

Advancing the Sexual and Reproductive Health and Human Rights of People Living With HIV

A Case Study of Discordant Couples in the FCT

March 2010



Nigeria

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARVs	Antiretroviral drugs
FGD	Focus Group Discussions
FMOH	Federal Ministry of Health
GNP+	Global Network of People Living with HIV
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
IDIs	In-Depth Interviews
IBBSS	Integrated Behavioural and Biological Sero Surveillance Survey
MSM	Men who have sex with men
MSWs	Male Sex Workers
NACA	National Agency on the Control of HIV/AIDS
NASCP	National AIDS/STI Control Programme
NEPWHAN	Network of People Living with HIV and AIDS in Nigeria
PLHIV	People living with HIV
PMTCT	Prevention of Mother-To-Child Transmission
SPSS	Statistical Package for Social Scientists
SRHR	Sexual Reproductive Health Rights

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The Advancing the Sexual and Reproductive Health and Human Rights of People Living With HIV: A Guidance Package is one of five evidence-gathering tools being implemented through the HIV Leadership through Accountability programme. The programme combines specific HIV evidence-gathering tools, national AIDS campaigns and targeted advocacy to achieve Universal Access to prevention, treatment, care and support. For more information about the HIV Leadership through Accountability programme please visit www.hivleadership.org.

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Introduction

1.1 HIV and AIDS Situation in Nigeria

Nigeria is the most populous country in sub-Saharan Africa and has a land area of 923,768 square kilometres. Based on the 2006 national population census figure, Nigeria's population is estimated at over 140 million (NPC, 2006). Approximately two-thirds of the population lives in rural areas, which are areas mostly lacking in many modern social amenities. The population distribution in Nigeria is very uneven. While large expanses are sparsely populated in some parts of the country, many of the major urban centres have high population density. A high level of rural-urban migration occurs in the country and this has implications for the demands on the social and physical infrastructure, general development planning and quality of life of the citizenry.

The spread of HIV has increased significantly in Nigeria since the official report of the first case in 1986. The results of periodic national surveys among ante-natal clinic attendees has shown a progressive increase in adult HIV sero-prevalence rate from 1.8% in 1991 through 4.5% in 1996 to a peak at 5.8% in 2001 before declining to 5.0% and 4.4% in 2003 and 2005 respectively. The 2008 survey puts the new figure at 4.6%; an increase of 0.2% from the last survey results in 2005.

Going by the 2008 HIV prevalence, about 2.87million people in Nigeria are estimated to be living with HIV and AIDS (FMOH, HIV SENTINEL SURVEY 2008). Nigeria is currently experiencing a generalized epidemic with every state of having a prevalence of over 1%. HIV and AIDS have extended beyond the commonly classified high-risk groups and now prevalent in the general population.

HIV in Nigeria cuts across both sexes and all age groups. However, youths between the ages 20–29 years are disproportionately infected with sero-prevalence rates of 4.9% for 25-29 age group and 4.7% for 20-24 age group.

The number of HIV-positive children is increasing, with mother-to-child-transmission as the principal route of infection. The number of children orphaned by AIDS has also increased substantially to an estimated 2.1 million (FMOH, HIV SENTINEL SURVEY 2008). By all indications, the HIV and AIDS epidemic has continued to grow largely through unprotected heterosexual sex, mother-to-child transmission and contaminated blood and blood products. Among the high-risk groups, however, the findings from the 2007 IBSS showed that the most affected group is Female Sex Workers (FSW) with HIV prevalence of 34.0% followed by Men having Sex with Men (MSM) and Injecting Drug Users (IDU) with prevalence of 13.5% and 5.6% respectively and the least is members of the Armed Forces with HIV prevalence of 3.1% (FMOH, 2007a).

1.2 Responses to HIV and AIDS Situation in Nigeria

Nigeria has passed through several phases in her responses to the AIDS epidemic. These stages included an initial period of denial, followed by a large health sector response, and now a multi-sectoral response that focuses on prevention, treatment and mitigation of impact interventions.

Program coordination and implementation have been positioned as two as distinct response components nationally. A central body is dedicated to leading and coordinating the national response, while the various sectors- including civil society organizations, faith based organizations, networks of people living with HIV and AIDS support groups focus on packaging and implementing interventions based on the national action plan.

The health response commenced with the setting up of an ad hoc National Expert Advisory Committee of AIDS (NEACA) in 1987. By 1988, the National AIDS and STDs Control Programme (NASCP) was formally established, with state counterparts set up thereafter to both organize and coordinate HIV and AIDS at the state level. Federal Ministry of Health's HIV/AIDS division (formerly known as NASCP) played a key role in developing guidelines on key interventions and monitoring of the epidemic.

In 1997, the National Council on Health formally endorsed the multi-sectoral approach and in 2000 the Federal Government of Nigeria commenced the implemented this approach with the establishment of a Presidential Council on AIDS (PCA) and the National Action Committee on AIDS (NACA). NACA has since transformed from a committee to an agency called the National Agency for the Control of AIDS. NACA is responsible for effective coordination of the national multi-sectoral response to HIV/AIDS. Nigeria's first HIV/AIDS Emergency Action Plan; was prepared by NACA and approved in 2001 for a 3-year period.

The Plan's objectives included

- Increasing awareness and sensitization of general population and key stakeholders
- Promoting behavior change in both low-risk and high-risk populations;
- Ensuring that communities and individuals are empowered to design and initiate community-specific action plans;
- Ensuring that laws and policies encourage the mitigation of HIV/AIDS;
- Institutionalizing best practices in care and support for people living with HIV/AIDS;
- Mitigating the effect of the disease on people living with HIV/AIDS, orphans and other affected groups;
- Creating networks of people living with HIV/AIDS and others affected by AIDS;
- Establishing an effective HIV/AIDS surveillance system; and
- Stimulating research on HIV/AIDS. In 2004, Nigeria became one of the Presidents

Nigeria

Emergency Plan for AIDS Relief (PEPFAR) 15 focus countries. Under PEPFAR, Nigeria received grants to support comprehensive HIV/AIDS prevention, treatment and care programs. Also, Nigeria received funding for other HIV/AIDS

bilateral programs and contributions via the Global Fund to Fight AIDS, Tuberculosis and Malaria, and Canadian CIDA. These resources have supported antiretroviral treatment, prevention of new HIV infections, and care and support including orphans and vulnerable children (www.usaid.gov).

1.3 SRHR situation for PLHIV in Nigeria

The first global agreement to define reproductive rights was the Programme of Action developed at the 1994 International Conference on Population and Development (ICPD). The declaration affirmed people's right to enjoy a safe and satisfying sex life and to make decision freely- without coercion, discrimination or violence about matters relating to their sexuality, including their sexual and reproductive health. The rights of people living with HIV are not specifically discussed in this document, nor in Millennium Development Goals developed in 2000.

After the 1994 ICPD meeting, many countries including Nigeria shifted the focus of their population and development programmes to reproductive health. Available statistics show that reproductive health status of men, women and adolescents has remained poor in Nigeria.

People Living with HIV (PLHIV) have the right to a pleasurable and enjoyable sexual life; as well as the right to intimacy, to have children, and to love. HIV positive people also have the fundamental right to access sexual and reproductive health services without fear of being stigmatized or judged for their sexual and reproductive health choices.

Nigeria's poor health system and its uneven distribution within urban and rural areas have led to poor reproductive health service provision and these services non-existent in many health facilities across the country. Comprehensive integrated HIV and SRH services are generally non-existent in Nigeria and where they are available; they are not affordable for most people.

1.4 SRHR initiatives

Significant developments have occurred in the field of sexual and reproductive health and rights (SRHR) globally in the last decade. However, this has yet to translate into improved status of SRHR in developing countries. SRHR programs in Nigeria in the last couple of years have predominantly targeted adolescents and youths. These efforts have yielded reports of significantly improved SRHR awareness among people in this targets group but little increased access to SRH services. No intervention addressing the sexual and reproductive health needs of persons living with HIV and AIDS has been undertaken in Nigeria.

1.5 Rationale for the study

People living with HIV have the right to healthy, satisfying sex lives, and need both laws to protect this right and appropriate services to promote and ensure their sexual and reproductive health. Decision-makers and service providers must recognize that people living with HIV enter into relationships have sex and have children. Ensuring that they can do these things safely is key to maintaining their own health, and that of their partners and families.

People living with HIV developed an SRHR Guidance Package to help policymakers, programme managers, health professionals, donors, and advocates better understand the specific steps that must be taken to support their sexual and reproductive health and rights. The Network of people Living with HIV AIDS (NEPWHAN) designed this study (using the SRHR Guidance Package as a basis) to further deconstruct the sexual and reproductive health and rights of sero-discordant couples in Nigeria in order to inform future development of national SRHR and HIV programmes and policies.

Goals and Objectives

Goal

The purpose of this research is to gather information about the SRHR needs and experiences of sero-discordant couples in Nigeria in order to inform future planning for access to SRHR services for people living with HIV

Objectives

The specific objectives of this research are to:

- Develop an evidence-gathering tool (e.g. questionnaire, survey, etc.) informed by people living with HIV;
- Document the lived SRHR experiences of sero-discordant couples.

Expected results/outcomes

A report documenting the SRHR needs and experiences of couples in sero-discordant relationships in Abuja, Nigeria.

Methodology

Nigeria with a population of about 140 million people has more than 250 ethnic groups. The official language of communication is English and other frequently spoken languages include Hausa, Igbo and Yoruba. Since 1995 when the first case of HIV was discovered, the country has struggled with the health, social and economic consequences of the disease.

3.1 Study area

The study area for this research was Abuja, the Federal Capital Territory, Abuja (FCT) covers a total land area approximately 7,315 sq. km and located in the geographic center of Nigeria. It is made up of both urban and rural settlements that are home to many of the diverse social groups that makes up the Nigeria Nation. The socio-economic status of the inhabitants is mostly professionals, civil servants, artisans and traders etc. (www.fct.gov.ng)

3.2 Target Population

All participants in this study were people in heterosexual couple relationships (one man and one woman) in which one partner was HIV positive and the other HIV negative. All were members of a hospital based or community support group of PLHIV. Study recruitment proceeded in two phases. In the first phase, Focus Group Discussions were held to collect qualitative data and gather information to inform the development of the survey instrument used in phase two.

The eligibility criteria used to recruit FGD participants were:

1. The individual must have been in a sero- discordant sexual relationship for at least one year.
2. HIV negative men must have had an HIV test confirming their HIV status within the last three months.
3. The HIV-positive partner in each sero-discordant relationship must have disclosed his/her status to the HIV-negative partner at least one year ago.

Once the survey instrument was designed and pre-tested, phase two of the study was conducted to collect quantitative data. The eligibility criteria used to recruit participants for this phase two were:

- The individual must have been in a sero- discordant sexual relationship for at least six month.

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- The HIV- positive partner in the sero-discordant relationship must have disclosed his/her status to the HIV -negative partner at least six month ago.

3.3 Sampling procedures

A stratified random sampling technique was used in phase one to recruit participants for the FGD. In phase two, a combination of stratified random and simple random techniques were used to recruit survey participants from health facilities and support groups for PLHIV. There are biases that exist when these sampling techniques are applied and extra caution was taken to reduce participants' biases.

3.4 Sample size

16 persons were recruited for the FGDs and these were divided into two of eight persons each:

- One group was comprised of eight (8) HIV positive women whose partners are negative
- The other group was comprised of eight (8) HIV negative men whose partners are positive

Groups were chosen because women are the primary recipient of SRH services. It also seemed important to collect data from men about the challenges that their partners face in accessing SRH services.

A sample size of fifty (50) persons in sero-discordant relationship was recruited for the quantitative survey

3.5 Questionnaire

The following questions were asked in the qualitative (FGD) survey.

1. How long have you been in a sero-discordant relationship and elaborate on your wellness status and that of your partner?
2. Have you experienced any form of tension in your relationship as a result of your been in a discordant relationship?
3. As an individual, do you decide freely and responsibly the number, timing and spacing of children without interference?
4. Do you have the information and education and means to achieve question 3. above?
5. Do you have adequate and accurate information on how to handle your sexual needs in order to attain the highest standard of sexual and reproductive health?
6. What are the safer sex practices you have adopted with your partner?

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The quantitative questionnaire collected data in the following modules:

- a. Socio-demographic characteristics
- b. Duration of Relationship and HIV Counseling and Testing (HCT) record
- c. Risk reduction behavior and health status
- d. Access to service provision

3.6 Training of data collectors

A one-day training for data collectors was held at the NEWPHAN Abuja's conference room. The goal of the training was to prepare data collectors to use the research instrument; a questionnaire developed for use in the survey. The data collectors were tested on their ability to understand and interpret the questionnaire. A total of three data collectors were recruited and trained for this purpose. The following topics were discussed;

- Informed consent
- Eligibility criteria
- Questionnaire review and administration

3.7 Pilot test

The questionnaire was pretested on 9 individuals in sero discordant relationships drawn from a health facility in Nasarawa state, Nigeria.

3.8 Data collection & fieldwork

The study was carried out with a total of 3 researchers and 1 supervisor for data collection in the field, data entry and analysis. Supervisor checked the questionnaire to detect possible interviewer errors while still in the field so that data collectors could return to respondents if data were missing. Respondents were drawn from ART clinics' and support groups of PLHIV. At the end of questionnaire administration period, 50 questionnaires had been administered. A period of a month was allocated for data editing and entry.

3.9 Data Entry

Data from these 50 questionnaires were entered using SPSS 16.0 statistical software. Data from the field were stored in a safe place to ensure validity and reliability of responses generated from the field. The data was validated and cleaned for errors before data analysis. Descriptive statistical analysis was carried out and summary tables presented.

Results

4.0 Demographic Characteristics

A demographic profile of the study population was constructed from the questionnaire provided by respondents. Table 4.0 shows the sex of respondents and Table 4.1 the age distribution of respondents. About 48 % of those interviewed were within the ages 25-39 years

Table 4.0 Sex of respondents

Sex	frequency	percent
male	18	36
female	32	64
Total	50	100

36% of respondents were males and 64% were females as shown in table 4.0

Table 4.1 Age distribution of respondents

S/N	Age Group	Frequency	Percent
1	20-24	3	6.0
2	25-29	12	24
3	30-34	12	24
4	35-39	10	20
5	40-44	9	18
6	45-49	3	6.0
7	50-54	1	2
	TOTAL	50	100

As shown in table 4.1, 48% of respondents are in the age group 25-34

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Figure 4.0.1 Religion of Respondents

92% of respondents are Christians and 8% are Muslims as indicated in figure 4.0.1

■ Christian ■ Muslim

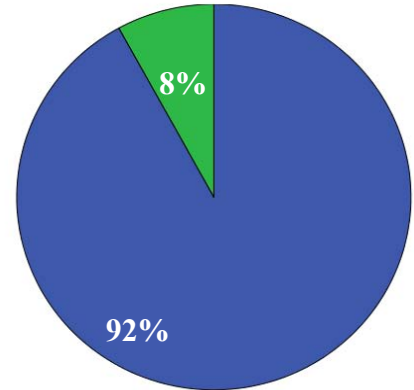
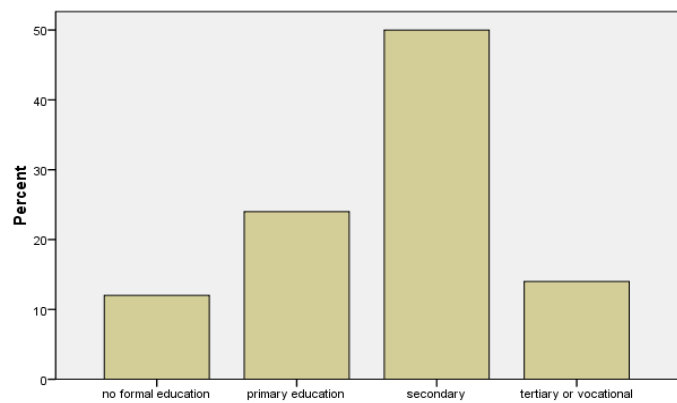


Figure 4.0.2 Level of Education

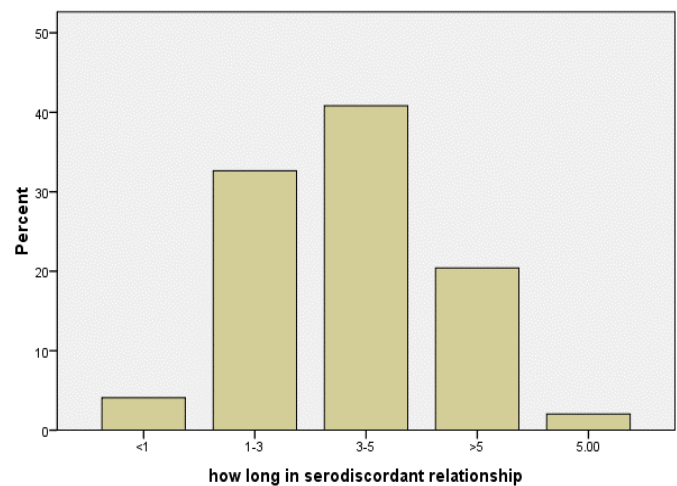
Figure 4.0.2 indicates 88% of respondent had formal education



4.1 Duration of Relationship and HCT

Figure 4.1.1 Number of years in sero-discordant relationship

In figure 4.1.1 about 61.2% of respondents have been in sero-discordant relationship for 3 years and above



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Figure 4.1.2 Sex of infected partner among sero-discordant couples

In figure 4.1.2 females accounted for 78% and males 22% of HIV infected partner in sero-discordant relationship among survey population

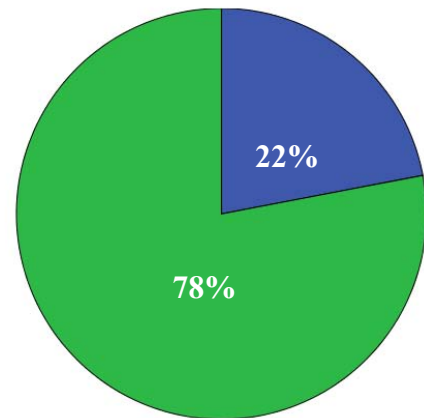


Figure 4.1.3 Frequency of HCT uptake by HIV uninfected partner among sero-discordant couples

Figure 4.1.3 shows that 88% of HIV uninfected partner among sero-discordant couples in sample population take up routine HCT once every 3months (48%) and 6months (40%) respectively

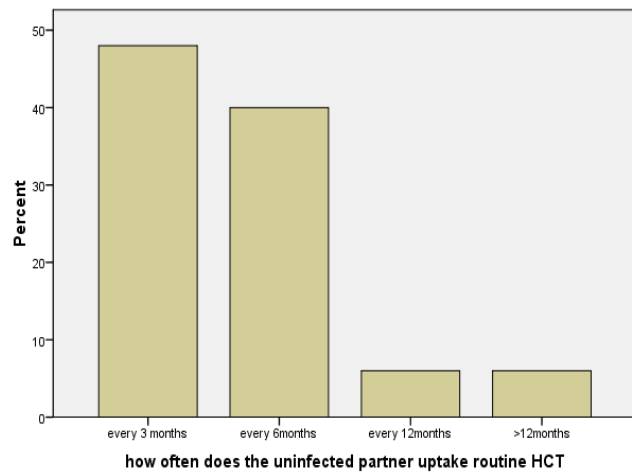
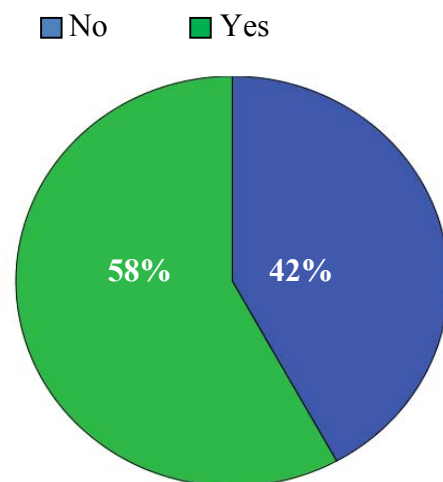


Figure 4.1.4 Affection of sexual intimacy among sero-discordant couples

Figure 4.1.4 58% of respondents said sexual intimacy with their partner has been affected by this sero –discordant circumstance, though 42% claimed sexual intimacy has remained same with their partner as indicated in figure 4.0.6



4.2 Risk Reduction Behaviour

Figure 4.2.1 Condom usage by sero-discordant couples

Figure 4.2.1 indicates condom use amongst respondents: 32% use condoms occasionally and 40% of respondents never use a condom during sexual intercourse with their partner. FGDs highlight two reasons: the desire to have children and intimacy in the relationship.

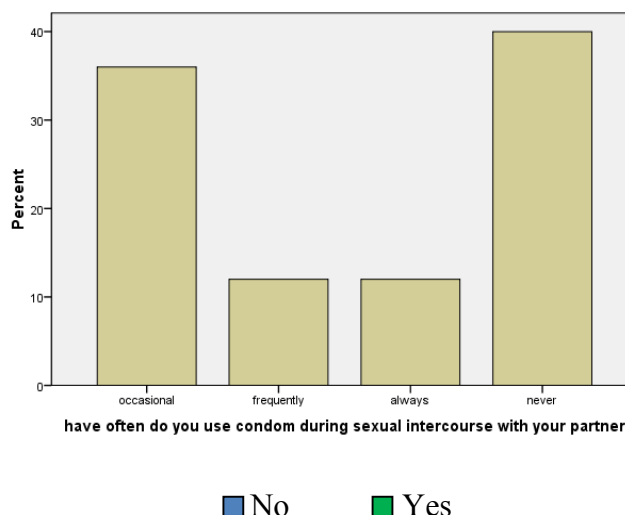
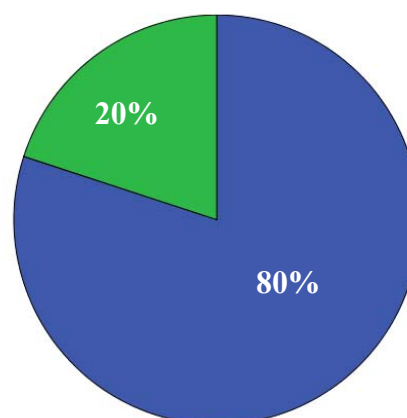


Figure 4.2.2 HIV positive partner on ARVs

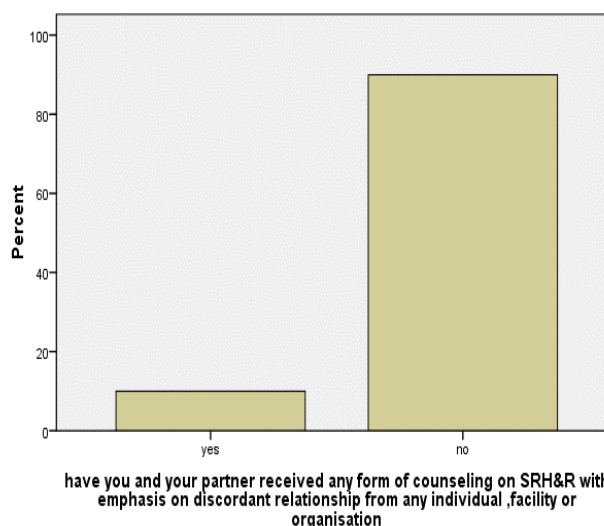
Figure 4.2.2 shows that 80% of HIV positive persons in sero- discordant relationship among survey population are on ARVs



4.3 Access to Service

Figure 4.3.1 Sero-discordant couples who have received SRH counseling from any individual, facility or organization

90% of respondent have never been counseled on SRHR before as depicted by figure 4.3.1



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Figure 4.3.2 Sero-discordant couples who have the necessary information to determine the number, timing and spacing of their children

Only 6% of respondent have the necessary information to determine, the number, timing and spacing of their children before as illustrated in figure 4.3.2

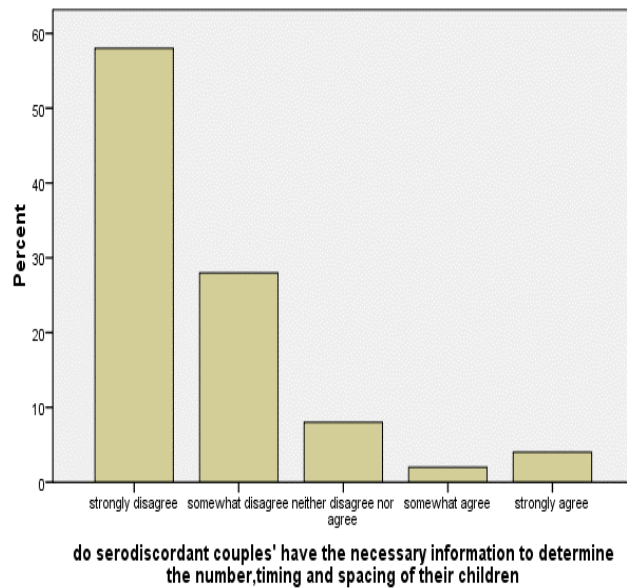


Figure 4.3.3 Sero-discordant couples experiences with service providers as regards provision of non-judgmental and supportive SRH services

86% of respondent stated that service providers do not offer non-judgmental and supportive SRH services as shown in figure 4.3.3

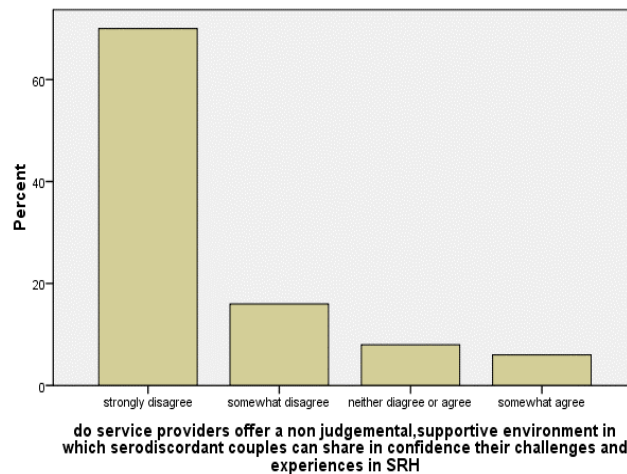
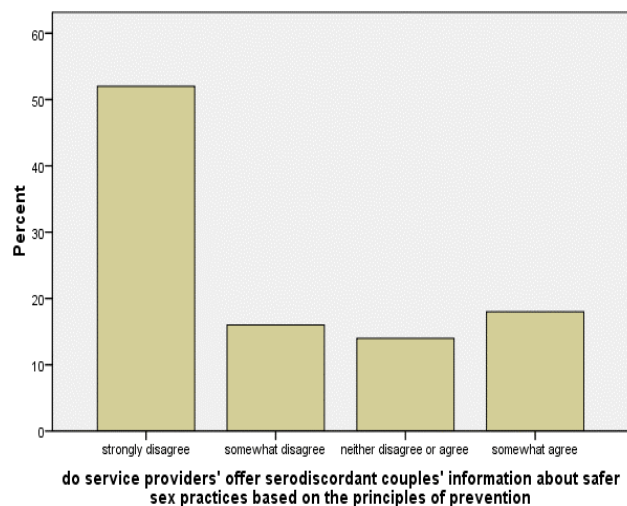


Figure 4.3.4 Service providers offering of information on safer sex practices based on the principles of prevention to sero- discordant couples

Figure 4.3.4 shows that 68% of respondents disagree with the statement that service providers offer information about safer sex based on principles of prevention, while 18% partially agree.



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Figure 4.3.5 Service providers offering of information that acknowledges the positive aspect of sexuality and attainment of sexual pleasure & satisfaction to sero-discordant couples

As indicated in Figure 4.3.5 only 8% of respondents agree with the statement that service providers offer information that acknowledges the positive aspect of sexuality and the attainment of sexual pleasure and satisfaction.

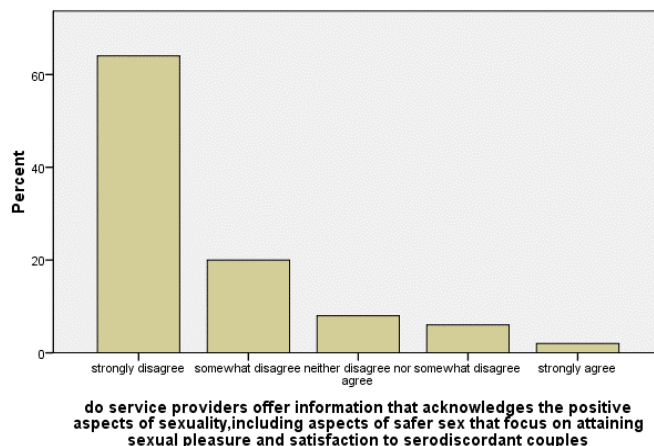


Figure 4.3.6 Service providers offering of information on fertility options, planning a pregnancy and contraception to sero discordant couples

Figure 4.3.6 shows that 78% of respondents disagree with the statement that service providers offer information on fertility options, planning a pregnancy and contraception sero-discordant couples

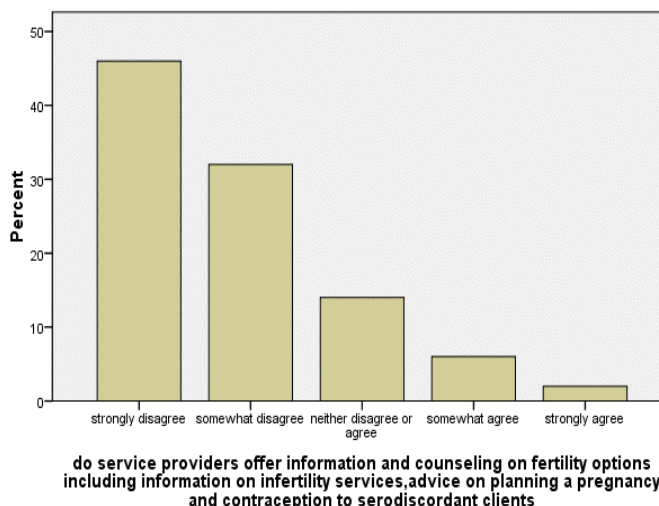
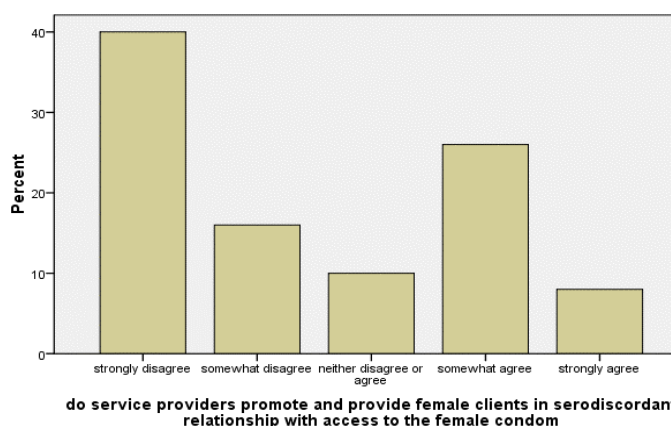


Figure 4.3.7 Provision of female condoms to females in sero-discordant relationship by service providers

Figure 4.3.7 shows that 56% of respondent disagree with the statement that service providers make available females condoms to sero-discordant couples and 46% agree.

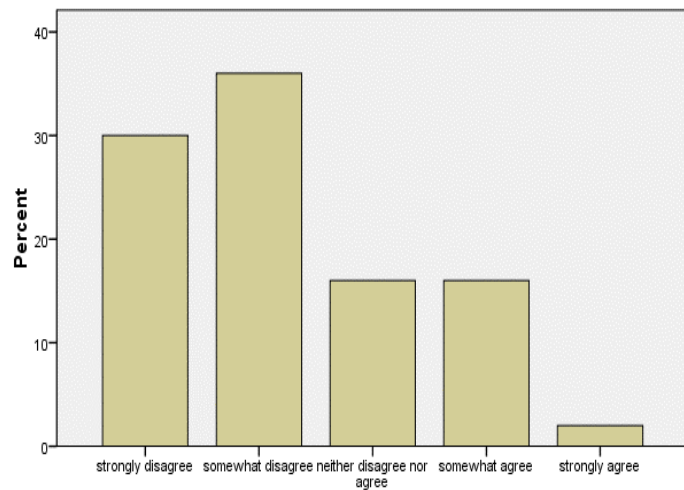


I agree because I use to see female condoms with my wife. (Male respondent)

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Figure 4.3.8 Service providers offering PMTCT information & referrals to women in sero-discordant relationship

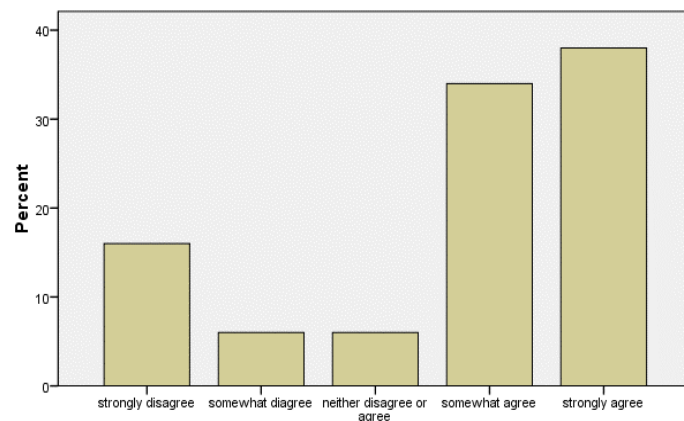
Figure 4.3.8 shows that 66% of respondents disagree with the statement that service providers offer information & referrals to women in sero-discordant



do service providers offer information about and referrals to PMTCT for women in serodiscordant relationship who wish to get pregnant or women who are already pregnant

Figure 4.3.9 Service providers offering PMTCT sero-discordant clients information on the risk and benefits of different modes of delivery

72% of respondents agree with the statement that service providers offer PMTCT sero-discordant clients on the risks and benefits of modes of delivery as indicated in Figure 4.3.9



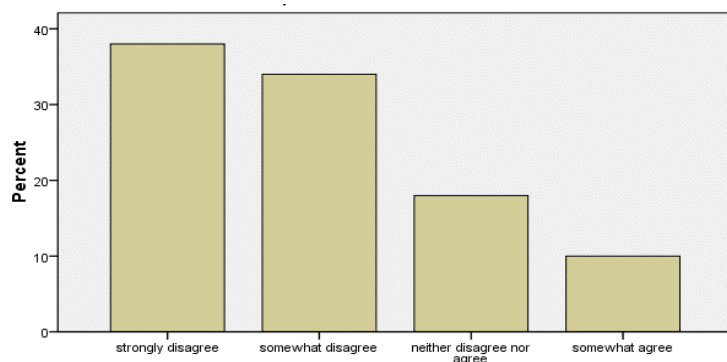
do service providers offer PMTCT serodiscordant clients information about the risk and benefits of different modes of delivery, and inform them about their access to elective caeserean section

Figure 4.3.10 Service providers offering information and access (directly or via referral) on modern contraceptive method to sero-discordant couples

Figure 4.3.10 shows that 72% of respondents disagree with the statement that service providers offer information and access (directly or via referral) on modern contraceptive to sero-discordant couples.

Most times when you ask questions and seek clarification the health maybe out of tiredness respond by telling you that you are asking too much question

“Am I the one that gave you HIV? One health worker asked me some time ago” (Female FGD participant)



are serodiscordant clients offered information and access (either directly or via a referral to another facility)to other contraceptive methods such as hormonal and injectable contraceptives,a diaphragm or an IUD in service provision centers

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Figure 4.3.11 Sero-discordant couples experiences at healthcare centers as regards provision of SRH services in a supportive and all inclusive manner

Figure 4.3.11 depicts that 94% of respondents disagree that healthcare facilities provides a supportive and all inclusive environment for discordant couples seeking SRH services

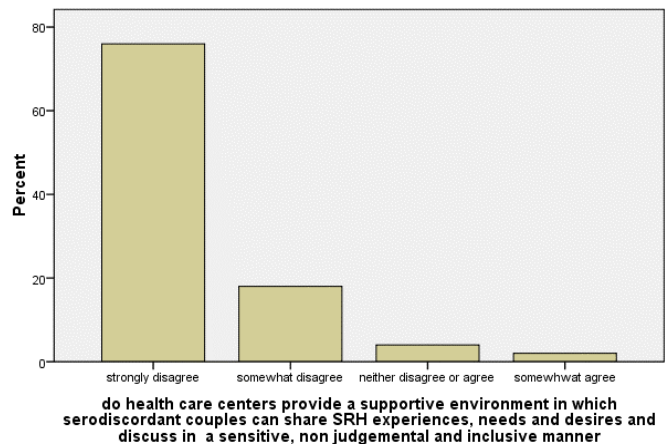
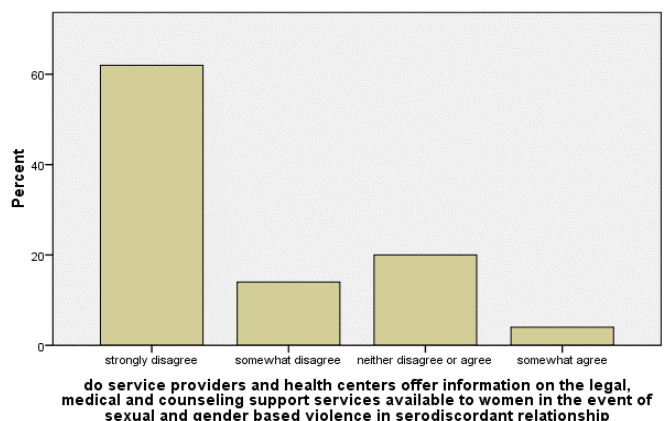


Figure 4.3.12 Service providers offering information on the legal, medical and counseling support services available to women in the event of sexual and gender based violence in sero-discordant relationship

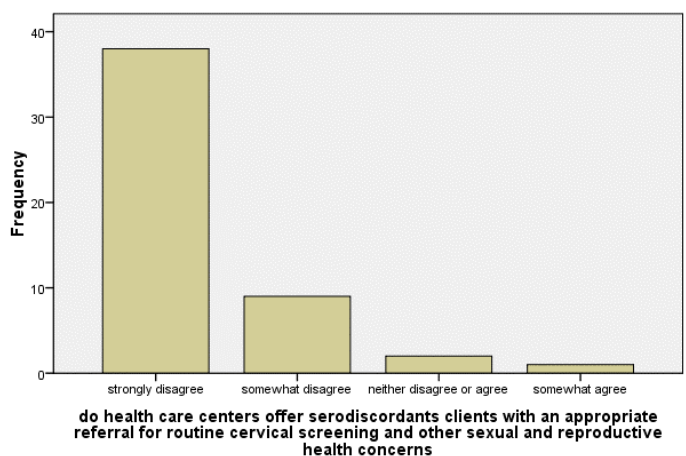
As shown in figure 4.3.12 only 2% of respondent agree with the statement 'service providers offer information on legal, medical and counseling support services available to women in the event of sexual and gender based violence in sero-discordant relationship.



I am not enjoying my marriage talk more of sex, my husband beats me every day since I discovered my HIV status and am scared he will soon disclose my status to his people and divorce me. (Female respondent)

Figure 4.3.13 Service providers offering appropriate referrals for routine cervical screening and other sexual and reproductive health concerns.

Figure 4.3.13 shows that 94 % of respondents disagree with the statement "service providers offer appropriate referrals for routine cervical screening and other sexual and reproductive health concerns".



Nigeria

Figure 4.3.14 Sero-discordant couples views on the possession of requisite skills by services providers in handling their SRH needs

88% of respondent disagree with the statement “service providers have requisite skills in handling SRH needs of sero-discordant couples as highlighted in figure 4.3.14

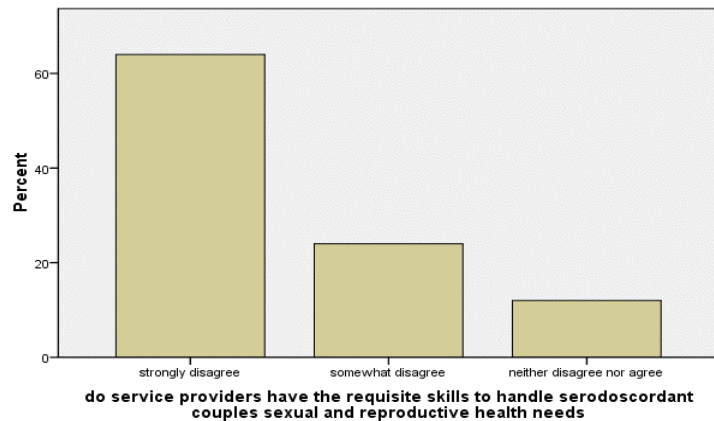


Figure 4.3.15 Sero-discordant couples views on the preparedness of health facilities to handle their SRH needs

Figure 4.3.15 illustrates that 76% of respondents disagree with the statement “health facilities are well prepared to manage the SRH needs of sero-discordant couples

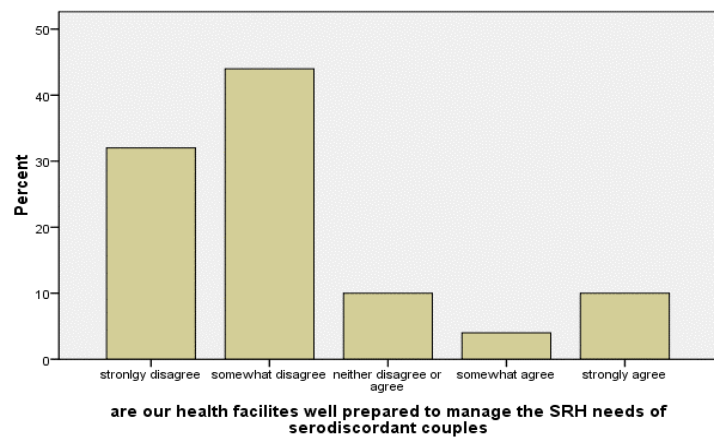
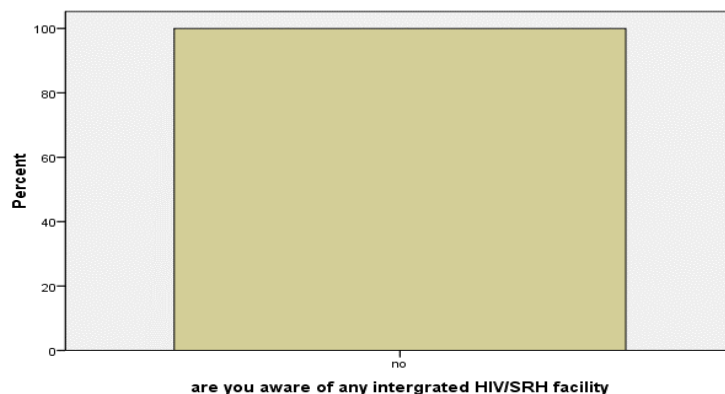


Figure 4.3.16 sero-discordant couples awareness of HIV/SRH integrated facility

Figure 4.3.16 shows that all respondents are not aware of any facility where integrated SRH/HIV services are offered.



Study Limitations

Sampling Size

Due to financial constraints, the sample size was constrained and thus limited to 50 respondents for the quantitative study.

Reporting Bias

Reporting bias concerns among participants was common in two areas; sexual intimacy among couples and the adequacy of integrated HIV/SRH facilities. In the first area attempts were made to reduce this bias by asking respondents to comment on; levels of sexual intimacy with their partners before and after the status of the positive partner was detected. In the second area where some respondents were unsure of what services an ideal SRH/HIV integrated facility should offer; efforts were made to clarify this by listing out the mandatory services of an ideal SRH/HIV integrated facility.

Discussion

Very little attention has been paid by policy makers and health care providers to the sexual and reproductive health concerns and challenges confronting sero-discordant couples, especially in sub Saharan Africa. This is particularly unfortunate given that HIV infection in this region has assumed a pandemic dimension over the years; and the region is likely home to more discordant couples than any other. The region's cultural beliefs also make procreation almost a necessity after marriage, leaving discordant couples caught in the dilemma of wishing to have a satisfying and enjoyable sexual life and the possibility of children while also wanting to make efforts not to infect their partners.

SRH services are essential to enabling discordant couples to cope with this conflict effectively through informed decision making and choices. Appropriate and timely sexual and reproductive health information and services targeted to the specific needs of sero-discordant couples should be available and accessible to them in a supportive and non-discriminatory manner. This is not only a matter of necessity but is also in keeping with 1994 ICPD declarations in which sexual and reproductive rights were identified as fundamental human rights.

Socio demographic characteristics

The demographic data gathered from study participants indicate that they are similar in many ways to the national profile of people living with HIV documented by the National HIV/AIDS Sentinel Survey (National HIV Sentinel Survey page 11, 2008). 60% of the respondents are reported to be in the 25-39 age group, the sexually active, part of the work force and part of the population segment with the highest HIV prevalence rate, as is also the case in many other developing countries. The participants in this study can be described in similar terms and, more than eighty percent of them had some form of formal education - ranging from primary to tertiary.

The similarity between study participants and the national profile of people living with HIV helps to build the advocacy case for increasing PLHIV involvement in HIV programming, starting at the level of program design. It also highlights availability of a knowledgeable human resource reservoir who can be recruited and prepared to actively participate and contribute to the development of SRHR programming for discordant couples in Nigeria.

Duration of Relationship and HCT Record

A significant proportion of respondents knew for certain that they had been in a discordant relationship for between three and five years. This could be partially attributable to the scaling up and increased uptake of HCT, particularly PMTCT, in the past decade. The majority of the study participants confirmed that PMTCT had been their entry point to HCT services, making it reasonable to suppose that they might not have sought out HCT had they not been drawn into PMTCT services when their availability increased.

This underscores the value of pointing out to policy makers and program planners the multiple benefits of scaling up of PMTCT services in rural and underserved areas. Such services not only prevent perinatal transmission and maternal deaths but also assist pregnant women in discordant relationship and their partners to access HCT and, though it, other essential services and supports.

The survey showed that more than two-third of this group access routine HCT every three and six months. It is necessary to recommend continued confirmation of sero-status for the uninfected partner. Regularly repeated HCT is also provides an opportunity for service providers to offer additional SRH information and services to the target group. Program planners and policy makers should consider the costs, both in terms of public health and in terms of individual health and well-being, of failing to take this opportunity to meet the SRH needs of discordant couples.

Effect on Sexual Intimacy

Over half of the respondents (58%) said that sexual intimacy with their partner had been affected by the fact that the relationship was sero-discordant, while 42% reported that it remained the same (see figure 4.1.4). For the majority, fear on the part of the negative partner of contracting the virus was cited as the primary reason for the change.

Sexual intimacy with my wife has been affected because I can't touch her without a condom and meanwhile I am not enjoying sex with a condom. (Male respondent)

I look at myself as if am a different person now. My husband doesn't even want to use condom, he is afraid of having sex with me. I don't have sex when I want unless at his own convenient time (Female respondent)

From the onset I did not believe such illness like HIV, I have been having sex with her regularly without condom up till now and I am still negative. She has been on drugs for 10 years. (Male FGD participant)

Nigeria

Last 3 weeks I fell sick, she forced me to go do my test again and I was still negative and I began to fear having sex with her. The fear just came from within me that if I continue I may get infected and I'm very confused now and we have been in this relationship for over three years. (Male FGD participant)

Sexual intimacy between us has been affected because my husband is afraid of having sex with me; he says he wants to remain negative. (Female respondent)

For me my husband doesn't disturb me and he is even showing more love since I discovered my HIV status over 3years ago during child birth (Female respondent)

How can we use a condom when we don't have a child yet after marriage? (Female FGD respondent)

As these comments indicate, this impact on sexual intimacy has resulted in conflict in some homes, diminishing the ability of both partners to enjoy a pleasurable sexual life. Such conflicts lead in some cases to infidelity, deprivation and abandonment which further increase the vulnerability of the partner living with HIV, particularly among women.

The above quotes also show how lack of supportive and effective SRH services to sero-discordant couples can result in heightened HIV transmission risk. If the man does not see the need for condom use, he risks sero-conversion himself (if negative) or transmitting HIV to his partner (if he is positive). In this study, 40% of respondents said that they never used condoms and 32% said they used them only occasionally (see figure 4.2.1). The two main reasons respondents gave as responsible for this is one -the desire to have children, which was mostly reported by female respondents and secondly most males claimed not to enjoy sex with a condom. Sero -discordant couples are usually caught in the dilemma of wanting to reproduce and same time concerned about not wanting to infect their partners. This underscores the need to provide support services at every level to enable discordant couples cope with the situation effectively.

Studies have shown (e.g Sullivan P, Kayitenkore K, Chomba E, et al.) that prescribing ARVs to the HIV infected partner in a discordant relationship significantly reduces the risk of transmitting HIV to the HIV negative partner. In this study, 80% of HIV positive respondents reported that they were taking ARVs and about 20% reported that they were not. (see figure 4.2.2), possibly because, under national ARV treatment guidelines, they are not qualified for ARV initiation. The role of ARVs in HIV prevention needs to be clarified for people living with HIV. Advocacy efforts aimed at policy makers and service providers to adopt international best preventive practices must be encouraged.

Access to Service Provision

People living with HIV have a fundamental right to access sexual and reproductive health services without fear of being stigmatized or judged for their sexual and reproductive health choices.

Presently, there are very few trained HCT couple counselors in Nigeria and even fewer who are trained on managing the specific issues challenging HIV discordant couples. This effects of this deficit were evident in the study data, which indicated that 90% of respondents had never any form of counseling on sexual and reproductive health rights from a health facility, organization or even within their respective support groups (see figure 4.3.1)

We don't even have any program addressing discordant couples. There is none even among support group meeting that we talk about discordant couples. (Female FGD participant)

Another training and capacity gap is suggested by the fact that over 90% of study respondents also did not having the necessary information to determine the number, timing and spacing of their children (see figure 4.3.2). This is hardly surprising given that 78% of respondents said that service providers do not offer information on fertility options, planning a pregnancy and contraception to sero-discordant couples (see figure 4.3.6)

Whenever they hear you are a discordant couple in health centers, the next thing they say is you must be using condom; and some of us want children. There is no enlightenment on how to go about it. (Female FGD participant)

The possibility that provider training should include modules on attitudes and professional behavior, as well as knowledge, is highlighted by the fact that 85% of respondents in this study said that service delivery had not occurred in a non-judgmental and supportive manner (see figure 4.3.3).

I was maltreated after my status and that of my husband was disclosed to us by the health worker because the keep asking me if am sure am faithful to my husband. I am HIV positive and my husband is not. (Female respondent)

The day I went to do family planning I told the service provider I want implant. She said why you want implant when you know you are HIV positive. The "Nyanmayana" you have carried you want to infect your husband with it. The nurse started quarrelling. This attitude is very common. They will say implant is not good for positive people". (Female FGD participant)

Most times when you ask questions and seek clarification the health maybe out of tiredness respond by telling you that you are asking too much question "Am i the one that gave you HIV? One health worker asked me some time ago" (Female FGD participant)

Nigeria

People have the right to make sexual and reproductive health choices and decisions free of coercion, duress and stigma. This right cannot be exercised unless SRH services are offered in a non-judgmental and supportive manner because clients who do not feel respected in the health care setting are far less likely to be forth-coming about their symptoms, problems and needs with clinical and support staff.

A picture suggesting lack of appropriate staff training, supervision and protocols in SRH areas relating to the needs of sero-discordant couples also emerged from respondent reports on the following:

- 68% disagreed with the statement that service providers offered them information about safer sex based on principles of prevention, while 18% partially agreed with this statement (see figure 4.3.4)
- only 8% of respondents agreed that service providers offer information that acknowledges the positive aspects of sexuality and the attainment of sexual pleasure and satisfaction (see figure 4.3.5)

In commenting on this situation, some respondents said:

There is a challenge in accessing sexual information. Our culture sees discussing sex as a taboo. We don't have access to enough information. Sex is not a thing of discussion sometimes when you see a pregnant woman and tell her you got pregnant through sex she would say it's not true". (Female FGD participant)

I was told in our support group that as being positive we don't need to engage in frequent sex. It affects our viral load and weakens your immune system (Female FGD participant)

With regard to prevention of mother-to-child transmission (PMTCT) services, however, service providers' attitudes and knowledge appeared to be much more positive and well-informed. This may be due, in part, to more recent, explicit and thorough training in this area. Almost three quarters (72%) of respondents reported that service providers offer sero-discordant couples PMTCT services and information on the risks and benefits of various modes of childbirth (see figure 4.3.9).

Interestingly, study respondents were about evenly divided on the issue of female condoms availability. Slightly over half (56%) disagreed with the statement that service providers make female condoms available to sero-discordant couples, while 46% agreed with it (see figure 4.3.7).

The findings of this study also suggest that service provider' processes for referring clients to

Sexual and Reproductive Health and Rights

other service providers may also need improvement, and their comments highlight the seriousness of this gap. For example:

- 94% said that service providers do not offer appropriate referral for routine cervical cancer screening and other sexual and reproductive health concerns (see figure 4.3.13).
- 66% of respondents disagree with the statement that service providers offer information and referrals to women in sero-discordant relationships (see figure 4.3.8)
- Only 2% agreed with the statement that service providers offer information on legal, medical and counseling support services available to women in the event of sexual and gender-based violence in sero-discordant couples (see figure 4.3.12).

I am not enjoying my marriage talk more of sex, my husband beats me every day since I discovered my HIV status and am scared he will soon disclose my status to his people and divorce me. (Female respondent)

The majority (88%) of respondents in this study expressed the opinion that health facilities and service providers do not have the requisite skills, knowledge or preparation to handle sero-discordant couples and their SRH needs and issues (see figure 4.3.14 and 4.3.15). None of the respondents were aware of the presence or location of any service provider offering integrated SRH/HIV services (see figure 4.3.16).

Poor funding and continued neglect over the years have culminated in a Nigerian health care system that is almost moribund and largely staffed by a de-motivated workforce that is frequently insufficiently trained and prepared to deal with the multiple emerging health issues confronting them. This study reveals an uneven experience among the clients surveyed; characterized by some positive interactions with health care service providers (such as the high level of awareness of the importance of PMTCT services and at least some access to female condoms) and a majority of experiences that demonstrate seriously problematic deficits in service provider knowledge and professional preparedness to meet the needs of sero-discordant couples.

These deficits compromise the health and well-being of sero-discordant couples, abridge their SRH rights and, by extension, have a negative impact on their families and the communities in which they live.

Within the context of our present health structure, integrating SRH into existing HIV programs would be an appropriate step in the direction of correcting these deficiencies, rather than creating parallel structure of SRH interventions. However, advocacy efforts aimed at increasing and sustaining funding for Nigerian SRH/HIV programs and intervention will be essential to strengthen all facets in our weakened health system and enable it to adequately meet the SRH needs and yearnings of sero-discordant couples.

Conclusion

This study provided an overview of access to sexual and reproductive health information and services by sero-discordant couples in Abuja and its immediate environs. Their access to SRH counseling and support services were examined, as was the capacity and preparedness of our health facilities and service providers to managed the SRH issues and needs of sero-discordant couples.

The study findings highlighted low levels of knowledge about SRH among participants as well as insufficient access to care and services designed to meet their needs. Together, these factors appear to impede their power to make and implement effective decisions relating to their sexual and reproductive health. The urgent need to address these critical deficits is highlighted in the survey, as is the extent to which the current circumstances militate against the full realization of the sexual and reproductive health and rights of the sero-discordant couples surveyed.

Recommendation

- This study illustrated that an enabling environment and prepared health workforce is fundamental in meeting the SRH needs of discordant couples.
- Intervention programs specifically targeting discordant couples should be designed to provide accurate and timely information on 'HIV discordance' at various HCT entry points. Also, training of HIV discordant couples to serve as counselors on the issue will further strengthen such intervention programs and activities in support groups of PLHIV.
- Service providers should be well informed and trained to provide information and services on all aspects of sexual and reproductive health to discordant couples in accordance with its peculiarity.
- Creating an enabling environment within health facilities where SRH services can be offered to discordant couples in a non-judgmental and supportive environment should be made a top priority for policy makers and program planners.
- Capacity building for HCT counselors and other service providers on HIV and discordance should be strengthened so that they are better able to serve as linkages to SRH information and service provision. The inability of present interventions to adequately address the SRH needs of discordant couples has resulted in loss of reproductive rights, reduced intimacy amongst partners, strife and increased vulnerability to abandonment and separation.
- The need to scale up PMTCT in rural and underserved communities was also emphasized.
- Integration of SRH into HIV programming and leveraging it into existing structures and systems should be made a priority for policy makers and program policy.
- Integrated SRH/HIV service provision should be encouraged and supported as it could be a panacea in view of all present health system that is seriously underfunded and grossly under staffed.
- Advocacy efforts aimed at increasing funding for HIV/SRH program must be sustained.
- Further research and study should be carried on discordant couples to understanding coping skills, reproductive choices and rights violations; this will help to gather relevant information and assist in designing more appropriate intervention activities with the shared experiences and insight on challenges and issues confronting discordant couples.

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Questionnaire

Advancing the Sexual and Reproductive Health and Human Rights of People Living With HIV and AIDS in Nigeria



A case study of Discordant couples in the FCT, Abuja

Serial No:

Name of Interviewer:

Name of Interviewee:

Location of Interview:

Date of Interview:

INFORMED CONSENT FORM

The Name of our organisation is Network of People Living with HIV and AIDS in Nigeria [NEPWHAN]. It is the umbrella and administrative body of all support groups of people living with HIV/AIDS (PLWAs) in Nigeria. Being an administrative body implies that it does not execute programs while it assists its member support groups to carry out its stated mission and activities leading to achievement of our goal and objectives. NEPWHAN however is actively involved in the mobilization of PLWAs throughout the Federation and organizing them into new or existing support groups thereby broadening its own organizational base. The network is also actively involved in individual and institutional capacity building of some of these support groups and their members, advocacies to relevant stake holders on behalf of support group members are carried out to various government levels to influence policy change, shift or initiation.

We are interviewing people in Abuja to gather information about the Sexual and Reproductive Health and Rights of HIV discordant couples. We will need to ask you personal questions which you may find difficult to answer. Your answers will be kept completely confidential and will not be shown to other persons. The information collected from you and other persons like you will be used solely for research purpose. Your honest answers will be greatly appreciated. You have the right to decline and withdraw at any given point you choose to. We will greatly appreciate your help in responding to the survey and taking part in the study. The survey will take XX minutes to ask the questions.

Interviewer asks if the respondent has any questions and provides the necessary clarifications before proceeding with the informed consent] Would you be willing to participate? Now that the study has been well explained to me and I fully understand the content of the study process. I will be willing to be part of the programme.

Serial number of respondent /Date

Signature of Interviewer/ Date

SOCIO DEMOGRAPHIC CHARACTERISTICS

1. In what month and year were you born?

Month year

2. How old were you as at your last birthday?

.....

3. Have you ever attended school?

Yes No

4. What is the highest level of school you attended?

- A. No formal education
- B. Primary school
- C. secondary school
- D. tertiary or vocational school

5. Religion

- A. No religion
- B. Christian
- C. Islam
- D. others

DURATION OF RELATIONSHIP AND HCT RECORD

6. How long have you been in a sero-discordant relationship?

- 1
- 1-3
- 3-5
- 5

7. Who is the HIV infected partner in the sero-discordant relationship?

- A. male
- B. female

8. How often does the HIV uninfected partner in the relationship uptake routine HCT for status confirmation?

- A. every 3months
- B. every 6months
- C. every 12months
- D.>12months

9. Have sexual intimacy with your partner been affected by this sero-discordant circumstance?

Yes No

RISK REDUCTION BEHAVIOUR AND HEALTH STATUS

10. Have you experienced any form of tension in your relationship as a result of this discordant circumstance?

.....

11. How often do you use a condom during sexual intercourse with your partner?

- A. occasional
- B. frequently
- C. always
- D. never

12. Is the HIV positive partner in the sero-discordant relationship on ARVs?

Yes No

If yes, how long?

Responses for questions 14, 15, 17-20 and 21-29 will follow the under listed pattern

- A. Strongly disagree
- B. somewhat disagree
- C. Neither disagree nor agree
- D. somewhat agree
- E. strongly agree

ACCESS TO SERVICE PROVISION

13. Have you and your partner received any form of counseling on Sexual and Reproductive Health& Rights (SRH&R) with emphasis on discordant relationship from any individual, facility or organization?

Yes No

14. Do sero-discordant couples' have the necessary information to determine the number, timing and spacing of their children?

- A. Strongly disagree
- B. somewhat disagree
- C. Neither disagree nor agree
- D. somewhat agree
- E. strongly agree

15. Do service providers offer a non-judgmental, supportive environment in which sero-discordant couples can share in confidence their challenges and experiences in SRH?

- A. Strongly disagree
- B. somewhat disagree
- C. Neither disagree nor agree
- D. somewhat agree
- E. strongly agree

16. Do service providers offer prevention strategies so that sero-discordant couples are provided with the necessary information and support to make informed decisions about their sexual health and that of their sexual partner(s)?

.....

17. Do service providers' offer sero-discordant couples' information about safer sex practices based on the principles of prevention?

- A. Strongly disagree
- B. somewhat disagree
- C. Neither disagree nor agree
- D. somewhat agree
- E. strongly agree

18. Do service providers offer information that acknowledges the positive aspects of sexuality, including aspects of safer sex that focus on attaining sexual pleasure and satisfaction to sero-discordant couples?

- A. Strongly disagree
- B. somewhat disagree
- C. Neither disagree nor agree
- D. somewhat agree
- E. strongly agree

19. Do service providers' offer information and counseling on fertility options including information on infertility services, advice on planning a pregnancy and contraception to sero- discordant clients?

- A. Strongly disagree
- B. somewhat disagree
- C. Neither disagree nor agree
- D. somewhat agree
- E. strongly agree

20. Do service providers promote and provide female clients in sero-discordant relationship with access to the female condom?

- A. Strongly disagree
- B. somewhat disagree
- C. Neither disagree nor agree
- D. somewhat agree
- E. strongly agree

21. Do service providers' offer information about, and the possibilities to advocate for the realization of the sexual and reproductive health rights of sero –discordant couples'?

For example, in accessing SRH services that are sensitive to the specific SRH needs in terms of being in a sero-discordant sexual relationship, deciding whether or not to have children.

.....

22. Do service providers offer information about and referrals to PMTCT for women in sero-discordant relationship who wish to get pregnant or women who are already pregnant?

- A. Strongly disagree
- B. somewhat disagree
- C. Neither disagree nor agree
- D. somewhat agree
- E. strongly agree

23. Do service providers offer PMTCT sero- discordant clients information about the risk and benefits of different modes of delivery, and inform them about their access to elective caesarean section?

- A. Strongly disagree
- B. somewhat disagree
- C. Neither disagree nor agree
- D. somewhat agree
- E. strongly agree

24. Are sero- discordant clients offered information and access (either directly or via a referral to another facility) to other contraceptive methods such as hormonal and injectable contraceptives, a diaphragm or an IUD in service provision centers?

- A. Strongly disagree
- B. somewhat disagree
- C. Neither disagree nor agree
- D. somewhat agree
- E. strongly agree

25. Do health care centers provide a supportive environment in which sero-discordant couples can share SRH experiences, needs and desires and discuss in a sensitive, non-judgmental and inclusive manner?

- A. Strongly disagree
- B. somewhat disagree
- C. Neither disagree nor agree
- D. somewhat agree
- E. strongly agree

26. Do health care centers provide a supportive environment in which sero-discordant couples can share SRH experiences, needs and desires and discuss in a sensitive, non-judgmental and inclusive manner?

- A. Strongly disagree
- B. somewhat disagree
- C. Neither disagree nor agree
- D. somewhat agree
- E. strongly agree

27. Do health care centers offer sero discordant clients with an appropriate referral for routine cervical screening and other sexual and reproductive health concerns?

- A. Strongly disagree
- B. somewhat disagree
- C. Neither disagree nor agree
- D. somewhat agree
- E. strongly agree

28. Do service providers' and health centers offer information on the legal, medical and counseling support services available to women in the event of sexual and gender-based violence in sero- discordant relationship?

- A. Strongly disagree
- B. somewhat disagree
- C. Neither disagree nor agree
- D. somewhat agree
- E. strongly agree

29. Do service providers have the requisite skills to handle sero-discordant couples sexual and reproductive health needs?

- A. Strongly disagree
- B. somewhat disagree
- C. Neither disagree nor agree
- D. somewhat agree
- E. strongly agree

30. Are our health facilities well prepared to manage the SRH needs of sero-discordant couples?

- A. Strongly disagree
- B. somewhat disagree
- C. Neither disagree nor agree
- D. somewhat agree
- E. strongly agree

31. Are you aware of any integrated HIV/SRH facility?

Yes No

If yes state where

Notes



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