PERSPECTIVES PAPER

Tackling the Sexual and Reproductive Health and Rights of Adolescents Living with HIV/AIDS: A Priority Need in Nigeria

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Abstract

Very little is known about the sexual and reproductive health (SRH) needs of adolescents living with HIV (ALHIV) in general and the needs of those in Nigeria specifically. A review was conducted to identify the SRH of ALHIV, assess if these are different from the SRH of adolescents who are free from HIV infection, and from those of adults living with HIV. Few research have been conducted on how ALHIV deal with sexual and reproductive health challenges faced in their everyday lives - as adolescents and as persons living with HIV living in sub-Saharan Africa - to help make any meaningful inferences on these differing needs. The review suggests that the SRH needs and practices of ALHIV may differ from that of other adolescents and that of adults living with HIV. ALHIV would require support to cope with sex and sexual needs, through full integration of individualized SRH services into the HIV services received. Service providers need to appreciate the individualistic nature of health problems of ALHIV and address their health care from this holistic perspective. A 'one-size-fits-all' approach for designing SRH programmes for ALHIV would not be appropriate. We conclude that research evidence should inform the design and implementation of ALHIV friendly SRH programmes services in both urban and rural settings in Nigeria. *(Afr J Reprod Health 2014; 18[3]: 102-108)*

Keywords: Nigeria, Adolescents living with HIV, Sexual, Reproductive, Health, Needs

Résumé

On est très peu renseigné sur les besoins de santé sexuelle et de la reproduction (SSR) des adolescents vivant avec le VIH (AVVIH) en général et les besoins de ceux qui son atteints au Nigeria en particulier. Une étude a été menée afin d'identifier la SSR des AVVIH, de déterminer si celles-ci sont di fférentes de la SSR des adolescents qui sont indemnes du virus VIH, et de celles des adultes vivant avec le VIH. Peu de recherches ont été menées sur la façon dont AVVIH et le SIDA font face à des défis de la santé sexuelle et de la reproduction auxquels ils sont confrontés dans leur vie quotidienne - que les adolescents et que les personnes vivant avec le VIH vivent en Afrique sub-saharienne - pour aider à faire des inférences significatives sur ces différents besoins. L'analyse suggère que les besoins et les pratiques de SSR des AVVIH peuvent différer de celles d'autres adolescents et celles des adultes vivant avec le VIH. Les AVVIH auraient besoin de soutien pour faire face à des rapports sexuels contre des besoins, grâce à l'intégration complète des services de SSR individualisés dans les services liés au VIH reçus. Les fournisseurs de services ont besoin de comprendre la nature individualiste des problèmes de santé de ces adolescents et de répondre à leurs soins de santé dans cette perspective holistique. Une approche fondée sur « une seule taille va pour tous » pour la conception de programmes de SSR pour les AVVIH ne serait pas appropriée. Nous concluons que la preuve de la recherche devrait guider la conception et la mise en œuvre des services des programmes de SSR qui sont adaptés aux besoins des AVVIH dans les milieux urbains et ruraux au Nigeria. *(Afr J Reprod Health 2014; 18[3]: 102-108)*

Mots-clés: Nigeria, adolescents vivant avec le VIH, sexuelle, reproductive, santé, besoins

Introduction

It is important to understand the sexual and reproductive health (SRH) needs of adolescents living with HIV (ALHIV). Global estimates show that nearly 50% of the 35.3 million people infected with HIV acquired their infection before age 25 years through sexual transmission[1], with young people between the age of 15 and 24 accounting for 45% of all new infections in 2007[2].

Statistics from Nigeria show that about 15.3% girls and 6.2% of boys aged 15 to 19 years had

initiated sex by 15years[3], and 60% of boys and girls by 18years[2]. Within the last 12 months of the 2012 National HIV and AIDS Reproductive Health Survey (NARHS), 37.4% of females and 19.7% of males age 15years – 19 years had had sex[4]. Of those who had engaged in sexual intercourse, 33.6% of unmarried women and 41.0% of unmarried men used a form of contraception[4]. The use of contraceptives by married adolescents (15 to 19 years) is much lower – 3.5% by women and 8.3% for men[4], and these rates are much lower than amongst youths 20 – 24years of age.

Various factors, including one's HIV status, may affect the decision to become sexually active as an adolescent. This is a justification for the need to understand the 'sexuality' as well as sexual and reproductive health needs of ALHIV, and how the two themes influence each other. Still, evidence from studies in Uganda suggests that sexual behaviour and practices among ALHIV do not differ significantly from what was observed in the general population. HIV infection seems not to have significantly changed attitudes towards childbearing[5] with pregnancy rates amongst ALHIV being similar to the pattern observed in the general population[5]. Within the culture, the desire to have children early in adult life remains strong independent of HIV status[6], and a romantic relationship is not considered legitimate unless it produces a baby. The study conducted by Birungi et al[6] among ALHIV in Uganda show that 52% of their study respondents were currently in a non-marital relationship and 5% in marital or long-term relationship.

Yet, within the context of this slow changing sexual behaviour is the increasing access of the girl child to education which consequently increases her age of marriage. A rising age of marriage, in turn, creates a gap between adolescence and age of marriage. The implication of this is that young people are more likely to have intimate sexual relations[7], the possibility of premarital pregnancy is increased, and some young women may seek abortion as an option to prevent exclusion from education or to prevent the birth of an unintended child[2]. Evidences show that most adolescent pregnancies are unwanted and occur outside the context of marriages, the pregnancy is often terminated (adolescent abortions account for 55% of abortions in Nigeria), and abortion is often sought from unskilled providers[2]. However, there is little known about how HIV infection modulates the choices ALHIV make when addressing premarital pregnancies vis a vis choice for abortion and the need to continue with their education. Birungi et al[6] reported a high rate of retention of pregnancies amongst ALHIV in Uganda. Their study showed that 41% of the sexually active female ALHIV had ever been pregnant and 73% delivered the child. Less than 20% of sexually active adolescent males reported having ever impregnated a girl, and for half of those who had done so, their partners kept the pregnancy. There was no analysis relating abortion and educational status though comments from the focus group discussion conducted showed a desire to delay child bearing due to interest in pursuing education. It would be important to know how the HIV status of adolescents inform their choices of managing unwanted pregnancies as this can inform programmes and policies design for the community.

Very little is known about the sexual and reproductive health needs of ALHIV in Nigeria. Yet, with the advent of antiretroviral therapy and associated decreased mortality with use of antiretrovirals, a large number of children who acquire HIV infection perinatally are becoming adolescents. Unfortunately, there is no policy or national programme in place to address the needs of ALHIV in Nigeria. We have therefore reviewed the literature and summarized the findings of research on sexual and reproductive health needs of ALHIV. Based on our findings, we make recommendations for sexual and reproductive health policy and programming for ALHIV in Nigeria.

Adolescent Experiences, Sexual Initiation and Contraception Use

As highlighted earlier, a large number of adolescents initiate sex early. Less than 70% of the population in Nigeria use contraceptives, including condoms[4]. Factors influencing the low use of contraceptive amongst adolescents are largely not

due to lack of awareness[6] as 9 out of 10 women age 15 to 24 years in countries around the world can name at least one contraceptive method[2]. A study conducted in Uganda[6] showed that use of contraceptives by ALHIV followed the same trend in knowledge and actual practice as their peers not living with the virus. To summarize, 63% were aware of the need to use condom to prevent HIV re-infection yet only 30% reported usage to prevent infecting the partner with HIV/STIs. The most common reason given for current use of condoms was for pregnancy prevention (57%). This mismatch was also noticed with the knowledge about and use of contraceptives to prevention pregnancy. However, while the use of condom amongst ALHIV was similar to that observed among the general population, the rate of use of contraceptive use by ALHIV was much higher than that of the general population, suggesting more careful behavior among the HIV-infected adolescents. There is however, no evidence suggesting that this behaviour is universal and more country based studies are necessary. Such studies should therefore focus on understanding how ALHIV make choices of contraceptive methods, when these decisions are, their point of access to these contraceptive tools, and how appropriate information on contraceptive choices related to their sexual and reproductive health needs can be shared in an accessible manner. Birungi et al[6] showed that ALHIV had erroneous concerns about hormonal contraceptives which might impact on its uptake and use. Such concerns may not differ from concerns by their peers who do not live with the infection. But then, it is important to understand how these concerns may impact on contraceptive choices and promotion of use in the community especially with the new WHO recommendation for PLHIV to use condoms along with hormonal contraceptives[8,9].

Initiating sex before the age of 15 years (early sexual debut) also increases the prospect for multiple sex partnering. Due to high level of poverty, the tendency for young female adolescents having sexual intercourse with older men who can cater for the financial needs of young girls (sugar daddies) is becoming 'normalized'. As high as 21% of young women ages 15–17 years in Nigeria had recently had sex with men at least 10 years older[10]. For some, the first sexual experience is with a man at least 10 years older than them[10]. Also, there are also increasing tendencies for older men to choose to have sex with younger girls in a bid to avoid HIV infection due to the erroneous beliefs that younger girls are likely free of HIV infection[11]. Early sexual debuts lead to high risk behaviours such as having multiple sexual partners, engaging in anal and oral sex to reduce in a bid to reduce the risk for pregnancy[12,13] and erroneous believe of reducing the risk for HIV infection[12].

Data from Nigeria show that large numbers of adolescents aged 15 to 19 years engaged in high sexual risk behaviour: 43.6% of sexually active boys and 61.6% of sexually active girls had had sex without the use of condom with non-marital sex partner in the last 12 months of the survey[14]. Also, non-use of condom during transactional sex was comparatively higher among adolescents when compared to 20-39 years old for boys and 20 – 34years old females[3,4,12]. Analysis of the NARHS data on condom use by adolescents with boyfriend and girlfriends 15-19years of age showed no significant increase in the number of adolescents who used the male condom at the last sexual act over a five years period (45.0% vs 39.4%; p=0.11) although a decrease in the number of sexually active females by 2012 ($p<0.001$) and a non-statistically significant increase (p=0.90) in the number of sexually active males were also observed[15].

While these evidences have implications for planning sexual health education for adolescents, there is little known about factors that drive the choice of sexual practices and sexual behaviours in ALHIV. It may be assumed there are few differences between adolescents living with or without HIV infection, but then, we need objectively derived evidences to inform the design of interventions that will help improve the quality of lives of ALHIV, including reducing their risk for STI and HIV re-infection.

Adolescents also face sexual violence; a recognised problem and a leading SRH issue. Adolescents face and have to deal with sexual abuse and sexual coercion in their daily lives. The prevalence of sexual violence ranges between 15 to 40% in sub-Saharan Africa[2] with studies

showing rates of sexual coercion and abuse among adolescents in Nigeria ranging between 11 to 55%[16,17]. The report of rape ranges between 4% and 6%[17-20]. We did not identify data on the experiences of ALHIV and sexual violence, and how HIV status affects the way adolescents cope with traumatic experiences including rape. It is the opinion of the authors that this data is important for planning of preventive and supportive care for ALHIV since it is a leading SRH concern for adolescents.

Also, the experiences of adolescents are by no means universal. This is often shaped by societal context, including gender expectations and the socialisation process at the family level. Thus, it is important to recognise that adolescence is a dynamic concept that may differ from place to place[21]. Within this context, SRH needs of adolescents are also shaped and defined by societal and cultural norms. Birungi et al[6] provided evidence to show that for ALHIV in Uganda, the cultural value placed on having children is one reason ALHIV engage in early sexual relationships so as to ensure they have children before they die. Little is however known and understood about how the cultural and social context of the lives of ALHIV in Nigeria may inform their SRH choices.

Designing Sexual and Reproductive Health Programmes For Adolescent Living with HIV In Nigeria

The difficulties of working with adolescents in general on issues of SRH are made even more complex for ALHIV. Key interventions to alter disease transmission and prevent pregnancy among adolescents emphasized delaying sexual debut, reducing the number of sexual partners, and increasing correct and consistent condom use. A major limitation is that these interventions have focused on the general population, which is assumed to be either HIV negative or unaware of their HIV status. The absence of targeted research on the fertility intentions and/or SRH needs of ALHIV have rendered targeted SRH interventions for ALHIV difficult, if not impossible. While some existing HIV and AIDS treatment centers in Nigeria are now beginning to offer family planning, these services tend to target HIV positive adults and do not offer the entire spectrum of SRH services. In addition, where SRH is discussed during counseling of young HIV positive clients, it tends to focus on delaying sexual initiation with little attention given to fertility intentions, often leaving sexually active ALHIV un-prepared and unable to negotiate contraceptive use or even to access contraceptive methods[6].

Studies conducted by Fielden et al[22] show that at least 27% of adolescents with perinatally acquired HIV were sexually active. Other studies also reveal that the prevalence of unprotected sex among HIV positive young people is high. A study in the US that included samples of HIV positive youth aged 13-24years after the advent of highly active antiretroviral therapy showed they were more likely to have unprotected sex with a partner they knew was HIV positive[23]. Anecdotal evidence from TASO, Uganda and from South Africa suggests that most HIV positive individuals are likely to seek sexual relationships amongst themselves (known as serosorting), and thus are more likely to have unprotected sex. Studies on serosorting are better documented among men who have sex with men[24-26] with little or nothing known about this sexual behaviour among adolescents. This emerging evidence reinforces the need to fully understand the nature and expectations of relationships among ALHIV and their implications for SRH information and services, especially for those who are sexually active[6].

Evaluation of current services available to youth living with HIV show less than 3% acknowledge receiving sexual health services from their health care providers (personal communication with Adam Garner, GNP+). Health care providers were often more pre-occupied with providing clinical services that relates directly with management of the clinical infection – blood tests and medication. Recent WHO/UNFPA guidelines on care, treatment and support for women living with HIV and AIDS and their children in resource-constrained settings have underscored the need to address the particular SRH needs of adolescent girls with HIV, ensuring availability of age-appropriate information and

counseling on SRH and safer sexual practices, and offering family planning counseling and services that are adolescent-friendly[27]. A study in Canada[22] reinforces the importance of healthy sexual development for ALHIV and growing into adulthood, highlighting a need for supportive policies and services, especially around family planning and partner notification. HIV treatment, care and support programmes in Nigeria will need to provide ALHIV with information and practical support to make decisions about their fertility, negotiate vital aspects of their lives, avoid undesired consequences like unwanted pregnancies, overcome stigma, and prevent infection of others and re-infection. There is also need to develop integrated counseling strategies that emphasize dual protection and family planning. Providers will need to understand the reasons why ALHIV may or may not choose to have children and to tailor their counseling to address client's needs, perceptions and circumstances. Effective counseling should also be provided so that ALHIV can make informed choices and be able to balance responsibility with sexual and reproductive needs.

Discussion and Conclusion

Evidence suggests differences in the SRH needs and practices of adolescents living with or without the virus. There is significantly less evidence on how ALHIV deal with the sexual and reproductive health challenges they face in their everyday lives as adolescents and as PLHIV living in sub-Saharan Africa to help make any possible inferences on differing needs between adolescents who living with or without the virus. There is a dire need for more research on the social context of the everyday lives of ALHIV that affects their SRH choices. Such researches should take into consideration ethical challenges highlighted by Folayan et al[28,29] in prior publications.

Many ALHIV want the same things that other young people want at their age: to enjoy loving relationships, experience and explore their sexuality, travel, get an education (in all its forms), gain independence, get married, start families and find work. All these stages of a young person's life can become increasingly more difficult to negotiate for adolescents who are HIV positive. There should be a sense of curiosity and fulfillment that comes from these experiences for the first time, but unfortunately because of ignorance and discrimination, for many adolescent living with HIV, this is a period of uncertainty, self-stigmatization and in some cases, depression.

In view of this, service providers delivering HIV and SRH interventions can play an active role in supporting the process of motivating and helping ALHIV face peculiar life challenges they live through. While there are evidence-based interventions to help positive adolescents in coping with peculiar issues of sex and sexuality they face, sexual and reproductive health should be fully integrated with HIV services, specifically by building upon existing resources. This should evolve from service provision that appreciates the individualistic nature of health problems and concerns and addresses health care from this holistic approach and do not rely on 'one-size-fits-all' programmes. This approach will include efforts at ensuring greater integration between support provided by service providers and the possible support that parents/guardians can also provide. Strengthening of the capacity of health service providers and parents/guardians of ALHIV is important as these group of care provider have vital roles to play at different stages in the life of the adolescent - younger ALHIV are more likely to need/want family oriented programmes while older ALHIV (15-19years) are more likely to want community and health based programmes. These capacity building efforts must be such that promotes an integrated seamless support system.

As noted, information is important and critical. Information provided from the various sources - organisation, family, media, and faith-based – needs to be coherent so as to ensure that adolescents are not presented with conflicting messages. As the number of young people living with HIV increases new and innovative ways to talk about sex, disclosure, and health need to be developed for HIV-positive adolescents. Such communication and information sharing while culturally relevant, should also take cognisance of the growing globalisation and adolescent on sexual

and reproductive health issues.

These all have policy implications. Support and funding of adolescent friendly HIV and SRH services in both urban and rural settings should be a key priority. There must be adequate investment in building the capacity of both clinic-based health care workers and NGOs to enable them support and provide age appropriate services to adolescents in general and those living with HIV (or other chronic diseases) specifically. Adolescents are complex in many ways as they are subject to rapid social and physical transition. Ongoing service quality assessments should ensure services meet the needs of an adolescent at each point in their development.

Any adolescent health agenda will need good data. Such data needs to include information on, specific challenges adolescent face due to specific diseases they live with – especially chronic infections like HIV. Such data collection efforts should equally focus on their harmonization as adolescents do not live in isolation and so the need to contextualise their health needs – including their sexual and reproductive health needs – within the framework of the health needs of those within the society they live. Information generated on adolescents become relevant in different nations and cultures in view of the growing evidence that globalization is bringing a convergence in health problems of adolescents in various countries independent of wealth status[30]. Data collection should therefore use common indicators, motivated in part by the need to measure progress towards the MDGs. There are evidences of such indicator development for HIV as this has played an important role in guiding recent global data collections[31]. Establishing core indicators for adolescent health might similarly be useful in encouraging coherence in data collection globally. Such indicators might eventually form the basis of a global adolescent health index, linked both to data collection systems and the evaluation of policy initiatives[1].

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Contribution of Authors

MO conceptualise the need for a study on adolescents living with HIV in Nigeria. MOF developed the framework for the paper. MOF, MO, HA and BB all provided comments and supportive literature for the desk review. All authors authorised the submission of the final version of the paper.

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