

HIV incidence rates in adolescent girls and young women in sub-Saharan Africa

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The global acceleration of the AIDS response over the past decade, particularly increased access to antiretrovirals for HIV treatment, has resulted in declining HIV incidence in many regions of the world and a 33% reduction in AIDS-related deaths between 2010 and 2018.¹ Despite these gains, a substantial global HIV burden still remains, with 38 million people living with HIV and 1·7 million diagnosed with new HIV infections in 2018.²

New HIV infections continue in certain regions and among key populations. Populations that are disproportionately affected by HIV include sex workers, men who have sex with men, transgender individuals, and people who inject drugs. In sub-Saharan Africa, adolescent girls and young women aged 15–24 years are particularly vulnerable. In this region, despite representing just 10% of the population, adolescent girls and young women accounted for 25% of all new HIV infections globally in 2017.¹ Of all HIV infections occurring among adolescents in sub-Saharan Africa, 80% are in girls aged 15–19 years. Adolescent girls and young women are also twice as likely to be living with HIV than young men of the same age.²

In *The Lancet Global Health*, Isolde Birdthistle and colleagues present their systematic review and meta-analysis,³ collating available data for HIV incidence in adolescent girls and young women from nine high HIV-burdened African countries between 2005 and 2015; Lesotho was initially included in the study but had no available data. This period corresponds with the substantial scale up of antiretroviral therapy (ART) in Africa and is before the implementation of large projects that specifically targeted HIV prevention for adolescent girls and young women.

Although there is evidence of a decline in the absolute levels of HIV incidence among adolescent girls and young women between 2005 and 2015 in Rakai (Uganda), Manicaland (Zimbabwe), and among female sex workers in Kenya, HIV incidence has remained largely unchanged in the highest-burdened communities in South Africa.³ HIV incidence rates have also remained high in certain high-risk groups such as fishing communities in Uganda, where HIV incidence of up to 12·4% are observed among teenage girls aged 15–19 years, and among female sex workers aged 18–24 years in South Africa (HIV incidence

of 13·2%) and Zimbabwe (10·8%). Gender disparities in HIV persist; HIV risk is six times higher among young women than among men in southern Africa and three times higher in eastern Africa.

The summary estimates of HIV incidence from several published studies, although limited in terms of the studies selected and the inclusion of prevalence-based estimates of incidence, still provides some useful insights. They suggest that the prevailing approach to HIV prevention during this period, which was largely focused on increasing ART coverage and scaling up medical male circumcision, has been insufficient to affect HIV incidence rates in adolescent girls and young women, particularly in high-burdened settings.

Given that adolescent girls and young women primarily acquire infections from HIV-positive men aged in their late 20s and early 30s,⁴ who are often unaware that they have HIV and are less likely to be on ART, the minimal decrease in HIV incidence among young women is not surprising. Although relationships with older men might be one of the fundamental drivers of the rapid spread of HIV infection in young women, a complex interplay of biology, gender-power disparities, and socioeconomic and other social triggers, including violence against women, affect vulnerability in women in Africa.⁵ A combination of prevention strategies, including structural, biomedical, and behavioural programmes for both men and adolescent girls and young women are likely to be needed to have an effect on HIV incidence for high-risk populations.

In 2014, PEPFAR launched the DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe) initiative, which aims to meet the prevention needs of adolescent girls and young women through a multipronged approach that includes national campaigns, access to combination prevention, the engagement of men (eg, linkage to HIV testing and counselling, treatment, and voluntary medical male circumcision), integration of HIV services into sexual and reproductive services, provision of pre-exposure prophylaxis, and efforts to keep girls in school.⁶ This systematic review and meta-analysis also provides useful baseline HIV incidence rates that could be used to assess whether the DREAMS

initiative has met its aims of decreasing HIV incidence among adolescent girls and young women. More studies providing reliable estimates of HIV incidence are needed to establish the effect of prevention interventions, understand HIV epidemic dynamics, and interpret temporal trends in different populations and subgroups.

Progress towards achieving the UN's goal of ending AIDS as a public health threat by 2030 will not likely be reached unless a major effort is made to reduce HIV incidence rates in adolescent girls and young women. This group remains a very high global priority. Ongoing accurate measurement of HIV incidence is essential in order to monitor progress towards this global target, an important part of the UN's Sustainable Development Goals.

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