

# NORTH AMERICA, WESTERN AND CENTRAL EUROPE

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

	Adults and children living with HIV	Number of women living with HIV	Adults and children newly infected with HIV	Adult prevalence (%)	Adult and child deaths due to AIDS
2004	1.6 million [1.1–2.2 million]	420 000 [290 000–570 000]	64 000 [34 000–140,000]	0.4 [0.3–0.6]	23 000 [15 000–32 000]
2002	1.6 million [1.1–2.2 million]	390 000 [270 000–550 000]	62 000 [33 000–140 000]	0.4 [0.3–0.6]	22 000 [15 000–31 000]

*AIDS is affecting new sections of populations, and an increasing proportion of people are becoming infected through unprotected heterosexual intercourse.*

Some 64 000 [34 000–140 000] new infections occurred in North America and in Western and Central Europe in 2004, raising the number of people living with HIV in these countries to between 1.1 million and 2.2 million. Among young people 15–24 years of age, 0.1% of women [0.1–0.2%] and 0.2% of men [0.1–0.5%] were living with HIV by the end of 2004. Widespread access to life-extending antiretroviral treatment kept the number of AIDS deaths at between 15 000 and 32 000 in 2004. However, there are ample indications that prevention efforts are not keeping pace with the changing epidemics in several countries.

Sex between men and, to a lesser extent, injecting drug use remain prominent factors in the epidemics in these countries, but the patterns of HIV transmission are changing. New sections of populations are being affected, with an increasing proportion of people becoming infected through unprotected heterosexual intercourse.

In the **United States of America** the epidemic has altered demonstrably during the past decade. An estimated 40 000 people have been infected with HIV each year in the United States in the last ten

years, but the epidemic is now disproportionately lodged among African Americans and is affecting much greater numbers of women.

In 2003, African Americans accounted for at least 25% of all AIDS cases, compared with 20% in 2001. That proportion could be higher, since the estimate was based on data collected in just 29 states. Although African Americans represent just 12% of the country's population, over half of new HIV diagnoses in recent years have been among them (in 2002 the proportion was 54%, according to the most recent available data). Especially affected are African American women, who account for up to 72% of new HIV diagnoses in all US women. At the turn of the century already, AIDS ranked among the top three causes of death for African American men aged 25–54 and for African American women aged 35–44 years (Centers for Disease Control and Prevention, 2003a).

It should go without saying that race and ethnicity are not per se risk factors for HIV. Poverty and other forms of socioeconomic deprivation, however, are known to increase vulnerability

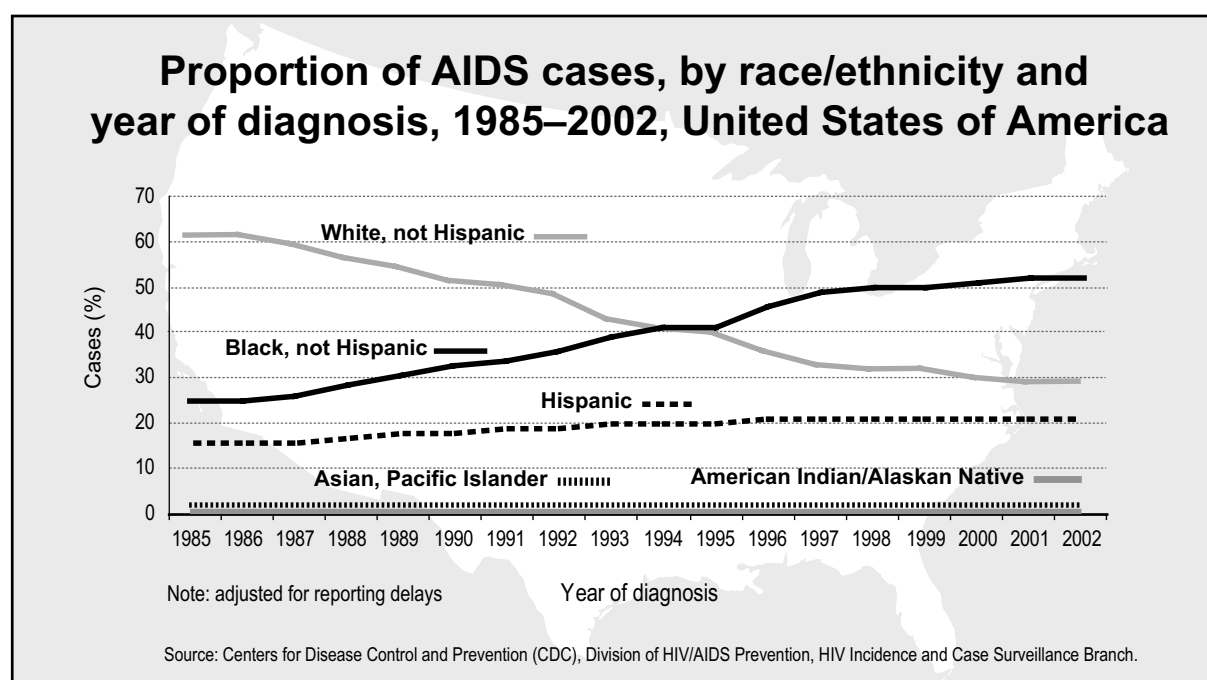


Figure 25

to HIV infection. It is estimated that one in four African Americans lives in poverty, and some studies in the US have discerned a close relationship between higher AIDS incidence and lower income (Centers for Disease Control and Prevention, 2003b; Census Bureau, 2000; Diaz, et al., 1994). It is possible that high incarceration rates, particularly for African American men,

that women were more than twice as likely to be infected by a husband or steady boyfriend than by casual sex partners. Along with injecting drug use, unsafe sex with other men on the part of male partners appears to be a significant risk factor for some women (McMahon et al., 2004). A seven-city study among men who have sex with men has found that 9% of them also had sex with

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could be an amplifying factor in the epidemic through injecting drug use and unprotected sex in prison institutions.

For men overall, and African American men specifically, the vast majority of HIV infections occur during injecting drug use and sex between men. High levels of risk behaviour are still being found especially among younger men who have sex with men. However, heterosexual intercourse accounts for most HIV diagnoses among women, and there are strong indications that the main risk factor for many women acquiring HIV is the often-undisclosed risk behaviour of their male partners. Recent research in a low-income area of New York City, for example, has shown

women, and a more recent study among young African American men who have sex with men found that 20% of the men reported also having female sex partners (Valleroy et al., 2004; Centers for Disease Control and Prevention, 2004b).

The majority of people living with HIV in the **United States of America** are men who have sex with men. Evidence in recent years of increasing cases of syphilis and other sexually transmitted infections among men who have sex with men triggered concerns that risk behaviour was on the rise and that a new wave of HIV infections could follow. Studies in Los Angeles and San Francisco found dramatic increases in the number of syphilis cases (from 4 to 260 in Los Angeles

county in 1998–2000, and from 67 to 299 in San Francisco in the same period). However, new research suggests that those increases have not had a substantial impact on HIV incidence, which stayed steady in 1999–2002 among men who have sex with men (Centers for Disease Control and Prevention, 2004a). In addition, a new, 16-state study indicates that a majority of HIV-positive men who have sex with men have

Canada in 2002 were attributable to unsafe sex between men (40%) and injecting drug use (30% and declining slightly in recent years). There has been an increase in infections linked to unsafe heterosexual intercourse, a small percentage (less than 10%) of them among refugees or immigrants from high-prevalence countries in sub-Saharan Africa and the Caribbean (Health Canada, 2003).

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been taking precautionary measures (including condom use, abstinence or staying faithful to one partner) to prevent further HIV transmission. The study urges, though, that more intensive prevention efforts should reach the small number of HIV-positive men who still practice unsafe sex with other men (Centers for Disease Control and Prevention, 2004c).

After the introduction of antiretroviral therapy in 1995–1996, AIDS-related deaths fell steeply in the **United States of America** until the late 1990s and then continued to decline more gradually—from 19 005 reported AIDS deaths in 1998 to 16 371 deaths in 2002 (UNAIDS, 2004). However, the rate of death due to AIDS among African Americans was over twice as high as that among whites in 2002. African Americans now have the poorest survival rates among people diagnosed with AIDS—probably reflecting late diagnoses (often after the disease has become symptomatic) and inadequate access to quality health care services.

In the 12 **Western European** countries with data for newly diagnosed HIV infections, HIV diagnoses in people who were infected through heterosexual contact increased by 122% between 1997 and 2002. In contrast to Canada, a large share of those diagnoses are in people originating from countries with serious epidemics, principally countries in sub-Saharan Africa (Hamers and Downs, 2004) and, for the **United Kingdom**, the English-speaking Caribbean. There are signs, too, that the resurgence of risky sex between men noted in previous years is leading to increased HIV transmission in some countries among men who have sex with men.

HIV diagnoses among men who have sex with men increased by 22% in 2001–2002 in **Western Europe**, reversing the slow decline seen in the previous years (Hamers and Downs, 2004). Data on new diagnoses should not be mistaken for HIV incidence, however, since data may reflect an increased uptake of testing services (and therefore include people who became infected several years

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To the north, in **Canada**, most recent estimates indicate that some 56 000 people were living with HIV at the end of 2002 (Geduld et al., 2004), as many as one third of them unaware of their HIV status. Indigenous persons appear twice as likely to be HIV-infected compared with non-Indigenous persons. Most new HIV infections in

earlier). The recent rise in new HIV diagnoses in the **United Kingdom** appears partly attributable to increases in HIV testing (half of the men who had sex with men who were diagnosed in 2002 had been infected for more than six years). Nevertheless, HIV infection is now the fastest-growing serious health condition in England

(Department of Health United Kingdom, 2003). In **Germany**, where greater treatment access had already boosted uptake of testing in the late 1990s, a recent increase in diagnoses (from 642 HIV diagnoses in 2000 to 742 in 2002) likely reflects an actual increase in new infections. Given persistently high HIV prevalence among men who have sex with men in western Europe—between 10% and 20% in several countries, and even higher in large cities—there is an urgent need to revitalize and improve safer sex campaigns for men who have sex with men (Hamers and Downs, 2004).

Although injecting drug use accounts for a diminishing share of newly diagnosed HIV infections in most Western European countries, it

the north-east of the country and the Balearic Islands (De la Fuente, 2003). In **Portugal** (where the rates of new HIV diagnoses are higher than elsewhere in Europe), injecting drug use still accounted for almost 50% of HIV diagnoses in 2002. HIV prevalence of 20% and higher is still being found among injecting drug users in parts of other countries (including **France, Italy** and **Netherlands**) (Hamers and Downs, 2004). A survey among drug injectors at treatment centres in Marseille, France, for example, found 22% were HIV-infected (Emmanuelli et al., 2004). Encouragingly, none of the injectors younger than 30 years was found to be HIV-positive. Nevertheless, ongoing efforts are needed to further limit HIV transmission among injecting drug users—and from them to their

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remains an important factor in several countries' epidemics, among them Italy, Portugal and Spain, and in some cities in other countries. In most cases, this reflects declines in unsafe injecting practices likely associated with effective prevention efforts among injecting drug users in many western European countries. Spain offers a striking example of how a comprehensive set of harm-reduction efforts (including methadone maintenance programmes and needle-exchange projects) can reverse an epidemic among injecting drug users. New HIV infections among drug injectors reached as high as 16 000 in 1985-1986, but plummeted subsequently (De la Fuente et al., 2003).

Nevertheless, in **Spain**, as in several other European countries, HIV prevalence among drug injectors can vary considerably in different parts of the country (European Monitoring Centre for Drugs and Drug Addiction, 2003). A survey of drug injectors at Spanish drug-treatment centres in Catalonia still found HIV prevalence of 38% in 2001, for example (Centre d'Estudis Epidemiològics sobre l'HIV/Sida de Catalunya, 2001). Indeed, injecting drug use in Spain now appears concentrated largely in

sexual partners. Indeed, in Portugal heterosexual infections accounted for more than 40% of newly diagnosed HIV infections in 2002. Based on available data, similar trends have been detected in some regions or provinces of Italy and Spain (Hamers and Downs, 2004).

There is an increasing trend in the share of HIV infections attributable to heterosexual intercourse in Western Europe—and with it, a rise in the number of women who are being diagnosed with the virus. In the 12 Western European countries for which data are available, the proportion of women among people newly diagnosed with HIV infection increased from 25% (1955 out of 7770) in 1997 to 38% (4269 out of 11 337) in 2002 (Hamers and Downs, 2004). In **France**, some two thirds of new HIV diagnoses in 2003 were in people infected during heterosexual intercourse, while in the **United Kingdom** the proportion was about 49% and in **Germany** 41%. A significant number of female sex workers are still being infected in some countries, such as the **Netherlands**, where a 2002-2003 study found 7% of sex workers (and up to 12% of those working in the street) in Rotterdam were HIV-

positive (Van Veen et al., 2004). Approximately 5% of immigrant sex workers (male and female) in Madrid, **Spain**, were found to be HIV-positive during 1998–2003, according to a recent study. Most of the sex workers were from sub-Saharan Africa (Gutierrez et al., 2004).

Migrants from countries experiencing serious AIDS epidemics, notably in sub-Saharan Africa, bear a disproportionate and growing share of HIV infections throughout Western Europe. In **Germany** and the **United Kingdom**, for example, a large share of newly diagnosed, heterosexually-acquired infections in recent years have been in people originating from high prevalence countries (Hamers and Downs, 2004). In the United Kingdom, as many as three quarters of heterosexual infections probably occurred in sub-Saharan Africa, while in **Sweden**, more than 80% of such infections were probably acquired abroad. The majority of migrants living with HIV appear to be unaware of their serostatus; by and large, HIV diagnoses tend to occur when individuals become symptomatic or get pregnant. In most countries, migrants are not being reached with adequate, appropriate and socially relevant prevention, treatment, and care services. Remedying this situation will require concerted efforts, including forthright steps to counter the social and legal discrimination, and the administrative hurdles migrants encounter.

In the countries of central Europe (including **Czech Republic** and **Hungary**), numbers of new HIV infections have stayed stable since the late

1990s, with most of the new infections being recorded in **Poland**. In the **Czech Republic**, **Hungary**, **Slovenia**, and the **Slovak Republic**, sex between men is known to be the predominant mode of HIV transmission.

Unlike elsewhere in the world, a large majority of people in most countries in this region who need antiretroviral treatment do have access to it. As a result, AIDS deaths have stayed low since plummeting in the mid-to-late 1990s. In Western Europe, the number of reported deaths among AIDS patients was 3101 in 2002 (UNAIDS, 2004). Two trends, though, warrant concern. In some countries, a large share of HIV infections remain undiagnosed; in the **United Kingdom**, for example, an estimated one third of people with HIV do not know their serostatus and are likely to discover it only once afflicted by AIDS-related illnesses (Department of Health, 2003). And there is worrying evidence of antiretroviral drug resistance among some newly HIV-infected individuals in Western Europe (Girardi, 2003).

Overall in these countries, thousands of new infections are occurring every year and large numbers of HIV-infected persons are unaware of their HIV status. The main challenges are to provide early and effective treatment and care to all HIV-infected people, to rejuvenate prevention efforts and adapt them to the changing patterns of the epidemic, and to reduce the psychosocial, economic and physical repercussions of HIV infection.

