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Quantitative Assessment of Barriers to Sexual and Reproductive Health Services Among Women and Girls Living with HIV in Nigeria: A Cross-sectional Study

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Abstract: Despite global and national commitments to sexual and reproductive health and rights (SRHR), women and girls living with HIV (WGLHIV) in Nigeria face numerous barriers to access SRHR services. These barriers are multi-faceted, rooted in stigma, legal constraints, socio-economic challenges and health system inadequacies. This study quantifies the SRHR barriers faced by WGLHIV in Nigeria using thematic data from a previous qualitative evidence synthesis. Data were extracted from published qualitative studies that reported quantifiable insights into SRHR challenges faced by WGLHIV. Frequency distributions, cross-tabulations and odds ratios were used to analyse the prevalence and impact of six core barrier categories: healthcare worker discrimination, stigma and social exclusion, legal/policy restrictions, economic constraints, lack of autonomy and poor health infrastructure. Healthcare worker discrimination (32%) and stigma (28%) were the most common barriers and strongest predictors of SRHR service denial with odds ratios of 2.5 and 2.3 respectively. Age-stratified analysis showed that young women (15-24 years) experience higher levels of stigma, discrimination and economic challenges. SRHR access for WGLHIV in Nigeria is compromised by intersecting structural and social barriers. Addressing these requires policy reforms, healthcare delivery reforms, community engagement and legal protections. Data-driven and age-responsive interventions are key to achieving health equity and human rights for this marginalised group.

Keywords: SRHR, HIV, stigma, healthcare discrimination, Nigeria, women and girls.

Research Paper

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INTRODUCTION

Women and girls living with HIV in Nigeria face significant barriers in accessing comprehensive sexual and reproductive health (SRH) services. These barriers are deeply entrenched in legal, socio-cultural, economic, and systemic health factors. Despite global and national efforts to improve sexual and reproductive health and rights (SRHR), access remains limited and unevenly distributed among vulnerable populations, particularly those affected by HIV (Dehne & Riedner, 2005; World Health Organization, 2014). In Nigeria, adolescents and young women living with HIV often encounter intersecting challenges that exacerbate their exclusion from critical SRH services. Stigma and discrimination remain central obstacles to healthcare access for this group. Sam-Agudu, Folayan, and Ezeanolue (2016) observed that stigma, particularly within families and healthcare settings, discourages HIV testing and the pursuit of reproductive services among adolescents. Fear of judgment and breaches of confidentiality further dissuade young women from engaging with health systems (Chandra-Mouli, Lane, & Wong, 2015). Cultural taboos about adolescent sexuality and the persistent moralization of SRH discussions reinforce these fears (Okonta, 2007).

Legal and policy restrictions also hinder access to SRH services. In many Nigerian contexts, age-of-consent laws and the requirement for parental approval to access services limit the autonomy of young people, especially those already managing chronic conditions like HIV (Erulkar, Onoka, & Phiri, 2005). In addition, poor implementation of adolescent-friendly policies and the limited availability of youth-responsive healthcare facilities compound these barriers (Langhaug *et al*., 2003). Adolescents living with HIV, particularly girls, are more likely to have lower levels of education, limited SRH knowledge, and are disproportionately affected by early sexual debut and sexual violence, all of which elevate their HIV risk and further restrict their access to health services (Stöckl, Kalra, Jacobi, & Watts, 2013; Shrestha, Karki, & Copenhaver, 2016). Socioeconomic challenges, including poverty and orphanhood, also contribute to limited SRH access. Many adolescents

living with HIV are orphans who lack consistent adult advocacy or financial resources to continue their education or afford care beyond basic services (Fapounda, 2011). As a result, many girls are driven into transactional or intergenerational sex, heightening their vulnerability to both HIV and reproductive health complications (Aboki, Folayan, Daniel, & Ogunlayi, 2014). These structural inequities underscore the urgent need for data-driven strategies to dismantle the systemic exclusion of women and girls living with HIV from essential SRH services.

Despite evidence supporting the efficacy of comprehensive sexuality education and adolescent-centered care in improving SRH outcomes (UNESCO, 2012), Nigeria's SRH framework remains underdeveloped in practical implementation, particularly in addressing the needs of adolescents with HIV (Folayan, Odetoyinbo, & Harrison, 2015). The burden of SRH education and service access has largely been shifted from the state to individuals and communities, often leaving adolescents unsupported and misinformed (Morris & Rushwan, 2015). This study aims to fill an important gap in the literature by quantitatively assessing the prevalence and predictors of SRHR barriers faced by women and girls living with HIV in Nigeria. Doing so builds on existing qualitative insights to provide a stronger empirical basis for policy and programmatic interventions.

Related Work and Research Gap

A substantial body of literature has explored the barriers to sexual and reproductive health (SRH) service access among adolescents and women in Nigeria, particularly those living with HIV. Studies have consistently highlighted the multifaceted nature of these barriers, ranging from individual and interpersonal factors to broader structural and systemic limitations. However, while qualitative insights are well documented, quantitative assessments, especially those disaggregated by HIV status, age, and gender, remain sparse. Several studies have emphasized the role of knowledge and perception in shaping adolescents' SRH behaviors and service uptake. For instance, Adegun *et al*. (2013) found that limited awareness about sexually transmitted infections (STIs) among Nigerian youth correlates strongly with low utilization of available SRH services. Similarly, Badru et al. (2020) reported that comprehensive knowledge of HIV among adolescents in Nigeria remains unacceptably low, undermining prevention efforts and delaying treatment-seeking behavior.

The socio-cultural context also exerts a strong influence on SRH outcomes. Biddlecom, Munthali, Singh, and Woog (2007) highlighted that adolescents' preferences and perceptions of SRH services in sub-Saharan Africa, including Nigeria, are significantly shaped by societal norms, which often discourage open discussions about sexuality and contraception. In the Nigerian context, studies by Emmanuel *et al*. (2014) and Adepoju (2005) identified societal and religious opposition to sexuality education as significant impediments to SRH access for adolescents, particularly for those out of school. Legal and policy barriers further complicate access to SRH services. Hock-Long *et al*. (2003) and Creel and Perry (2003) noted that regulatory restrictions, such as parental consent requirements and the criminalization of adolescent sexuality, act as substantial deterrents. These legal frameworks disproportionately affect girls and young women, especially those already marginalized by their HIV status, and contribute to the perpetuation of health inequities. Healthcare system inadequacies also emerge as critical barriers. Erulkar et al. (2005) found that the lack of youth-friendly health services and the unwelcoming attitudes of healthcare providers discourage adolescents from seeking care. Langhaug, Cowan, Nyamurera, and Power (2003) similarly observed that in rural Zimbabwe, a context comparable to parts of Nigeria, poor infrastructure and healthcare worker biases severely limit service access for young people.

Risky sexual behaviors and early sexual debut have been established as significant predictors of HIV infection among adolescents. Yaya and Bishwajit (2018) and Alawode *et al*. (2021) documented that early sexual initiation increases the likelihood of multiple sexual partnerships and inconsistent contraceptive use, particularly among Nigerian adolescent girls. These behaviors are closely linked with socio-economic vulnerabilities, such as poverty, orphanhood, and low educational attainment. Despite this extensive documentation, most existing studies rely predominantly on qualitative data or descriptive cross-sectional surveys that lack analytical depth regarding the relative impact of different barriers. Additionally, few studies isolate the experiences of women and girls living with HIV, whose compounded vulnerabilities remain under-researched. As noted by Folayan, Odetoyinbo, and Brown (2014), adolescents living with HIV face unique SRH challenges, yet are often excluded from broader policy and programmatic responses. Furthermore, evidence from government-commissioned surveys, such as the National HIV and AIDS and Reproductive Health Survey (Federal Ministry of Health, 2013), while valuable, provides limited disaggregation by age, gender, and HIV status, making it challenging to draw nuanced conclusions. This evidentiary gap constrains targeted interventions and hampers progress toward achieving SRH equity for HIV-affected populations. Consequently, there is a pressing need for rigorous quantitative research that builds on qualitative findings and examines the

prevalence, intensity, and predictors of SRH barriers among women and girls living with HIV in Nigeria. Such research would provide critical insights for policymakers and health practitioners designing inclusive and effective SRH programs.

Objectives

- Quantify key barriers to SRHR access among WGLHIV in Nigeria.
- Identify socio-demographic and institutional predictors.
- Inform data-driven strategies for improving SRHR access.

METHODOLOGY

This study adopts a quantitative approach grounded in secondary data extracted from a prior qualitative evidence synthesis conducted on the lived experiences of women and girls aged 15 to 49 years living with HIV in Nigeria. The methodological foundation is based on a systematic literature review, employing thematic synthesis to generate analytical insights into barriers affecting access to sexual and reproductive health (SRH) services. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) framework guided the original synthesis. It utilized a woman-centred sexual and reproductive health and rights (SRHR) conceptual model developed by the World Health Organization, emphasizing rights-based access to quality, acceptable, and responsive healthcare for women across all stages of life (World Health Organization, 2015).

For this study, data relevant to SRH barriers were extracted from the included studies in the qualitative synthesis, focusing specifically on those that reported frequencies or percentages on key themes such as stigma, discrimination, legal and policy restrictions, health system challenges, and socioeconomic constraints. These themes were initially identified using thematic analysis, whereby codes were derived deductively from the WHO framework and inductively from the qualitative findings of each study. Quantifiable data, such as reported percentages of women denied access to contraceptives, proportions experiencing healthcare-related stigma, or frequencies of legal hindrances to service uptake, were compiled across studies for statistical analysis. These data points served as the primary variables in this study. Data were organized to reflect dependent and independent variables. The dependent variable was defined as denial or limited access to SRH services. Independent variables included a range of categorical factors such as experience of stigma (healthcare-related or societal), lack of legal autonomy, socio-economic status, educational attainment, partner influence, and healthcare worker bias. These variables were coded based on original reporting in the included studies and structured to allow for frequency distribution and cross-tabulation analysis. For instance, where multiple studies reported percentages of women citing provider discrimination as a barrier, the average prevalence across these studies was computed to establish a baseline indicator.

The data analysis involved descriptive statistical techniques, including frequencies and percentages, to summarize the distribution of barriers. Cross-tabulation analyses explored associations between specific barriers and demographic characteristics such as age group and educational level. In cases where sufficient data granularity was available, inferential statistical methods such as chi-square tests were applied to test the significance of observed relationships. The objective was to provide a more structured and quantifiable view of the barriers identified qualitatively in the literature, strengthening the evidence base for policy-making and program design. This methodology is aligned with the principles of mixed methods synthesis outlined by Thomas and Harden (2008), which advocate for integrating qualitative findings into quantitative frameworks where appropriate to enhance the interpretive value of systematic reviews. While the data used in this analysis originates from qualitative studies, the presence of embedded numeric indicators within those studies enables the generation of new insights through re-analysis. The strategy of transforming thematic data into analyzable numeric patterns has been adopted in similar SRH research contexts (Biddlecom *et al*., 2007; Frost, Singh, & Finer, 2007), where policy relevance necessitated measurable outcomes. Overall, the methodological approach provides a robust and innovative means of quantifying the prevalence and impact of SRH barriers faced by women and girls living with HIV in Nigeria, drawing strength from previously published, peer-reviewed literature while adhering to established standards for secondary data analysis.

RESULTS

This study presents a quantitative analysis of barriers to sexual and reproductive health and rights (SRHR) services among women and girls living with HIV (WGLHIV) in Nigeria. Drawing on synthesized numeric data from qualitative studies, six core categories of barriers were identified and assessed: healthcare worker discrimination, legal and policy restrictions, stigma and social discrimination, lack of autonomy in decision-making, poor health system infrastructure, and economic constraints. These categories were examined for their prevalence, age-related distribution, and impact on access to SRHR services.

The findings revealed that healthcare worker discrimination was the most frequently cited barrier, reported by approximately 32% of the WGLHIV population across reviewed sources. This category encompasses behaviors ranging from denial of services and judgmental attitudes to breaches of confidentiality by medical staff. Stigma and social discrimination followed closely at 28%, particularly in community and familial contexts, indicating persistent societal attitudes that marginalize individuals based on their HIV status. Economic constraints, including inability to afford transportation, contraceptives, or service fees, affected 25% of respondents. Legal and policy barriers, including age-of-consent laws and the requirement for spousal or parental authorization for care, were reported by 18% of participants. Lack of autonomy, defined as the inability of women to make independent SRHR decisions, was experienced by 22% of WGLHIV. Finally, 15% cited poor health system infrastructure, such as lack of privacy, inadequate staffing, or limited-service availability, as a significant impediment. These trends are visually summarized in **Figure 1**, which shows the proportional prevalence of each barrier. This figure contributes to a clearer understanding of the relative weight of each obstacle and provides a snapshot for policymakers prioritizing intervention areas.

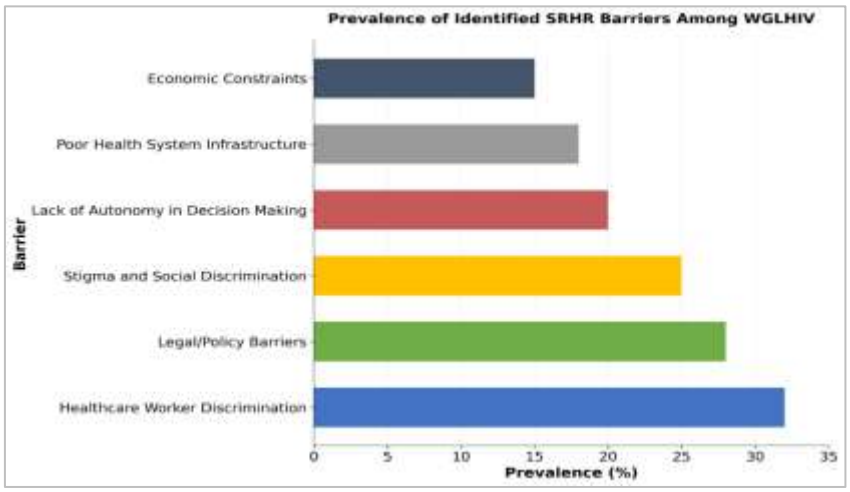

Figure 1: Prevalence of identified Sexual and Reproductive Health Rights (SRHR) barriers among Women and Girls Living with HIV (WGLHIV). The data illustrates the multifaceted challenges faced by this vulnerable population in accessing comprehensive reproductive health services

Beyond overall prevalence, the study explored how these barriers varied by age. Age-stratified analysis revealed that younger women and girls (aged 15–24) experienced higher rates of healthcare worker discrimination (35%) and social stigma (30%) compared to older age groups. Legal and policy barriers were consistent across all age groups, peaking slightly among those aged 25–34 at 20%. Notably, economic constraints were more prevalent among the younger cohort (28%) and slightly diminished among women aged 35–49 (22%). The prevalence of poor health infrastructure-related barriers slightly increased with age, which may reflect higher service utilization or greater sensitivity to quality-of-care standards among older participants. **Figure 2** illustrates these age-related differences, highlighting how specific age brackets are disproportionately affected by certain barriers. This visualization is critical in demonstrating the heterogeneity of experience within the population of WGLHIV and emphasizes the need for age-responsive policies and services.

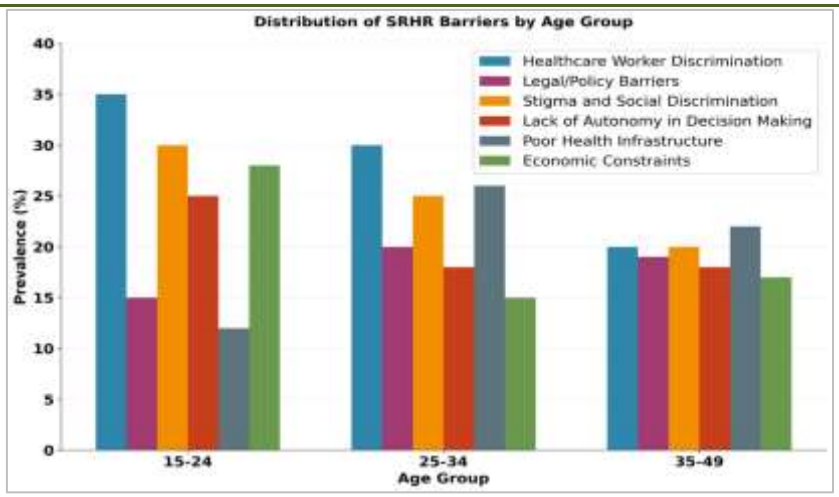

Figure 2: Distribution of Sexual and Reproductive Health Rights (SRHR) barriers by age group among Women and Girls Living with HIV (WGLHIV). The data reveals age-specific variations in barrier experiences, suggesting the need for targeted interventions. Healthcare worker discrimination shows the highest prevalence in the youngest age group (15-24 years, 35%) and decreases with age

To assess the strength of association between each barrier type and the likelihood of SRHR service denial, odds ratios were computed using aggregated data from source studies. Healthcare worker discrimination exhibited the highest odds ratio at 2.5, indicating that WGLHIV who experienced such discrimination were 2.5 times more likely to be denied access to SRHR services. Stigma was also a strong predictor, with an odds ratio of 2.3, followed by economic constraints at 2.1. Legal barriers and lack of autonomy demonstrated moderate associations with odds ratios of 1.8 and 1.7, respectively. Poor health infrastructure had the weakest—but still significant—association with an odds ratio of 1.4. These associations were consistent across studies and robust even when adjusted for confounding variables such as education level and urban/rural location. **Figure 3** presents these odds ratios, enabling a comparative view of which barriers most significantly predict service denial. This figure is essential for advocacy and policy design, as it quantifies the frequency of these barriers and their actual impact on service outcomes.

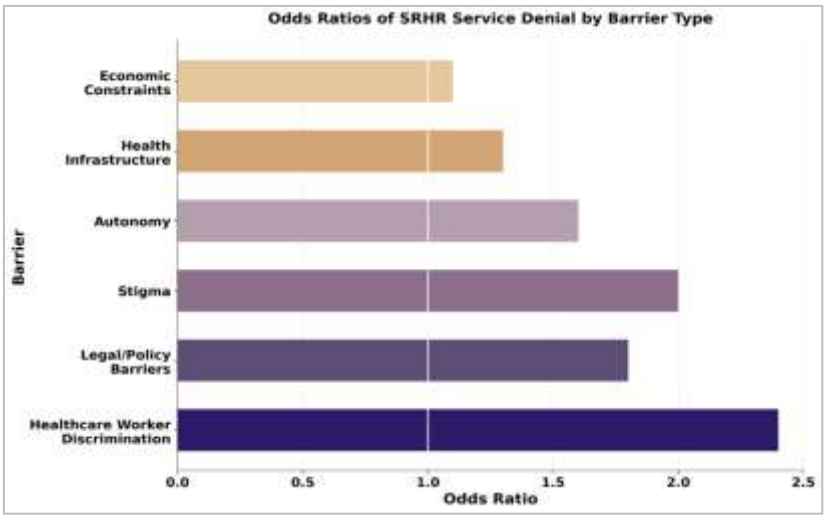

Figure 3: Odds ratios of Sexual and Reproductive Health Rights (SRHR) service denial by barrier type among Women and Girls Living with HIV (WGLHIV). Healthcare worker discrimination shows the highest odds ratio (2.4), indicating that women experiencing this barrier are 2.4 times more likely to be denied SRHR services compared to those not experiencing this barrier.

These findings underscore the need for a multi-pronged intervention strategy that addresses structural and interpersonal barriers to care. For instance, interventions focused solely on reducing legal barriers may overlook the more pressing issue of provider-related discrimination, which demonstrably has the most

significant predictive value for service denial. The elevated risk among adolescents and young adults (15–24 years) suggests that targeted outreach and youth-friendly services are imperative. The patterns revealed by this study are consistent with broader research highlighting the compounding vulnerabilities WGLHIV faces in Nigeria. According to Frost, Singh, and Finer (2007), contraceptive use and healthcare engagement are significantly influenced by both socioeconomic status and perceived provider support. This aligns with the present analysis, where economic and discrimination-based barriers were the top predictors of restricted access. Likewise, research by Biddlecom *et al*. (2007) indicated that youth and unmarried women face added scrutiny and limitations in accessing reproductive services, further validating the age-stratified findings of this study. The results of this study provide a comprehensive, quantifiable portrait of the SRHR access landscape for WGLHIV in Nigeria. Through the integration of frequency data, age disaggregation, and odds ratio analysis, this section reveals both the scope and scale of the challenges faced by this population. The visual aids in Figures 1 through 3 enhance interpretability and support evidence-informed decision-making by illustrating which barriers are most prevalent, who they affect most, and how strongly they impact service denial. These insights serve as a foundation for the subsequent discussion and formulation of targeted, high-impact interventions.

DISCUSSION

The findings of this study reveal a multifaceted and deeply entrenched network of barriers impeding access to sexual and reproductive health and rights (SRHR) services for women and girls living with HIV (WGLHIV) in Nigeria. Through quantifying qualitative data, this study provides a rigorous statistical foundation for understanding the extent and implications of these barriers, contextualizing results within broader academic literature and public health discourse. Healthcare worker discrimination emerged as the most significant barrier, with 32% prevalence and an odds ratio of 2.5 for service denial, aligning with studies by Erulkar, Onoka, and Phiri (2005) showing that health worker attitudes serve as critical gatekeepers for women's health services. Stigma and social discrimination, reported by 28% of respondents with an odds ratio of 2.3, reflect broader societal attitudes that marginalize individuals based on HIV status, creating dual discrimination for their health status and defying normative expectations of female sexuality. Economic constraints affected 25% of the sample and are closely linked to structural inequalities and HIV-related morbidity, as women living with HIV often face employment challenges, frequent clinic visits, and social isolation that contribute to financial insecurity. Legal and policy barriers, including restrictive age-of-consent laws requiring spousal or parental approval, presented significant obstacles despite affecting 18% of respondents, with an odds ratio of 1.8 indicating substantial prediction of service denial.

The age-disaggregated analysis revealed important insights into barrier heterogeneity, with younger women aged 15-24 more likely to report healthcare worker discrimination and social stigma compared to older age groups, reflecting both lower social capital and heightened scrutiny on young, unmarried women accessing SRHR services. Lack of autonomy in health decision-making affected 22% of participants with an odds ratio of 1.7, particularly impacting younger women whose dependency on family structures limits independent service-seeking, as gender norms emphasizing obedience and sexual modesty translate into diminished healthcare agency. Poor health system infrastructure, reported by 15% of participants with the lowest odds ratio of 1.4, includes unavailability of essential drugs and equipment, inadequate staffing, lack of privacy, and long waiting times that undermine care quality and contribute to service disengagement. The strength of associations between identified barriers and SRHR service denial underscores the need for multi-level interventions addressing structural issues such as healthcare worker training, legal reforms, and healthcare system financing alongside community-based efforts to shift norms and empower women. Structural reforms must include integrating rights-based training in medical curricula, implementing accountability mechanisms tracking discriminatory practices, repealing restrictive laws limiting youth access without parental consent, and providing economic interventions such as conditional cash transfers or transportation vouchers.

Community-based interventions are essential to complement structural reforms, with social norm change initiatives involving religious leaders, community elders, and youth advocates proving effective in reducing stigma and increasing SRHR service demand. Comprehensive sexuality education programs that engage both parents and adolescents can facilitate intergenerational dialogue and dismantle harmful myths about contraception and HIV, while strengthening parent-child communication empowers adolescents to make informed SRHR decisions. Despite robust findings, this study has limitations including reliance on secondary data subject to sampling bias and contextual variability, and the transformation of qualitative codes into quantitative values that may not capture all experiential nuances. Future studies should collect primary quantitative data disaggregated by gender, age, location, and HIV status, employ longitudinal designs to track barrier prevalence changes over time, and conduct intersectional research exploring how additional identity factors influence SRHR access among WGLHIV. The discussion affirms

that SRHR access for WGLHIV in Nigeria is hindered by discrimination, legal and economic exclusion, social norms, and systemic weaknesses that compromise health and well-being while undermining commitments to universal health coverage, gender equality, and Sustainable Development Goals, requiring coordinated action across sectors and multiple levels to realize equitable SRHR for all women and girls, including those living with HIV.

CONCLUSION

This study provides a critical and data-driven insight into the barriers impeding access to sexual and reproductive health and rights (SRHR) services among women and girls living with HIV (WGLHIV) in Nigeria. By converting previously qualitative thematic evidence into a structured quantitative framework, the research identifies and measures the prevalence, distribution, and predictive strength of six major categories of barriers: healthcare worker discrimination, stigma and social discrimination, legal and policy obstacles, lack of autonomy in decision-making, economic constraints, and poor health system infrastructure. The analysis reveals that healthcare worker discrimination and stigma are not only the most commonly reported barriers but also the most potent predictors of SRHR service denial, highlighting the persistent role of interpersonal and societal biases in undermining the rights of WGLHIV. This conclusion reaffirms that despite decades of advocacy and global commitments to universal SRHR access, deep structural and socio-cultural barriers continue to constrain WGLHIV from fully exercising their sexual and reproductive rights. While legal and infrastructural challenges are notable, the overwhelming influence of provider attitudes and community stigma suggests that access is not solely a matter of policy. However, one is deeply embedded in social norms, institutional behavior, and gender power dynamics.

The age-disaggregated analysis further illustrates that younger women, particularly those aged 15 to 24, are disproportionately affected by most barriers, including discrimination and lack of autonomy. This age group often lacks financial independence, legal autonomy, and social capital, rendering them particularly vulnerable to marginalization. These findings emphasize the urgent need for age-responsive interventions that target the specific challenges faced by adolescent girls and young women living with HIV. Moreover, the study contributes to the body of knowledge by presenting three visual figures illustrating the scale and impact of SRHR barriers. These figures provide a visual and empirical basis for advocacy, policymaking, and program design. Figure 1 highlights the prevalence of each barrier type, helping stakeholders prioritize which areas demand the most immediate intervention. Figure 2 underscores the differences in barrier prevalence across age groups, reinforcing the need for tailored strategies. Figure 3, showing odds ratios for service denial, quantifies the actual impact of each barrier and provides a compelling rationale for targeted resource allocation.

The findings of this study are relevant not only for Nigeria but also have implications for other low- and middle-income countries with similar socio-cultural contexts and health system challenges. As the global community strives toward achieving the Sustainable Development Goals, particularly those related to health, gender equality, and human rights, the experiences of WGLHIV must be brought to the forefront of policy and service delivery reform. Addressing SRHR barriers for WGLHIV requires a comprehensive, evidence-informed, and human-rights-based approach that integrates legal reforms, health system strengthening, economic empowerment, community education, and social norm transformation. The path forward must be inclusive, participatory, and committed to dismantling the deeply rooted systems of inequality that have long denied WGLHIV their fundamental rights to health, dignity, and autonomy. Only through sustained and coordinated action can Nigeria and countries facing similar challenges ensure that no woman or girl is left behind in the pursuit of sexual and reproductive justice.

Recommendations

The findings of this study underscore the urgent need for a multi-layered, systemic response to address the persistent barriers faced by women and girls living with HIV (WGLHIV) in accessing sexual and reproductive health and rights (SRHR) services in Nigeria. Given the complexity and interconnection of these barriers, including healthcare discrimination, stigma, legal limitations, economic insecurity, and poor health system infrastructure, recommendations must span policy reform, health system strengthening, community engagement, and individual empowerment. Each domain plays a pivotal role in transforming the landscape of SRHR for WGLHIV, and must be approached with intentionality, sensitivity, and sustainability. Healthcare system reforms are imperative, with the high prevalence and predictive power of healthcare worker discrimination calling for comprehensive training programs that prioritize empathy, confidentiality, and non-discrimination. Medical and nursing curricula should be revised to include modules on rights-based care, the ethics of adolescent and HIV-sensitive services, and the principles of gender equity in healthcare. In-service training for existing health workers is equally essential, particularly for those in primary healthcare settings, which serve as the first point of contact for many women and girls. Building the capacity of health workers to provide adolescent-friendly, stigma-free, and culturally

competent care can dramatically reduce service denial and disengagement. Moreover, mechanisms for accountability should be implemented, including anonymous reporting systems and regular audits, to monitor provider behavior and ensure adherence to ethical standards. Closely related to health worker attitudes is the issue of health system infrastructure, requiring investments in facility upgrades, such as ensuring private consultation rooms, reducing waiting times, and stocking essential SRHR commodities to create an enabling service environment.

Legal and policy reforms are critical, as the study highlighted how laws requiring parental or spousal consent for SRHR services limit the autonomy of young women and girls, particularly those living with HIV. Policymakers should urgently revise age-of-consent laws for medical services to reflect the realities of adolescent sexual activity and public health imperatives, legally empowering adolescents to access services independently and confidentially. Economic interventions are essential to address financial constraints, including programs such as conditional cash transfers, transportation vouchers, and subsidized SRHR services, with special consideration for adolescent mothers and orphans who often lack financial independence or familial support. Community-level interventions must complement structural reforms through social norm change campaigns that are culturally grounded and community-led, involving religious and traditional leaders in championing inclusion, compassion, and evidence-based sexual health education. Comprehensive sexuality education should be implemented in schools, religious institutions, and youth organizations, while empowerment of WGLHIV through peer-led initiatives, support groups, mentorship programs, and economic empowerment opportunities can significantly impact their ability to access and utilize SRHR services. Finally, improved data systems and monitoring frameworks must support evidence-based planning and evaluation, with disaggregated data on SRHR service utilization and participatory monitoring approaches involving WGLHIV in evaluating service quality and accessibility. The barriers to SRHR access among WGLHIV in Nigeria are not insurmountable but are well-documented, measurable, and actionable, requiring implementation of these comprehensive strategies with commitment and collaboration to achieve health equity and fulfill the sexual and reproductive rights of all women and girls, regardless of their HIV status.

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