TECHNICAL BRIEF

SAFEGUARDING THE FUTURE:

GIVING PRIORITY TO THE NEEDS OF ADOLESCENT AND YOUNG MOTHERS LIVING WITH HIV

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HIV SERVICE DELIVERY

World Health Organization

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CONTENTS

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BACKGROUND

Adolescent girls and young women (15-24 years old) represent one in five of the adults acquiring HIV globally and 30% of the people acquiring HIV in sub-Saharan Africa. Globally, an estimated 260 000 adolescent girls and young women acquired HIV in 2020, with sub-Saharan Africa representing 85% of the people acquiring HIV in that age group *(1)*.

According to UNAIDS 2021 epidemiological estimates, about 300 000 adolescent girls and young women living with HIV became pregnant in 2020 in sub-Saharan Africa. Adolescent and young mothers are disproportionately represented among the people acquiring HIV. Although 26% of pregnant women living with HIV were 15-24 years old, 42% of the pregnant and breastfeeding women acquiring HIV were in this age group *(2,3)*.

Adolescent and young mothers (pregnant and parenting women 15-24 years old) living with HIV risk falling between the cracks of primarily adult-oriented maternal care and the prevention of mother-to-child-transmission of HIV. They require targeted services and support to prevent maternal and newborn illness and mortality and enjoy good health and well-being.

Although some adolescent pregnancies are planned, at least half are unintended, reflecting a high unmet need for effective contraception *(4)*. Adolescent girls 15-19 years old have higher rates of pregnancy and childbirth complications than women 20-24 years old *(4,5)*, and maternal conditions are the leading cause of death among adolescent girls 15-19 years old globally. Infants born to adolescent and young mothers are at increased risk of dying in their first month of life, especially when born to young women who have experienced multiple births *(6)*. Adolescent and young mothers are more likely to have a repeat pregnancy within a year of giving birth, placing both themselves and their children at risk for negative health outcomes *(7)*. Adolescent pregnancy also has implications for the mother's mental health outcomes, and poor maternal health is, in turn, a risk marker for the development of the child *(8)*.

Many adolescent and young mothers, especially those who are unmarried, are vulnerable to the negative social and economic effects of early pregnancy, including stigma, rejection, violence, inadequate social support and reduced educational and economic opportunities *(9,10)*. Having HIV adds another layer of complexity. Adolescent and young mothers living with HIV have multi-layered issues to manage, including pregnancy, childbirth and parenting, alongside lifelong antiretroviral therapy (ART), preventing HIV transmission to their infant, potentially caring for a child with HIV, mental health challenges and often HIV-associated stigma and discrimination *(11)*.

Adolescent and young women may attend antenatal care but often only late in their pregnancies and for fewer than the WHO-recommended number of 4-8 minimum visits *(12)*. In addition, they are often unable to access the specialized, adolescent-friendly care that is vital to their continued engagement in maternal services, including postnatal care *(12,13)*. Limited antenatal care and postnatal care attendance represent missed opportunities to receive testing and treatment services for HIV and other sexually transmitted infections, alongside contraceptives and other support essential for maternal and child health.

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There have been tremendous efforts to reduce the number of children acquiring HIV. Nevertheless, in 2015, 190 000 children 0-14 years old acquired HIV by vertical transmission worldwide. Available evidence indicates that adolescent and young mothers living with HIV and their infants have lower uptake and higher attrition of services to prevent the mother-to-child transmission of HIV, including delayed treatment initiation, especially before conception, and lower retention of mother-infant pairs, contributing to higher rates of mother-to-child transmission of HIV versus adult pregnant and breastfeeding women living with HIV *(14)*. Although some adolescent and young mothers may already know their HIV status and be receiving treatment, others first learn of their HIV status at antenatal care when confirming their pregnancy, increasing the risk of vertical transmission during pregnancy. HIV infection during pregnancy or breastfeeding reflects the gap in HIV prevention for adolescent girls and young women and results in a heightened risk of mother-to-child transmission of HIV *(15)*. Population-based surveys in several countries in sub-Saharan Africa indicate that adolescent girls and young women living with HIV have lower rates of suppression of viral loads than women 25 years and older *(16)*, increasing the risk of poor maternal health and horizontal and vertical transmission. Low rates of suppression of viral loads also suggest that receiving ART might not be enough—adolescent girls and young women living with HIV require additional care and support to ensure adherence to treatment and retention in care.

In 2019, WHO and Coalition for Children Affected by AIDS (CCABA) convened a learning session of scientific and programmatic experts to consolidate the evidence on why HIV-affected adolescent mothers and their children are being left behind and to deliberate on the multiple-level changes needed to improve their outcomes. This technical brief is a follow on from that learning session and will be useful to HIV programme managers in health ministries and other adolescent- and youth-linked line ministries, especially those in in sub-Saharan Africa, in implementing, monitoring and evaluating adolescent and youth-responsive and -friendly health services for young mothers living with HIV. The publication will also be a valuable resource for healthcare workers and will assist international organizations, nongovernmental organizations and other implementing partners in better contextualizing, planning and delivering youth friendly health services for young mothers living with HIV. It begins with a call to action with alignment to key global maternal, adolescent and child strategic documents, identifies key strategic actions with implementation case examples from available models, and ends with some key multi-sectoral actions with alignment from the learning session.


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A CALL TO ACTION