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Sexuality Issues Among Adolescents Living with HIV and AIDS in Botswana

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ABSTRACT

Most of the adolescents living with HIV and AIDS were born prior to the introduction of the Antiretroviral Therapy in Botswana. This cohort had just reached adolescence and it was imperative to understand their sexuality and 26 ALWHA aged 15 to 19 years, their parents/guardians and health care providers participated in the study. An elicitation survey was conducted among this group followed by Focus Group Discussions. In-depth interviews were conducted among 8 and 25 parents/guardians and health care providers respectively. Thematic content analysis was adopted to analyze the data. The following themes were derived: difficulty to disclose one's HIV-infected status, parents/guardians failure to discuss sexuality issues with adolescents, mode of HIV transmission, sexual activity and inactivity, sex education, sexual violations, conscripted intimacy, and the right to sexual relations. The same issues were expressed by parents/guardians and health care providers. Sexuality education needs to be incorporated and strengthened at both nursing curricula and at policy level. Programes that reinforce parent- child communication should be instituted and strengthened at community, institutional and national levels.

1. Introduction

Researchers have studied adolescent sexuality comprehensively to understand issues relating to sexual socialization and psycho-sexual development, and factors that enhance or stifle their positive sexual-selves. Studies on adolescents mostly focused on sexual risk behaviors and facilitating factors. Minimal attention was given to psychosexual development, sexual socialization, sexual health and sexual rights; as well as confusing messages on sexuality and gender based issues (Dixon-Mueller & Germain, 2015). Sexuality among adolescent living with HIV and AIDS (ALWHA) is complex. Botswana is faced with the challenge of caring for adolescents who were born HIV positive, most of whom are orphans. It is essential to examine sexuality issues in this population.

This paper provides a comprehensive assessment of sexuality issues among HIV-infected adolescents (15 -19 years). The results are part of a collaborative study between the Universities of Botswana and Pennsylvania entitled 'HIV /STI Prevention among adolescents in Botswana'. The research questions relating to ALHWA's sexual activity and inactivity, their experiences of sex education, sexual violations and their perceptions of intimacy, disclosure and the right to sexual relations motivated this paper.

2.Literature Review

2.1 The Concept of Sexuality

Sexuality can be understood and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors and practices in relationships. It is influenced by factors such as interaction among biological, socio-economic, political, cultural, ethico-legal, religion and spirituality. It encompasses sex, gender identities, sexual orientation, eroticism, pleasure, intimacy and reproduction (Organization, 2017). Sexuality has to be recognized as a natural and precious aspect of life and as a fundamental human right (Higgins & Hynes, 2018). Adolescents like all human beings have sexual rights and they should be given the respect and space to enjoy their rights regardless of their HIV and AIDS status. They experience emotional and physiological changes related to puberty, sexuality, self-esteem, identity and in response to external pressures associated with cultural expectations/roles/responsibilities (Kubanji et al., 2018).

2.2 Gaps in Sexuality Related Research

There is a paucity of literature on ALWHA in Botswana, particularly on sexuality issues. Few studies investigated sexuality and intimacy relationships among ALWHA. A few have paid particular attention to ALWHA who acquired HIV infection through vertical transmission (Fernet et al., 2007). Further, it has also been established that studies have paid very little attention to experience of sexual health among younger and older HIV-infected adolescents (Landolt, Lakhonphon, & Ananworanich, 2011). Approximately 70% of adolescent deaths in 2016 alone occurred in low and middle income countries (Mwandali et al., 2020). Among the list, fatalities resulted from maternal conditions such as; HIV, suicide, and gender bassed violence to mention some in top five leading causes documented (WHO, 2018). Complications from maternal conditions (pregnancy and childbirth) stood out the most in girls aged 15–19 years (Angrist et al., 2019). About The 95% of these conditions occurred in Low Middle Income Countries (Mwandali et al., 2020). In addition to complications of pregnancies, STIs, particularly HIV was viewed as another problem affecting adolescents.

These studies suggest that ALWHA who were provided with counseling in a health facility were more motivated to protect themselves and their sexual partners. According to Bakeera-Kitaka, Nabukeera-Barungi, Nöstlinger, Addy, and Colebunders (2008), some of the hitherto sexually active decided to abstain as a protective measure to avoid re-infection. Those who did not abstain however, claimed consistent use of condoms. Most of the younger ALWHA preferred abstaining from sex.

Therefore, attention should be given to the complex sexuality issues, their vulnerabilities and sexual and reproductive health and rights of this emerging sub population.

2.3 The Need for Supportive Intervention on Sexuality Issues

According to Fernet et al. (2007), it cannot be ignored that adolescents in today's life reach puberty earlier than before and this exposes youth to increased interest in romantic activities and exploration of sexual acts. Thus they need supportive and educational programmes that will enhance their sexual health, particularly in the era of HIV and AIDS (Landolt et al., 2011). Unfortunately, the sexual needs of ALWHA are usually not catered for (Hodgson, Ross, Haamujompa, & Gitau-Mburu, 2012).

(Quay, 2017) observed that children at risk are always searching for the right answers to mitigate the risk. Therefore spirituality intervention may be one of the answers because it may provide the necessary support and empower ALHWA to cope with the daily challenges of living with HIV and AIDS. It is also essemtial to conduct research that focuses on ALWHA girls, given the various risk-taking behaviors, mental health challenges they face, including the different coping strategies (Malik & Dixit, 2017).

2.4 Sexual Risks and Sexual Behavior

Adolescents in general are sexual risk takers. Specific to ALWHA the sexual risks identified include inconsistent condom use, early sexual debut, unwanted pregnancies and re-infections with HIV and other STIs (Bauermeister, Elkington, Brackis-Cott, Dolezal, & Mellins, 2009; Vagi et al., 2013) Inconsistent condoms use was also reported, either due to inability to procure or that they were too big. Some ALWHA were vulnerable to sexual exploitation by their caregivers (Fernet et al., 2007).

According to Bakeera-Kitaka et al. (2008) and Rashid and Mwale (2016), 25% of ALWHA reported having had unprotected sexual intercourse several times due the beliefs they held about sexual relations. For instance, ALWHA believed that they could not become pregnant because of their HIV positive status and that initial semen from boys could not make one pregnant. Older teens on the other hand, stated that semen does not carry HIV virus but only blood. Menstruation was perceived a protective measure against transmitting HIV.

It is important for men and boy children to be empowered on sexuality issues. This is because men generally have control over sexual matters. Available research evidence suggests that men generally coerce their sexual partners to have unprotected sex, making them vulnerable to infection with STIs and ART resistant HIV (Garegae & Gobagoba, 2009; Van Dyk, 2012).

2.5 Disclosure, Anxieties and Developmentally Appropriate Communication.

According to Kaushansky et al. (2017), disclosure is influenced by the duration of the relationship with the caregiver. The longer the relationship, the easier the disclosure. Early disclosure creates the opportunity for children to ask questions and for parents/guardians to provide answers to questions that may cause anxiety and fear. However, several factors inhibit parents to disclose their children's HIV positive status, these include guilt, anxiety about the child's reaction, and the likely impact of the disclosure on the child's emotional health (Abadia-Barrero & LaRusso, 2006). Marhefka et al. (2011) asserts that seropositive girls are highly motivated to prevent transmission of HIV but are hindered by their lack of negotiation skills for condom use. Furthermore, once they disclose their HIV positive status to their male partners they shift the entire responsibility of prevention to their partner.

According to Abadia-Barrero and LaRusso (2006), disclosing children's HIV positive status has positive outcomes. These include, *inter alia*, effective communication between the child and parents/guardians, improved child psychosocial adjustment and coping, and minimized parental anxiety. Furthermore, a child whose HIV status has been timely disclosed is likely to adopt safer sexual practices in future.

3. Methodology

3.1 Research Design

This was a qualitative study that utilized focus group discussions (FGDS) with ALWHA and in-depth interviews with health care providers (HCPs) and parents/guardians.

3.2 Population and Setting.

The target population of the study was ALWHA aged 15 to 19 years. The study was conducted in an urban area , Gaborone, a capital city of Botswana with a population of approximately 227, 333 and a peri-urban village - Mochudi, with a population of about 44, 337 (Botswana, 2014) about 40 kilometers north of Gaborone. The research sites comprised of the Princess Marina Referral Hospital Infectious Disease Care Clinics (IDCCs), the Baylor'Children Centre of Excellence (BCCE) and the Deborah Retief District Hospital in Mochudi IDCC. These institutions listed above provide HIV and AIDS services to ALWHA and their families (Picton, 2012).

3.3 Sample and Sampling Procedures.

ALWHA completed an elicitation survey to capture their demographic characteristics before they participated in FGDs. Participants were recruited and purposively selected from all the IDCCs sites referred to above. The eligibility criteria were (a) health care providers must have worked in the IDCCs or Baylor COE for at least six months; (b) parents/caregivers presently taking care of adolescents (15-19 years) living with HIV; and, (c) HIV infected adolescents 15-19 years. Participants consisted of 26 ALWHA (n=16 female & n=10 males) 25 HCPs (n=15 females & n=10 males and 8 ALWHA parents/guardians (n=7 females & n=1male).

3.4 Data Collection Procedures.

Three FGDs were conducted with ALWHA, two of females only and males only. The third FGD was a mixed group (a combination of both males and females). A structured 2 to 3 hours FGD discussion guide and probes were used to solicit ALWHA`s views on various sexuality issues they experienced. Two researchers conducted the FGDs; one asked questions and facilitated the discussion while the other recorded the responses.

The structured 1 to 1 ½ hours in-depth interviews guide was used to collect data from HCPs who consisted of nurses, medical doctors, social workers, psychologists, nutritionists and adolescents' officers and parents/guardians caregivers a questionnaire on their demographics was completed. The interviews covered ALWHA's HIV and ART knowledge, disclosure, stigma and discrimination, risky sexual behaviors, social support, and sexuality education.

3.5 Ethical Considerations

The Institutional Review Boards (IRBs) of the University of Botswana, University of Pennsylvania and the Ministry of Health Research Development Committee approved the study. Participants were recruited from the COE and IDCCs through the assistance of the Adolescent officer whose role is planning and implementation of adolescent service programmes. The registered nurses working with adolescents and their parents/guardians also assisted with recruitment. Parental/guardian consent was obtained for adolescents to participate and assent was sort from ALWHA. Individual consent was also sought from HCPs who were willing to participate in the study. Confidentiality and privacy were assured by entering data in password

protected computers and anonymity was assured through the use of codes instead of names. Participation in the study was voluntary.

3.6 Data Analysis

Thematic content analysis was utilized to generate themes from the qualitative data obtained from ALWHA and in-depth interview data given by parents/guardians and service providers. There after formulation of categories; patterns and clusters as well as descriptions of the data generated through observations (Bradley, Curry, & Devers, 2007). The process involved i) open coding of each in-depth interview and FGD data by more than one researcher to formulate categories, ii) salient response patterns formulated across the participants were organized in structured categories iii) the codes were then rigorously applied to data from the three participants groups and were clustered to generate themes for further analysis. Categories were merged to formulate themes and later used to code the transcripts. Data from the three groups of participants (ALWHA, HCPs, and parents/guardians) were triangulated to enhance trustworthiness.

3.7 Limitations of the Study

A small sample size of parents/guardians was obtained because it was difficult in finding a suitable time to conduct interviews. Some ALWHA were not at home and as such could not be interviewed.

4. Results

The findings in this study were categorized under the following thematic areas: sample characteristics, mode of HIV transmission among ALWHA, sexual activity and inactivity, sex education, sexual violations, conscripted intimacy, disclosure and the right to sexual relations.

4.1 Sample Characteristics and Mode of HIV Transmission

ALWHA (N=26) were all in school and were predominantly of Christian religious denomination, only one respondent was not affiliated to any religion. The majority (N=21) were in lower secondary schools, 4 were in senior secondary school, and only 1 was not in school. Whereas the most common mode of HIV transmission in the general population is through heterosexual intercourse, HCPs, parents/guardians and confirmed that these children got infected vertically. Unlike HIV negative adolescents, according to HCPs, ALWHA's sexual development and 'maturity is slow' as it is stifled by opportunistic infections resulting in prolonged illness during childhood and in part probably due to some drug side effects.

4.2 Sexual Activity and Inactivity among ALWHA

From the elicitation survey, the majority (N=23) reported that they were not sexually active, only 3 reported being sexually active, 2 reported to have used a condom during sexual intercourse and one did not. None of the boys reported being sexually active,. All have participated in a range of club activities at school such as "I Care Club."

On teenage sexual issues, one participant asserted that:

Teenage sex is a bad idea…; you have to take care of yourself first, grow up and mature. When you are ready, then the idea of remaining with one partner will make sense and practicing safe sex.

Although some ALWHA said they were not sexually active, they did not turn a blind eye to their risk taking friends. Like other teenagers some ALWHA do go on dates.

As one participant put it, "you just remind your friend to be careful if you think they are doing something stupid.' The boys did not support the idea of not disclosing to a girl friend.

As one participant states, '… you have to tell someone you want to date at some point, about your status, ….you also have to know her status…'

During the boys only FGD regarding the risks of transmitting HIV, they mentioned that some ALWHA have unprotected sex. One participant said:

multiple sex-partners increase the risk of spreading the virus around; ……By not disclosing to your partner, you spread the virus around; it becomes difficult to take necessary protection measures. Inter-generational sex is problematic.

Sexual inactivity of ALWHA was also confirmed during in-depth interviews with HCPs and parents/guardians. According to HCP2, "most ALWHA were not sexually active for fear of spreading the disease."

Sex education, abstinence and condom use emerged as the dominant messages during both in-depth interviews and FGDs. This is clearly captured in quotes below from HCPs:

As HCP 10 and 6 underscored the importance of abstainance and condom us thus:

'Abstinence and condom use is important for those who cannot abstain and I encourage them to abstain until they are old enough to be able to handle unexpected reactions'.

The HCPs reported that they place emphasis on abstinence in their counseling sessions in order to encourage ALWHA to avoid early sexual debut. This will help them to develop life skills that would enable them to handle the effects of disclosure.

4.3 Adolescents are Self Conscious of HIV and Self acceptance.

In a mixed FGD, ALWHA maintained that those who are sexually active reported consistent condom use. The reasons advanced were to avoid re-infection and infecting other people. However, HCPs believe that sexually active ALWHA, like other teenagers are likely to use condoms inconsistently or engage in unprotected sex.

Condoms are available at IDCCs and at Baylor COE where the ALWHA receive care and treatment. Although condoms are readily available, the social worker discouraged ALWHA to enage in sexual relationships, if they do, they should condomise.

4.4 Sex Education

ALWHA are exposed to a range of sources of information about sexuality, mostly by HCPs, counselors, guidance and counseling teachers, extended family members, public media, and in some instances, through participation in traditional initiation schools (*Bojale* for girls and *Bogwera* for boys). One ALWHA mentioned that she participated in the traditional initiation school for girls (*Bojale*). She however, refused to share what she learnt with the group as they were instructed not to disclose what they learnt to people who never attended the inition school.

From in-depth interviews, it became apparent that HCPs, social workers and teen clubs were primary source of sex education for ALWHA. HCPs affirmed that ALHWA know a lot about safer sex" but that parents should reinforce what is taught at the clinic and try and address issues of safe sex. However, parents/guardians reported that it is not culturally acceptable to discuss sexuality matters with children because it may encourage initiation of sexual activities.

This is clearly captured in the quote below by HCP 1 ALWHA are counseled on sex and sexual relationships. Risky behaviors such as unprotected sex, infection and re-infection are addressed.

4.5 Sexual Violations

Like their counterparts, ALWHA are also at risk of gender based violence. Incidences of rape and sexual abuse among ALWHA was reported by HCPs. Some ALWHA who were victims of rape became pregnant while perpetrators got away unpunished. HCPs and social workers, confirmed that some ALWHA are subjected to sexual abuse either by boyfriends and/or close family members. Others live in environments where other family members are engaged in intergenerational sexual relationships which is yet another form of sexual abuse. Transactional sex and intergenerational sex were also reported during mixed FGD, and rewarded with material things such as the five Cs (cell-phones, cash, celebrity, cars and clothes). The older men also picked adolescents from school and bought them lunch, nice present and are "given money".Because of power and age differences, "condom use may not be practiced."

HCP 5 made the following comment on ALWHA sexual violations:

Some ALWHA just copycat intergenerational sex practiced at home. There is one teenager who the mother trusted so much …until one day she called her mother following a gang rape. She has become alcoholic following the incidence. There were 3 rape cases which resulted in pregnancy.

Additionally HCP 6 stated:

"Although there is much attention to intergenerational sex, I think we need to start talking about intra-generational sex between teens who are HIV-infected from birth"

4.6 Conscripted intimacy, disclosure and the right to sexual relations

Like all adolescents, ALWHA ask their parents/guardians and HCPs general and specific questions relating to their health and wellbeing. Questions asked reflect anxieties about the future. Such questions include; how long will I live? Would it be possible to find HIV-infected partners? Should I date HIV-uninfected partners? Should I disclose my HIV status to partners? Will a cure for HIV ever be found? Will I ever have children? What would happen should I stop taking ARVs? Other questions relate to intimacy and sexual relationships such as who to date, when to disclose to one's partner, anxieties about infecting sexual partner.

However, regardless of all risks and anxieties both ALWHA, parents and HCPs agreed that like every human being, these adolescents have sexual rights.

Here is what a parent of a teenager had to say about ALWHA:

> As they mature at some point they will be like everyone else. Its natural, it is not a question of whether they can have sex, but like everyone else, the concern is about safe sex. They want to have children at some point, these are the challenges they have to deal with as they grow older, I can't really prescribe to him when. He will have to address issues of safe sex, reason for practicing safe sex, family planning, having children. Right now he is just a child who likes to play with his friends.

HCP 5 stated that:

> Those who desire to do so cannot be stopped and sex is a natural human activity, yes, but they should use protective measures to avoid re-infection or spreading the virus.

HCP7 also noted that:

> Men find these kids attractive. But they may be afraid to disclose their HIV status, and insist on condom use and thus infecting their partners or getting re-infected. Assertiveness training is necessary after disclosure to reinforce their ability to negotiate safer sex.

ALWHA reported that disclosure of their status to sexual partners is a great challenge. One would not know the correct time to disclose to the partner. Health care providers advised the girls not to disclose on the first date and to wait until they are ready to do so.

5. Discussion

Fernet et al. (2007) observed that HIV is believed to slow down sexual development among ALWHA and that those infected at birth commence their sexual relationships later than their HIV-uninfected counterparts.

To this end, it is important to engage on sexual issues among ALWHA with a view to understanf their sexuality, risks and challenges.In the present study, majority of ALWHA (23) were not sexually active, only three reported to be sexually active. Those who are not sexually active may have had intentions to abstain from sexual intercourse. Those who dealayed sex reported that they did so to ensure that they were mature enough to make informed decisions on sexuality issues. Two out of the three who were sexually active claimed that they used condoms correctly and consistently .These behaviors are less likely to expose ALWHA to reinfection and the spread HIV and STIs.

ALWHA's FGDs revealed that they advised their sero-positive friends who were sexually active to practice safe sex. On the other hand, HPCs stated that they encourage younger ALWHA to abstain from sex, and also informed those who are sexually active to use condoms correctly and consistently. Ganle (2016) asserts that young women should remain virgins, and continue to be faithful and committed to their husbands. Generally, the stage of puberty brings about intense feeling for sexual relationships, and early puberty has increased sexual risks and minimized protective factors.

Evidence obtained from the discussion on disclosure to prospective sexual partners revealed shared and mixed reactions, others felt it is important to disclose to someone's sexual partner and others did not. Challenges identified include; ALWHA's concerns about whether to date HIV-uninfected or HIV-infected persons; whether and when to disclose one's sero positive status to a sexual partner. Naswa and Marfatia (2010) recommend that ALWHA may get assistance from counselling and supportive care in order to answer these questions and deal with their anxieties.

Lack of disclosure may lead to unsafe sex that may result in infecting partners or getting re-infected(Bauermeister et al., 2009; Ngwenya et al., 2011; Vagi et al., 2013).

Parents discourage disclosure of ALWHA's seropositive status due to fear of discrimination and stigmatization. Caregivers and ALWHA in Western Kenya define HIV and AIDS stigma as the main part of daily life for HIV infected and affected persons (McHenry et al., 2017). Similarly observations were made in Botswana by (Ngwenya et al., 2011). Stigma and discrimination were impediments to disclosure among ALWHA and that the negative consequences of disclosure may create conflict among ALWHA and their family members. The HCPs and parents/guardians expressed similar sentiments. They concurred that ALWHA as a population group are exposed to sexual risks that may result in spreading the infection and getting re-infected due to stigmatization .This may impede disclosure of their sero positive status to their partners(Ngwenya et al., 2011) and (Nthomang, Phaladze, Ngwenya, Oagile, & Kubanji, 2011)

Although the majority of ALWHA in this study reported sexual inactivity, it is of paramount importance that their sexuality needs be taken into consideration to prepare them for future challenges. According to Nleya and Segale (2015), teachers reported that children engaged in sex at a young age, and it was important that they are informed about sex and its consequences and should be properly equipped to protect themselves.

Comprehensive sexuality education (CSE) is essential for all young people because it influences positive attitudes that can in turn effect, positive intentions towards informed decicion- making. There is need for partnerships between teachers, HCPs and parents and guardians regarding CSE. In Malaysia, the researchers underscored the significance of parents participation in sexuality education of children (Khalaf, Low, Merghati-Khoei, & Ghorbani, 2014).The need to engage professionals,adolescents and caregivers/parents in establishing appropriate ways of conducting HIV research among ALWHA is also emphasized (Rennie et al., 2017).

Studies have revealed that young people prefer to discuss their sexuality matters with their grandmothers, maternal and paternal aunts. Thus cultural channels of communication need to be utilized. Lack of communication among young people and their parents creates barriers between parents and their children to discuss sexuality issues (IPPF, 2010)**.**

6. Conclusion

In conclusion, ALHWA face common challenges when it comes to accommodating sexuality issues. AHLWA's sexual inactivity will contribute to their sexual risk reduction. Thus as a strategic intervention there is need to create initiatives that promote abstinence from sex among young people. Health care providers mainly administered sex education while schools, parents and guardian were left behind. Implementation of the comprehensive sexuality education should be strengthened within the school curriculum.There is also need to empower parents/guardians in parent-child communication. A dialogue on sex education between parents and guardians enhances parenting abilities. Some ALHWA have been victims of gender based violence. Further research on gender based violence may contribute to reduction of sexual risk. While most ALHWA were abstinent, with time, there is need to address issues relating to their sexual reproductive issues and rights, intimacy and disclosure.

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Conflict of Interest

The authors declare that there is no conflict of interest.

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