

**EXAMINING SEXUAL AND REPRODUCTIVE HEALTH NEEDS OF
ADOLESCENTS INFECTED WITH HIV AT CHIEDZA CHILD CARE CENTRE,
HARARE, ZIMBABWE**

by

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DECLARATION

I declare that: **Examining sexual and reproductive health needs of adolescents infected with HIV at Chiedza Child Care Centre, Harare, Zimbabwe**, is my work and all the sources I have used or quoted have been acknowledged by means of complete references.

Lynnette Murimba

Signature:.....Date:.....

DEDICATION

I dedicate my dissertation to the following people:

- My mother who has been always my inspiration in my life and my father who passed away before he witnessed his children's success.
- My husband, Christopher Murimba and my two sons, Tanyaradzwa and Darren who could not spend quality time with me due to the time and effort required to complete this study.
- All adolescents living with HIV.

ABSTRACT

The study examined the sexual and reproductive health needs of adolescents infected with HIV and AIDS. This was a qualitative study that involved semi-structured interviews and observation. The sampling method used was purposive and it entailed 10 adolescents (4 boys and 6 girls) who are living with HIV at Chiedza Child Care Centre in Zimbabwe. This study revealed that adolescents' sexual and reproductive health needs are the desire to have sex, desire to have children, the need for prevention of unwanted pregnancy and care and treatment support. However, their knowledge of HIV and AIDS was inadequate. Adolescents also revealed their lack of proper information regarding their health care and treatment needs. However, adolescents illustrated an adequate knowledge of the services available for them for their health, treatment and care needs.

The study recommended that there is need to strengthen the provision of information and services on adolescents' sexual and reproductive health issues. The study also recommended that counsellors should improve their counselling skills so that they can empower adolescents living with HIV to be able to negotiate condom usage, matters of dating and handling relationships.

KEY WORDS: Adolescents living with HIV and AIDS, sexual needs, reproductive health needs, health care and treatment needs, youth friendly services, health care services.

TABLE OF CONTENTS	PAGES
Acknowledgement	ii
Declaration	iii
Dedication	iv
Abstract	v
Keywords	v
Table of contents	vii
List of figures	xi
List of tables	xi
List of acronyms and abbreviations	xi
	v

CHAPTER 1: INTRODUCTION	1
1.1 INTRODUCTION.....	1
1.2 BACKGROUND TO THE STUDY	2
1.3 PROBLEM STATEMENT	4
1.4 RESEARCH QUESTIONS	4
1.5 RATIONALE.....	5
1.6 AIMS OF THE STUDY	5
1.7 RESEARCH OBJECTIVES.....	6
1.8. DELIMITATIONS OF THE STUDY.....	7
1.9 LIMITATIONS OF THE STUDY.....	7
1.10 DEFINITION OF KEY CONCEPTS.....	8
1.11 OUTLINE OF THE STUDY	9
CHAPTER 2: LITERATURE REVIEW	10
2.1 INTRODUCTION.....	10
2.2 THEORETICAL FRAMEWORK.....	10
2.3 DEVELOPMENTAL STAGES OF ADOLESCENTS.....	14
2.4 FACTS ABOUT HIV AND AIDS	17
2.4.1 What is HIV?	17
2.4.2 What is AIDS?	18
2.4.3 Modes of HIV transmission	19
2.4.3.1 Sexual transmission of HIV infection	19
2.4.3.2 Mother to child transmission.....	19
2.4.3.3 Transmitting HIV through contaminated blood	19
2.4.4 Prevention of HIV transmission	20
2.4.4.1 Prevention of mother to child transmission.....	21
2.4.4.2 Condom use.....	22
2.4.4.3 Voluntary medical male circumcision	23
2.5 THE IMPACT OF HIV/AIDS ON ADOLESCENTS	23
2.6 SEXUAL AND REPRODUCTIVE HEALTH NEEDS OF ADOLESCENTS	24
2.6.1 Sexual needs of adolescents	25
2.6.1.1 Desire to have sex.....	26

2.6.1.2 Dating	28
2.6.2 Reproductive needs of adolescents living with HIV	28
2.6.2.1 Prevention of unwanted pregnancy	29
2.6.2.2 Childbearing	30
2.7 SEXUAL AND REPRODUCTIVE CHALLENGES OF ADOLESCENTS	
LIVING WITH HIV	32
2.8 PSYCHOLOGICAL AND EMOTIONAL RESPONSES OF DOLESCENTS	
LIVING WITH HIV	33
2.8.1 Disclosing HIV status	34
2.9 PROBLEMATIC SEXUAL BEHAVIORS OF ADOLESCENTS	35
2.10 HEALTH CARE SERVICES FOR YOUTHS.....	36
2.10.1 Existing health care services for youths	36
2.10.1.1 Youth Friendly clinics	38
2.10.2 Health care and medical treatment needs.....	39
2.10.2.1 Health care needs of adolescents living with HIV.....	40
2.10.2.2 Medical treatment needs	40
2.11 SOURCES OF INFORMATION FOR ADOLESCENTS LIVING WITH HIV.....	41
2.12 ADOLESCENTS' RIGHTS IN TERMS OF THEIR SEXUAL AND	
REPRODUCTIVE HEALTH.....	43
2.13 SUMMARY	44
CHAPTER 3: RESEARCH METHODOLOGY	46
3.1 INTRODUCTION.....	46
3.2 RESEARCH APPROACH	46
3.2.1 Qualitative research approach	46
3.2.1.1 Explorative approach.....	47
3.2.1.2 Descriptive approach.....	47
3.3 RESEARCH SETTING.....	48
3.4 UNITS OF ANALYSIS	48
3.5 SAMPLING PROCEDURE AND SAMPLE SIZE	49
3.6 DATA COLLECTION METHODS.....	50
3.6.1 Interview process	50

3.6.2 Semi-structured interviews	50
3.6.3 Observation	51
3.6.4 Preparation for data collection.....	51
3.7 DATA ANALYSIS	52
3.7.1 Data processing	52
3.7.1.1 Describing, classifying and interpreting	53
3.7.2 Coding process	53
3.8 CRITERIA FOR MEASUREMENT OF QUALITY	54
3.8.1 Reliability.....	54
3.8.2 Validity.....	54
3.9 LIMITATIONS OF THE STUDY.....	54
3.10 ETHICAL CONSIDERATIONS.....	55
3.10.1 Voluntary participation.....	56
3.10.2 No harm to the participants	56
3.10.3 Anonymity and Confidentiality	57
3.10.4 Deception of subjects	57
3.11 SUMMARY.....	58
CHAPTER 4: DATA PRESENTATION AND ANALYSIS	59
4.1 INTRODUCTION.....	59
4.2 ANALYSIS OF DATA FROM SEMI-STRUCTURED INTERVIEWS.....	59
4.3 PRESENTATION OF DATA FROM SEMI-STRUCTURED INTERVIEWS.....	62
4.3.1 Adolescents' understanding of HIV and sexual needs	63
4.3.1.1 Adolescents' inadequate knowledge about HIV and AIDS.	63
4.3.1.2 Challenges experienced by adolescents in intimate relationships.....	65
4.3.1.3 Comparison of the needs of HIV positive and HIV negative adolescents.	68
4.3.2 Adolescents' understanding of HIV and AIDS and reproductive health needs.70	
4.3.2.1 Inadequate knowledge of preventive and contraceptive methods.	70
4.3.2.2 Pregnancy and child bearing intentions amongst adolescents living with HIV.....	71
4.3.2.3 Adolescents' sources of information and support in regard to sexuality	72
4.3.3 Emotional experiences of adolescents living with HIV.....	74

4.3.3.1 Psychological distress experienced by adolescents	75
4.3.3.2 Family as a support system to alleviate negative emotions.....	76
4.3.4 Care and treatment needs of adolescents living with HIV	77
4.3.4.1 Adequate knowledge of the availability of services for adolescents	77
4.3.4.2 Challenges experienced by adolescents at health facilities.....	78
4.3.4.3 Insufficient information on the reproductive and sexual needs of adolescents	79
4.4 INTERPRETATION OF DATA.....	80
4.5 SUMMARY	82
CHAPTER 5: DISCUSSION OF THE FINDINGS.....	83
5.1 INTRODUCTION.....	83
5.2 DISCUSSION OF FINDINGS FOCUSING ON THE RESEARCH QUESTIONS	83
5.2.1 <i>Research question:What are the sexual and reproductive health needs of adolescents infected with HIV and AIDS?.....</i>	83
5.2.1.1 Adolescents' understanding of HIV and sexual needs	84
5.2.1.2 Adolescents' understanding of HIV and reproductive health needs	87
5.2.2 <i>Research question: What kind of information do young HIV positive people require for them to be able to make informed choices about their sexual and reproductive health needs?</i>	88
5.2.2.1 Adolescents' source of information and support about sexuality.	88
5.2.3 <i>Research question: To what extent are existing treatment, care and support services addressing the sexual and reproductive health needs of HIV positive young people?.....</i>	89
5.2.3.1 Care and treatment need of adolescents living with HIV.	89
5.3 DISCUSSION OF FINDINGS BASED ON OTHER EMPIRICAL RESEARCH THEMES	91
5.3.1 Psychological distress experienced by adolescents after HIV positive diagnosis.	91
5.4 COMMENTS ON THE AIMS AND OBJECTIVES OF THE STUDY	92
5.5 REVIEW OF THE THEORETICAL FRAMEWORK FOR THE EXAMINATION OF THE SEXUAL AND REPRODUCTIVE HEALTH NEEDS OF	

ADOLESCENTS LIVING WITH HIV.....	94
5.5.1 Review of the Social Constructionist Theory	94
5.5.2 SUMMARY	95
CHAPTER 6: SUMMARIES, CONCLUSIONS AND RECOMMENDATIONS	97
6.1 Introduction	97
6.2 SUMMARIES AND CONCLUSIONS	97
6.2.1 Adolescents’ understanding of HIV and AIDS and sexual health needs	97
6.2.2 Adolescents’ understanding of HIV and reproductive health needs	98
6.2.3 Emotional experiences of adolescents living with HIV.....	99
6.2.4 Care and treatment needs of adolescents living with HIV	100
6.3 RECOMMENDATIONS BASED ON THE FINDINGS OF THE STUDY	101
6.3.1 Adolescents’ understanding of HIV and AIDS and sexual health needs	101
6.3.2 Adolescents’ understanding of HIV and reproductive health needs	101
6.3.3 Emotional experiences of adolescents living with HIV.....	101
6.3.4 Care and treatment needs of adolescents living with HIV	102
6.4 RECOMMENDATIONS FOR FURTHER STUDY	102
6.5 SUMMARY.....	102
7. REFERENCES.....	103

APPENDICES

Appendix A: UNISA Ethics Committee Approval.....	119
Appendix B: Access letter to Chiedza Child Care Centre.....	120
Appendix C: Consent form for participation.....	121
Appendix D: Assent form for participation	122
Appendix E: Interview schedule.....	123
Appendix F: Chiedza Child Care Centre Approval letter.....	126

LIST OF FIGURES

Figure 1: Map of Zimbabwe.....1

LIST OF TABLES

Table 4.1: Themes and sub- themes.....61

LIST OF ACRONYMS AND ABBREVIATIONS

‘ABC’	Abstain, Be faithful, Condomise
AIDS	Acquired Immune Deficiency Syndrome
ALWHI	Adolescents living with HIV
ARV	Antiretroviral
HIV	Human immuno-deficiency virus
MOESC	Ministry of Education Sport and Culture
MOHCW	Ministry of Health and Child Welfare
PMTCT	Prevention of Mother to Child Transmission
STI	Sexually Transmitted Infection
UNAIDS	United Nations Programme on AIDS
UNISA	University of South Africa
UNGASS	United Nations’ General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children’s Fund

UNFPA United Nations Population Fund

VCT Voluntary Counseling and Testing

WHO World Health Organisation

CHAPTER 1: INTRODUCTION

1. INTRODUCTION

The study examined sexual and reproductive health needs of adolescents living with HIV. The Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) pandemic is one of the greatest challenges confronting Zimbabwe. The virus affects and destroys the immune system and people become more prone to opportunistic infections (Lindsay, 2001:4). The high prevalence of HIV/AIDS poses major challenges for young people and their families. HIV was first diagnosed in Zimbabwe in 1985 and only few people were affected and infected (MOHCW, 2005:1). However, since that time, HIV and AIDS have moved from being an individual problem to being everyone's problem as it has affected the lives of many families in Zimbabwe.

Zimbabwe is a landlocked country in Southern Africa. It borders Zambia to the north, Botswana in the south west, Mozambique in the east, South Africa in the south, and Namibia in the west. The largest city, Harare is the capital city of Zimbabwe.

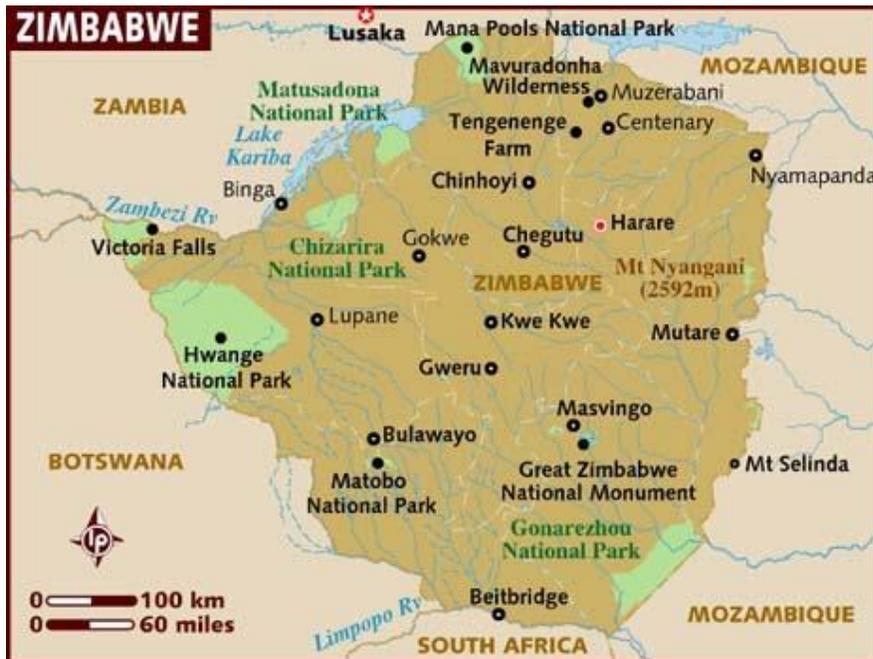


Figure 1: Zimbabwe map.maps.google.co.za

1.2 BACKGROUND TO THE STUDY

There are more than 1 billion adolescents (aged 10-19) in the world today and their importance as a demographic group is increasing, especially in the developing world as the age distribution of populations changes over time (UNFP, 2003). Despite their numbers, they have not traditionally been considered a health priority since they have lower mobility and mortality than younger and older groups. Nonetheless, in areas such as sexual and reproductive health, adolescents suffer disproportionately.

The high prevalence of HIV and AIDS poses major challenges for young people and their families. Globally, 34 million people are living with HIV and AIDS (UNAIDS, 2011). According to the UNICEF report (2013), Sub-Saharan Africa is more heavily affected by HIV and AIDS than any other region of the world. An estimated 22.5 million people (68% of the global total) were living with HIV in this region at the end of 2010 and approximately 1.8 million additional people were infected with HIV during that year. In the same year, the AIDS epidemic in Africa claimed the lives of an estimated 1.5 million people in this region, including Zimbabwe. According to national HIV estimates for 2010, HIV prevalence among young people in Zimbabwe aged 15 and more was 14.3%.

Young people aged 10-24 comprise 37% of the Zimbabwean population (Zimbabwe National Family Planning, 2002:2-4). Many migrate to Harare in search of economic opportunities, and come into contact with other adolescents living with HIV. The Chiedza Child Care Centre in Harare and other several organisations that support HIV and AIDS orphans have registered a fairly substantial number of adolescents living with HIV, who contracted the disease through sexual contact or injecting themselves with drugs, while others have been infected since birth.

The health care of young people is a much neglected field, particularly in developing countries (Kibel, 1995:111) like Zimbabwe. Worldwide, efforts to provide sexual and reproductive health services to HIV positive adolescents are impeded by weak and fragmented health systems and sexual taboos, gender inequalities and HIV stigma and

discrimination. In Zimbabwe, there is culture of silence on issues relating to reproductive health. For those with access to treatment, a diagnosis of HIV infection is no longer an imminent death sentence; although still incurable, HIV and AIDS can be managed as a chronic disease. However, in Zimbabwe, there is an assumption that teenagers are too young to be given sexual health information and services, thus denying them the opportunity to acquire practical knowledge and skills to protect themselves from re-infection, pregnancy, unsafe abortions and child birth.

The Government of Zimbabwe has introduced an HIV and AIDS curriculum in schools at both primary (Grades 4 -7) and secondary schools (Forms 1-6).The curriculum was developed in 1993 and revised in 2003. The purpose of HIV and AIDS education and life skills in schools is to provide information about HIV to learners, and to promote healthy lifestyles, positive values, attitudes and responsible behavior among young people (MOESC, 2003:5). This is in line with the Zimbabwean National HIV and AIDS policy which states that children should have access to the knowledge and life skills that are required to avoid infection (MOESC, 2003:22). However there is a gap in the services provided to adolescents who are already living with HIV.

The Chiedza Child Care Centre is a non-profit organisation which runs a community home-based care programme for children and adolescents who are affected and infected with HIV and AIDS. Most of these adolescents have been living with HIV since birth and are aware of their HIV status. The centre operates in the crowded urban centres of Mbare, Sunningdale and Ardbennie/Prospect. It has registered about 500 children, of whom 40 are adolescents living with HIV in 2010. Adolescents receive services like material and nutritional support from the Centre. They are also helped with their homework by the counsellors. There are no health services at the centre, therefore adolescents visit the nearest clinics and hospitals in the community to collect their medication and regular checkups. The researcher worked with these adolescents for two years, and realised that HIV positive adolescents have needs which are not being addressed by the centre and other organisations that support them. Constant pregnancies amongst adolescents living with HIV have also raised concerns about the

adequacy of existing reproductive health services. There is a lack of knowledge about what these adolescents' sexual and reproductive health needs are and how to address them through service programmes.

1.3 PROBLEM STATEMENT

The researcher observed that sexual and reproductive health needs of adolescents living with HIV are not addressed at the centre. In the context of this study, adolescents living with HIV have the right to fulfill their sexual needs and experience parenthood. Therefore, acknowledging sexual and reproductive health needs is essential to vindicate the basic human rights of HIV positive people. At the same time, because most HIV infection worldwide occurs as a result of sexual intercourse, global HIV prevention efforts must address the sexual and reproductive needs of people living with HIV. For both these reasons, meeting the sexual and reproductive health service needs of adolescents with HIV should be considered a global priority.

The researcher observed that sexual and reproductive health needs of adolescents living with HIV were not observed as the centre focuses on the provision of nutritional and material support. It is in light of these observations that the researcher developed an interest in examining the sexual and reproductive health needs of young people who are HIV positive.

1.4 RESEARCH QUESTIONS

The following research questions guided the study:

- What are the sexual and reproductive health needs of adolescents infected with HIV?
- What kind of information do young HIV positive people require for them to be able to make informed choices about their sexual and reproductive health needs?
- To what extent do existing treatment, care and support services address the sexual and reproductive health needs of HIV positive young people?

1.5 RATIONALE

Since the first case of HIV was diagnosed in 1981, global prevention and treatment efforts have been directed to combating its impact on society (MOHCW, 2003). With the first case being diagnosed in Zimbabwe in 1985, there has been an effort to address the sexual and reproductive health needs of young people that have been living with HIV for a long time (MOHCW, 2003). While several different organisations in Zimbabwe are involved in HIV and AIDS activities, behavioural change, especially among young people is still insufficient as many engage in unprotected sexual intercourse ((MOHCW, 2003).The city of Harare has been strongly affected by HIV, as it is a centre of attraction for young people who have dropped out of school and are looking for work. Adolescents are constantly in contact with others who are either HIV positive or negative.

This research study is likely to contribute to an increase in the level of awareness of the sexual and reproductive health needs of adolescents living with HIV. It also aims to facilitate a better understanding of the reproductive health needs of male and female adolescents living and growing up with HIV and to help them to make informed decisions. The study also seeks to advocate an overall health care system that recognises the importance of catering for the needs of HIV positive adolescents in its programmes.

1.6 AIMS OF THE STUDY

The aim of this study is to examine the sexual and reproductive health needs of adolescents infected with HIV with a view to empower adolescents with information and knowledge on their sexual and reproductive health needs. They need to know about services such as Prevention of Mother to Child Transmission (PMTCT) and other antenatal health care services in order for them to make informed choices. The study also aimed to examine the availability and accessibility of reproductive health services for HIV positive adolescents. Furthermore, there is a need for health care education that

will enable them to make informed decisions about fertility, unwanted pregnancies, sexually transmitted infections and self-re-infection.

This study recommended that interventions should be based on the identified needs so that the level of existing services can be upgraded. This might help to integrate young people's sexual and reproductive issues into the existing treatment, care and support programmes that serve them.

1.7 RESEARCH OBJECTIVES

- To identify the sexual and reproductive health needs of adolescents living with HIV.
- To determine whether adolescents living with the HIV have knowledge of their sexual and reproductive health needs.
- To examine the availability and accessibility of reproductive health services for HIV positive adolescents in order for them to make informed decisions.
- To provide recommendations on how best to address the sexual and reproductive needs of HIV positive adolescents.

1.8. DELIMITATIONS OF THE STUDY

The sample population selected for this study was limited to adolescents living with HIV and registered with Chiedza Child Care Centre in Zimbabwe. As such, the ability to generalize the findings to the entire population of the Chiedza Child Care Centre and other community based organisations in Zimbabwe is severely limited. The sample however, is reflective of the characteristics of the target populations of community based organisations in Zimbabwe and thus can be generalised.

The sample population was also limited to adolescents who had disclosed their HIV status to one of their family members and to counsellors at the centre. This was to ensure provision of continuous support to participants who might require it as it was anticipated due to the sensitive nature of the study.

1.9 LIMITATIONS OF THE STUDY

According to Fisher et al. (2002:117), there is no such thing as a perfect study. This study was conducted among a small number (10) of adolescents living with HIV who are receiving support from the Chiedza Child Care Centre. The researcher identified the following limitations:

Study site: The study was restricted to a specific child care centre in Zimbabwe. The results of this study are therefore not fully representative of other centres in the country.

Sample size: The sample for this study was very small; only ten participants were interviewed as most of the adolescents were not willing to participate due to the sensitive nature of the study. Its findings should therefore be interpreted with caution as the general centre population was not fully represented.

1.10 DEFINITION OF KEY CONCEPTS

Adolescents

Adolescence is a transitional stage between childhood and adulthood. WHO (2010) defines adolescents as a period of biological, social, emotional and cognitive development which, if not negotiated satisfactorily, can lead to emotional and behavioral problems in adult life. According to Nash et al (1990: 56), adolescence begins at 11-13 years of age (early stage) and moves to 15-18 years (middle stage) and 19-22 years of age (late stage). In this study, the terms adolescents, teenagers and young people are used interchangeably to refer only to adolescents aged 15-19 (middle stage).

Reproductive Health

This is a state of complete physical, mental and social well-being and not merely the absence of disease or illness in all aspects related to the reproductive system, its function and processes, UNFPA (2008).

Sexual health

UNFPA (2008) defines sexual health as a state of physical, mental and social well-being in relation to sexuality. It requires possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

HIV and AIDS

The Human Immunodeficiency Virus (HIV) is the virus that causes AIDS. According to Army (2006: 57), this virus is passed from one person to another through blood-to-blood and sexual contact. HIV infection does not mean that one has AIDS. AIDS occurs when the HIV infection has badly damaged the immune system, a process that may take years.

Acquired Immune Deficiency Syndrome (AIDS) is an infectious disease caused by HIV. The virus affects and destroys the immune system and people become prone to opportunistic infections and illnesses. No vaccine is currently available to prevent HIV infection or to cure it.

Examine

Means to study or analyse, observe carefully and critically so as to elicit facts or information.

1.11 OUTLINE OF THE STUDY

Chapter 1 introduced the study and described the background to the study, research problem, aims of the study, objectives, delimitation of the study and limitations of the study.

Chapter 2 reviews the relevant literature on the sexual and reproductive health needs of adolescents globally, in Africa and in Zimbabwe.

Chapter 3 outlines the methodology used in the study, including the population and sample, and data collection methods and ethical considerations will be discussed.

Chapter 4 presents the data analysis and interpretation.

Chapter 5 discusses the findings of the study.

Chapter 6 provides summaries, conclusions and recommendations based on the research findings.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

This chapter reviews the literature on the sexual and reproductive health needs of young people living with HIV from a global, regional and national perspective so as to place it in context. The theoretical framework for the study, social constructionism theory, is outlined. The chapter also highlights adolescents' developmental stages and how HIV affects their normal development.

Facts about HIV are presented, including modes of transmission and prevention of HIV. This is followed by the impact of HIV on adolescents, focusing on adolescents living with HIV. The sexual and reproductive health needs of adolescents are also discussed, with an emphasis on the needs of adolescents living with HIV. The challenges faced by adolescents living with HIV are identified, as well as the psychological problems encountered by these adolescents. The health care and treatment services available for adolescents living with HIV are also examined. The chapter concludes by discussing the sources of information for adolescents as well as their rights.

2.2 THEORETICAL FRAMEWORK

The social construction theory was adopted to understand the sexual and reproductive health needs of adolescents living with HIV. According to the social construction perspective, human beings' experiences are usually based on the way they interpret the world and themselves, thus essentially building the realities in which they live (Burr, 1995:50).

This theory is rooted in the ideas of French philosopher, Michael Foucault (1978). Foucault posited that knowledge is constructed through social interpretation; that is, what we perceive as reality has been shaped by a system of social, cultural and interpersonal processes. People construct their knowledge of the world (Foucault,

1994:68). Furthermore, it is through daily interactions between people in the course of social life that our version of knowledge is fabricated. Social interactions of all kinds, particularly language, are of great interest to social constructionists. Lock and Strong (2010:6) define social constructionism as being concerned with meaning and understanding as a central feature of human activities. With respect to meaning, socio-cultural processes are specific to particular times and places. This means that, the meaning of particular events and our ways of understanding them vary in different situations.

According to Burr (1995:54), social constructionism theory is guided by the following assumptions:

- People construct stories, ideas and theories to help them deal with reality.
- People from varying socio-cultural traditions are instrumental in creating the discourses they use to define themselves. Thus, people are self-defining and socially constructed in their shared lives.
- The constructs we make of the world around us can only be made through interaction with others. Knowledge only exists when it is shared with another person.
- The importance of language i.e., the meanings of words are specific to languages and cannot be translated without loss of meaning. Because all knowledge is the result of negotiation through interaction, language is a crucial factor. In our society we give meaning to events by describing them with words. In short, social constructionism focuses on the creation of meaning, and on the existence, development and role of joint meaning.

Based on the above assumptions, this theory facilitated an understanding of the social and cultural norms, values and beliefs in Zimbabwean societies that influence, guide or control sexual behaviours among adolescents in their everyday lives (Robson, 2002: 54). Thus, the study acknowledges that the phenomena of adolescent sexual behaviours and their meanings are not objective, but are created through human social interaction, through a process of socialisation, negotiation and renegotiation (Greenwood, 1994:93).

Furthermore, social constructionism is based on shared meanings to describe, explain or account for the understandings attached to customised social beliefs, attitudes, values and actions which are communicated symbolically in a society (Gergen, 2003:87). An in-depth understanding of the socio-cultural factors that influence adolescent sexual and reproductive behaviours could facilitate the design of effective and appropriate health interventions for adolescents rather than basing such interventions on health professionals' knowledge which is sometimes not effective. As Kunitz (1990:106) observed, many health problems in both rich and poor countries are still not properly understood. Understanding their incidence, prevalence, and distribution, as well as their prevention and treatment, may require intimate understanding of particular people and settings. In other words, some health professionals' attitudes of 'we know what is best for you' might result in inappropriate interventions that do not address the health needs of adolescents (Armstrong, 1989:3). Due to its focus on the local context, the social constructionist approach would help in designing effective health promotion interventions for adolescents in Zimbabwe.

Berger and Luckmann (1996:134) concur that all knowledge, including the most basic, taken-for-granted common sense knowledge of everyday reality, is derived from and maintained by social interactions. When people interact, they do so with the understanding that their respective perceptions of reality are related, and as they act on this understanding their common knowledge of reality is reinforced. Since this common sense knowledge is negotiated by people, human typifications, significations and institutions come to be presented as part of an objective reality, particularly for future generations who were not involved in the original process of negotiation.

Based on the above assumptions, constructions of adolescent sexual health and reproductive needs are central to the discourse of sexual and reproductive health promotion. The meanings of sexual and reproductive needs vary across cultures and ethnic groups. Due to these variations, the lives and sexual and reproductive health needs of adolescents may vary considerably across different groups, and programmes

and interventions need to be designed to take this diversity into account (UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction, 2002:3).

Moore & Rosenthal (2006:34) also support the notion that adolescent sexuality is subject to a complex web of influences, including the physical and psychological characteristics of the individual, and the historical and ecological setting. The decisions that young people make about their sexuality, the behaviours they engage in, and their values and attitudes are shaped by the particular context in which they live their lives. As such, understanding the conceptualisations of adolescence and sexual health in a specific cultural context is necessary for effective sexual and reproductive health programmes.

Social constructionists also interpret sexual orientation as arising from interactions between people, the way they use language and 'discourses' or underlying assumptions of culture (Moore and Rosenthal, 2006:36). Foucault argued that sexuality is not merely a biological drive whose character is the same across time and culture, but is a social construct. The meaning is derived from the language; each institution in a society has a discourse about sex, a way of thinking and talking about the broad array of behaviours and people who are involved in sexual expression (Lock and Strong 2010:6). The theory emphasises an individual's active role in constructing reality, while being guided by his or her culture. In the context of this study, views that adolescents should not engage in sexual relationships before marriage and that they should not seek family planning services, as this means that they are indulging in sexual behaviour which is unacceptable to the society, are socially constructed.

Gagnon and Simons (1973:301)'s notion of sexual scripts is another example of social constructionists' approach to sexuality. Sexual scripts are defined as social prescriptions for sexual behaviour that exist in any society and the way we behave in accordance with these prescriptions (Moore and Rosenthal, 2006:38). Every culture develops scripts for how to behave, for example, as a man or a woman or as child or an

adult. For instance, in Zimbabwe if you are a woman or a girl you cannot negotiate the use of a condom during sexual intercourse (Jackson, 2002:122). This is problematic when a young woman is aware of her HIV status and wants to avoid transmission to her partner.

In the context of this study, the notion that adolescents who access reproductive health services are promiscuous, resulting in them being frequently turned away from clinics in favor of adults, contributes to their situation; this is seen as a form of pathology. Therefore, in this study, the researcher examines the views and needs of adolescents living with HIV in order to hopefully change the way they are seen in society. In this way, the realities of their sexual and reproductive needs and services for adolescents can be 'deconstructed' and new meanings of realities can be co-created by the researcher and the participants (Coale, 1994:54).

2.3 DEVELOPMENTAL STAGES OF ADOLESCENTS

Adolescence is defined as a developmental period between childhood and adulthood. This is the time when adolescents experience physical, psychological, cognitive, emotional and social changes (Abott, 2001:105). The WHO (2004) defines adolescence as the period between 10 and 18 years old. Nash (1990:139) describes early adolescence stage as the stage between the ages of 11 and 15, middle adolescence as being between 15 and 17 years old and late adolescence as 17 to 20 years old. This study focussed on adolescents between the ages of 15 and 19. Adolescents experience the following changes during their period of development:

Physical development

During puberty, adolescents develop primary and secondary sex characteristics, the capacity for reproduction, and a mature physical appearance (Neinstein and Kaufman, 2002:146). Girls start menstruation and boys experience changes such as a deepening of the voice, pubic hair growth and first ejaculation.

Biologically, perinatally HIV infected adolescents go through puberty significantly later and are smaller in stature than their HIV negative peers (Buchacz et al., 2004:75). These delays can cause psychological distress. For example, girls' menstruation might also start only after 15 years of age (Buchacz et al., 2004:76). Both boys and girls experience delays in growth as the virus can change the hormonal systems that are responsible for growth and puberty. HIV can also leave physical marks, such as scarring from skin infections which may impact an adolescent's sense of self. These physiological events also have psychosocial implications, as adolescents adjust to their changing bodies, redefine their self-image, and learn to manage their emerging sexuality.

Psychological development

Erickson (1959), cited in Manaster (1989:256) describes eight stages of psycho-sexual development in human beings. His fifth stage, labelled 'identity versus role confusion', is the most critical for adolescents. According to Erickson, adolescents are confronted by the crisis of answering the question "who am I?" in order to provide themselves with an identity (Moshman, 2005:47). Adolescents undergo an identity crisis in which they examine values and make decisions about their life roles, for example, deciding to become sexually active. Bennett (2001:203) describes adolescence as a period in which young people must negotiate fundamental psychological tasks in their development towards maturity and independence. The major developmental tasks of adolescents are:

- Development of realistic, stable, positive self-identity
- Achieving independence from parents and other adults
- Formation of sexual identity
- Negotiate peer and intimacy relationships
- Formation of their own moral value system
- Identity development and identity crisis.

An adolescent living with HIV will struggle with his or her illness and this can cause confusion in establishing own identity. Psychologically, the virus has been also associated with neuro-cognitive delays and a high prevalence of several mental illnesses (Nelson and Cole, 2007).

Social development

Social development implies becoming aware of the needs of others and one's own duties and privileges as a member of society (Nash et al., 1990:138). At a social level, parent-child relationships are transformed, as adolescents learn to make decisions independently and function autonomously (Laurence and Steinberg, 2009:104). Simultaneously, the peer group becomes increasingly important as young people seek intimacy and acceptance outside of the family unit (Crockett and Petersen, 1993:37). Progression through school, entry into the labour force and the adjustments which accompany these events, also occur during this period. These local interactions take place within wider societal frameworks, which carry dominant streams of expectations, values and ideologies. Adolescents must learn how to navigate these structures in order to become successful and active participants in society.

However, in adolescents living with HIV, independence from parents, peer acceptance and participation in society are complicated by the desire for secrecy about their status and fears of stigma or rejection (Menon et al., 2007). In addition to dealing with these direct obstacles to standard developmental processes, HIV positive adolescents are faced with more challenges than those who are HIV negative. The fear of dying may also have a negative impact on their social and emotional development.

Emotional development

Delamater (2006:78) describes emotion as a subjective feeling state, often accompanied by facial and bodily expressions and having arousing and motivation

properties. Adolescents experience a growing sense of awareness of their feelings. They experience emotions such as anger, joy, happiness, sadness, love, affection, guilt, fear, mood swings, anxiety and loneliness (Louw, 2007:267). All adolescents experience these feelings but those living with HIV must cope with the stressors associated with their illness including status disclosure, fear of dying, stigma and isolation which have a negative impact on their emotional development.

According to Knut-Inge (2008:235), the transition from childhood to adulthood for young people living with HIV is interlaced with concerns about medication regimens, doctor's appointments, life expectancy, disclosure, and transmitting HIV to others. Of course, the virus poses similar concerns for all HIV positive individuals at other life stages. However, the extensive changes that characterise adolescence render the second decade of life particularly unique. The combination of ordinary developmental issues and HIV-related worries creates a distinctive environment, which frames adolescents' daily experiences and their interactions with health care systems.

2.4 FACTS ABOUT HIV AND AIDS

2.4.1 What is HIV?

Human Immunodeficiency Virus (HIV) is the virus that causes AIDS. This virus is passed from one person to another through blood-to-blood and sexual contact. Nana (2005:52) describes HIV as a retrovirus disease transmitted primarily through sexual intercourse but also through infected blood from mother to newborn child. According to Gallo (2006: 56), HIV was discovered in the early 1980s by scientists in France and America. The first case in Zimbabwe was diagnosed in 1985.

HIV infection affects the immune system which is the body's defense system against infections. The immune system produces cells called antibodies which kill or fight microorganisms. HIV infects and eventually destroys special cells in the immune system

called lymphocytes. These cells carry antigens called CD4 and T-cells. The weakness of the immune system is called immunodeficiency (WHO, 2001:4).

Baptista (2000: 22) states that HIV is part of the group of smaller living organisms that need to infect other cells in order to develop and multiply. During the multiplication of cells, HIV can undergo changes which can provide resistance to one or more medications, making the virus as a whole resistant to treatment. HIV survives by replicating inside CD4 blood cells, the very cells which normally protect the body against infection. Within a few weeks of entering the body, HIV spreads rapidly and may cause 'flu like symptoms and a rash, both of which disappear after a few days. The viral load, which is the amount of virus in the blood, falls and most people do not show symptoms for several years. During this period the viral load slowly rises again and the number of CD4 cells falls, making the individual increasingly susceptible to opportunistic infections such as tuberculosis that people without HIV are more likely to resist (WHO, 2004:6). As the immune system of the HIV person slowly weakens, the person progresses towards AIDS. Most of the adolescents who participated in this study were perinatally infected, meaning that they were born with HIV.

2.4.2 What is AIDS?

AIDS stands for Acquired Immune Deficiency Syndrome caused by HIV. According to Van Dyk (2005:3), this disease is 'acquired' because it is inherited. Immunity is the body's natural ability to defend itself against infection and disease. A 'deficiency' is a shortcoming, a weakening of the immune system so that it can no longer defend itself against passing infections. A 'syndrome' is a medical term for a collection of specific signs and symptoms that occur together and are characteristic of a particular condition. Therefore, AIDS is not a specific illness but a collection of many different conditions that manifest in the body because HIV has weakened the body's immune system and it can no longer fight diseases. Van Dyk (2005:3) defined AIDS as a syndrome of opportunistic diseases, infections and certain cancers, each or all of which has the ability to kill the infected person in the final stages of the disease. Presently, there is no cure for HIV and AIDS.

2.4.3 Modes of HIV transmission

HIV can be transmitted through unprotected sexual intercourse with an infected partner or through contact with infected blood, semen, or cervical or vaginal fluids. Unprotected sexual intercourse is the most common mode of transmission of HIV worldwide (WHO, 2004:5). Injecting equipment such as needles, skin piercing with equipment contaminated with HIV, and mother to child transmission which occurs through pregnancy, labour and delivery are other ways in which HIV can be transmitted.

2.4.3.1 Sexual transmission of HIV infection

HIV is sexually transmitted primarily through unprotected, penetrative vaginal or anal intercourse. According to Jackson (2002:83), 70% of HIV infection worldwide is due to sexual intercourse between men and women. HIV is transmitted when the virus enters a person's bloodstream through the body fluids of an infected individual.

2.4.3.2 Mother to child transmission

HIV can also be transmitted from the infected mother to her baby via the placenta during pregnancy, through blood contamination during childbirth or through breastfeeding.

In October 2000, the WHO recommended that Voluntary Testing and Counseling (VCT) and Anti-Retroviral Virus drugs (ARVs) should be introduced in all maternal child health programmes to prevent HIV. The Zimbabwean government showed its commitment to this strategy in its 1999 HIV and AIDS policy, which adopted prevention of mother to child transmission (PMTCT) as one HIV prevention strategy. However, when this policy was implemented, some children had already been born with HIV (MOHCH, 2005: 6).

2.4.3.3 Transmitting HIV through contaminated blood

The virus can be transmitted from one person to another when a person receives HIV contaminated blood in a blood transfusion, or when he or she uses needles that are

contaminated with HIV infected blood to inject drugs (Van Dyk, 2005:27). HIV can be also transmitted when one is injured with blood contaminated needles, syringes, razor blades and other sharp instruments. The re-use of instruments used in traditional African healing and some cultural practices such as circumcision and sacrification also poses the risk of HIV transmission.

2.4.4 Prevention of HIV transmission

As there is no cure for HIV, the best defense against infection is prevention. Effective prevention requires accurate knowledge of how people behave in different situations and under what conditions they will be prepared to change their sexual behaviour (Van Dyk 2005:89). The only 100% effective way of preventing sexual transmission of HIV is total abstinence from sex; however this is not realistic for young people. HIV can also be transmitted from a mother to her baby during pregnancy, labour and delivery and later through breastfeeding (Van Dyk, 2005:23).

Efforts to prevent the spread of HIV in Zimbabwe have been spearheaded by the National AIDS Council (NAC), non-governmental, religious and academic organisations (WHO, 2004). The major prevention strategies in Zimbabwe include the use of condoms, PMTCT and voluntary male circumcision. Although mortality rates have also played a large part in reducing the number of people living with HIV among the population of Zimbabwe, it is believed that prevention programmes aimed at behaviour change and PMTCT have also been instrumental in bringing about a decline in HIV prevalence (UNFPA, 2003). Prevention schemes have been significantly expanded since the turn of the millennium, but remain critically under-funded. Three methods of prevention will be discussed, PMTCT, condom use and voluntary circumcision.

2.4.4.1 Prevention of mother to child transmission

In 2010, HIV prevalence among pregnant women in Zimbabwe (aged 15-49) was 16% and mother-to-child transmission accounted for the highest number of HIV infections after heterosexual sex, the primary route of transmission (UNGASS, 2010). In Zimbabwe, more than 15 000 children were infected with HIV every year, the majority through mother to child transmission (UNFPA, 2011). As with voluntary counselling and testing (VCT), the provision of services to prevent the transmission of HIV between mothers and their children during pregnancy was gradually scaled up. A PMTCT pilot programme was launched at four sites in 1999 and the programme has now been rolled out nationwide. It aims to provide pregnant women with free VCT and give them access to antiretroviral drugs, which significantly decreases the chances of mother to child transmission.

In 2011, UNAIDS produced 'The Global Plan towards the elimination of new infections among children and keeping their mothers alive' (UNAIDS, 2011). The plan recognises the need to consider different ways of preventing mother to child transmission, and to integrate HIV interventions with other family planning; maternal health and child health services. The following are broader strategies to prevent transmission of HIV from mother to child.

- Preventing HIV infection among prospective parents - making HIV testing and other prevention interventions available in services related to sexual health such as antenatal and postpartum care and focusing on preventing HIV in women of a child-bearing age.
- Avoiding unwanted pregnancies among HIV positive women - providing appropriate counselling and support to women living with HIV to enable them to make informed decisions about their reproductive lives and ensuring that contraception is available to those who want it.
- Preventing the transmission of HIV from HIV positive mothers to their infants during pregnancy, labour, delivery and breastfeeding.

- Integration of HIV care, treatment and support for women found to be positive and their families.

Pregnant women who require antiretroviral treatment will usually be advised to take it, beginning either immediately or after the first trimester. Their newborn babies will usually be given a course of treatment for the first few days or weeks of life, to lower the risk even further. Adolescents living with HIV need to have this information so that they can plan to have children without fear of having HIV positive babies.

2.4.4.2 Condom use

In 2003, the Zimbabwean government introduced the 'ABC' campaign that is, abstain from sex or delay first sex, be faithful to your partner and use condoms to try to prevent HIV transmission. Increased condom use has been recognised as a major factor in the decline in Zimbabwe's HIV prevalence rate (UNGASS, 2010). The number of free condoms distributed by the government, NGOs and social marketing campaigns trebled during the 1990s, and increased further in subsequent years. The number of condoms sold through the private sector has also increased dramatically, and most condoms are now purchased rather than acquired free of charge, suggesting that condom use has become more accepted in Zimbabwean society (UNAIDS, 2007). The UNAIDS report also indicated that condoms are highly effective in preventing HIV infection if used consistently and correctly. However the 'ABC' campaign did not go a step further in considering people who were born with HIV.

Furthermore, sales and distribution of female condoms in Zimbabwe are among the highest in the world (Centre for Health and Gender Equity, 2011). The use of this prevention method has been partly implemented by hairstylists from 500 salons in low-income settings, who have been trained to distribute female condoms and answer women's questions about them.

2.4.4.3 Voluntary medical male circumcision

There have been efforts in Zimbabwe to scale up voluntary medical male circumcision (VMMC) as a prevention method. Circumcision can reduce the chance of a man becoming infected with HIV through heterosexual transmission by up to 60% (UNAIDS, 2011). Although only a small proportion of the Zimbabwean population practices circumcision as a cultural rite, following large-scale campaigns about the preventative effects of circumcision, a survey showed that 52% of men were prepared to undergo the procedure. The government has set a target to circumcise 1.2 million men by 2015 and Zimbabwe has had one of the largest increases in VMMC of any country, with the number of operations increasing from 2 801 in 2009 to 11 176 in 2010 (WHO and UNICEF, 2011).

2.5 THE IMPACT OF HIV/AIDS ON ADOLESCENTS

The HIV and AIDS epidemic had many negative implications for Zimbabwean society, which stem from illness and eventual death (WHO, 2011). Young people are experiencing, and will experience at an increasing rate, the deaths of their parents, other family members, teachers and at times their peers due to HIV related illness. According to the UNICEF report (2011), deaths will affect the provision of services, education, health and welfare. Adolescents will grow up in societies where death is a common experience, affecting them emotionally, economically and psychologically. Adolescents who have lost one or both parents to AIDS are vulnerable. They face exploitation, including physical and sexual abuse. They take on more responsibility and it is hard for them to access adequate nutrition. Schooling is disrupted as they drop out due to their inability to pay school fees (Jackson, 2002:28). However, this study focuses on adolescents living with HIV and how HIV affects their sexual and reproductive health needs.

Thirty four (34) million people were living with HIV worldwide in 2011 (UNAIDS, 2011). The report also noted that, the rate of infection among girls is as much as five to six

times higher than among boys in sub-Saharan Africa. Adolescents are particularly vulnerable to HIV and AIDS due to their age, biological and emotional development and financial dependence (Van Dyk 2005:163). Adolescents' development is characterised by their cognitive, emotional, moral and social identity. These young people have more realistic fears of HIV and AIDS than young children. Their understanding of the biological mechanisms underlying the causes and prevention of HIV and AIDS makes them more realistic. They are confused and stressed due to their rapid emotional, physical and social development and the constant onslaught of new experiences (Van Dyk, 2005:168). George (1999:45) observed that people with HIV frequently experience a loss of identity. They may feel sexually unacceptable and lose interest and confidence in having sex. The strain of adjustment to their health status, and the anxiety and depression caused by uncertainty about their future, as well as the symptoms or treatment of HIV related illnesses may lead to disharmony in relationships and other challenges. Boys and girls with HIV suffer the physical consequences of infection in the form of stunted growth and disability. Society's response also violates their rights and increases their susceptibility to the health effects of the virus (Foster et al., 2005:68). Living with HIV causes stigma and psychological distress.

Adolescents living with HIV come from the world's poorest regions and are at risk of poverty, which may include lack of access to education, economic opportunities and health related services (UNAIDS, 2001). Zimbabwe is among those countries which are experiencing political instability and high levels of poverty, impacting on the prevalence of HIV/AIDS amongst adolescents.

2.6 SEXUAL AND REPRODUCTIVE HEALTH NEEDS OF ADOLESCENTS

The sexual and reproductive health needs of adolescents include the desire to have children, prevent unplanned pregnancy, and child bearing and access to comprehensive health care (Obono, 2010:30). The needs of HIV positive adolescents are not entirely different from those who are HIV negative. However, meeting their needs depends on

the promotion of their human rights, access to health without discrimination and catering for their psycho-social health issues.

Knut-inge (2008:99) defines sexuality as an expression of who we are as human beings. Sexuality includes all feelings, thoughts and behaviours of being a male or a female, being attractive and being in love as well as being in relationships that include intimacy and physical sexual activity. Sexual health is a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence (WHO, 2012).

On the other hand, reproductive health is a state of complete physical, mental and social wellbeing and not merely the absence of a disease or infirmity in all matters relating to the reproductive system and functions and processes (WHO, 2004). Reproductive health therefore implies that people are able to have satisfying and safer sex, and have the capacity to reproduce and the freedom to decide if, when and how to do so. Adolescents need to be informed of and have access to safe, effective, affordable and acceptable fertility regulation methods of their choice, as well as the right of access to appropriate health care services that will enable teenage girls to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

The following discussion focuses firstly on adolescents' sexual needs, followed by the reproductive health needs of adolescents living with HIV.

2.6.1 Sexual needs of adolescents

Sexuality begins before birth and lasts throughout the course of a life span (Montgomery, 2003:7). A person's sexuality is shaped by his or her values, attitudes, behaviours, physical appearance, beliefs, emotions and the ways in which he or she has been socialised. On the other hand, the Anova Health Institute (2011) describes

sexual health as involving behaviours related to producing children, enjoying sexual behaviours and maintaining our sexual and reproductive organs. Issues like sexual intercourse, pregnancy and sexually transmitted infections (STIs) are also part of sexual health.

Adolescents living with HIV have similar sexual needs to adolescents who are HIV negative. However adolescents living with HIV are confronted with decisions on whether to have sex or not, whether to date or not, are not sure about negotiating safe sex and are not sure whether and how to disclose their status or not.

2.6.1.1 Desire to have sex

Sex is a normal part of an adult life, and sexual initiation often occurs during the second decade of life. Like HIV negative teenagers, HIV positive adolescents are also likely to date and may engage in sexual intercourse. However, adolescents living with HIV face challenges when it comes to unprotected sex leading to unwanted pregnancy, acquisition of another sexually transmitted infections, or re-infection with a different strain of HIV (Rathus et al., 2008:351). There is also the possibility of transmitting the virus to others. For HIV positive adolescents, safeguarding their own sexual health and that of others means understanding and avoiding risks such as HIV transmission to a partner, infection with STIs and re-infection with a different strain of HIV (Weiner et al., 2007:471).

Due to extensive physical development during puberty, adolescents become increasingly aware of their sexuality. An important developmental task of adolescents is to satisfy their sexual needs in a socially acceptable way that contributes to the development of their identity (Louw, 2007:334). However, adolescents living with HIV experience strong pressure from family members to abstain from sexual activity and not to have their own children. Obono (2010:29) observed that people living with HIV are not usually expected to experience sexual feelings. This may be the result of a

judgmental attitude that implies that most people contracted HIV through illicit sexual relationships.

The potential costs of engaging in sexual activity are thus exceptionally high for both infected young people and their partners. For HIV positive youth, competency in the domain of sexual health must necessarily involve the development of behaviours that minimise the risk of the undesired consequences resulting from sex. However, addressing sexual behaviour should go beyond risk reduction and encourage the formation of a positive sense of sexuality among young people living with HIV (Birungi et al., 2007).

On other hand, horizontally infected adolescents continue to have sex, even after they become aware of their serostatus. In the United States, high risk sexual behavior is extremely prevalent in this group, with various studies reporting high rates of partner exchange, lifetime sexual transmitted infection, sexual abuse and transactional sex (Johnson et al., 2003). While unprotected intercourse is less prevalent among HIV positive adolescents than their peers, condom or contraceptive use nonetheless remains inconsistent in a significant portion of young people (Belzer et al., 2001:78). The decision whether or not to use a condom during sexual intercourse appears to be mediated by a wide range of individual and environmental factors.

Increasingly, perinatally infected youth are also engaging in sexual behaviour, though at slightly lower rates than their uninfected peers (Battles and Wiener, 2007). A study of 57 vertically infected adolescents between the ages of 13 and 24 found that 79% had a prior or current boyfriend or girlfriend, and 33% were sexually experienced. Birungi (2009:51) also noted that the limited available data suggest that, youth living with HIV are just as likely to be sexually active as their peers, and express similar fertility desires. At the same time, youth living with HIV express concerns about unwanted pregnancy and STIs, and their specific anxiety about passing HIV on to their partners has been documented.

Adolescents develop sexual needs and desires, yet their sexual health needs remain largely unaddressed by existing HIV and AIDS programmes. For instance, sexual health issues discussed during the counseling of an HIV positive client tend to be about refraining from or postponing sexual initiation (Birungi,2008:6). However these adolescents are born with HIV and some were raped; even if they postpone sexual intercourse, they need to know a safer way of engaging in it.

Furthermore, many societies have different understandings and expectations of young people's sexuality and social conduct. For instance, in Zimbabwe, girls are told to abstain from sex, while boys receive almost no information about sex and no support from the adult community (Phiri and Erulker, 1997:153).

2.6.1.2 Dating

Adolescents living with HIV do not construct their lives around their illness; instead they aspire to lead a normal life like other adolescents, including dating and relationships (Birungi et al., 2007). Like their HIV negative peers, adolescents living with HIV mature sexually and have questions about their ability to date and engage in sexual activities (Battles and Weiner et al., 2007:472).

Adolescents are also no different from their non-infected peers in terms of the concerns that are typical at this stage of development, for example, starting to form romantic relationships and exploring their sexuality (Army, 2010:42). However, their experiences are often clouded by fears about status, disclosure and rejection, transmission of the virus, re-infection, stigma and discrimination and concern about their future roles as husband, wife, partner or parent. In addition, they face challenges related to their HIV status, most notably around issues of sex and sexuality.

2.6.2 Reproductive needs of adolescents living with HIV

Hartmann (1987:55-56) defined reproductive health as including the following: the freedom to decide how many children to have and when to have them, entitlement to

family planning information and services, and a wide choice of contraceptive methods with full information on the benefits and risks. Infected and uninfected adolescents have the right to have children, a family and access to reproductive health care.

Adolescents require information, including comprehensive sex education; access to a full range of sexual and reproductive health services, including condoms and other means of contraception as appropriate and other interventions for the prevention, treatment and care of sexually transmitted infections, including HIV; and safe and supportive environments free from exploitation and abuse (WHO, 2011). This would promote the reproductive health of adolescents and prevent adolescent mothers and their babies from dying during pregnancy. It would also prevent unintended pregnancies and other sexual and reproductive health risks.

Infected adolescents also have various needs including the desire to have children, a family and access to reproductive health care regardless of their status. They have the right to choose whether or not they should terminate an unwanted pregnancy, to use contraceptives and to decide on abortion when a woman's life is endangered. Most importantly, they need education on issues like PMTCT and how to prevent re-infection (WHO, 2012). They also need to be empowered with skills that will enable them to disclose their HIV status to their sexual partners in order to easily negotiate safer sex.

2.6.2.1 Prevention of unwanted pregnancy

Adolescents have the right to be informed and to have access to safe, effective and affordable and acceptable methods of the family planning method of their choice, and the right to access appropriate health care services that enable them, for instance if they are girls, to have a safe pregnancy and childbirth.

Due to cultural beliefs and societal attitudes, many adolescents do not use protection as they fear that condom use might raise questions from their partners about being sexually active and whether they have good moral values (Di Clemente, 1992:29). Insufficient knowledge regarding the use of contraception contributes to unwanted

pregnancies among Zimbabwean adolescents (UNFPA, 2003). This is due to a lack of information. In a study conducted by Ehlers & Maja (2001), 35 of the 50 pregnant teenagers who were asked about emergency contraception had never heard of it. Only 12 knew about emergency contraceptives and of this total, 10 knew that morning after pills could be taken to prevent pregnancy after unprotected sex.

A community-based organisation in Uganda, The AIDS Support Organization (TASO) was one of the first organised community responses to the AIDS epidemic in Uganda. It was formed by a group of volunteers in late 1987 and provides counseling information, medical and nursing care and material assistance to people living with HIV and AIDS and their families. A study conducted by TASO reported nine (9) pregnancies among youths receiving HIV and AIDS treatment, care and support. It is unclear whether these pregnancies were intended or not, but it appears that HIV infection may not have significantly changed attitudes towards childbearing in Uganda (Kurumira, 1996:45).

Key interventions to prevent HIV transmission and prevention among adolescents have tended to emphasise delaying sexual debut, reducing the number of sexual partners and increasing correct and consistent condom use. A major limitation is that these interventions have tended to target the general population, who are either HIV negative or unaware of their HIV status and do not take adolescents living with HIV into consideration.

2.6.2.2 Childbearing

HIV infected and non-infected adolescents have the right to have children, a family and access to reproductive health care. However, due to a lack of knowledge, adolescents infected with HIV are afraid to have children as they believe they are going to die and that they will have an HIV positive child. Hartmann (1987:54) observed that it is an adolescent's right to decide the number of children they want to have and when to have them. The desire to have children early in adult life is very common, including among young people living with HIV. Adolescents living with HIV should be able to enjoy safer

and satisfying sexual relationships, and know that should they want to start a family one day, they can do so under the guidance and care of health professionals.

According to Phiri and Erulkar (2004), giving birth and motherhood play a significant role in the social status and self-identity of women in many cultures; the Zimbabwean culture manifests these expectations. While adolescents living with HIV want to have children, they confront psychological difficulties compounded by negative attitudes among communities and health workers who do not believe that people living with HIV can or should have children. Knut-inge (2008:51) stated that people living with HIV experience strong pressure from family members to give up the idea of having children either because of the risk of perinatal HIV transmission or out of concern for the welfare of children raised by parents who may die of AIDS. However, the WHO (2006) has indicated that perinatal transmission of HIV is below 2% with antiretroviral treatment, safe delivery and safe infant feeding.

The study conducted by TASO in Uganda found that, some young people living with HIV strongly expressed the desire to live independently immediately they reach puberty so as to have children of their own before they die due to AIDS. Generally, Ugandan youths have their first sexual experience very early in life. According to the HIV/AIDS sero-behavioral survey of 2004-2005, 14% of young women and men have sex before the age of 15, and 63% of women and 47% of men have sex before the age of 18 (UNAIDS, 2005). A survey in Zimbabwe found that 19% of youth reported having their first sexual intercourse before the age of 15, of whom 7% were females and 12% were males (Mahobva et al., 2006:42). In this context, young people living with HIV may desire and or succumb to family and social pressure to have children early so that they do not die without offspring. However, existing HIV care and support programmes do not seem to address the fertility aspirations or desires of this small but rapidly growing population of young people who are infected with HIV.

Whether planned or not, HIV positive adolescents are having children. Between 2001 and 2004, data from 28 American states indicated that 1 090 HIV infected people

between the ages of 13 and 21 gave birth to 1 183 babies (Koenig et al., 2007). This is not a new phenomenon among horizontally infected youth; indeed, a large proportion of horizontally infected young people are diagnosed with HIV during pregnancy (Levin et al., 2001). In comparison with adolescents who are HIV negative, they need information on the interventions available to prevent the child from getting the virus, for example, PMTCT.

2.7 SEXUAL AND REPRODUCTIVE CHALLENGES OF ADOLESCENTS LIVING WITH HIV

Adolescence is a time of both physiological and social transition to adulthood, during which children develop secondary sexual characteristics, and take on increasing levels of independence and responsibility (Louw et al., 2007:278). They pass through three transitional stages: early, middle and late adolescence. Early adolescents focus on a shift in attachment from parent to peer groups. During middle adolescence, adolescents work on their self-image and begin to develop abstract reasoning. Late adolescence is when they begin to feel comfortable with who they are and becoming adult members of the broader society. Adolescents living with HIV encounter additional challenges as they pass through these stages. If they are HIV positive and not on antiretroviral treatment, their physical development may be delayed, i.e. they may appear younger than their peers. An adolescent who looks different from their peers will have a harder time bonding with them, adversely affecting their peer attachment (Army, 2010:34).

Adolescents begin to form their own personal identities while also seeking to adhere to community norms. This is often a time of experimentation and risk-taking, including in relation to sexual behavior, as young people become aware of sexual desires and attractions (Aka Dako Akribi, 2004:19). Vulnerability to adverse sexual and reproductive health outcomes is enhanced during adolescence due to increased biological susceptibility to infection (among girls), and social and cultural constraints on access to the information and services required to make informed choices (DiClemente, 2005:825).

Battles and Weiner (2002:165) noted that while this period of transition can be challenging for all young people, the issues are particularly complex for those who have been diagnosed with HIV. In addition to the established physical, developmental and cognitive difficulties that can result from living with HIV, youth confront anxieties related to fitting in with their peers, disclosing their status to others, particularly to potential sexual partners, and negotiating the use of protection to prevent transmission to others or re-infection themselves. This puts adolescents at risk of transmitting HIV to others. In 2003, UNICEF organised a dialogue with HIV positive adolescents in Zimbabwe to determine their experiences. The dialogue showed that adolescents fear that they might never experience a sustainable romantic relationship and they are confused as to how to go about conceiving children (UNICEF, 2003).

Those who were perinatally infected with HIV may experience health challenges throughout their lives, including delayed development. They may struggle, particularly with puberty, developing sexuality and making decisions about their sexual activities (AIDS Education and Training Centre). Thus, meeting the unique needs of youth, particularly for sexual and reproductive health services, is very critical.

2.8 PSYCHOLOGICAL AND EMOTIONAL RESPONSES OF ADOLESCENTS LIVING WITH HIV

People living with HIV have great emotional needs and require support to come to terms with their status. The feelings that people living with HIV experience include shock or anger, fear over how the disease will progress; fear of isolation by friends and families, and concerns about infecting others (American Psychiatric Association, 2008). Adolescents living with HIV take ARV treatment which lowers the progression of the disease. However, this can be a challenging time as they realize that ARV drugs will have to be taken daily for life, a constant reminder of being infected with a chronic disease. For ARV treatment to be most effective, patients must adhere well to the regimen, meaning that they must take their medicine at a prescribed time (Maureen et

al 2006:81). Young mothers living with HIV can also face an additional emotional burden due to fear that they will transmit the virus to the child (UNFPA, 2003).

Adolescents deal with disclosure issues at multiple levels, from discovering their HIV status to deciding to disclose it to others. Disclosing HIV status can be stressful, especially if the HIV positive adolescent has deep feelings for their partner and fears rejection. They need to feel accepted in the same way that their peers are (Maureen et al., 2006:121).

Adolescents also experience the fear of death due to popular notions of HIV infection. Cao et al. (2006:525) associated the fear of death with HIV and AIDS related stigma. Their study revealed that some infected participants believed that death from HIV infection was immediate; it was therefore a greatly feared infection. People living with HIV feel isolated, guilty, dirty and full of shame which is often incorporated into their identity (Kalichman et al., 2004). They are afraid of stigma and discrimination, fear which has been shown to create problems for disclosure (Menon, 2007:350).

2.8.1 Disclosing HIV status

Disclosure is defined as revealing private information. People evaluate how much they want to tell, when they want to tell and who they want to tell as the information is risky (Greene et al., 2003:4). Disclosure is also generally considered voluntary, that is, a person makes a choice to tell another person without undue threat, coercion and deception.

People diagnosed with HIV experience different reactions when others learn about their diagnosis. Simons et al. (1995) conducted a study among women living with HIV to determine their families' reaction to HIV disclosure. The study found that families provide emotional support whilst lovers provide support but are likely to withdraw and become angry. The decision to disclose one's status to a relational partner is complex. Besides possibly attaining social support, there is an added dimension of the need for

safer sex or other potential risks (Green et al., 2003:68). Infected persons are at risk of re-infection with another strain of HIV and may be at risk of other STDs that are dangerous for persons living with HIV (Kalichman et al., 2004:175).

Adolescents are afraid to disclose their HIV status to peers for fear of rejection, stigma and discrimination. It is an even greater challenge to disclose to their sexual partners as they are afraid of losing them and that they will spread the news to everyone. While it is critical for adolescents to have protected sex, the challenge is how to negotiate it and tell their partners why they have to use condoms. Adolescents are also afraid of how their partners will respond after disclosure (Green et al., 2003:64). Young people who are HIV positive therefore need skills to deal with issues of disclosure to their partners to prevent the spread of the HIV virus and make informed decisions about reproductive health issues.

2.9 PROBLEMATIC SEXUAL BEHAVIORS OF ADOLESCENTS

Kalichman et al. (2004) noted that in Western countries about one-third of people living with HIV continue to practice unprotected high risk sexual behaviors that might put uninfected individuals at risk. These behaviours could be related to a lack of knowledge and skills to practice safer sex. They could be also linked with the anxiety arising from concerns about disclosure and fear of rejection.

Peer pressure is more pronounced during adolescents' developmental stages, as they turn away from their families and become closer to their peers. They share ideas and information that may not be accurate with peers (Edelman & Mandle 2006:518). It was also found that the chief motive for involvement in sexual activity among male adolescents was to impress females and friends with their sexual experiences (Steyn et al., 2006:512). Youths also think that friends will laugh at them if they do not engage in sex (Karima et al., 2003:16). Peer pressure encourages adolescents to engage in various levels of sexual experimentation which expose them to the risk for STIs and unwanted pregnancy (Obono, 2010:35).

Alcohol and substance abuse are common risk behavior amongst adolescents due to peer pressure. Adolescents commonly use tobacco, alcohol and marijuana. However, substance abuse can have major negative medical consequences for adolescents living with HIV. Alcohol abuse can lead to increased susceptibility to opportunistic infections and also suppress the immune system, strengthening the virus. Nana (2005:74) noted that adolescents who are under the influence of alcohol may choose to engage in unprotected sex, putting their sexual partners at risk of contracting HIV.

2.10 HEALTH CARE SERVICES FOR YOUTHS

Within the broad framework of health systems, support for the sexual and reproductive health of people living with HIV involves a package of specific services. Some are driven by needs that people living with HIV share with their HIV-negative counterparts, such as condoms to prevent transmission of HIV and other STIs (Baptista, 2000:56). People living with HIV may also need additional services, such as PMTCT.

In general, health services that assist people living with HIV to attain and maintain sexual and reproductive health include the diagnosis, management, and treatment of HIV and STIs, sex education and information; psychosocial support to cope with living with HIV; family planning; services for safe abortion in circumstances where it is not against the law and post-abortion care; services to assist conception; antenatal and postnatal care; safe delivery services; cancer diagnosis and treatment; services to address gender- and sexuality-based violence; counseling and treatment to address sexual dysfunction; and HIV prevention (UNAIDS, 2006).

2.10.1 Existing health care services for youths

According to WHO guidelines, health services describe all the organisations, institutions, and resources that a society devotes to improving, maintaining, or restoring health.

This includes staff, funding, information, supplies, transport, and communications. Health services encompass specific health clinics and interventions, as well as the larger infrastructure that supports them. Good health systems are critical to ensuring that people are able to get the care they need. In Zimbabwe, existing services that adolescents can access include clinics, public and private hospitals and medical practitioners.

The quality of services provided to adolescents is of great significance if they are to embrace their reproductive health needs. However, adolescents do not seek reproductive services for a variety of reasons, one of which is the belief that these services are not intended for them. They also fear that their parents might learn of their visits, are embarrassed that they need or want these services and are put off by the lack of confidentiality and privacy (MOHCH, 2002:12).

Langhaug et al.'s (2003:93) study on improving young people's access to reproductive health care in Zimbabwe found that adolescents are neither well-received nor comfortable in mainstream family planning clinics which are mostly government owned. Furthermore, health service providers impose age restrictions on family planning methods. The WHO (1998) has issued guidelines for friendly services for adolescents clients. Adolescent services must be blameless and acceptable to potential users and responsive to cultural and social norms, taking into consideration aspects such as privacy and confidentiality.

At the present moment, it is argued that there is desperate need to improve reproductive health services for adolescents within the public sector. The problems they encounter include feelings of fear, humiliation and distress, a lack of confidentiality and a lack of information (Langhaug et al., 2003:106). The majority of health care services in Harare City are reported to be inaccessible, unavailable and unaffordable and do not respect consumers' privacy (Magwentsu, 2000:205). Furthermore, condoms are only available at health facilities during normal working hours when adolescents are at school.

The health systems in Zimbabwe also lack the human and financial capacity to meet people's health needs. Gaps and weaknesses in policies, training and programmes further undermine the ability of health systems to support the sexual and reproductive health of people living with HIV (UNGASS, 2006). The Government of Zimbabwe finances health care systems by collecting user fees for services. This can result in some people, particularly those who are underprivileged, avoiding or postponing care until they reach more advanced stages of illness.

HIV is linked with sex, blood and death; issues that are culturally difficult to handle, often taboo and are stigmatised (Nana, 2005:74). The notion of HIV as an immoral disease in early prevention programmes contributed significantly to the stigma that persists today. Fearful of discrimination, individuals at high risk of contracting HIV may avoid information and prevention services. The Government of Zimbabwe introduced services to address the needs of teenagers called 'Youth Friendly Clinics'.

2.10.1.1 Youth Friendly clinics

Youth friendly clinics' main objectives are to assist young people to access HIV counseling and testing, STI screening and treatment, family planning, pregnancy care, fertility evaluation, cancer evaluation, sexual dysfunction and other disorders related to the reproductive system (WHO, 1998). The clinics also help young people to cope positively with the consequences of testing and offer support in accessing ARVs.

Youth clinics have been in operation since the 1980s in Zimbabwe (Phiri et al., 1997:4). The initiative was developed in response to evidence that young people often feel unwelcome at clinics and hospitals. However, these clinics tend not to be utilised by young people due to various factors such as shyness, lack of awareness, staff's judgmental attitudes, a lack of privacy and high costs (Amunyunzu et al., 2005:23).

The Population Council of Zimbabwe evaluated three youth friendly centres under the auspices of the Zimbabwe National Planning Council. The Council is responsible for

guiding family planning policy development on behalf of the Ministry of Health and Child Welfare. The main findings revealed that adolescents who visit these centres are often stigmatised by members of the community and youths themselves. Staff members are highly knowledgeable but often judgmental (Knut-inge et al., 2008:252). Furthermore, an evaluation of youth centres in Zimbabwe, Ghana and Kenya found that these centres were marginally effective in providing girls and younger adolescents with reproductive information and services (Population Council, 1999). Adolescents stigmatise and regard youth centres as places for those who are sexually active or have STIs.

The WHO (2000) has issued guidelines intended to ensure teenager-friendly services. The guidelines state that youth friendly services should be acceptable to potential users and responsive to cultural and social norms, taking into consideration aspects such as privacy and confidentiality. The guidelines further state that health workers should be non-judgmental in providing services to adolescents. Magwenhu (2000:54) states that a service that is adolescent-friendly should be welcoming, pleasing and helpful.

As noted above, these youth friendly clinics are not as 'friendly' as they are supposed to be and health workers tend to label or judge adolescents who visit the clinic. According to UNFPA (2003), certain qualities make health services youth friendly, including specialised, trained staff, respect, privacy and confidentiality and the availability of peer counselors. Health workers should not only provide management of STIs or target pregnant teenagers, but should also provide informed information on the sexual and reproductive health of youths such as prevention of unwanted pregnancies, prevention of STIs and many more services. Most importantly, these clinics should offer more effective counseling to young people living with HIV and address issues like adherence to medication and the use of condoms to avoid re-infection (Mangwentshu, 2000:67).

2.10.2 Health care and medical treatment needs

According to Jackson (2002:55), medical care and treatment of HIV ranges from the prevention and treatment of opportunistic infections, to treatment that directly targets the

virus itself. All adolescents have health and treatment care needs. However, adolescents living with HIV require additional health and treatment care. This section focuses on the health and medical treatment care needs of adolescents living with HIV.

2.10.2.1 Health care needs of adolescents living with HIV

Regular check-ups should be done to monitor changes in adolescents living with HIV. According to van Dyk (2005:70), check-ups should be done at least every four to six months if a person is healthy but more frequently if they are showing some symptoms. Evian (2003:61) noted that during check-ups, the health worker should check and record weight, and thoroughly examine the skin, respiratory system and genitals. This will enable them to identify and treat physical as well as psychological problems and to identify opportunistic infections such as tuberculosis, chronic diarrhoea and cancer at an early stage.

Adolescents living with HIV also require regular monitoring of their immune function i.e. CD4 cell count and viral load. According to the WHO guidelines, the normal CD4 count ranges from 500-2010 cells/mm³. It is important to regularly monitor the CD4 count to evaluate the status of the immune system and to treat opportunistic infections and diseases (Van Dyk, 2005:71). On the other hand, the viral load is useful in assessing the severity of HIV infection i.e. how the person's immune system has been affected; it also measures a person's response to antiretroviral treatment.

2.10.2.2 Medical treatment needs

All adolescents need health care as well as medical treatment in order for them to be well and free from illnesses (WHO, 2006). Adolescents who are HIV positive need antiretroviral (ARV) treatment to survive. ARV drugs are recognised by all governments as an essential element of the response to the global HIV and AIDS epidemic (Jackson, 2002:73). ARVs are medicines which are taken by people living with HIV (PLHIV) to reduce the HIV viral load to undetectable levels in their bodies. ARVs restore or

preserve immunological function so as to improve immune function and the quality of life of an HIV positive person. The immune system is the body's defense against disease, and protects a person from getting sick. Once a person begins taking ARVs and adheres to the treatment, their immune system will become stronger and they will be able to fight diseases.

Adolescents living with HIV need early treatment for STIs. According to Evian (2003:262), people with HIV develop immune deficiency which delays the healing of STIs such as herpes and syphilis. Herpes recurs more frequently, is more severe and remains active and painful for longer periods for people living with HIV than in non-positive people.

All adolescents on ARVs must adhere to treatment to achieve the best possible health outcomes (Jackson, 2002:57). Strict adherence to ARV therapy is extremely important to achieve viral suppression and avoid the risk of the mutation development of resistant strains of HIV and drug failure. The WHO report (2007) shows that adherence to drugs among adolescents is very low, with 41% of the service providers surveyed saying that adherence to medication was the most pressing challenge for HIV infected adolescents. In this regard, there is need to offer effective counseling, health intervention and awareness among adolescents to encourage them to change their lifestyle and live positively.

2.11 SOURCES OF INFORMATION FOR ADOLESCENTS LIVING WITH HIV

Access to information about sexual and reproductive health is a human right especially for youths (Jackson, 2002:122). Neilson (2007:45) noted that throughout the world, sex education in schools is inadequate. In developed countries like the United States of America and United Kingdom, teenagers' main sources of knowledge about sex are parents, books and the mass media (Moore and Rosenthal, 2006:74). Moore observed that, while schools and teachers provide sex education, there is little evidence that this information is learned, remembered and acted upon. It is not clear if it meets the needs

of the adolescents for whom it is designed and that there is adequate opportunity for discussion of problems, values and other concerns.

Zimbabwean adolescents lack knowledge of sexuality and reproductive health due to a lack of information. This has been a primary reason for not using contraceptives. UNAIDS (2007) indicated that less than 50% of youths in Zimbabwe know about contraception. Culture and religion still exert considerable influence on sexual behavior; for instance, in some parts of Zimbabwe, communities oppose sex education and condom use by young people as this is considered unethical (National AIDS Council, 2003:5). Furthermore, many Zimbabwean health service workers feel that it is inappropriate to provide contraceptives to adolescents, making it difficult for them to obtain condoms.

Kirkman et al.'s (2001) study sought to ascertain whether parents are involved in their children's sex education. The study found that sexuality was a difficult topic; parents expressed puzzlement, confusion, awkwardness and nervousness about talking about this topic. In the context of Zimbabwe, cultural barriers and perceptions have hampered sex education. Moore and Rosenthal (2006:67) note that, sex education is not compulsory in schools and there is no evidence that discussions on sex have had a significant influence in helping adolescents. This makes it harder for adolescents living with HIV to come to terms with their status and denies them information on safer sex practices. Ahleberg et al. (1997:237) also indicated that communicating about sexual and reproductive health is difficult both among young people and between adults and older people. Furthermore, many societies have different understandings and expectations of young boys' and girls' sexuality and social conduct. For instance, in Zimbabwe, girls are told to abstain from sex before marriage, while boys receive almost no information and no support from the adult community.

Adolescents commonly turn away from their families and move closer to their peers with whom they share information and ideas with about HIV transmission; such information may not be accurate (Edelman, 2006:512). Adolescents living with HIV need to be

empowered with knowledge and correct information in order to engage in safer sexual activities.

2.12 ADOLESCENTS' RIGHTS IN TERMS OF THEIR SEXUAL AND REPRODUCTIVE HEALTH

The WHO (2005) emphasises that for sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. Nonetheless, the right to sexuality information and services for young people living with HIV continues to be neglected. The UN Convention on the Rights of the Child (General Assembly Comment NO 3 January 2003) highlights the need to pay careful attention to children's sexuality.

In terms of Zimbabwe's Children's Act, No 38 Of 2005, every child has the right to have access to information on health promotion and the prevention and treatment of ill-health and diseases; sexuality and reproduction, have access to information regarding his or her health status, and confidentiality regarding his or her health status and the health status of a parent, caregiver or family member, except where maintaining such confidentiality is not in the best interests of the child. Information provided to children in terms of this sub-section must be relevant and should be presented in a form that is accessible to children, giving due consideration to the needs of disabled children.

Every young person has the right to be healthy, to have access to services and to exercise control in terms of decision making. When the sexual and reproductive health rights of adolescents are recognised, for example, by providing age-appropriate information about sexual and reproductive health issues and by helping young people to deal with the practice and outcomes of sex in a responsible, respectful and safe manner, it becomes possible for them to have satisfying relationships that are characterised by respect and concern. The Zimbabwean government is a signatory to the UN Convention on the Rights of the Child and The African Charter on the Rights and Welfare of the Child. Both recognise access to health-related education and

information, including sexual and reproductive health as an important health right. WHO/UNFPA (2010) guidelines on care, treatment and support for women living with HIV and AIDS and their children in resource-constrained settings, also underscore the need to address the particular sexual and reproductive health needs of adolescent girls with HIV, ensuring the availability of age-appropriate information and counseling on sexuality and safer sexual practices, and offering adolescent-friendly family planning counseling and services.

2.13 SUMMARY

The literature review provided information on adolescents' sexual and reproductive health needs and how HIV and AIDS affect their lives. It noted that there is an increase in the number of adolescents living with HIV and AIDS due to the roll out of ARVs. However, HIV interferes with adolescents' normal developmental stages in terms of physical, emotional, social and biological factors. The social construction theory that guides this study was discussed. The impact of HIV and AIDS on adolescents was also discussed with an emphasis on those living with HIV.

The sexual and reproductive health needs of adolescents living with HIV were also explored. The literature notes that HIV interferes with their sexual life. Adolescents living with HIV have the same need for sexual relationships as their peers who are HIV negative. However, they face a number of dilemmas: whether to date or not, whether to have sex or not and whether or not to disclose their status. Adolescents' reproductive health needs were also discussed, that is, what is required for an adolescent living with HIV to have a healthy child and a normal pregnancy. The challenges confronting adolescents in terms of sexuality and reproduction were discussed. Health care services for youths were also examined; the literature review showed that the health services available to adolescents tend to generalise their needs and do not take the needs of those living with HIV into account. For instance, some health messages like 'abstaining from sex', and 'being faithful' to prevent transmission of HIV, do not address the needs of those who were born with the virus and those who are living with it. The

chapter closed by discussing the sources of information and the rights of adolescents living with HIV. Since adolescents living with HIV have normal desires, they need information and knowledge to make informed choices. The following chapter discusses the research methodology employed in this study.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter describes the research approach and methodology employed in this study. According to De Vos et al., (2002:120), research methodology is defined as a description of the specific techniques to be employed, the specific measuring instruments to be utilised and the specific series of activities to be conducted in making measurements. This chapter explores the research methodology, sampling techniques, data collection methods, criteria of measurement, limitations of the study and ethical considerations.

Furthermore, this chapter briefly describes the research setting, that is, the Chiedza Child Care Centre in Harare, Zimbabwe. This is followed by a discussion on the units of analysis and preparation for data collection. Semi-structured interviews and observation constituted the data collection methods used in this study. Data analysis and criteria of measurement of quality are also discussed. Finally, the limitations of the study and ethical considerations are discussed.

3.2 RESEARCH APPROACH

The researcher used qualitative research approach which is described by Babbie and Mouton (2001:270) as an approach in social research according to which research takes place as its departure point the insider perspective on social action. Qualitative research methodologies used by the researcher were semi-structured interviewing and observation.

3.2.1 Qualitative research approach

As noted by Neuman (2000:122), qualitative researchers conduct detailed examinations of cases that arise in a natural flow of social life and try to present authentic

interpretations that are sensitive to specific socio-historical contexts. Qualitative research captures and discovers meaning once the researcher becomes immersed in the data. Furthermore, analysis proceeds by extracting themes or generalisations from evidence and organising the data to present a coherent and consistent picture.

The qualitative research approach was used in this study to enable the researcher to gain insight into the phenomenon under study, namely the sexual and reproductive health needs of adolescents living with HIV. Babbie and Mouton (2006:270) defined qualitative methodology as generic research, where the research takes as its departure point the insider perspective on social action. It is a type of inquiry in which the researcher conducts research on people's experiences, feelings and thoughts in their natural settings. The primary goal of studies using this approach is describing and understanding rather than explaining human behavior.

3.2.1.1 Explorative approach

According to Polit et al., (2001:19), explorative studies are undertaken when a new area is being investigated or when there is little knowledge of the area of interest. It is used to investigate the full nature of the phenomenon and other factors related to it. Neuman (2000:21) describes the exploratory approach as addressing the 'what' question. An exploratory approach was appropriate for this study to understand the sexual and reproductive health needs of adolescents living with HIV. While studies have been conducted on the reproductive health needs of adolescents in general, less is known about adolescents living with HIV.

3.2.1.2 Descriptive approach

Descriptive research is designed to provide a picture of a situation as it happens naturally (Burns and Groove 2003:201). Descriptive designs can be used in both qualitative and quantitative studies. In qualitative studies, description aims to facilitate an intensive investigation of a phenomenon and its deeper meaning. For the purpose of this study, descriptive approach was used to understand the sexual and reproductive health needs of adolescents living with HIV. This will help to integrate the sexual and

reproductive needs of HIV positive young people into the existing treatment, care and support programmes that serve them.

3.3 RESEARCH SETTING

The context is significant in qualitative research. Holloway and Wheeler (2001:34) noted that the context includes the environment and conditions in which the study takes place as well as the culture of the participants and the location. The research was conducted at the Chiedza Child Care Centre, a non-profit organisation based in Harare, Zimbabwe that runs a community home-based care programme for children and adolescents who are affected and infected with HIV and AIDS. These adolescents have been living with HIV since birth and are aware of their HIV status. The centre operates in the crowded urban centres of Mbare, Sunningdale and Ardbennie/Prospect. It has registered about 500 children, 40 of whom were adolescents living with HIV in 2010. The research was conducted at the centre, a setting that the research participants are used to, that is within their community.

3.4 UNITS OF ANALYSIS

According to Neuman (2000:132), the unit of analysis refers to the type of unit a researcher uses when measuring an individual, household, corporation, organisation or a group. Babbie and Mouton (2006:84) described the unit of analysis as “What” one is interested in investigating in a study. Polit and Hungler (2004:218) also describe units of analysis as the target population which is the total group of people who possesses the characteristics that the researcher is interested in studying and to whom the findings of the study can be generalized.

The units of analysis for this study were 10 female and male adolescents aged 15-19 living with HIV of whom four were male and six were female. These adolescents have disclosed their HIV positive status.

3.5 SAMPLING PROCEDURE AND SAMPLE SIZE

According to Polit and Hungler (2004:291), the sampling technique refers to the process of selecting elements or respondents who are representative of the population under study. The sampling technique used in this study is non-probability purposive sampling. In purpose sampling, a researcher uses his/her own knowledge and experience to select the most suitable respondents for the study. Neuman (2000:198) explained that purposive sampling is appropriate in three situations, namely:

- When a researcher wants to select unique cases that are especially informative e.g. when the researcher wants to use content analysis to study magazines to find cultural themes, he or she will select a popular women's magazine.
- When a researcher wants to select members of a difficult-to-reach, specialised population.
- When a researcher wants to identify particular types of cases for in-depth investigation. The purpose is less to generalise to a larger population than to gain a deeper understanding of types.

The researcher selected the sample of 20 adolescents based on her personal judgment, that is, respondents were selected who could provide the best information that would assist in understanding the needs of adolescents living with HIV. However, 10 adolescents, 4 boys and 6 girls participated in the study as some participants were not willing to participate due to the sensitive nature of the study. Furthermore, the main focus was on adolescents who are registered with the Chiedza Child Care Centre who participate in the organisation's support groups; the researcher has operational knowledge of the Centre as she once worked there. The researcher informed the Director of the centre about the study and requested permission to interview these adolescents at a time that was convenient to them.

3.6 DATA COLLECTION METHODS

Data collection is defined as the process of gathering the information required to address the research problem. Different ways of collecting data in qualitative research include focus group discussions, interviews, observation and documentary study (De Vos et al., 2002:280). For the purpose of this study, semi-structured interviews and observation methods were used.

3.6.1 Interview process

According to De Vos et al., (2002:292), interviewing is the predominant mode of data collection in qualitative research. It is defined as an attempt to understand the world from the participants' point of view, to unfold the meaning of people's experiences, and uncover their lived world prior to scientific explanations. Interviewing involves interaction between the researcher and the participant. The researcher used semi-structured interviews with an interview guide in order to solicit specific categories of information, which would ultimately answer the research questions. A major advantage of interviews is that the interviewer can follow up ideas, probe responses and investigate motives and feelings.

3.6.2 Semi-structured interviews

Data were collected through semi-structured interviews. According to De Vos et al (2002:302), semi-structured interviews are used by researchers to gain a detailed picture of the participant's beliefs about, or perceptions or accounts of a particular topic. A general interview guide was used. According to Anderson and Kanuka (2003:85), the advantage of a semi-structured interview over a structured interview is that the former offers both structure (ordered/preplanned questions) and non-structure (open-ended questions).

3.6.3 Observation

Observation method was also used by the researcher in the form of direct observation which involves systematically selective watching and recording behavior. According to Babbie and Mouton (2006:295), people's actions are more important than their verbal accounts and observing these are valuable. Observation entails the systematic noting and recording of events, behaviours, and artifacts (objects) in the social setting selected for study. The observational record is frequently referred to as field notes - detailed, non-judgmental, concrete descriptions of what has been observed. For studies relying exclusively on observation, the researcher makes no special effort to play a particular role in the setting; it is sufficient to be tolerated as an unobtrusive observer (Adler et al., 1994:377). For the purpose of this study, non-verbal cues such as eye movements, facial expressions and language behaviour were observed and noted in writing by the researcher.

3.6.4 Preparation for data collection

Before conducting the interviews, the researcher familiarised herself with how to conduct research interviews. She started the research process by seeking permission from the centre Director to conduct the study. The researcher also discussed how the research was going to be conducted with centre management. Management provided a letter granting permission for the researcher to gain access to the centre (See appendix E). Thereafter, the researcher obtained a list of possible participants and their parents. Participants were contacted and interview appointments were made. The participants who agreed to participate, signed consent and assent forms. The researcher used a tape recorder to record the interviews after seeking permission from the participants to do so. Holloway and Wheeler (2002:86) view the tape recorder as the best way to record interview data as the tapes contain the exact words of the interview including questions and the researcher does not forget important information. A tape recorder provides a much fuller record than notes taken during an interview. It also allows the researcher to concentrate on how the interview is proceeding and where to go next (De

Vos, 2002:304). However, the researcher also took notes during the interviews in the event that the recording equipment failed. The researcher ensured that the room used for interviews was private and confidential.

Conducting the interview: The researcher followed the interviewing process suggested by Creswell (2003: 186-187), who noted that a researcher should establish rapport with participants, listening carefully and attentively, clarifying questions, alerting the interviewee when the interview is drawing to a close and encouraging the participants to ask questions. Field notes formed part of the data and served as a measure of triangulation.

3.7 DATA ANALYSIS

Qualitative data analysis was employed in this study. Data analysis involves making sense of the text, moving deeper and deeper into understanding the data, representing the data and interpreting its larger meaning (Creswell, 2007:183). Data was analysed following Tesch's eight steps which entail the organisation of data for analysis (Cresswell, 2003:192). The focus was on the themes and sub-themes that emerged from the semi-structured interviews.

3.7.1 Data processing

This was the first step in data analysis after completion of data collection. During data processing, a researcher converts his/her files to appropriate text units, e.g. a word, sentence, or an entire story for analysis either by hand or computer (Creswell, 2003:343). Marshall and Rossman (1999) cited by Creswell (2003:344) suggest that the process of preserving the data and meaning on tape and the combined transcription and preliminary analysis greatly improve the efficiency of data analysis.

Following the face-to-face interviews, the researcher played the recorded interviews. She listened repeatedly and then transcribed all the interviews alongside the field notes

in order to facilitate the coding and categorising of the raw data. All notes were word processed for easy handling, categorised and developed for analysis. Texts were coded and clusters were compiled along emergent or pre-defined themes and sub-themes for subsequent analysis (Knut-Inge, 2008:220). After carefully reading the transcribed data, categories of answers were coded with a key word or a theme.

3.7.1.1 Describing, classifying and interpreting

Marshall and Rossman (1999) cited by Creswell (2003:344) noted that this is the most complex, ambiguous and creative phase. It involves identifying salient themes, recurring ideas or language and the pattern of beliefs that link people and settings. Creswell adds that classifying means taking the text or qualitative information apart and looking for the categories, themes or dimensions of information. He also describes interpretation as making sense of the data. For this study, the researcher used coding to analyse the data.

3.7.2 Coding process

Coding is a process where a researcher organises the raw data into conceptual categories and creates themes or concepts which can be used to analyse it (Neuman 2000:420). According to De Vos (1998:76), coding is the process whereby raw data is transformed into standardised data using symbols, descriptive words and category names. For this study, all data was word processed for easy handling, categorised and developed for analysis. After carefully reading the transcribed data, categories of answers were coded with a theme. Neuman (2000:421) described a good thematic code as one that captures the qualitative richness of the phenomenon. To code data into themes the researcher needs to see or recognise themes in the data. Recognising these themes rests on:

- Recognising the patterns in the data
- Thinking in terms of systems and concepts

- Having in-depth knowledge of the background e.g. for the purpose of this study, knowledge about adolescents in general and adolescents living with HIV and their sexual and reproductive needs in particular
- Possessing relevant knowledge

The above abilities helped the researcher to code the data.

3.8 CRITERIA FOR MEASUREMENT OF QUALITY

3.8.1 Reliability

According to Babbie and Mouton (2001:119), reliability concerns whether a particular technique applied repeatedly to the same object would yield the same result each time. To ensure reliability, the researcher pre-tested the interview schedule on male and female adolescents registered at two different organisations in Harare. These organisations also support adolescents who are living with HIV and AIDS. The respondents were not part of the sample and this was done to identify vague and unacceptable questions and test the consistency of the results.

3.8.2 Validity

The term 'validity' refers to the extent to which an empirical measure adequately reflects the real meaning of the concept under consideration (Babbie & Morton 2001:122). The researcher used content validity, that is, how much a measure covers the range of meaning included within the concept. In this case, the researcher ensured that the instrument covered as much meaning as possible within the range of the sexual and reproductive health needs of adolescents living with HIV. The interview schedule was validated by one of the Sociology lecturer from the University of UNISA and also by the research coordinator from Wits Reproductive Health Institute.

3.9 LIMITATIONS OF THE STUDY

Fisher et al (2002:117), note that, there is no such thing as a perfect study. This study was conducted among a small sample of adolescents living with HIV who were registered with the Chiedza Child Care Centre. The researcher confronted the following limitations:

Time constraints: A study of this magnitude should have required more time. However, as the research is in partial fulfilment of the degree requirements, it was conducted over a few months. As a result the researcher worked under much pressure.

Research site: The research was conducted in Zimbabwe and the researcher was a full time employee in South Africa. However, she arranged leave to conduct the research. Furthermore, since the study focused on only one child care centre, the findings could not be generalised to other child care centres in the country.

3.10 ETHICAL CONSIDERATIONS

De Vos (2002:63) defines ethics as a set of moral principles that are suggested by an individual or a group and are subsequently widely accepted that offer rules and behavioural expectations about the most correct conduct towards subjects and respondents. Ethics are also associated with morality as both deal with matters of right and wrong; hence one needs to be aware of what is proper or improper in the conduct of a scientific inquiry (Babbie, 2001:520). Neuman (1997:445) states that ethical research requires a researcher to balance the value of knowledge against the value of non-interference in the lives of others. Ethics offer rules and expectations regarding the most correct behaviour before, during and after the study. Various authors (Cosby, 1997:45; Dane 1990:78; De Vos et al 1998:98) have outlined guidelines that should be taken into account in order to prevent any harm or violation on the part of anyone involved in the research.

As this study dealt with some participants who were below the age of 18 and living with HIV, some of whom were too young to understand what it means to live with the virus, the researcher observed the following ethical principles:

3.10.1 Voluntary participation

The researcher explained to the participants that their participation was completely voluntary. The participants were accurately informed about the nature of the research. As indicated by Babbie (2007:68), a researcher should obtain written or verbal consent to participate and no one should be forced to participate. For the purpose of this study, written consent and assent were obtained. The researcher sought informed consent from participants who are 18 years and older and assent from parents of participants who are younger than 18 years. Neuman (2011:135) suggests that it is not enough to get permission from participants; they need to know what they are being asked to participate in so that they can make an informed decision. Coercion was not used to force participation and participants were informed that they had the freedom to withdraw from participating in the study at any time.

3.10.2 No harm to the participants

Babbie (2001:522) clearly stated that social research should never injure the people being studied. Therefore, regardless of voluntary participation, the researcher must guard against harm to the participants. Babbie (2001:522) also noted that it is possible for subjects to be psychologically and emotionally harmed during the course of the study. The researcher was aware of the subtle danger of injuring the participants and guarded against this happening. HIV and AIDS is a sensitive topic that needs careful consideration when interviewing participants. Since this study focussed on adolescents who might be traumatised by the fact that they are living with HIV, the researcher avoided asking sensitive questions which might have resulted in the subjects' psychological discomfort.

The researcher ensured that the subjects were not harmed by ensuring that the research maximised the benefits and minimised any harmful effects of participation. This was achieved by providing sufficient information on the benefits of the research study, in that the findings will contribute to recommendations on how best to address the sexual and reproductive health needs of HIV positive adolescents in health institutions, and to improve interventions and services based on their identified needs. A debriefing session was offered after the interview and counsellors at the center were requested to follow up with participants in case some got traumatised.

3.10.3 Anonymity and Confidentiality

Anonymity and privacy: The researcher protected the subjects' interests by not revealing their identities to the public. Dane (1991) and Babbie (2001) quoted by de Vos (2001:68) distinguish between anonymity and confidentiality. Confidentiality implies that only the researcher and possibly a few staff should be aware of the identity of participants. Anonymity means that no one, including the researcher, should be able to identify any subjects afterwards. Babbie (2007:65) stated that a research project guarantees confidentiality when the researcher can identify a given person's responses but essentially promises not to do so publicly.

Confidentiality: All names and addresses were removed from the questionnaires and replaced with identification numbers. Code numbers or pseudonyms were used and identification of the participants was not revealed in the reports and publications of the study. The researcher also used private space when interviewing the participants and assured them that their HIV status would not be disclosed to anyone.

3.10.4 Deception of subjects

The researcher was also truthful in revealing her position as a researcher registered with the University of South Africa (UNISA). She explained the purpose of the study to the participants, that is, to understand the sexual and reproductive health needs of

adolescents infected with HIV and AIDS. Participants were informed that the study was part of a university programme's requirements. The researcher received ethical clearance from UNISA to conduct the research. English was used as a medium of communication during interviews therefore was no need for translation.

3.11 SUMMARY

This chapter described the research methodology employed for this study. A qualitative research approach was adopted. The research setting, units of analysis and sampling procedure (purposive sampling) were discussed. The study used interviews and observation methods to collect data. The methods of data analysis were examined, as well as measurement criteria, that is, validity and reliability. Finally, the limitations of the study as well as ethical considerations were presented. The researcher practised and observed all ethical considerations throughout the course of this study. The following chapter presents and analyses the data collected for this study.

CHAPTER 4: DATA PRESENTATION AND ANALYSIS

4.1 INTRODUCTION

This chapter presents and analyses the data collected during the study. Data analysis is described as a process through which researchers intentionally immerse themselves in the data, and then re-read the data (Liamputtong and Ezzy ,2005:257). In this study, the researcher followed De Vos (1998:123) thinking on the data analysis,

According to Seale and Kelly (1998:153), the initial stage in the analysis of qualitative data is to develop a set of codes that both reflect the initial aims of the research project and take into account any unexpected issues that emerged during data collection. Du Plessis (2009:2) states that researchers have to order and reduce the data according to the objectives and topics of discussion.

One of the objectives of this study is to determine whether adolescents living with HIV have knowledge of their sexual and reproductive health needs. To this effect, the analysis entails adolescents' understanding of HIV and AIDS, the reproductive needs and challenges experienced by adolescents in intimate relationships and a comparison of the reproductive health needs of HIV positive adolescents and HIV negative adolescents. The objectives of the study also included an examination of the availability and accessibility of services for HIV positive adolescents. Care and treatment needs of adolescents living with HIV were analysed, as well as their knowledge of the availability of services and the challenges they face when accessing health facilities.

4.2 ANALYSIS OF DATA FROM SEMI-STRUCTURED INTERVIEWS

The data was analysed using Tesch's descriptive methods of open coding. Creswell (2009:186) describes Tesch's eight steps in the organisation of data for analysis as follows:

- Getting a sense of the whole by reading all the transcripts carefully and writing down ideas as they come to mind.
- Picking one transcript and reading through it to understand the underlying meaning of the text. This step involves critical thinking about the underlying meaning rather than the substance of the information.
- Repeatedly reading transcripts for several participants and compiling a list of topics.
- Clustering similar topics and dividing topics into unique topics and leftovers.
- Revisiting data with the list at hand. An abbreviation for each of the topics was assigned in the form of codes that were written next to appropriate segments of the text. This preliminary organising scheme was used to establish whether new categories and codes emerged.
- Finding the most descriptive wording for topics and turning them into categories. The list of categories was reduced by grouping topics that relate to each other together. Lines were drawn between categories to show interrelations.
- A final decision on the abbreviation for each category was made and the codes were alphabetised.
- The data belonging to each category was assembled in one place and a preliminary analysis was performed.

Process of data analysis by the researcher: Following the steps outlined above, the researcher transcribed and analysed the data manually in order to organise, provide structure to and elicit meaning from the data (Polit 2001:381). The researcher created categories and codes from the data obtained from the semi-structured interviews. Themes and sub-themes emerged after examining the categories and codes.

Themes and sub-themes: A theme is an implicit topic that organises a group of repeating ideas. It is a feature of participants' accounts characterising particular perceptions and experiences that the researcher sees as relevant to the research questions. In this study, it is the main idea that emerged from the semi-structured interviews. A sub-theme is a class or group of things possessing common qualities, about the main thing the researcher wants to find out.

Table 4.1: Themes and sub-themes

The table below demonstrates the themes and sub-themes identified by the researcher when analysing data from the semi-structured interviews.

Themes	Sub-themes
1. Adolescents' understanding of HIV and AIDS and sexual needs	
1.1 Adolescents' inadequate knowledge about HIV and AIDS	<ul style="list-style-type: none"> • Facts about HIV and AIDS • Different modes of HIV transmission • Prevention of HIV transmission
1.2 Challenges experienced by adolescents in intimate relationships	<ul style="list-style-type: none"> • Insecurities about dating • Doubts regarding disclosure • Negotiating condom usage
1.3 Comparison of needs of HIV positive and HIV negative adolescents	<ul style="list-style-type: none"> • Adolescents have sex with extra caution • Taking care and responsibility for one's health • Using protection during sexual intercourse
2. Adolescents' understanding of HIV and reproductive needs	
2.1 Inadequate knowledge of preventive and contraceptive methods	<ul style="list-style-type: none"> • Condoms as the only method of family planning • Taboos on issues related to family planning
2.2 Pregnancy and child bearing intentions of adolescents living with HIV	<ul style="list-style-type: none"> • Desire to have and keep children

2.3 Adolescents' source of information and support about sexuality	<ul style="list-style-type: none"> • Parents and caregivers rarely talk about sexuality issues • Friends as source of inaccurate information
3. Emotional experiences of adolescents living with HIV	
3.1 Psychological distress experienced by adolescents after being diagnosed HIV positive	<ul style="list-style-type: none"> • Fears about death • Fear of negative consequences of disclosure • Negative emotions
3.2 Family as a support system to alleviate negative emotions	<ul style="list-style-type: none"> • Family members support for taking ARVs
4. Care and treatment needs of adolescents living with HIV	
4.1 Adequate knowledge of availability of services	<ul style="list-style-type: none"> • Hospitals and clinics as health service providers for adolescents
4.2 Challenges experienced by adolescents at health facilities	<ul style="list-style-type: none"> • Health services not youth friendly
4.3 Insufficient information on sexual and reproductive health issues	<ul style="list-style-type: none"> • Limited information on HIV and pregnancy, dating, contraceptives and disclosure

4.3 PRESENTATION OF DATA FROM SEMI-STRUCTURED INTERVIEWS

In this section, the researcher presents and discusses the data from the themes and sub-themes outlined in table 4.1.

4.3.1 Adolescents' understanding of HIV and sexual needs

This section deals with the adolescents' understanding of HIV and sexual needs, challenges experienced by adolescents in intimate relations and a comparison of the needs of HIV positive and HIV negative adolescents.

4.3.1.1 Adolescents' inadequate knowledge about HIV and AIDS.

The empirical investigation demonstrated the following:

Facts about HIV: In response to the question "What is HIV?", respondents gave different responses. **Respondent 1** said "*HIV is a disease in people's bodies*". **Respondent 3** mentioned that "*HIV is a deadly disease that cannot be treated*". Most of the respondents agreed with the above respondents that HIV is a disease which kills. Only two respondents described the acronym HIV as the Human Immunodeficiency Virus and partially explained it as a virus that one can get through sex. As noted in the literature review, HIV stands for Human Immunodeficiency Virus. This virus is passed on from one person to another through blood-to-blood and sexual contact. Nana (2005:52) describes HIV as a retrovirus disease transmitted primarily through sexual intercourse but also through infected blood from mother to new-born child. The first response is partially incorrect because HIV is not a disease. Therefore the responses from the adolescents demonstrated inadequate knowledge of HIV.

With regard to the definition of AIDS, some respondents knew what the acronym means, that is, Acquired Immunodeficiency Syndrome. Few respondents knew that there is currently no cure for AIDS. Most were not clear on what AIDS is all about. The responses included:

Respondent 2: "*AIDS is when a person is dying and gets slim*". **Respondent 4** said, "*Hmmmm it is a dangerous disease and people die with it*". Similarly, **respondent 6** said, "*AIDS is when a person is sick and you can tell with symptoms like thin face and*

you cannot walk properly”. **Respondent 7** said, *“It is a disease and I do not know what causes it... and many people are dying of it.”*

From the responses given by all participants, the researcher observed that respondents had insufficient knowledge of HIV and AIDS. Some could not differentiate between HIV and AIDS; they know it as one disease. As noted in the literature review, AIDS stands for Acquired Immunodeficiency Syndrome. It is a syndrome of opportunistic diseases, infections and certain cancers, each or all of which has the ability to kill the infected person in the final stages of the disease. There is currently no cure for HIV and AIDS (Van Dyk, 2005:5).

Different modes of HIV transmission: On the question of how HIV is transmitted, most of the respondents indicated that HIV is transmitted from mother to child and also through sexual contact. Few participants said that HIV is transmitted through infected needles. **Respondents 4 and 10** similarly said:

“HIV is transmitted through the mother to a baby in a womb. A baby will be born with HIV and starts taking ARVs. It can be also transmitted through blood conduct and unprotected sex”.

“HIV is transmitted through sex, mother to baby and needles”

The above responses demonstrate that participants had some understanding of how HIV is transmitted. HIV can be transmitted through unprotected sexual intercourse with an infected partner or through contact with infected blood, semen, and cervical or vaginal fluids (WHO, 2004). Unprotected sexual intercourse is the most common mode of transmission of HIV worldwide.

Prevention of HIV transmission: In terms of prevention of HIV, the majority of the respondents said that HIV can be prevented by the use of condoms during sexual intercourse. This was confirmed by **respondent 7** who said *“You can prevent HIV transmission by having sex with the condom”.*

All the respondents concurred that HIV can be prevented by the use of condoms. However, as noted in the literature review, effective prevention requires accurate knowledge of how people behave in different situations and under what conditions they will be prepared to change their sexual behaviour (Van Dyk, 2005:89). The only 100% effective way of preventing sexual transmission of HIV is total abstinence from sex; this is not realistic for young people. HIV can be transmitted from a mother to her baby during pregnancy, labour and delivery and later through breastfeeding (Van Dyk, 2005:23).

4.3.1.2. Challenges experienced by adolescents in intimate relationships.

The participants revealed that adolescents living with HIV experience some challenges regarding intimate relationships. Challenges mentioned by respondents included insecurity about dating, doubt regarding disclosure of HIV status and negotiating condom usage.

Insecurity about dating: Young people living with HIV do not primarily construct their lives around their illness, but aspire to lead normal lives just like other adolescents including engaging in dating and relationships (Birungi et al., 2007). Asked if adolescents living with HIV engage in love relationships, all the respondents agreed that they can have relationships but are faced with some challenges. Common statements expressed by respondents included that adolescents living with HIV should: *play safe, be very careful, and aware of themselves*. **Respondent 5**, a female, observed:

“All adolescents are same HIV positive or negative when it comes to dating. We also need love and affection. That is how we were created that one needs a man or a woman in their lives. We are not sick always, we do not feel the pain in our bodies so we are the same with those who are negative. The only extra thing you need to do as a positive person is to play safe.... use a condom when you are having sex.”

A male respondent stated: *“It is not a crime to be HIV positive. I feel adolescents living with HIV can date and have relationships as they need someone to really care for them.*

I have my girlfriend and I am very happy. We discuss with friends about these girlfriends, they do not know my status and I feel the same as they feel. What you need is to be very careful when you are intimate so that you do not pass the virus...sex is a need" (he laughed).

The above responses indicate that participants felt that adolescents living with HIV can date and have relationships. There was no significant difference in the proportions of female and male respondents reporting that there are challenges in dating if one is HIV positive. HIV positive adolescents face the additional challenge of always being aware of their status when it comes to intimacy. Some respondents felt that adolescents living with HIV should consider dating those who are also HIV positive as they felt that there would be the same understanding of their condition. **Respondent 6** said:

"Adolescents living with HIV can have relationships but eish; it is a challenge to be in a relationship. At times you feel that people are seeing you with the virus. If those thoughts come to you, haaa you do not feel like having a relationship. However you are forced to do like any other person as you do not want your friends to laugh at you. It is better to date a person who is also HIV positive".

Adolescents behave in certain ways in order to please their peers. Respondent 6 indicated that it is hard to be in a relationship due to the fact that he felt that people might be seeing him with the virus. Furthermore, he wanted to be accepted by his friends. The literature review revealed that peer pressure is more pronounced during adolescence as adolescents turn away from their families and become closer to their peers (Edelmen and Mondle, 2006:518). The researcher also noticed that there were no different opinions between male and females respondents regarding dating when one is HIV positive. Both males and female respondents felt that there are some challenges in dating especially if one is aware of one's HIV status.

Doubts regarding disclosing HIV: Another challenge facing adolescents living with HIV which emerged during the interviews is how to disclose their HIV status to their sexual partners that are living in the community. All the adolescents interviewed had

disclosed their status only to their close relatives. Some were born HIV positive and relatives were involved in their HIV testing and treatment. However, all the respondents who reported having partners said that they had not disclosed to them as they are afraid of rejection, isolation, stigma and discrimination. They felt that they would not be able to cope with the consequences.

Respondent 7 said: *“It is not easy to tell your partner especially if she is negative as she might go around telling people about your status. If people know that you are HIV positive they do not want to be associated with you....At least it is much better to tell your relative as she might give you support”*. **Respondent 3** said: *“You need to trust somebody whom you are going to tell about your status. The problem is that if you tell your boyfriend that you are HIV positive, he can leave you and go to another person and it really hurts. So it is better to remain quiet until you feel it is the right time. He can also spread the information to the whole community and this will lead to stigmatization”*.

Furthermore, **respondent 4** said: *“I will not disclose to my boyfriend, it is not a good idea, he will tell the whole world and tell people not to date with you and you will be in trouble for the rest of your life”*. The respondents' views are in line with Makin et al.'s (2008:908) observation that disclosure is a process that involves decisions about timing as to whom, how and under what conditions. As noted above by one of the respondents, timing is therefore very important.

Negotiating condom usage: Adolescents also face challenges with regard to negotiating condom usage with a sexual partner. This was supported by **respondent 8** when she said, *“Yes you can have a relationship but the problem is that people want to sex always and they think that makes the relationship going. So the challenge will be on how to tell a person to use a condom, they will think you do not love them.....so you will be stressed because you know your condition and your partner does not know”*.

Di Clemente (1992:29) has a different view regarding the use of condoms amongst adolescents. Due to cultural beliefs and social attitudes, most adolescents do not use

protection as they fear that condom use might raise questions from their partners about being sexually active and whether they have good moral values. **Respondent 8** talked about her dilemma regarding the perceptions of a partner who might think that if they do not have sex it means there is no love.

4.3.1.3 Comparison of the needs of HIV positive and HIV negative adolescents.

One of the objectives of the study was to identify the reproductive and sexual health needs of adolescents living with HIV. In this regard, the data from the semi-structured interviews indicated that while all adolescents have similar needs, those living with HIV have additional needs compared with their peers who are HIV negative. According to Obono (2010:30), the sexual and reproductive needs of adolescents living with HIV include a desire to have children, prevention of unplanned pregnancy and child bearing.

The participants indicated that while HIV positive adolescents need to have sex, they need to exercise extra caution, taking care and responsibility for their health, and using protection during sexual intercourse. The participants revealed the following:

Adolescents with HIV should have sex with extra caution: Participants were asked whether adolescents living with HIV could have sexual relationships. They stated that adolescents living with HIV need to have sexual relationships but should exercise extra caution.

Respondent 6 said: *“Yes adolescents have same needs like having sex but those living with HIV needs to do it in an advanced way. They need to be very responsible so that they do not spread the virus and also having unwanted pregnancy. With those who are negative I think they are worried about having unwanted pregnancy only. They do not care much but positive adolescents need to use a condom to be safe.....but also a condom is not 100% safe, it can burst. Surely adolescents living with the virus need sex but the challenge of having this disease makes someone not enjoy it.”* The researcher observed that the respondent was a bit shy when she was talking about sex.

The researcher noted that adolescents living with HIV have similar sexual and reproductive health needs to adolescents who are HIV negative. However, adolescents living with HIV are concerned about infecting others and unwanted pregnancies.

Respondent 1 mentioned that: *“Sex is fun and adolescents who are HIV positive just need to play safe by using protection. Those who are negative do not have problems as they can have sex without a condom and at times they will not be pregnant.”*

Eight of the respondents indicated that they were in a relationship and have the desire to have sex but are very careful. When probed regarding the difference between those who are HIV positive and those who are HIV negative, most respondents emphasised the need to use condoms to prevent the transmission of the virus.

Taking care and responsibility regarding one’s health: The participants also indicated that adolescents who are living with HIV need to take extra care in taking their ARVs. Adolescents living with HIV need to take care of their health; they are different from those who are HIV negative because they need to take medication i.e. they should take ARVs for the rest of their lives. **Respondent 2** emphasised the importance of taking care and responsibility for one’s health:

“I think they have different needs. Positive ones need to go to the clinic always, at times hospitalized. They need extra care because they are living with a disease no one knows much about it. They also need to be aware of themselves every time for example they cannot drink alcohol, cannot have sex anytime and need to protect themselves”.

This concurs with the literature that notes that regular check-ups should be conducted to monitor changes in adolescents living with HIV. Those medical check-ups should be done at least once every four to six months if a person is healthy but more frequently if they are showing symptoms of illness. This can help health professionals to identify physical as well as psychological problems at an early stage (Dyk, 2005:70).

Respondent 3 further said: *“Adolescents living with HIV have different needs, they need to take medication every day to survive.....Negative ones are just worried about unwanted pregnancy only and they do not go to clinic every day. Respondent 5* agreed: *“Yes they have different needs; positive people need ARV to survive.....they need to be extra responsible.”*

The researcher observed that most of the participants were aware of the importance of adhering to ARVs medication in order to live a better life. This might be a sign that adolescents living with HIV have a positive attitude towards life.

4.3.2 Adolescents’ understanding of HIV and AIDS and reproductive health need.

The second objective of the study was to determine whether adolescents living with HIV have knowledge about their reproductive health needs. The researcher assessed their understanding of HIV and AIDS and their reproductive needs by asking adolescents about family planning, their views on adolescents who are HIV positive if they find out that they are pregnant, dating and relationships and adolescents’ sources of information on sex, contraceptives and relationships.

4.3.2.1 Inadequate knowledge of preventive and contraceptive methods.

Condoms as the only method of family planning: Respondents were asked about their understanding of family planning. Significantly, all the females mentioned using condoms to prevent pregnancy. Only a few male respondents said that condoms are used to avoid transmission of HIV. Most participants indicated that condoms are for people who are married and do not want to have children.

The respondents described family planning as follows:

Respondent 1: *“Family planning is when people use condoms so that they do not have children. It is when married people plan to say that they need a certain number of children so they use condoms to avoid pregnancy”.*

Respondent 4: *“Hmm I am not sure but I think it’s when you want to have certain number of children, for example if you want two children you will use a condom every time after those two”.*

Taboos on issues related to family planning: As noted in the literature review, Zimbabwean adolescents still lack proper knowledge of contraception (UNAIDS, 2007). This could be due to the influence of culture and religion on sexual health. For instance, in some parts of Zimbabwe, people still oppose sex education and condom use as they consider them unethical. Furthermore, certain cultural and social barriers make youth reluctant to seek reproductive health services; going to a health centre for sexual and reproductive services implies that young women are indulging in sexual activities (Keller, 1997:134).

One of the participants said that they do not discuss issues about family planning at home. **Respondent 5** also said: *“We do not talk about family planning. It is for married people. I do not even know much what it means but I think it is about planning what you want in your life when you are married”.*

The researcher is of the opinion that adolescents who are living with HIV should have access to effective contraception and should be strongly advised to use condoms, not only as a family planning method, but to prevent transmission of HIV and re-infection.

4.3.2.2 Pregnancy and child bearing intentions amongst adolescents living with HIV.

Desire to have and keep children: Respondents were also asked if adolescents living with HIV have the desire to have children. The data indicated that adolescents living with HIV become pregnant intentionally and have child bearing intentions.

Most adolescents living with HIV dream of getting married and having children of their own (Birungi et al., 2007). The participants, who were mostly female, acknowledged that they received messages about not falling pregnant, but they felt that they can have children who are HIV negative if they join the PMTCT programme. Some participants said that they wished to have children but end up aborting the pregnancy due to fear. Still others felt that pregnancy would weaken their immune system.

Responding to the question on whether adolescents living with HIV can have children, one of the young women responded: *“Adolescents can have children if they are to be told at the clinic that they need to take pills which help them to prevent transmission of the virus to the child.”* **Respondent 5** said: *“Yes an adolescent can be pregnant; if they are on Stocrin (one of the ARVs) the pill which can make the child negative”* **Respondent 8** who is male, agreed with **Respondent 5**: *“Yes adolescents living with HIV can be pregnant as they say that there are pills to prevent the child...they need to be treated fast for the child to be negative.”*

The researcher was fascinated by the fact that one of the participants knew one of the ARV drugs by name. This suggested that the participant might intend to have a child in the future. Furthermore, one of the young men indicated that he was aware that there are certain drugs which help a child born to an HIV positive mother to remain healthy.

As noted in the literature review, adolescents have the right to decide the number of children to have and when to have them (Hartmann, 1987:54). Adolescents living with HIV have a fundamental need and desire to reproduce under certain circumstances. It is best to take a non-judgmental approach to reproductive decision-making which respects the adolescent’s autonomy (Mauren et al., 2006:123).

4.3.2.3 Adolescents’ sources of information and support in regard to sexuality

Parents or caregivers rarely talk to adolescents about sexuality: Seven out of the ten participants interviewed, indicated that they had never talked to their parents or caregivers about dating, sex and contraception. They are comfortable talking with

friends and counsellors. The literature review indicated that parents feel that sexuality is a difficult topic and that it is even more difficult to talk to children (Kirkman et al., 2000). In the context of Zimbabwe, cultural barriers and perceptions have hampered sex education.

These were some of the participants' views when they were asked if it is helpful for an adolescent to discuss sex, contraceptives and relationships with parents or friends:

Respondent 1 who is a 17 year-old male said: *“I think it is better to talk to friends; it is difficult with parents as they will think that I now want to start sleeping around with girls. With me my grandmother, she will kill me if I start that topic. If I have a concern or a question about sex or it can be relationship, I feel comfortable talking to the counsellor, they do not judge you instead they give you the correct information. When I was 13 years I was not sure if I was going to have a girlfriend because I am HIV positive. I went to the counsellor at one of the clinic and she helped me a lot. Now I do have my girlfriend and I am going to ask on how to tell her about my status. I cannot talk about this with my grandmother, I won't feel comfortable. We do not talk about those things”.*

Respondent 2 who is a female stated: *“We grew up being told that you cannot speak those things with parents, maybe you can talk to the aunt. But now there are no aunties to give you the information. So we rather get the information from our friends. Yes it is important for them to do the right thing. For us who are HIV positive we do have questions like can I have sex with my lover if I am positive. We are different as compared to those who are negative because the information is clear.”*

The researcher observed that adolescents are comfortable talking to friends about issues relating to sexuality and reproductive health. This is partly due to the way they were socialised; some topics should not be discussed openly with adults. Some respondents felt that it is easier to talk with service providers, as their parents would not listen to them.

Friends as a source of inaccurate information: Most participants were aware that, even though they get information from their friends, this information tends to be inaccurate. Furthermore, friends might betray them. This is clear from **respondent 7**'s response below:

“It is not easy to talk to parents; however it is helpful as they have the correct information. It is not easy as those topics about sex are seen as for adults only. It is better maybe to talk to the counsellor. It is very important and I think these are the matters of life because for us positive we need to be given the correct information for us to live longer. Friends can really betray you”.

Respondent 6 also felt that it is difficult to tell if the information they get from friends is correct or not: *“We do not talk about these things to parents they will judge you that you are asking this because now you want to sleep around. They will tell us that we are too young for this. So we talk with friends but eish you are not sure if the friend is telling you the right thing”.*

The above responses clearly demonstrate that it is not easy for adolescents to talk about their sexuality and reproductive issues with parents or caregivers. They would rather talk to their friends who do not always have accurate information. As peer pressure is more pronounced in adolescence, they commonly turn away from their families and move closer to their peers with whom they share information and ideas about their life, but this may be inaccurate (Edelman, 2006:512). Some of the participants added that they felt that it is critical for adolescents who are living with HIV to have accurate information on sex, relationships and dating in order to make informed choices. Most participants also said that they would rather seek advice from counselors.

4.3.3 Emotional experiences of adolescents living with HIV

Most respondents indicated that they experienced negative emotions and psychological distress after being told their HIV status.

4.3.3.1 Psychological distress experienced by adolescents after being diagnosed HIV positive

The participants' responses clearly showed that adolescents living with HIV experience psychological distress after an HIV positive diagnosis. They are afraid of dying, fear the negative consequences of disclosure and have negative feelings. More than half of the respondents are worried about being HIV positive, with no significant difference between female and male respondents. The main worry of a few of the participants was infecting others with HIV and becoming or making someone pregnant. A significantly higher proportion of male than female participants were worried about infecting others with HIV.

Fear of death: Participants demonstrated that adolescents living with HIV are afraid of death. Most were very emotional when they told the researcher how they felt after being told their HIV status. Female participants cried a lot and boys had sad faces; the researcher could also hear their voices shaking as they spoke. One participant who is a female shared her fears of death: *"I always think that I am going to die. The problem with HIV is that there is no cure so every time I think that if I am sick and it gets worse, what will happen to me. I do not want to die and this stresses me"*.

Cao et al. (2006:525) associated the fear of death with HIV and AIDS in their studies of HIV- and AIDS-related stigma. Their study revealed that some uninfected participants believed that death from HIV infection was immediate; it was therefore a greatly feared infection. However, the current study revealed that HIV positive people also fear death. One respondent said: *"It was bad, I was very angry and sad, and I thought I was going to die. I do not want to die, this disease does not have a cure so I thought it was the end"*.

The above responses clearly reflect that adolescents living with HIV are afraid of death as there is no cure.

Experiences of negative emotions: Being diagnosed with HIV can create a raft of emotions including anger, denial, depression, anxiety, shock, and fear of death (WHO, 2003). Most participants said that they felt bad, sad, angry and depressed after being diagnosed with HIV.

Respondent 2 stated: *“I felt sad. The bad part of it is that I do not know where I got the virus from because my mother is not there to tell me”* (she burst into tears).

Respondent 4 said sadly *“I was very depressed and I was thinking that I was going to die”*.

Respondent 5 said: *“I was very angry and thought of killing myself. I blamed my mother for giving me this disease and I thought it was the end of the world”*.

Respondent 8 observed: *“Hey it was bad, I was very angry and sad, I thought I was going to die.”*

When asked why they felt that way, most participants said that they were worried when they first heard of their HIV positive diagnosis, citing either fears that they would become more ill and die or disbelief that they could have this illness. Many felt sad upon learning about their HIV status, because of their young age and the stigma associated with the illness.

Studies cited in the literature review, noted that young people reported feeling sad, depressed, and lonely and isolated from family and friends when they were diagnosed HIV positive (Lewis, 2001: 123; Lyon and D’Angelo, 2006: 56 and Miah, 2004:159). They are afraid other people will find out and also find it difficult not being able to talk about HIV with their families.

4.3.3.2 Family as a support system to alleviate negative emotions

Family members supporting adolescents on treatment: The participants indicated that, even though adolescents living with HIV experience negative feelings, family

members provide support in terms of reminding them to take their ARVs. The statements included the following,

“They were very supportive”

“They treat me normal”

“They are very supportive and love me just like any child”

“I told my aunt, I am very close to her and she always comforts me”

“They love me as a normal child. I do not see the difference”

“They are encouraging me to take my treatment”

The above responses demonstrate that adolescents did receive support after disclosing their HIV status to their family members. Family members reminded them to take their medication and this resulted in good adherence to ARV treatment.

4.3.4 Care and treatment needs of adolescents living with HIV

The third objective of the study was to examine the availability and accessibility of reproductive health services for HIV positive adolescents in order for them to make informed decisions. Respondents were asked if they know about services that provide advice, care and treatment for adolescents living with HIV, what makes adolescents use these services, issues that need to be addressed by service providers and whether or not privacy and confidentiality are important when dealing with adolescents.

4.3.4.1 Adequate knowledge of the availability of services for adolescents

Participants demonstrated that they have adequate knowledge of the services available for adolescents who are living with HIV.

Hospitals and clinics as health service providers for adolescents: All the respondents indicated that they visit either a clinic or a hospital for their care and treatment needs. Eight respondents said they go to a clinic to get their ARVs and also to consult when they are sick. One respondent stated that she visits the Sunningdale

community centre, one of the locations in Harare, Zimbabwe, for her support group for teenagers living with HIV. The other respondent said that she is normally admitted to hospital when she is sick. These responses indicate that the participants have adequate knowledge of the services available for their health, treatment and care needs.

4.3.4.2 Challenges experienced by adolescents at health facilities

Most participants indicated that adolescents living with HIV experience some challenges in accessing health facilities. They mentioned that health services are not youth friendly, staff members have attitude problems and there is insufficient information on adolescents' reproductive and sexual health issues.

Health services are not youth friendly: Respondents reported that health services are not friendly to adolescents living with HIV. Feeling judged and finding that their privacy and confidentiality are not respected, are some of the factors that discourage them from visiting clinics. The respondents described how some staff members react to adolescents seeking health services:

Respondent 1: *“The moment you are in a room with the nurse or staff member at the clinic they pass comments which makes you feel bad and blame yourself like you must not sleep around with men as you are still young “*

Respondent 5: *“The moment you go to the nearest clinic to seek treatment and tell the nurse that you are HIV positive; they think you got it because you were sleeping around with men. It is worse if you want to access condoms as they think they are only for married people not us teenagers. Everyone in the clinic will know your status and look at you as if you have killed someone. By the end of the day you think it is better not to go there or you think ten times before you go there”.*

From the above responses, the researcher observed that adolescents are particular regarding issues of privacy and confidentiality. Furthermore, most participants were concerned about clinic staff members' perceptions about how one contracts HIV. The above responses indicate that staff's attitude is one of the major challenges adolescents

living with HIV experience in accessing health services. The respondents stated that staff members judge and blame adolescents living with HIV for their status. However, some were born with HIV and some became HIV positive after having been raped.

The literature review noted that adolescent-friendly services should be welcoming, pleasing and helpful. Adolescent services must not apportion blame, and should be acceptable to potential users and responsive to cultural and social norms, taking into consideration aspects such as privacy and confidentiality (Magwenhu, 2000:54). However, the participants indicated that this is not the case with health services for adolescents living with HIV in Zimbabwe.

4.3.4.3 Insufficient information on the reproductive and sexual needs of adolescents

Most participants indicated that they do not receive important information regarding their sexual and reproductive health at hospitals and clinics. To support this statement, some of the responses included:

Respondent 1: *“Issues like pregnancy, how can we be safely pregnant, no one is telling us that information”.*

Respondent 2: *“We want them to tell us other things not always talking about HIV, like drug abuse, peer pressure”.*

Respondent 3: *“Adherence to our ARVs, they should keep on emphasising on taking our medication”.*

Respondent 4: *“They should tell us about contraceptives. Now we are attending adult clinic from paediatric clinic. It is a problem there as the staff does not understand our issues as adolescents. They treat us as adults. We would want information on dating and relationships, sex, pregnancy and living with this disease. We do not know what to do if I want to date or to have children. It is difficult to discuss those issues as they always tell us to be responsible. They emphasise on adherence to treatment, respecting parents and healthy eating. Yes I need that but I have critical issues”.*

The researcher observed that adolescents do not need to only focus on their illness but also want information which affects their lives. They need information on pregnancy, drug abuse, contraceptives and other sexual and reproductive health topics. This will help them to make informed choices and decisions.

The literature review noted that, health services that assist people living with HIV should include the diagnosis, management, and treatment of HIV and STIs, sex education and information; psychosocial support to cope with living with HIV; and family planning (UNAIDS, 2006) . However, the respondents felt that adolescents living with HIV are not receiving information on contraceptives, dating, relationships, pregnancy, drug abuse and peer pressure.

4.4 INTERPRETATION OF DATA

The data was interpreted based on the four major themes discussed below which emerged from the semi-structured interviews with the participants.

Adolescents' knowledge of HIV and AIDS

The data collected from the participants illustrated that there is inadequate knowledge of HIV amongst adolescents living with HIV. The participants indicated that HIV is a disease which leads to death. Furthermore, they also indicated that AIDS is a disease which leads to death. According to the data analysed, adolescents failed to differentiate between HIV which is a virus and AIDS which is a disease. There is therefore inadequate knowledge of HIV and AIDS amongst adolescents who are living with HIV, as the participants regarded HIV and AIDS as one and the same thing. This could be due to the fact that most people use the term 'HIV/AIDS', leading to the perception that it is one condition.

Understanding of HIV and sexual and reproductive needs of adolescents

The participants' responses on their sexual and reproductive health needs showed that adolescents are aware of their sexual and reproductive health needs, but that they experience several challenges. Most participants agreed that adolescents living with HIV can engage in sexual relationships; however, there are challenges relating to disclosure. Furthermore, participants were also aware that adolescents living with HIV can have children and go to the clinic to consult although a few felt that pregnancy would weaken their immune system. However, the researcher noted that participants had inadequate knowledge of contraceptive use, as they regarded condoms simply as a method to prevent unwanted pregnancy. Adolescents living with HIV have additional needs compared with their peers who are HIV negative. The researcher also found that, as much as the participants are aware of their needs, these are not addressed by health facilities or by their parents.

Emotions experienced by HIV positive adolescents

The data revealed that adolescents living with HIV found it difficult to accept their status. They experienced psychological distress after being told their status, describing feelings of sadness, anger and shock. The researcher concluded that adolescents living with HIV fear death as there is currently no cure for HIV.

Health care services needed by adolescents living with HIV

The data showed that adolescents need services which are youth friendly. The most common concern was that health providers have a negative attitude towards adolescents living with HIV and do not respect privacy and confidentiality. Participants stated that adolescents living with HIV need respect, information regarding their sexual and reproductive health needs and a friendly health environment and information from service providers. It is clear from the analysis and interpretation of the participants' responses that the sexual and reproductive health needs of adolescents living with HIV

are not being met. This study also confirmed the existence of wide gaps in health services in addressing the sexual and reproductive health needs of adolescents living with HIV. The findings therefore provide a tangible basis to generate discussions on how existing programmes can be strengthened to provide adolescents with appropriate information and services.

4.5 SUMMARY

In this chapter, the researcher presented and analysed the data collected from semi-structured interviews. The data analysis method used in this study included Tesch's descriptive method of open coding as discussed by Creswell (2003:186). Four major themes emerged from the data: adolescents' understanding of HIV and reproductive health needs; adolescents' understanding of HIV and sexual needs; the emotional experiences of adolescents living with HIV; and the care and treatment needs of adolescents living with HIV. The themes were further sub-divided into sub-themes, e.g., adolescents' inadequate knowledge of HIV; challenges experienced by adolescents in intimate relationships; psychological distress experienced by adolescents after being diagnosed HIV positive; and the challenges faced by adolescents at health facilities. The data collected was presented and analysed in a descriptive form using verbatim quotes from the participants. The following chapter discusses the findings of the study with regard to the themes and sub-themes that emerged from the data collected. This is followed by the conclusions and recommendations.

CHAPTER 5: DISCUSSION OF THE FINDINGS

5.1 INTRODUCTION

This chapter begins by interpreting and discussing the findings of this study based on the four major themes that emerged from the data collected. The researcher responds to the research questions and discusses other empirical research themes. The findings are compared with those of the literature review to indicate areas where they either confirm or differ from previous studies.

The aims and objectives of this study are stated and used as a focal point to determine whether or not its goals have been achieved. Furthermore, a theoretical review is undertaken in order to ascertain whether the social constructionist theory used was helpful in guiding the research.

5.2 DISCUSSION OF FINDINGS FOCUSING ON THE RESEARCH QUESTIONS

This study examined the sexual and reproductive health needs of adolescents infected with HIV and AIDS. The first part of the discussion on the findings is guided by the research questions stated in section 1.4 of this study. The findings are discussed according to the main themes and sub-themes that emerged from the analysis of the data in the previous chapter, namely, adolescents' understanding of HIV and AIDS and reproductive health needs; adolescents' understanding of HIV and AIDS and sexual needs; and the care and treatment needs of adolescents living with HIV.

5.2.1 Research question: What are the sexual and reproductive health needs of adolescents infected with HIV and AIDS?

Two major themes emerged with regard to the sexual and reproductive health needs of adolescents living with HIV. In response to this question, the discussion focuses on

adolescents' understanding of HIV and reproductive health needs and their understanding of HIV and sexual needs.

5.2.1.1 Adolescents' understanding of HIV and sexual needs

Adolescents' inadequate knowledge about HIV and sexual needs: The findings of this study revealed that adolescents have inadequate knowledge about HIV and AIDS; this impacts negatively on their decisions relating to sexual and reproductive health issues. Most of the participants demonstrated limited knowledge of HIV and AIDS as they were unable to differentiate between HIV and AIDS. Participants viewed HIV as a very dangerous disease and stated that, a person would die as soon as they are diagnosed. This contradicts Nana's (2005:52) definition of HIV as a retrovirus disease that is primarily transmitted through sexual intercourse but also through infected blood from mother to newborn child. HIV can be treated by taking ARVs.

Most of the participants showed some understanding of HIV transmission as they indicated that HIV is transmitted sexually, while a few indicated that it is transmitted from mother to child and through needles. This finding corroborates the WHO's (WHO ,2004) statement that HIV can be transmitted through unprotected sexual intercourse with an infected partner; through contact with infected blood, semen, and cervical or vaginal fluids; and from mother to child. Unprotected sexual intercourse is the most common mode of transmission of HIV worldwide. The participants stated that HIV can be prevented by the use of condoms. The literature review indicated that condoms are highly effective in preventing HIV infection if used consistently and correctly (UNAIDS, 2004). However, Van Dyk (2005:89) stated that the only 100% effective way of preventing the sexual transmission of HIV is total abstinence from sex; this is not realistic for young people.

Challenges experienced by adolescents in intimate relationships: The research findings showed that although adolescents living with HIV engage in relationships, they confront some challenges, including insecurities about dating, disclosure and discussing

condom usage. All the participants stated that adolescents living with HIV can have relationships, but confront challenges in doing so. Previous studies (e.g. Army, 2010:42) have noted that adolescents living with HIV engage in romantic relationships and explore their sexuality, but their experiences are often clouded by fear about their status, disclosure and rejection, transmission of the virus, re-infection, stigma and discrimination. Rathus et al. (2008:351) noted that an adolescent living with HIV faces challenges when it comes to unprotected sex, leading to unwanted pregnancy, acquisition of another sexually transmitted infection (STI), or re-infection with a different strain of HIV. Birungi et al. (2007) adopts a different view and observes that young people living with HIV do not primarily construct their lives around their illness; instead they aspire to lead normal lives like other adolescents, including dating and relationships.

The participants revealed that although adolescents living with HIV engage in sexual relationships, disclosing their HIV status is a big challenge and can be stressful, especially if they have deep feelings for their partners. All the participants mentioned that adolescents living with HIV do not know how to disclose their HIV status to their sexual partners as they are afraid of being rejected. They therefore felt that it is not a good idea to disclose to partners as they will not be able to cope with the negative consequences. All the participants had disclosed their status to their families. A study conducted at Kampala's Mulago Hospital focussed on 20 adolescents' experience of disclosing their HIV status to their peers, friends and family. Partner disclosure proved to be the most challenging for the participants, who cited fear of rejection, and loss of respect and care, if their status became known (Bakeera-Kitaka et al., 2010).

Army (2010:78) adopts a different perspective. He states that disclosure is the gateway to access support and care; in other words, disclosure enables adolescents to be accepted unconditionally and receive relevant support which will enable them to fight stigma. People living with HIV may reduce infection of their sexual partners and so diminish the spread of HIV by disclosing their status.

The research findings also indicated that adolescents living with HIV experience challenges in negotiating the use of protection during sexual intercourse to prevent transmission of HIV to others or re-infection of themselves. Most of the participants felt that proposing to use condoms means that someone does not love their partner and might raise questions from partners about being sexually active. This is in agreement with Di Clemente's (1992:29) observation that due to cultural and social beliefs, most adolescents do not use protection as they fear that condom use might raise questions from their partners about being sexually active and whether they have good moral values.

Comparison of the needs of HIV positive and HIV negative adolescents: The study findings revealed that HIV positive and HIV negative adolescents have similar needs. However, adolescents living with HIV have additional needs. All the participants indicated that adolescents living with HIV have the same sexual needs as their HIV negative peers, namely, the desire to engage in sexual relationships, but they have different sexual and reproductive health needs. While Obono (2010:30) states that the sexual and reproductive needs of adolescents living with HIV include the desire to have children, prevention of unplanned pregnancy and sexual relationships, he did not mention their sexual and reproductive health needs.

While the participants stated that they desire to have sex, they engage in it with extra caution. One participant stated that although adolescents living with HIV can engage in relationships, they need to avoid transmission of HIV; they should use condoms to avoid re-infection, unwanted pregnancy and transmission of HIV to their partners. Their peers who are HIV negative are only concerned about unwanted pregnancy and transmission of HIV. All participants stated that, while they want to have sex, they fear the consequences.

The study findings also revealed that adolescents need to take more care of their health than their HIV negative peers. The participants stated that adolescents living with HIV require regular check-ups and need ARV treatment for the rest of their lives. This finding

is confirmed by Van Dyk (2005:70) who stated that adolescents living with HIV need regular check-ups to monitor changes in their health; this will assist health professionals to identify and treat physical problems at an early stage.

5.2.1.2 Adolescents' understanding of HIV and reproductive health needs

Inadequate knowledge of preventative and contraceptive methods: The findings of this study revealed that adolescents living with HIV have inadequate knowledge of available preventative and contraceptive methods. The majority of the participants, mainly females, stated that condoms are used for family planning, while a few male participants said that condoms are used to avoid HIV transmission. Furthermore, the participants were of the view that condoms are for married adults who are planning to have a certain number of children. It was noted in the literature review that the Zimbabwean government introduced the “ABC” campaign (Abstain, Be faithful and Condomise) to encourage condom use to prevent HIV transmission (UNIGRASS, 2010). The research findings revealed that adolescents living with HIV require more information on contraceptives; Neilson (1991:45) noted that, throughout the world, sex education is inadequate.

The research findings also revealed that participants have little knowledge of the use of contraceptives as they do not normally talk about them. This finding is supported by previous studies that found that Zimbabwean adolescents lack proper knowledge of contraceptives, possibly due to the influence of culture and religion on sexual health (UNAIDS, 2007).

The study also revealed that adolescents living with HIV strongly desire to have children in the future. Most of the participants, male and female, said that an adolescent should keep the baby if she discovers that she is pregnant. One participant stated: “*Yes an adolescent living with HIV can be pregnant; if they are on stocrin (one of the ARVs) the pill which can make the child negative.*” This is in agreement with the findings in the literature that most adolescents living with HIV dream of getting married and having children of their own (Birungi et al., 2007). The literature also indicated that adolescents

living with HIV have the right to decide on the number of children to have and when to have them (Hartmann, 1987:54).

5.2.2 Research question: What kind of information do young HIV positive people require for them to be able to make informed choices about their sexual and reproductive health needs?

5.2.2.1 Adolescents' source of information and support about sexuality.

The research findings showed that adolescents living with HIV need information on sex, dating, and contraceptives. The participants indicated that they are not comfortable talking about sex with their parents and caregivers as they have been socialised to not talk about sex with adults. One of the participants described how difficult it is to discuss sex with an adult as follows: *"I think it is difficult with parents as they think that I am now sleeping around with girls. With me my grandmother will kill me if I start the topic"*. Ahlerberg et al., (1997:67) observe that it is difficult for both young people and adults to talk about sexual and reproductive health. In contrast, Moore (2006: 74) notes that in countries like United States of America (USA), teenagers' major sources of information about sex are parents, books and the mass media.

The research findings revealed that adolescents living with HIV are comfortable talking about sexual and reproductive issues with friends, although they are aware that the information they receive from friends may be inaccurate. Previous studies have shown that adolescents tend to turn away from their families and move closer to their peers with whom they share information and ideas about their lives, which may be inaccurate (Edelman, 2006:512).

Participants also indicated that they need information on safe dating and relationships. Most indicated that they do get this information from their parents or health workers; this prevents them from fulfilling their sexual and reproductive health needs. One participant strongly expressed her need for information by saying:

“Now we attending adult clinic from paediatric clinic. It is a problem there as staff members do not understand our issues as adolescents. We want information on dating, relationships, sex, pregnancy and living with this disease. We do not know what to do if we want to date and have children. It is difficult to discuss those issues as they always tell us to be responsible”.

Jackson (2002:122) notes that access to information about sexual and reproductive health is a human right, especially for youths.

The study participants did not mention male circumcision as an HIV prevention method and only one participant indicated that there are drugs which prevent HIV transmission from mother to child. The literature review noted that PMTCT services are an integral component of antenatal care for HIV positive mothers to reduce the likelihood of vertical transmission of HIV (WHO, 2006). The major HIV prevention strategies in Zimbabwe include the use of condoms, PMTCT and voluntary male circumcision (WHO, 2002).

5.2.3 Research question: To what extent are existing treatment, care and support services addressing the sexual and reproductive health needs of HIV positive young people?

5.2.3.1 Care and treatment need of adolescents living with HIV.

Adequate knowledge of availability of services: The participants stated that they are aware of existing services for adolescents living with HIV, including hospitals and clinics. The WHO (2000) guidelines state that health services describe all the organizations, institutions and resources that a society devotes to improving and restoring health.

Although adolescents living with HIV are aware of health services, most participants revealed that they face challenges in accessing health facilities. They said that health

services are not youth-friendly and that there is insufficient information on adolescents' sexual and reproductive health.

Challenges experienced by adolescents at health facilities: The participants felt that health services target married people. They indicated that healthcare workers have very negative attitudes and judge them. Furthermore, the lack of privacy and confidentiality discourages them from accessing these services. Amunyunzu et al. (2005:23) note that clinics tend not to be utilized by young people due to various factors such as shyness, the judgmental attitudes adopted by staff and a lack of privacy.

The WHO (2000) guidelines state that youth-friendly services should not apportion blame, be non-judgmental and should be acceptable to potential users and responsive to cultural and social norms, taking into consideration aspects such as privacy and confidentiality. Magwenhu (2000:54) suggests that an adolescent-friendly service should be welcoming, pleasing and helpful. However, such services do not appear to be provided in Zimbabwe.

Most of the participants stated that the health facilities do not provide information on important issues like pregnancy, contraceptives, dating and relationships, drug abuse and peer pressure. This concurs with Birungi et al.'s (2008) study that found that counseling services are not responsive to the needs of HIV positive adolescents, as service providers focus on their responsibilities rather than their needs.

UNAIDS (2006) indicated that health services that assist people living with HIV should include the diagnosis, management, and treatment of HIV and STIs; sex education and information; psychosocial support to cope with living with HIV; family planning; services for safe abortion in circumstances where it is not against the law and post-abortion care; safe delivery services; counseling and treatment to address sexual dysfunction; and HIV prevention. However, this is not the case with Zimbabwean health facilities.

5.3 DISCUSSION OF FINDINGS BASED ON OTHER EMPIRICAL RESEARCH THEMES

The other theme which emerged from the research findings is that adolescents living with HIV experience negative emotions after being diagnosed HIV positive. All the study participants said that they experienced psychological distress after their HIV positive diagnosis.

5.3.1 Psychological distress experienced by adolescents after HIV positive diagnosis.

The participants revealed that, after being told their HIV status, they experienced a fear of death, fear of the negative consequences of disclosing their HIV status and other negative emotions.

Fear of death: Most participants mentioned that they are afraid of dying due to HIV. They think constantly about dying as there is no cure for HIV. Cao et al. (2006:525) stated that infected people believe that death from HIV is immediate. The literature review also showed that people living with HIV do not only experience fear of death; they also experience fear of not knowing how the disease will progress and fear of isolation by friends and families (American Association Psychiatric Association, 2008).

Fear of negative consequences of disclosing HIV status: The participants revealed that they are afraid of disclosing their HIV status to their peers and their sexual partners as they are not prepared to handle the consequences of disclosure. This finding concurs with Kalichman's (2004:43) observation that adolescents living with HIV are afraid of disclosing their HIV status to their peers for fear of rejection, stigma and discrimination. All the participants felt that it was better not to disclose their status, especially to their sexual partners. This contradicts the findings of previous studies (Green et al., 2003:68) that disclosure reduces the burden on HIV positive people and leads to support from friends and loved ones.

Experience of negative emotions: All the participants revealed that they felt bad, sad, angry and depressed after being diagnosed with HIV. Previous studies (e.g. Lewis 2001; Miah 2004) have reported that young people felt sad, depressed and lonely after being diagnosed HIV positive.

5.4 COMMENTS ON THE AIMS AND OBJECTIVES OF THE STUDY

The empirical investigation was guided by the following objectives:

(i) To identify the sexual and reproductive health needs of adolescents living with HIV

The study sought to identify the sexual and reproductive health needs of adolescents living with HIV in order to inform the design of intervention programmes which meet their needs. This will also help to improve available services targeting adolescents and empower adolescents with accurate information on their sexual and reproductive health needs.

The research findings confirmed that adolescents living with HIV lack information and knowledge on sexual and reproductive health issues. Hence, programmes need to strengthen the provision of information and services relating to family planning and HIV prevention. The study also confirmed that adolescents living with HIV need to know about services such as PMTCT and other antenatal health care services in order for them to make informed choices. Health care education should also be provided to adolescents to enable them to make informed decisions about fertility, unwanted pregnancies, STIs and self-re-infection. The researcher therefore concludes that this objective was not only necessary in guiding the research, but was also successful in doing so.

(ii) To determine whether adolescents living with the HIV virus have knowledge of their sexual and reproductive health needs and services

It was important for the researcher to establish whether or not adolescents living with HIV have knowledge of their sexual and reproductive health needs so as to assess whether there is a need to improve the provision of services and information targeting adolescents. Such knowledge will determine whether or not adolescents are able to make informed decisions on their involvement in sexual relationships, pregnancy and child bearing. Without such knowledge, they risk unwanted pregnancies and HIV re-infection. Furthermore, assessing this knowledge will increase these adolescents' level of awareness of their sexual and reproductive health needs. The researcher concludes that this objective was necessary in achieving the aims of the study.

(iii) To examine the availability and accessibility of reproductive health services for HIV positive adolescents in order for them to make informed decisions

The examination of the availability and accessibility of reproductive health services for HIV positive adolescents assisted the researcher in generating discussions on how existing health services could be strengthened to provide adolescents with appropriate interventions. It was also important to check if adolescents know who the service providers are and where to go when they need health services. The researcher concludes that this objective helped to achieve the aims of the study.

(iv) To provide recommendations on how best to address the sexual and reproductive needs of HIV positive adolescents.

It was important to provide recommendations on how best to address the sexual and reproductive needs of HIV positive adolescents. This will empower adolescents with information and knowledge on their sexual and reproductive health needs and enable them to make informed decisions.

5.5 REVIEW OF THE THEORETICAL FRAMEWORK FOR THE EXAMINATION OF THE SEXUAL AND REPRODUCTIVE HEALTH NEEDS OF ADOLESCENTS LIVING WITH HIV.

5.5.1 Review of the Social Constructionist Theory

Social constructionism theory provided the framework for this study. This theory is rooted in the ideas of French philosopher, Michael Foucault (1978) who posited that knowledge is constructed through social interpretation; that is, what we perceive as reality has been shaped by a system of social, cultural and interpersonal processes (Foucault ,1994:68).

This theory enabled researcher to understand why participants do not talk about family planning and other sexual and reproductive health issues with adults. In Zimbabwean culture, it is taboo to discuss sex with young people (Di Clemente, 1992:37). The participants stated that family planning is for adults who want to plan their families. The communities and societies the participants live in therefore construct the meaning that sexual and reproductive health issues are for adults.

Foucault's theory that what we perceive as reality has been shaped by a system of social, cultural and interpersonal processes also enabled the researcher to understand why the participants perceived that HIV and AIDS is a deadly disease that kills human beings. This might be due to societal perceptions. When HIV was first discovered in Zimbabwe, it was associated with death and the perception was that there was no hope for the future after diagnosis. The participants' description of how they felt about their diagnosis, i.e., anger, depression, sadness and surprise, is a reality shaped by how people perceive HIV and AIDS.

Furthermore, social constructionism theory holds that there are social scripts in different societies; social prescriptions for sexual behavior exist in any society and people behave in accordance with these prescriptions (Gagnon and Simmons, 1973:301). This helped the researcher to understand why female participants mentioned that it is difficult

to negotiate condom use as it will appear that they are promiscuous. The participants also revealed that they are judged by health providers if they seek information on reproductive health. This might be due to the fact these services are for adults and married people in the Zimbabwean context.

Foucault also argues that sexuality is not merely a biological drive whose character is the same across time and culture; it is a social construct. Meaning is derived from language; each institution in the society has a discourse about sex, a way of thinking and talking about the broad array of behaviors and people who are involved in a sexual expression (Lock and Strong, 2010:6). This helped the researcher to understand why participants indicated that sex and contraception are for adults. Participants also indicated that they experience challenges in accessing reproductive services like condoms because adults will see them as young people who are indulging in sexual behavior, which is not acceptable in their society.

Another tenet of social constructionism theory is that the constructs we make of the world around us can only be made through interactions with others and knowledge only exists when it is shared with another person. These constructs are useful in everyday life. This notion helped the researcher to understand the inadequacy of knowledge about HIV, reproductive needs and inadequate knowledge of preventative and contraceptive methods among adolescents living with HIV. This might be due to the fact that adolescents do not discuss these issues with adults who could give them accurate information, but rely on their peers who have limited information on sexual and reproductive health. Participants strongly indicated that health services should not only inform them about HIV, but provide information on pregnancy, contraceptives, dating and relationships.

5.6 SUMMARY

In summary, the social constructionism theory guided the researcher in understanding why respondents did not have sufficient knowledge of some sexual and reproductive

health issues such as contraceptives, relationships and sex. This might be due to socially constructed norms in their communities and societies. Participants indicated that they do not talk about certain topics like condom usage as these are meant for adults only.

CHAPTER 6: SUMMARIES, CONCLUSIONS AND RECOMMENDATIONS

6. 1 INTRODUCTION

This section presents the summary of the study. The summaries were according to the four main themes and sub-themes that emerged from the data collected. This is followed by conclusions, recommendations based on the findings and recommendations for further study. The main themes summarized are adolescents' understanding of HIV and AIDS and sexual health needs; adolescents' understanding of HIV and AIDS and reproductive health needs; emotional experiences of adolescents living with HIV; and care and treatment needs of adolescents living with HIV.

6.2. SUMMARIES AND CONCLUSION

6.2.1 Adolescents' understanding of HIV and AIDS and sexual health needs

According to the research findings, participants demonstrated an inadequate knowledge of HIV and AIDS even though they are living with the HIV virus. They were unsure how to differentiate between HIV and AIDS. Some participants viewed HIV as very dangerous and thought that a person would die as soon as he or she is diagnosed with the virus. On the other hand, participants showed that they have some understanding of how HIV is transmitted sexually and through mother to child transmission. They also mentioned that HIV can be prevented by the use of condoms. The literature review also indicated that condoms are highly effective in preventing HIV infection if used consistently and correctly (UNAIDS, 2004). The major HIV prevention strategies in Zimbabwe include the use of condoms, PMTCT and voluntary male circumcision (WHO, 2002).

Adolescents living with HIV engage in romantic relationships and explore their sexuality (Army, 2010:42). However, their experiences are often clouded by fears about status; disclosure and rejection; transmission of the virus; re-infection; stigma and

discrimination; and concerns about their future roles as husband, wife, partner or parent. The adolescents who participated in this study also experienced challenges regarding dating and negotiating condom usage.

Conclusion: According to the research findings, most of the participants described HIV as a deadly disease and few had some understanding of what HIV is. In terms of defining AIDS, some of the participants were not clear on what it is except that it kills and few indicated that it is a disease with no cure. Regarding HIV transmission, all participants had some knowledge of how it is transmitted. However, this finding revealed inadequate knowledge about HIV and AIDS.

With regard to dating, all of the participants stated that adolescents living with HIV can date, but should exercise caution. A few revealed that they prefer to date others living with HIV as they understand the implications of not using protection. The researcher therefore concludes that as much as adolescents living with HIV desire sexual relationships, they need to take extra precautions to avoid transmission and re-infection.

6.2.2 Adolescents' understanding of HIV and reproductive health needs

The study found that adolescents living with HIV have the same reproductive health needs as their peers who are HIV negative. However, the findings revealed inadequate knowledge of preventative and contraceptive methods among adolescents living with HIV. They also face challenges related to their HIV status, most notably around reproductive health issues. Furthermore, they need to take extra precautions like using condoms to avoid re-infection, unwanted pregnancies and transmission of HIV to their partners.

The study participants said that want to have children, even though they are afraid that pregnancy might weaken their immune system. Furthermore, most mentioned that they talk to their peers rather than their caregivers or parents about sexual and reproductive

health issues. However, they are aware that their peers do not always provide accurate information that would help them to make informed decisions.

Conclusion: Of the 10 participants interviewed, most indicated that condoms are for family planning and that family planning is for married people. Only few indicated that condoms are used to prevent HIV transmission. This suggests that most of the adolescents who participated in this study did not know much about family planning. This was confirmed by Langhaug et al.'s (2003:93) study on improving young people's access to reproductive health care in Zimbabwe, which found that adolescents are not properly received and are not comfortable in mainstream government family planning clinics. Hence, adolescents do not have access to reliable information on family planning. With regard to the sources of information and support, most of the participants revealed that they had never spoken to their parents or caregivers about contraceptives, sex and dating; they only talk to their friends. Only a few stated that they are comfortable talking to both their friends and counsellors. It is therefore concluded that most adolescents do not talk about sex, dating and contraceptives with adults; this might be due to cultural and social beliefs that such topics are for adults only.

6.2.3 Emotional experiences of adolescents living with HIV

An HIV positive diagnosis may be traumatic and is difficult to deal with as there is currently no cure for HIV and AIDS. People perceive it as a death sentence. The research findings revealed that adolescents living with HIV experience psychological distress after they are diagnosed HIV positive. They fear dying and also fear disclosing their HIV status to their sexual partners. All the participants indicated that they had disclosed their status to their close family members, but most had not disclosed to their sexual partners. The participants also experienced negative emotions which included feelings of sadness, anger, depression and shock.

Conclusion: Most of the participants revealed that they are afraid of dying. This corroborates the findings of Cao et al.'s (2006:525) study that noted that, adolescents living with HIV believed that death from HIV infection was immediate; it was therefore a

greatly feared infection. All the participants in this study experienced negative emotions; however, they confirmed that their families supported them to alleviate those negative emotions.

6.2.4 Care and treatment needs of adolescents living with HIV

Like their HIV negative peers, adolescents living with HIV require health care and medical treatment. However those living with HIV need additional medical treatment. The research findings showed that all the participants were all aware of existing services for adolescents living with HIV. However, they revealed that adolescents living with HIV experience challenges in accessing health facilities; health services are not youth-friendly and there is insufficient information on adolescents' reproductive and sexual issues.

Conclusion: The study found that all of the participants had adequate knowledge of the availability of services, as they mentioned hospitals and clinics as major health service providers to adolescents. The participants also indicated that they regularly go either to a clinic or a hospital to collect medication. Jackson (2002:57) notes that all adolescents on ARVs must take their medication as prescribed to achieve the best health outcomes. It is concluded that the adolescents who participated in this study had an adequate knowledge of accessible health care service providers in their areas.

In terms of the challenges faced by adolescents at health facilities, most of the participants revealed that health services in the community are not youth-friendly, as staff members have negative attitudes, they are judged by staff members and privacy and confidentiality are not respected. All the participants stated that they do not receive important information regarding pregnancy, drug abuse, and contraceptives and dating at the health facilities. It is concluded that it is critical that healthcare workers respect privacy and confidentiality. Furthermore, health care services for adolescents living with HIV should be welcoming and not judgmental.

6.3 RECOMMENDATIONS BASED ON THE FINDINGS OF THE STUDY

6.3.1 Adolescents' understanding of HIV and AIDS and sexual health needs

- Conduct HIV and AIDS awareness with adolescents living in various communities to impart more information which will also reach adolescents living with HIV.
- Encourage HIV and AIDS counsellors to improve their counselling skills, so that they can assist and empower adolescents living with HIV to negotiate condom usage and handle dating and relationships.
- Establish adolescent clinics which are user-friendly and community-based disclosure groups to empower adolescents with skills on how to safely disclose their HIV status.

6.3.2 Adolescents' understanding of HIV and reproductive health needs

- Health workers should provide a platform for adolescents to discuss issues around sexuality and reproductive health.
- A full range of adolescent sexual and reproductive health services should be provided, including all available contraceptives.
- Programmes should put mechanisms in place to involve parents or caregivers in discussing sexual and reproductive health issues with adolescents living with HIV.

6.3.3 Emotional experiences of adolescents living with HIV

- Provide ongoing supportive counselling to adolescents living with HIV, to help them deal with the emotions experienced after being diagnosed HIV positive. This should be provided by skilled counsellors.

- Establish peer support groups and clubs to address the psychological needs of adolescents living with HIV. These can be used to empower adolescents to make informed decisions and choices about their lives and their sexual and reproductive health needs.

6.3.4 Care and treatment needs of adolescents living with HIV

- Improve services for adolescents by establishing youth-friendly services which will enable health workers to better respond to adolescents' needs.
- Services for adolescents living with HIV should be respectful, private, confidential and non-judgemental.

6.4 RECOMMENDATIONS FOR FURTHER STUDY

Based on the findings of this study, it is suggested that further research be conducted in the following areas:

- A comparison of the sexual and reproductive health needs of perinatally and behaviourally infected adolescents;
- An examination of youth-friendly services for adolescents living with HIV.

6.5 SUMMARY

The main aim of this study was to examine the sexual and reproductive health needs of adolescents living with HIV. This was achieved through semi-structured interviews with 10 participants living with HIV at Chiedza Child Care Centre in Harare, Zimbabwe. The study revealed that adolescents living with HIV have unique sexual and reproductive health needs which need to be addressed.

This study confirmed that there are gaps in serving the sexual and reproductive health needs of adolescents living with HIV. Based on the study findings, the researcher concluded that adolescents living with HIV have the same desires and aspirations as those who are HIV negative. However they have additional sexual and reproductive

health needs. Adolescents living with HIV need to have sexual relationships; however, they need to be empowered to negotiate condom usage to avoid re-infection and transmitting the virus to others. They also need to be responsible regarding their health by adhering to ARV treatment and going for regular check-ups at clinics or hospitals.

Furthermore, the study revealed that adolescents living with HIV also wish to have children. A non-judgemental approach that respects their autonomy should be adopted in terms of their reproductive decision-making. Adolescents living with HIV face challenges with regard to dating, relationships and disclosure, also struggling with intimacy and negotiating safer sex. The participants also revealed that adolescents living with HIV experience psychological distress after an HIV positive diagnosis. This has negative effects on their ability to fulfil their sexual and reproductive needs and their general quality of life.

Adolescents living with HIV face multiple barriers in accessing reproductive and sexual health services. These include insufficient information and education, a lack of youth-specific services, concerns about privacy and confidentiality, social pressures and taboos. Health workers, who are supposed to support adolescents, judge them and have negative attitudes towards adolescents who access these services.

In conclusion, it is critical to acknowledge that adolescents living with HIV have additional sexual and reproductive health needs that should be accorded serious attention. Policies and programmes therefore need to be developed and implemented to address these needs.

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APPENDICES

Appendix A (UNISA Ethics Committee Approval)



Department of Sociology
College of Human Sciences
3 November 2011

Proposed title: Examining sexual and reproductive health needs of adolescents infected with HIV or living with AIDS at the Chiedza Child Care Centre, Harare, Zimbabwe

Principal investigator: Lynette Murimba (student number 42963133)

Reviewed and processed as: Class approval (see paragraph 10.7 of the UNISA Guidelines for Ethics Review)

Approval status recommended by reviewers: Approved

The Higher Degrees Committee of the Department of Sociology in the College of Human Sciences at the University of South Africa has reviewed the proposal and considers the methodological, technical and ethical aspects of the proposal to be appropriate to the tasks proposed. Approval is hereby granted for Ms. Murimba to proceed with the study in strict accordance with the approved proposal, the recommendations made by the HDC on the 1st of November 2011 and the ethics policy of the University of South Africa.

In addition the candidate should heed the following guidelines:

- To only start this research study after obtaining informed consent from the interviewees and from the management of the Chiedza Child Care Centre
- To carry out the research according to good research practice and in an ethical manner
- To maintain the confidentiality of all data collected from or about research participants, and maintain security procedures for the protection of privacy
- To notify the committee in writing immediately if any adverse event occurs.

Kind regards



Dr C Thomas
Chair, Department of Sociology
Tel + 2712 429 6301



www.unisa.ac.za

Appendix B (Access letter to Chiedza Child Care Centre)

No 125 Hampton Court

Edenglen, Edenvale

Johannesburg

29 July 2011

Chiedza Child Care Centre

Strachan Street, Ardebennie,

Harare,Zimbabwe.

Dear Sir /Madam

RE: REQUEST FOR PERMISSION TO DO A RESEARCH AT CHIEDZA CHILD CARE CENTRE

I do hereby request for permission to conduct a research in your organization in partial fulfillment of my studies in Masters Degree in Social Behavioral Studies in HIV and AIDS with the University of South Africa(UNISA)

The purpose of the research is to examine the sexual reproductive health needs of adolescents living with HIV and AIDS at Chiedza Child Care Centre in Zimbabwe. The focus will be on adolescents between the ages of 15-19 years old. The process will involve interviewing which will be recorded and transcribed. The recordings and transcripts will be used by the researcher and her supervisor for the purpose of the study only and will be destroyed when they are no longer needed.

Thank for your consideration

Yours sincerely

Lynnette Murimba

Appendix C (Consent form for participation-adolescent)

I, Lynnette Murimba,(Student number 42963133) am a student at the University of South Africa(UNISA). I am currently registered for Masters Degree in Social Behavioral Studies in HIV and AIDS. In partial fulfillment of the programme requirements, I am supposed to do a research project. The purpose of the research is to examine the sexual reproductive health needs of adolescents living with HIV and AIDS. The focus will be on adolescents between the ages of 15-19 years old.

I want to conduct an interview with you and this might take approximately an hour of your time. The interview will focus on sexual reproductive health needs of adolescents, knowledge about sexual reproductive health needs and also services available for adolescents living with HIV and AIDS. The interview will be recorded and transcribed. However, your anonymity will be maintained as you will be assigned a pseudo name which will be used during the recording. The recordings and transcripts will be used by the researcher and her supervisor for the purpose of the study only and will be destroyed when they are no longer needed.

Your participation will be strictly voluntary and you have the right to withdraw at any time during the course of the interview. This will not have any effect whatsoever to your relationship with the researcher. If you have any questions about the study that you wish to raise, you can contact the researcher on this cell number-0728185643.

Thank you for participating in the study.

Lynnette Murimba (Researcher)

.....

I voluntarily agree to participate in this study and acknowledged that the consent form has been read and explained to me. I have been assured that my identity will not be revealed while the study is being conducted or when the study is published.

Participant's signature_____ Date_____

Researcher's signature_____ Date_____

Appendix D (Assent form for participation -adolescents’ parents/guardians)

I, Lynnette Murimba,(Student number 42963133) am a student at the University of South Africa(UNISA). I am currently registered for Masters Degree in Social Behavioral Studies in HIV and AIDS. In partial fulfillment of the programme requirements, I am supposed to do a research project. The purpose of the research is to examine the sexual reproductive health needs of adolescents living with HIV and AIDS. The focus will be on adolescents between the ages of 15-19 years old.

I want to conduct an interview with your child and this might take approximately an hour of his/her time. The interview will focus on sexual reproductive health needs of adolescents, their knowledge about sexual reproductive health needs and also services available for adolescents living with HIV and AIDS. The interview will be recorded and transcribed. However, your child’s anonymity will be maintained as he/she will be assigned a pseudo name which will be used during the recording. The recordings and transcripts will be used by the researcher and her supervisor for the purpose of the study only and will be destroyed when they are no longer needed.

Your child’s participation will be strictly voluntary and he/she have the right to withdraw at any time during the course of the interview. This will not have any effect whatsoever to his/her relationship with the researcher. If you have any questions about the study that you wish to raise, you can contact the researcher on this cell number-0728185643.

Thank you for allowing your child to participating in the study

Lynnette Murimba (Researcher)

.....
.....

I give my full consent for my child’s participation in this study and acknowledged that the implications of my consent have been explained to me.

Parent/Guardian’s signature_____ Date_____

Researcher’s signature_____ Date_____

Appendix E (Interview schedule for participants)

Lynnette Murimba

Student number: 42963133

Topic: Examining sexual reproductive health needs of adolescents infected with HIV
Chiedza Child Care Centre in Harare, Zimbabwe.

Interview Schedule

The following are the main questions that will be asked during the interview to examine and determine whether adolescents living with HIV and AIDS have knowledge on their sexual reproductive health needs.

Specific questions will be asked to find out if they know what their sexual reproductive health needs are, and if services are available and accessible to meet their sexual and reproductive health needs.

Questions

1. Adolescents' understanding of HIV/AIDS and reproductive health needs

1.1 Can you tell me what you know about HIV and AIDS?

1.2 How is HIV transmitted?

1.3 How can HIV re-infection be prevented?

1.4 What is reproductive health needs?

1.5 What are the reproductive health needs for adolescents?

1.6 Do you think adolescents who are HIV positive have similar needs with those who are HIV negative?

2. Adolescents' knowledge of sexual and reproductive health needs?

2.1 Where did you learn about sexual and reproductive health needs?

2.2 Do you think it is helpful for adolescents to talk about sexual health needs with their parents or their friends?

2.3 What are the fears and concerns of adolescent living with HIV/AIDS?

2.4 Is it important to inform adolescents living with HIV about the sexual reproductive health needs?

2.5 How can this information and knowledge help them?

3. Reproductive health services for adolescents living with HIV/AIDS

3.1 Do adolescents living with HIV/AIDS know where to seek reproductive health treatment?

3.2 What are the issues that should be addressed by health practitioners for adolescents visiting these services?

3.3 Do the existing health services meet reproductive health needs of adolescents living with HIV and AIDS?

3.4 How do you think the health services can be improved to meet the needs of adolescents?

3.5 Are issues of privacy and confidentiality important when dealing with reproductive health needs of adolescents?

4. Recommendations on how best sexual reproductive needs of HIV positive adolescents can be addressed

4.1 What should be done to make sure that adolescents living with HIV know about their sexual and reproductive health needs?

4.2 What other recommendations would you make for improvements of health services rendered for adolescents living with HIV and AIDS?

Appendix F (Chiedza Child Care Centre Approval Letter)



37 Strachan Street Ardebenie.

P.O Box W142 Waterfalls Harare

Tel: 0026377218797

15 December 2011

Dear Mrs. Murimba

Subject: Approval of Research

The research proposal titled "Examining sexual and reproductive health needs of adolescents living with HIV at Chiedza Child Care Centre" was reviewed by the Centre management team. The proposal is hereby approved for research to be taken at Chiedza Child Care Centre.

Make necessary arrangements with the Psychosocial support team before commencing with your research project. Your final report must be posted to Chiedza Child Care Centre, P.O Box W142 Waterfalls Harare and an electronic copy to zvimba@chiedza.org.zw

For any additional information, please do not hesitate to contact Mr Zvimba on 00263 77218797

Yours sincerely

Mr Zvimba

A handwritten signature in black ink, appearing to read "Zvimba", is written over a horizontal dotted line.

Deputy Director