

Understanding the latest estimates of the 2006 report on the global AIDS epidemic

Part one: The data

1. What data do UNAIDS and WHO base their HIV prevalence estimates on?

The *precise* numbers of people living with HIV, people who have been newly infected or who have died of AIDS are not known. Achieving 100% certainty about the numbers of people living with HIV globally, for example, would require testing every person in the world for HIV every year—which is logistically impossible and pose ethical problems. But we can estimate those numbers by using other sources of data.

UNAIDS/WHO estimates are based on all pertinent, available data—including surveys of pregnant women attending antenatal clinics, population-based surveys (conducted at the household level), sentinel surveillance among populations at higher risk of HIV infection, case reporting, vital registration systems (the official recording of births and deaths), as well as other surveillance information.

Different sets of data are used to calculate estimates of HIV prevalence for *generalized* (high-level - where adult HIV prevalence among the general adult population is at least 1% and transmission is mostly heterosexual) and *concentrated* (low-level - where HIV is concentrated in groups with behaviours that expose them to a high risk of HIV infection) epidemics.

In countries with *generalized* epidemics, estimates of HIV prevalence are primarily based on surveillance among pregnant women attending sentinel antenatal clinics (ANC). Such data are collected on an annual basis and are currently our primary basis for the assessment of trends. If available, population-based sample surveys that include testing for HIV infection (conducted much less frequently) are used to improve the antenatal clinic data-based estimates

For countries with low-level or *concentrated* epidemics, HIV estimates are based on studies among key populations who are at higher risk of HIV exposure—such as injecting drug users, sex workers, or men who have sex with men.

Countries with concentrated epidemics sometimes have additional sources of data which can help refine estimates. In countries such as Argentina and Brazil, which have extensive voluntary counselling and testing programmes, case reports can add to the estimation process and make estimates more precise.

Better data from country surveillance and steady improvements in the modelling methodology are enabling UNAIDS/WHO to develop more accurate estimates.

3. What are the strengths and weaknesses of using antenatal and household surveys in estimating HIV infection levels for generalized epidemics?

Each of these methods has its strengths and weaknesses. Generally, estimates based on antenatal clinic attendees provide a good indication of HIV infection *trends* among 15–49 year-olds over time.

Studies have shown that high proportions of women in most of the highly-affected countries have access to antenatal clinic services. Where possible, estimates derived from antenatal clinic data have been compared at local level with HIV prevalence data acquired in community-based surveys. Such validation exercises have concluded that estimates based on antenatal clinic sentinel surveillance provide a good approximation of HIV prevalence among adults aged 15-49 (men and women combined) in the local community. However, ANC surveillance is limited in that it only samples pregnant women attending public health services and therefore excludes women who are not pregnant or sexually active and who do not attend public health clinics. The most important limitation is often related to the selection of sentinel antenatal clinics. In general, clinics with larger volumes of pregnant women are needed to obtain a minimum of 300 samples during the 4-6 week annual survey of sentinel clinics. Such clinics are more likely to be in urban areas, and the sample of clinics is often not geographically representative. Remote rural clinics are underrepresented for the most part, although countries are increasingly trying to increase their representation as in-country surveillance efforts are expanding.

National population-based household surveys, on the other hand, can reveal important information about the national prevalence level and about the spread of HIV, particularly among young people, men and residents in rural areas. However, population-based surveys by their nature exclude certain high-risk populations (e.g., people living in hostels, army recruits, etc.) and might therefore underestimate HIV prevalence. Non-response due to absence from households and refusing to participate in these surveys could also lead to bias in the HIV estimates. Current research, however, indicates that in most instances these biases are relatively small.

Population-based surveys are costly, complex undertakings, especially if biological testing is included. Therefore, they are done with long intervals in-between and few countries have done more than one national survey with HIV testing since 2000.

Considered together, the various data can yield more accurate estimates of HIV infection levels and the demographic impact of AIDS. However, HIV and AIDS estimates (whether derived from household surveys or sentinel surveillance data) need to be assessed carefully, and the data and assumptions reviewed continually.

4. Are population-based surveys more accurate than antenatal surveys?

For all diseases a sound population-based sample provides better estimates of disease prevalence than a clinic-based sample. National population-based surveys reveal important information about the national prevalence level and about the spread of HIV, particularly among young people, men and residents in rural areas. If response rates are good (e.g. over 75%) and there is no evidence of systematic biases of exclusion of a large proportion of the population with likely different levels HIV infection, then national estimates that consider data from all sources (surveillance, population-based surveys and if available mortality data) should be close to the household survey result.

5. Which are the more accurate sources of data: sentinel surveillance or case reporting?

Case reporting generally tends to substantially underestimate the number of people living with HIV. Most countries that rely on case reporting focus the data collection on specific at-risk groups, often missing other groups. Often, case reporting tends to focus heavily on injecting drug users, and often the data collected reflect trends only among those users who interact with government authorities (for example, by being arrested or attending drug treatment clinics).

However, in countries that have extensive voluntary counselling and testing programmes (such as Argentina and Brazil), case reports may enable more precise estimates to be developed. Nonetheless, case reporting is unlikely to capture people living with HIV who were recently infected, and who therefore present no symptoms of infection. For these reasons, case reports can only indicate the minimum number of people living with HIV.

On the other hand, reliance on *sentinel surveillance* of at-risk groups can lead to overestimation of HIV prevalence in these groups. This is because such surveillance in some cases detects HIV infection rates among individuals who are at highest risk of HIV infection. For example, sentinel surveillance among sex workers or their clients often focuses on those who seek treatment at sexually transmitted infection clinics—and who, by definition, have had unprotected sex. However, other sex workers and clients who *do* practise safe sex—and who therefore tend not to present at these clinics with sexually transmitted infections—generally are not captured in this surveillance.

Part Two: From the data to the estimates

6. How are the HIV/AIDS estimates arrived at?

UNAIDS and WHO, in close consultation with countries, employ a six-step method to obtain estimates of HIV prevalence for men and women. An increasing number of countries have adopted these methods to develop national estimates.

Different approaches are used for *generalized* epidemics (where adult HIV prevalence exceeds 1% and transmission is mostly heterosexual) and *low-level* or *concentrated* epidemics (where HIV is concentrated in groups with behaviours that expose them to a high risk of HIV infection).

Between March 2005 and April 2006, UNAIDS and WHO conducted 12 regional workshops, training national personnel/ technicians from over 150 countries responsible for HIV estimates in the specific tools and methodologies used to produce the national estimates in this report. In addition UNAIDS and WHO participated in 10 country-specific consensus meetings on HIV estimates. These methods allow for standardization in measurement methods and allow cross-national comparisons and regional aggregation and estimates.

Details on the six-step method and selected references to the wide range of papers published by leading scientists from around the world, UNAIDS and WHO can be found in Annex A.

7. Can the new estimates be compared with those from 2004?

The latest estimates cannot be compared directly with estimates published in previous years. Nor should these latest estimates be compared directly with those UNAIDS/WHO will

publish in the years to come. Why not? Because the assumptions, methodologies and data used to produce the estimates are gradually changing as a result of ongoing enhancement of our knowledge of the epidemic. Comparing the latest estimates with those published in previous years is liable to yield misleading conclusions.

In a nutshell, the latest estimates—for the current year and for past years—will tend to be more accurate and reliable than those produced in previous years, since they are based on improved methods and more data than earlier estimates. This kind of caution is not unusual when dealing with global estimates of disease.

8. Why have UNAIDS and WHO changed the age group ranges?

The new estimates of the number of adults living with HIV (and of adults with new infections and of AIDS mortality) are no longer restricted to those in the 15–49 age group. Historically, UNAIDS and WHO restricted the estimates to this age group to ensure comparability across countries, especially for HIV prevalence. However, it has become evident that a substantial proportion of people living with HIV are 50 years and older, as shown in age distributions of HIV and AIDS case reports, community studies and population-based surveys. Accordingly, UNAIDS and WHO now present estimates of adults living with HIV, new infections and AIDS deaths among adults for all adults '15 years and older'. In addition, we continue to provide estimates of HIV prevalence for 'adults 15–49 years', to continue to allow for comparisons across countries. UNAIDS and WHO also estimate trends among children 'less than 15 years of age'.

9. Why are UNAIDS and WHO publicizing ranges of HIV and AIDS estimates?

The ranges reflect the degree of uncertainty associated with estimates and define the boundaries within which the actual numbers lie.

In earlier UNAIDS/WHO reports, we reported point estimates (for example, fixing HIV prevalence in country X at 12.5%). In addition, we also published the ranges of uncertainty around those point estimates, depending on the quality of the data that had yielded the estimates. This was done because all estimates were associated with some level of uncertainty.

Because the quality of data varies from country to country, the ranges of uncertainty surrounding our estimates can widen or narrow depending on the country. As well, presenting point estimates might have encouraged a false sense of precision, notwithstanding the fact that ranges of uncertainty were also provided.

Improved methods, enhanced data and new estimation tools are enabling a better understanding of the degrees of uncertainty that surround HIV and AIDS estimates. This is part of an ongoing process of improving estimates and developing appropriate ranges—all of which are vital for effective HIV/AIDS planning and programming at national and regional levels.

UNAIDS and WHO are confident that the actual numbers of people living with HIV, people who have been newly infected or who have died of AIDS lie within the reported ranges.

10. If UNAIDS and WHO claim the current estimates are more accurate, why are the ranges for some countries so large?

The ranges reflect the degrees of uncertainty around HIV estimates in particular countries. Accordingly, the ranges vary, depending on the quality of HIV data available in different countries.

Four factors determine the extent of the ranges around the HIV estimates:

- (i) *The HIV prevalence level* – Ranges tend to be smaller when HIV prevalence is higher. Thus the bounds around the best estimate of adults living with HIV in Zambia are relatively small (1,100,000 – 1,200,000) while they are much wider in a lower prevalence country such as Djibouti (3,900 – 31,000).
- (ii) *The quality of the data* – Countries with better quality data have smaller ranges than countries with poorer quality data. The ranges for Asia and the Pacific are comparatively broad—which reflects the fact that HIV surveillance of key populations (such as injecting drug users, sex workers and men who have sex with men) is relatively poor in most countries in that region, hence resulting in more uncertainty. In general, the ranges for sub-Saharan Africa are narrower, because of recent improvements in the collection and interpretation of HIV data in that region.
- (iii) *The number of steps or assumptions used to arrive at an estimate* – The more steps and assumptions, the wider the uncertainty range is likely to be (since each step introduces additional uncertainties). For example, ranges around estimates of adult HIV prevalence are smaller than those around estimates of HIV incidence among children, which require additional data on the probability of mother-to-child HIV transmission. The latter are based on prevalence among pregnant women, the probability of mother-to-child HIV transmission, and estimated survival times for HIV-positive children. There is therefore greater uncertainty in these estimates than for adult prevalence alone.
- (iv) *The type of epidemic (generalized or low-level/concentrated)* – Ranges tend to be wider in countries with low-level or concentrated epidemics than in countries with generalized epidemics because in low-level or concentrated epidemics, one needs to estimate both the numbers of people in the groups at higher risk of HIV infection *and* HIV prevalence rates in those groups.

11. How confident are UNAIDS and WHO about the estimates of the number of people who die of AIDS each year?

Estimates of adult AIDS mortality are based on several assumptions and additional sets of data—including estimates of the numbers of adults and children who are HIV-infected, and estimations of survival times from infection with HIV to death for adults and children infected with HIV.

Civil registration systems are the best source to obtain an estimate of the mortality due to AIDS. However, in most countries with generalized epidemics, coverage of civil registration is too low to provide useful information on AIDS mortality. Some countries have local demographic surveillance or general information on adult mortality from censuses and surveys that can help estimate mortality levels due to AIDS.

Estimating mortality in countries with low-level or *concentrated* epidemics is even more difficult. Some at-risk groups are likely to have different background mortality, in other words they are more prone to other causes of death (for example, injecting drug users are vulnerable to fatal drug overdoses and other life-threatening hazards). All this can have substantial effects on patterns of mortality. Unfortunately, country-specific data on mortality and on changes in risk behaviour are seldom available. However, some countries with low-level/concentrated epidemics have well-functioning vital registration systems that include the cause of death.

12. What is being done to improve national HIV estimates?

New and different sources of data, such as national population-based surveys, are enabling more accurate estimates and more refined understandings of the epidemic's trends.

Importantly, the roles of national AIDS programmes have changed significantly since the first set of UNAIDS/WHO country specific estimates was produced in 1997. Initially, countries were requested to comment on provisional estimates. The extent of their involvement has increased subsequently

In the past several years, for example, UNAIDS and WHO, along with their technical partners (including East-West Center, Family Health International, The Futures Group, the US Census Bureau and the US Centers for Disease Control and Prevention), carried out a series of regional training workshops in which epidemiologists from over 150 countries were trained in the HIV estimation process.

Such efforts have led to much greater involvement by national programmes, national statistics offices and other government and academic organizations in the production of estimates. The result has been better quality estimates, due to the use of additional data and the application of local knowledge.

UNAIDS and WHO continue to work with countries, partner organizations and experts to improve data collection. These efforts will ensure that the best possible estimates are available to assist governments, non-governmental organizations and others in gauging the status of the epidemic and monitoring the effectiveness of prevention and care efforts.

Part three: Interpreting the new estimates

13. Is the AIDS epidemic slowing down?

We can say that the epidemic is slowing down globally, but not all countries are experiencing a decline in new HIV infections. Globally, the HIV incidence rate (the annual number of new HIV infections as a percent of previously uninfected persons) is believed to have peaked in the late 1990s and to have stabilized subsequently. However, the numbers of people living with HIV have continued to rise, due to population growth and, more recently, the life-prolonging effects of antiretroviral therapy.

14. Has the epidemic peaked in sub-Saharan Africa?

UNAIDS Secretariat and WHO analyses over the past five years show that the epidemic is levelling off in much of sub-Saharan Africa, albeit at unacceptably high levels. However, it is important to realise that a stable prevalence is only possible if HIV-associated deaths are replaced by new infections. Thus, a stable prevalence in sub-Saharan Africa still represents nearly 3 million new infections each year.

The number of people living with HIV in the region rose dramatically in the late 1980s and 1990s, and was still growing in 2005, although at a slower rate. This slower growth is a result of a peak in new infections which occurred in the late-1990s and an increase in the annual number of people who die of AIDS.

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

Even though HIV prevalence rates have stabilized in this region the actual *number* of people infected continues to grow because of population growth. Applying the same prevalence *rate* to a growing population will result in increasing *numbers* of people living with HIV.

14.1 What might be causing the apparent stabilization of HIV prevalence in sub-Saharan Africa?

Two factors are causing the apparent stabilization or “levelling off” of prevalence rates observed in much of the region: AIDS mortality rates and HIV incidence. High and, in some countries, rising rates of AIDS mortality and continuing high HIV incidence offsetting this mortality are the cause of this appearance of levelling off. In Zambia, for example, national HIV prevalence appears to have stayed relatively stable for the past 8–10 years. Since it is estimated that close to 100,000 people living in Zambia have been newly infected annually over that period, overall prevalence has remained level because AIDS has killed about the same number of people each year. HIV prevalence might therefore appear stable, but it hides a persistently high number of annual, new HIV infections and an equally high number of AIDS deaths.

On the other hand, as ARV therapy coverage increases, it is possible that we will see prevalence levels increase as more people infected with HIV live longer.

But we are not, unfortunately, witnessing a region-wide decline in the epidemic. In the absence of effective interventions, the epidemic will continue to wreak havoc in these countries.

14.2 There is no such thing as the “African” AIDS epidemic

It is important to remember that there is not one, typical “African” AIDS epidemic. In ten countries, adult HIV prevalence is below 2%, while in five other countries it is over 20%. These extreme differences in prevalence levels fall roughly into geographically separate areas. Eight countries of southern Africa (Botswana, Lesotho, Mozambique, Namibia, South Africa, Swaziland, Zambia, Zimbabwe) have prevalence above 15%, with Swaziland having prevalence over 30%. In West Africa, HIV prevalence is much lower with no country having a prevalence above 10% and most having prevalence between one and

five percent. Adult prevalence in countries in Central and East Africa falls somewhere between these two groups.

The countries of the region also differ in the time course of their epidemics, with epidemics starting earlier in East and Central Africa and much later in countries in southern Africa. Uganda is an example where adult HIV prevalence peaked in the early 1990s.

15. Is the percentage of women infected with HIV rising globally?

No, this estimate is roughly the same as it was in 2001. UNAIDS/WHO estimate that almost half (49%) of adults aged 15 years and over living with HIV are women. However, the numbers of women living with HIV globally are rising. This is because the overall numbers of people living with HIV are rising. By far the majority of women living with HIV are in sub-Saharan Africa. In sub-Saharan Africa, young women are much more likely to be HIV-infected than young men – a ratio of 3 to 1.

The concentration of HIV-infected children in sub-Saharan Africa reflects the estimate that 59% of HIV-infected adults in that region are women and that women in Africa have more children than elsewhere in the world. No other region proportionately has as many women living with HIV. However, in the Caribbean women already account for nearly half of the adults living with HIV.

16. Are more young people becoming infected with HIV?

UNAIDS estimates that about half of all new HIV infections worldwide are among children and young people up to 25 years.

Additional sources of information:

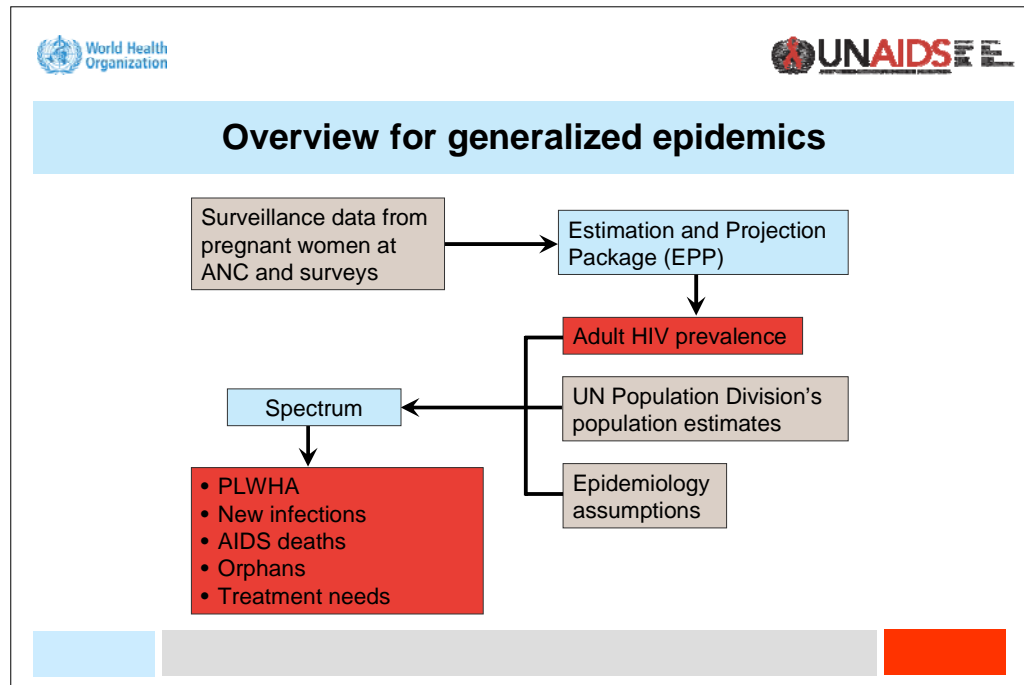
For a technical description of the processes used to arrive at the estimates and further explanation on the quality of HIV, please see:

Walker N, Grassly NC, Garnett GP, Stanecki KA, Ghys PD (2004) Estimating the global burden of HIV/AIDS: What do we really know about the HIV pandemic? *Lancet* 2004:336, 26 June 2004.

For a detailed description of the methods, software, quality of data and development of ranges, please see the series of seven articles published in the journal *Sexually Transmitted Infections* the second week of July 2004. The articles can be downloaded for free from their website at www.Sti.bmjjournal.com.

More information on the UNAIDS Reference Group on Estimates, Modelling and Projections can be found at www.epidem.org.

Annex A



This is how the six-step process works for countries with a generalized epidemic:

Step One ... All available surveillance data gathered from HIV-tested blood samples of pregnant women attending antenatal clinics and HIV prevalence results from population-based surveys are entered into ...

Step Two ... a specialized software programme (called the "Estimation and Projection Package"). This programme generates a curve that describes the evolution of ...

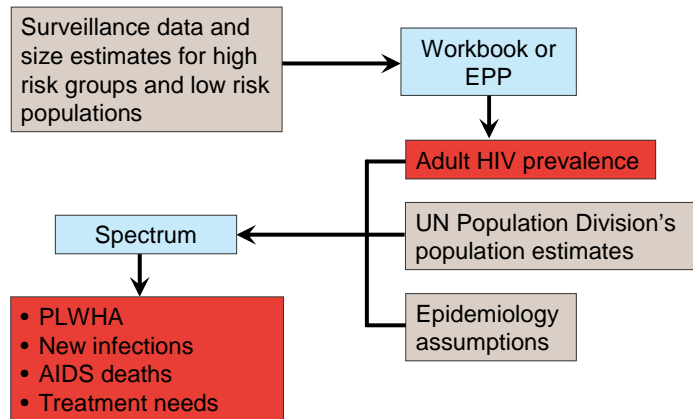
Step Three ... adult HIV prevalence rates over time. This adult prevalence curve, along with the ...

Step Four ... national population estimates obtained from the UN Population Division, along with ART coverage and ...

Step Five ... various epidemiological assumptions (fertility rates, male/female ratios, survival time after HIV infection, etc.) are then entered into the ...

Step Six ... Spectrum software programme which calculates the number of adults and children infected, new infections, deaths, orphans and treatment needs.

Overview for low-level/concentrated epidemics



For countries with a low-level or *concentrated* epidemic, estimates emerge from this process:

Step One -- Surveillance data are gathered for populations at high risk (sex workers, men who have sex with men and injecting drug users). Estimates are made of the size of those populations, and of populations that are at lower but significant risk (for example, the partners of sex workers and their clients, injecting drug users, etc.). That information is then entered into ...

Step Two ... spreadsheet models to produce curves that describe the evolution of ...

Step Three ... adult HIV prevalence rates over time. This adult prevalence curve, along with the ...

Step Four ... national population estimates obtained from the UN Population Division along with ART coverage and ...

Step Five ... various epidemiological assumptions (fertility rates, male/female ratios, survival time after HIV infection, etc.) are then entered into the ...

Step Six ... Spectrum software programme which calculates the number of adults and children infected, new infections, deaths and treatment needs.