PREGNANCY AND MOTHERHOOD AMONG ADOLESCENT GIRLS AFFECTED BY HIV:

RISK PATHWAYS AND PROMISING PROTECTIVE PROVISIONS

KEY MESSAGES

- Adolescent girls in Eastern and Southern Africa experience high rates of unintended first pregnancies. Adolescent mothers, particularly those living with HIV, are more likely to experience sexual risk exposure than adolescents who have never been pregnant.
- Although antiretroviral (ART) uptake during pregnancy was high for adolescents living with HIV, only a third had started ART before pregnancy and overall, engagement in antenatal care was suboptimal.
- Postpartum contraception use, particularly dual protection rates, was extremely low.
- Poor mental health was higher among adolescent girls compared to adolescents who had never experienced pregnancy, with the prevalence of any common mental health disorder being highest among adolescent mothers living with HIV.
- Multi-sectoral packages – that include school access during pregnancy, formal childcare, confidence strengthening, and youth-friendly clinic services - are a crucial step in supporting adolescent mothers with school continuation and progression after giving birth, reducing HIV risk behaviours, strengthening a positive future outlook, and supporting healthy development of their child
- Despite multiple pregnancy-related challenges, most adolescent mothers are the primary caregivers of their children and are hopeful about their life trajectories.

BACKGROUND

Eastern and Southern Africa (ESA) have among the world's highest rates of adolescent pregnancy and parenthood, with an estimated 20% of girls becoming pregnant before the age of 20[1]. The demands of parenthood, often coupled with low partner support, compound adolescent mothers' vulnerability to school dropout, poverty, isolation, and HIV acquisition[2].

Two-thirds (64.7%) of the global population of adolescents living with HIV, ages 10-19, reside in ESA[2]. Challenges related to pregnancy and parenthood can threaten ART adherence among adolescents living with HIV, whose ART adherence rates are already lower than those of all other age groups[4]. These disadvantages are predicted to extend to the children of adolescent mothers, with the next generation showing lower educational achievement, higher poverty, and increased risk of becoming adolescent parents themselves[5].

Yet, there is limited research on how to improve health, economic, and social outcomes for adolescent mothers and their children[6]. This brief summarises adolescents' experiences of pregnancy and early motherhood, with a special focus on adolescents and young mothers living with HIV. It also highlights key programming considerations that can foster positive pregnancy and parenting experiences and good outcomes for adolescent mothers and their children.

METHODS

We used quantitative and qualitative data from interviews conducted between 2018-2019 with adolescent girls and young women, some of whom had become mothers. Adolescent girls and young women were enrolled in the following cohort studies:

The Mzantsi Wakho study is a cohort study of 1,519 adolescents aged 10-19 years, both living with HIV (n=1,046) and without HIV (n=473), recruited from 53 public healthcare facilities and neighbouring communities in the Eastern Cape, South Africa. About 57% of this cohort is female and median age is 13.6 years.

The Helping Empower Youth Brought up in Adversity with their Babies and Young (HEY BABY) study is a mother-child dyad cohort study of 1,046 adolescent mothers, both living with HIV and without HIV, and their 1,145 children. Participants were living in the Eastern Cape, South Africa, and the average age of the firstborn child was 20 months at time of interview.

1 https://doi.org/10.1186/s12978-018-0640-2 | 2 https://doi.org/10.1086/678983 | 3 http://dx.doi.org/10.7448/IAS.20.1.21858 | 4 Aidsinfo.unaids.org
5 http://www.ncbi.nlm.nih.gov/pubmed/21334563 | 6 https://doi.org/10.1186/s12884-019-2204-z | 7 https://doi.org/10.1007/s10461-021-03474-8 | 8 https://doi.org/10.1007/s10826-006-9082-5

DEFINITIONS

- **Sexual risk exposure:** past year exposure to any of the following:
  - Age-disparate sex: any sexual partner more than five years older.
  - Transactional sex: receipt of money or material reward (drinks, clothes, airtime, a place to stay, better marks at school, school fees, food, etc.) in exchange for sex.
  - Multiple sexual partners: two or more sexual partners.
  - No condom use at last sex: instance of not using a condom when they last had sex.
- **Mental health disorder:** scoring above the cut-off on any of the four mental health symptomology measures: depression, post-traumatic stress disorder, anxiety, and suicidality[7].
- **Positive parenting and discipline:** noticing and praise your child's good behaviour, speaking calmly with your child when you were upset with them and planning ways to prevent problem behaviour.[8]

FINDINGS

1. Adolescent girls and young women – regardless of HIV status – aspire to have families, yet first pregnancies are largely unintended[9,10].

- Over two-thirds (69%) of adolescent girls and young women interviewed wanted to have at least two children in their lifetime. Yet, nearly all (95%) first pregnancies were reported as unintended.
- Reproductive aspirations and rates of unintended pregnancies were comparable between those living with HIV and without HIV.
- Approximately 1 in 10 (9.2%) adolescent mothers had two or more children, and this proportion was higher among adolescent mothers living with HIV than those without HIV.
  - Nearly 1-in-5 adolescent girls and young women (18.4%) living with HIV had two or more children compared to 1-in-20 (5.1%) among those without HIV.
  - After adjusting for other demographic factors, having a second live birth within 24 months of birth of the first child was more common among adolescents who had their first child before the age of 16 and/or had been in an age-disparate relationship with the father of their first child.

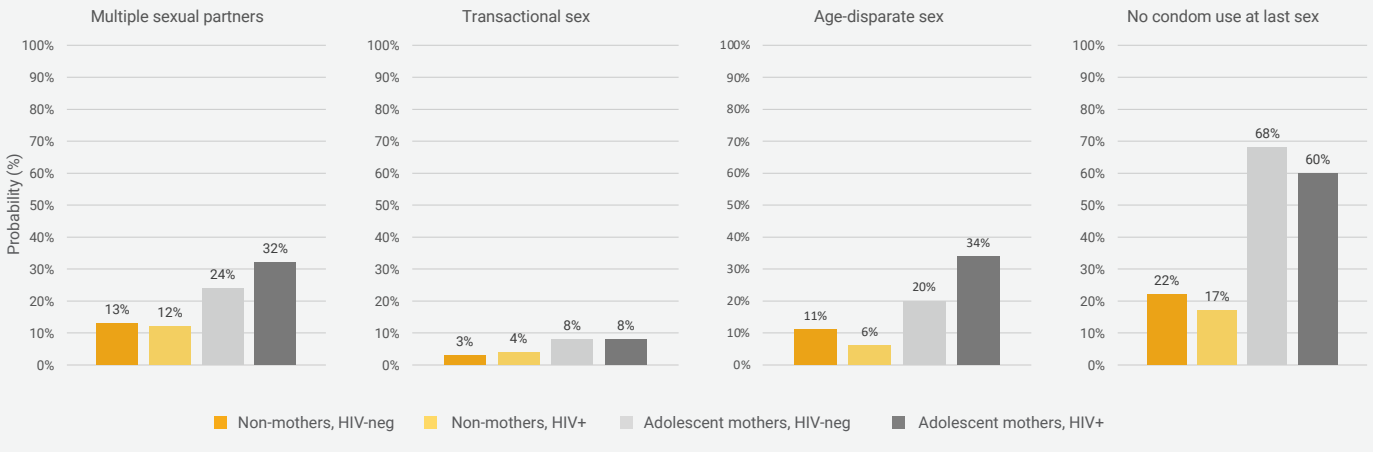
2. Compared to never-pregnant adolescents and young people, adolescent mothers have higher rates of sexual risk exposure [11,12].

- Sexual risk exposure was more common among adolescent mothers (71%), regardless of HIV status, than among adolescent girlsand young women who were not mothers (28%) [Figure 1].
- Among those living with HIV, the likelihood of experiencing both sexual risk exposure and ART non-adherence was more common among adolescent mothers than adolescent girls and young women who were not mothers.

3. One-third of adolescent mothers did not return to school following delivery and the majority did not received any information from their school about having a safe pregnancy [13-14].

- About 87% of adolescent girls became pregnant whilst attending school. Of these:
  - Nearly all adolescent mothers (97%) reported that they had not received any information about having a safe pregnancy from their schools.
  - A quarter (25%) withdrew from school before the third trimester of their pregnancy.
  - After giving birth to their child, 70% returned to school within three months.
- The odds of early school dropout during pregnancy were higher for adolescent girls who were grade-delayed before the pregnancy (over three times higher) or had not received information on safe pregnancy from their caregiver (1.6 times higher).

Figure 1: Past-year prevalence of four sexual exposure risks by adolescent motherhood and HIV status.



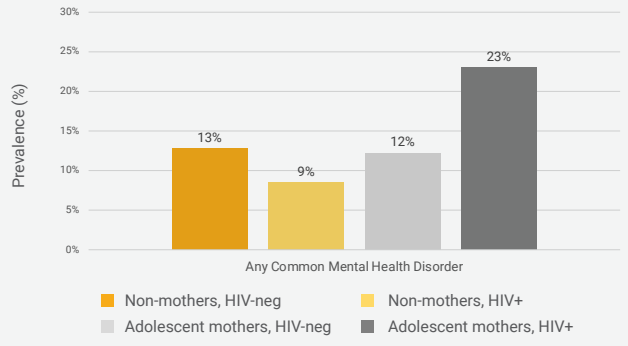
4. Although uptake of recommended antenatal and postpartum care packages by adolescent mothers was suboptimal, the majority of adolescent mothers living with HIV did start ART before giving birth.

- Less than one-quarter (23%) of adolescent mothers attended half or more of the recommended antenatal care visits. However, 99% of births occurred in health facilities.
- While almost all adolescent mothers accessed postpartum contraception immediately after the birth, 23% reported not using birth control or HIV prevention methods at last sex.
- Attendance at antenatal care visits and use of birth control or HIV prevention methods at last sex did not differ by HIV status.
- Adolescent mothers living with HIV were more likely to practice exclusive breastfeeding during the first six months postpartum than their HIV-negative counterparts (38% vs 21%).
- Among adolescents living with HIV, the majority (92%) were on ART before the birth of their first child.
  - A third (34%) had started ART before the pregnancy, a quarter (25%) started ART during the first trimester, and another third (34%) started ART during the second or third trimester of their pregnancy.
  - 1 in 10 adolescents stopped taking their ART medication either while pregnant or when breastfeeding.

5. Adolescent motherhood is associated with a higher mental health burden, and this burden is more pronounced among adolescent mothers living with HIV[8] [Figure 2]**.**

- Poor mental health was elevated among adolescent mothers compared to never-pregnant adolescents (18% vs. 10%).
- Prevalence of any common mental disorder was found to be highest amongst adolescent mothers living with HIV (23.0%). A higher proportion of adolescent mothers living with HIV reported depressive and suicidality symptomology compared to HIV-negative adolescent mothers and never-pregnant adolescent girls.
- During pregnancies, some adolescent and young mothers reported feeling compelled by schools and communities to stay at home and hide their pregnancy from others, covering themselves with clothes, what they described as "blankets of shame"

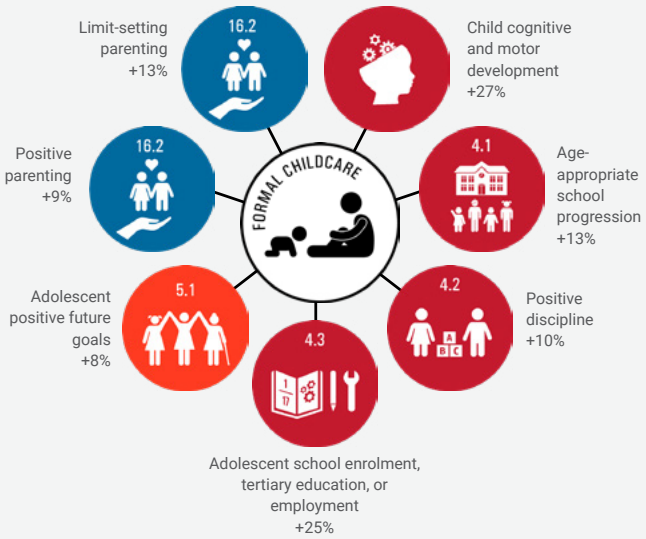
Figure 2: Prevalence of any common mental health disorder stratified according to motherhood status and maternal HIV status.



6. Supporting the wellbeing of adolescent mothers and their children requires a multi-sectoral approach to overcome the social and economic barriers in the home and within the community[15,17].

- Being food secure reduced multiple sexual risks exposure among adolescent mothers, whilst also supporting school enrolment. Food security reduced the predicted probability of reporting any sexual risk exposure by 13% for transactional sex, by 7% for age-disparate sex, and by 5% for sex while on substances.
- Use of formal childcare services increased the odds of an adolescent mother returning to school after birth. Use of formal childcare also increased adolescent mothers' engagement with school and employment (by 25%), promoted age-appropriate school progression (by 13%), and heightened a positive future outlook (by 8%) [Figure 3].
  - Adolescent mothers who had access to formal childcare showed improved practice of positive parenting and discipline, and their children also had better child development scores.

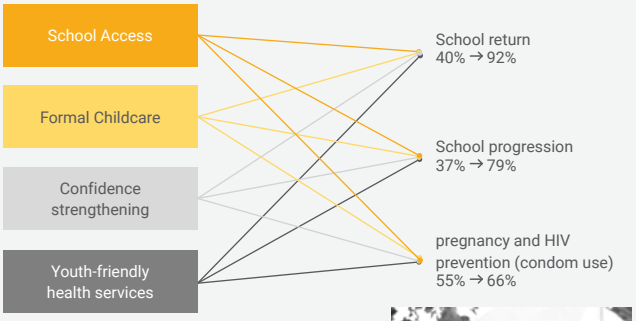
Figure 3: Effects of formal childcare use on increasing the adjusted probabilities of multiple outcomes.



- In collaboration with South Africa's Department of Basic Education, we investigated provisions and outcomes aligned with the national policy for the management of pregnant and parenting learners. Results showed a package including four components – school access during pregnancy, use of formal childcare, confidence strengthening, and youth-friendly services – improved multiple outcomes significantly. Figure 4 shows that, compared with no provided package, access to a full package achieves improvements in: School return after birth (from 40% to 92%), age appropriate school progression (from 37% to 79%), and pregnancy and HIV prevention (condom use) (from 55% to 66%).

9 https://doi.org/10.1002/jia2.25558 | 10 https://doi.org/10.1371/journal.pone.0278163 | 11 https://doi.org/10.1002/jia2.25928
12 https://doi.org/10.1097/QAD.0000000000003044 | 13 https://doi.org/10.1016/j.ijedudev.2021.102484 | 14 https://doi.org/10.1080/17441692.2022.2049846
15 Moodley S. Hidden realities. | 16 https://doi.org/10.1111/cch.13138 | 17 https://doi.org/10.1080/17441692.2023.2206465

Figure 4: Adjusted probabilities showing the effects of policy-aligned outcomes when no provisions versus all four provisions are accessed by adolescent mothers.



School access during pregnancy defined as stayed in school until the 8th month of pregnancy. Confidence and self-efficacy included items capturing an individual belief on their capacity and items assessing positive attitudes towards the future. Friendly health services refers to respectful treatment when they visited clinics (e.g. kind, scared, worried, ashamed).

Image:@Diegochuene/Twitter

7. Adolescent mothers reported that they enjoyed being parents and were optimistic about their futures and those of their children.

- Over 96% of adolescent mothers were the primary caregiver to their children, and 99% of them lived with their own caregiver, highlighting the intergenerational composition of the households in which adolescent mothers and their children live.
- When asked about their aspirations, 84% of adolescent mothers said they were very likely to have happy and healthy children. Quotations from some of the adolescent mothers follow:

> "I am proud to see my child grow fast and healthy, and also to be Akhona's (pseudonym) mum.
>
> ...
>
> I'm good at taking care of my child.
>
> ...
>
> One day, I will build a school. It will offer karate and chess. Then youth won't become gangsters... My boy will finish school. The school will keep my child and other children there safe."

WHAT DOES THIS MEAN FOR PRACTICE?

- Scale up differentiated health and social services to respond to adolescent girls' parenthood aspirations and needs, not only their sexual risk exposure. Alongside, ensure quality of service provision (youth friendly services) and support for improving access.
- Integrate SRH services into adolescent health and maternal health services to improve contraception uptake, particularly during the postpartum period. Integration can reduce rates of unintended and repeat pregnancies.
- Implement multiplatform social behaviour change programmes that provide information and address social norms on safe pregnancy and motherhood during adolescence. Programmes can be implemented at the household, school, community level.
- Establish national referral frameworks that link adolescents and young mothers from antenatal care to key needed services and support, for example, mental health, childcare, social protection, and food and nutrition.
- Develop and implement policies to support school engagement school engagement during and after pregnancy.

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