Positive motherhood: Teenage girls living with HIV in Kenya

Anke van der Kwaak and Francis Obare

Kawangware informal settlement in Nairobi, Kenya

Maternal and child health services in much of sub-Saharan Africa do not adequately meet the needs of teenage mothers. This is partly due to weaknesses in the health care system and partly because of the social stigma surrounding teenage motherhood in the region (Katz and Naré 2002; Warenius et al. 2006; Wood and Jewkes 2006).

Teenage mothers living with HIV are also likely to face additional challenges resulting from stigma and discrimination linked to being infected with the virus. This means that although the increased availability of antiretroviral treatment (ART) in many affected parts of the region should, in theory, lead to improved birth outcomes for all HIV-positive women, teenage mothers living with the virus may still be disadvantaged.

Understanding the pregnancy and birth experiences of HIV-positive teen mothers is thus an important step towards identifying their challenges and designing suitable programmes to address them. This article examines the pregnancy and birth experiences of HIV-positive teenagers aged 15-to-19 years in Kenya, based on a diagnostics study done in 2009 in Nyanza and Nairobi provinces, both with the highest prevalence in the country. The implications of these experiences for the provision of maternal and child health services to HIV-positive teenagers are also discussed.

Pregnancy experiences

A major finding of the study was HIV-positive teenagers' strong desire to become mothers. Nearly three-quarters (73%) of the girls interviewed expressed the intention to have children in future (n=471). There were also high rates of sexual activity and teenage pregnancies. In particular, more than four out of every five (88%) of the HIV-positive adolescent girls interviewed had ever had sex (n=471) while more than two-thirds (68%) of those who had ever had sex had been pregnant (n=413). In addition, 27 per cent of those who had ever been pregnant had experienced multiple pregnancies.

In spite of most of the respondents expressing the desire to have children in future, most of their pregnancies were unintended (75%; n=369) suggesting that many of them would have preferred to delay childbearing. Although unintended pregnancies have been linked to poor outcomes in some settings, most pregnancies to HIV-positive adolescents (86%) resulted in a live birth with only 9% ending in abortion, miscarriage or stillbirth.

The extent to which HIV-positive teenage mothers use maternal health services may also influence pregnancy outcomes. There was high use of antenatal care services by the teenage mothers interviewed (87% of the pregnancies), which is consistent with the high utilisation of antenatal care services in Kenya. And yet despite national and international guidelines that stress provision of PMTCT services for HIV-positive mothers as part of antenatal care (NASCOP 2009; WHO 2007), the proportion of pregnancies for which mothers received PMTCT services (71%) was lower than that of pregnancies for which they received antenatal care services. This shows there are still gaps in meeting the PMTCT service needs of pregnant HIV-positive teenagers (Obare et al. 2010).

The use of health facility delivery, skilled delivery care and post-natal care services was, however, high even by national standards: 74 per cent of the births to HIV positive teenagers were delivered at a health facility or under skilled care while mothers received post-natal care services for 86 per cent of the births. This could be due to the fact that adolescents living with HIV who were interviewed have regular contacts with clinics and are thus more likely to seek services. In contrast, only 49 per cent of all births to teenage girls in Kenya are delivered in a health facility, 50 per cent under skilled care while teen mothers receive post-natal care services for 48 per cent of births (KNBS and ICF Macro 2010).

Child health outcomes

Among pregnancies to HIV-positive teenage mothers that resulted in live births, 87 per cent of the infants were tested for HIV. In nearly all the cases where the infant was tested (98%), the mothers were willing to share the test results. Seventeen per cent of the infants that were tested and whose mothers shared the test results, were HIV-positive. As expected, the proportion of HIV-positive infants was significantly higher among those whose mothers did not receive PMTCT services than among those whose mothers received the services (33% versus 13% respectively). That the proportion of infants born with HIV is still high shows the urgency to strengthen PMTCT services for teenage mothers in the country. Most of the infants that were born alive (91%) were still living by the time of the survey with a slightly higher proportion of those who were HIV-negative, compared to those who were HIV-positive, being alive (96% compared to 89%).

Implications for service provision

As part of the diagnostic study, focus group discussions (FGDs) were held with male and female adolescents living with HIV on study sites. A question explored during the FGDs was adolescents' view of what should constitute services that meet their needs. The excerpts below highlight some of their views with implications for appropriate service provision:

- "It should be near a school, where your parents can't see you go and be opened until Sunday. It should offer "chill" services (advocate for abstinence)".
- "It should offer contraception services and ... the correct information on its

uses. Like if you are in the reproductive age you have a right to contraception rather than getting pregnant and going to seek for abortion."

- "All family planning methods including Norplant should be available at all times and they should operate until Saturday half day."
- "HIV and AIDS services should be offered together with other services."
- "To give teenagers with HIV time to access these services, it's easier if they are under one roof because the doctor understands you and it's also easier for you to choose a family planning method."

World Health Organization (2007) states that the success of PMTCT services depends on full integration of these services into maternal, newborn and child health (MNCH) packages and high coverage of antenatal and skilled delivery care services. Experiences with motherhood among teen girls living with HIV in Kenya and their views of how services should be organised to meet their needs underscore the importance of WHO's views regarding PMTCT services. A key question, however, is the conditions needed to realise effective good quality services for young people living with HIV. They include:

1. Improving provider knowledge, attitudes and practices regarding adolescent sexual and reproductive health (SRH) needs. This can, for instance, be achieved through updating the counselling and support packages to include SRH counselling and screening for HIV-positive adolescents and re-orienting service providers on the updated packages. It was, for instance, apparent from the FGDs that the young people felt uneasy with most of the providers. Their concerns are captured below:

- "Health care providers should not be older women; it should involve trained youth who understand us. Older women will stress you and one can easily open up to an age-mate (Female FGD participant)."
- "Health care providers should be friendly and assure us of confidentiality (Female FGD participant)."
- "He/she should be understanding and not harsh and be at our level. Somebody we can talk to, explain ourselves and he/she does understand (Female FGD participant)."
- "The health providers should be women/female. This is because most men tend to bond with females compared to fellow men and so this will help them to open up more about their situation (Male FGD participant)."
- "I think the health providers should be youth just like us; they have gone through the same challenges as we so they will understand us better (Male FGD participant)."

2. Creating effective linkages between HIV and AIDS programmes and MNCH clinics is crucial for improving the uptake of PMTCT services among this segment of the population. However, it is important to enhance the capacity of service providers in both HIV and AIDS programmes and MNCH clinics to effectively offer services to young people. Building trust and rapport between providers and clients is also essential for increasing uptake of services by young people.

3. Other evidence shows that community health workers or other local support systems play a crucial role in encouraging clients to seek services. Strong ties between the community and the facility are a must. These same actors and systems are crucial in follow up, adherence and managing side-effects of treatment. They can also encourage expectant teenage girls living with HIV to seek the relevant services. This should be accompanied by information, education and communication campaigns emphasising the importance of antenatal and PMTCT services for expectant mothers living with HIV.

4. There should be local ownership for such a process through involvement of the adolescents themselves as peer educators, providers of peer support, and decision-makers. It was evident from the diagnostic study that most of the teenagers living with HIV know very well what they want and have strong opinions on how services meant for them could be better organised. ■

Lessons learned

- Creating effective linkages between HIV and AIDS programmes and MNCH clinics is crucial for improving the uptake of PMTCT services among tteenage mothers living with HIV.
- In nearly all the cases where the infant was tested for HIV (98%), the mothers were willing to share the test results.
- That the proportion of infants born with HIV is still high shows the urgency to strengthen PMTCT services for teenage mothers in Kenya.

Anke van der Kwaak
Senior Health Advisor

Correspondence
KIT Development and Policy
Royal Tropical Institute
T +31 (0)20 568 8497
E-mail: a.v.d.kwaak@kit.nl
Mauritskade 63 [1092 AD]
P.O. Box 95001, 1090 HA Amsterdam
The Netherlands
http://www.kit.nl.

Francis Obare, PhD
Senior Analyst

Correspondence
Population Council
Ralph Bunche Road
P.O. Box 17643 Nairobi, Kenya
E-mail:obareonyango@yahoo.com

Young girls living with HIV in Kibera, Nairobi represent their identity and dreams through a poster.

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