

**THE YOUTH**

**BULGE**

**AND HIV**

# THE YOUTH BULGE AND HIV

In many sub-Saharan African countries, declines in child mortality combined with a slow decline in fertility have resulted in children and young adults comprising a large part of the overall population. This is known as the youth bulge.

The youth bulge is not new. Younger generations have almost always been larger than the previous generation. However, before the twentieth century, high child mortality meant that a large proportion of children did not survive to adulthood.

Huge improvements in nutrition and health services over the past 30 years have had a significant impact on population trends in sub-Saharan Africa. Thanks to remarkable decreases in child mortality—and large decreases in mother-to-child transmission of HIV—child survival rates have improved significantly. Young people in Africa are now not only surviving but thriving, and approximately 60% of the continent's population is under the age of 25 years.

## YOUNG PEOPLE AT HIGHER RISK OF HIV

In some countries, there has been limited progress in the response to HIV among young people aged 15–24 years. Knowledge about HIV prevention among young people has remained stagnant over the past 20 years. Nationally representative surveys conducted between 2012 and 2017 revealed that only 34% of young men and 28% of young women in sub-Saharan Africa had a basic knowledge of how to protect themselves from HIV.

Population-Based HIV Impact Assessments conducted in Malawi, Zambia and Zimbabwe have found that less than 50% of young people living with HIV were aware of their HIV status, compared to between 74% and 80% of adults aged 35–49 years living with HIV in the same countries.

## HIV IN EASTERN AND SOUTHERN AFRICA

One of the challenges of the youth bulge is that, as the overall number of young people grows, and coverage of prevention services remains the same, more young people are at risk of HIV infection. In eastern and southern Africa, young women are already at considerably higher risk. In 2017, around 290 000 [160 000–390 000] new HIV infections occurred among young people aged 15–24 years. Two out of three of those new HIV infections occurred among young women aged 15–24 years.

Low levels of knowledge of HIV prevention and high rates of new HIV infections among young women in eastern and southern Africa are putting the gains made in child survival at risk.

Data from South Africa reveal a vicious cycle of HIV transmission from older men to younger women. It is not uncommon for young women to begin a sexual relationship with men 10–20 years older than themselves and to receive cash or

gifts in exchange for sex. Often, the women are unaware of the need to protect themselves from HIV or are unable to negotiate the use of condoms. The women can acquire HIV but are often unaware of their HIV status. As the young women mature they begin to have relationships with men of their own age, who then also acquire HIV. The men grow older and, still unaware of their HIV status, go on to have relationships with young women and continue the cycle.

## **THE DOUBLE IMPACT**

This cycle of transmission has implications for decreasing the overall number of new HIV infections, particularly among young women between the ages of 15 and 24 years. Globally, young women aged 15–24 years accounted for 19% of new HIV infections in 2017—more than 80% of those infections are among young women in sub-Saharan Africa.

The cycle of HIV transmission in sub-Saharan Africa is underpinned by gender inequalities, violence and harmful masculinities. Poor access to education, lower levels of economic independence and intimate partner violence erode the ability of young women to negotiate safer sex and have control of their bodies. Men tend to seek health services infrequently and they tend to be diagnosed with HIV and initiate treatment too late.

As increasing numbers of girls born free from HIV become young women, services dedicated to ensuring that they stay free from HIV must keep up with demand. Equally, as the youth bulge grows, a lack of sufficient health services to support the increasing number of young people could result in the number of new HIV infections plateauing or, worse, beginning to increase.

The youth bulge is already having an effect on the ability of sub-Saharan Africa to reduce the number of new HIV infections among young people. An analysis of UNAIDS data shows that new HIV infections among young people aged 15–24 years declined by 22% between 2010 and 2017. However, had the population size and incidence rate remained stable, the decline in new HIV infections among young people aged 15–24 years would have been 36%.

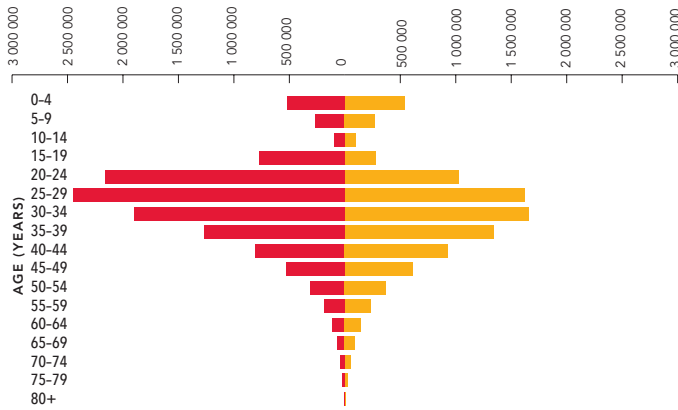
## **THE CHALLENGE OF THE YOUTH BULGE**

As the number of young people aged 15–24 years increases, efforts to provide HIV prevention services to meet their needs must be scaled up if the world is to meet the global targets for reducing new HIV infections.

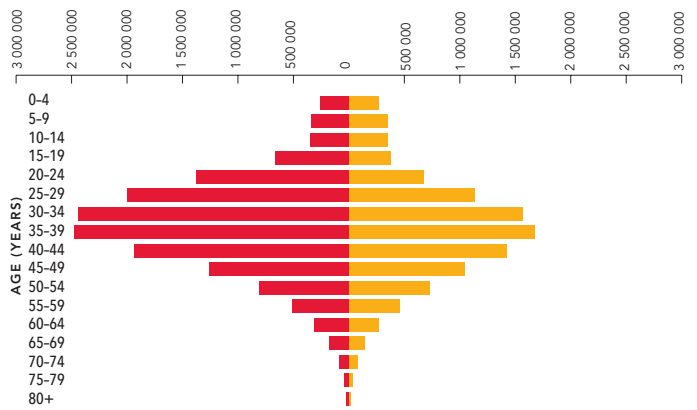
From 1990 to 2012, the percentage of women aged 15–49 years who received at least four antenatal care visits from skilled health professionals in sub-Saharan Africa only increased slightly, from 48% to 50%. However, the estimated number of births in the region for which women received four antenatal visits increased by more than half, from 11 million in 1990 to 17 million in 2012 (1). Sub-Saharan Africa has undergone clear demographic changes, generating more demand for services that are not always in place to respond to the demand.

# THE YOUTH BULGE

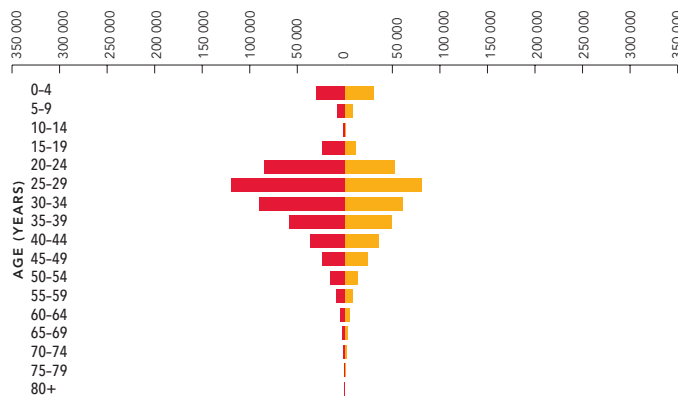
SUB-SAHARAN AFRICA, FEMALE, 2000 SUB-SAHARAN AFRICA, MALE, 2000



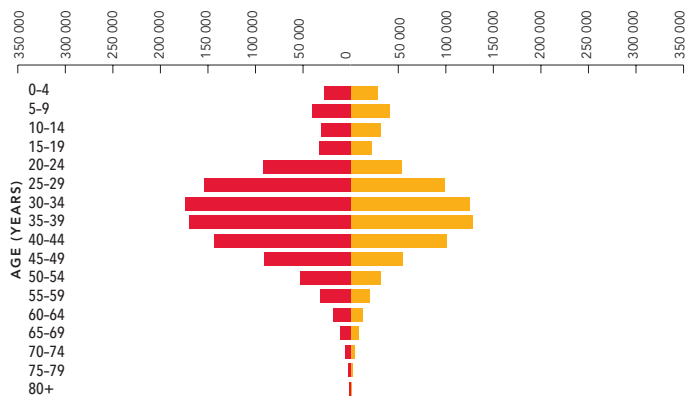
SUB-SAHARAN AFRICA, FEMALE, 2016 SUB-SAHARAN AFRICA, MALE, 2016



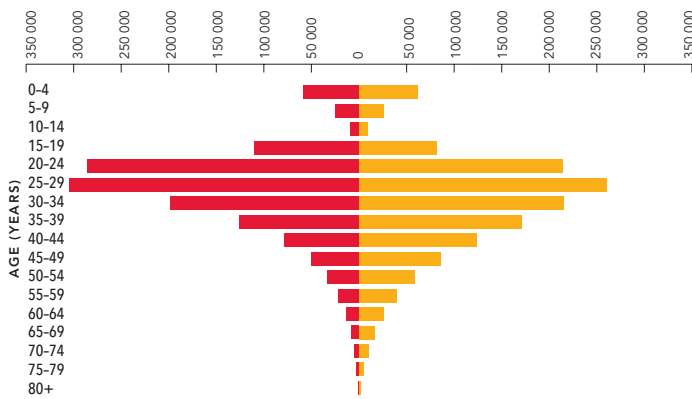
MOZAMBIQUE, FEMALE, 2000 MOZAMBIQUE, MALE, 2000



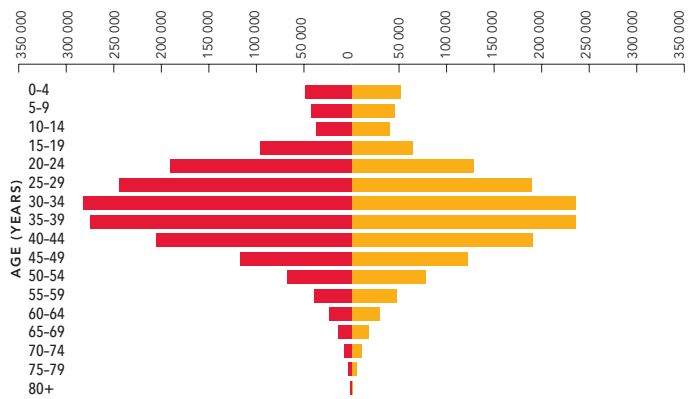
MOZAMBIQUE, FEMALE, 2016 MOZAMBIQUE, MALE, 2016



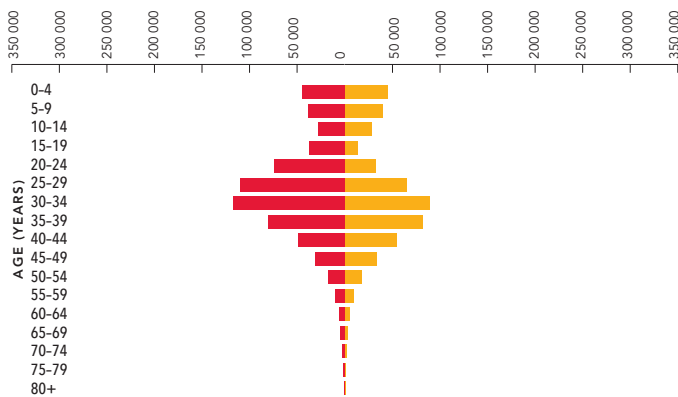
NIGERIA, FEMALE, 2000 NIGERIA, MALE, 2000



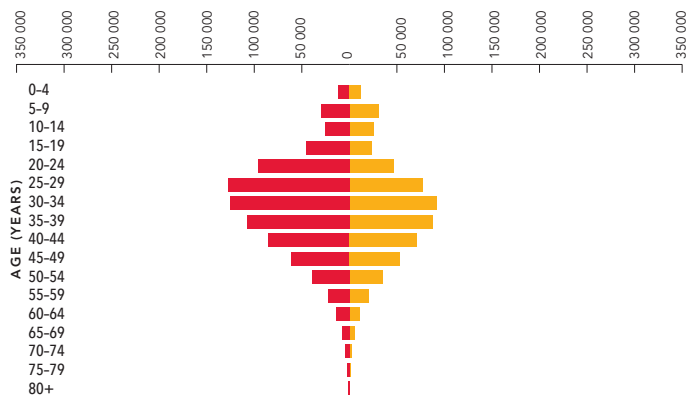
NIGERIA, FEMALE, 2016 NIGERIA, MALE, 2016



UGANDA, FEMALE, 2000 UGANDA, MALE, 2000



UGANDA, FEMALE, 2016 UGANDA, MALE, 2016



Foreseen demographic changes in the next 15 years require the adaptation of health services to meet a growing demand from the population, without jeopardizing the gains already achieved in HIV and sexual and reproductive health. In Africa, the United Nations Population Division projects that the number of births will increase by 28% by 2030—from 35 million births in 2012 to 45 million in 2030. In addition, there will be an increase of 65% in the population of women of reproductive age in Africa—353 million women in 2030, with Africa becoming the region with the second largest number of women of reproductive age, after eastern Asia (2).

The interlinkages between the use of contraception and access to HIV prevention options among adolescents are well known. The Global HIV Prevention Coalition urges countries to ensure that at least 90% of adolescents, in particular girls, have access to combination HIV prevention that includes sexuality education, economic empowerment and access to sexual and reproductive services. A study undertaken in Nigeria found that women with more decision-making power were almost twice as likely to use modern contraception as women with lower decision-making power (3).

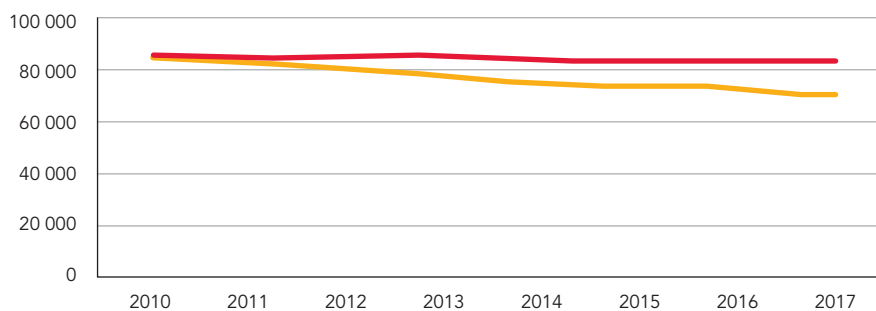
Countries need to invest in health systems that promote access to sexual and reproductive health services among adolescents. Scaling up health services includes increasing access to condoms and diagnostics, increasing the number of trained health service providers, including community health workers, and increasing the number of health-care-related buildings.

Equally, programmes to address the intergenerational cycle of HIV infection should be scaled up. Efforts begin with identifying and eliminating barriers, such as restrictive laws, policy implementation gaps and harmful societal and gender norms, and addressing provider limitations on the availability of services for young people. Cross-sectoral programmes that ensure access to sexual and reproductive health care for young people, decrease gender-based violence against young women and adolescent girls, increase retention of young women and adolescent girls in school and provide economic opportunities for young people, particularly young women, should be scaled up.

## **EXAMPLES OF THE IMPACT OF THE YOUTH BULGE IN SOME COUNTRIES**

The graphs on the next page show the impact of the additional youth population on new HIV infections. The orange lines show estimates of the number of new HIV infections had the same HIV incidence been applied to a population that remained the same size between 2010 and 2017. In rapidly expanding populations, such as Nigeria's, there would have been 57 000 fewer HIV infections without the youth bulge, in Mozambique there would have been 53 000 fewer new infections and in Uganda there would have been 18 000 fewer infections during that time period. Overall in sub-Saharan Africa, there would have been 340 000 fewer HIV infections in the 15–24-year-old population without the youth bulge between 2010 and 2017.

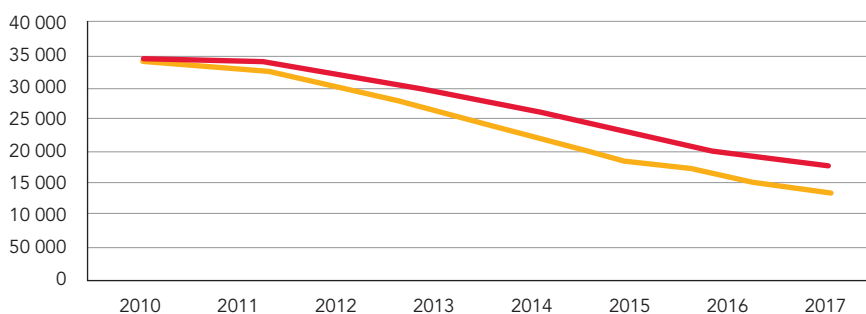
## NUMBER OF NEW HIV INFECTIONS AMONG YOUNG PEOPLE AGED 15–24 YEARS, NIGERIA



— UNAIDS 2018 estimates

— Assuming no population growth between 2010 and 2017

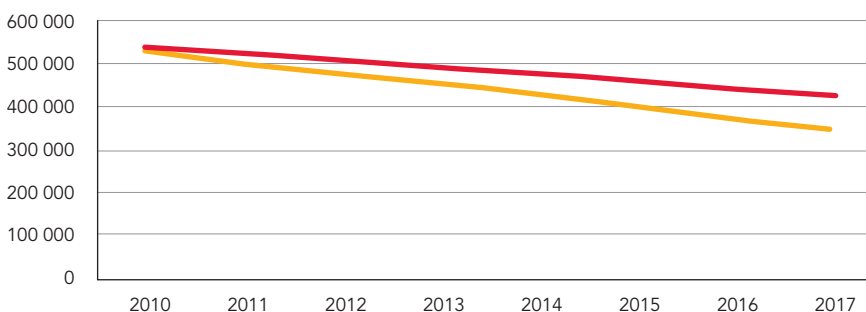
## NUMBER OF NEW HIV INFECTIONS AMONG YOUNG PEOPLE AGED 15–24 YEARS, UGANDA



— UNAIDS 2018 estimates

— Assuming no population growth between 2010 and 2017

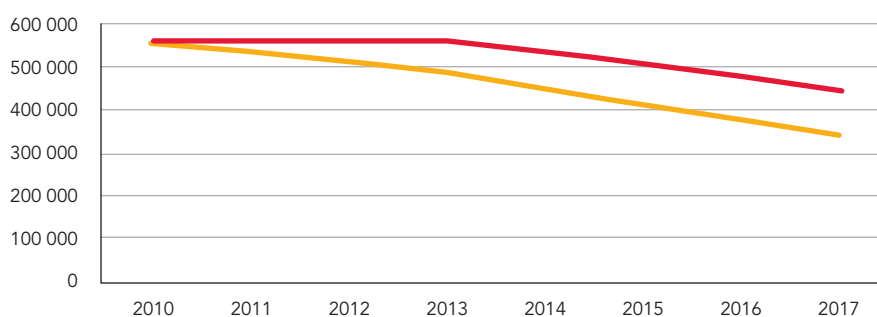
## NUMBER OF NEW HIV INFECTIONS AMONG YOUNG PEOPLE AGED 15–24 YEARS, SUB-SAHARAN AFRICA



— UNAIDS 2018 estimates

— Assuming no population growth between 2010 and 2017

## NUMBER OF NEW HIV INFECTIONS AMONG YOUNG PEOPLE AGED 15–24 YEARS, MOZAMBIQUE



— UNAIDS 2018 estimates

— Assuming no population growth between 2010 and 2017

### FIVE ACTIONS FOR NATIONAL RESPONSES

The Global HIV Prevention Coalition highlights five prevention pillars to support the strengthening of national HIV programmes:

- 1.** Increase access to combination prevention for adolescent girls and young women and their male partners. The scale-up includes HIV prevention services, comprehensive sexuality education, economic empowerment, addressing harmful masculinities, gender norms and gender-based violence and access to sexual and reproductive health services and rights, including contraception.
- 2.** Ensure that combination prevention programmes for all key populations are evidence-informed and human rights-based and include community empowerment, peer outreach and condom distribution, harm reduction services for people who use drugs and access to HIV testing and referral to treatment that is free from stigma and discrimination. Strengthened programmes should be implemented at scale, be community-based and community-led and be tailored to the HIV and wider sexual and reproductive health needs of key populations.
- 3.** Strengthen national condom and related behaviour change programmes. This includes behaviour change communication and condom demand creation, adequate procurement and supplies of male and female condoms and lubricants and free distribution, social marketing and private sector sales in order to ensure access everywhere, towards an expanded and sustainable condom market.
- 4.** Increase the availability and uptake of voluntary medical male circumcision in countries with high levels of HIV prevalence and low levels of male circumcision, as part of wider sexual and reproductive health service provision for men and boys.
- 5.** Offer pre-exposure prophylaxis (PrEP) to population groups at substantive risk of HIV, and experiencing high levels of HIV incidence, with the meaningful involvement of these groups in programme design and implementation.

## REFERENCES

1. United Nations Population Division. Population facts. New York: United Nations; 2014 (United Nations [http://www.un.org/en/development/desa/population/publications/pdf/popfacts/PopFacts\\_2014-6.pdf](http://www.un.org/en/development/desa/population/publications/pdf/popfacts/PopFacts_2014-6.pdf)).
2. United Nations Population Division. Population facts. New York: United Nations; 2014 (United Nations [http://www.un.org/en/development/desa/population/publications/pdf/popfacts/PopFacts\\_2014-6.pdf](http://www.un.org/en/development/desa/population/publications/pdf/popfacts/PopFacts_2014-6.pdf)).
3. Funmilola M. Having a say matters: influence of decision-making power on contraceptive use among Nigerian women ages 35–49 years. *PLoS One*. 2014;9(6): e98702. Published online 2014 Jun 4. doi: 10.1371/journal.pone.0098702.