-term high levels of HIV infection, estimated crude death rates including AIDS mortality are greater by 50 to 500 percent in eastern and southern Africa over what they would have been without AIDS. For example, in Kenya with an adult HIV prevalence of 14 percent at the end of 1999, crude death rates are estimated to be twice as high, 14.1, than they would have been without AIDS, 6.5. In South Africa, with an estimated 20 percent adult HIV prevalence level, crude death rates are also twice as high, 14.7, than they would have been without AIDS. 7.4.

In Asia and Latin America the estimated crude death rates are also higher than they would have been without AIDS.

In many sub-Saharan African countries, crude death rates will be even higher in 2010 than in 2000, even though mortality due to non-AIDS causes will continue to decline.

In Botswana, crude death rates will increase from 22.8 in 2000 to 36.0 in 2010. In South Africa, crude death rates will increase from 14.7 to 30.3 and in Zimbabwe from 22.4 to 31.6. In all three of these countries, crude death rates would have been 5 to 7 without AIDS.

In Latin America and the Caribbean, The Bahamas and Guyana will see a doubling of crude death rates with AIDS over what they would have been without AIDS.

In Asia, crude death rates will be slightly higher with AIDS than they would have been without AIDS. In Thailand crude death rates with AIDS will be 7.8 compared to 6.9 without AIDS. In Cambodia, crude death rates will be 9.5 with AIDS versus 7.7 without AIDS.

In some sub-Saharan African countries, infant mortality rates are now higher than they were in 1990.⁷

AIDS mortality has reversed the declines that had been occurring during the 1980s and early 1990s. Over

⁷U.S. Census Bureau, International Data Base and unpublished tables.

30 percent of all children born to HIV infected mothers in sub-Saharan Africa will be HIV positive either through the birth process or due to breast feeding. The relative impact of AIDS on infant mortality will depend on both the levels of HIV prevalence in the population and the infant mortality rate from other causes. In 1990⁸ infant mortality in Zimbabwe was 54; in 2000 it is 62. In Kenya, infant mortality in 1990 was 67, in 2000 it is 69. Without AIDS infant mortality in Zimbabwe would have been 30 and in Kenya it would have been 55.

In countries with less severe epidemics, such as in western and central Africa, infant mortality rates are higher than they would have been without AIDS. The increase ranges from 3 percent in Benin to 12 percent in Côte d'Ivoire and 15 percent in Rwanda.

In those countries most affected by AIDS in Latin America, the Caribbean and Asia, infant mortality rates are also higher than they would have been without AIDS. In Latin America and the Caribbean, infant mortality rates are 2 to 6 percent higher. And in Asia, infant mortality is 1 to 3 percent higher in Thailand, Burma and Cambodia.

In four countries of sub-Saharan Africa, more infants will die from AIDS in 2010 than from all other causes.

In Botswana and Zimbabwe, twice as many infants will die from AIDS than from all other causes. South Africa and Namibia are the other two countries where more infants will die from AIDS than from all other causes. Although overall infant mortality rates are projected to decline between 2000 and 2010, infant mortality due to AIDS is projected to increase.

The only projected decline in AIDS mortality among infants are for Uganda and Thailand.

In 26 sub-Sahara African countries, child mortality rates have increased over what they would have been without AIDS.

The impact on child mortality is highest among those countries who had significantly reduced child mortality due to other causes and where HIV prevalence is high. Many HIV infected children survive their first birthdays, only to die before the age of 5. In Zimbabwe, 70 percent of all deaths among children less than 5 are due to AIDS. In South Africa that percentage is 45.

In The Bahamas, 60 percent of deaths among children less than 5 are due to AIDS.

In Burma, Cambodia and Thailand, 1 percent of deaths among children are due to AIDS.

Based on current trends, child mortality rates in 2010 will continue to be much higher with AIDS than they would have been without AIDS.

In Zimbabwe and Botswana, where child mortality rates may have been below 30 without AIDS, over 150 children per 1000 will die. Of that total, 80 percent will be due to AIDS. In many of the countries in southern Africa, over 50 percent of childhood deaths will be due to AIDS. In Malawi and Mozambique, where child mortality rates due to other causes is already high, AIDS mortality will increase those rates by 30 percent.

In The Bahamas and Guyana, over 50 percent of childhood deaths will be due to AIDS.

In Asia, child mortality rates will be around 10 percent higher with AIDS mortality in Burma, Cambodia and Thailand, than they would have been without AIDS.

⁸ Figures for 1990 also include AIDS mortality.

Populations in most sub-Saharan African countries will continue to increase, despite the high levels of mortality. The exceptions are Botswana, South Africa and Zimbabwe.

Although AIDS mortality has resulted in lower growth rates, fertility is still high and populations growth is still positive. Populations will continue to increase. The exceptions are Botswana, South Africa and Zimbabwe. These populations will take a long time to rebound from the current levels of HIV prevalence and AIDS mortality even if current AIDS control programs result in lowering future HIV incidence and prevalence.

At the beginning of the 21st Century, AIDS is the number one cause of death in Africa and 4th globally.⁹

Emerging just 20 years ago, few would have predicted the current state of the epidemic, particularly in sub-Saharan Africa. That 25 percent of adults would be living with HIV/AIDS in any country was unthinkable. Yet, this is the current situation in 4 countries. In seven sub-Saharan African countries, at least 1 out of 5 adults are living with HIV/AIDS and in an additional 9 sub-Saharan African countries, 1 out of 10 adults is HIV positive.¹⁰

Many individuals have difficulty grasping the results of these high prevalence levels. The resulting AIDS mortality is difficult to comprehend. Yet given these current rates, many more millions of individuals will die due to AIDS over the next decade than have over the past 2 decades. In many of the southern African countries, they are only beginning to see the impacts of these high levels of HIV prevalence.

There have been success stories: Thailand, Senegal, and Uganda. In Thailand and Uganda, concerted efforts at all levels of civil society have turned around increasing HIV prevalence rates. In Senegal, programs put into place early in the epidemic have kept HIV prevalence rates low. These success can be repeated. However, the current burden of disease, death and orphanhood, will be a significant problem in many countries of sub-Saharan Africa for the near future.

⁹The World Health Report 1999, Making a Difference. World Health Organization, 1999.

¹⁰Report on the Global HIV/AIDS epidemic. UNAIDS/WHO June 2000



I-Demographics

UNITED STATES DEPARTMENT OF COMMERCE
Economics and Statistics Administration
U.S. Census Bureau
Washington, DC 20233-0001

June 30, 2000

Dear Colleague:

I am enclosing our latest research note (No. 27) based on information in our *HIV/AIDS Surveillance Data Base*, June 2000.

Research Note No. 27 is the "Recent HIV Seroprevalence Levels by Country: June 2000," which contains updated summary tables and maps showing seroprevalence estimates for high- and low-risk population groups by country and region. Tables are provided for HIV-1 and for HIV-2, where available, in major cities and in rural areas. Also, a third table provides detailed information for the data cited in the other two tables.

We welcome comments, suggestions, and additional material for our data base. Also, we would be pleased to add additional subscribers to our data base which is distributed at no charge on CD-ROM. Additional copies of our reports are also available.

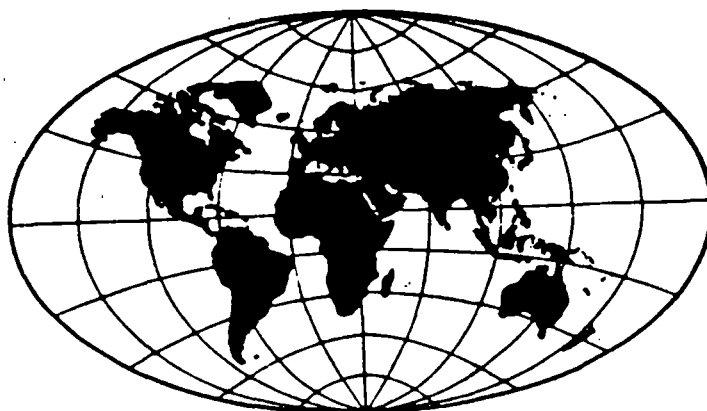
I hope that you will share these materials with your colleagues.

Sincerely,

Karen A. Stanecki
Chief, Health Studies Branch
International Programs Center
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E-mail: kstaneck@census.gov

Enclosure

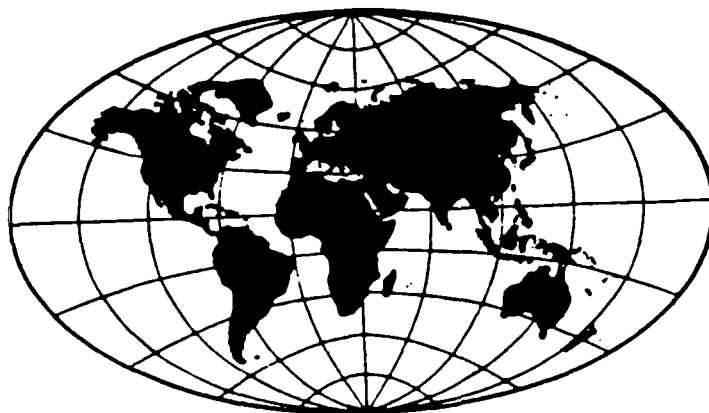
**RECENT HIV SEROPREVALENCE LEVELS
BY COUNTRY: JUNE 2000**



**Health Studies Branch
International Programs Center
Population Division
U. S. Census Bureau**

**Research Note
No. 27
June 2000**

**RECENT HIV SEROPREVALENCE LEVELS
BY COUNTRY: JUNE 2000**



**Health Studies Branch
International Programs Center
Population Division
U. S. Census Bureau**

**Research Note
No. 27
June 2000**

Preface

The International Programs Center of the Population Division conducts specialized studies of population, economics, labor force, health and aging issues. However, the use of data not generated by the U. S. Census Bureau precludes performing the same statistical reviews normally conducted on its own data.

This research note is the 27th of a series of short research documents resulting from analysis conducted in the Health Studies Branch. Distribution in the research note format is intended to allow for rapid dissemination of results to a specialized audience, highlighting recent developments or emerging trends. Reports containing a more thorough presentation and discussion of research findings will continue to be issued in the International Programs Center Staff Paper series.

The preparation of this report was supported by funding from the U.S. Agency for International Development.

This note was prepared by the staff of the Health Studies Branch ---- Jinkie Corbin, Laura Heaton, Maizie Archie, Lisa Mayberry, Vickie Hart-Spriggs and Jack Gibson and edited by Chief, Health Studies Branch - Karen A. Stanecki. Comments and questions regarding this study should be addressed to Karen A. Stanecki (kstaneck@census.gov), International Programs Center, Population Division, U. S. Census Bureau, Washington, D.C. 20233-8860; telephone (301) 457-1406.

RECENT HIV SEROPREVALENCE LEVELS BY COUNTRY: June 2000

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Recent HIV Seroprevalence Levels by Country: June 2000

Introduction

Since 1987, the International Programs Center, Population Division, U. S. Census Bureau, has been compiling HIV seroprevalence information for its *HIV/AIDS Surveillance Data Base*. This work has been supported by funding from the U.S. Agency for International Development.

The present update to the data base incorporates all available epidemiological information for developing countries presented at the following Conference on AIDS, 5th International Congress on AIDS in Asia and the Pacific, Kuala Lumpur 1999, and XI International Conference on AIDS and STDs in Africa, Lusaka, and Zambia. Currently, the *HIV/AIDS Surveillance Data Base* contains about 53,139 individual data records drawn from 5,065 publications and presentations. It is our goal to incorporate all available data from seroprevalence studies conducted in developing countries.

Several items drawn from the data base are included in this report. These include summary tables showing available seroprevalence estimates for high- and low-risk population groups in major cities and outside major cities for all developing countries. Tables are provided for HIV-1 and HIV-2, where available. A figure showing the most recent data for pregnant women from the capital city or major urban centers of the most affected countries in each region is included. Urban data for Africa and three Asian countries, Cambodia, Thailand, and Vietnam have been plotted on maps as well, showing the distribution by country. A brief review of data quality issues and discussion of selection criteria follows. We recognize the somewhat arbitrary nature of this selection and welcome comments.

Data Quality and Qualifications

With rare exception, surveys of HIV seroprevalence are not based on national samples. Therefore, every seroprevalence estimate has a bias if generalized beyond its sample population. The amount of bias is determined by how different the sampled population group or geographic area is from the generalized description placed on the estimate. For instance, an estimate of the HIV seroprevalence of pregnant women in Kampala, Uganda, may be generalized to "urban, low-risk group." Yet, Kampala is not representative of all urban areas in Uganda, and pregnant women are not representative of all low-risk adults (since by definition they may be more sexually active than many low-risk groups, such as the aged).

Several factors contribute to biases or confusion surrounding HIV seroprevalence estimates:

- Sample-Size Bias: The sample sizes of seroprevalence studies are generally very small. Small samples of non-random populations may tend to overestimate the seroprevalence.
- Nonrepresentative Samples: Many surveys are taken of populations convenient for the medical team drawing blood for testing. Therefore, many are "samples of convenience," taken in clinics or hospitals where the available sample of people may be sicker than those who do not attend the clinic.
- Geographic Bias: As in the case of samples of convenience, samples may also be taken in more-accessible rather than less-accessible geographic areas. Given what is known regarding the spread of HIV infection, we would expect that this would tend to bias upward the estimate of HIV seroprevalence, if the available sources are taken to represent the country as a whole. Note, however, that this particular factor may not bias estimates of seroprevalence in the geographic areas that were, in fact, surveyed.
- Testing Bias: In the first several years of the AIDS epidemic, the ELISA test was the predominant test used to determine seropositivity. The ELISA test, however, gives a number of false positives and, therefore, the test results must be confirmed by a second test; in general, the Western Blot. Not all studies report confirmatory testing, although they increasingly do so.
- HIV-1 and HIV-2 Overlap: In countries where both HIV-1 and HIV-2 are present, tests are done for both viruses and often find people who test positive for both. To report the people who are only infected with HIV-1 will understate the total infected population because it does not take into account the joint infections. Thus, care must be used in discussions of data from these areas to avoid either double counting or omitting various categories of infected population.

In order to minimize the biases and confusion in using current seroprevalence estimates, we have developed several criteria to select the most representative sample estimate:

- larger samples are generally favored over smaller samples;
- more recent estimates are selected over older estimates; and
- better-documented data are usually selected over poorly-documented data; data without documentation are not used.

These criteria only attempt to minimize the biases in the data, not eliminate them. Therefore, all seroprevalence data must be used with caution.

Data Organization

The data presented in the following seroprevalence tables are taken from the *HIV/AIDS Surveillance Data Base*. The specific rates presented are taken from the most recent studies with a sufficiently large sample size. Where recent data are not available and where sample sizes are small, footnotes qualify the data. In some cases, results from large samples were not included due to insufficient documentation about the sample design, tests or place. The data are imperfect and caution should be used in drawing conclusions. Although they are listed by country name, they are not national level estimates. We can only draw conclusions for the area where these studies were conducted.

The tables that follow are based on data selected as the best available data on HIV-1 and HIV-2 seroprevalence among high- and low-risk populations in developing countries (see Tables 1 and 2). The terms "high risk" and "low risk" are used in these tables and charts to differentiate population subgroups with known risk factors for HIV infection from those without such known risks. As a result of the various transmission modes and the prevalence of the virus in Africa, no group can be considered to have no risk of infection. Sampled populations treated as high risk in this report include prostitutes, bar girls, etc.; clients of prostitutes; and sexually-transmitted disease clinic patients. Sampled populations considered to be low risk include the general population with no known risk, pregnant women, and blood donors.

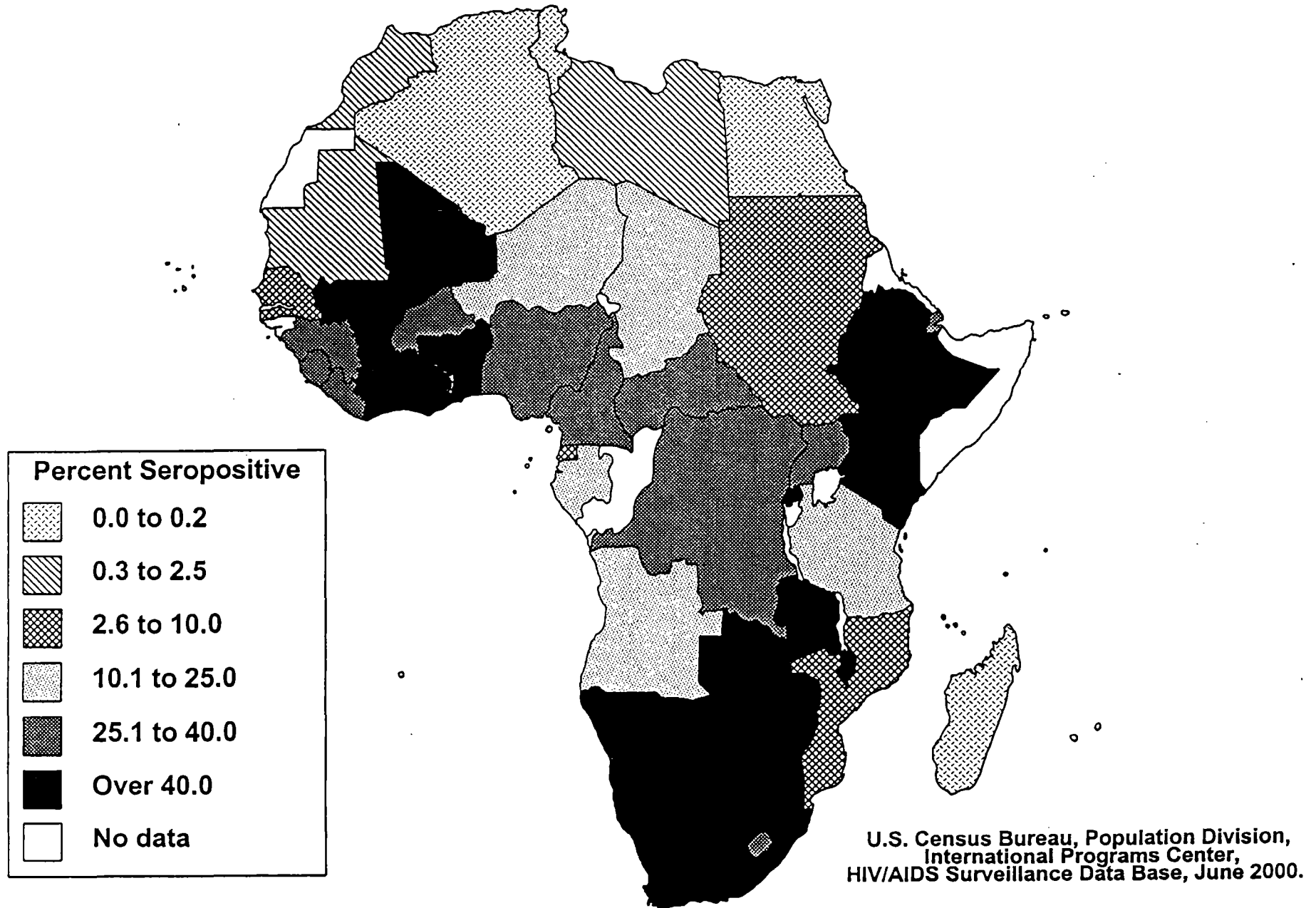
Data were selected using criteria of sample size, recency of data, presence of two diagnostic tests, and minimal evident bias in sample selection, given the target population. Since each figure is based on a single study, it is not an average or composite figure. As yet, there are insufficient comparable studies to make estimates of an "average" seroprevalence meaningful. Detailed sample information for these studies is contained in Table 3. Sources for the data shown in the tables are contained in a unified reference listing.

The tables are also divided by Capital/Major City and Outside Major City. In many studies it is difficult to determine whether or not the universe is a strictly rural area. The geographical boundaries may include some urbanized centers. Is a sample drawn from three villages necessarily a study of the rural population? When the study area is described as a province in the country it is listed in the table as outside the capital/major city. It is usually fairly clear when a study is conducted in the capital or a major city.

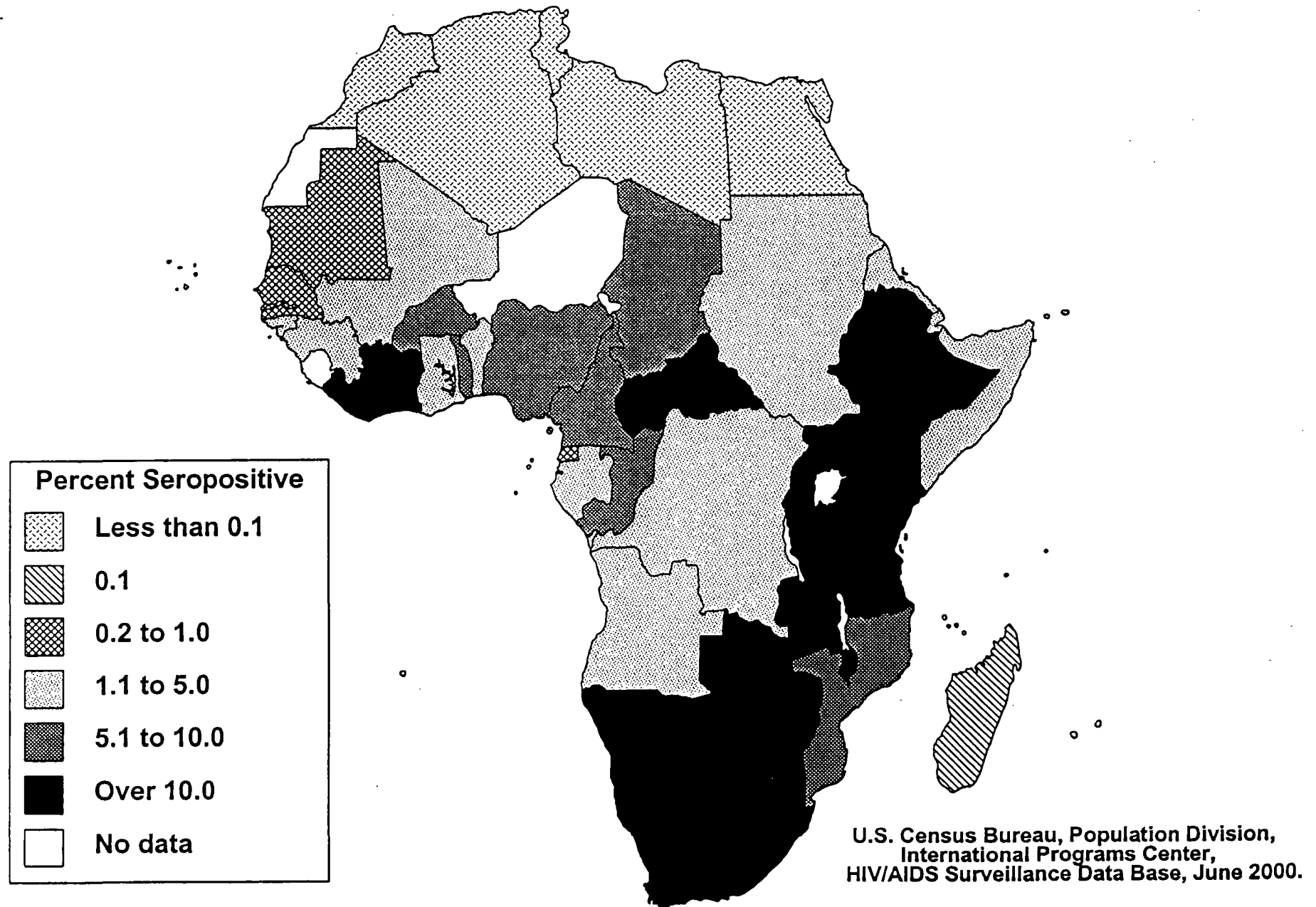
We will periodically update these materials with the latest and best available data, at times including a brief discussion of a topic of particular interest.

We welcome comments and suggestions from users of the data base. We also welcome copies of articles or references to information which may have been overlooked.

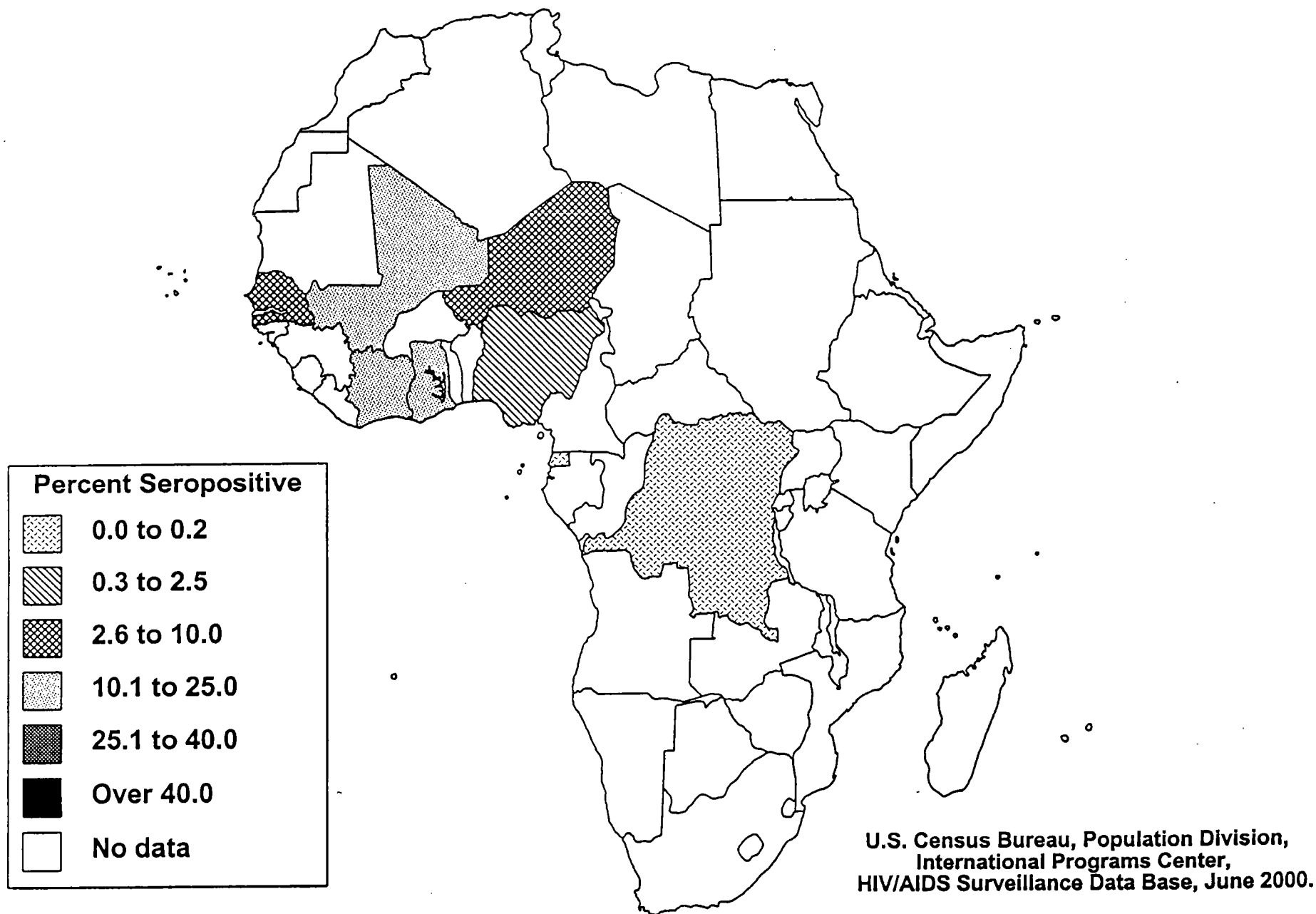
African H V-1 Seroprevalence for High-Risk Urban Populations



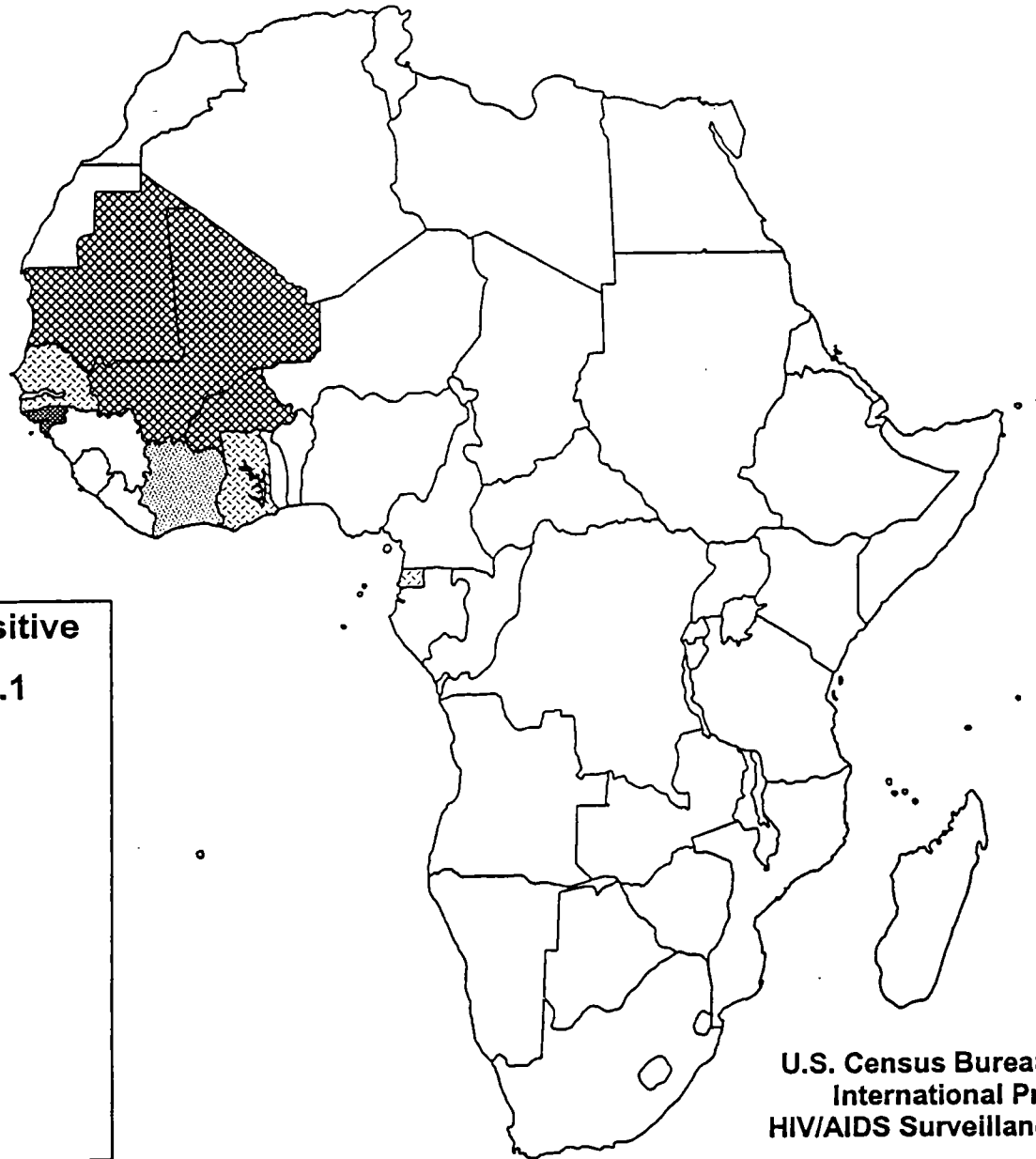
African HIV-1 Seroprevalence or Low-Risk Urban Populations



African HIV-2 Seroprevalence for High-Risk Urban Populations

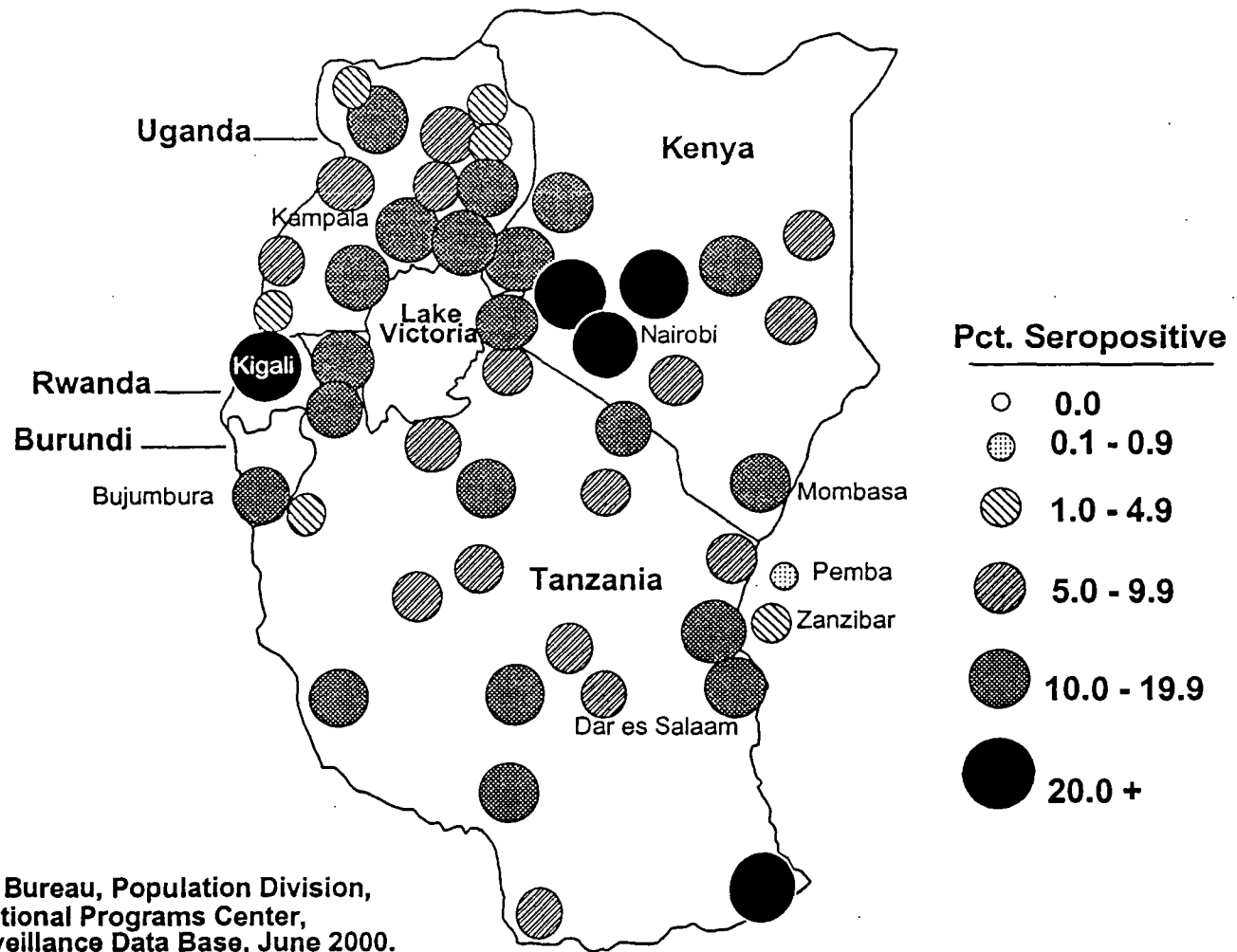


African HIV-2 Seroprevalence for Low-Risk Urban Populations

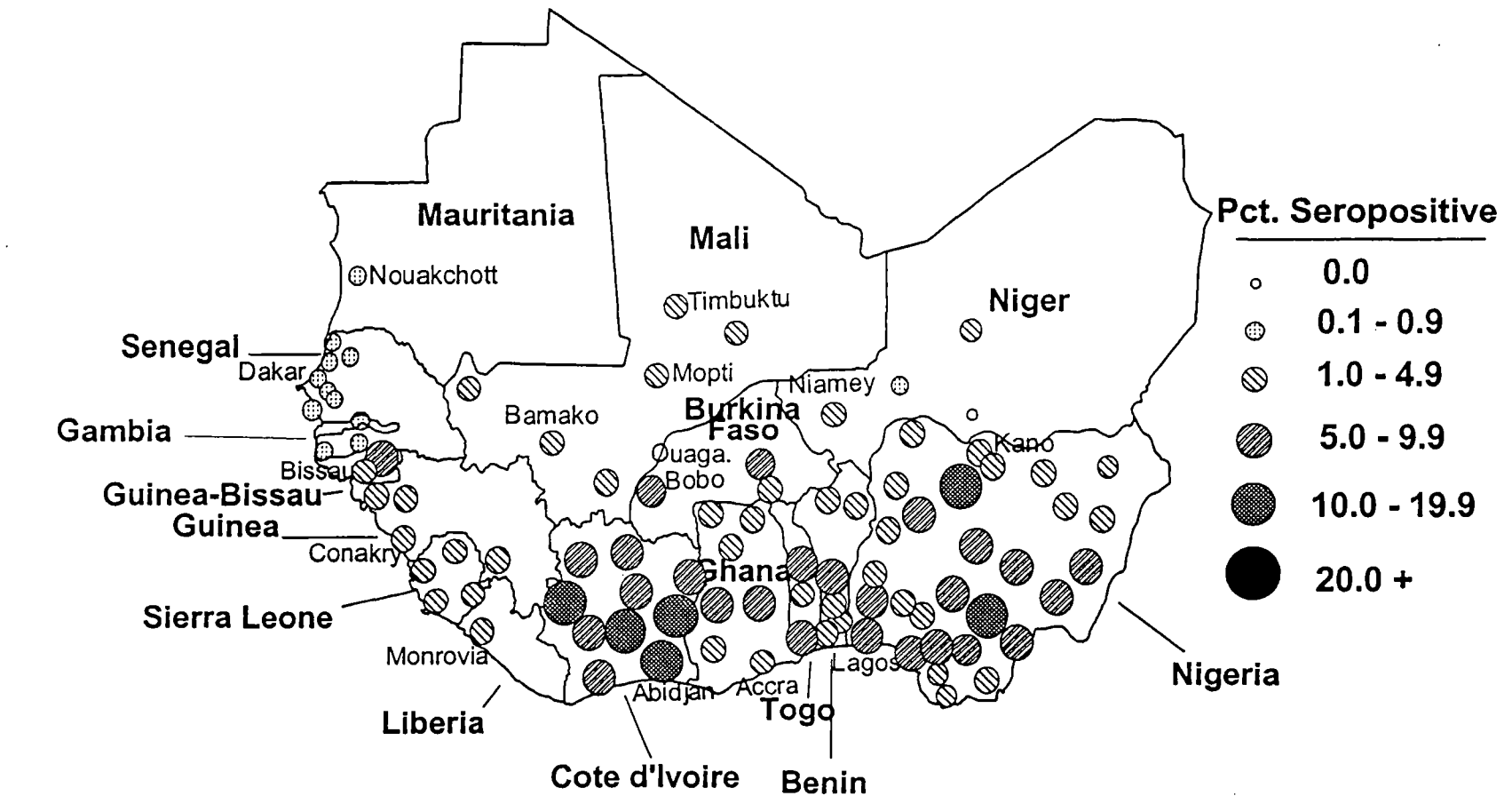


**U.S. Census Bureau, Population Division,
International Programs Center,
HIV/AIDS Surveillance Data Base, June 2000.**

Seroprevalence of HIV-1 for Low-Risk Populations in East Africa



Seroprevalence of HIV-1 for Low-Risk Populations in West Africa



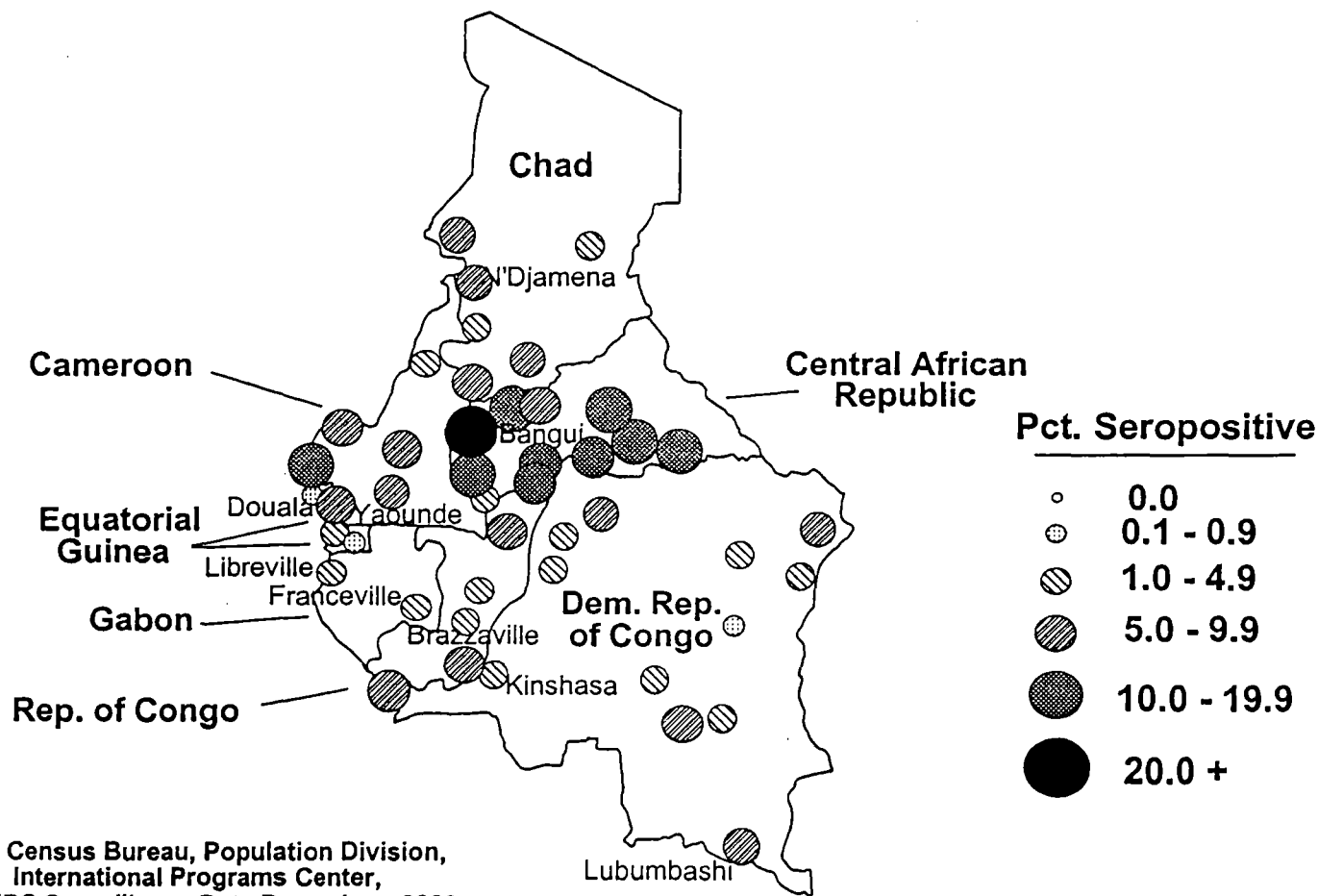
U.S. Census Bureau, Population Division,
International Programs Center,
HIV/AIDS Surveillance Data Base, June 2000.

Seroprevalence of HIV-2 for Low-Risk Populations in West Africa



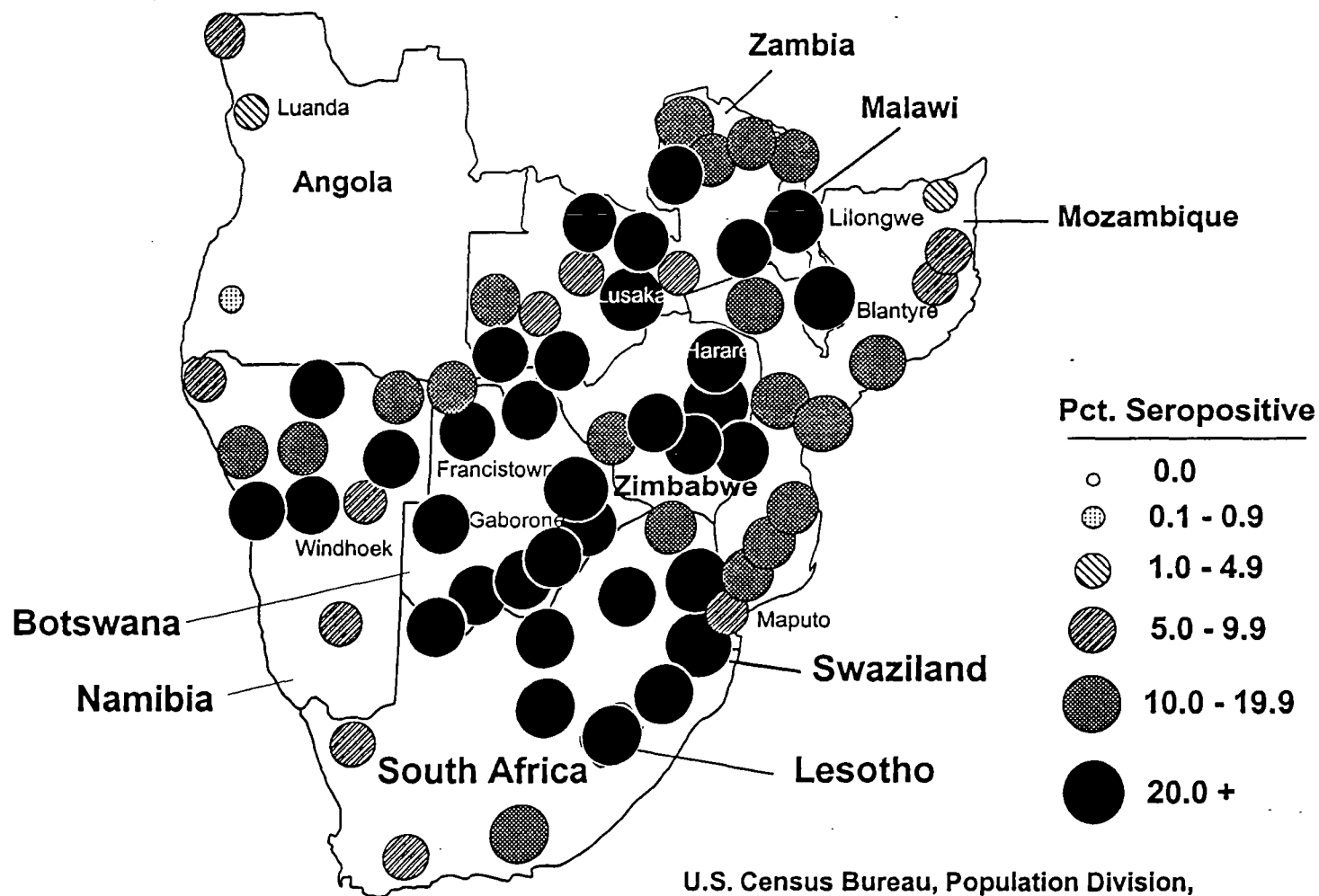
U.S. Census Bureau, Population Division,
International Programs Center,
HIV/AIDS Surveillance Data Base, June 2000.

Seroprevalence of HIV-1 for Low-Risk Populations in Central Africa



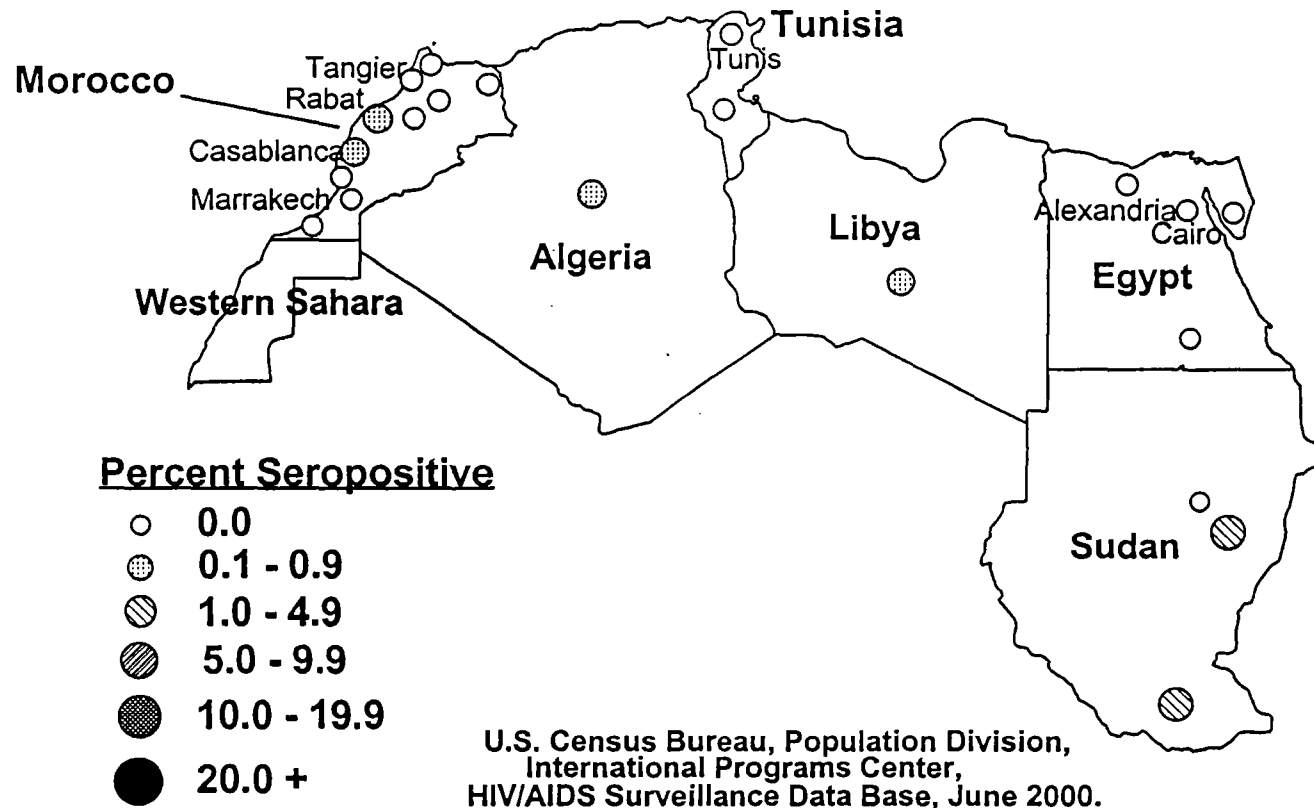
U.S. Census Bureau, Population Division,
International Programs Center,
HIV/AIDS Surveillance Data Base, June 2000.

Seroprevalence of HIV-1 in Low-Risk Populations in Southern Africa

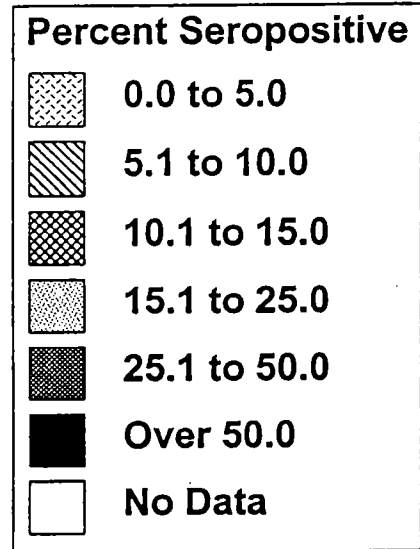
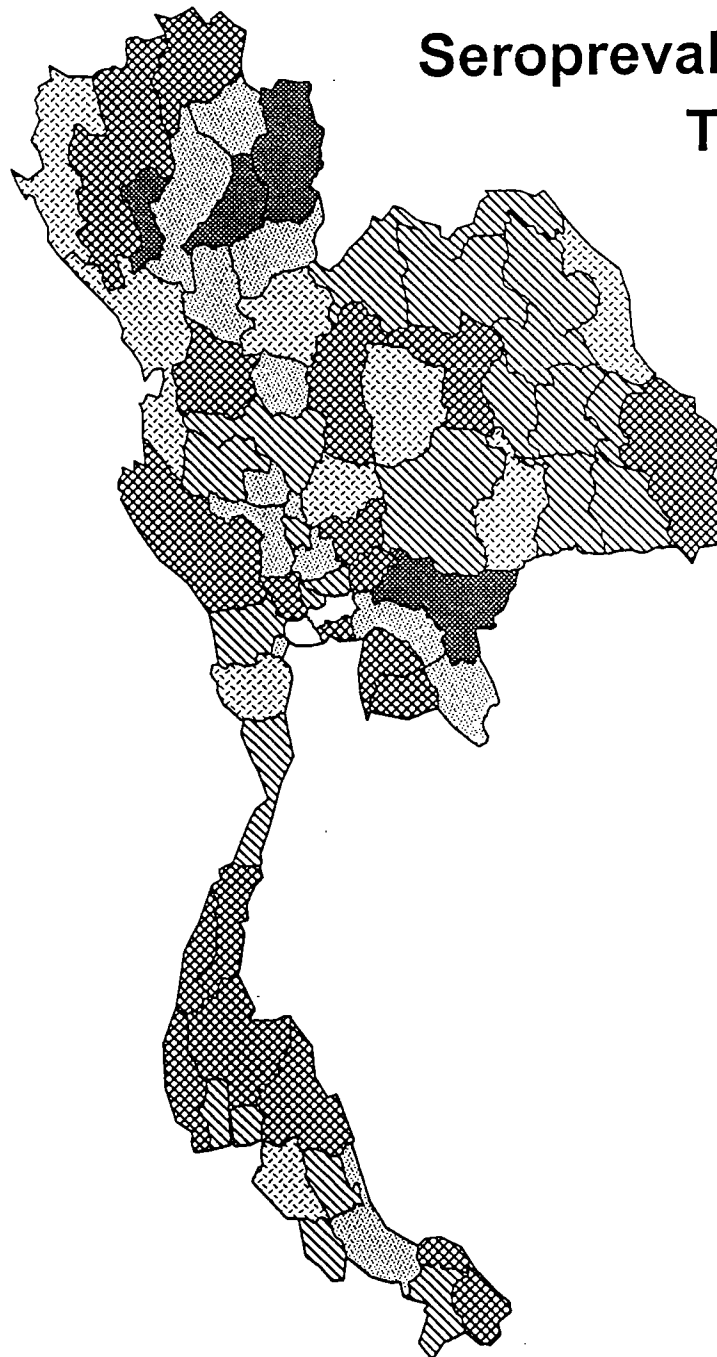


U.S. Census Bureau, Population Division,
International Programs Center,
HIV/AIDS Surveillance Data Base, June 2000.

Seroprevalence of HIV-1 for Low-Risk Populations in North Africa

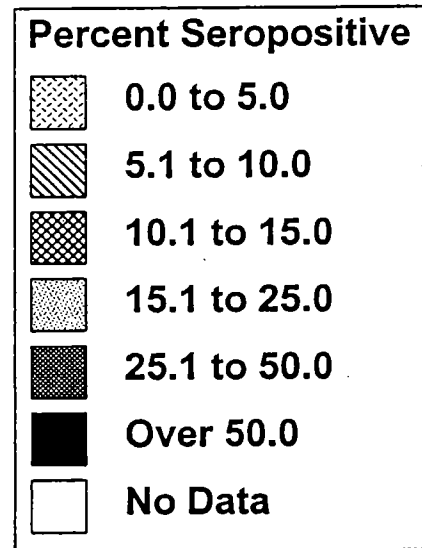
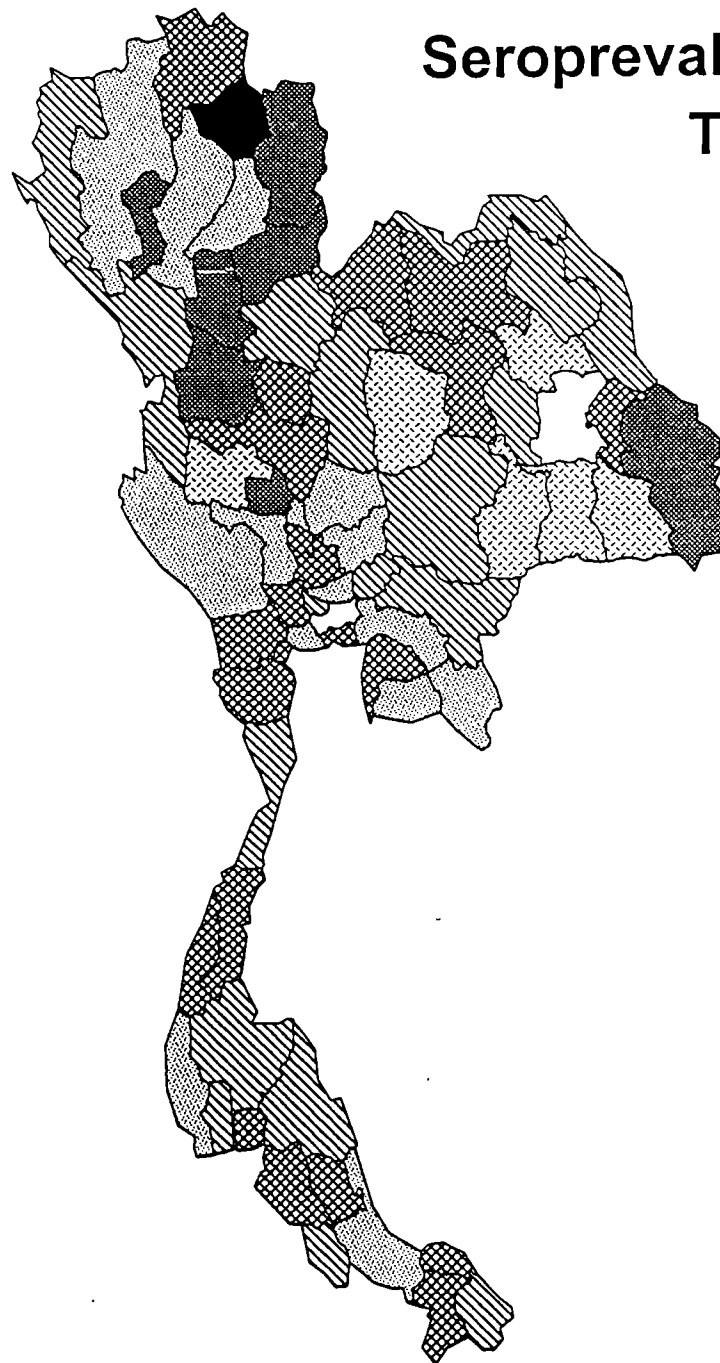


Seroprevalence of HIV-1 for Prostitutes Thailand: June 1999



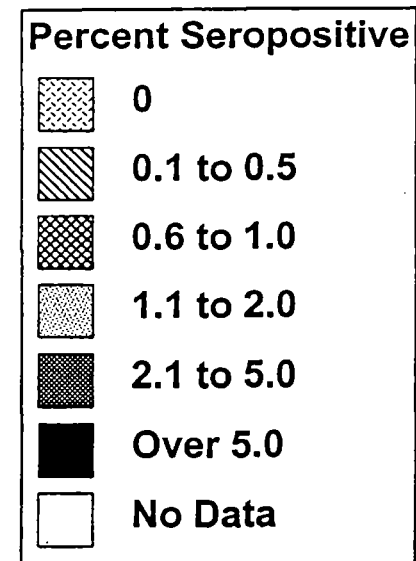
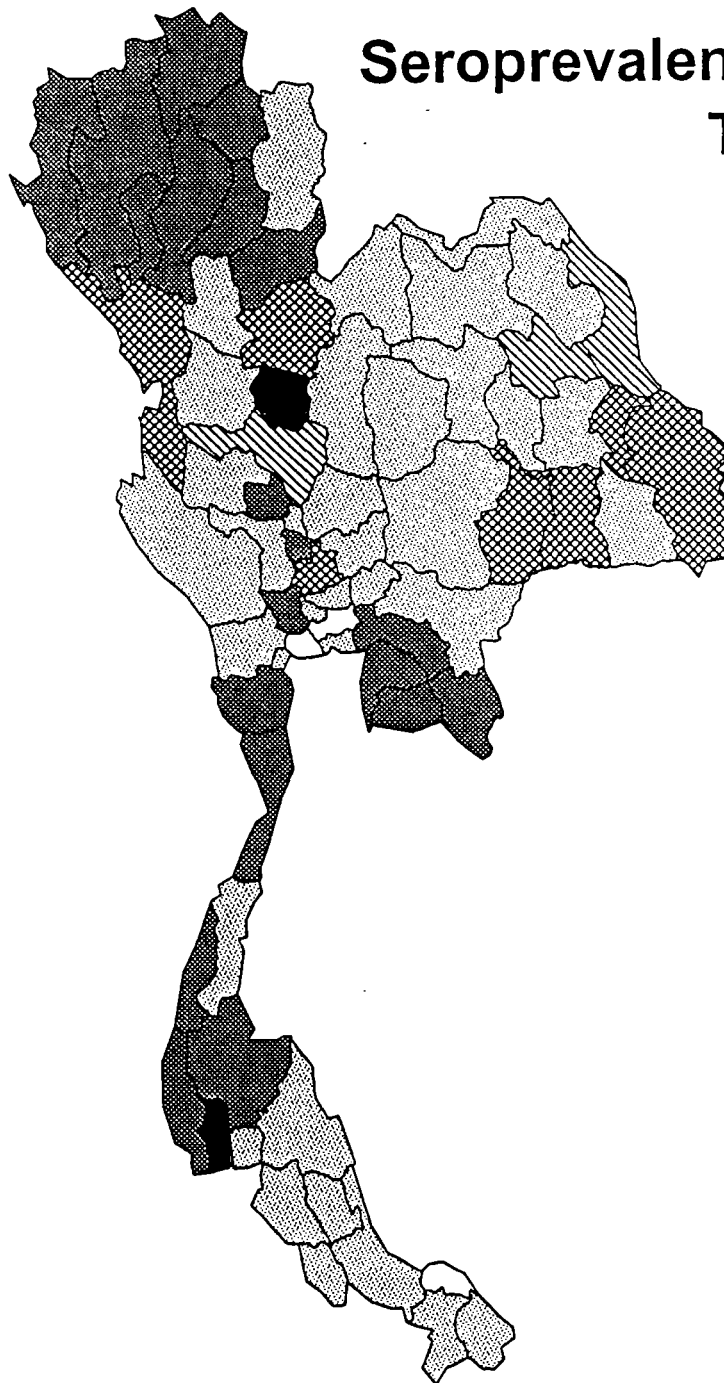
U.S. Census Bureau, Population Division,
International Programs Center,
HIV/AIDS Surveillance Data Base, June 2000.

Seroprevalence of HIV-1 for Prostitutes Thailand: June 1998



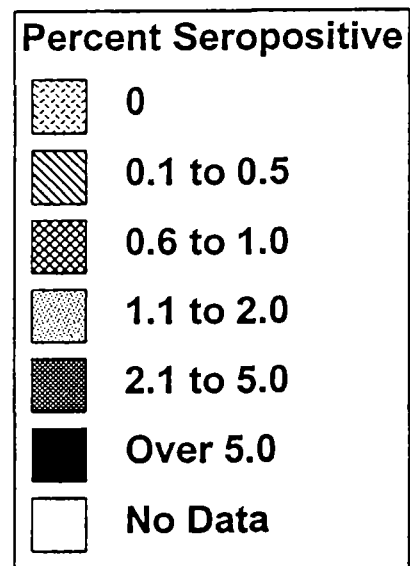
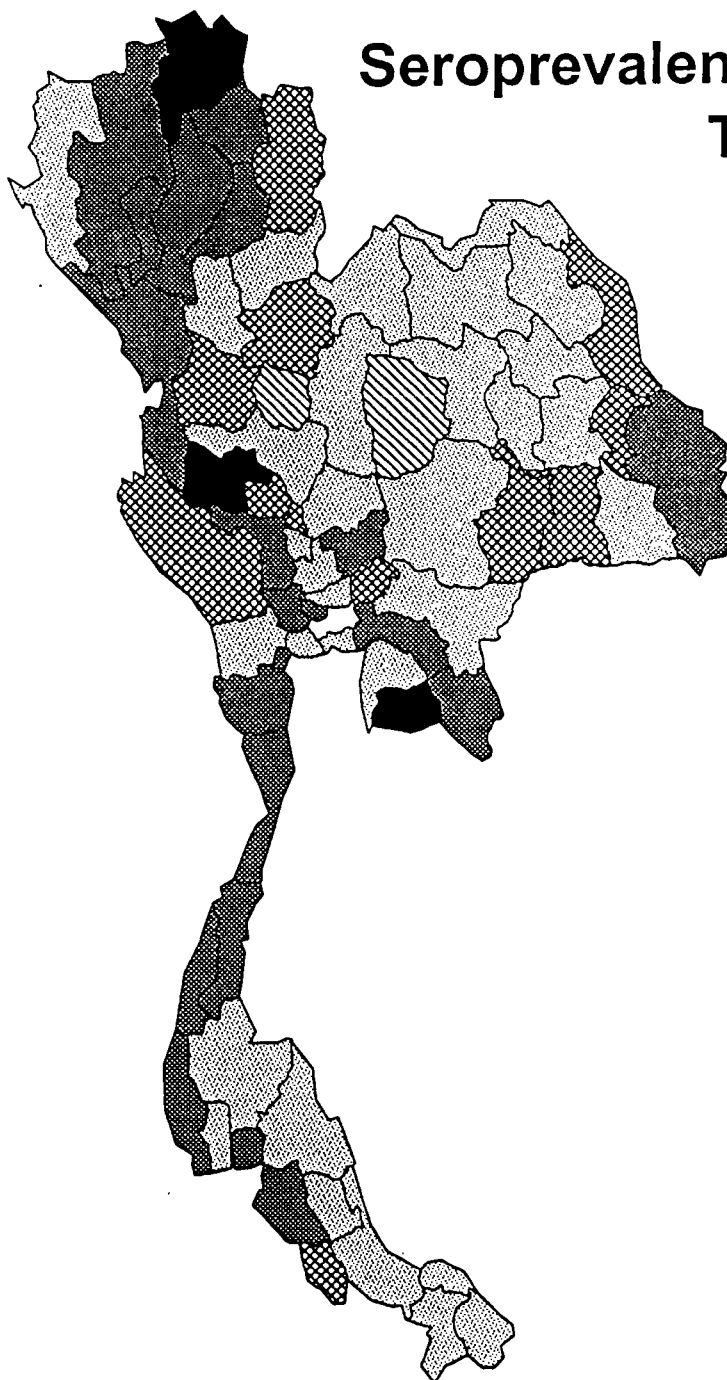
U.S. Census Bureau, Population Division,
International Programs Center,
HIV/AIDS Surveillance Data Base, June 2000.

Seroprevalence of HIV-1 for Pregnant Women Thailand: June 1999



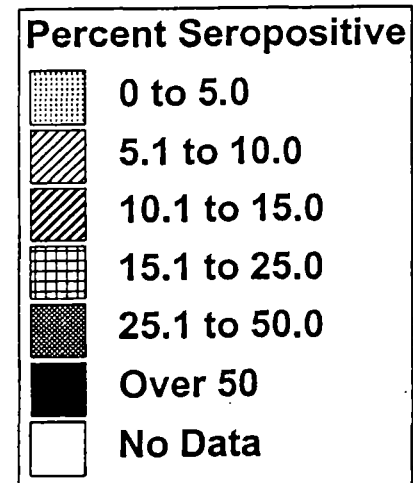
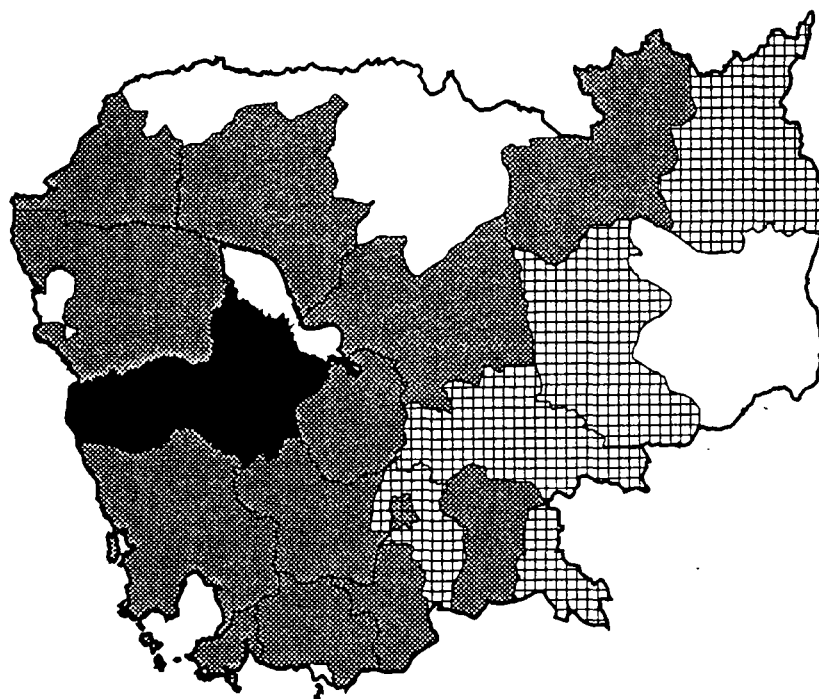
U.S. Census Bureau, Population Division,
International Programs Center,
HIV/AIDS Surveillance Data Base, June 2000.

Seroprevalence of HIV-1 for Pregnant Women Thailand: June 1998



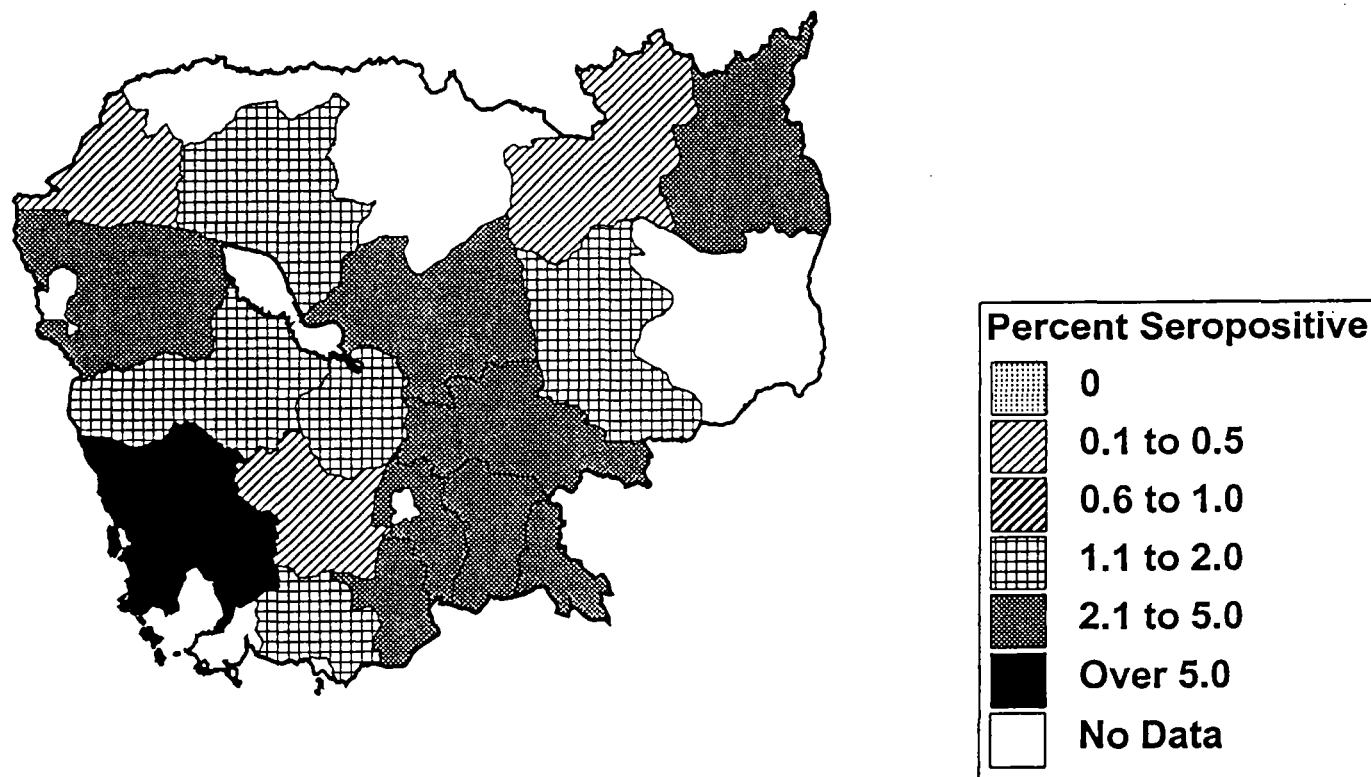
U.S. Census Bureau, Population Division,
International Programs Center,
HIV/AIDS Surveillance Data Base, June 2000.

HIV Seroprevalence among Prostitutes in Cambodia: 1998



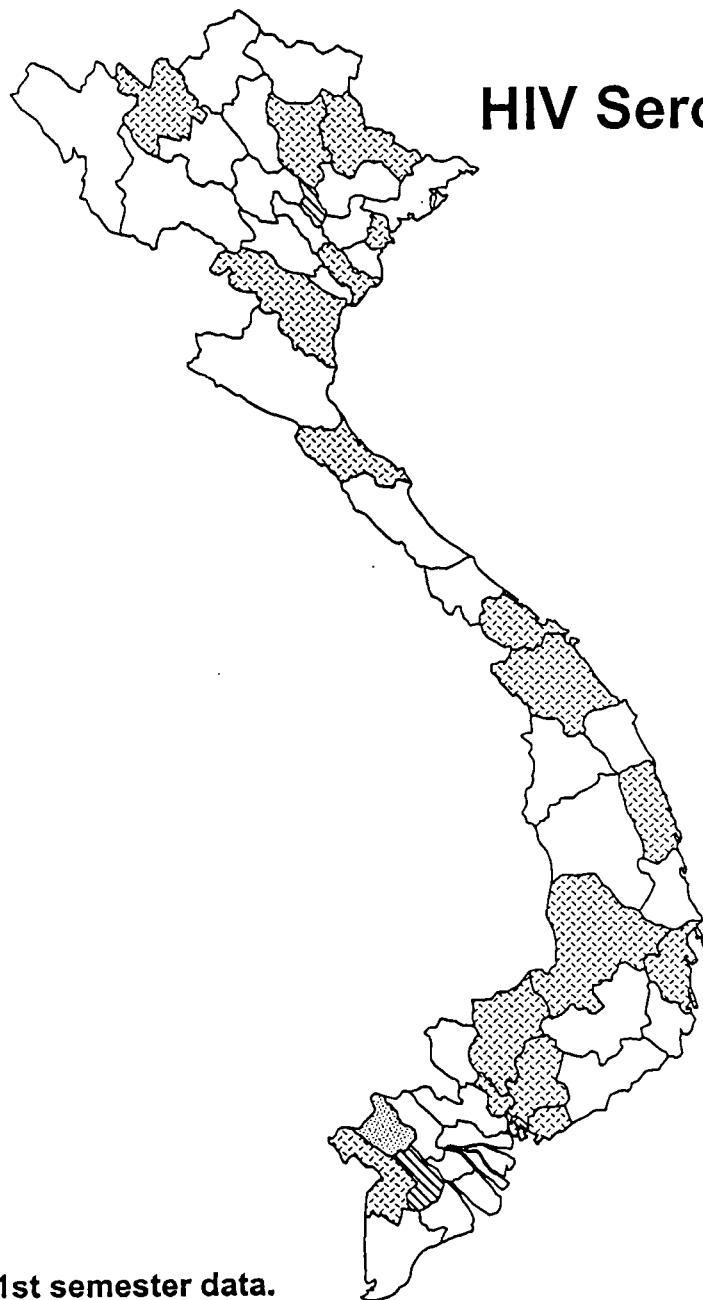
U.S. Census Bureau, Population Division,
International Programs Center,
HIV/AIDS Surveillance Data Base, June 2000.

HIV Seroprevalence among Married Women of Reproductive Age in Cambodia: 1998

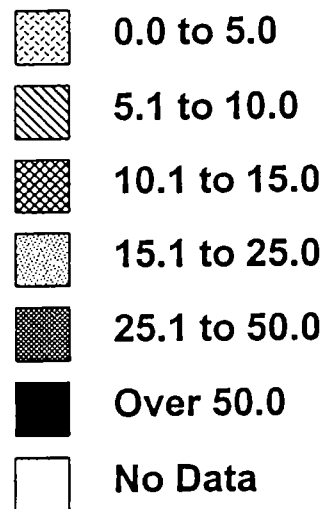


U.S. Census Bureau, Population Division,
International Programs Center,
HIV/AIDS Surveillance Data Base, June 2000.

HIV Seroprevalence among Prostitutes Vietnam: 1999



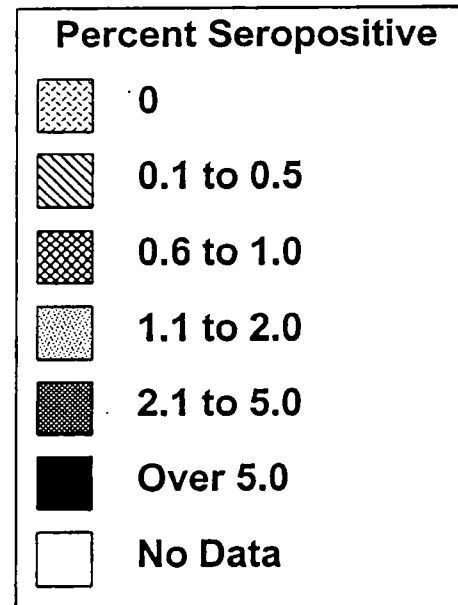
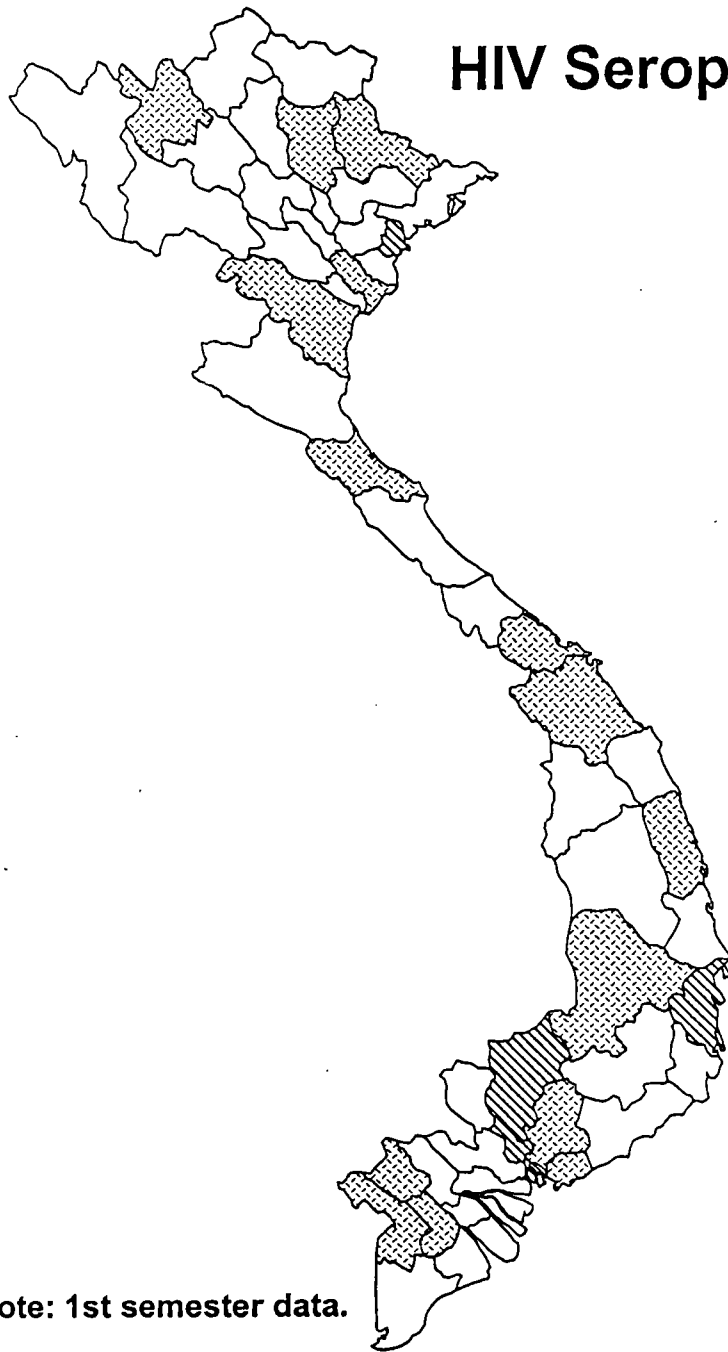
Percent Seropositive



Footnote: 1st semester data.

U.S. Census Bureau, Population Division,
International Programs Center,
HIV/AIDS Surveillance Data Base, June 2000.

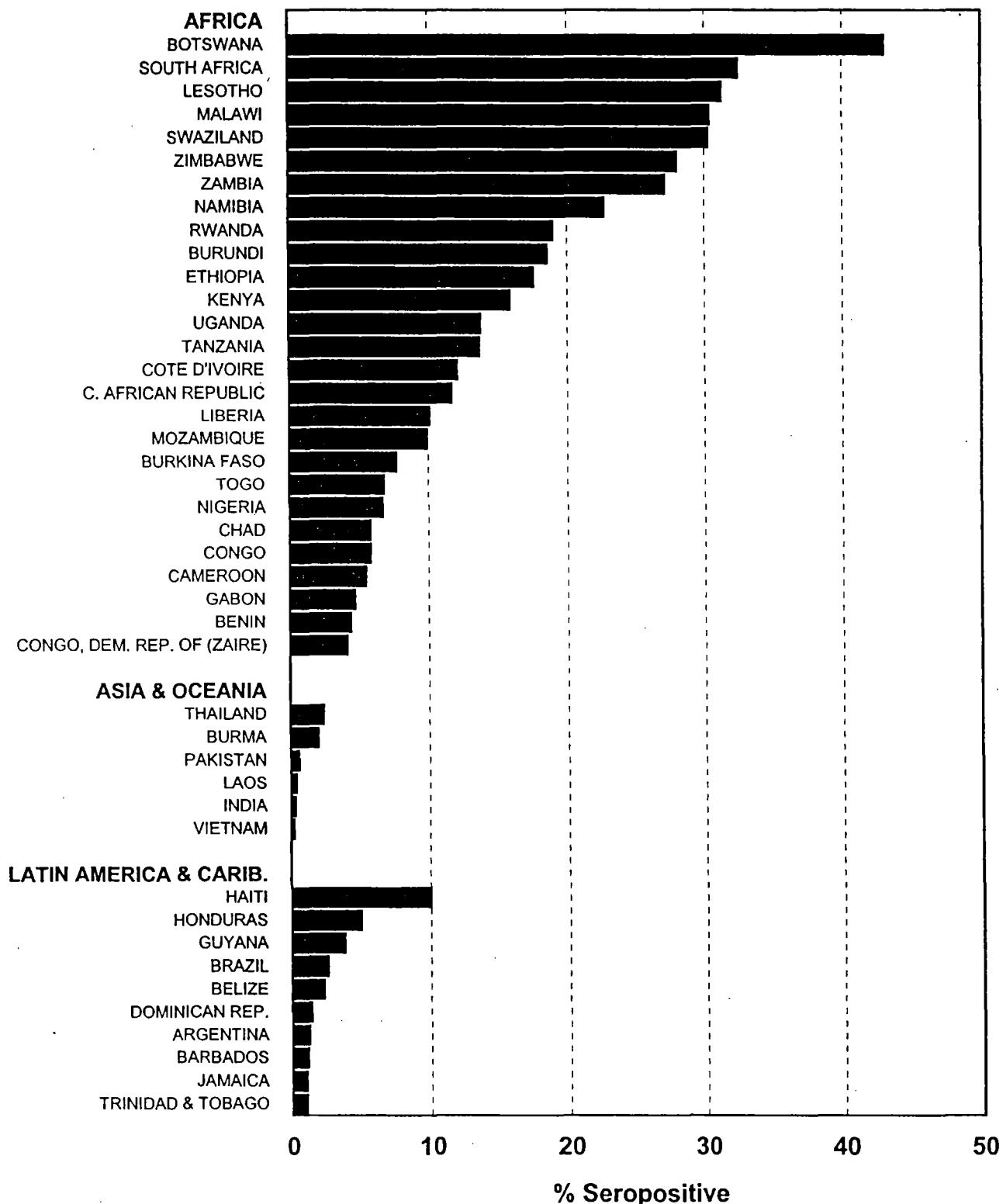
HIV Seroprevalence among Pregnant Women Vietnam: 1999



Footnote: 1st semester data.

U.S. Census Bureau, Population Division,
International Programs Center,
HIV/AIDS Surveillance Data Base, June 2000.

HIV-1 Seroprevalence Among Pregnant Women from Capital City or Major Urban Centers in Selected Countries



Footnote: Based on the most recent available data.

Table 1: Estimates of HIV-1 Seroprevalence, by Residence and Risk Factor, for Selected Countries: Circa 1999

Region and Country	Capital/Major City		Outside Major City		Urban City Sources		Outside City Sources	
	Low Risk	High Risk	Low Risk	High Risk	Low Risk	High Risk	Low Risk	High Risk
AFRICA								
Algeria	.0	.0	-	-	R0196	R0196		
Angola	3.4 b	19.4 b	8.0 b	-	U0057	G0264	G0264	
Benin	4.4 c	57.5	1.5	5.9	A0229	B0406	A0229	A0229
Botswana	43.0	60.4	32.7 c	50.8 c	J0074	J0074	J0074	J0074
* Burkina Faso	7.7 ac	28.6	6.6 a	-	B0393	O0101	B0393	
Burundi	18.6	-	3.9	-	N0239		B0386	
* Cameroon	5.5	33.3	6.7	9.0	M0614	B0406	B0344	Z0045
Cape Verde	-	-	-	-				
Central African Rep.	11.7 c	27.9	15.3	33.3	M0541	M0610	M0541	M0541
Chad	5.8 c	13.4	5.0 c	21.6 bc	C0312	A0200	C0312	C0312
					C0313		C0313	C0313
Comoros	.0	56.8	-	-	T0171	D0227		
Congo	5.8	-	-	-	P0186			
* Congo, Dem. Rep.	4.1 c	29.0	3.9	-	D0246	M0549	B0389	
* Cote d'Ivoire	12.1 a	61.0 ab	9.8 b	-	K0309	G0223	S0492	
Djibouti	2.4	28.2	-	-	B0362	B0362		
Egypt	.0	.0	-	-	S0486	S0486		
* Equatorial Guinea	.4	3.2	.3	2.2	Z0077	Z0077	S0397	S0397
Eritrea	3.0 b	-	-	25.0 b	T0147			T0147
Ethiopia	17.6 bc	73.7	9.2	16.2 b	S0443	A0237	A0230	A0230
Gabon	4.7	16.7 b	-	-	M0535	M0535		
Gambia, The	1.0	-	2.4 bc	-	L0247		L0247	
* Ghana	2.7 c	72.6 a	3.4 a	-	G0261	M0558	G0261	
Guinea	1.5 b	36.6	1.4 b	-	N0215	B0271	N0215	
* Guinea-Bissau	2.6 a	-	3.4	-	N0209		C0265	
Kenya	15.9	74.7	5.6 b	-	J0076	B0406	N0253	
Lesotho	31.3	35.6	27.1	40.7	L0272	M0515	U0054	U0054
Liberia	10.1 b	28.7 b	-	-	L0279	E0064		
Libya	.0	.5	-	-	S0486	S0486		
Madagascar	.1	.0	.4	1.3	R0143	I0049	R0173	I0049
Malawi	30.4	70.4	11.2	-	N0243	K0233	N0243	
* Mali	2.5 a	42.1 a	2.2	-	B0341	K0254	C0207	
* Mauritania	.5 a	.9	-	1.7	A0166	A0166		A0173
Mauritius	-	-	.0	7.5			M0594	M0594
Mayotte	-	-	-	-				
Morocco	.0	.9 b	-	-	M0590	M0590		
Mozambique	9.9	9.0 b	17.0	27.3 b	A0228	A0228	A0228	A0228
Namibia	22.7	44.6	12.6	27.7 b	N0251	N0251	N0251	N0251
* Niger	-	23.6 a	2.1 a	33.6 a		H0141	O0093	A0212
* Nigeria	6.7 c	30.5 a	5.0	60.6 a	A0245	E0059	A0245	E0059
Reunion	-	-	-	-				
Rwanda	19.0 bc	42.1 c	7.5 b	13.2	V0091	V0089	V0091	V0089
St. Helena	-	-	-	-				
Sao Tome & Principe	-	-	-	-				
* Senegal	.4 a	6.1 a	.5 a	21.9 a	S0485	S0485	S0485	S0485
Seychelles	-	1.6 b	-	-		C0266		

Table 1: Estimates of HIV-1 Seroprevalence, by Residence and Risk Factor, for Selected Countries: Circa 1999

Region and Country	Capital/Major City		Outside Major City		Urban City Sources		Outside City Sources	
	Low Risk	High Risk	Low Risk	High Risk	Low Risk	High Risk	Low Risk	High Risk
Sierra Leone	-	26.7	-	-	K0209			
Somalia	3.0	-	1.0	-	A0231		A0231	
South Africa	32.5 b	50.3	9.9 b	-	R0204	R0180	R0204	
Sudan	3.5 b	6.6	-	-	S0480	M0554		
Swaziland	30.3	49.8	31.5	49.5	S0444	S0444	S0444	S0444
Tanzania	13.7	24.4 b	18.2 bc	27.3 c	K0308	M0563	T0208	T0207
Togo	6.8	78.9	4.6	-	T0177	B0020	T0177	
Tunisia	.0	.0	-	-	S0486	S0486		
		.3				S0486		
Uganda	13.8 bc	29.4 b	7.7 b	-	U0049	U0049	U0049	
Western Sahara	-	-	-	-				
Zambia	27.1 c	68.7	10.3	-	N0241	B0406	N0241	
Zimbabwe	28.0	86.0	29.3	71.8	Z0076	M0433	Z0076	Z0061
ASIA AND OCEANIA								
Australia	.3 b	.4	-	-	K0245	N0222		
Bahrain	.2	.9	-	-	B0164	B0164		
Bangladesh		.6	-	-		I0050		
		2.5				I0050		
Burma	2.0	16.1	.8	2.0	M0620	M0620	M0620	M0620
Cambodia	3.8	61.3	2.5	28.0	S0476	S0476	S0476	S0476
China, Hong Kong	.0	.1	-	-	W0112	L0156		
China, Mainland	.0	2.3 bc	-	-	F0097	Q0013		
		25.6 c				C0315		
China, Taiwan		.0	-	-		Y0031		
		7.7				C0308		
Cyprus	.0	.0	-	-	S0486	S0486		
India	.3 c	.8	.3	5.6	N0252	N0252	N0252	N0252
	2.6 c	56.3 c						
Indonesia	.0	.2	-	.0	D0253	P0218		C0307
Iran	.0 b	.5	-	-	S0486	S0486		
Iraq	.0	.0	-	-	S0486	S0486		
Japan	.0	19.4	-	-	K0333	I0045		
Jordan	.0	.0	-	-	S0486	S0486		
Kuwait	.0	.0	-	-	K0303	S0486		
		.0				S0486		
Laos	.4	-	-	-	L0262			
Lebanon	.0	.0	-	-	S0486	S0486		
Malaysia	.0	6.3	.1	.9	I0054	I0054	J0058	J0058
		16.8				I0054		
Nepal	-	16.0	-	4.3		T0211		R0198
New Zealand	.0	.5	-	-	N0242	N0242		
Oman	.0	.0 b	-	-	S0486	S0486		
Pakistan	.6	3.7	-	-	P0144	P0144		
Papua New Guinea	.2	1.9	-	-	M0506	M0506		
Philippines	.0	.0	-	-	W0112	D0210		
Qatar	.0	4.5	-	-	S0486	S0486		
Singapore	.0	3.7 b	-	-	W0112	G0161		

Table 1: Estimates of HIV-1 Seroprevalence, by Residence and Risk Factor, for Selected Countries: Circa 1999

Region and Country	Capital/Major City		Outside Major City		Urban City Sources		Outside City Sources	
	Low Risk	High Risk	Low Risk	High Risk	Low Risk	High Risk	Low Risk	High Risk
Sri Lanka	.0	.0	.0	.0	S0484	S0484	S0484	S0484
Syria	.0	.1	-	-	S0486	S0483		
Thailand	2.4	19.1	-	-	T0216	T0216		
Turkey	.0	.1	-	-	T0203	T0203		
Vietnam	.2	4.9b	.0	.6	H0145	H0145	H0145	H0145
		26.9		12.4		H0145		H0145
Yemen	.0	2.9	-	-	S0486	S0486		
LATIN AMERICA/CARIBBEAN								
Argentina	1.2	10.8	.5	2.8	B0390	B0390	B0390	B0390
Barbados	1.1	-	-	-	P0200			
Belize	2.3	-	-	-	P0142			
Bolivia	.5	2.0b	-	-	Z0075	Z0075		
Brazil	2.6	6.0c	.6c	2.8c	V0093	C0279	C0279	C0279
Chile	.1b	3.0b	.0b	-	C0271	C0271	C0271	
Colombia	1.1	3.4	.4	.6	G0184	G0184	G0184	G0184
Costa Rica	.3	.9	.1	-	M0574	H0139	M0574	
Cuba	.0	-	-	-	M0484			
Dominican Rep.	1.4	3.9	2.1	4.5	R0188	R0188	R0188	R0188
El Salvador	.5	6.0	-	-	D0202	D0202		
Guatemala	.4	1.1	-	.8	C0251	C0251		C0250
Guyana	3.8	43.6	-	-	W0121	P0197		
Haiti	10.0b	-	4.8	-	G0225		C0284	
Honduras	5.0b	13.0	1.4b	3.0	T0200	B0383	M0495	B0383
Jamaica	1.0	6.4	-	-	J0059	J0059		
Mexico	.1	1.0	-	-	L0238	S0468		
Nicaragua	-	.2	-	-		P0177		
Panama	.9	.3	-	-	G0263	G0263		
Peru	.5	5.0	-	-	A0188	G0209		
Trinidad & Tobago	1.0b	5.9	-	-	L0234	L0243		
Uruguay	.1c	24.4c	-	-	B0373	B0373		
					B0374	B0374		
					B0376	B0376		
					B0378	B0378		
		.5c				B0373		
						B0374		
						B0376		
						B0378		
Venezuela	.0	1.1b	.0	-	P0203	F0111	P0203	
EUROPE								
Albania	.0	-	-	-	A0224			
Armenia	.1	.0b	.0	.0	A0232	A0232	A0232	A0232
Azerbaijan	.1	.2	-	-	A0233	A0233		
		2.3				A0233		
Belarus	.0	6.7	.0	66.8	B0380	B0380	B0391	B0365
Bulgaria	.0	.0	-	-	B0381	B0381		
Croatia	.0	1.1	-	-	C0285	C0285		
Czech Republic	.0	.0	-	-	C0291	C0291		

Table 1: Estimates of HIV-1 Seroprevalence, by Residence and Risk Factor, for Selected Countries: Circa 1999

Region and Country	Capital/Major City		Outside Major City		Urban City Sources		Outside City Sources	
	Low Risk	High Risk	Low Risk	High Risk	Low Risk	High Risk	Low Risk	High Risk
		.2				M0556		
Estonia	.0	.0	-	-	E0066	E0066		
Georgia	.0	.0	-	-	G0250	G0250		
Hungary	.0	.0	-	-	H0148	U0051		
Kazakhstan	.0	.0	-	-	K0301	K0301		
Kyrgyzstan	.0	-	-	-	K0298			
Latvia	.0	.1	-	-	L0270	L0270		
		11.0				L0270		
Lithuania	.0	.0	-	-	L0268	L0268		
Moldova	.0	1.3	-	-	M0581	M0581		
Poland	.0	45.9	-	38.0	P0206	P0206		A0208
Romania	.0	.5	-	-	R0187	R0187		
Russia	.0	.7	-	-	P0191	P0191		
Slovakia	.0	.0	-	-	S0477	S0477		
Slovenia	.0	1.5	-	-	S0461	K0279		
Ukraine	.0	0.6	.2	2.3	U0050	U0050	U0050	U0050
		3.1		22.2		U0050		U0050

- No data found

* See table 2 for HIV-2 data

a Rate represents infection with HIV1 only and dual infection (HIV1 and HIV2), therefore addition of rates from table 1 and 2 is not advised.

b Data are best available but are not necessarily reliable due to small (<100) or unknown sample size.

c Data combined.

NOTES:

Definition: High risk--prostitutes and clients, STD patients, or other persons with known risk factors.

Low risk--pregnant women, blood donors, or other persons with no known risk factors.

SOURCE: U.S. Census Bureau, HIV/AIDS Surveillance Data Base, 6/2000 Update

Table 2: Estimates of HIV-2 Seroprevalence, by Residence and Risk Factor, for Selected Countries: Circa 1999

Region and Country	Capital/Major City		Outside Major City		Urban City Sources		Outside City Sources	
	Low Risk	High Risk	Low Risk	High Risk	Low Risk	High Risk	Low Risk	High Risk
AFRICA								
* Burkina Faso	.9 ac	-	1.4 a	-	B0393		B0393	
* Cameroon	-	-	-	.0				Z0045
* Congo, Dem. Rep.	-	.0	-	-		M0549		
* Cote d'Ivoire	1.3 a	15.0 ab	-	-	K0309	G0223		
* Equatorial Guinea	.0	.0	-	-	Z0077	Z0077		
* Ghana	.0 c	14.4 a	.8 a	-	G0261	M0558	G0261	
* Guinea-Bissau	5.2 a	-	9.6	-	N0209		C0265	
* Mali	.4 a	10.2 a	.7	-	B0341	K0254	C0207	
* Mauritania	.2 a	-	-	-	A0166			
* Niger	-	7.1 a	1.7 a	5.7 a		H0141	O0093	A0212
* Nigeria	-	1.3 a	-	1.5 a		E0059		E0059
* Senegal	.0 a	3.6 a	.4 a	17.8 a	S0485	S0485	S0485	S0485

- No data found

* See table 1 for HIV-1 data

a Rate represents infection with HIV2 only and dual infection (HIV1 and HIV2), therefore addition of rates from table 1 and 2 is not advised.

b Data are best available but are not necessarily reliable due to small (<100) or unknown sample size.

c Data combined.

NOTES:

Definition: High risk--prostitutes and clients, STD patients, or other persons with known risk factors.

Low risk--pregnant women, blood donors, or other persons with no known risk factors.

SOURCE: U.S. Census Bureau, HIV/AIDS Surveillance Data Base, 6/2000 Update

Table 3: Detailed Listing of Estimates of HIV-1 and 2 Seroprevalence, by Residence and Risk Factor, for Selected Countries: Circa 1999

Region/ Country	Risk Geographic Area Area	Year	Sub-population	Sex Age	Prev. Rate	Sample Data Size Type	Test Type	Source ID
*AFRICA								
ALGERIA	+UL NOT SPECIFIED	1996	BLOOD DONORS	B ALL	.0	70468 HIV	UNK	R0196
	+UH NOT SPECIFIED	1998(?)	STD PTS.	B ALL	.0	1727 HIV	UNK	R0196
ANGOLA	+UL LUANDA	1999	PREGNANT WOMEN	F ALL	3.4 b	N/A HIV	UNK	U0057
	+UH LUANDA	1999	PROSTITUTES	F ALL	19.4 b	N/A HIV	UNK	G0264
	+OL CABINDA PROVINCE	1999	PREGNANT WOMEN	F ALL	8.0 b	N/A HIV	UNK	G0264
BENIN	+UL COTONOU/3 SITES	1998	PREGNANT WOMEN	F ALL	4.4 c	812 HIV	UNK	A0229
	+UH COTONOU	1997-98	PROSTITUTES	F ALL	57.5	275 HIV	UNK	B0406
	+OL MISSERETTE	1998	PREGNANT WOMEN	F ALL	1.5	201 HIV	UNK	A0229
	+OH NATITINGOU	1998	STD PTS.	B ALL	5.9	118 HIV	UNK	A0229
BOTSWANA	+UL FRANCISTOWN	1998	PREGNANT WOMEN	F ALL	43.0	796 HIV	UNK	J0074
	+UH FRANCISTOWN	1998	STD PTS.	M ALL	60.4	429 HIV	UNK	J0074
	+OL SIX DISTRICTS	1998	PREGNANT WOMEN	F ALL	32.7 c	1676 HIV	UNK	J0074
	+OH SIX DISTRICTS	1998	STD PTS.	M ALL	50.8 c	483 HIV	UNK	J0074
BURKINA FASO	+UL OUAGA./2 SITES	1998	PREGNANT WOMEN	F ALL	7.7 ac	839 HIV1	UNK	B0393
	+UL2 OUAGA./2 SITES	1998	PREGNANT WOMEN	F ALL	0.9 ac	839 HIV2	UNK	B0393
	+UH BOBO-DIOULASSO	1999(?)	PROSTITUTES	F ALL	28.6	350 HIV	UNK	O0101
	+OL OUAHIGOUYA	1998	PREGNANT WOMEN	F ALL	6.6 a	286 HIV1	UNK	B0393
	+OL2 OUAHIGOUYA	1998	PREGNANT WOMEN	F ALL	1.4 a	286 HIV2	UNK	B0393
BURUNDI	+UL BUJUMBURA	1998	PREGNANT WOMEN	F ALL	18.6	291 HIV	UNK	N0239
	+OL JENDA(RURAL)	1997	PREGNANT WOMEN	F ALL	3.9	259 HIV	UNK	B0386
CAMEROON	+UL YAOUNDE	1998	PREGNANT WOMEN	F ALL	5.5	1532 HIV1	UNK	M0614
	+UH YAOUNDE	1997-98	PROSTITUTES	F ALL	33.3	336 HIV	UNK	B0406
	OL BERTOUA	1996	PREGNANT WOMEN	F ALL	6.7	254 HIV	UNK	B0344
	OH BANKA(SEMIRURAL)	1994	STD PTS.	B ALL	9.0	100 HIV1	ELISA*3,RAPID	Z0045
	OH2 BANKA(SEMIRURAL)	1994	STD PTS.	B ALL	.0	100 HIV2	ELISA*3,RAPID	Z0045
C. AFRICAN REPUBLIC	UL BANGUI/3 SITES	1996	PREGNANT WOMEN	F ALL	11.7 c	697 HIV	ELISA*2	M0541
	+UH BANGUI	1999(?)	STD PTS.	F ALL	27.9	280 HIV	ELISA	M0610
	OL BANGASSOU	1996	PREGNANT WOMEN	F ALL	15.3	261 HIV	ELISA*2	M0541
	OH BOUZOU	1996	STD PTS.	B ALL	33.3	150 HIV	ELISA*2	M0541
CHAD	+UL N'DJAMENA/3S	1999	PREGNANT WOMEN	F ALL	5.8 c	656 HIV	UNK	C0312
								C0313
	UH N'DJAMENA	1995	FREE WOMEN	F ALL	13.4	250 HIV	UNK	A0200
	+OL 4 URBAN SITES	1999	PREGNANT WOMEN	F ALL	5.0 c	951 HIV	UNK	C0312
								C0313
	+OH 2 URBAN SITES	1999	STD PTS.	B ALL	21.6 bc	74 HIV	UNK	C0312
								C0313
COMOROS	UL MORONI	1996	PREGNANT WOMEN	F ALL	.0	160 HIV	ELISA*2,WB	T0171
	UH MORONI	1994	PROSTITUTES	F ALL	56.8	111 HIV	UNK	D0227
CONGO	UL BRAZZAVILLE	1997	PREGNANT WOMEN	F ALL	5.8	155 HIV	UNK	P0186

Table 3: Detailed Listing of Estimates of HIV-1 and 2 Seroprevalence, by Residence and Risk Factor, for Selected Countries: Circa 1999

Region/ Country	Risk Geographic Area Area	Year	Sub-population	Sex Age	Prev. Rate	Sample Data Size Type	Test Type	Source ID
CONGO, DEM. REP. OF (ZAIRE)	+UL KINSHASA/3 SITES	1999	PREGNANT WOMEN	F ALL	4.1 c	1380 HIV	ELISA,RAPID	D0246
	+UH KINSHASA	1997	PROSTITUTES	F ALL	29.0	100 HIV1	RAPID,ELISA, LIA	M0549
	+UH2 KINSHASA	1997	PROSTITUTES	F ALL	.0	100 HIV2	RAPID,ELISA, LIA	M0549
	+OL KABINDA	1997	PREGNANT WOMEN	F ALL	3.9	484 HIV	RAPID	B0389
COTE D'IVOIRE	+UL ABIDJAN	1998-99	PREGNANT WOMEN	F ALL	12.1 a	909 HIV1	RAPID	K0309
	+UL2 ABIDJAN	1998-99	PREGNANT WOMEN	F ALL	1.3 a	909 HIV2	RAPID	K0309
	+UH ABIDJAN	1997	PROSTITUTES	F ALL	61.0 ab	N/A HIV1	ELISA,WB	G0223
	+UH2 ABIDJAN	1997	PROSTITUTES	F ALL	15.0 ab	N/A HIV2	ELISA,WB	G0223
	+OL BOUAKE	1998	PREGNANT WOMEN	F ALL	9.8 b	N/A HIV1,2	ELISA*3,WB	S0492
DJIBOUTI	UL NOT SPECIFIED	1998	BLOOD DONORS	B ALL	2.4	620 HIV	UNK	B0362
	UH NOT SPECIFIED	1998	PROSTITUTES	F ALL	28.2	117 HIV	UNK	B0362
EGYPT	+UL NOT SPECIFIED	1999	BLOOD DONORS	B ALL	.0	124344 HIV	UNK	S0486
	+UH NOT SPECIFIED	1999	STD PTS.	B ALL	.0	775 HIV	UNK	S0486
EQUATORIAL GUINEA	+UL MALABO	1995-96	PREGNANT WOMEN	F ALL	.4	486 HIV1	ELISA*3	Z0077
	+UL2 MALABO	1995-96	PREGNANT WOMEN	F ALL	.0	486 HIV2	ELISA*3	Z0077
	+UH MALABO	1995-96	STD PTS.	B ALL	3.2	380 HIV1	ELISA*3	Z0077
	+UH2 MALABO	1995-96	STD PTS.	B ALL	.0	380 HIV2	ELISA*3	Z0077
	OL INSULAR REGION	1995	PREGNANT WOMEN	F ALL	.3	761 HIV1	RAPID,ELISA,WB	S0397
	OH INSULAR REGION	1995	STD PTS.	B ALL	2.2	274 HIV1	RAPID,ELISA,WB	S0397
ERITREA	UL NOT SPECIFIED	1994	PREGNANT WOMEN	F ALL	3.0 b	N/A HIV	UNK	T0147
	OH NOT SPECIFIED	1994	PROSTITUTES	F ALL	25.0 b	N/A HIV	UNK	T0147
ETHIOPIA	UL ADDIS ABABA/4S	1997	PREGNANT WOMEN	F ALL	17.6 bc	N/A HIV	UNK	S0443
	+UH ADDIS ABABA	1998	PROSTITUTES	F ALL	73.7	372 HIV	UNK	A0237
	+OL SODO	1998	PREGNANT WOMEN	F ALL	9.2	249 HIV	UNK	A0230
	+OH MOYALE	1998	PROSTITUTES	F ALL	16.2 b	99 HIV	UNK	A0230
GABON	UL FOUR CITIES	1996-97	PREGNANT WOMEN	F ALL	4.7	129 HIV	UNK	M0535
	UH FOUR CITIES	1996-97	STD PTS.	B ALL	16.7 b	60 HIV	UNK	M0535
THE GAMBIA	UL BANJUL	1997(?)	PREGNANT WOMEN	F ALL	1.0	210 HIV	UNK	L0247
	OL FOUR SITES	1997(?)	PREGNANT WOMEN	F ALL	2.4 bc	N/A HIV	UNK	L0247
GHANA	+UL ACCRA/2 SITES	1998	PREGNANT WOMEN	F ALL	2.7 c	885 HIV1	ELISA,RAPID, LIA	G0261
	+UL2 ACCRA/2 SITES	1998	PREGNANT WOMEN	F ALL	.0 c	885 HIV2	ELISA,RAPID, LIA	G0261
	UH ACCRA	1997	PROSTITUTES	F ALL	72.6 a	368 HIV1	ELISA,RAPID, LIA	M0558
	UH2 ACCRA	1997	PROSTITUTES	F ALL	14.4 a	368 HIV2	ELISA,RAPID, LIA	M0558
	+OL CAPE COAST	1998	PREGNANT WOMEN	F ALL	3.4 a	500 HIV1	ELISA,RAPID, LIA	G0261
	+OL2 CAPE COAST	1998	PREGNANT WOMEN	F ALL	.8 a	500 HIV2	ELISA,RAPID, LIA	G0261

Table 3: Detailed Listing of Estimates of HIV-1 and 2 Seroprevalence, by Residence and Risk Factor, for Selected Countries: Circa 1999

Region/ Country	Risk Geographic. Area Area	Year	Sub-population	Sex Age	Prev. Rate	Sample Data Size Type	Test Type	Source ID
GUINEA	UL CONAKRY	1996	PREGNANT WOMEN	F ALL	1.5 b	N/A HIV1,2	UNK	N0215
	UH CONAKRY	1994	PROSTITUTES	F ALL	36.6	112 HIV	WB	B0271
	OL GUECKEDOU	1996	PREGNANT WOMEN	F ALL	1.4 b	N/A HIV1	UNK	N0215
GUINEA- BISSAU	UL BISSAU	1997	PREGNANT WOMEN	F ALL	2.6 a	1493 HIV1	ELISA, WB	N0209
	UL2 BISSAU	1997	PREGNANT WOMEN	F ALL	5.2 a	1493 HIV2	ELISA, WB	N0209
	OL FOUR RURAL TOWNS	1997(?)	WOMEN	F ALL	3.4	146 HIV1	ELISA*3	C0265
	OL2 FOUR RURAL TOWNS	1997(?)	WOMEN	F ALL	9.6	146 HIV2	ELISA*3	C0265
KENYA	+UL NAIROBI	1996-97	PREGNANT WOMEN	F ALL	15.9	1218 HIV1	ELISA*2	J0076
	+UH KISUMU	1997-98	PROSTITUTES	F ALL	74.7	296 HIV	UNK	B0406
	+OL KAPLONG(RURAL)	1999	PREGNANT WOMEN	F ALL	5.6 b	N/A HIV	UNK	N0253
LESOTHO	+UL MASERU	1994	PREGNANT WOMEN	F ALL	31.3	399 HIV	RAPID	L0272
	UH MASERU	1993-94	STD PTS. W/ GU	B ALL	35.6	104 HIV	ELISA, WB, IFA	M0515
	+OL 4 SITES	1999	PREGNANT WOMEN	F ALL	27.1	2322 HIV	UNK	U0054
	+OH 4 SITES	1999	STD PTS.	B ALL	40.7	457 HIV	UNK	U0054
LIBERIA	+UL NOT SPECIFIED	1998	PREGNANT WOMEN	F ALL	10.1 b	99 HIV	RAPID*2	L0279
	UH NOT SPECIFIED	1997	TESTING CTR ATTENDEES	B ALL	28.7 b	N/A HIV	UNK	E0064
LIBYA	+UL NOT SPECIFIED	1998	PREGNANT WOMEN	F ALL	.0	1000 HIV	UNK	S0486
	+UH NOT SPECIFIED	1998	IVDU	B ALL	.5	400 HIV	UNK	S0486
MADAGASCAR	UL THREE CITIES	1995	PREGNANT WOMEN	F ALL	.1	1587 HIV	ELISA, WB	R0143
	+UH ANTANANARIVO	1998	STD PTS.	B ALL	.0	1196 HIV	UNK	I0049
	OL ANTIRANANA PR.	1996	PREGNANT WOMEN	F ALL	.4	529 HIV	ELISA, WB	R0173
	+OH ANTIRANANA PR.	1998	PROSTITUTES	F ALL	1.3	149 HIV	UNK	I0049
MALAWI	+UL BLANTYRE	1998	PREGNANT WOMEN	F ALL	30.4	677 HIV	ELISA	N0243
	UH BLANTYRE	1995	STD PTS.	B ALL	70.4	250 HIV	ELISA	K0233
	+OL EIGHT DIST./RUR	1998	PREGNANT WOMEN	F ALL	11.2	883 HIV	ELISA	N0243
MALI	UL BAMAKO	1997	PREGNANT WOMEN	F ALL	2.5 a	554 HIV1	RAPID, LIA	B0341
	UL2 BAMAKO	1997	PREGNANT WOMEN	F ALL	.4 a	554 HIV2	RAPID, LIA	B0341
	UH BAMAKO	1995	PROSTITUTES	F ALL	42.1 a	176 HIV1	RAPID, ELISA, LIA	K0254
	UH2 BAMAKO	1995	PROSTITUTES	F ALL	10.2 a	176 HIV2	RAPID, ELISA, LIA	K0254
	OL KAYES	1994	PREGNANT WOMEN	F ALL	2.2	412 HIV1	RAPID	C0207
	OL2 KAYES	1994	PREGNANT WOMEN	F ALL	.7	412 HIV2	RAPID	C0207
MAURITANIA	UL NOUAKCHOTT	1993-94	PREGNANT WOMEN	F ALL	.5 a	1106 HIV1	ELISA*2, RAPID	A0166
	UL2 NOUAKCHOTT	1993-94	PREGNANT WOMEN	F ALL	.2 a	1106 HIV2	ELISA*2, RAPID	A0166
	UH NOUAKCHOTT	1993-94	STD PTS.	F ALL	.9	430 HIV	ELISA*2, RAPID	A0166
	OH FOUR CITIES	1996(?)	STD PTS.	B ALL	1.7	628 HIV	ELISA*2	A0173
MAURITIUS	+OL TWO ISLANDS	1998	PREGNANT WOMEN	F ALL	.0	7099 HIV	UNK	M0594
	+OH NOT SPECIFIED	1997-98	PROSTITUTES	F ALL	7.5	107 HIV	UNK	M0594
MOROCCO	+UL CASABLANCA	1997	PREGNANT WOMEN	F ALL	.0	549 HIV	UNK	M0590
	+UH CASABLANCA	1997	STD PTS.	B ALL	.9 b	N/A HIV	UNK	M0590

Table 3: Detailed Listing of Estimates of HIV-1 and 2 Seroprevalence, by Residence and Risk Factor, for Selected Countries: Circa 1999

Region/ Country	Risk Geographic Area Area	Year	Sub-population	Sex Age	Prev. Rate	Sample Data Size Type	Test Type	Source ID
MOZAMBIQUE	+UL MAPUTO	1998	PREGNANT WOMEN	F ALL	9.9	607 HIV	ELISA,RAPID	A0228
	+UH MAPUTO	1998	STD PTS.	B ALL	9.0b	N/A HIV	UNK	A0228
	+OL TETE	1998	PREGNANT WOMEN	F ALL	17.0	800 HIV	ELISA,RAPID	A0228
	+OH TETE	1988	STD PTS.	B ALL	27.3b	N/A HIV	UNK	A0228
NAMIBIA	+UL WINDHOEK	1998	PREGNANT WOMEN	F ALL	22.7	207 HIV	ELISA	N0251
	+UH WINDHOEK	1998	STD PTS.	B ALL	44.6	222 HIV	UNK	N0251
	+OL NANKUDU(RURAL)	1998	PREGNANT WOMEN	F ALL	12.6	198 HIV	ELISA	N0251
	+OH NANKUDU(RURAL)	1998	STD PTS.	B ALL	27.7b	65 HIV	UNK	N0251
NIGER	UH NIAMEY	1997(?)	PROSTITUTES	F ALL	23.6a	140 HIV1	ELISA	H0141
	UH2 NIAMEY	1997(?)	PROSTITUTES	F ALL	7.1a	140 HIV2	ELISA	H0141
	+OL AGADEZ	1997(?)	NOMADS	B ALL	2.1a	424 HIV1	WB	O0093
	+OL2 AGADEZ	1997(?)	NOMADS	B ALL	1.7a	424 HIV2	WB	O0093
	OH DIRKOU	1994	PROSTITUTES	F ALL	33.6a	122 HIV1	ELISA,RAPID	A0212
	OH2 DIRKOU	1994	PROSTITUTES	F ALL	5.7a	122 HIV2	ELISA,RAPID	A0212
NIGERIA	+UL LAGOS STATE/2S	1999	PREGNANT WOMEN	F ALL	6.7c	520 HIV1,2	ELISA,RAPID	A0245
	UH LAGOS STATE	1996	PROSTITUTES	F ALL	30.5a	236 HIV1	UNK	E0059
	UH2 LAGOS STATE	1996	PROSTITUTES	F ALL	1.3a	236 HIV2	UNK	E0059
	+OL DELTA STATE	1999	PREGNANT WOMEN	F ALL	5.0	300 HIV1,2	ELISA,RAPID	A0245
	OH MAIDUGURI	1996	PROSTITUTES	F ALL	60.6a	137 HIV1	UNK	E0059
	OH2 MAIDUGURI	1996	PROSTITUTES	F ALL	1.5a	137 HIV2	UNK	E0059
RWANDA	+UL KIGALI/2 SITES	1997	PREGNANT WOMEN	F ALL	19.0bc	N/A HIV	UNK	V0091
	+UH KIGALI/2 SITES	1996	STD PTS.	B ALL	42.1c	590 HIV	ELISA	V0089
	+OL NYAGATARE(RURAL)	1997	PREGNANT WOMEN	F ALL	7.5b	N/A HIV	UNK	V0091
	+OH RULI(RURAL)	1996	STD PTS.	B ALL	13.2	295 HIV	ELISA	V0089
SENEGAL	+UL DAKAR	1997	PREGNANT WOMEN	F ALL	.4a	232 HIV1	ELISA,WB	S0485
	+UL2 DAKAR	1997	PREGNANT WOMEN	F ALL	.0a	232 HIV2	ELISA,WB	S0485
	+UH DAKAR	1998	PROSTITUTES	F ALL	6.1a	760 HIV1	ELISA,WB	S0485
	+UH2 DAKAR	1998	PROSTITUTES	F ALL	3.6a	760 HIV2	ELISA,WB	S0485
	+OL LOUGA	1998	PREGNANT WOMEN	F ALL	.5a	774 HIV1	ELISA,WB	S0485
	+OL2 LOUGA	1998	PREGNANT WOMEN	F ALL	.4a	774 HIV2	ELISA,WB	S0485
	+OH ZIGUINCHOR	1998	PROSTITUTES	F ALL	21.9a	146 HIV1	ELISA,WB	S0485
	+OH2 ZIGUINCHOR	1998	PROSTITUTES	F ALL	17.8a	146 HIV2	ELISA,WB	S0485
SEYCHELLES	UH NOT SPECIFIED	1995	STD PTS.	B ALL	1.6b	N/A HIV	ELISA,WB	C0266
SIERRA LEONE	UH FREETOWN	1995(?)	PROSTITUTES	F ALL	26.7	150 HIV	UNK	K0209
SOMALIA	+UL HARGEYSA	1997	PREGNANT WOMEN	F ALL	3.0	236 HIV	RAPID,ELISA	A0231
	+OL BOSASO	1997	PREGNANT WOMEN	F ALL	1.0	300 HIV	RAPID,ELISA	A0231
SOUTH AFRICA	+UL NATAL/KWAZULU PR	1998	PREGNANT WOMEN	F ALL	32.5b	N/A HIV	ELISA*2	R0204
	UH NATAL/KWAZULU PR	1996-97	PROSTITUTES	F ALL	50.3	145 HIV	UNK	R0180
	+OL NORTHERN CAPE PR	1998	PREGNANT WOMEN	F ALL	9.9b	N/A HIV	ELISA*2	R0204

Table 3: Detailed Listing of Estimates of HIV-1 and 2 Seroprevalence, by Residence and Risk Factor, for Selected Countries: Circa 1999

Region/ Country	Risk Area	Geographic Area	Year	Sub-population	Sex	Age	Prev. Rate	Sample Size	Data Type	Test Type	Source ID
SUDAN	+UL	JUBA	1998	PREGNANT WOMEN	F	ALL	3.5b	N/A	HIV	UNK	S0480
	UH	JUBA	1994	STD PTS.	B	ALL	6.6	333	HIV	UNK	M0554
SWAZILAND	+UL	HHOHHO REGION	1998	PREGNANT WOMEN	F	ALL	30.3	472	HIV	ELISA	S0444
	+UH	HHOHHO REGION	1998	STD PTS.	B	ALL	49.8	564	HIV	ELISA	S0444
	+OL	LUBOMBO REGION	1998	PREGNANT WOMEN	F	ALL	31.5	447	HIV	ELISA	S0444
	+OH	LUBOMBO REGION	1998	STD PTS.	B	ALL	49.5	442	HIV	ELISA	S0444
TANZANIA	+UL	DAR ES SALAAM	1996-98	PREGNANT WOMEN	F	ALL	13.7	7646	HIV1	ELISA*2,WB	K0308
	UH	DAR ES SALAAM	1997	STD PTS.	F	ALL	24.4b	86	HIV	UNK	M0563
	+OL	MBEYA RG/2 RUR S	1998	PREGNANT WOMEN	F	ALL	18.2bc	N/A	HIV	UNK	T0208
	+OH	MBEYA RG/6 RUR S	1997(?)	STD PTS.	B	ALL	27.3c	428	HIV	UNK	T0207
TOGO	UL	LOME	1997	PREGNANT WOMEN	F	ALL	6.8	518	HIV	ELISA*2,RAPID	T0177
	UH	LOME	1992	PROSTITUTES	F	ALL	78.9	123	HIV1,2	ELISA	B0020
	OL	CENTRAL REGION	1997	PREGNANT WOMEN	F	ALL	4.6	500	HIV	ELISA*2,RAPID	T0177
TUNISIA	+UL	NOT SPECIFIED	1999	PREGNANT WOMEN	F	ALL	.0	108	HIV	UNK	S0486
	+UH	NOT SPECIFIED	1999	PROSTITUTES	F	ALL	.0	570	HIV	UNK	S0486
	+UH	NOT SPECIFIED	1997	IVDU	B	ALL	.3	584	HIV	UNK	S0486
UGANDA	+UL	KAMPALA/2 SITES	1998	PREGNANT WOMEN	F	ALL	13.8bc	N/A	HIV	UNK	U0049
	+UH	KAMPALA	1998	STD PTS.	B	ALL	29.4b	N/A	HIV	UNK	U0049
	+OL	SOROTI	1998	PREGNANT WOMEN	F	ALL	7.7b	N/A	HIV	UNK	U0049
ZAMBIA	+UL	LUSAKA/4 SITES	1998	PREGNANT WOMEN	F	ALL	27.1c	2323	HIV	RAPID*2,ELISA	N0241
	+UH	NDOLA	1997-98	PROSTITUTES	F	ALL	68.7	319	HIV	UNK	B0406
	+OL	MINGA(RURAL)	1998	PREGNANT WOMEN	F	ALL	10.3	497	HIV	RAPID*2,ELISA	N0241
ZIMBABWE	UL	HARARE	1997	PREGNANT WOMEN	F	ALL	28.0	601	HIV	UNK	Z0076
	UH	HARARE	1994-95	PROSTITUTES	F	ALL	86.0	147	HIV	ELISA	M0433
	OL	MAKONI(RURAL)	1997	PREGNANT WOMEN	F	ALL	29.3	300	HIV	UNK	Z0076
	OH	MASVINGO	1996	STD PTS.	B	ALL	71.8	206	HIV	UNK	Z0061
*ASIA & OCEANIA											
AUSTRALIA	UL	NOT SPECIFIED	1996	HETEROSEXUALS	F	ALL	.3b	N/A	HIV	UNK	K0245
	UH	6 URBAN SITES	1997	HIGH RISK GROUPS	M	ALL	.4	3211	HIV	UNK	N0222
BAHRAIN	+UL	URBAN AREAS	1998	PREGNANT WOMEN	F	ALL	.2	627	HIV	UNK	B0164
	+UH	URBAN AREAS	1998	IVDU	M	ALL	.9	336	HIV	UNK	B0164
BANGLADESH	+UH	CENTRAL AREA	1998	PROSTITUTES	F	ALL	.6	659	HIV	ELISA,LIA	I0050
	+UH	CENTRAL AREA	1998	IVDU	B	ALL	2.5	402	HIV	ELISA,LIA	I0050
BURMA	+UL	MANDALAY	1999	PREGNANT WOMEN	F	ALL	2.0	200	HIV	UNK	M0620
	+UH	MANDALAY	1999	STD PTS.	F	ALL	16.1	100	HIV	UNK	M0620
	+OL	BAGO	1999	PREGNANT WOMEN	F	ALL	.8	200	HIV	UNK	M0620
	+OH	MONYWA	1999	STD PTS.	F	ALL	2.0	100	HIV	UNK	M0620

Table 3: Detailed Listing of Estimates of HIV-1 and 2 Seroprevalence, by Residence and Risk Factor, for Selected Countries: Circa 1999

Region/ Country	Risk Geographic Area Area	Year	Sub-population	Sex Age	Prev. Rate	Sample Data Size Type	Test Type	Source ID
CAMBODIA	UL PHNOM PENH	1998	WOMEN	F ALL	3.8	400 HIV	RAPID, ELISA	S0476
	UH PHNOM PENH	1998	PROSTITUTES - DIRECT	F ALL	61.3	150 HIV	RAPID, ELISA	S0476
	OL 3 PROV./RURAL	1998	WOMEN	F ALL	2.5	1200 HIV	RAPID, ELISA	S0476
	OH KAMPONG CHAM PR.	1998	PROSTITUTES - DIRECT	F ALL	28.0	150 HIV	RAPID, ELISA	S0476
CHINA, HONG KONG	UL NATIONAL	1994	BLOOD DONORS - VOL.	B ALL	.0	172151 HIV	UNK	W0112
	UH NOT SPECIFIED	1994	STD PTS.	B ALL	.1	14496 HIV	UNK	L0156
CHINA, MAINLAND	UL 16 CITIES	1997(?)	PREGNANT WOMEN	F ALL	.0	8596 HIV	ELISA*2, WB	F0097
	+UH NANNING	1998	PROSTITUTES	F ALL	2.3 bc	N/A HIV	ELISA*2	Q0013
	+UH XINJIANG PROV.	1997	IVDU	B ALL	25.6 c	1682 HIV	UNK	C0315
CHINA, TAIWAN	UH TAIPEI & PREF.	1995-96	PROSTITUTES-BROTHEL	F ALL	.0	132 HIV1	ELISA, WB	Y0031
	+UH KAOHSIUNG	1995-99	HOMOSEXUALS	M ALL	7.7	620 HIV	UNK	C0308
CYPRUS	+UL NOT SPECIFIED	1999	PREGNANT WOMEN	F ALL	.0	2086 HIV	UNK	S0486
	+UH NOT SPECIFIED	1999	PROSTITUTES - BAR	F ALL	.0	3603 HIV	UNK	S0486
INDIA	+UL NEW DELHI/2 S	1999	PREGNANT WOMEN	F ALL	.3 c	800 HIV	UNK	N0252
	+UL MUMBAI/4 SITES	1999	PREGNANT WOMEN	F ALL	2.6 c	1600 HIV	UNK	N0252
	+UH NEW DELHI	1999	STD PTS.	B ALL	.8	250 HIV	UNK	N0252
	+UH MUMBAI/2 SITES	1999	STD PTS.	B ALL	56.3 c	375 HIV	UNK	N0252
	+OL DURGAPUR	1999	PREGNANT WOMEN	F ALL	.3	400 HIV	UNK	N0252
	+OH GULBURGA	1999	STD PTS.	B ALL	5.6	250 HIV	UNK	N0252
INDONESIA	+UL BALI	1999	PREGNANT WOMEN	F ALL	.0	397 HIV	ELISA, WB	D0253
	+UH BALI	1998-99	PROSTITUTES	F ALL	.2	600 HIV	ELISA, WB	P0218
	+OH KUPANG	1998	PROSTITUTES	F ALL	.0	213 HIV	UNK	C0307
IRAN	+UL NOT SPECIFIED	1997	PREGNANT WOMEN	F ALL	.0 b	71 HIV	UNK	S0486
	+UH NOT SPECIFIED	1998	IVDU	B ALL	.5	8202 HIV	UNK	S0486
IRAQ	+UL NOT SPECIFIED	1999	PREGNANT WOMEN	F ALL	.0	582 HIV	UNK	S0486
	+UH NOT SPECIFIED	1998	PROSTITUTES - BAR	F ALL	.0	1027 HIV	UNK	S0486
JAPAN	+UL 30 PREFECTURES	1998	PREGNANT WOMEN	F ALL	.0	179462 HIV	UNK	K0333
	UH TOKYO	1996	HOMOSEXUALS	M ALL	19.4	165 HIV	RAPID, ELISA, WB	I0045
JORDAN	+UL NOT SPECIFIED	1999	BLOOD DONORS	B ALL	.0	59528 HIV	UNK	S0486
	+UH NOT SPECIFIED	1995	STD PTS.	B ALL	.0	781 HIV	UNK	S0486
KUWAIT	+UL SABAH AREA	1998	PREGNANT WOMEN	F ALL	.0	501 HIV	UNK	K0303
	+UH KUWAIT	1998	STD PTS.	B ALL	.0	523 HIV	UNK	S0486
	+UH KUWAIT	1998	IVDU	B ALL	.0	181 HIV	UNK	S0486
LAOS	UL VIENTIANE	1996	PREGNANT WOMEN	F ALL	.4	502 HIV	ELISA, WB	L0262

Table 3: Detailed Listing of Estimates of HIV-1 and 2 Seroprevalence, by Residence and Risk Factor, for Selected Countries: Circa 1999

Region/ Country	Risk Area	Geographic Area	Year	Sub-population	Sex	Age	Prev. Rate	Sample Size	Data Type	Test Type	Source ID
LEBANON	+UL	NOT SPECIFIED	1995	PREGNANT WOMEN	F	ALL	.0	2005 HIV		UNK	S0486
	+UH	NOT SPECIFIED	1995	PROSTITUTES	F	ALL	.0	2438 HIV		UNK	S0486
MALAYSIA	+UL	KUALA LUMPUR ST.	1996	BLOOD DONORS	B	ALL	.0	465754 HIV		UNK	I0054
	+UH	KUALA LUMPUR ST.	1996	PROSTITUTES	F	ALL	6.3	1033 HIV		UNK	I0054
	+UH	KUALA LUMPUR ST.	1996	IVDU	B	ALL	16.8	9032 HIV		UNK	I0054
	OL	SABAH STATE	1996	PREGNANT WOMEN	F	ALL	.1	1502 HIV		UNK	J0058
	OH	SABAH STATE	1996	STD PTS.	B	ALL	.9	115 HIV		UNK	J0058
NEPAL	+UH	KATHMANDU	1998	PROSTITUTES - STREET	F	ALL	16.0	300 HIV		UNK	T0211
	+OH	MAHENDRANAGAR	1998	STD PTS.	B	ALL	4.3	300 HIV		UNK	R0198
NEW ZEALAND	+UL	NATIONAL	1998	BLOOD DONORS	B	ALL	.0	78010 HIV		UNK	N0242
	+UH	FIVE URBAN AREAS	1997	IVDU	B	ALL	.5	591 HIV		UNK	N0242
OMAN	+UL	NOT SPECIFIED	1999	BLOOD DONORS	B	ALL	.0	13028 HIV		UNK	S0486
	+UH	NOT SPECIFIED	1999	STD PTS.	B	ALL	.0b	75 HIV		UNK	S0486
PAKISTAN	UL	LAHORE	1995	PREGNANT WOMEN	F	ALL	.6	2000 HIV		RAPID, ELISA	P0144
	UH	LAHORE	1995	STD PTS.	B	ALL	3.7	295 HIV		RAPID	P0144
PAPUA NEW GUINEA	UL	PORT MORESBY	1995	PREGNANT WOMEN	F	ALL	.2	3653 HIV		ELISA, RAPID	M0506
	UH	PORT MORESBY	1995	STD PTS.	B	ALL	1.9	1235 HIV		ELISA, RAPID	M0506
PHILIPPINES	UL	NATIONAL	1994	BLOOD DONORS	B	ALL	.0	499511 HIV		UNK	W0112
	+UH	METRO CEBU	1994	PROSTITUTES - REG.	F	ALL	.0	303 HIV		WB	D0210
QATAR	+UL	NOT SPECIFIED	1999	BLOOD DONORS	B	ALL	.0	2464 HIV		UNK	S0486
	+UH	NOT SPECIFIED	1999	STD PTS.	B	ALL	4.5	2249 HIV		UNK	S0486
SINGAPORE	UL	NATIONAL	1994	BLOOD DONORS - VOL.	B	ALL	.0	59716 HIV		UNK	W0112
	UH	NOT SPECIFIED	1994	PROSTITUTES	F	ALL	3.7b	N/A HIV		UNK	G0161
SRI LANKA	+UL	GALLE	1998	BLOOD DONORS	B	ALL	.0	600 HIV		ELISA*2, RAPID, WB	S0484
	+UH	COLOMBO	1998	PROSTITUTES	F	ALL	.0	407 HIV		ELISA*2, RAPID, WB	S0484
	+OL	RATNAPURA	1998	BLOOD DONORS	B	ALL	.0	600 HIV		ELISA*2, RAPID, WB	S0484
	+OH	RATNAPURA	1998	PROSTITUTES	F	ALL	.0	174 HIV		ELISA*2, RAPID, WB	S0484
SYRIA	+UL	NOT SPECIFIED	1999	BLOOD DONORS	B	ALL	.0	98604 HIV		UNK	S0486
	+UH	FOUR CITIES	1998	STD PTS.	B	ALL	.1	858 HIV		UNK	S0483
THAILAND	+UL	CENTRAL REGION	1999	PREGNANT WOMEN	F	ALL	2.4	25087 HIV		UNK	T0216
	+UH	CENTRAL REGION	1999	PROSTITUTES - DIRECT	F	ALL	19.1	2631 HIV		UNK	T0216
TURKEY	+UL	NATIONAL	1996	BLOOD DONATIONS	B	ALL	.0	1048479 HIV1		UNK	T0203
	+UH	NATIONAL	1996	PROSTITUTES	F	ALL	.1	24073 HIV1		UNK	T0203

Table 3: Detailed Listing of Estimates of HIV-1 and 2 Seroprevalence, by Residence and Risk Factor, for Selected Countries: Circa 1999

Region/ Country	Risk Area	Geographic Area	Year	Sub-population	Sex	Age	Prev. Rate	Sample Size	Data Type	Test Type	Source ID
VIETNAM	+UL	HO CHI MINH	1999	PREGNANT WOMEN	F	ALL	.2	1006	HIV	UNK	H0145
	+UH	HO CHI MINH	1999	PROSTITUTES	F	ALL	4.9b	81	HIV	UNK	H0145
	+UH	HO CHI MINH	1999	IVDU	B	ALL	26.9	238	HIV	UNK	H0145
	+OL	DONG NAI PROV.	1999	PREGNANT WOMEN	F	ALL	.0	800	HIV	UNK	H0145
	+OH	HA TINH PROVINCE	1999	PROSTITUTES	F	ALL	.6	163	HIV	UNK	H0145
	+OH	NAM DINH	1999	IVDU	B	ALL	12.4	170	HIV	UNK	H0145
YEMEN	+UL	NOT SPECIFIED	1998	BLOOD DONORS	B	ALL	.0	19813	HIV	UNK	S0486
	+UH	NOT SPECIFIED	1998	STD PTS.	B	ALL	2.9	585	HIV	UNK	S0486
*LATIN AMERICA & *CARIBBEAN											
ARGENTINA	+UL	BUENOS AIRES PR.	1998	PREGNANT WOMEN	F	ALL	1.2	12881	HIV	UNK	B0390
	+UH	BUENOS AIRES PR.	1998	STD PTS.	B	ALL	10.8	454	HIV	UNK	B0390
	+OL	SANTA CRUZ PROV.	1998	PREGNANT WOMEN	F	ALL	.5	832	HIV	UNK	B0390
	+OH	ENTRE RIOS PROV.	1998	STD PTS.	B	ALL	2.8	502	HIV	UNK	B0390
BARBADOS	UL	NATIONAL	1996	PREGNANT WOMEN	F	ALL	1.1	1012	HIV	UNK	P0200
BELIZE	UL	BELIZE DISTRICT	1995	PREGNANT WOMEN	F	ALL	2.3	474	HIV	UNK	P0142
BOLIVIA	UL	COCHABAMBA	1997	PREGNANT WOMEN	F	ALL	.5	980	HIV	ELISA*2	Z0075
	UH	COCHABAMBA	1997	STD PTS.	B	ALL	2.0b	99	HIV	ELISA*2	Z0075
BRAZIL	UL	RIO DE JANEIRO	1996-97	PREGNANT WOMEN	F	ALL	2.6	966	HIV	ELISA*2, WB	V0093
	UH	SOUTHEAST AREA	1997	STD PTS.	B	ALL	6.0c	2053	HIV	UNK	C0279
	OL	CENTER WEST AREA	1997	PREGNANT WOMEN	F	ALL	.6c	1163	HIV	UNK	C0279
	OH	CENTER WEST AREA	1997	STD PTS.	B	ALL	2.8c	1113	HIV	UNK	C0279
CHILE	UL	METROPOLITAN RG.	1996-97	PREGNANT WOMEN	F	ALL	.1b	N/A	HIV	UNK	C0271
	UH	METROPOLITAN RG.	1996-97	STD PTS.	B	ALL	3.0b	N/A	HIV	UNK	C0271
	OL	ANTOFAGASTA RG.	1996-97	STD PTS.	B	ALL	.0b	N/A	HIV	UNK	C0271
COLOMBIA	UL	BARRANQUILLA	1994	PREGNANT WOMEN	F	ALL	1.1	1233	HIV1	UNK	G0184
	UH	BARRANQUILLA	1994	PROSTITUTES & STD PTS.	B	ALL	3.4	119	HIV1	UNK	G0184
	OL	PUTAMAYO	1994	PREGNANT WOMEN	F	ALL	.4	1947	HIV1	UNK	G0184
	OH	PUTAMAYO	1994	PROSTITUTES	F	ALL	.6	470	HIV1	UNK	G0184
COSTA RICA	UL	SAN JOSE	1997	PREGNANT WOMEN	F	ALL	.3	800	HIV	ELISA, WB	M0574
	UH	SAN JOSE	1995	PROSTITUTES	F	ALL	.9	2296	HIV	UNK	H0139
	OL	LIMON	1997	PREGNANT WOMEN	F	ALL	.1	800	HIV	ELISA, WB	M0574
CUBA	UL	NOT SPECIFIED	1996(?)	PREGNANT WOMEN	F	ALL	.0	1668237	HIV	ELISA, WB	M0484
DOMINICAN REPUBLIC	+UL	SANTO DOMINGO	1998	PREGNANT WOMEN	F	ALL	1.4	970	HIV1	ELISA	R0188
	+UH	SANTO DOMINGO/3S	1998	PROSTITUTES	F	ALL	3.9	460	HIV1	ELISA	R0188
	+OL	LA ROMANA	1998	PREGNANT WOMEN	F	ALL	2.1	195	HIV1	ELISA	R0188
	+OH	LA ROMANA	1998	PROSTITUTES	F	ALL	4.5	157	HIV1	ELISA	R0188

Table 3: Detailed Listing of Estimates of HIV-1 and 2 Seroprevalence, by Residence and Risk Factor, for Selected Countries: Circa 1999

Region/ Country	Risk Area	Geographic Area	Year	Sub-population	Sex	Age	Prev. Rate	Sample Size	Data Type	Test Type	Source ID
EL SALVADOR	UL	NOT SPECIFIED	1996	WOMEN	F	ALL	.5	2195	HIV	ELISA	D0202
	UH	NOT SPECIFIED	1995-96	STD PTS.	B	ALL	6.0	531	HIV	ELISA	D0202
GUATEMALA	UL	GUATEMALA CITY	1996	BLOOD DONORS	B	ALL	.4	845	HIV	ELISA, WB	C0251
	UH	GUATEMALA CITY	1996	PROSTITUTES	F	ALL	1.1	283	HIV	ELISA*2	C0251
	OH	JUTIAPA DIVISION	1994	PROSTITUTES	F	ALL	.8	131	HIV	RAPID, ELISA	C0250
GUYANA	+UL	GEORGETOWN	1997	PREGNANT WOMEN	F	ALL	3.8	265	HIV1	ELISA, WB	W0121
	UH	GEORGETOWN	1997	PROSTITUTES	F	ALL	43.6	124	HIV	ELISA*2	P0197
HAITI	+UL	PORT-AU-PRINCE	1996	PREGNANT WOMEN	F	ALL	10.0b	N/A	HIV	UNK	G0225
	OL	MIREBALAIS	1996	PREGNANT WOMEN	F	ALL	4.8	273	HIV	UNK	C0284
HONDURAS	+UL	SAN PEDRO SULA	1998	PREGNANT WOMEN	F	ALL	5.0b	N/A	HIV	UNK	T0200
	+UH	SAN PEDRO SULA	1997	PROSTITUTES	F	ALL	13.0	200	HIV	UNK	B0383
	OL	TELA	1994	PREGNANT WOMEN	F	ALL	1.4b	N/A	HIV	UNK	M0495
	+OH	COMAYAGUA	1997	PROSTITUTES	F	ALL	3.0	100	HIV	UNK	B0383
JAMAICA	+UL	THREE PARISHES	1997	PREGNANT WOMEN	F	ALL	1.0	908	HIV	UNK	J0059
	+UH	THREE PARISHES	1997	STD PTS.	B	ALL	6.4	1103	HIV	UNK	J0059
MEXICO	UL	MEXICO CITY	1997	PREGNANT WOMEN	F	ALL	.1	3849	HIV	UNK	L0238
	UH	18 STATES	1996	PROSTITUTES	F	ALL	1.0	5153	HIV	UNK	S0468
NICARAGUA	UH	NOT SPECIFIED	1997	PROSTITUTES	F	ALL	.2	420	HIV	ELISA*3, WB	P0177
PANAMA	UL	PANAMA OESTE RG	1997	PREGNANT WOMEN	F	ALL	.9	227	HIV	ELISA*3	G0263
	UH	NOT SPECIFIED	1997	PROSTITUTES	F	ALL	.3	4285	HIV	ELISA*3, IFA, WB	G0263
PERU	UL	LIMA	1996-97	PREGNANT WOMEN	F	ALL	.5	12436	HIV	ELISA, WB	A0188
	UH	LIMA	1995-96	PROSTITUTES - UNREG.	F	ALL	5.0	311	HIV	UNK	G0209
TRINIDAD & TOBAGO	UL	NOT SPECIFIED	1995/96	PREGNANT WOMEN	F	ALL	1.0b	N/A	HIV	ELISA	L0234
	+UH	SAN FERNANDO	1996	STD PTS.	B	ALL	5.9	479	HIV	ELISA*2, WB	L0243
URUGUAY	UL	MONTEVIDEO	1997	BLOOD DONORS	B	ALL	.1c	94706	HIV1,2	ELISA, IFA, WB	B0373 B0374 B0376 B0378
	UH	MONTEVIDEO	1997	IVDU	B	ALL	24.4c	409	HIV1,2	ELISA, IFA, WB	B0373 B0374 B0376 B0378
	UH	MONTEVIDEO	1997	PROSTITUTES	F	ALL	.5c	1127	HIV1,2	ELISA, IFA, WB	B0373 B0374 B0376 B0378
	UH	MONTEVIDEO	1997	PROSTITUTES	F	ALL	.5c	1127	HIV1,2	ELISA, IFA, WB	B0373 B0374 B0376 B0378
	UH	MONTEVIDEO	1997	PROSTITUTES	F	ALL	.5c	1127	HIV1,2	ELISA, IFA, WB	B0373 B0374 B0376 B0378
	UH	MONTEVIDEO	1997	PROSTITUTES	F	ALL	.5c	1127	HIV1,2	ELISA, IFA, WB	B0373 B0374 B0376 B0378
VENEZUELA	UL	CARACAS	1996	PREGNANT WOMEN	F	ALL	.0	560	HIV1	IFA	P0203
	+UH	BOLIVAR STATE	1996	PROSTITUTES	F	ALL	1.1b	88	HIV	ELISA*2, WB	F0111
	OL	MACUTO	1996	PREGNANT WOMEN	F	ALL	.0	460	HIV1	IFA	P0203

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Region/ Country	Risk Area	Geographic Area	Year	Sub-population	Sex	Age	Prev. Rate	Sample Size	Data Type	Test Type	Source ID
*EUROPE											
ALBANIA	UL	NATIONAL	1996	BLOOD DONATIONS-	ADULT	B ALL	.0	18692	HIV1	UNK	A0224
ARMENIA	+UL	YEREVAN	1998	PREGNANT WOMEN	F	ALL	.1	1545	HIV	UNK	A0232
	+UH	YEREVAN	1998	STD PTS.	M	ALL	.0b	61	HIV	UNK	A0232
	+OL	LORI REGION	1998	PREGNANT WOMEN	F	ALL	.0	438	HIV	UNK	A0232
	+OH	LORI REGION	1998	STD PTS.	F	ALL	.0	151	HIV	UNK	A0232
AZERBAIJAN	+UL	BAKU	1998	PREGNANT WOMEN	F	ALL	.1	9827	HIV	UNK	A0233
	+UH	BAKU	1998	STD PTS.	B	ALL	.2	1277	HIV	UNK	A0233
	+UH	BAKU	1998	IVDU	B	ALL	2.3	477	HIV	UNK	A0233
BELARUS	UL	MINSK CITY	1996	BLOOD DONATIONS	B	ALL	.0	113372	HIV1	UNK	B0380
	UH	NATIONAL	1996	ADULT DRUG USERS	B	ALL	6.7	8364	HIV1	UNK	B0380
	+OL	GOMEL REGION	1997	PREGNANT WOMEN	F	ALL	.0	636	HIV	UNK	B0391
	OH	SVETLOGORSK	1997	IVDU	B	ALL	66.8	202	HIV	UNK	B0365
BULGARIA	UL	NATIONAL	1993	PREGNANT WOMEN	F	ALL	.0	39797	HIV1	UNK	B0381
	UH	NATIONAL	1993	STD PTS.	B	ALL	.0	1863	HIV1	UNK	B0381
CROATIA	UL	NATIONAL	1996	BLOOD DONATIONS	B	ALL	.0	160721	HIV1	UNK	C0285
	UH	NATIONAL	1995	DRUG USERS	B	ALL	1.1	353	HIV1	UNK	C0285
CZECH REPUBLIC	+UL	NATIONAL	1998	PREGNANT WOMEN	F	ALL	.0	123436	HIV	UNK	C0291
	+UH	NATIONAL	1998	STD PTS.	B	ALL	.0	6355	HIV	UNK	C0291
	UH	PRAGUE	1996-97	DRUG USERS	B	ALL	.2	617	HIV1	ELISA, WB	M0556
ESTONIA	UL	NATIONAL	1996	BLOOD DONATIONS-	ADULT	B ALL	.0	49166	HIV1	UNK	E0066
	UH	NATIONAL	1996	ADULT STD PTS.	B	ALL	.0	3359	HIV1	UNK	E0066
GEORGIA	+UL	TBILISI	1997	PREGNANT WOMEN	F	ALL	.0	3168	HIV	UNK	G0250
	+UH	NATIONAL	1997	STD PTS.	B	ALL	.0	4253	HIV	UNK	G0250
HUNGARY	UL	NATIONAL	1996	PREGNANT WOMEN	F	ALL	.0	4710	HIV1	UNK	H0148
	UH	NOT SPECIFIED	1997	IVDU	B	ALL	.0	180	HIV	UNK	U0051
KAZAKHSTAN	+UL	NATIONAL	1998	BLOOD DONORS	B	ALL	.0	374535	HIV	UNK	K0301
	+UH	NATIONAL	1998	PROSTITUTES	F	ALL	.0	12965	HIV	UNK	K0301
KYRGYZSTAN	UL	NATIONAL	1996	PREGNANT WOMEN	F	ALL	.0	25769	HIV1	UNK	K0298
LATVIA	+UL	NATIONAL	1998	PREGNANT WOMEN	F	ALL	.0	4989	HIV	UNK	L0270
	+UH	NATIONAL	1998	STD PTS.	B	ALL	.1	17299	HIV	UNK	L0270
	+UH	THREE CITIES	1998	IVDU	B	ALL	11.0	310	HIV	UNK	L0270
LITHUANIA	UL	VILNIUS REGION	1996	BLOOD DONATIONS	B	ALL	.0	42348	HIV1	UNK	L0268
	UH	VILNIUS REGION	1996	STD PTS.	B	ALL	.0	7800	HIV1	UNK	L0268

Table 3: Detailed Listing of Estimates of HIV-1 and 2 Seroprevalence, by Residence and Risk Factor, for Selected Countries: Circa 1999

Region/ Country	Risk Area	Geographic Area	Year	Sub-population	Sex	Age	Prev. Rate	Sample Size	Data Type	Test Type	Source ID
MOLDOVA	UL	NATIONAL	1995	PREGNANT WOMEN	F	ALL	.0	14112	HIV1	UNK	M0581
	UH	NATIONAL	1996	DRUG USERS	B	ALL	1.3	3676	HIV1	UNK	M0581
POLAND	UL	NATIONAL	1996	ADULT BLOOD DONOR- NEW	B	ALL	.0	156777	HIV1	UNK	P0206
	UH	WARSAW REGION	1993	ADULT DRUG USERS	B	ALL	45.9	205	HIV1	UNK	P0206
	OH	UPPER SILESIA	1996	IVDU	B	ALL	38.0	623	HIV	UNK	A0208
ROMANIA	UL	NATIONAL	1996	BLOOD DONATIONS	B	ALL	.0	373289	HIV1	UNK	R0187
	UH	NATIONAL	1996	ADULT STD PTS.	B	ALL	.5	3849	HIV1	UNK	R0187
RUSSIA	UL	NOT SPECIFIED	1997	PREGNANT WOMEN	F	ALL	.0	2831597	HIV	UNK	P0191
	UH	NOT SPECIFIED	1997	IVDU	B	ALL	.7	175248	HIV	UNK	P0191
SLOVAKIA	UL	NATIONAL	1995	PREGNANT WOMEN	F	ALL	.0	15974	HIV1	UNK	S0477
	UH	NATIONAL	1996	STD PTS.	B	ALL	.0	2079	HIV1	UNK	S0477
SLOVENIA	UL	LJUBLJANA REGION	1994	PREGNANT WOMEN	F	ALL	.0	3652	HIV1	UNK	S0461
	UH	LJUBLJANA REGION	1997	HOMOSEXUALS	M	ALL	1.5	136	HIV1,2	ELISA*2,WB	K0279
UKRAINE	UL	KIEV REGION	1996	PREGNANT WOMEN	F	ALL	.0	4060	HIV1	UNK	U0050
	UH	KIEV REGION	1996	STD PTS.	B	ALL	0.6	4636	HIV1	UNK	U0050
	UH	KIEV REGION	1996	DRUG USERS	B	ALL	3.1	1607	HIV1	UNK	U0050
	OL	NIKOLAIEV REGION	1996	PREGNANT WOMEN	F	ALL	.2	7114	HIV1	UNK	U0050
	OH	NIKOLAIEV REGION	1996	STD PTS.	B	ALL	2.3	3876	HIV1	UNK	U0050
	OH	NIKOLAIEV REGION	1996	DRUG USERS	B	ALL	22.2	6906	HIV1	UNK	U0050

a Rate represents co-infection with HIV1 and HIV2 and should not therefore be combined with other figures.

b Data are best available but are not necessarily reliable due to small (<100) or unknown sample size.

c Data combined.

+ Data changed and/or added.

Risk Area Codes:

UL -- Urban low risk

UH -- Urban high risk

OL -- Outside city low risk

OH -- Outside city high risk

2 -- Data for HIV2

SOURCE: U.S. Census Bureau, HIV/AIDS Surveillance Data Base, 6/2000 Update

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Position Paper
HIV/AIDS in Southern Africa
 Prepared by Professor Alan Whiteside
 Health Economics and HIV/AIDS Research Division
 University of Natal South Africa
 20 November 1998.

Background.

Southern Africa is currently experiencing the worst HIV epidemic in the world. HIV prevalence has risen to levels that seemed impossible a few years ago. Even more worrying is that the spread is far more uniform between rural and urban areas than was the case in Uganda and other East African countries. A quick review of the data from the region shows how serious the situation is. This is shown in Table 1, compiled from UNAIDS sources and the United Nations Human Development Reports. The first column shows the estimated national adult HIV prevalence, the second the number of people living with HIV and AIDS.

Table 1. HIV Prevalence, Infections, Orphans and Life Expectancy in SADC

Country	1. Est. adult prevalence	2. No. of adults & children living with HIV/AIDS	3. Est.no. of orphans	Life Expectancy		HDI Ranking	
				4. 1993	5. 1995	6. 1996	7. 1998
Angola	2.12	110 000	16 000	46.8	47.4	165	156
Botswana	25.10	190 000	25 000	65.2	51.7	71	97
D R Congo	4.35	950 000	310 000	52	52.4	141	143
Lesotho	8.35	85 000	8 500	60.8	58.1	130	134
Malawi	14.92	710 000	270 000	45.5	41	157	161
Mauritius	0.08	No data	No data	70.4	70.9	54	61
Moçambique	14.17	1 200 000	150 000	46.4	46.3	167	166
Namibia	19.94	150 000	7 300	59.1	55.8	116	107
Seychelles	-	-	-	-	64.1	60	56
South Africa	12.91	2 900 000	180 000	63.2	72.0	100	89
Swaziland	18.50	840 000	7 200	57.8	58.8	110	115
Tanzania	9.42	1 400 000	520 000	52.1	50.6	144	150
Zambia	19.07	770 000	360 000	48.6	42.7	136	146
Zimbabwe	25.84	1 500 000	360 000	53.4	48.9	124	130

Source: UNAIDS and WHO, **Epidemiological Fact Sheets on HIV/AIDS and sexually transmitted diseases**, Geneva 1998 and available at www.UNAIDS.org

The consequence of HIV infection is that people will fall ill and die. The impact is most easily seen in terms of increased orphaning and decreased life expectancy. While an infected women has about a 30% chance of infecting her child with HIV, a child born to an infected mother has virtually a 100% chance of being orphaned. The number of living orphans is shown in the third column. There are a number of models of the impact of AIDS on life expectancy. Two have been published: the first in the annual Human Development Report produced by the United Nations Development Programme; the second by the US Bureau of the Census.¹

The UNDP figures are shown in columns four and five of Table 1. It was only in the 1997 Human Development Report that AIDS mortality was considered as having an impact on life expectancy. The table shows 1993 life expectancy figures (in the 1996 report) and 1995 figures (from the 1998

¹ United Nations Development Programme, **Human Development Report 1996 and 1998**, Oxford University Press, New York 1996 & 1998. United States Bureau of the Census, **World Population Profile 1998**, Population Division International Programme Centre, Washington DC, 1998.

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report). These figures have added significance, as life expectancy provides one third of the weighting for the calculation of the Human Development Index. As can be seen from the table (columns 6 and 7) the effect of the epidemic is to push down countries down the index.

It should be noted that the calculations by the US Bureau of the Census provide a rather bleaker picture for some of the SADC countries, and this is shown in Tables 2 and 3.

Table 2. Demographic Indicators for 1998 with and without AIDS

Country	Life Expectancy		Child Mortality Rate	
	With AIDS	Without AIDS	With AIDS	Without AIDS
Botswana	40.1	61.5	121.1	57.4
Democratic Republic of Congo	49.3	54.4	152.7	139.3
Lesotho	54	62	120.2	98.3
Malawi	36.6	51.1	231.6	190.3
Namibia	41.5	65.3	125.5	62.1
South Africa	55.7	65.4	95.5	69.7
Swaziland	38.5	58.1	168.1	114.4
Tanzania	46.4	55.2	160.1	137.8
Zambia	37.1	56.2	181.2	125.7
Zimbabwe	39.2	64.9	123.4	50.5

Source: United States Bureau of the Census, *World Population Profile 1998*, Population Division International Programme Centre, Washington DC, 1998.

Table 3. Demographic Indicators for 2010 with and without AIDS

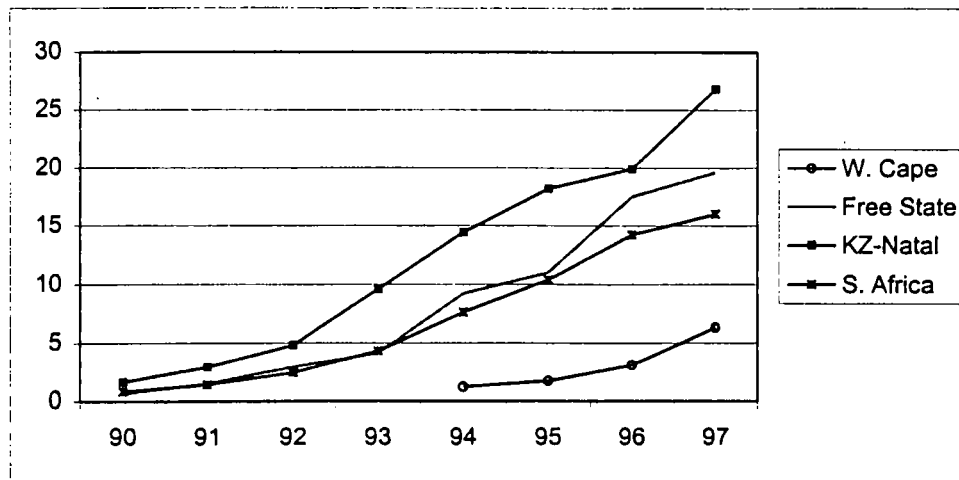
Country	Life Expectancy		Child Mortality Rate	
	With AIDS	Without AIDS	With AIDS	Without AIDS
Botswana	37.8	66.3	119.5	38.3
Democratic Republic of Congo	51.9	59.8	116.2	97.3
Lesotho	44.7	65.9	121.9	70.7
Malawi	34.8	56.8	202.6	136
Namibia	38.9	70.1	118.8	37.5
South Africa	48	68.2	99.5	48.5
Swaziland	37.1	63.2	152.2	77.5
Tanzania	46.1	60.7	131.3	95.8
Zambia	37.8	60.1	160.7	96.9
Zimbabwe	38.8	69.5	115.6	31.8

Source: United States Bureau of the Census, *World Population Profile 1998*, Population Division International Programme Centre, Washington DC, 1998.

The data above are for nations. The situation is not uniform across countries. For example in South Africa the situation varies from province to province. The worst affected is KwaZulu-Natal, where the 1997 survey of ante-natal clinic attenders found an HIV prevalence rate of 26.9%. By contrast in the Western Cape it is 6.3 per cent. The variation in prevalence by province in South Africa is illustrated in Figure 1. The region is also where the highest HIV prevalence in a "low-risk" group

has ever been recorded. According to UNAIDS, in Beitbridge in Zimbabwe "HIV prevalence in pregnant women shot up from 32% in 1995 to 59% in 1996".²

Figure 1 HIV-positivity in women attending antenatal clinics in South Africa, by selected province overall (%)



Because the HIV rates have risen so rapidly, it is likely that the AIDS cases will show a similar rapid increase. The current situation is that in much of the region impact is restricted to the health care system, where 50 to 70 per cent of medical beds are occupied by people with HIV-related disease. In the medium-term there will be a range of demographic, economic, social, and security implications. The extent and magnitude of these is not yet clear, but it is a source of considerable concern for researchers and activists. Unfortunately these concerns do not appear to be shared by the majority of the governments, politicians, planners and policy-makers in the region.

The Response

The donor community is increasingly worried about the AIDS epidemic, and this is illustrated by the recent decision by UNAIDS and the WHO to launch a "Southern Africa Initiative on HIV/AIDS". SADC has recognised the importance of the HIV/AIDS epidemic to the region for some time. In part the impetus for SADC actions came from the joint EU/SADC Regional Conference on HIV/AIDS held in Lilongwe, Malawi in December 1996. The conference resulted in two key outcomes, a statement on regional responses to HIV/AIDS, a SADC Plan of Action, and two publications "Conference on HIV/AIDS: Proceedings and Background Papers" and "Conference on HIV/AIDS: Proposal for Regional Actions".

The SADC Plan of Action recognises that AIDS is not just a health issue and it requires co-ordinated social and economic policies. As well as identifying areas for regional support for national action, and interventions with added value if dealt with regionally, the plan has some specific proposals for action. These include the areas of employment; mining; education; tourism; medical drugs; and the treatment of people with HIV/AIDS; and the collection of data and exchange of information in the region.

At the SADC member states meeting in Mauritius in September 1998, HIV/AIDS was recognised as one of the Biennial Priorities for the Region. The meeting set 10 priorities and, as with the SADC Plan of Action, these recognise the need for a multi-sectoral response. SADC also has made further progress in that a Health Sector Co-ordinating Unit has been established in the Department of

² UNAIDS and WHO, Report on the global HIV/AIDS epidemic, June 1998, Geneva 1998.

Health in South Africa and the Director and Deputy Director took up their posts at the beginning of October 1998. The plans for this sector were adopted by the Council of Ministers and HIV/AIDS is one of the five priority areas for the sector. However it is likely that progress will be slow, as the staff in South Africa are junior and inexperienced. Furthermore SADC has to reflect the views of its member states, and unfortunately the reality is that in some countries AIDS is still not seen as a problem.

USAID and the SADC AIDS Crisis – one response.

USAID has been involved in the region for many years. As with most donors, it saw the ending of apartheid in South Africa as the chance for a new beginning for Southern Africa. It is now recognised that AIDS may well negate this opportunity and indeed could turn back the development clock. USAID is involved in one activity in the region that has the potential to assist in addressing the epidemic. The Project Award No. AOT-G-00-97-00375-00. Title: Operationalising HIV and AIDS, provides for a number of activities to be carried out by the Health Economics and HIV/AIDS Research Division of the University of Natal in Durban. It builds on work already carried out here with support from the European Commission of the European Union and USAID. In particular a toolkit was prepared for incorporating AIDS issues into the development activities of the European Union. This was published in French and English and is available on the World Bank AIDS Economics website as well as in hard copy form.

The activities under the contract are:

- Prepare new and update existing Sectoral AIDS Briefs. These were prepared under contract to the Global Programme on AIDS in 1995 and were published by The Academy for Educational Development with support from USAID in both French and English. Existing AIDS briefs include commercial agriculture; subsistence agriculture, education, health, manufacturing, mining, tourism, and the military. New briefs will include transport, financial sector, fishing, construction, small scale enterprises, entertainment and sport.
- Prepare AIDS briefs for professionals. The following briefs are in production: architects, relief workers, lawyers, town and regional planners, politicians, the media, social workers and NGOs.
- A Toolkit for Governments. This will set out activities to be carried out by the various ministries in government.
- A Toolkit for USAID. This will look at USAID activities and policy and make suggestions as to how AIDS can be incorporated into them.
- Training. The contract provides for training. Originally this was to be for government and other African officials. As this comes at the end of the project (which is scheduled to finish in September 1999) it could be adapted to fit USAID regional needs as well, both in Africa and Washington.

HIV/AIDS Prevalence Among Pregnant Women

Country/Regions	1994	1997	1998
Botswana			
Francistowne	29.7	42.9	43.0
Gabarone	27.8	34.0	39.0
S. Phikwe	27.0	33.0	49.8
Average			38.7
South Africa			
KZ-Natal	14.4	26.9	32.5
Mpumalanga	12.1	22.6	30.00
Freestate	9.2	20.0	22.8
Gauteng	6.4	17.1	22.5
Average	7.6	17.0	22.8
Swaziland			
Hhohho	15.5	26.3	30.3
Lubombo	16.7	26.3	31.5
Mamzini	15.6	27.7	34.8
Average	3.8	18.5	31.6

Source: 1998 Sentinal Survey Reports

Africa Bureau
Office of Development Plans
FY 2000 REVISED CONTROL LE

Rev. #2 - April 10, 1999

Date Printed: 21-Jun-99

Country/Program	TOTAL All Accounts	Development Fund for Africa							Other Health (DA-WVF)
		DFA Account Total Request	Economic Growth	Agriculture (1)	Human Cap. Develop.	Environment	Democracy Governance	Population	
BILATERAL	510,933	336,750	67,700	75,000	9,150	66,800	55,400	62,700	0
ANGOLA	8,000	4,500	1,100	0	0	400	3,000	0	0
BENIN	14,100	4,200	0	0	0	0	1,700	2,500	0
CONGO (5)	9,000	1,000	0	0	0	1,000	0	0	0
ERITREA	8,833	5,200	1,300	2,500	500	300	400	200	0
ETHIOPIA	37,050	12,200	300	3,000	0	500	2,400	6,000	0
GHANA	34,750	20,800	5,500	6,500	0	2,000	900	5,900	0
GUINEA	18,300	10,000	300	0	0	4,000	2,900	2,800	0
KENYA	26,900	20,900	1,900	6,700	0	2,900	3,000	6,400	0
LIBERIA	9,050	7,300	1,000	4,300	0	0	2,000	0	0
MADAGASCAR	17,000	14,000	1,400	0	0	8,500	500	3,600	0
MALAWI	30,850	23,600	0	10,000	0	8,900	1,900	2,800	0
MALI	37,000	24,200	6,950	5,600	150	5,000	2,500	4,000	0
MOZAMBIQUE	45,500	37,300	9,300	11,000	0	8,500	2,400	6,100	0
NAMIBIA	9,300	7,100	4,000	0	0	2,000	1,100	0	0
NIGERIA (2)	20,000	11,000	0	0	3,000	0	4,000	4,000	0
RWANDA	13,000	9,500	2,200	4,900	0	0	2,400	0	0
SENEGAL	21,050	17,050	8,000	0	0	3,600	2,750	2,700	0
SOMALIA	0	0	0	0	0	0	0	0	0
SOUTH AFRICA	47,400	38,750	11,900	0	5,500	5,600	14,550	1,200	0
TANZANIA	23,150	16,150	3,950	2,000	0	3,800	2,500	3,900	0
UGANDA	49,350	31,550	2,850	13,000	0	8,600	1,700	5,400	0
ZAMBIA	22,150	13,450	2,250	5,500	0	1,200	1,300	3,200	0
ZIMBABWE	9,200	7,000	3,500	0	0	0	1,500	2,000	0
REGIONAL	234,070	175,810	73,340	17,245	24,600	32,100	16,150	10,500	1,875
RCSA	23,815	23,815	12,415	3,100	0	6,400	1,900	0	0
REDSO/ESA	25,450	19,950	9,300	3,300	0	2,000	4,750	600	0
West Africa Regional	15,300	7,000	0	0	0	0	0	7,000	0
AFR/SD	60,850	35,008	4,863	6,845	0	18,400	2,900	2,000	0
AFR/DP (3)	5,362	4,812	3,812	0	0	1,000	0	0	0
SAHEL	6,950	6,750	1,450	2,000	0	1,900	500	900	0
Microenterprise Core	11,500	11,500	11,500	0	0	0	0	0	0
Oncho Transfer	3,500	0	0	0	0	0	0	0	0
Undistributed Polio	1,993	0	0	0	0	0	0	0	0
Regional EA/SA HIV	750	0	0	0	0	0	0	0	0
DCOF Unallocated (4)	3,750	0	0	0	0	0	0	0	0
WVF Unallocated (4)	3,750	1,875	0	0	0	0	0	0	1,875
CGIAR	2,000	2,000	0	2,000	0	0	0	0	0
Labor	3,000	3,000	0	0	0	0	3,000	0	0
Micronutrients Unalloc.	3,000	0	0	0	0	0	0	0	0
Regional EPI	0	0	0	0	0	0	0	0	0
DHRF	3,100	3,100	0	0	0	0	3,100	0	0
Trade Devel. Initiative	30,000	30,000	30,000	0	0	0	0	0	0
Food Security Unalloc. (1)	0	0	0	0	0	0	0	0	0
Education Unalloc. (2)	30,000	27,000	0	0	24,600	2,400	0	0	0
TOTAL Request	745,003	512,560	141,040	92,245	33,750	98,900	71,550	73,200	1,875

CHS Account Total Request	Child Survival & Diseases Fund					
	Child Survival	(Polio) (Included in CHS)	HIV/AIDS	Other Health	Infectious Diseases	Basic Education
174,183	54,000	(9,868)	45,500	5,648	9,035	60,000
3,500	3,500	(1,200)	0	0	0	0
9,900	1,800	(263)	800	200	800	6,300
8,000	6,000	(900)	1,000	500	500	0
3,633	2,300	(43)	200	748	385	0
24,850	5,200	(2,730)	5,500	0	800	13,350
13,950	2,300	(703)	4,000	700	500	6,450
8,300	1,300	(286)	1,500	0	0	5,500
6,000	1,500	0	3,200	300	1,000	0
1,750	500	(589)	0	1,000	250	0
3,000	2,400	(701)	600	0	0	0
7,250	1,500	(167)	2,200	0	800	2,750
12,800	4,000	(138)	2,500	500	0	5,800
8,200	4,000	(500)	3,100	400	700	0
2,200	0	0	0	0	0	2,200
9,000	3,600	(1,000)	3,400	0	0	2,000
3,500	1,000	(270)	1,500	700	300	0
4,000	2,300	(46)	1,700	0	0	0
0	0	0	0	0	0	0
8,650	2,200	0	900	0	800	4,750
7,000	2,700	0	3,500	0	800	0
17,800	2,300	0	4,400	400	600	10,100
8,700	3,600	(332)	3,500	0	800	800
2,200	0	0	2,000	200	0	0
58,260	28,610	(6,132)	9,600	6,300	5,750	8,000
0	0	0	0	0	0	0
5,500	3,600	0	200	1,200	500	0
8,300	2,000	0	5,800	0	500	0
25,842	12,042	(4,138)	2,750	1,500	4,750	4,800
550	350	0	0	0	0	200
200	0	0	100	100	0	0
0	0	0	0	0	0	0
3,500	0	0	0	3,500	0	0
1,993	1,993	(1,993)	0	0	0	0
750	0	0	750	0	0	0
3,750	3,750	0	0	0	0	0
1,875	1,875	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
3,000	3,000	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
3,000	0	0	0	0	0	3,000
232,443	82,610	(16,000)	55,100	11,948	14,785	68,000

1) FY 2000 CP Agriculture levels include \$45 million AFSI Allocations as follows:

Ethiopia \$3.0; Ghana \$3.5; Kenya \$3.0; Liberia \$3.0; Malawi \$5.0; Mali \$4.0; Mozambique \$5.0; Rwanda \$3.5; Tanzania \$2.0; Uganda \$5.0; Zambia \$3.5; AFR/SD \$2.0; Sahel \$.5; and CGIAR \$2.0.

2) EDDI Total for FY 2000 is \$35 million: \$5 million is already in Nigeria bilateral level.

3) Includes \$1.0 EG and \$1.0 ENV for WA Regional Design

4) Funds for these directives were taken from levels previously approved in the FY 1999 CP Controls table. The WVF is being coded as 'Promotional Health' under the Other Health DA column.

5) Rev. #2 since CP sent to Hill, decreased Congo AIDS by \$1 mil and increased Congo CHS by \$1 mil.

AFRICA BUREAU
Office of Development Planning
Proposed FY 99 NOA OYB Allocations: 653(a) NOA Levels

FINAL

04-Feb-99
04:07 PM

Country/Program	TOTAL	Development Assistance Account							Child Survival & Disease Fund						
		DA Account Total	Economic Growth	Agriculture	Human Cap Devel.	Environment	Democracy Governance	Population	CSD Account Total	Child Survival	Polio (included in CHS)	HIV/AIDS	Other Health	Infectious Diseases	Basic Education
	489,748	303,895	55,375	61,471	8,321	61,365	57,950	59,413	185,853	65,283	(9,868)	48,595	6,607	7,056	58,312
ANGOLA	11,200	8,500	1,000	3,500		500	3,500	0	2,700	2,700	(1,200)	0	0	0	0
	15,738	4,275	0	0		0	1,900	2,375	11,463	2,263	(263)	1,200	500	500	7,000
CONGO	7,900	2,500	500	0		0	2,000	0	5,400	2,400	(900)	1,914	1,000	86	0
ER	10,000	4,990	0	1,850	2,140	200	400	400	5,010	3,743	(43)	217	950	100	0
ETHIOPIA	39,915	13,950	300	5,500		2,400	2,000	3,750	28,965	7,130	(2,730)	5,540	595	500	12,200
GHANA	36,921	20,923	6,200	4,248		2,800	1,500	6,175	15,998	4,103	(703)	4,000	200	0	7,695
	16,961	9,175	1,000	0		4,000	1,800	2,375	7,786	1,586	(286)	1,200	0	0	5,000
IA	19,300	12,600	2,000	2,000		800	2,500	5,300	6,700	2,100	0	3,300	300	1,000	0
	7,771	5,000	1,500	1,500		0	2,000	0	2,771	1,589	(589)	0	812	370	0
MADAGASCAR	15,528	11,925	800	0		7,000	800	3,325	3,601	3,101	(701)	500	0	0	0
MALAWI	32,128	22,681	0	9,511		7,900	2,250	3,000	9,467	2,167	(167)	2,600	0	500	4,200
MALI	34,494	23,792	2,744	7,562	1,181	5,925	1,850	4,530	10,702	3,142	(138)	2,230	0	0	5,340
Mozambique	40,720	29,300	7,500	9,200		5,100	2,700	4,800	11,420	6,100	(500)	2,820	1,000	1,500	0
	8,650	6,650	3,900	0		2,000	750	0	2,000	0	0	0	0	0	2,000
NIGER	0	0	0	0		0	0	0	0	0	0	0	0	0	0
NIGERIA	12,500	8,500	0	0		0	4,000	2,500	6,000	4,000	(1,000)	2,000	0	0	0
RWANDA	11,270	8,500	3,400	2,600		0	2,500	0	2,770	520	(270)	2,000	250	0	0
SENEGAL	23,224	17,243	5,400	1,000		2,940	2,000	5,903	8,981	3,207	(46)	2,774	0	0	0
SOMALIA	1,500	500	0	0		0	500	0	1,000	1,000	0	0	0	0	0
SOUTH AFRICA	47,006	34,206	4,431	0	5,000	8,575	14,200	2,000	12,800	5,000	0	1,500	0	1,000	5,300
TANZANIA	21,650	14,760	4,250	2,000		2,500	2,150	3,850	6,900	2,400	0	4,000	0	500	0
UGANDA	46,442	27,555	5,450	7,500		6,725	2,300	5,580	18,887	3,300	0	6,010	1,000	0	8,577
ZAMBIA	20,432	11,450	3,050	2,000		2,000	1,850	2,550	8,982	3,732	(332)	3,250	0	1,000	1,000
ZIMBABWE	8,500	6,950	1,950	1,500		0	2,500	1,000	1,550	0	0	1,550	0	0	0
REGIONAL	214,567	156,238	70,834	15,979	20,500	32,170	8,018	8,737	56,329	28,617	(6,132)	7,405	6,393	7,944	7,970
RCSA	28,000	28,000	17,000	1,900		8,100	1,000	0	0	0	0	0	0	0	0
REDSO/E/S/GHAI	22,624	18,022	9,570	3,147		2,550	2,430	325	4,602	3,750	0	250	102	500	0
West Africa Regional	13,977	6,567	0	0		0	0	6,567	7,410	3,006	0	3,405	0	1,000	0
									0	0	0	0	0	0	0
AFR/SD	52,570	29,490	4,550	5,920		17,220	850	950	23,080	13,569	(4,139)	3,080	2,741	500	3,270
AFR/DP	8,559	4,509	4,509	0		0	0	0	1,050	800	0	0	50	0	200
SAHEL	5,950	5,950	1,605	1,012		1,800	638	895	0	0	0	0	0	0	0
Microenterprise Core	6,100	5,100	5,100	0		0	0	0	0	0	0	0	0	0	0
Onco Transfer	3,500	0	0	0		0	0	0	3,500	0	0	0	3,500	0	0
Undistributed Polio	1,993	0	0	0		0	0	0	1,993	1,993	(1,993)	0	0	0	0
Regional EA/SA HIV	750	0	0	0		0	0	0	750	0	0	750	0	0	0
DCOF	0	0	0	0		0	0	0	0	0	0	0	0	0	0
	0	0	0	0		0	0	0	0	0	0	0	0	0	0
CGIAR	2,000	2,000	0	2,000		0	0	0	0	0	0	0	0	0	0
Labor	0	0	0	0		0	0	0	0	0	0	0	0	0	0
nutrients	2,500	0	0	0		0	0	0	2,500	2,500	0	0	0	0	0
Regional EPI	3,000	0	0	0		0	0	0	3,000	3,000	0	0	0	0	0
DHRF	3,100	3,100	0	0		0	3,100	0	0	0	0	0	0	0	0
Undistributed	5,944	0	0	0		0	0	0	5,944	0	0	0	0	5,944	0
Trade Devel. Initiative	30,000	30,000	28,500	0		1,500	0	0	0	0	0	0	0	0	0
AFSI Undistributed (1)	2,000	2,000	0	2,000		0	0	0	0	0	0	0	0	0	0
Education	26,000	21,500	0	0	20,500	1,000	0	0	4,500	0	0	0	0	0	4,500
															0
TOTAL	704,316	460,133	126,209	77,450	28,821	93,535	65,968	68,150	244,182	93,900	(16,000)	56,000	13,000	15,000	66,282
M OYB Controls	704,315	460,133		78,000		93,535		68,150	244,182	93,900	(16,000)	56,000	13,000	15,000	66,282

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**AIDS Cuts Life Expectancy in Many African Countries,
Census Bureau Notes in World Population Profile**

AIDS has cut life expectancy by four years in Nigeria, 18 years in Kenya and 26 years in Zimbabwe -- only a few of the countries where mortality from the disease is having a major demographic impact, the Commerce Department's Census Bureau reported today.

"AIDS results in higher mortality rates in childhood, as well as among young adults where mortality otherwise is low," said Karen Stanecki, a contributing author of the Census Bureau's new report, World Population Profile: 1998. "As a result, AIDS deaths will have a larger impact on life expectancies than on some other demographic indicators in these nations."

The Census Bureau assessment shows 21 countries in Sub-Saharan Africa are significantly affected by AIDS. According to the report, HIV/AIDS epidemics continue to spread in Sub-Saharan Africa, particularly in Botswana and South Africa. Other severely affected countries include Namibia, Swaziland, Zambia and Zimbabwe, where 18 to 25 percent of all adults are HIV-positive.

Seven developing countries in Asia and Latin America also are significantly affected -- Guyana, Burma, Haiti, Cambodia, Honduras, Brazil and Thailand.

In addition to the update on AIDS mortality worldwide, World Population Profile: 1998 provides a comprehensive picture of population size and growth, fertility and mortality levels, and age structure in 227 countries and territories during the next quarter century.

The report also examines trends in family planning likely to play a key role in determining fertility and natural population increases during the coming decades.

Other points from the report:

- The world population will reach 6 billion in 1999.

- Between 1998 and 2025, the world's elderly population (age 65 and over) will more than double while the world's young (under age 15) will grow by only 6 percent.
- Early in the next century, international migration will become more of a critical variable in population growth in the United States and other developed countries, where the balance of births and deaths will otherwise lead to a stable or decreasing population.
- About 96 percent of world population increase now occurs in the developing regions of Africa, Asia and Latin America.
- A child born in Latin America or Asia can expect to live between seven and 13 fewer years, on average, than one born in North America or Western Europe.
- An estimated 120 million married women in the world's developing regions have an "unmet need" for contraceptive services and products, meaning they would like to regulate their fertility but currently are not using any means of contraception.

Data in the report are from the Census Bureau's International Data Base, HIV/AIDS Surveillance Data Base and unpublished tables.

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The AIDS Pandemic in the 21st Century

The Demographic Impact in Developing Countries

by

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Paper prepared for presentation at the XIIIth International AIDS Conference, Durban, South Africa, 9-14 July 2000. Excerpts from US Census Bureau's World Population Profile 2000 focus chapter, to be published 2000.

The AIDS pandemic in the 21st century continues to have its greatest impact in the developing world.

The overwhelming majority of people with HIV, 95 percent of the global total, live in the developing world. The Joint United Nations Programme on HIV/AIDS (UNAIDS) expects that this proportion will continue to rise in countries where poverty, poor health systems and limited resources for prevention and care fuel the spread of the virus.¹

An estimated 71 percent of the global total of HIV-positive people, 24.5 million out of 34.3 million, live in sub-Saharan Africa. Sub-Saharan Africa contains only 11 percent of the global population. Over eight percent (8.6%) of all adults in sub-Saharan Africa are HIV positive compared to 0.6 percent of Americans. Since the beginning of the epidemic, 14.8 million Africans have died from AIDS; 2.2 million AIDS deaths occurred in 1999.

Southern and eastern Africa have been the most severely affected regions. Seven countries now have an estimated² adult HIV prevalence of 20 percent or greater: Botswana, Lesotho, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe. In these countries, all in southern Africa, at least one adult in five is living with HIV. An additional 9 countries have adult HIV prevalence levels higher than 10 percent.

In comparison, HIV prevalence levels in Asia are relatively low. Adult HIV prevalence exceeds 1 percent in only three countries: Burma, Cambodia, and Thailand. In other countries, the prevalence rate is much lower.

In Latin America and the Caribbean, the HIV/AIDS epidemics vary from those that are concentrated among IV drug users and men who have sex with men to epidemics that seem to be mostly driven by heterosexual transmission. These include The Bahamas, Haiti, and Guyana, the countries with the highest adult HIV prevalence rates in the region.

In sub-Saharan Africa, more women than men are HIV positive.

At the end of 1999, UNAIDS estimated that 55 percent of all HIV infections in sub-Saharan Africa were among women. Peak HIV prevalence among women occurs at a younger age than among men. Among women, HIV prevalence tends to peak around 25 years of age. Peak HIV prevalence among men occurs 10 to 15 years later and generally at lower levels.

Several studies³ comparing data from antenatal clinic with community based studies have shown that HIV prevalence among antenatal clinic (ANC) women still gives a reasonable overall estimate of HIV prevalence in the general adult population. ANC prevalence tends to underestimate the prevalence among women but overestimates HIV prevalence among men.

Mortality patterns are driven by HIV prevalence patterns.

Median survival with HIV/AIDS is estimated to be around 10 years. In South Africa, by 2020, mortality for adults ages 20 to 45 will be much higher than it would have been without AIDS. Mortality for women will peak during the ages of 30-34, earlier than the peak seen for men during the ages of 40-44.

¹ AIDS epidemic update: December 1999, © UNAIDS December 1999.

² Report on the Global HIV/AIDS Epidemic, June 2000, © UNAIDS.

³ Fylkenes, Musonda, Sichone, *et al*, 1999.

At the beginning of the 21st century the growth rate in Zimbabwe has been reduced to nearly zero due to AIDS mortality.⁴

Other countries with sharply reduced growth rates include several other southern African countries: Botswana, Malawi, Namibia, South Africa, Swaziland, and Zambia.

The negative population growth seen in Guyana in 2000, is the impact of AIDS mortality compounded by out-migration. The underlying growth rate for Guyana is 0.1. with AIDS, the growth rate for Guyana is -0.1.

In Asia, AIDS mortality results in slightly lower growth rates in Burma, Cambodia and Thailand.

By the year 2003, Botswana, South Africa and Zimbabwe will be experiencing negative population growth.

By 2010, the growth rate for these countries will be around a -1 percent. This negative population growth is due to the high levels of HIV prevalence in these countries and relatively low fertility. This is the first time the Census Bureau is estimating negative population growth due to AIDS for any country. Previously, HIV/AIDS experts never expected HIV prevalence rates to reach such high levels, nationally, in any country. By the end of 1999, adult HIV prevalence had reached an estimated 36 percent in Botswana, 20 percent in South Africa, and 25 percent in Zimbabwe.⁵

Other countries in southern Africa will be experiencing a growth rate of nearly 0 including Lesotho, Malawi, Mozambique, Namibia, and Swaziland. Without AIDS, these countries would have been experiencing a growth rate of 2 percent or greater.

In Latin America and the Caribbean, The Bahamas and Guyana will be experiencing the greatest impact on their growth rates. Growth rates will be reduced from 1 percent to 0.4 percent.

In Asia, growth rates will be slightly reduced for Burma, Thailand, and Cambodia.

AIDS mortality will produce population pyramids that have never been seen before.

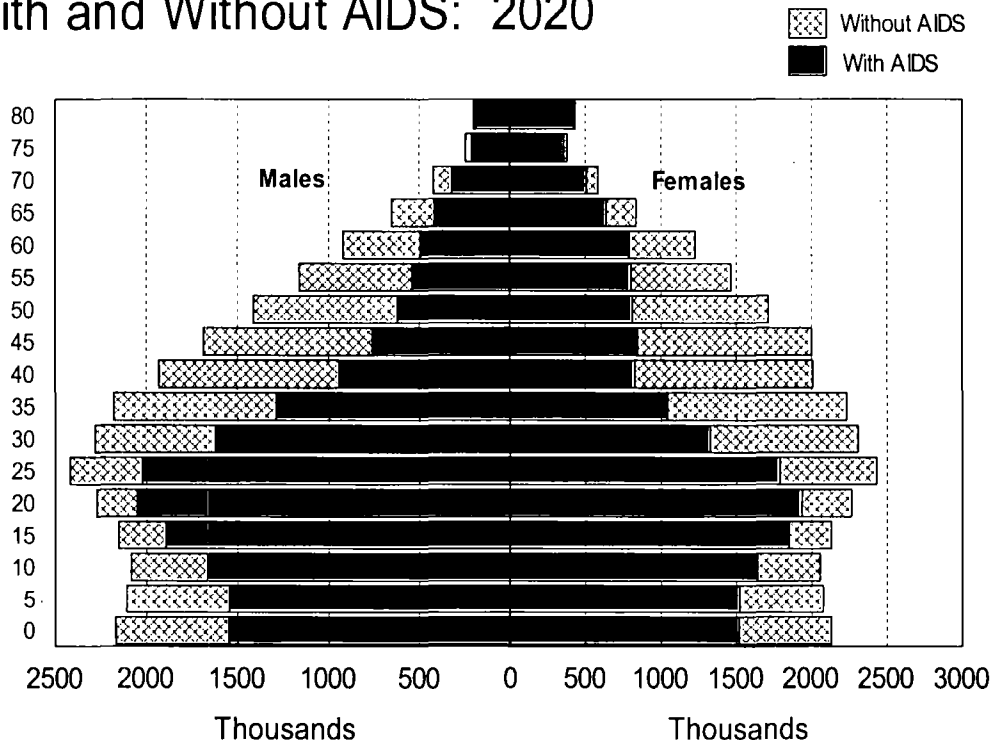
Particularly in those countries with projected negative population growth, Botswana, South Africa and Zimbabwe, population pyramids will have a new shape^{BA}the population chimney.[@] (See figure below). The implications of this new population structure are not clear. By 2020, between the ages of 15 and 44, there are more men than women in each of the 5-year-age cohorts which may push men to seek partners in younger and younger age cohorts. This factor in turn may increase HIV infection rates among younger women. Current evidence⁶ indicates that older men are infecting younger women, who then go on to infect their partners, particularly through marriage. This vicious cycle could result in even higher HIV infection levels.

⁴Refer to appendix tables for country specific indicators.

⁵Report on the Global HIV/AIDS Epidemic, June 2000", UNAIDS

⁶Multicentre Study on Factors Determining the Differential Spread of HIV in 4 African Towns. Buve, A., R. Musonda, M. Carael, *et al.* XI International Conference on AIDS and STDs in Africa, Lusaka, Zambia, Late Breaker Session, 1999.

Population of South Africa, With and Without AIDS: 2020



In countries with moderate epidemics, AIDS mortality will have less of an effect on the population structure.

For example, in Uganda, the greatest relative differences in future population size by cohort are evident in the youngest age groups and in those 30 to 50 years of age. However, the population pyramid still continues to maintain its traditional shape.

AIDS mortality is resulting in falling life expectancies.

Already, life expectancies have fallen in many countries in sub-Saharan Africa from levels they would have been without AIDS. In Botswana, life expectancy is now 39 instead of 71. In Zimbabwe, life expectancy is 38 instead of 70. In fact, six countries in sub-Saharan Africa: Botswana, Malawi, Mozambique, Rwanda, Zambia, and Zimbabwe have life expectancies below 40 years of age. They would have been 50 years or greater without AIDS.

In Latin America and the Caribbean, the impact on life expectancy is not as great as in sub-Saharan Africa because of lower HIV prevalence levels. However, they are still lower than they would have been without AIDS. In The Bahamas, life expectancy is now 71 instead of 80. And in Haiti, life expectancy is now 49 instead of 57.

In Asia, Thailand, Cambodia, and Burma have lost three years of life expectancy.

In ten years time, 2010, many countries in southern Africa will see life expectancies falling to near 30 years of age, levels not seen since the beginning of the 20th century.

In a region that would have expected life expectancies to reach 70 years of age by 2010, many will see life

expectancies falling to around 30:

\$ BotswanaB29
\$ NamibiaB33
\$ SwazilandB30
\$ ZimbabweB33

Many other countries will see life expectancies falling to 30-40 years of age instead of 50-60 years.

AIDS mortality will continue to result in falling life expectancies in Latin America, the Caribbean and Asia. In Latin America and the Caribbean, life expectancy will be 14-15 years lower in The Bahamas and Guyana than they would have been without AIDS. In Asia, life expectancies will be two years lower in Thailand and 4 years lower in Cambodia and Burma.

The most direct impact of AIDS is to increase the number of deaths in populations affected.

Crude death rates, the number of people dying per 1,000 population, have already been affected by AIDS.

In Africa, HIV epidemics have had their greatest impact in eastern and the southern regions. Adult HIV prevalence is 20 percent or higher in 7 countries and an additional 9 countries have HIV prevalence rates between 10 and 20 percent. In many of these countries, reports indicate the presence of the HIV virus since the early 1980s.

As a result of these long-term high levels of HIV infection, estimated crude death rates including AIDS mortality are greater by 50 to 500 percent in eastern and southern Africa over what they would have been without AIDS. For example, in Kenya with an adult HIV prevalence of 14 percent at the end of 1999, crude death rates are estimated to be twice as high, 14.1, than they would have been without AIDS, 6.5. In South Africa, with an estimated 20 percent adult HIV prevalence level, crude death rates are also twice as high, 14.7, than they would have been without AIDS. 7.4.

In Asia and Latin America the estimated crude death rates are also higher than they would have been without AIDS.

In many sub-Saharan African countries, crude death rates will be even higher in 2010 than in 2000, even though mortality due to non-AIDS causes will continue to decline.

In Botswana, crude death rates will increase from 22.8 in 2000 to 36.0 in 2010. In South Africa, crude death rates will increase from 14.7 to 30.3 and in Zimbabwe from 22.4 to 31.6. In all three of these countries, crude death rates would have been 5 to 7 without AIDS.

In Latin America and the Caribbean, The Bahamas and Guyana will see a doubling of crude death rates with AIDS over what they would have been without AIDS.

In Asia, crude death rates will be slightly higher with AIDS than they would have been without AIDS. In Thailand crude death rates with AIDS will be 7.8 compared to 6.9 without AIDS. In Cambodia, crude death rates will be 9.5 with AIDS versus 7.7 without AIDS.

In some sub-Saharan African countries, infant mortality rates are now higher than they were in 1990.⁷

AIDS mortality has reversed the declines that had been occurring during the 1980s and early 1990s. Over

⁷U.S. Census Bureau, International Data Base and unpublished tables.

30 percent of all children born to HIV infected mothers in sub-Saharan Africa will be HIV positive either through the birth process or due to breast feeding. The relative impact of AIDS on infant mortality will depend on both the levels of HIV prevalence in the population and the infant mortality rate from other causes. In 1990⁸ infant mortality in Zimbabwe was 54; in 2000 it is 62. In Kenya, infant mortality in 1990 was 67, in 2000 it is 69. Without AIDS infant mortality in Zimbabwe would have been 30 and in Kenya it would have been 55.

In countries with less severe epidemics, such as in western and central Africa, infant mortality rates are higher than they would have been without AIDS. The increase ranges from 3 percent in Benin to 12 percent in Côte d'Ivoire and 15 percent in Rwanda.

In those countries most affected by AIDS in Latin America, the Caribbean and Asia, infant mortality rates are also higher than they would have been without AIDS. In Latin America and the Caribbean, infant mortality rates are 2 to 6 percent higher. And in Asia, infant mortality is 1 to 3 percent higher in Thailand, Burma and Cambodia.

In four countries of sub-Saharan Africa, more infants will die from AIDS in 2010 than from all other causes.

In Botswana and Zimbabwe, twice as many infants will die from AIDS than from all other causes. South Africa and Namibia are the other two countries where more infants will die from AIDS than from all other causes. Although overall infant mortality rates are projected to decline between 2000 and 2010, infant mortality due to AIDS is projected to increase.

The only projected decline in AIDS mortality among infants are for Uganda and Thailand.

In 26 sub-Sahara African countries, child mortality rates have increased over what they would have been without AIDS.

The impact on child mortality is highest among those countries who had significantly reduced child mortality due to other causes and where HIV prevalence is high. Many HIV infected children survive their first birthdays, only to die before the age of 5. In Zimbabwe, 70 percent of all deaths among children less than 5 are due to AIDS. In South Africa that percentage is 45.

In The Bahamas, 60 percent of deaths among children less than 5 are due to AIDS.

In Burma, Cambodia and Thailand, 1 percent of deaths among children are due to AIDS.

Based on current trends, child mortality rates in 2010 will continue to be much higher with AIDS than they would have been without AIDS.

In Zimbabwe and Botswana, where child mortality rates may have been below 30 without AIDS, over 150 children per 1000 will die. Of that total, 80 percent will be due to AIDS. In many of the countries in southern Africa, over 50 percent of childhood deaths will be due to AIDS. In Malawi and Mozambique, where child mortality rates due to other causes is already high, AIDS mortality will increase those rates by 30 percent.

In The Bahamas and Guyana, over 50 percent of childhood deaths will be due to AIDS.

In Asia, child mortality rates will be around 10 percent higher with AIDS mortality in Burma, Cambodia and Thailand, than they would have been without AIDS.

⁸Figures for 1990 also include AIDS mortality.

Populations in most sub-Saharan African countries will continue to increase, despite the high levels of mortality. The exceptions are Botswana, South Africa and Zimbabwe.

Although AIDS mortality has resulted in lower growth rates, fertility is still high and populations growth is still positive. Populations will continue to increase. The exceptions are Botswana, South Africa and Zimbabwe. These populations will take a long time to rebound from the current levels of HIV prevalence and AIDS mortality even if current AIDS control programs result in lowering future HIV incidence and prevalence.

At the beginning of the 21st Century, AIDS is the number one cause of death in Africa and 4th globally.⁹

Emerging just 20 years ago, few would have predicted the current state of the epidemic, particularly in sub-Saharan Africa. That 25 percent of adults would be living with HIV/AIDS in any country was unthinkable. Yet, this is the current situation in 4 countries. In seven sub-Saharan African countries, at least 1 out of 5 adults are living with HIV/AIDS and in an additional 9 sub-Saharan African countries, 1 out of 10 adults is HIV positive.¹⁰

Many individuals have difficulty grasping the results of these high prevalence levels. The resulting AIDS mortality is difficult to comprehend. Yet given these current rates, many more millions of individuals will die due to AIDS over the next decade than have over the past 2 decades. In many of the southern African countries, they are only beginning to see the impacts of these high levels of HIV prevalence.

There have been success stories: Thailand, Senegal, and Uganda. In Thailand and Uganda, concerted efforts at all levels of civil society have turned around increasing HIV prevalence rates. In Senegal, programs put into place early in the epidemic have kept HIV prevalence rates low. These success can be repeated. However, the current burden of disease, death and orphanhood, will be a significant problem in many countries of sub-Saharan Africa for the near future.

⁹The World Health Report 1999, Making a Difference. World Health Organization, 1999.

¹⁰Report on the Global HIV/AIDS epidemic. UNAIDS/WHO June 2000

Appendix A.

Detailed Tables



New estimates and projections of population and vital rates are made for each issue of the *World Population Profile* based on the latest information available. Sometimes the latest information requires making a revision to estimated data for the past as well as new projections for the future. Therefore, the user is cautioned against creating time series of population or the components of population change from different issues of the report.

A data diskette has been prepared to accompany *World Population Profile: 1998*. Available on request, at no charge, the WP98 data diskette is a 3.5" diskette containing all data shown in the Appendix A tables and data for additional years for Tables A-5, A-7, A-9, and A-10. Data are stored on the diskette in Lotus 1-2-3 wk1 format. See page 4 in the Introduction to this report for information about ordering this diskette.

Table A-1.
World Population by Region and Development Category: 1950 to 2025

[Midyear population in millions. Figures may not add to totals due to rounding]

Region	1950	1960	1970	1980	1990	1998	2000	2010	2025
WORLD.....	2,556	3,039	3,707	4,454	5,278	5,927	6,082	6,846	7,921
Less Developed Countries	1,749	2,129	2,703	3,372	4,136	4,751	4,901	5,639	6,708
More Developed Countries	807	911	1,004	1,081	1,142	1,176	1,181	1,207	1,213
AFRICA.....	228	283	360	468	621	761	798	995	1,323
Sub-Saharan Africa.....	184	227	289	378	502	620	652	820	1,108
North Africa	44	56	71	90	119	141	146	175	216
NEAR EAST.....	44	57	75	101	135	166	175	223	307
ASIA.....	1,368	1,628	2,038	2,498	2,987	3,363	3,451	3,863	4,398
LATIN AMERICA AND THE CARIBBEAN.....	166	218	286	362	443	507	523	596	695
EUROPE AND THE NEW INDEPENDENT STATES.....	572	639	703	750	787	798	799	802	786
Western Europe.....	304	326	352	367	375	385	386	385	366
Eastern Europe	88	100	108	117	122	122	122	124	121
New Independent States.....	180	214	242	266	289	291	290	293	298
NORTH AMERICA.....	166	199	227	252	278	301	306	332	374
OCEANIA.....	12	16	19	23	27	30	30	34	39
EXCLUDING CHINA:									
World.....	1,983	2,374	2,868	3,446	4,113	4,661	4,797	5,479	6,479
Less Developed Countries	1,176	1,464	1,864	2,365	2,971	3,486	3,616	4,273	5,266
Asia.....	795	963	1,199	1,490	1,823	2,098	2,166	2,497	2,957
Less Developed Countries	711	868	1,094	1,373	1,699	1,972	2,039	2,370	2,837

Note: Reference to China in tables A-1 through A-3 encompasses China, Hong Kong S.A.R. and Taiwan. Direct access to this table and the International Data Base is available through the Internet at <http://www.census.gov/ipc/www>.

Source: U.S. Bureau of the Census, International Data Base.

Table A-2.
Average Annual Rate of Growth by Region and Development Category: 1950 to 2020

[In percent]

Region	1950-60	1960-70	1970-80	1980-90	1990-2000	2000-10	2010-20
WORLD	1.7	2.0	1.8	1.7	1.4	1.2	1.0
Less Developed Countries	2.0	2.4	2.2	2.0	1.7	1.4	1.2
More Developed countries	1.2	1.0	0.7	0.5	0.3	0.2	0.1
AFRICA	2.1	2.4	2.6	2.8	2.5	2.2	1.9
Sub-Saharan Africa	2.1	2.4	2.7	2.8	2.6	2.3	2.0
North Africa	2.4	2.4	2.5	2.7	2.1	1.8	1.5
NEAR EAST	2.7	2.6	3.0	3.0	2.6	2.4	2.2
ASIA	1.7	2.2	2.0	1.8	1.4	1.1	0.9
LATIN AMERICA AND THE CARIBBEAN	2.7	2.7	2.4	2.0	1.7	1.3	1.1
EUROPE AND THE NEW INDEPENDENT STATES	1.1	0.9	0.7	0.5	0.1	(Z)	-0.1
Western Europe	0.7	0.8	0.4	0.2	0.3	(Z)	-0.3
Eastern Europe	1.3	0.9	0.8	0.4	-0.1	0.2	-0.1
New Independent States	1.7	1.3	0.9	0.8	(Z)	0.1	0.2
NORTH AMERICA	1.8	1.3	1.1	1.0	1.0	0.8	0.8
OCEANIA	2.3	2.1	1.6	1.6	1.3	1.1	0.9
EXCLUDING CHINA:							
World	1.8	1.9	1.8	1.8	1.5	1.3	1.2
Less Developed Countries	2.2	2.4	2.4	2.3	2.0	1.7	1.4
Asia	1.9	2.2	2.2	2.0	1.7	1.4	1.2
Less Developed Countries	2.0	2.3	2.3	2.1	1.8	1.5	1.3

Z Between -0.05 percent and +0.05 percent.

Note: Direct access to this table and the International Data Base is available through the Internet at <http://www.census.gov/ipc/www>.

Source: U.S. Bureau of the Census, International Data Base.

Table A-3.
Population, Vital Events, and Rates by Region and Development Category: 1998

[Population and events in thousands. Figures may not add to totals because of rounding]

Region	Midyear population	Births	Deaths	Natural increase	Births per 1,000 population	Deaths per 1,000 population	Rate of natural increase (percent)
WORLD	5,926,830	132,779	54,146	78,633	22	9	1.3
Less Developed Countries.	4,751,248	119,563	41,898	77,665	25	9	1.6
More Developed Countries.	1,175,581	13,216	12,248	968	11	10	0.1
AFRICA	760,737	29,370	10,663	18,707	38	14	2.4
Sub-Saharan Africa	619,787	25,511	9,662	15,849	41	16	2.5
North Africa	140,950	3,859	1,001	2,858	27	7	2.0
NEAR EAST	166,298	5,137	969	4,168	31	6	2.5
ASIA	3,363,431	72,761	27,055	45,706	22	8	1.4
LATIN AMERICA AND THE CARIBBEAN	507,436	11,848	3,497	8,351	23	7	1.6
EUROPE AND THE NEW INDEPENDENT STATES	798,152	8,866	9,143	-277	11	11	(Z)
Western Europe	385,349	3,986	3,878	108	10	10	(Z)
Eastern Europe.	121,686	1,248	1,307	-59	10	11	(Z)
New Independent States	291,117	3,632	3,957	-325	12	14	-0.1
NORTH AMERICA	301,116	4,266	2,602	1,664	14	9	0.6
OCEANIA	29,659	530	216	314	18	7	1.1
EXCLUDING CHINA:							
World	4,661,300	112,912	45,341	67,570	24	10	1.4
Less Developed Countries.	3,485,719	99,696	33,094	66,602	29	10	1.9
Asia	2,097,901	52,894	18,251	34,643	25	9	1.7
Less Developed Countries.	1,971,970	51,602	17,251	34,351	26	9	1.7

Z Between -0.05 percent and +0.05 percent.

Note: Direct access to this table and the International Data Base is available through the Internet at <http://www.census.gov/ipc/www>.

Source: U.S. Bureau of the Census, International Data Base.

Table A-4.
Population by Region and Country: 1950 to 2025

[Midyear population in thousands. Figures may not add to totals because of rounding]

Region and country or area	1950	1960	1970	1980	1990	1998	2000	2010	2025
WORLD	2,555,983	3,039,434	3,706,605	4,453,910	5,277,903	5,926,830	6,082,493	6,845,901	7,920,868
Less Developed Countries	1,749,190	2,128,793	2,702,888	3,372,473	4,136,085	4,751,248	4,901,292	5,639,070	6,707,572
More Developed countries	806,793	910,641	1,003,718	1,081,437	1,141,818	1,175,581	1,181,201	1,206,832	1,213,296
AFRICA	228,341	282,876	359,558	468,311	620,954	760,737	798,116	994,535	1,323,280
Sub-Saharan Africa	184,421	227,187	288,916	377,833	502,075	619,787	651,616	819,725	1,107,612
Angola.....	4,118	4,797	5,606	6,794	8,430	10,865	11,487	14,932	21,598
Benin.....	1,673	2,055	2,620	3,444	4,676	6,101	6,517	8,955	13,541
Botswana.....	430	497	584	903	1,304	1,448	1,479	1,570	1,634
Burkina Faso.....	4,376	4,866	5,626	6,939	9,024	11,266	11,892	15,371	21,360
Burundi.....	2,363	2,812	3,513	4,138	5,285	5,537	5,931	7,539	10,469
Cameroon.....	4,888	5,609	6,727	8,761	11,894	15,029	15,892	20,632	29,108
Cape Verde.....	146	197	269	296	349	400	411	464	532
Central African Republic.....	1,260	1,467	1,827	2,244	2,798	3,376	3,516	4,314	5,545
Chad.....	2,608	3,042	3,733	4,507	5,889	7,360	7,760	10,055	14,360
Comoros.....	148	183	236	334	429	546	581	782	1,160
Congo (Brazzaville).....	768	931	1,183	1,620	2,206	2,658	2,776	3,368	4,246
Congo (Kinshasa).....	13,569	16,462	21,395	28,129	37,978	49,001	51,988	70,276	105,737
Côte d'Ivoire.....	2,860	3,576	5,504	8,261	11,904	15,446	16,190	20,565	27,840
Djibouti.....	60	78	158	279	370	441	454	588	841
Equatorial Guinea.....	211	244	270	256	369	454	478	615	876
Eritrea.....	1,403	1,612	2,153	2,555	2,945	3,842	4,142	5,737	8,438
Ethiopia.....	20,175	24,252	29,673	36,413	48,015	58,390	60,967	74,832	98,763
Gabon.....	416	446	514	808	1,078	1,208	1,244	1,445	1,800
Gambia, The.....	305	391	502	676	964	1,292	1,381	1,864	2,678
Ghana.....	5,297	6,958	8,789	10,880	15,190	18,497	19,272	22,929	28,191
Guinea.....	2,586	3,019	3,587	4,320	5,936	7,477	7,611	9,440	13,135
Guinea-Bissau.....	573	617	620	789	998	1,206	1,263	1,579	2,102
Kenya.....	6,121	8,157	11,272	16,685	23,674	28,337	29,251	32,443	34,774
Lesotho.....	726	859	1,067	1,346	1,744	2,090	2,167	2,445	2,724
Liberia.....	824	1,055	1,397	1,900	2,265	2,772	3,090	4,342	6,524
Madagascar.....	4,620	5,482	6,766	8,678	11,525	14,463	15,295	20,096	29,306
Malawi.....	2,817	3,450	4,489	6,129	9,139	9,840	10,154	11,330	12,475
Mali.....	3,688	4,486	5,525	6,731	8,231	10,109	10,751	14,611	22,647
Mauritania.....	1,006	1,117	1,289	1,550	1,979	2,511	2,660	3,582	5,446
Mauritius.....	481	663	830	964	1,074	1,168	1,196	1,328	1,488
Mayotte.....	22	28	37	52	80	109	117	168	270
Mozambique.....	6,250	7,472	9,304	12,103	14,056	18,641	19,614	24,809	33,308
Namibia.....	464	591	765	975	1,409	1,622	1,674	1,915	2,310
Niger.....	2,482	3,168	4,182	5,629	7,644	9,672	10,260	13,678	20,424
Nigeria.....	31,797	39,230	49,309	65,699	86,530	110,532	117,171	150,274	203,423
Reunion.....	244	338	445	507	600	705	730	847	1,017
Rwanda.....	2,439	3,032	3,769	5,170	7,161	7,956	8,337	9,881	12,159
Saint Helena.....	5	5	6	6	7	7	7	8	8
Sao Tome and Principe.....	60	63	74	94	119	150	160	219	331
Senegal.....	2,654	3,270	4,318	5,640	7,408	9,723	10,390	14,362	22,456
Seychelles.....	33	42	54	66	73	79	80	84	91
Sierra Leone.....	2,087	2,396	2,789	3,333	4,283	5,080	5,509	7,380	11,010
Somalia.....	2,438	2,956	3,667	5,791	6,675	6,842	7,434	10,132	15,192
South Africa.....	13,596	17,417	22,740	29,252	37,191	42,835	43,982	47,503	49,851
Sudan.....	8,051	10,589	13,788	19,064	26,628	33,551	35,530	46,573	64,757
Swaziland.....	277	352	455	607	840	966	1,004	1,202	1,589
Tanzania.....	8,909	10,876	14,038	18,690	24,886	30,609	31,963	39,390	50,661
Togo.....	1,172	1,456	1,964	2,596	3,680	4,906	5,263	7,401	11,712
Uganda.....	5,522	7,262	9,728	12,298	17,227	22,167	23,452	31,768	49,181
Zambia.....	2,553	3,254	4,247	5,638	7,957	9,461	9,872	12,150	16,156
Zimbabwe.....	2,853	4,011	5,515	7,298	9,958	11,044	11,272	11,953	12,366

are 900,000 fewer people in South Africa, 1.3 million fewer people in Uganda, and 1.6 million fewer people in Zimbabwe directly and indirectly due to AIDS (Figure 37).

By the year 2010, there will be a total of 71 million fewer people in the region. Kenya will have 6.7 million fewer people, South Africa will have 5.6 million fewer people, Nigeria will have 11.7 million fewer people, Uganda will have 4.2 million fewer people, and Zimbabwe will have 4.4 million fewer people than there would have been without the effect of AIDS (Figure 37 second panel).

In Asia, current estimates indicate that there are 400,000 fewer people in Burma, 200,000 people less in Cambodia, and 300,000 fewer people in Thailand. By the year 2010, Burma will have 1.6 million fewer people, Cambodia's population will have been reduced by a potential 500,000 people and Thailand will have 1.1 million fewer people.

The population of Brazil is one of the largest in Latin America, and with the AIDS epidemics, will lose the most people. Current estimates show 2.3 million fewer people in Brazil with a projected loss of population of 10 million people by the year 2010. Current estimates only indicate a population loss in Haiti, with 400,000 fewer people. By the year 2010, Haiti will have 900,000 fewer people.

Perhaps the Largest Demographic Impact of AIDS Mortality Will Be on Life Expectancies

Many potential years of life will be lost due to the AIDS epidemics. AIDS will result in higher mortality rates in childhood, as well as among young adults where normal mortality is quite low.

As a result, AIDS deaths will have a relatively larger impact on life expectancies

than on perhaps any other demographic indicator. In Kenya, the AIDS epidemic has resulted in 18 years of life lost. In Nigeria, current estimated life expectancy has been reduced 4 years and in Zimbabwe, 26 years of life have been lost (Figure 38). In those countries most seriously affected by AIDS, life expectancies have been reduced by 4 to 26 years.

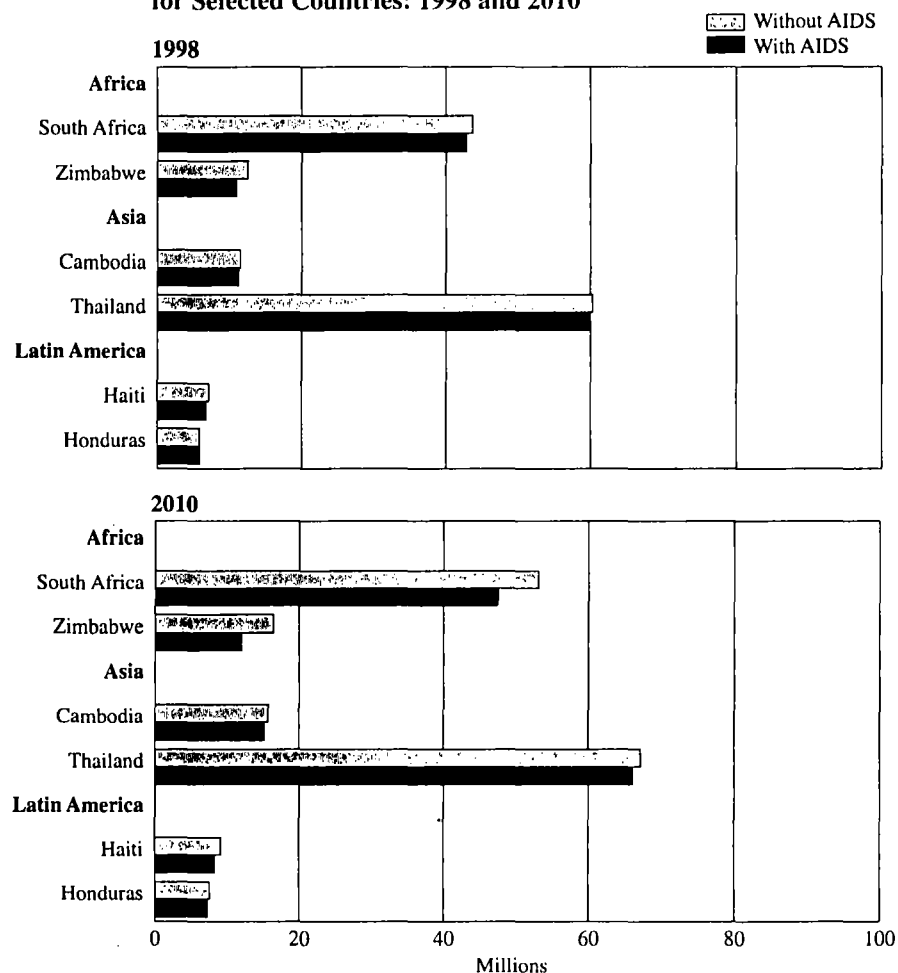
By the year 2010, 8 to 31 years of life will have been lost in those countries most seriously affected by AIDS in Sub-Saharan Africa. Without AIDS, life expectancies would have reached 69.5 in Zimbabwe, but with the AIDS epidemic, life expectancy has been reduced by 31 years. In Kenya, 26 years of life will

have been lost, in Nigeria 19 years and in Uganda, 12 years (Figure 38 second panel).

In Asia, life expectancy has been reduced by 2 to 3 years. In Burma and Cambodia nearly 3 years of life have been lost and in Thailand life expectancy has been reduced 2 years. By the year 2010, life expectancies will be reduced by 2 to 4 years in these Asian countries.

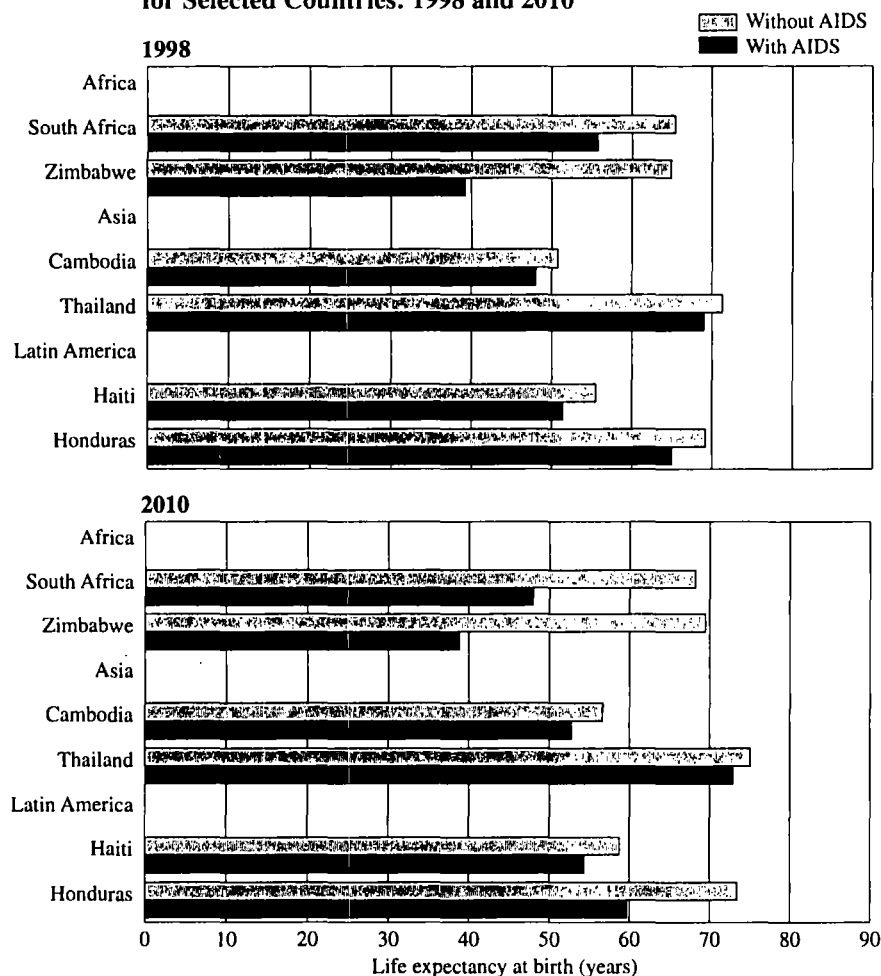
In Latin America and the Caribbean, AIDS deaths have reduced current life expectancies from 3 to 7 years. Life expectancy in Brazil has been reduced 7 years, Honduras and Haiti are now experiencing 4

Figure 37.
Population Size With and Without AIDS
for Selected Countries: 1998 and 2010



Source: U.S. Bureau of the Census, International Data Base and unpublished tables.

Figure 38.
Life Expectancy With and Without AIDS
for Selected Countries: 1998 and 2010



Source: U.S. Bureau of the Census, International Data Base and unpublished tables.

years of life lost and in Guyana, life expectancy is now 3 years lower. By the year 2010, life expectancies will have been reduced by 4 to 17 years in these countries.

In 21 African Countries More Than 5 Percent of the Urban Population Is HIV Positive¹⁴

Many of the epidemics in Africa can be described as generalized, with high (over 5 percent) HIV prevalence in the general adult population and increasing

urban to rural equalization of HIV prevalence.¹⁵ In 21 African countries, HIV prevalence among low-risk urban adult populations (15-49 year olds) has reached 5 percent. The most severely affected countries are Botswana, Namibia, Swaziland, Zambia, and Zimbabwe, where 18 to 25 percent of all adults are HIV positive. Over 2 million adults are HIV positive in each of the following countries: Ethiopia, Kenya, Nigeria, and South Africa.

Although HIV epidemics have stabilized or declined in some urban areas, in others the epidemics are increasing

rapidly (Figure 39). HIV seroprevalence levels among antenatal clinic women have declined in Kampala, Uganda from a peak of 30 percent in 1992 to 15 percent in 1996. And in Lusaka, Zambia, HIV prevalence among antenatal women tested remained around 25 percent between 1990 and 1994. In Francistown, Botswana, however, HIV prevalence among antenatal clinic women increased from 8 percent in 1991 to 43 percent in 1996. Similarly, HIV prevalence among antenatal clinic women tested in Kwazulu-Natal, South Africa, increased from 2 percent in 1990 to 20 percent in 1996. High prevalence levels among antenatal clinic attendees have also been reported in other provinces of South Africa: Free State, 17 percent; North West, 25 percent; and Mpumalanga, 16 percent.

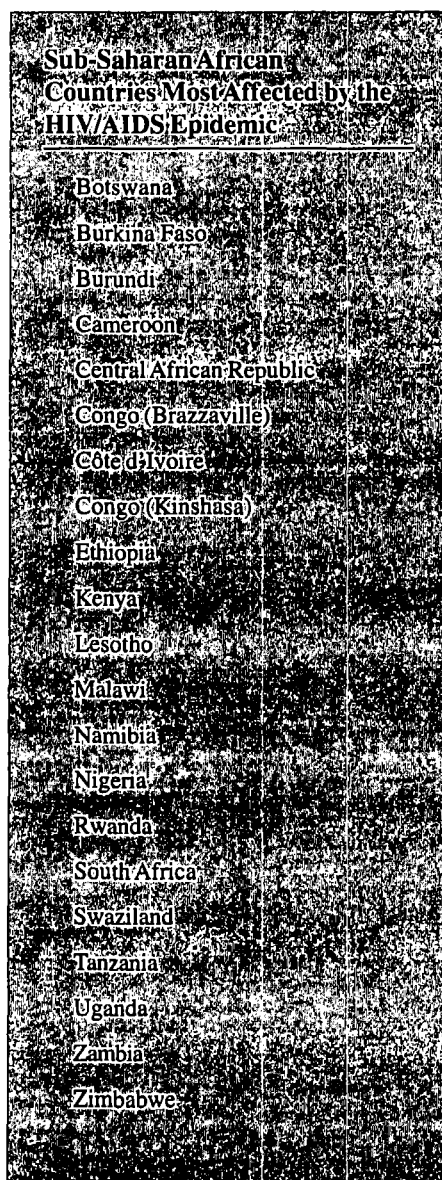
Some countries initially spared are now seeing increases in HIV seroprevalence. In Nigeria, median prevalence among antenatal clinic women tested in urban sites increased from less than 1 percent in 1991-92 to 4 percent in 1993-94. In Lagos State, 7 percent of antenatal clinic women tested in 1993-94 were HIV positive. In Yaounde, Cameroon, HIV prevalence among antenatal clinic women increased from 1 percent in 1989 to 3 percent in 1995 and in Douala, HIV prevalence increased from 1 percent in 1990 to 6 percent in 1994.

The HIV Pandemic in Asia is Extremely Diverse

There is no evidence of an HIV epidemic in some countries of Asia such as Mongolia and South Korea. In other countries, such as Thailand and Burma, 2 percent of the adult population are now HIV positive. In Cambodia, nearly 5 percent of the adult population is HIV positive. In Asia, HIV transmission occurs mainly through heterosexual contact, from mother to child, and through injecting drug use.

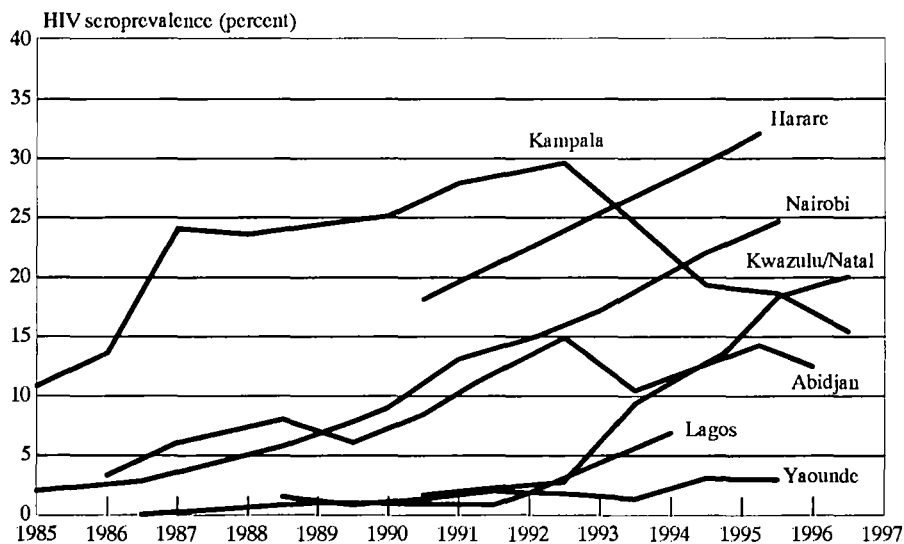
¹⁴All HIV prevalence data cited in this report can be found in the HIV/AIDS Surveillance Data Base, 1998 version, U.S. Bureau of the Census.

¹⁵World Bank (1997).



Rapid increases in HIV prevalence have been occurring in Cambodia over the last few years (Figure 40). HIV prevalence among sex workers tested in Phnom Penh increased from 10 percent in 1992 to 42 percent in 1996. Among sex workers tested in 17 sites in 1996, HIV prevalence ranged from 13 percent

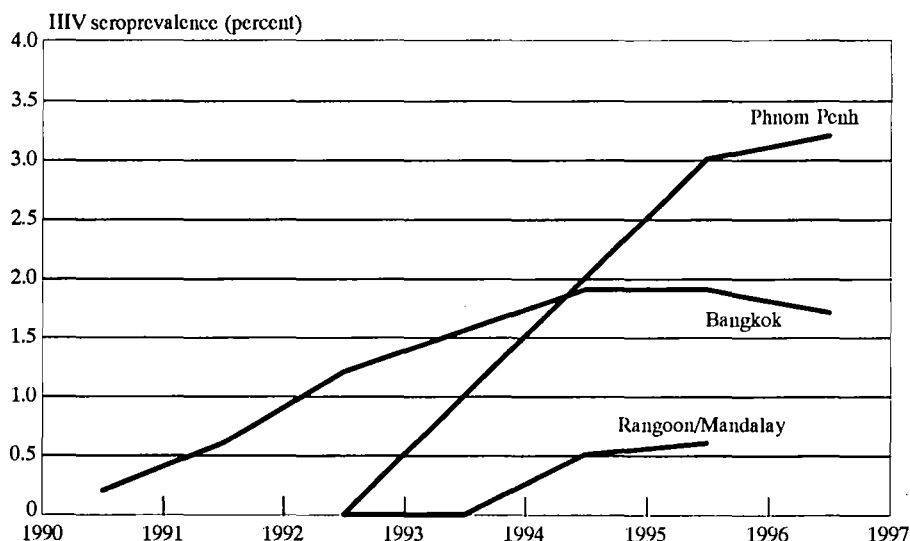
Figure 39.
HIV Seroprevalence for Pregnant Women in
Selected Urban Areas of Africa: 1985-1997



Note: Includes infection from HIV-1 and/or HIV-2.

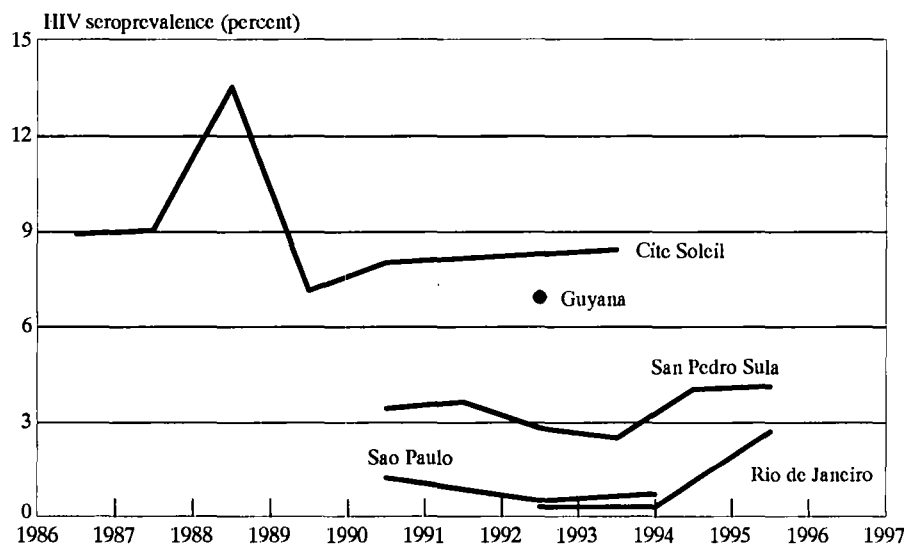
Source: U.S. Bureau of the Census, HIV/AIDS Surveillance Data Base, 1998.

Figure 40.
HIV Seroprevalence for Pregnant Women in
Selected Urban Areas of Asia: 1990-1997



Source: U.S. Bureau of the Census, HIV/AIDS Surveillance Data Base, 1998.

Figure 41.
HIV Seroprevalence for Pregnant Women in Selected
Urban Areas of Latin America: 1986-1997



Source: U.S. Bureau of the Census, HIV/AIDS Surveillance Data Base, 1998.

in Kandal province to nearly 60 percent in Battambang province. HIV prevalence among antenatal clinic attendees in Phnom Penh increased from no evidence of HIV infection in 1992 to 3 percent of women tested in 1996. In the 17 sentinel surveillance sites outside of Phnom Penh, HIV prevalence ranged from less than 1 to 6 percent of antenatal clinic attendees tested.

In Thailand and Burma, the HIV epidemic continues to affect the population. As in other parts of Asia, HIV transmission occurs through heterosexual contact, from mother to child, and via injecting drug use. In Rangoon and Mandalay, HIV prevalence among sex workers increased from 4 percent in 1992 to 21 percent in 1996. Among antenatal clinic women tested in Rangoon and Mandalay in 1995, less than 1 percent were HIV positive. However, HIV prevalence among antenatal clinic women in Tachileik had reached 8 percent by 1995.

In Thailand, HIV prevalence among sex workers in Bangkok reached a peak of 18 percent in 1992 but appears to be

declining. Seven percent of sex workers tested in Bangkok in 1996 were HIV positive. Declines are also being seen among antenatal clinic women in Bangkok (Figure 40). In other areas of the country, HIV prevalence among sex workers appears to have stabilized between 18 and 20 percent between 1993 and 1996. Among antenatal clinic attendees tested in 1996, HIV prevalence ranged from 2 to 8 percent with the highest prevalence in the Northern region.

The epidemic in India differs from state to state, with high HIV prevalence in west and southern India to low levels of HIV in east and northern India. In Mumbai (Bombay), HIV prevalence increased from 2 to 3 percent in sexually transmitted disease (STD) clinic attendees before 1990 to 36 percent in 1994. HIV prevalence among sex workers tested in Mumbai rose from 1 to 51 percent between 1987 and 1993. Studies among sex workers in Calcutta, in contrast, show clear and consistently low prevalence of one percent. Among antenatal clinic attendees tested in

Mumbai, two percent tested positive for HIV in 1995. In Manipur, in the north, an HIV epidemic is occurring among injecting drug users, where 60 to 70 percent of injecting drug users tested in 1996 were HIV positive. A concurrent epidemic is now occurring among the antenatal clinic attendees in that area. However, there is a general lack of consistent HIV seroprevalence information making it difficult to analyze the extent of the spread of the HIV epidemic in India.

HIV/AIDS is Well Established In the Caribbean and Latin American Region but Information is Scarce

The spread of HIV/AIDS has been slower in Latin America and the Caribbean than in other developing regions of the world, but sentinel surveillance data are rare and information on the HIV prevalence is difficult to find. What can be determined to date is that the HIV epidemic varies from country to country, with some countries in the nascent stage with few cases of AIDS and low HIV prevalence in high-risk groups; and others in the concentrated stage, with high prevalence in predominantly homosexual/bisexual or injecting drug user groups with low prevalence in general adult population. In some countries, transmission through injecting drug use has had an important impact on the epidemic.

In the Caribbean the HIV epidemic has been characterized as mostly a heterosexual epidemic. In Haiti, HIV prevalence has remained stable over the past several years at around 5 percent of the adult population. In Guyana, among antenatal clinic women tested in 1992, 7 percent were HIV positive (Figure 41). The epidemic increased from 1 percent of adults infected in 1994 to 2 percent in 1997 and is projected to increase to 13 percent by 2010.

The epidemics in Central America also appear to be mostly caused by heterosexual transmission. Recent data from Honduras indicate an increase in HIV prevalence in the major urban centers. HIV prevalence among sex workers increased in Tegucigalpa from 6 percent in 1989 to 8 percent in 1996. In San Pedro Sula, HIV prevalence among sex workers has ranged from 15 to 20 percent since 1989. HIV prevalence among antenatal clinic attendees in Tegucigalpa increased from 0.2-0.3 percent in 1991-1993 to 1 percent in 1996. In San Pedro Sula, HIV prevalence among antenatal clinic attendees had increased to 4 percent by 1994.

In Brazil, there is considerable HIV transmission due to injecting drug use and the epidemic has progressed since the early 1980's from one predominated by homosexual/bisexual transmission to one with an increasing heterosexual component. High rates of HIV infection among injecting drug users in Brazil have been found since the late 1980s. Fifty percent of injecting drug users tested in two sites in Sao Paulo were HIV positive in 1989. Since 1990, a third of all injecting drug users tested in major urban areas tested positive for HIV. In 1990, 1 percent of antenatal women in Sao Paulo tested positive for HIV. As more sentinel sites began reporting, the median HIV prevalence rate among antenatal clinic attendees varied around 1 percent of women tested. In 1995, nearly 3 percent of antenatal women tested in Porto Alegre and Rio de Janeiro tested positive for HIV and in 1996, 5 percent of women in Santos tested positive for HIV.

The HIV/AIDS Pandemic Continues to Evolve

By the end of 1997, the United Nations Joint Programme on HIV/AIDS (UNAIDS) estimated that over 40 million people had become infected with HIV since the beginning of the pandemic and that over 11 million of these people have already died. The majority of the infections have occurred in Sub-Saharan Africa, but the increases that are occurring in Asia may result in more infections in that region than in Sub-Saharan Africa.

This is the third round of population estimates in which the Census Bureau has incorporated AIDS mortality. Some of our original conclusions have remained the same:

- AIDS will not overcome the momentum of population growth in the most affected counties, particularly in Sub-Saharan Africa. The region's current high fertility rate ensures that the population will continue to increase.
- Changes in behavior, both spontaneous and induced, may help to create an early plateau in some epidemics and ultimately may result in declines in HIV infection levels. We are clearly seeing this in Thailand and in certain areas of Uganda.
- Given the uncertainties surrounding the course of AIDS epidemics, it is probable that refinements and adjustments in the method for the incorporation of AIDS-related mortality into these population projections will be adopted in future rounds of the projection process.

Uganda:

A Rare Example of Success

When the general public thinks about the AIDS epidemic in Africa, they usually think of Uganda first, and they assume that the epidemic is worse there than in any other country. However, HIV surveillance data show that the AIDS epidemics are far worse in some of the countries in Southern Africa such as in Botswana, Zimbabwe, and Zambia. HIV prevalence among Ugandan antenatal women in Kampala and the Rakai district have been high, as high as 30 percent. However, in other areas of the country prevalence is much lower and since 1993, prevalence rates have fallen to 15 percent among antenatal women in Kampala.

Uganda, however, was the first country in Africa to admit they had an AIDS epidemic and, with the strong backing of President Museveni, AIDS prevention programs are making an impact. At the opening ceremony of the IXth International Conference on AIDS and STDs in Africa held in Kampala, President Museveni stressed the importance of political leadership in the fight against AIDS. And the results of this leadership are showing in Uganda.