Case Report

Prevalence of Pregnancy Among Adolescent Living with HIV in Muhoroni Sub County Kisumu County, Kenya

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Abstract: Background: Pregnant and breastfeeding adolescents HIV-infected are a particularly vulnerable group that require special attention and enhanced support to achieve optimal maternal and infant outcomes. Aim: To find out the prevalence of pregnancy in adolescent living with HIV, review evidence about antenatal care (ANC) service delivery and outcomes for HIV-infected pregnant adolescents in Muhoroni Sub County. Setting: The study was conducted in Muhoroni Sub County, Kisumu County, Kenya. Method: Questionnaire was used on the total 98 girls who were on care at the Referral center containing the adolescents’ center which was Masogo sub-county hospital and Muhoroni County Hospital within the sub-county to obtained the results. Result: Of the 98 girls 25 (25.5%) had pregnancy history in which 10 (10.2%) had knowledge on PMTCT, while only 4 (4.1%) were having knowledge on PNS and lastly all the pregnant girls were having knowledge on both ANC and Drug adherence and only 10 (10.2%) pregnancy were planned while 15 (15.3%) were unplanned in which 10 (10.2%) pregnancy were aborted and 11 (11.2%) were delivered safely while 4 (4.1%) of the girls were currently pregnant. Conclusions: Reasons for the poor outcome among adolescents in ANC and PNS need to be further explored and addressed, there is enough evidence that immediate action is needed to address the unique needs of this population. Such changes could include integration of adolescent-friendly services into PMTCT settings and PNS among the HIV infected adolescents youths who are sexually active with enhanced retention and follow-up activities

Keywords: Pregnant, Adolescents, HIV, Antenatal Care

1. Introduction

Around 1 in 6 people are adolescents aged 10 to 19 years old globally. [1] Adolescent pregnancy is defined as a pregnancy in girls 10–19 years of age. About 16 million girls 15–19 years old give birth each year, contributing 11% of all births worldwide. [2] Even though adolescent fertility rates are falling globally, about 18 million girls under the age of 20 give birth yearly, in which 2 million of these births are girls under 15 years of age [3]. Above 90% of these births occur in low and middle-income countries [2, 3]. Most teenage pregnancies and childbirths take place in west and central Africa, east and southern Africa, South Asia and Latin America. [4]

Most literature show that the prevalence of teenage pregnancy varies across regions of the world, where in the Asia Pacific regions, it ranges up to 43% in Bangladesh [5] and from 11.1% to 47.3% in Nepal [6, 7]. In Jordan, the prevalence is 25%. [8] In Africa the prevalence of teenage pregnancy also varies; for instance, in Nigeria, it ranges from 6.2% in Niger Delta state [9] to 49% in Abia State [10]. In South Africa [11], East Africa (Kenya) [12], Assossa (Ethiopia) [13], and Sudan [13], it ranges from 2.3 to 19.2%, 31%, 20.4%, and 31%, respectively.

Pregnancy in adolescents is common in Kenya, and an important demographic factor making the country in top ten most populous in Africa, with a total population of about 45 million in 2019 [14]. According to the KDHS 2019 finding, the prevalence of teenage pregnancy is 20% [15].

For the past three years, there has been an increase in global
resources and advocacy targeting HIV prevention, care and treatment for adolescents worldwide. Through a public–
private partnership, the US President’s Emergency Plan for AIDS Relief (PEPFAR) launched the DREAMS Initiative in
2014 to reduce new HIV infections in adolescent girls and young women in 10 sub-Saharan African countries [16].
Similarly, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and The United Nations Children’s Fund
(UNICEF) announced in July 2014 the All In Initiative, aiming to ensure that adolescents infected and affected by HIV
are adequately included in the global HIV response [17].

Although these global initiatives have focused energy and
resources on the large and vulnerable population of adolescents within Kisumu County, special attention is needed
for a subgroup of this population - the pregnant and breastfeeding adolescents living with HIV. Prevention of
mother-to-child HIV transmission (PMTCT) programmes must join the global momentum to focus on the needs of
HIV-infected pregnant adolescent girls aged 10–19 years, develop service delivery packages which address their needs
as both HIV-infected adolescents and HIV-infected mothers and Partner Notification Services (PNS) programmes should
also be considered.

2. Materials and Methods

2.1. Study Design and Setting

This was Hospital-based cross-sectional study conducted in
Muhoroni Sub County from January to March 2020. Muhoroni Sub County is one of the sub county in Kisumu
County, 100 km to the East of County headquarter. According
to the national census report of 2019, the projected population
of Muhoroni Sub County for the year 2018 was 52,459 of
whom 24.5% were adolescents 15-19 years of age. The study
was conducted in the Adolescent facility within the sub county
that is Muhoroni County hospital and Masogo sub county hospital.

2.2. Source and Study Population

All female adolescents 15-19 years of age who are on care
in the Adolescent facility were the source population of this
study. All prospective and retrospective cohort studies, cross-sectional studies, case control and Demographic and
Health Survey (DHS) reports of Sub County were included in
this study.

2.3. Data Collection Instruments and Procedures

Data were collected using a pretested, structured,
interviewer administered questionnaire which was first
prepared in English and translated into the local language by a
language expert. Then, the local language was again translated
back to English to check for consistency. The structured,
interviewer-administered questionnaire was adapted from the
WHO (Illustrative-questionnaire for interview survey with
young people developed by John Cleland) standard tool which
was developed to assess the sexual and reproductive health of
adolescents and youth.

Modifications were made to fit with the local set up. I
conducted a pretest and made some simple analysis to see if I
can address the desired objectives or not, from the results of
the pretest.

Some language corrections and rearrangements on the order
of questions were made to keep the logical flow of the
questions, based on the comments from the pretest. Two data
collectors, with diploma in nursing and one supervisor, with a
diploma of public health was employed. The supervisor and
data collectors were females chosen in order to minimize
participant discomfort.

2.4. Sample Size

The sample size was the total female adolescent attending
the Adolescent facility within the study area which was giving
the total sample of 98 girls

2.5. Study Variables

Dependent Variable: Teenage pregnancy.

Independent Variables: Sociodemographic variables, like
age, sex, marital status, occupation, education, and income
were considered. History of sexual and reproductive health,
like age at first sexual intercourse, early marriage, and
contraceptive use, perception on teenage pregnancy, family
income, family education, peer pressure, and casual sex
assessed.

2.6. Data Analysis

Statistical analysis was performed using Stata software.
Data on socio-demographics were summarized by frequencies
and percentages.

2.7. Ethical Considerations

Confidentiality and privacy were strictly adhered to and no
names of individuals were recorded or made known in the
collection or reporting of information. The study was granted
ethical clearance by Kisumu County ministry of health
department and from the sub county MOH office.

3. Result

There was high prevalence of HIV at the age of 18 with
30 (30.6%), followed by age 19 with 25 (25.5%), age 17 with
18 (18.4%), age 16 with 15 (15.3%) and lastly age 15 with
10 (10.2%). Out of 98 girls 10 (10.2%) were married in
which 8 of them were housewife, while 88 (89.8%) were
single where 20 (20.4%) were in college, 38 (38.8%) were
in secondary level, 25 (25.5) were in primary level and
lastly 15915.3%) 0f the girls were non educated one . On
occupation 17 (17.3%) of the girls were housemaid, 8
(8.2%) were housewife and 73 (74.5%) were student in all
the levels. Out of the total girls 83 (84.7%) lives with the
parents/guardians while 10 (10.2%) with husband and 5
(5.1%) live alone (Table 1).
Table 1. Sociodemographic characteristics of Adolescent girls living with HIV in Muhoroni sub-county, Kenya 2020.

<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>FREQUENCY (N=98)</th>
<th>PERCENT (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age in years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>10</td>
<td>10.2</td>
</tr>
<tr>
<td>16</td>
<td>15</td>
<td>15.3</td>
</tr>
<tr>
<td>17</td>
<td>18</td>
<td>18.4</td>
</tr>
<tr>
<td>18</td>
<td>30</td>
<td>30.6</td>
</tr>
<tr>
<td>19</td>
<td>25</td>
<td>25.5</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>10</td>
<td>10.2</td>
</tr>
<tr>
<td>Single</td>
<td>88</td>
<td>89.8</td>
</tr>
<tr>
<td>Education status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>College</td>
<td>20</td>
<td>20.4</td>
</tr>
<tr>
<td>Secondary</td>
<td>38</td>
<td>38.8</td>
</tr>
<tr>
<td>Primary</td>
<td>25</td>
<td>25.5</td>
</tr>
<tr>
<td>None</td>
<td>15</td>
<td>15.3</td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housewife</td>
<td>08</td>
<td>8.2</td>
</tr>
<tr>
<td>Housemaid</td>
<td>17</td>
<td>17.3</td>
</tr>
<tr>
<td>Student</td>
<td>73</td>
<td>74.5</td>
</tr>
<tr>
<td>Live with</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent/Guardians</td>
<td>83</td>
<td>84.7</td>
</tr>
<tr>
<td>Alone</td>
<td>5</td>
<td>5.1</td>
</tr>
<tr>
<td>Husband</td>
<td>10</td>
<td>10.2</td>
</tr>
</tbody>
</table>

Table 2. Sexual and reproductive health characteristics of Adolescent girls living with HIV in Muhoroni sub-county, Kenya 2020.

<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>FREQUENCY (N=98)</th>
<th>PERCENT (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever hard sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NO</td>
<td>33</td>
<td>33.6</td>
</tr>
<tr>
<td>YES</td>
<td>65</td>
<td>66.4</td>
</tr>
<tr>
<td>Age at first sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13-15</td>
<td>10</td>
<td>10.2</td>
</tr>
<tr>
<td>16-18</td>
<td>24</td>
<td>24.4</td>
</tr>
<tr>
<td>&gt;18</td>
<td>31</td>
<td>31.6</td>
</tr>
<tr>
<td>Contraceptive use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>YES</td>
<td>40</td>
<td>40.8</td>
</tr>
<tr>
<td>NO</td>
<td>58</td>
<td>59.2</td>
</tr>
<tr>
<td>Reason for contraceptive non use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do not have knowledge</td>
<td>18</td>
<td>18.4</td>
</tr>
<tr>
<td>Do not have access</td>
<td>40</td>
<td>40.8</td>
</tr>
<tr>
<td>want to be pregnant</td>
<td>10</td>
<td>10.2</td>
</tr>
<tr>
<td>Ever had pregnant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>YES</td>
<td>25</td>
<td>25.5</td>
</tr>
<tr>
<td>NO</td>
<td>73</td>
<td>74.5</td>
</tr>
<tr>
<td>Currently pregnant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>YES</td>
<td>4</td>
<td>4.1</td>
</tr>
<tr>
<td>NO</td>
<td>94</td>
<td>95.9</td>
</tr>
<tr>
<td>Condition of pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planned</td>
<td>10</td>
<td>10.2</td>
</tr>
<tr>
<td>unplanned</td>
<td>15</td>
<td>15.3</td>
</tr>
<tr>
<td>Outcome of pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delivered (live birth)</td>
<td>11</td>
<td>11.2</td>
</tr>
<tr>
<td>Aborted</td>
<td>10</td>
<td>10.2</td>
</tr>
</tbody>
</table>

On sexual and reproductive I find that they were sexual at age>18 with 31 (31.6%), followed by 16-18 with 24 (24.4%) and lastly 13-15 with 10 (10.2%) girls who have ever hard sex making a total of 65 (66.4%) girls ever hard sex. On contraceptive use 58 (59.2%) of girls were not using any method in which 18 (18.4%) of them have no knowledge, 40 (40.8%) have no access while 10 (10.2%) of them wanted to be pregnant. Out of 25 girls who have been pregnant 10 (10.2%) pregnancy were planned while 15 (15.3%) were unplanned in which 10 pregnancy were aborted and 11 were delivered safely while 4 (4.1%) of the girls were currently pregnant (Table 2).

Knowledge on care among the 25 pregnant girls I find that 10 (40%) hard knowledge on PMTCT, while only 4 (16%) were having knowledge on PNS and lastly all the pregnant girls (100%) were having knowledge on both ANC and Drug adherence (Table 3).

Table 3. Knowledge on care among the Pregnant and Breast feeding Adolescent living with HIV in Muhoroni sub-county, Kenya 2020.

<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>FREQUENCY (N=25)</th>
<th>PERCENT (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>knowledge on</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ANC</td>
<td>25</td>
<td>100</td>
</tr>
<tr>
<td>PMTCT</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td>PNS</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>Drug Adherence</td>
<td>25</td>
<td>100</td>
</tr>
</tbody>
</table>

4. Discussion

This study highlight that HIV-infected pregnant adolescents have poorer prevention of mother-to-child HIV transmission (PMTCT) service outcomes including lower PMTCT service uptake where only 10 (40%) girls hard knowledge on it, and PNS uptake in which only 4 (16%) girls hard knowledge compared to HIV-infected pregnant adults. This finding concurs with a previous study conducted in comparative among adult and adolescents living with HIV in which high percentage of 92% of the total adult living with HIV were high PMTCT and PNS uptake as compare to the adolescents [10].

This findings suggests that there may be higher rates of mother-to-child HIV transmission among infants of HIV-infected pregnant adolescents and increase transmission among the adolescent youths themselves due to the poor knowledge on care among them.

It was also highlighted that 10 (40%) of the girls hard planned pregnancy while 15 (60%) of them hard unplanned pregnancy which leads to abortion of 40% among the pregnant one. This finding concurs with a previous study conducted in Nigeria, where it ranges from 6.2% in Niger Delta state [9].

The study find out that there was a high prevalence of HIV infection at the age of 18 years with 30 (30.6%), followed by age 19 with 25 (25.5%), age 17 with 18 (18.4%), age 16 with 15 (15.3%) and lastly age 15 (10.2%). This increased as per the age increase was due to expose of the adolescent and increase personal demand leading them to sex for the exchange to their demands. This finding concurs with a previous study conducted in East Africa (Kenya) which reveal high percentage of infection at age group of 16-19 years old [12].

5. Conclusions

Reasons for the poor outcome among adolescents in ANC and PNS need to be further explored and addressed, there is enough evidence that immediate action is needed to address the unique needs of this population. Such changes could
include integration of adolescent-friendly services into PMTCT settings and PNS among the HIV infected adolescents youths who are sexually active with enhanced retention and follow-up activities.

6. Recommendations

The ministry of health of kisumu county should provide awareness to youth on PNS and this research should be done to entire county.

Authors’ Contributions

S. O. Awuor was the principal investigator and was the scientist involved in study methodology and design.

Disclaimer

The views and opinions expressed in this article are those of the authors and do not necessarily reflect the official policy or position of any affiliated agency of the authors.

Competing Interests

The author declare that they have no competing interests

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References


