Concurrent driving the African HIV epidemics: where is the evidence?

Mark N. Lurie
Brown University

Samantha R. Rosenthal
Johnson & Wales University - Providence, Samantha.Rosenthal@jwu.edu

Follow this and additional works at: https://scholarsarchive.jwu.edu/health_fac

Part of the Medicine and Health Sciences Commons

Repository Citation
Lurie, Mark N. and Rosenthal, Samantha R., "Concurrent driving the African HIV epidemics: where is the evidence?" (2009). Health & Wellness Department Faculty Publications and Research. 27.
https://scholarsarchive.jwu.edu/health_fac/27
problems, substance abuse, legal systems, and sometimes the societal tolerance of sexual violence.1

However, studies do suggest that there are beliefs that HIV can be cured through sexual intercourse with virgin youth. A qualitative study from Zambia examining problems of HIV-affected women and children cited existence of this belief,2 and a roadside sign in that country certainly suggests that the belief is common enough to warrant an educational campaign (figure). Lema3 and Meursing4 discuss the existence of this belief, mainly in terms of traditional healers encouraging sex with virgin youth to cure a disease. Meursing4 presented two case studies of young girls who became infected with HIV because of “cleansing” practices and concluded that this practice could be widespread. Another study suggested that a contributing factor to sexual abuse in young virgins is the belief that they are less likely to be HIV-positive.5

It is true that the references to this belief are largely anecdotal and there is a clear need for rigorous research on such belief structures. The extent to which such beliefs might have a motivational role in sexual violence, and how such practices are distributed across countries and regions needs to be established. However, the frequency with which this myth is suggested in studies and from anecdotal reports by field workers in several countries make it a potential influencing factor that should not be overlooked or disregarded.

We declare that we have no conflicts of interest.

Concurrence driving the African HIV epidemics: where is the evidence?

James Shelton’s “Why multiple sexual partners?” Comment (Aug 1, p 367)1 begins with the statement that “multiple sexual partnerships—particularly overlapping or concurrent partnerships—lie at the root of the generalised HIV epidemic in southern and eastern Africa.” Yet an objective reading of the available data suggests that the evidence is far from conclusive.2

Defining and measuring concurrence is difficult and studies that measure sexual behaviour and individual or community levels of HIV suffer from the temporal problem that concurrence is generally measured over the previous year (or shorter time period), whereas HIV infection might have occurred several years earlier. To support the concurrence hypothesis, we need a precise definition of concurrence, a way of measuring it, and a significant association between the measured concurrence and the prevalence or incidence of HIV, controlling for potential confounders.

A four-city African study actually found lower rates of concurrence in places with larger HIV epidemics,3 and a study using nationally representative surveys in 22 countries (all but one of which was in Africa) concluded that “the prevalence of concurrence does not seem correlated with HIV prevalence at the community level or at the country level, neither among women nor among men.” Additionally, Wellings and colleagues reviewed global sexual behaviour and could not find sufficient data to assess whether rates of concurrence differ across the world.

Adequate empirical evidence is urgently needed to assess the extent to which concurrency might or might not be driving the sub-Saharan African epidemics.

We declare that we have no conflicts of interest.

Author’s reply

I completely agree with Mark Lurie and colleagues that we need more research to understand better concurrent sexual partnerships. But I find their presentation of evidence rather selective. Actually, the evidence of a pivotal role for concurrent or overlapping partners in generalised heterosexual epidemics is compelling. Moreover, Lurie and colleagues offer no credible alternative explanation.

In one sense, the pivotal role of concurrent partnerships is rather