

HIV prevalence and associated factors among orphaned adolescents and youth aged 12-24 years in South Africa

Philisiwe Ndlovu (

ndlovuphilisiwe3@gmail.com)

University of the Witwatersrand

Musawenkosi Mabaso

Human Sciences Research Council

Inbarani Naidoo

Human Sciences Research Council

Noloyiso Vondo

Human Sciences Research Council

Nompumelelo Zungu

Human Sciences Research Council

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Abstract

Objectives

The aim of this study examines the HIV prevalence and associated factors orphaned adolescents and youth in South Africa using the 2017 population based national survey.

Results

Of 1 978 orphaned participants aged 12-24 years. The overall HIV prevalence was 7.8% (95% CI: 6.3–9.6). HIV was higher among females (9.2%) compared to males (6.4%). HIV prevalence was significantly (p < 0.05) higher among Black Africans than other race groups (8.2% versus 1.4%), unemployed compared to those who are employed (8.2% versus 1.3%), no condom use at last sex act (13.8% versus 5.8% who used a condom), had high self-perceived risk of HIV infection (11.4% versus 5.7% with low perception), and those who ever had an HIV test (9.5% versus 5.3% never tested). In the final multivariate model, the odds of HIV infection were significantly higher among female than males [AOR = 2.9 (95% CI: 1.1–7.8), p = 0.032] and those residing in rural informal/tribal areas than urban areas [AOR = 2.9 (05% CI: 1.1–7.7), p = 0.031]. The findings suggest a need for intervention to create employment opportunities, promote protective sex, address perceived susceptibility to HIV and encourage routine testing. Prioritising orphaned female adolescents and youth and those residing in rural informal/tribal areas.

Background

The United Nations Children's Fund (UNICEF) defines an 'orphan' as a minor who is below the age of 18 that has lost one or both biological parents to death [1]. Globally as at year 2022, there is approximately 14.9 million orphan children aged 0–17 years with 11.2 million living in sub-Saharan Africa and 960 000 in South Africa [2]. Children aged 0–18 years living in sub-Saharan Africa have been negatively affected by the HIV epidemic due to being orphaned at a tender age [3, 4]. Literature has shown that adolescent orphans are at an increased risk of contracting HIV compared to their non-orphaned counterparts [5]. Data from 19 countries suggest that they are two to three times more likely to contract HIV during adolescence compared to non-orphans [6].

In South Africa, orphanhood among adolescents aged 15–19 years living with HIV (ALHIV) declined from 55.7% in 2012 to 43.7% in 2017, respectively [7]. With the highest rate of orphans being paternal orphans at 17.4% and maternal orphanhood at 13.4% in 2017 [4, 7, 8]. However, the impact of adult mortality on orphanhood in South Africa remains to be seen. Estimates of orphanhood among children younger than 18 years of age using data for 21 countries over a one-year period between 2020–2021, found that South Africa ranked among the top six countries with regards to orphaned children [9]. Literature has shown that adolescent orphans are at an increased risk of contracting HIV. Orphans are often victims of sexual exploitation and are at an increased risk of being physically or sexually exploited by the neighbours, relatives, caregivers, or guardian [5, 7, 10, 11]. They are often coerced to engage in high-risk behaviours at a young age such as unprotected sexual intercourse, early sexual debut, having multiple sexual partners,

age disparate sexual relationship, and sex in exchange for money, goods, or other favours [12] which also results in an increased risk of contracting HIV [13].

The mode of contracting HIV among young orphans is not only through risky sexual behaviour, but also through mother to child transmission [14–16]. Some HIV positive orphans are undiagnosed due to the challenge of connecting HIV positive orphans to universal test and treat programs because these programs are not targeted to orphans [17]. This results in an increased number of orphans who are either not diagnosed or initiated on antiretroviral therapy (ART) or are diagnosed and initiated on ART late compared to non-orphaned children [17, 18].

Orphanhood also increases psychological vulnerability with data showing that, ALHIV who have lost their parents to AIDS tend to show symptoms of depression and post-traumatic stress disorder (PTSD) compared to non-orphaned adolescents, and this manifests itself in poor physical and mental health [3, 7, 19]. In addition to the trauma of losing their parents, orphans face many obstacles that can be attributed to the effects of the epidemic. A great number of orphans become the heads of households, are forced to look after themselves and siblings, and are vulnerable to many forms of abuse which affect their psychological well-being [3].

Evidence shows that the combined social vulnerability due to economic hardship, mental distress, and sexual victimization predispose orphans to greater sexual risk taking and exposure to HIV risk [20]. Reducing risk behaviours in this population is crucial to prevent the spread of HIV to achieve an AIDS-free generation. Improved understanding of factors associated with HIV in this population is important for developing tailored and targeted interventions. While there is a growing number of studies that looked at the factors associated with HIV among young people in the general population, fewer have focused on the orphan population [15]. This study aims to examine HIV prevalence and associated factors among reported orphaned adolescents aged 12–24 years in South Africa using the 2017 National HIV Prevalence, Incidence, Behaviour and Communication Survey.

Methods

This study is a secondary data analysis and utilises data from the 2017 nationally representative population-based household survey on HIV prevalence, incidence, behaviour, and communication survey [5]. The methodology is described in detail in Simbayi et al 2019 [5]. The survey was conducted using a multi-stage random sampling design involving both stratification and clustering. Different questionnaires were administered to children aged 12–14 years and 15 + years. The main outcome of interest in these analyses was HIV serostatus (HIV positive = 1 and HIV negative = 0) among orphans. Orphanhood status is based on responses to two questions; Is your biological mother alive? Is your biological father alive? Responses were pooled and dichotomised into a binary outcome (yes = 1 and no = 0) indicating orphanhood status.

Explanatory variables included socio-demographic, behaviours, health, and HIV related factors. Socio-demographic factors included age (12–19 years, 20–24 years), sex (male and female), race (Black

African and other including White, Coloured, and Indian population groups), level of education (no education or up to primary school, secondary school and tertiary), employment (unemployed and employed), locality type (urban, rural informal/ tribal area and rural formal/farm areas), disability (no and yes).

Socio-behavioural variables included age of sexual debut (had sex before the age of 15 years, had sex aged 15 years and older), age of sexual partner (partner more than five years younger, partner within five years of age, partner more than five years older), number of sexual partners in the last 12 months (one partner, two or more partners), condom use at last sex (yes, no). Including risky behaviour such as alcohol use using alcohol Abuse Disorder Identification Test (AUDIT) score (abstainers, low risk (with scores ranging from1–7), risky/ hazardous level (8–15), high risk/harmful (16–19), very high risk (20+) [21].

HIV related factors: correct HIV knowledge and myth rejection (no and yes) based on responses from the following questions (Can AIDS be cured? Can a person reduce the risk of HIV by having fewer sexual partners? Can a healthy-looking person have HIV? Can a person get HIV by sharing food with someone who is infected? Can a person reduce the risk of getting HIV by using a condom every time he/she has sex?), self-perceived risk of contracting HIV infection (no and yes). Self-perceived risk of HIV infection (no and yes), ever tested for HIV (no and yes) and awareness of HIV status (no and yes).

Statistical analysis

Descriptive statistics were used to summarize characteristics of study participants and HIV prevalence. Chi-square tests were used to assess differences among categorical variables. An adjusted multivariate logistic regression model using backward stepwise selection method was fitted to determine factors associated with HIV prevalence. Adjusted odds ratios (AOR) with 95% confidence intervals (CIs) and p < 0.05 were used to determine direction of the relationship and statistical significance. All analysis were conducted in Stata version 15.0 [22]. Coefficient plots were used to display the results of the final models.

Results

Characteristics of the study participants

Table 1 shows socio-demographic, socio-behavioural and HIV related characteristics of the study sample (n = 1 978). Most orphaned young people were aged 12–19 years (83.6%) and were black Africans (93.8%). Half of the participants were males (50.2%). Most participants had high school educational level (96.5%). Over half of the participants (53.1%) reported a low socio-economic status and most participants were unemployed (96.5%), lived in urban areas (54.9%). Most participants had sexual debut at age 15 years and older (92.2%), had a sexual partner within five years of their age (80.2%), reported having one sexual partner (81.2%), used a condom at last sex (66.1%), inconsistent condom use (98.5%), and abstained from alcohol (85.4%). A high proportion of participants did not have correct knowledge of HIV and did not reject myths about HIV (70.2%). A high proportion of orphans also had a low self-

(52.3%).		

perceived risk of HIV infection (84.8%). Just above half of the participants had never tested for HIV

Table 1 **C**haracteristics of the study sample (adolescents and youth aged 12–24 years), South Africa 2017 survey

Variables	Total	%
Age groups in years		
12-19	1677	83.6
20-24	301	16.4
Sex		
Male	878	50.2
Female	1100	49.8
Race groups		
African	1808	93.8
Other	170	6.2
Education level		
No education/Primary education	51	11.5
Secondary education	318	84.5
Tertiary education	14	4.0
Employment Status		
Unemployed	1349	96.5
Employed	63	3.5
Asset based SES		
Low SES	1039	53.1
HIGH SES	747	46.9
Locality type		
Urban areas	884	54.9
Rural informal/tribal areas	946	42.1
Rural/farms areas	148	3.0
Age at sexual debut		

Not all sub-totals add to the overall totals due to non-response and missing data; Not all sub-totals add to the overall totals due to non-response and missing data., SES socio-economic status, AUDIT Alcohol Use Disorder Identification Test

Variables	Total	%
Age groups in years		
Younger than 15 years	105	7.8
15 years and older	1314	92.2
Age disparate sexual relationships (partner age)		
Within 5 years	364	80.2
Younger than 5 years	3	1.0
Older than 5 years	107	18.8
Number of sexual partners in the last 12 months		
One partner	400	81.2
Two and more partners	77	18.8
Condom use at last sex act		
No	174	33.9
Yes	311	66.1
Consistent condom use		
No	472	98.5
Yes	10	1.5
AUDIT score		
Abstainers	1620	85.4
Low risk alcohol drinkers (1-7)	159	10.2
High risk alcohol drinkers (8-19)	60	4.2
Hazardous alcohol drinkers (20+)	4	0.1
Correct knowledge of HIV and associated myth rejection		
No	1366	70.2
Yes	608	29.8
Self-perceived risk of HIV		
Low	1643	84.8

Not all sub-totals add to the overall totals due to non-response and missing data; Not all sub-totals add to the overall totals due to non-response and missing data., SES socio-economic status, AUDIT Alcohol Use Disorder Identification Test

Variables	Total	%
Age groups in years		
High	270	15.2
Ever had an HIV test		
Yes	917	47.7
No	1022	52.3
Awareness of HIV status		
Yes	686	35.5
No	1259	64.5

Not all sub-totals add to the overall totals due to non-response and missing data; Not all sub-totals add to the overall totals due to non-response and missing data., SES socio-economic status, AUDIT Alcohol Use Disorder Identification Test

Hiv Prevalence Among Orphans

Table 2 shows HIV prevalence by socio-demographic, socio-behavioural and HIV related factors among study participants. Overall, the HIV prevalence was 7.8% among orphaned adolescents and youth aged 12–24 years in 2017. Although not statistically significant HIV prevalence was higher among females (9.2%) compared to males (6.4%). HIV prevalence was only significantly (p < 0.05) higher among Black Africans (8.2% versus 1.4%) and those who were unemployed (8.2% versus 1.3%). HIV prevalence by socio-behavioural and HIV related factor among study participants. HIV prevalence was significantly higher among those who reported no condom use at last sex act (13.8% versus 5.8%), those with high self-perceived risk of HIV infection (11.4% versus 5.7%), and those who had ever tested for HIV (9.5% versus 5.3%).

Table 2
HIV prevalence by socio-demographic, socio-behavioural and HIV related factors among adolescents and youth aged 12–24 years, South Africa 2017 survey

youth aged 12-24 years, South	N	%	95% CI	p-value
Age groups in years				
12-19	1677	7.9	6.2-9.9	0.818
20-24	301	7.4	4.7-11.5	
Sex				
Male	878	6.4	4.4-9.2	0.112
Female	1100	9.2	7.1-11.7	
Race groups				
African	1808	8.2	6.6-10.1	0.039
Other	170	1.4	0.2-9.4	
Education level				
No education/Primary education	51	10.6	4.2-24.3	0.636
Secondary education	318	10.1	6.0-16.6	
Tertiary education	14	-	-	
Employment status				
Unemployed	1349	8.2	6.4-10.6	0.001
Employed	63	1.3	0.3-4.4	
Asset SES				
Low SES	1039	7.5	5.6-9.9	0.790
High SES	747	7.9	5.6-11.2	
Locality type				
Urban	884	7.1	5.0-9.9	0.485
Rural informal (tribal areas)	946	8.7	6.7-11.1	
Rural (farms)	148	9	4.4-17.2	
Age at sexual debut				

Not all sub-totals add to the overall totals due to non-response and missing data, SES socio-economic status, CI confidence intervals. AUDIT Alcohol Use Disorder Identification Test

	N	%	95% CI	p-value
Age groups in years				
Less than 15 years	105	5.5	2.3-12.6	0.372
15 years and older	1314	8.2	6.3-10.6	
Age disparate sexual relationship				
Within 5 years	364	7.8	4.7-12.7	0.434
Younger than 5 years	3	-	-	
Older than 5 years	107	13.4	7.1-23.9	
Number of sexual partners in the last 12 month?				
One partner	400	9.4	6.1-14.3	0.489
Two and more partners	77	6.5	2.4-16.5	
Condom use last sex act				
No	174	13.8	7.5-24.0	0.025
Yes	311	5.8	3.6-9.3	
Consistent condom use				
No	472	8.6	5.7-12.7	0.863
Yes	10	10.2	1.3-49.2	
AUDIT score				
Abstainers	1620	8.1	6.5-10.1	0.260
Low risk drinkers (1-7)	159	3.7	1.7-7.9	
High risk drinkers (8–19)	60	14.0	4.1-38.3	
Hazardous drinkers (20+)	4	-	-	
Correct knowledge of HIV and myth rejection				
No	1366	8.1	6.2-10.4	0.635
Yes	608	7.2	5.0-10.4	
Self-perceived risk of HIV				
Low	1643	5.7	4.3-7.5	0.008

Not all sub-totals add to the overall totals due to non-response and missing data, SES socio-economic status, CI confidence intervals. AUDIT Alcohol Use Disorder Identification Test

N	%	95% CI	p-value
270	11.4	7.3-17.4	
1022	5.3	3.7-7.5	0.009
917	9.5	7.2-12.5	
1259	6.4	4.7-8.7	0.055
686	9.7	7.2-13.1	
	270 1022 917 1259	270 11.4 1022 5.3 917 9.5 1259 6.4	270 11.4 7.3-17.4 1022 5.3 3.7-7.5 917 9.5 7.2-12.5 1259 6.4 4.7-8.7

Not all sub-totals add to the overall totals due to non-response and missing data, SES socio-economic status, CI confidence intervals. AUDIT Alcohol Use Disorder Identification Test

Factors Associated With Hiv Prevalence Among Orphans

The final model (Fig. 1) shows that the odds of HIV infection were significantly higher among females than males [AOR = 2.9 (95%CI: 1.1-7.8), p = 0.032]. The odds were also significantly higher among those residing in rural informal/tribal areas compared to urban areas [AOR = 2.9 (05% CI: 1.1-7.7), p = 0.031].

Discussion

This nationally representative study revealed that the overall HIV prevalence among orphaned adolescents and youth aged 12–24 years in South Africa was 7.8%. HIV prevalence among orphaned adolescents aged 12–19 years was higher (7.9%) compared to those observed in the general population (4.1%) [23, 24]. Several explanations have been advanced for the observed disparities in HIV infection between orphaned and non-orphaned adolescents, and these include marked differences in socioeconomic and sexual victimization vulnerabilities [6, 25]. However, in South Africa, more studies are needed to interrogate this difference and pre-disposing factors.

In this study, HIV prevalence was significantly higher among the unemployed orphaned youth, and this probably reflects the generational social vulnerability sustained by pervasive poverty in the country [26]. These observations suggest a need for social support beyond income grant for families of orphaned youth. Others have observed that empowerment of orphaned youth through social support such as cash transfers [27, 28] vocational and life skills training create self-sufficiency and opportunities for employment and reduce vulnerability [29–31].

HIV prevalence was significantly higher among orphaned youth who did not use a condom at last sex. This data supports existing evidence of heightened infection rate and high sexual risk behaviour among youth who are orphans [32, 33]. This is contrary to suggestions that maternal transmission is a more likely explanation, than sexual transmission for heightened HIV infection among orphans [25]. Nevertheless, maternal transmission still accounts for a number of HIV infections among ALHIV including orphans, previous studies suggest that the HIV virus progresses gradually in some infants, and a sizable percentage of HIV-positive children live until adolescence and beyond [25]. In South Africa more research is needed to distinguish between maternally and sexually acquired HIV and some research is being conducted in the country [34]. Nevertheless, national HIV programmes and interventions for sexual risk-reduction strategies and behaviour change communication should also be prioritized for sexually active orphaned adolescents and youth.

In addition, HIV prevalence was significantly higher among those who perceived themselves as being at high risk of HIV. Evidence shows that high HIV risk perception is associated with high risky sexual behaviour and high risk of contracting HIV [17]. Therefore, risk assessment should be implemented as part of HIV prevention programs among sexually active orphaned adolescent and youth to identify those who perceived themselves as being at an increased risk acquiring HIV towards risk reduction.

This study also showed that the HIV prevalence was significantly higher among those who ever had an HIV test. These findings also underscore the need to encourage positive prevention and appropriate HIV risk reduction and behaviour change through HIV testing and counselling services among orphaned adolescents and youth). HIV testing campaigns should encourage testing for all adolescent and youth, regardless of sexual behaviour [35].

The final multivariate model showed that orphaned females were more at risk of acquiring HIV than their male counterparts. The association between HIV infection and sex is well established, with evidence that the risk of HIV infection is higher among both orphan and non-orphaned female adolescent and youth [24]. Numerous factors that increase vulnerability of HIV among orphaned females have been advanced, these include among others transactional sex due to pressure to generate household income or assume adult responsibilities coupled with gender power dynamics and inability to negotiate safe sex especially where adolescent girls are sexually coerced by older men who exploit them for sex or early marriages including polygamy [6, 33, 36–38].

The final model also showed that orphans residing in rural informal/tribal areas were more at risk of acquiring the HIV virus than those residing in urban areas, this has been observed by other researchers elsewhere [24, 39]. Generally, the observed urban-rural disparities have been attributed to the complex relationship between HIV infection and poverty [39]. High HIV prevalence in rural areas has been associated with substantially greater barriers to care related to poor access to prevention and treatment services [40]. Orphans as a group are disadvantaged and vulnerable and should be prioritised and considered in the context of general poverty in rural areas.

Conclusions

This study described HIV prevalence and associated socio-demographic, socio-behavioural and HIV related factors. The findings suggest a need for intervention that address the social and structural drivers of HIV in this population. The intervention should also be aimed at creating independence by increasing employment opportunities, promoting protective sex, address perceived susceptibility to HIV, encourage routine testing and foster positive prevention and behaviour change among those who are test positive towards risk reduction. Such intervention should be tailored and targeted to the most vulnerable groups especially orphaned female adolescents, youth and those residing in rural informal/tribal areas. Future research should distinguish HIV infection acquired primarily through sexual and maternal transmission to design timely and highly specific interventions in the lives of orphaned adolescents and youth.

Limitations

The study is based on data from a cross-sectional survey and therefore cannot infer causality. The analysis used self-reported reported information which is prone to recall and social desirability bias. There may also be other unmeasured important risk factors for HIV prevalence that were not accounted for in the analysis. Nevertheless, probability sampling ensures that the current findings can be generalized for among orphaned adolescents and youth aged 12–24 years in South Africa.

Abbreviations

ALHIV
Adolescents living with HIV
ART
Antiretroviral therapy
UNICEF
United Nations Children's Fund.

Declarations

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Authors' contributions

PN drafted the manuscript, conducted the data analyses. MM supervised the data analyses and reviewed the manuscript drafts. IN and NV contributed to the review of the manuscript drafts. NZ secured funding and contributed to writing the manuscript. All authors read and approved the final manuscript.

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Availability of data and materials

The dataset used is available through the Human Sciences Research Council data research repository via the following link: http://curation.hsrc.ac.za/ Datasets-PFAJLA.phtml.

Ethical approval and consent to participate

Ethical approval for the 2017 National HIV Prevalence, Incidence, Behaviour and Communication Survey (SABSSM) was approved the Human Science Research Council Research Ethics Committee (REC 4/18/11/15). Data collection processes adhered to the ethical guidelines.

Consent to participate

Not applicable.

Consent for publication

Not applicable.

Competing interests

The authors declare that they have no competing interests.

Author details

¹Wits Reproductive Health and HIV Institute, University of the Witwatersrand, Johannesburg 2000, South Africa. ² Health and Well-Being, Human and Social Capabilities Division, Human Sciences Research Council, Durban, South Africa. ³ Health and Well-Being, Human and Social Capabilities Division, Human Sciences Research Council, Cape Town, South Africa. ⁴ Health and Well-Being, Human and Social Capabilities Division, Human Sciences Research Council, Pretoria, South Africa. ⁵School of Nursing and Public Health, University of KwaZulu Natal, Private Bag 7, Congella 4013, South Africa.

References

- 1. NAR. 2020 Orphan Report, Reseach INSAMER, May 2020.
- 2. UNICEF. Orphanhood 6 September 2022 [UNICEF Data]. Available from: https://data.unicef.org/topic/hivaids/orphanhood/
- 3. Chi P, Li X. Impact of parental HIV/AIDS on children's psychological well-being: a systematic review of global literature. AIDS Behav. 2013;17(7):2554-74.

- 4. Mejia-Pailles G, Berrington A, McGrath N, Hosegood V. Trends in the prevalence and incidence of orphanhood in children and adolescents <20 years in rural KwaZulu-Natal South Africa, 2000-2014. PLoS One. 2020;15(11):e0238563.
- 5. Simbayi L, Zuma K, Zungu N, Moyo S, Marinda E, Jooste S, et al. South African National HIV prevalence, incidence, behaviour and communication survey, 2017: Towards achieving the UNAIDS 90-90-90 targets. 2019.
- 6. Kidman R, Anglewicz P. Are adolescent orphans more likely to be HIV-positive? A pooled data analyses across 19 countries in sub-Saharan Africa. J Epidemiol Community Health. 2016;70(8):791-7.
- 7. Zungu N, Naidoo I. Being ALHIV: what do we know about adolescents living with HIV in South Africa. the human sciences Research Council and University of Cape town, AIDS and society research unit. Pretoria: Human Sciences Research Council. 2020.
- 8. George G, Govender K, Bachoo S, Penning S, Quinlan T. Comparative economic positions of orphan, non-orphan and mixed households: Findings from round 3 of the Amajuba District Study in KwaZulu-Natal, South Africa. Vulnerable Children and Youth Studies. 2014;9(1):28-42.
- 9. Hillis SD, Unwin HJT, Chen Y, Cluver L, Sherr L, Goldman PS, et al. Global minimum estimates of children affected by COVID-19-associated orphanhood and deaths of caregivers: a modelling study. The Lancet. 2021;398(10298):391-402.
- 10. Kidman R, Thurman TR. Caregiver burden among adults caring for orphaned children in rural South Africa. Vulnerable Child Youth Stud. 2014;9(3):234-46.
- 11. Burkholder M. The impact of HIV/AIDS on orphans in a South African context. 2019.
- 12. UNAIDS. Danger: UNAIDS Global AIDS 2022 [Available from: https://www.unaids.org/en/resources/documents/2022/in-danger-global-aids-update
- 13. Fite AC, Cherie A. Risky Sexual Behavior and Its Determinants among Orphan and Vulnerable Children in Addis Ababa, Ethiopia. World Journal of AIDS. 2016;06(04):111-22.
- 14. Luseno W, Zhang L, Rusakaniko S, Cho H, Hallfors D. HIV infection and related risk behaviors: does school support level the playing field between orphans and nonorphans in Zimbabwe? AIDS Care. 2015;27(9):1191-5.
- 15. Toska E, Zhou S, Laurenzi CA, Haghighat R, Saal W, Gulaid L, et al. Predictors of secondary HIV transmission risk in a cohort of adolescents living with HIV in South Africa. AIDS (London, England). 2022;36(2):267.
- 16. Moyo F, Mazanderani AH, Sherman G, Kufa T. Population-level risk factors for vertical transmission of HIV in the national prevention of mother-to-child transmission programme in South Africa: An ecological analysis. South African Medical Journal. 2022;112(3):219-26.
- 17. Pegurri E, Konings E, Crandall B, Haile-Selassie H, Matinhure N, Naamara W, et al. The missed HIV-positive children of Ethiopia. PLoS One. 2015;10(4):e0124041.
- 18. Mokgatle MM, Madiba S. The burden of disease on HIV-infected orphaned and non-orphaned children accessing primary health facilities in a rural district with poor resources in South Africa: a

- cross-sectional survey of primary caregivers of HIV-infected children aged 5-18 years. Infect Dis Poverty. 2015;4:18.
- 19. Cluver LD, Orkin M, Gardner F, Boyes ME. Persisting mental health problems among AIDS-orphaned children in South Africa. J Child Psychol Psychiatry. 2012;53(4):363-70.
- 20. Sherr L, Cluver LD, Betancourt TS, Kellerman SE, Richter LM, Desmond C. Evidence of impact: health, psychological and social effects of adult HIV on children. Aids. 2014;28:S251-S9.
- 21. Saunders JB, Aasland OG, Babor TF, de la Fuente JR, Grant M. Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO Collaborative Project on Early Detection of Persons with Harmful Alcohol Consumption–II. Addiction. 1993;88(6):791-804.
- 22. LLC S. StataCorp Stata statistical software: release 15.1. College Station, TX. 2017.
- 23. Mabaso M, Maseko G, Sewpaul R, Naidoo I, Jooste S, Takatshana S, et al. Trends and correlates of HIV prevalence among adolescents in South Africa: evidence from the 2008, 2012 and 2017 South African National HIV Prevalence, Incidence and Behaviour surveys. AIDS Res Ther. 2021;18(1):97.
- 24. Simbayi LC, Zungu N, Evans M, Mehlomakulu V, Kupamupindi T, Mafoko G, et al. HIV serostatus disclosure to sexual partners among sexually active people living with HIV in South Africa: Results from the 2012 National Population-Based Household Survey. AIDS and Behavior. 2017;21:82-92.
- 25. Kidman R, Anglewicz P. Why Are Orphaned Adolescents More Likely to Be HIV Positive?

 Distinguishing Between Maternal and Sexual HIV Transmission Using 17 Nationally Representative Data Sets in Africa. J Adolesc Health. 2017;61(1):99-106.
- 26. Hall K. Income poverty, unemployment and social grants. 2010.
- 27. Toska E, Cluver LD, Boyes ME, Isaacsohn M, Hodes R, Sherr L. School, Supervision and Adolescent-Sensitive Clinic Care: Combination Social Protection and Reduced Unprotected Sex Among HIV-Positive Adolescents in South Africa. AIDS Behav. 2017;21(9):2746-59.
- 28. Zungu N, Toska E, Gittings L, Hodes R. 11 Closing the gap in programming for adolescents living with HIV in Eastern and Southern Africa. Preventing HIV among young people in Southern and Eastern Africa. 2020:243.
- 29. Gega O. Challenges and Difficulties of Young Orphans in Tirana in Search of Employment. Academic Journal of Interdisciplinary Studies. 2016.
- 30. Losioki BE. Education Opportunities and Support for Orphans and Vulnerable Children in Bagamoyo District Tanzania. East African Journal of Education Studies. 2020;2(1):187-97.
- 31. Meli BM. Provision of Vocational Skills Education to Orphans: Lessons from Orphanage Centres in Dar es Salaam City, Tanzania. Journal of Education and Practice. 2015;6(15):65-75.
- 32. Rosen JG, Kayeyi N, Chibuye M, Phiri L, Namukonda ES, Mbizvo MT. Sexual debut and risk behaviors among orphaned and vulnerable children in Zambia: which protective deficits shape HIV risk? Vulnerable Child Youth Stud. 2022;17(2):130-46.
- 33. Operario D, Underhill K, Chuong C, Cluver L. HIV infection and sexual risk behaviour among youth who have experienced orphanhood: systematic review and meta-analysis. Journal of the

- International AIDS Society. 2011;14(1):1-11.
- 34. He E, Tolmay J, Zhou S, Saal W, Toska E. Mode of HIV acquisition among adolescents living with HIV in resource-limited settings: A data-driven approach from South Africa. Plos one. 2023;18(2):e0281298.
- 35. McClinton Appollis T, Duby Z, Jonas K, Dietrich J, Maruping K, Abdullah F, et al. Factors influencing adolescent girls and young women's participation in a combination HIV prevention intervention in South Africa. BMC Public Health. 2021;21(1):417.
- 36. Choudhry V, Ambresin AE, Nyakato VN, Agardh A. Transactional sex and HIV risks evidence from a cross-sectional national survey among young people in Uganda. Glob Health Action. 2015;8:27249.
- 37. Murewanhema G, Musuka G, Moyo P, Moyo E, Dzinamarira T. HIV and adolescent girls and young women in sub-Saharan Africa: A call for expedited action to reduce new infections. IJID Reg. 2022;5:30-2.
- 38. Mkandawire P, Luginaah I, Baxter J. Growing up an orphan: vulnerability of adolescent girls to HIV in Malawi. Transactions of the institute of British geographers. 2014;39(1):128-39.
- 39. Magadi MA. Understanding the urban-rural disparity in HIV and poverty nexus: the case of Kenya. J Public Health (Oxf). 2017;39(3):e63-e72.
- 40. Pellowski JA. Barriers to care for rural people living with HIV: a review of domestic research and health care models. Journal of the Association of Nurses in AIDS Care. 2013;24(5):422-37.

Figures

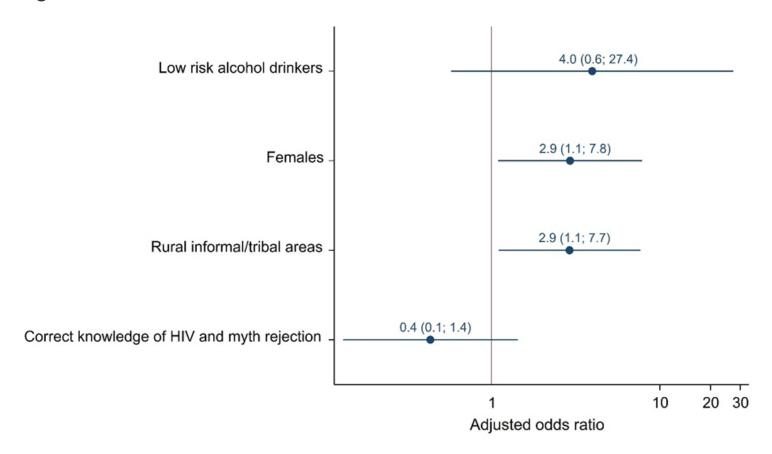


Figure 1

Multivariate model of factors associated with HIV prevalence among orphaned adolescents and youth aged 12-24 years, South Africa 2017 survey