

Appropriate Public Health Interventions Concerning Age-Disparate Relationships in Southern Africa

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In Southern Africa, and especially recently in South Africa, ‘anti-sugar daddy’ campaigns to discourage age-disparate relationships (ADR) between young women and older men, have been common (1). Politicians have been discouraging such relationships and attributing the severe HIV epidemic in South Africa to such relationships (2,3), though evidence for the importance of ADR in the transmission of HIV infection is limited. In 2014, when Harling et al. (4) were unable to find evidence that ADR is important in driving HIV incidence, many organisations and activists stopped advising against ADR (5). For the past few years, the HIV prevention community has been in abeyance about whether ADR-prevention interventions are appropriate, and if so, what should the messages contain.

The results from recent studies my colleagues and I have conducted offer a more nuanced picture about the nature of age differences and HIV transmission. Age differences in heterosexual relationships have the potential to both elevate the individual-level risk of acquiring HIV (e.g. through decreased condom use, longer relationship durations, and higher sex frequencies) (6,7), and help sustain the epidemic within some populations of South Africa and Malawi (8). Although the way in which age differences contribute to transmission may be different than what has been previously described in observational studies. The results suggest that moralising approaches stigmatising all relationships where the male partner is 5 or more years older, may not be appropriate, nor evidence-based. In reality, there cannot be a cut-off for age differences above which risk increases across all populations (7,8). Moreover – though this is common sense – age differences have the ability to affect transmission risk in men, as well as women (8). Complicating all of this, is the observation that high individual variability in partner ages, in addition to relationship age differences, is probably what drives transmission (7,8). Given these complexities, I propose the following public health intervention recommendations:

1. Raising awareness about potential HIV risks associated with larger age differences should be context dependent and evidence-based. For example, it might be appropriate to raise awareness among 18-49-year-old women on Likoma Island about the fact that increasingly large age differences may put them at

heightened risk of HIV infection until the age differences approach 12 years (7). However, larger age differences than 12 may potentially protect them from HIV transmission (7). It would not be appropriate to use that same information to raise awareness about age difference related risks in an urban, Johannesburg setting, for example, since this is an entirely new context with different social norms. In other settings the same sexual risk behaviours may not be associated with the same age differences. It should be additionally noted that the results from one study alone should not be used as the basis for an HIV risk awareness campaign.

2. There is a need to strengthen cultural, economic, educational and legal structures to protect and empower women (9). While there is evidence to suggest that women have control over partnership formation, as well as the number and type of partners they have, within these relationships they have less power in condom use negotiations and sex frequencies (10). Young women in Southern Africa have growing aspirations and limited opportunities for financial independence. Programmes incentivising women to stay in school longer, like state-sponsored cash-transfers, or start businesses, like micro-lending programmes, are examples of some avenues that may lead to financial independence, and thus, increased relationship power. However, if these programmes are not sustained over the long-term, so that young women have the opportunity to develop useful skills for a modern economy or acquire productive assets, then they may not be effective.
3. Thus far most of the intervention suggestions and framings of this topic in the literature have focussed on women. However, our studies also point to the need to protect young men from HIV transmission by older or age-similar partners. One of the most efficacious interventions for preventing transmission from women to men is medical male circumcision (13–15). Voluntary medical male circumcision programmes are ongoing, but there are still several barriers to scale-up. Lack of funding, programme inefficiencies, demand creation, low capacity of government

to manage programmes, as well as time-consuming and invasive medical procedures are all seen as shortcomings of the current programmes (16).

These intervention strategies have the potential to curb HIV incidence and potentially eliminate key transmission pathways in certain age groups, but they will require a great deal of political will to accomplish them. The high HIV incidence among young women is a multi-faceted problem, which cannot be addressed wholesale with campaigns to stigmatise sugar daddy relationships. Understanding age-mixing dynamics in high HIV prevalence settings is the key to identifying transmission pathways in those populations. Awareness of the male and female motives for partner age variability and preferences should be the basis for interventions to eliminate those transmission chains.

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