SEXUAL AND REPRODUCTIVE HEALTH OF ADOLESCENTS AND YOUNG PEOPLE AFFECTED BY HIV:

RISK PATHWAYS AND PROMISING PROTECTIVE PROVISIONS.

KEY MESSAGES

- Exposure to sexual risk and sexual violence is high for both boys and girls. However, adolescent girls and young women experience higher rates of both sexual risk exposure and sexual violence compared to their male counterparts.
- Among adolescent girls and young women, rates of dual protection (the use of condoms and contraception) were low - with usage rates lower for those living with HIV compared to those who have not acquired HIV.
- Among those living with HIV, adolescents and young people who have been recently diagnosed with HIV have an increased vulnerability to sexual risk, compared to their peers who acquired HIV perinatally.
- Combinations of interventions reaching adolescents and young people consistently over time can reduce early sexual risk exposure. These interventions include school feeding programmes, parenting programmes, and violence prevention.
- Among adolescent girls and young women living with HIV, these interventions – alone and in combination – are linked to lower rates of sexual risk exposure.

BACKGROUND

By 2050, it is estimated that 282 million adolescents and young people, ages 10-24, will live in Eastern and Southern Africa (ESA), accounting for nearly 26% of the region's projected total population[1]. While this vibrant demographic offers great potential for their own and future generations, young people often encounter significant sexual and reproductive health (SRH) challenges that threaten their wellbeing. In 2021, HIV infections among those aged 15-24 years were estimated to account for 37% of total new infections among those older than 15 years in the ESA region[2].

Early sexual risk– including through marriage and sexual violence – can result in unintended pregnancies, poor mental health, and the acquisition of sexually transmitted infections, including HIV[3]. Existing gender inequities and social stigma associated with being sexually active during adolescence negatively impact the availability, accessibility, and use of critical SRH services, such as comprehensive sexuality education, contraception, safe abortion, and HIV prevention and treatment[4]. Adolescents and young people living with HIV require tailored support to mitigate SRH and HIV-interrelated risk.

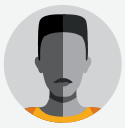
Understanding and meeting the SRH needs of adolescents and young people, including those living with HIV, is essential in supporting this generation to thrive. This brief summarises research findings on adolescents' and young people's experience of SRH from early adolescence, with a special focus on those living with HIV. It also highlights key programming considerations to support SRH and rights for this population.

METHODS

Findings are drawn from a 4-year (2014-2018) longitudinal cohort study. The dataset includes rich social science data. A variety of quantitative analysis techniques were used to investigate drivers of poor SRH outcomes, map risk pathways, and identify protective SRH interventions.

Recruitment: Adolescents (10-19 years) who initiated ART (n=1046) at one of the 53 public healthcare facilities in the Eastern Cape, South Africa were traced and approached for study participation. Adolescents not living with HIV (n=473) who were co-residents or living in neighbouring households were also recruited for study participation.

57% Female



43% Male

median age of 13.6 years

23% rural

70% living with HIV

1 https://esaro.unfpa.org/en/topics/demographic-dividend | 2 https://aidsinfo.unaids.org/ | 3 https://doi.org/10.3402/gha.v7.23717 | 4 https://www.unfpa.org/

DEFINITIONS

- **Sexual risk:** past year exposure to age-disparate sex, transactional sex, multiple sexual partners, or no condom use when they last had sex
  - Age-disparate sex: any sexual partner more than five years older.
  - Transactional sex: receipt of money or material gain (drinks, clothes, airtime, a place to stay, better marks at school, school fees, food, etc.) in exchange for sex.
  - Multiple sexual partners: two or more sexual partners.
  - No condom use when they last had sex: instance of not using a condom when they last had sex.
- **Parental/Caregiver monitoring or supervision:** specific, articulated expectations for adolescent's and caregiver's behaviour, and actions for keeping track of adolescents and ensuring their safety[5].
- **Adolescent-sensitive clinic care:** feeling respected and not being scolded while accessing family planning or SRH/HIV services.

FINDINGS

1. Adolescents and young people may start to engage in sexual exploration early in adolescence[6].

- The median age at the first intimate kiss and touching of someone else's private parts was 14.2 years for boys and 15.6 years for girls.
  - Boys were more likely to experience both kissing and touching someone else's private parts at a younger age than girls.
- About 89% of adolescents who had experienced kissing or touching of private parts reported having had sexual intercourse at some point in time.
- Among sexually active adolescents and young people, one-third (33%) knew their partner's HIV status.

2. Adolescent girls and young women reported higher rates of sexual risk exposure compared to their male counterparts[7].

- Overall, 1 in 4 adolescent girls and young women (26%) reported any sexual risk compared with 1 in 5 adolescent boys and young men (20%). Adolescent girls and young women were more likely to experience two or more forms of sexual risk.
- The higher rates of sexual risk exposure among adolescent girls and young women than their male counterparts were observed for both those living with HIV and those who are HIV-negative.

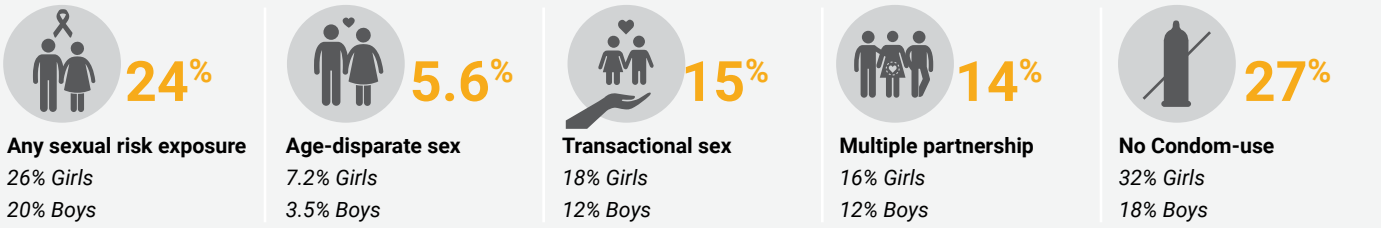
3. Over 80% of adolescent girls and young women were not using dual protection - with dual protection rates lower for those living with HIV[6].

- Approximately 17% reported using both condoms and hormonal contraception when they last had sex.
  - Approximately 32% reported using a condom when they last had sex and just under a half (48%), reported using hormonal contraception.
  - There was no difference in condom use when they last had sex by HIV status, however, adolescent girls and young women living with HIV were more likely to report hormonal contraception use compared to their peers who had not acquired HIV (55% vs 40%).
  - Rates of dual protection were 8% lower for those living with HIV than those who had not acquired HIV (10% and 18% respectively).
- Approximately 1 in 5 adolescent girls and young women reported not using either hormonal contraception or a condom when they last had sex (21%).

4. Adolescents and young people who recently acquired HIV, and who experience multiple vulnerabilities, are at greater risk of ART non-adherence and sexual risk exposure[8].

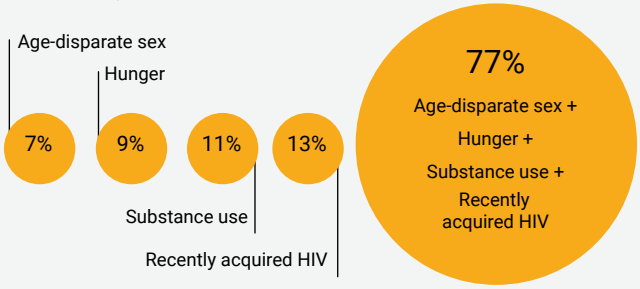
- Rates of ART non-adherence increased over the 4 year study period, from 45% to 63%.
- In an analysis examining the likelihood of ART non-adherence and exposure to any form of sexual risk, three factors were identified as negatively impacting the wellbeing of adolescents and young people.
  - Being in an age-disparate relationship, experiencing hunger, and substance use increased the probability of ART non-adherence and exposure to any form of sexual risk.
  - The likelihood of being ART non-adherent and exposed to sexual risk was higher among adolescents and young people who recently acquired HIV.
  - For adolescents and young people who recently acquired HIV, the presence of all three factors had a multiplying effect, with the probability of ART non-adherence and exposure to sexual risk increasing from 9% to 77%. [Figure 2]

Figure 1: Past year rates of sexual risk exposure among adolescents and young people



5 https://doi.org/10.1007/s10826-006-9082-5 | 6 https://doi.org/10.1002/jia2.25558 | 7 http://www.cssr.uct.ac.za/cssr/pub/wp/462 | 8 https://doi.org/10.1097/QAD.0000000000003044
9 https://doi.org/10.1016/j.chiabu.2022.105981 | 10 https://doi.org/10.1007/s10461-019-02735-x | 11 https://link.springer.com/article/10.1007/s10461-016-1539-y

Figure 2: Predicted risk of ART non-adherence coupled with any sexual risk exposure, among adolescents and young people living with HIV (controlling for covariates).



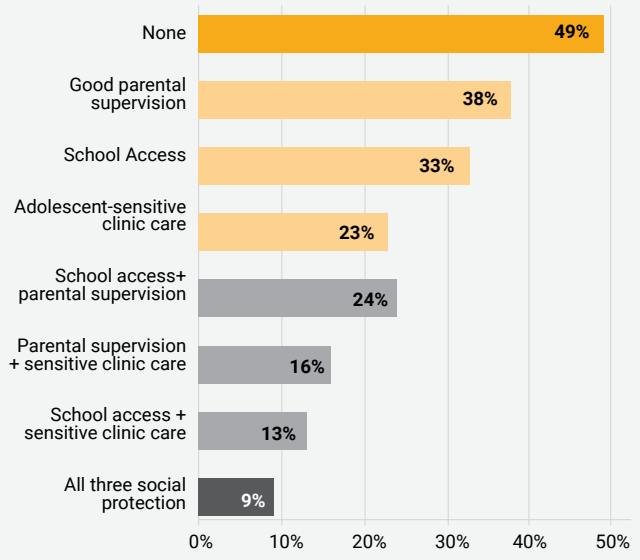
5. Beyond sexual risk exposure, rates of subjection to sexual violence were high for both sexes, and increased with age.

- Nearly a quarter of adolescents and young people had experienced sexual violence at some point in their lives. This included noncontact (unwanted showing of private parts), contact (coerced sexual debut, attempted and completed forced penetrative or oral sex) and transactional sexual exploitation.
- Girls reported higher rates of sexual violence than boys (28% vs 79%). The risk of exposure to sexual violence doubled for those aged 15 years or older.
- Rates of sexual violence did not differ by HIV status.

6. Consistent provisions of multisectoral packages over time can reduce early sexual risk exposure among adolescents and young people[10-11] [Figure 3].

- HIV prevention knowledge had the strongest effect on reducing sexual risk exposure. Those with a high HIV knowledge score were 57% less likely to report sexual risk exposure compared to adolescents and young people with a low HIV knowledge score.
- The individual effect of consistently receiving supportive parenting or living in an abuse-free household or receiving at least one meal a day at school individually was a reduction in the likelihood of sexual risk exposure by 45%.

Figure 3: Probability of no condom use when they last had sex by a combination of consistent provisions among adolescents girls living with HIV.



- This beneficial impact of consistently receiving these provisions intensified when individuals received a combination (two or more), which produced a greater reduction than any one single provision alone.
- In another analyses, receiving parental supervision, free schooling and adolescent-sensitive clinic care showed a strong additive effect in reducing no condom use when they last had sex, particularly among adolescent girls living with HIV.

WHAT DOES THIS MEAN FOR PRACTICE?

- Improving access, quality, and integration of SRH and HIV services for adolescents and young people, including those living with HIV, is critical. Particular efforts are needed to address the low uptake and inconsistent use of contraception and condom among adolescent girls and young women.
- Health services and systems need to account for the changing levels of sexual activity during adolescence, to minimise sexual risk exposure during this important developmental stage. SRH programming need to consider ways to identify and prepare adolescents and young people who are ready for sexual exploration but not yet sexually active. For example, providers can ask specific questions to encourage adolescents' knowledge of their partners' HIV status and to determine if romantic or intimate relationships are equitable.
- Adolescents and young people who have been recently diagnosed with HIV need additional support including risk reduction strategies, particularly for adolescent girls and young women.
- There is a need for consistent access to quality, reliable, and effective social behaviour change communication (SBCC) on SRH and HIV prevention. SBCC should go beyond models of HIV transmission and acquisition, be empowering, and include information on puberty, sexuality, consent, and healthy relationships.
- To improve SRH and HIV outcomes for adolescents and young people, programmes must move beyond single interventions to coordinate and deliver combination provisions including: integrated SRH and HIV services, social protection, violence prevention, parenting programmes, and SBCC. This will require strong multisectoral linkage and referral systems.

FUNDERS AND PARTNERS

University of Cape Town and University of Oxford. Sexual and reproductive health of adolescents and young people affected by HIV: Risk pathways and promising protective provisions: Policy Brief. 2023

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