Exploring the prevalence and impact of the HIV pandemic among young women in South Africa: A critical literature review.

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Abstract

Human immunodeficiency virus (HIV) is one of the leading causes of death in sub-Saharan Africa (SSA). South Africa (SA) has the largest HIV pandemic in the world with approximately 7.2 million people living with HIV as of 2017. There is a disproportionate incidence of HIV between women and men, particularly affecting young women aged 15–24 years. This paper reviewed 10 articles on HIV in South Africa among young women. A total of 10 articles on HIV in South Africa were selected for review using academic databases including Library One Search Pro, Google Scholar, the British Medical Journal, and Elsevier. The search generated 11,095 articles which were narrowed down to 10 by the criteria of being specific to gender and age and publication period. Five themes were identified from the findings as potential causes of HIV prevalence among young women these included Age-disparate relationships, Social Factors and sexual behaviour, Impact of HIV on communities and individuals, Gender and patriarchy including Poverty and social isolation. There is need to raise HIV awareness among young women to reduce the rate of infection.

Keywords: HIV, poverty, risk behaviour, Sub-Saharan Africa, young women

Introduction

HIV/AIDS continues to be one of the worst communicable diseases in history and the leading cause of death in SSA.[1] HIV is a deadly virus that almost swept the world, particularly in the SSA population during its peak in the mid-1980s to mid-1990s. This is because HIV has no cure and the treatment took approximately 10 years to mature. HIV is transmitted from one infected person to another through certain body fluids such as blood, semen, rectal fluids, vaginal fluids, pre-seminal fluids and breast milk.[2,3] HIV established itself by increasing the morbidity and mortality rates among a young population that should be healthy and productive. The HIV infection impacted on sickness and death which affected agricultural production through the loss of labour and exhausted resources due to the need to care for the sick and organise funerals. Furthermore, it increased the number of orphans, reducing opportunities for inter-generational knowledge and strategies for survival. The brunt of the impact of the HIV/AIDS virus fell on marginalised groups such as women, mothers, poor people, sex workers, lesbian and gay people and injecting drug users.[4] This epidemic reflected the deep-rooted disparities between the rich and poor, men and women and concerns of life and death. Although the illness has no cure, it can be managed by treatment such as antiretroviral therapy (ART).[(4)] The drugs regulate the virus and aid the prevention of transmission to enable people with HIV to live a healthy, long and productive life.[5]

HIV is a public health issue that has claimed many lives for decades and continues to be a burden in SSA, particularly in SA.[6] The data show that at least 77.3 million people have been infected and 36.4 million have lost their lives from related illnesses since the beginning of the epidemic.[7,8] Life expectancy at birth has reduced tremendously in SSA. For instance, in Botswana it dropped from 65 years in 1990 to below 40 in 2005 due to increased HIV infections. This led to the creation of the Millennium Development Goal in 2000. Goal 6 targeted HIV/AIDS, malaria and tuberculosis following recognition of a global humanitarian crisis by the world communities.[6] As such, HIV continues to be a key public health issue as evidence shows an increase of new HIV cases particularly in SSA.[9]

In Africa, AIDS is currently the leading cause of death in adolescents living with HIV and globally it is the second largest cause of death.[10] SSA accounts for 70% of people living with HIV, though the population is equivalent to 10% of the global population.[11] Globally there are around 2 million infected adolescents of which 82% live in SSA. In the most infected countries of the world, 80% of all new HIV infections are among adolescent girls, with one in five young women showing as HIV positive. Of these adolescents, 50% live in only six countries: South Africa, Nigeria, India, Tanzania, Kenya and Mozambique.[12] On average, at least 50 adolescent girls die every day from AIDS-related illnesses.[(13)] The research reveals that at least a third of women around the globe experience violence and are more likely to be infected by HIV.[8] The epicentre of the HIV epidemic is SSA, with SA being reported as home to the largest number of people living with HIV.[11] The country has the fastest growth of HIV infection and incidence rates in the world.

South Africa has at least 7.2 million people living with HIV,[13] where the infection continues to be a burden, particularly among young women, with approximately 2,000 new HIV cases each week.[14] Mampane[15] and Pomeroy[16] highlight some of the socio-demographic characteristics, and socio-cultural and socio-economic factors that potentially contribute to the prevalence of HIV among young women in South Africa. These factors include unemployment, low levels of education, early sexual activity, early marriages, peer pressure, inequality laws, harmful traditional norms, concurrent partners and poverty. From the socio-cultural factors, poverty has been quoted as one of the reasons for the inequality in HIV prevalence, accounting for an estimated 20–25% of new HIV infections among young women and girls.[17] The rate at which the HIV infection is acquired is of great concern as young women aged 15–24 years are mostly infected, at a rate four times higher than men in the same age range.[18] In addition, evidence reveals that women are infected with HIV 10 years earlier than men.[15] At least 45% of adolescents reported being forced into early marriages and experienced their first sexual activity then.[17] Most women were married before reaching their eighteenth birthdays. The country also has the highest rate of rape in the world.[19]

Allinder and Fleischman[20] have identified a gap in the reduction of the HIV infection in SA between the policy and effective implementation. The country lacks the public health infrastructure resources to increase prevention programmes such as the pre-exposure prophylaxis (PrEP) and other wide programmes that address the needs of adolescents and young adults. SA is faced with health challenges such as an increase in non-communicable diseases on top of shortages of health workers.

Method

The articles were selected for this study by analysing a range of literature and then narrowing it down to certain articles. The articles were analysed in detail using a systematic approach identified by Aveyard.[21] Different academic databases such as Google Scholar, the British Medical Journal and Elsevier were accessed to gather the relevant literature. The NTU Library One Search Pro was used to narrow the list by doing an advanced search on specific words. In this search, the public health setting was selected which brought up search tools such as Wiley Online Library, Social Care Online, PubMed, Cochrane Library and Science Direct, allowing access to a variety of journals concerned with all aspects of life, health, social sciences and humanities. When the key words were typed in, 11,095 articles were generated.

The search was then narrowed by the subject of gender and the date of publication (commencing from 2010). The results showed 4,316 articles. These were further narrowed by selecting the Journal of The International AIDS Society and Wiley Online and including articles published after 2015. This showed 215 articles of which only 26 were relevant to the study. A further reading of the abstracts reduced the articles to the 10 which form the basis of this article.

Inclusion criteria

The articles that were selected had to include the women's perspective, the prevalence of HIV and also a few that had the men's perspective to enable views from both genders. Articles that showed potential risk factors were also selected. As most of the studies showed Kwazulu-Natal as having high HIV prevalence, articles that included this province were also considered but not viewed as essential. The selected articles had to highlight the impact of HIV among young women in SA in either a rural or urban setting. See Figure 1 below for the search flow chart.

Figure 1-Search flow chart

Results

All 10 articles used for the study cited high HIV prevalence among young women aged 10–24 in South Africa. Although the reason for this prevalence is not known and is subject to debate, researchers have identified some socio-behavioural, socio-cultural and socio-economic issues as potential causes. Five themes were identified from the findings as potential causes of HIV prevalence among young women these included Age-disparate relationships, Social Factors and sexual behaviour, Impact of HIV on communities and individuals, Gender and patriarchy including Poverty and social isolation

Age-disparate relationships

Age-disparate relationships was identified as a high-risk factor for HIV prevalence among young women in SA.[22, 23, 24] Such relationships are very common in SSA but have been exaggerated in the media as the "blesser (Man) and blesse (Women)".[15] Furthermore, findings have shown an increase in women testing HIV positive for each year that the sexual partner was older than them.[22, 23, 25] It has also been noted that condom use is less common where there are age-disparate partners.[15, 23] In general, unprotected sex was 11% higher in rural areas compared with 8% in urban areas.[(23)] Accepting gifts for sex was found to be higher in urban settings at 21% compared with 1% in rural areas. Alcohol and sex, and age gaps of 5 years and over were

high in urban areas, compared to rural places.[23] The findings also showed that there were negative attitudes towards young women taking gifts due to potentially being associated with relationships with older partners known as 'sugar daddies'.[26]

Social Factors and sexual behaviour

Research found that there was a reduction in the likelihood of HIV where the respondents were married, lived in less poor households, where there was no domestic violence, where they had one sexual partner, where there was low alcohol intake, and where there was a difference in age of the sexual partner of five years or less.[(25)] It was noted that adolescents who got married at an earlier age were less likely to be infected by HIV. Jewkes et al.[27] found in their study that most women who were infected had experienced violence and high gender power inequality. The findings indicated that some women were sexually active at the age of 17 because they started having relationships around 15–16.[23,27,26] These young women cited being in relationships for various reasons such as love, satisfaction of feelings, having a man to provide for them, being socially accepted among their peers and, for some, receiving gifts made them feel more feminine. However, women lost their bargaining power once they were in the relationship, predominantly in terms of negotiating for condom use particularly regarding sex for exchange of money.[26]

Impact of HIV on communities and individuals

It is evidenced that SA has a lot of community norms in the rural settings such as men being viewed as givers and women as receivers because men pay a bride price for women when getting married.[15] Other norms include forced marriages to older men for material gain and precocious sex, which is one of the risk factors of HIV.[15, 26] SA has more people in rural settings than urban. Being single or unmarried was also very common among young women aged 20–24.[28] Women had unplanned pregnancies despite having experience with HIV through caring for a parent or a family member infected with the illness.[29] Young women were found to have knowledge of HIV but expressed a sense of invisibility.

Maughan-Brown et al. and Oliveira et al.[23, 24] found that transactional sex was high in rural areas, and was found to improve social status among peer groups although adding a risk of HIV infection.[15] Chimbindi et al.[28] found a decrease in condom use among young women from 58.7% to 44.9% of those aged 15–19 and from 55.1% to 48.2% among those aged 20–24 between 2011 and 2015. However, it was also found that sexual frequency was similar for different age groups.[24,23]

Gender and patriarchy

For decades African women have been discriminated against in their culture. Klaas et al.[30] found that women were not offered high position jobs in farms despite having the largest population. The study identified unequal power distribution among men and women in farms. Participants even confirmed that male managers and supervisors would use their managerial position to exploit women. Other participants confirmed that women were powerless, and gender inequality continues to be common in the farming community. Other research identified that some women engaged in sexual activities for money, gifts and favours such as securing a job.[23, 26] The men in their culture viewed themselves as superior to the women and felt that it was their right to have numerous sexual relationships. If a woman was

found to be HIV positive they faced repercussions for conveying the infection in the relationship while men were culturally forgiven for spreading the disease.[30]

Poverty and social isolation

Poverty and unemployment were identified as being among the high-risk factors in the prevalence of HIV among young women.[15] Those in rural SA generally have low socio-economic status and often live below the poverty line. The women in these areas tend to be unemployed, uneducated, unmarried and living in poor conditions, placing them in poverty, which is a driving force of HIV transmission.[15, 22] Mbaso et al. and Ranganathan et al.[25,26] found that women with tertiary education were less likely to have HIV. However, Jewkes et al.[27] found no difference in education and socio-economic status between women who were HIV positive and those who were negative.

Participants reported challenges due to poverty and low income not being enough to cover daily expenses.[30,15] The study found that women who work on farms are vulnerable and discriminated against in employment and fully depend upon men for their accommodation. Due to the lack of jobs in rural areas young women migrate to urban areas to seek employment but end up getting involved in transactional sexual behaviours to earn a living and acquire basic needs such as food and shelter. Orphans were also identified as at risk of HIV due to a lack of parental guidance.[29] They engaged with sexual partners for various reasons including financial, emotional and psychological support. Participants expressed a fear of losing social support from their partners with the culture of hiding their HIV status due to stigma and isolation. Table 1 below shows the articles that have addressed different main themes identified in this study and table 2 shows summary of the ten articles.

Table 1: Main themes

Table 2: Summary of the ten articles

Discussion

In recent studies, women have been identified as suffering the impact of HIV more than their counterparts. Women of reproductive age have been disproportionately affected, as approximately 75% of the infection occurs among young women aged 15–24 years.[10,13] The HIV prevalence continues to be very high in SA, despite improvements in the fight against HIV/AIDS.[25] Age-disparate relationships were found to be common in SSA particularly in SA [15,18] where at least a third of young women were in age-disparate partnerships. This practice has become the norm such that the media has given it the glamorous name of "blesser and blessee".[15,19] The majority of women in the studies expressed a desire to engage in inter-generational relationships. Women expressed contentment in these relationships as they confirmed being blessed with expensive gifts which their same-age male partners could not afford.[15]

Evidence suggests that, in general, women dated older men of their own will as some participants saw older men as being more respecting and sexually experienced compared with teenagers.[31] On the other hand, some women were not so keen on older partners because they perceived them as controlling, demanding more sex and being violent.[15] Age-disparate relationships have long been considered as a factor increasing the risk of HIV for young women, although there has been some contradictory evidence in recent studies. Studies by Maughan-Brown et al.[23] and George et al.[32] agree that the affiliation between age-disparate partnerships and the risk of HIV infection among young women is very complex and has not been fully understood. Findings of recent HIV studies on the link between an age gap and the risk of HIV at national level, however, confirm that age-disparate relationships continue to be a risk factor in young women in SA.[22]

Current studies have identified social, structural and behavioural factors associated with the increased risk of HIV in young women. Evidence suggests that young women aged 20–24 years have a higher HIV prevalence than those aged 15–19.[23, 25] Southern Africa studies have shown that the transition from adolescent women to young adults is hazardous as the risk of being infected with HIV is very high.[25] This is due to adolescents passing through the transitional period of physical, social and psychological development, following which, most become sexually active and engage in HIV risk behaviour. It is suggested that when adolescent girls and young women get to their 30s they perpetuate the HIV transmission cycle to men in their 30s, who, in turn, infect the next cohort of adolescent girls and young women.[24] The risk of the HIV transmission through this cycle is enhanced at community level by two key factors. First, it was noted that two-fifths of HIV positive residents were not aware of their HIV status and, second, only two-thirds of residents who were aware of being HIV positive had initiated ART, which resulted in sub-optimal viral suppression.[24]

Transactional sex is practised across the globe although the nature of the practice varies. It has been noted that sex workers have a higher risk of contracting sexually transmitted infections

(STI) and HIV compared with those practising transactional sex, although the number of women involved in transactional sex is higher than sex workers.[8] Klaas et al.[30] discovered that although women who are HIV positive may want to practise safe sex to avoid reinfection, they are often not in a position to do so due to the gender roles in maintaining relational connections. Men's unequal power over women plays a vital role in the spread of HIV as it subordinates women and renders them incapable of negotiating for safer sexual practice due to their poverty.

Poverty is associated with an increased risk of HIV among young women. Research suggests that living in less poor residential areas was a protective measure against HIV infection in adolescent girls.[25] Mampane[15] and Jewkes & Morrell[31] have noted that poverty is the main barrier for effectively managing the risk of HIV in SA. According to research conducted in 2016, 57% of South African residents live in poverty.[30] Women are identified as being at higher risk of contracting HIV due to poverty and socio-cultural practices.[1] These women are faced with complex and difficult circumstances mainly driven by a lack of community activities and schooling, and also unemployment. In addition, people who are less educated and poor are less likely to use condoms compared with more well-off and educated people. Most of the HIV prevention posters are written in English, which most people cannot read. The study by Mabaso et al.[25] show that tertiary education among young women has a protective effect against HIV infection, and argue that education of any form can help protect against HIV. However, 60% of girls in developing countries have no access to secondary education. There are many forms of education that people can benefit from. For instance, in the days before formal education, people learnt skills and acquired knowledge about life from their elders. Klaas et al.[30] point out that pupils with knowledge about HIV still did not practise safe sex due to economic difficulties and the imbalance of power between men and women. These young women became hardened to the fact that despite HIV prevention strategies people in the community continued to deteriorate and die from HIV-related illnesses. There is evidence that HIV became viewed as something not to be feared anymore.[29] Some people who experience poverty believe that their life is already short and therefore they have nothing to lose in risking infections in the fight for survival.[30]

Poverty has also been identified as a risk factor in gender inequality as it allows men to acquire power over young women particularly where sex is rewarded. Young women can be vulnerable and victims of men. Although women may want to express their feminism, they often surrender their power to men to enable their cultural life to be more meaningful.[31] Ranganathan et al.[26] argue that women desire to be economically independent from their families and therefore shape their aspirations in ways that may give limited job opportunities. Young women may aspire to get satisfying jobs and to live a life which is better than their parents' lives. However, people in rural SA living below the poverty line may be forced to engage in sexual behaviour, thus exposing themselves to HIV infection. Orphans have also been identified as being at risk of HIV infection due to the lack of parental guidance and financial support. SA has a lot of orphans due to children losing their parents from HIV-related diseases. Evidence suggests that orphans are worse off in poverty as they are forced to grow up too quickly in order to try and support their siblings.[29,33] They may engage in sexual activities for financial, emotional and psychological support from sexual partners. There is a high degree of isolation among orphans, so they may engage in sexual activities to avoid isolation and to fit into the social network. Orphans are obliged to look after their families regardless of their age. Some are driven to early marriages. Mabaso et al.[25] contrast the effects of low alcohol intake

and marriage against the risks of being infected by HIV particularly among adolescent girls as they develop into adulthood. Research has shown that they are at lower risk of HIV infection if they marry early and particularly if both marriage parties are HIV negative and remain faithful to each other.[25] However, some studies, on the contrary, suggest that marriage increases the vulnerability of young women due to reduced bargaining power within the marriage. Young women who are at child-bearing age are more prone to pregnancy which is a critical stage in the mother-to-child prevention. If this stage is not handled with care, the HIV infection continues in a vicious circle.

Due to poverty and stigma, people who are HIV positive adopt a culture of hiding their HIV status to maintain their social networks and financial support from their partners. Stigma is said to be socially constructed and attributable to historical, social and cultural factors. Individuals experience a sense of shame and guilt. Women who are HIV positive are usually referred to as 'vectors', 'diseased' and 'prostitutes'.[4] Infected women who are mothers are said to experience a triple burden. They have to carry the burden of caring for the family while also facing stigma. In addition, if their status is known to the community the children are equally stigmatised, hence these mothers may decide not to disclose their status, to protect themselves and their children. Some of the women pointed out that men may resist using condoms for fear of being discovered as HIV positive which could reduce their power over the women.[33] Despite evidence of different mechanisms of HIV transmission between men and women, little gender-specificity has been included in the prevention of HIV among the elderly.[34]

Violence is recognised as a big problem in SA, particularly rape, with estimations suggesting that a woman is raped every second.[33,13,31] Evidence suggests that the risk of HIV infection is more associated with intimate partner violence and gender inequalities than rape by a non-partner.[27] Although there is no empirical evidence that a reduction in violence exposure for women reduces incidence of HIV, a study by Evans et al.[22] shows that women suffering from job discrimination, illiteracy and power inequity were more vulnerable to sexual violence.

Although people may have knowledge of HIV and its transmission procedures, some are reluctant to practise what they know because of poverty and insecurity. Research has identified the lack of use of PrEP, pointing out that despite significant advancements of biomedical modernisation and new products being developed,[35] women's HIV prevention interventions continue to be limited in terms of their sexual practices and the way that health decisions are made in the socio-cultural context. Evidence suggests that there is a new HIV intervention therapy which women are in favour of, which does not require the involvement of the partner and offers long-term protection, unlike PrEP which is taken on a daily basis.[35] However, a product that requires the adoption of a new lifestyle is not likely to be taken up because women's decisions on health and products are embedded in the cultural context of being submissive to men, male dominance and gender norms. Understanding the intrapersonal interaction is crucial as it will widen the opportunities for HIV prevention.

Kilburn et al. [12] state that psychological factors need to be considered when planning policies and strategies to fight HIV among young women in SA. Due to the gender power imbalance there is a need for transformative gender interventions where women are empowered to exercise urgency on the intrapersonal level and men are encouraged to renounce control over women through interpersonal knowledge and negotiations.[35] As HIV prevalence continues

among adolescent and young women it is important to improve prevention efforts among this group of people.

Limitations of the study

This study was limited to ten articles from the many studies carried out on HIV and young women. Research covering a wider range of articles may provide diverse answers to the challenges of young women being affected by HIV. The study was a literature review based on already existing literature. However, a primary study on the issue may provide more current information on the topic in question.

Gap in knowledge

Although many research studies on HIV in young women have been undertaken in SA, there is a need to understand the intricate drivers of vulnerability to HIV among young women in order to provide an empowered response.

Implications for practice

Health-care practitioners need to be trained in understanding the needs of young women to enable them to open up to the service and get the best out of it. Sex education may be beneficial if introduced in schools and also in the community to cater for women who do not attend school. Sexual health practitioners need to train young women to be assertive and understand their rights during sexual transactions with different members of the community regardless of age or socio-economic status. Community health workers need to be competent in engaging with young women on sensitive issues such as sex education and the need for HIV testing and counselling.

Health organisations need to work in partnership with the community to identify health priorities to enable professionals to roll out community education aimed at addressing the impact of patriarchy on young women in SA.

The governments in SSA need to improve their sexual health services in terms of accessibility, affordability and effectiveness among young women. Organisations that drive the HIV agenda for women, such as the WHO and UNAIDS, should work to ensure that policies and interventions that reduce gender inequality are developed and fully implemented with mobilisation from the government. Practitioners need to invest in resources for testing and developing new interventions.

Recommendations for future research

Further research on HIV is required among adolescents and young women aged 15 to 24. Researchers need to liaise with community health workers to strengthen their research. Furthermore, a better understanding is required concerning the health-seeking behaviour of young women in order to provide supportive interventions and increase the uptake of sexual health services.

Conclusions

Young women are disproportionately affected by HIV in SA and there is a need to make sure that they are empowered to deal with the challenges associated with socio-economic factors and the uptake of sexual health services. More importantly, there is a need to embark on

nationwide research to understand the challenges experienced by young SA women with regard to abuse and vulnerability with older men.

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Conflicts of interest

All authors declare no conflict of interest.

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