

Teens 'sex for financial support' behind Aids spike

DESPITE the scale-up of antiretroviral therapy (ART) and HIV prevention strategies, HIV prevalence among adolescent girls and young women in South Africa remains alarmingly high – and reflects high prevalence in this group within the general population. Until we address infection in this key age group, progress in reducing the overall disease burden will be limited.

By examining HIV prevalence among young pregnant women aged between 15 and 24 visiting antenatal clinics for the first time in the rural area of Vulindlela in KwaZulu-Natal over a period of 12 years, we found that instead of declining in response to intensifying levels of prevention and treatment interventions, HIV prevalence in fact rose – from 35.3 percent in the years 2001 to 2003 before ART was available, to 39 percent in the years 2004 to 2008, when ART was just becoming available and reaching 39.3 percent in the years 2009 to 2013 when ART roll-out was in full swing.

While prevalence in teenage girls (under 20 year's old) showed a small, but encouraging, decline – from 22.5 percent to 17.2 percent – over the same period, our data revealed that having an older male partner increased the risk of HIV infection threefold if their male partners were more than five years older.

In generalised epidemic settings, such as South Africa, HIV prevalence in the 15 to 24 age category has come to be regarded as a useful indirect measure for the number of and trends in new

OPINION

Reducing HIV in young women is essential for the Aids response in Africa, writes Professor Salim Abdool Karim



infections. In fact, in high HIV burden environments, such as those in Vulindlela, HIV infection rates increase very shortly after sexual debut – from 16 years onwards.

Assuming that HIV transmission is highest during early and acute HIV infection, the burden of potential incident infections in teenagers and young women therefore has serious implications for fuelling the HIV epidemic in this community and South Africa, a country which still has the world's highest number of Aids cases – estimated by the Joint United Nations Programme on HIV/Aids in 2012 to be 6.1 million.

This means that although ART roll out in 2004 has had a substantial impact on survival, age-specific HIV prevalence stands out as a clear explanation for the lack of progress in reducing the overall disease burden. Understanding the disease and its transmission drivers for this group is thus seen as central to the design of additional interventions targeted specifically at teenagers and young women.

We know that the communities in which the study was conducted face enormous economic

and social challenges. The consistently high burden of HIV infection borne by young pregnant women in this rural community may be explained at least in part by young women engaging in high-risk sexual intercourse, which is frequently of a contractual nature and fuelled by the need for financial support.

Our surveys identify an urgent need to understand the causality of these relationships and how they are evolving over time. To what extent are these partnerships affected by the need for financial support in young women, or by the higher levels of illness and death in women over 25 years? What we do know is that teenage girls are a key group for HIV prevention, and understanding of HIV transmission dynamics in this population is a major gap in the knowledge of HIV.

Of major concern, our data shows that teenage pregnancies constituted an average of 30 percent of all pregnancies surveyed from 2001 to 2013.

The persistence of this high teen pregnancy rate comes against the backdrop of several, largely government-initiated and school-based behavioural

interventions and educational outreach programmes that target the teenage female population. These include programmes aimed at delaying sexual debut, preventing intergenerational sex, medical male circumcision, promoting condom use within the structured ABC guidelines (abstinence, being faithful to one's partner, and condom use), and even with earlier access to ART, which has been shown to prevent HIV transmission in randomised clinical trials and observational cohorts. However, as our data reveals, they have enjoyed limited success in reducing both pregnancy and HIV infection rates in this age group.

In addition to understanding the drivers of teenage pregnancies and age-disparate relationships, however, monitoring the impact of ART provision and the survival of women over 25 years continues to be critical. The high burden of HIV observed in this older group reflects the cumulative effect of HIV acquisition, underscores the extent of the care burden, and may help inform future prevention and treatment efforts.

Although HIV prevalence in South Africa varies widely by province and the generalisability

of results is limited, our studies in KwaZulu-Natal starkly demonstrate the unprecedented scale of the HIV epidemic at a local level. They also reveal unequivocal and unambiguously high pregnancy rates.

So what next? Given the eight to 10-year delay between HIV infection and Aids related morbidity and mortality, the continued scale-up of ART services at primary health care clinics remains one of the best chances we have of averting a further Aids catastrophe in this setting. However, in addition, it is imperative that we undertake research in teenage girls – one of our highest risk populations – to examine both HIV incidence and the reasons why they have a high risk of HIV infection. In this way we raise the chances of designing and implementing age-specific, targeted interventions that can make an impact on the epidemic where others thus far have failed.

The upcoming Aids conference in Durban gives us a valuable opportunity to learn from others what has worked in this population and to identify prevention gaps that might address the challenges presented by teenage girls and young women. We neglect this group of young people at our peril.

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