

Effect of HIV/AIDS on Maternal and Child Health in East Africa: A Narrative Review

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ABSTRACT

HIV/AIDS remains a major public health challenge in East Africa despite substantial progress in prevention of mother-to-child transmission (PMTCT) and antiretroviral therapy (ART) scale-up. Women of reproductive age constitute a disproportionately affected population, with significant implications for maternal morbidity, mortality, and child health outcomes. This review synthesizes current evidence on the epidemiology, biological mechanisms, and clinical consequences of HIV infection during pregnancy in East Africa. It further examines vertical transmission, adverse birth outcomes, pediatric HIV, and long-term developmental consequences in HIV-exposed uninfected (HEU) children. Although ART expansion has dramatically reduced mother-to-child transmission (MTCT), persistent gaps remain in retention in care, viral suppression, adolescent pregnancy, and socio-structural inequities. Strengthening integrated maternal-child health (MCH) services, optimizing ART adherence, and addressing health system barriers are critical to improving outcomes in the region.

Keywords: HIV/AIDS, maternal health, child health, PMTCT, East Africa, vertical transmission, HIV-exposed uninfected children

INTRODUCTION

Human Immunodeficiency Virus (HIV) infection remains one of the most significant public health challenges globally, with Sub-Saharan Africa (SSA) accounting for nearly two-thirds of the global burden. Within SSA, East Africa bears a disproportionately high prevalence of HIV, particularly among women of reproductive age [1]. Countries including Kenya, Uganda, Tanzania, Rwanda, Ethiopia, Burundi, and South Sudan continue to report substantial HIV incidence and prevalence despite decades of prevention and treatment efforts. The epidemiological landscape of HIV in East Africa is characterized not only by generalized epidemics but also by structural vulnerabilities linked to poverty, gender inequality, limited health infrastructure, and sociocultural norms that influence sexual and reproductive health [2]. A defining feature of the epidemic in SSA is its “feminization.” Women account for a higher proportion of HIV infections compared to men, particularly in the 15–49-year age group. Biological susceptibility, gender-based violence, limited access to education, economic dependency, and sociocultural power imbalances contribute to this disparity. The high prevalence among women of reproductive age has profound implications for maternal and child health (MCH), given the intersection between HIV infection, pregnancy, childbirth, and breastfeeding [3]. Pregnancy itself represents a unique physiological state marked by significant immunological modulation. To tolerate the semi-allogeneic fetus, maternal immune responses undergo adaptation, including shifts in cytokine profiles and cell-mediated immunity. These immunological changes may influence HIV viral replication and disease progression. Additionally, hormonal fluctuations during pregnancy may affect viral load dynamics and immune competence [4]. Conversely, HIV infection alters immune function and increases susceptibility to opportunistic infections, anemia, malnutrition, and other comorbidities that compromise maternal health. The interaction between HIV and pregnancy extends beyond maternal physiology to obstetric and neonatal outcomes. HIV infection has been associated with increased risks of maternal complications such as anemia, sepsis, tuberculosis co-infection, pre-eclampsia, and postpartum hemorrhage [5]. For infants, HIV exposure, whether infected or uninfected, has been linked to adverse outcomes including preterm birth, low birth weight, intrauterine growth restriction, stillbirth, and increased susceptibility to infections during early childhood. The introduction and scale-up of Prevention of Mother-to-Child Transmission (PMTCT) programs, particularly following the global adoption of Option B+ (lifelong antiretroviral therapy [ART] for all pregnant and breastfeeding women living with

HIV), have significantly reduced vertical transmission rates across East Africa [6]. Many countries in the region have achieved notable declines in new pediatric HIV infections. However, despite these gains, HIV remains a leading indirect cause of maternal mortality and a major contributor to under-five mortality in several East African countries. Furthermore, disparities in access to antenatal care (ANC), skilled birth attendance, ART adherence, and viral suppression persist between urban and rural settings. Beyond transmission, emerging concerns include the long-term health outcomes of HIV-exposed but uninfected (HEU) children, who now constitute a growing population in East Africa [7]. Evidence suggests that HEU children may face increased risks of growth faltering, neurodevelopmental delays, and infectious morbidity compared to HIV-unexposed peers. These outcomes underscore the broader systemic implications of HIV beyond vertical transmission alone. Given the evolving epidemiology of HIV, the expansion of ART coverage, and persistent maternal and child health challenges in East Africa, there is a critical need to synthesize current evidence on the multifaceted impact of HIV/AIDS on maternal and child health outcomes in the region [8].

Despite major investments in HIV prevention and treatment, East Africa still bears a heavy HIV burden among women of reproductive age, with ongoing consequences for maternal, neonatal, and early childhood outcomes. Although PMTCT programs have lowered mother-to-child transmission, HIV continues to contribute to maternal morbidity and mortality and to adverse perinatal outcomes. Persistent challenges include incomplete ART coverage and inadequate viral suppression in pregnancy, delayed antenatal booking and constrained access to quality obstetric care, and the added burden of co-morbidities such as tuberculosis, malaria, and malnutrition. Gaps in postnatal follow-up, especially for HIV-exposed infants alongside weak integration between HIV services and broader maternal and child health platforms further undermine continuity of care. Importantly, existing evidence is often fragmented, focusing separately on maternal outcomes, pediatric outcomes, or PMTCT efficacy, with limited synthesis of how epidemiological trends, biological mechanisms, clinical outcomes, and health system factors interact across East African countries. Policy and implementation variability, health infrastructure differences, and socio-economic inequities also complicate a coordinated regional response. This review therefore aims to (i) describe HIV epidemiological trends among reproductive-age women, (ii) explain biological/immunological pathways affecting pregnancy, (iii) assess maternal morbidity and mortality, (iv) evaluate neonatal and early childhood outcomes among HIV-infected and HIV-exposed infants, (v) appraise PMTCT/ART effectiveness and limitations, and (vi) identify policy gaps and propose strategies to strengthen integrated services. By providing a consolidated regional analysis, the study will support evidence-based policymaking, resource allocation, and SDG-aligned interventions to improve maternal survival and child health, including outcomes for the growing population of HIV-exposed uninfected children.

Epidemiology of HIV in Pregnant Women in East Africa

HIV epidemiology among pregnant women in East Africa is marked by substantial heterogeneity across countries. Uganda, Kenya, and Tanzania report relatively high HIV prevalence, while Rwanda and Ethiopia generally exhibit moderate levels. In fragile and conflict-affected contexts such as South Sudan, surveillance systems are constrained, resulting in limited and potentially incomplete prevalence estimates [9]. Across the region, women comprise more than half of all people living with HIV (PLHIV), underscoring the gendered nature of the epidemic. Adolescent girls and young women (AGYW) aged 15–24 years are particularly vulnerable and bear a disproportionate burden of infection. This elevated risk is driven by intersecting structural and social factors, including gender inequality, early marriage, restricted sexual autonomy, socioeconomic vulnerability, and intergenerational sexual partnerships that increase exposure risk and reduce negotiating power for safer sex [10]. In response, prevention and treatment efforts have expanded, and antiretroviral therapy (ART) coverage among pregnant women has risen markedly with the adoption of WHO Option B+, which provides lifelong ART for all pregnant women living with HIV. However, persistent gaps remain, especially in rural and resource-limited settings, where barriers such as limited access to services, health system constraints, stigma, and retention challenges can undermine consistent ART uptake and long-term maternal and infant outcomes [11].

Biological Mechanisms Linking HIV to Adverse Maternal Outcomes

HIV contributes to adverse maternal outcomes through several interrelated biological mechanisms. First, immunosuppression driven by CD4+ T-cell depletion reduces host defense and increases vulnerability to opportunistic infections such as tuberculosis, pneumonia, and malaria, which are major causes of morbidity during pregnancy and the postpartum period [12]. This weakened immunity also elevates the risk of postpartum sepsis and other puerperal infections, particularly where infection prevention and timely treatment are limited. Second, HIV is characterized by chronic inflammation and persistent immune activation, which can promote endothelial dysfunction and vascular injury. These processes may contribute to hypertensive disorders of pregnancy, including preeclampsia, and can exacerbate placental insufficiency and maternal organ stress [13]. Third, coinfections are common in East Africa especially TB, malaria, and sexually transmitted infections and HIV-related immune compromise increases both the frequency and severity of these conditions. Coinfection amplifies systemic illness, complicates clinical management, and is associated with higher risks of maternal complications and mortality.

Finally, while antiretroviral therapy (ART) substantially improves maternal survival and pregnancy outcomes overall, certain regimens have been linked to metabolic disturbances, and some studies suggest possible associations with preterm birth, though evidence remains mixed. In TB-endemic settings, drug–drug interactions between ART and TB treatments further complicate care [14].

Impact on Maternal Health Outcomes

HIV substantially worsens maternal health outcomes in East Africa and remains an important indirect contributor to maternal mortality. Risk is amplified by advanced immunosuppression, poor adherence to antiretroviral therapy (ART), late antenatal care (ANC) booking, limited access to viral load monitoring, and weak referral and emergency response systems [15]. In pregnancy and the postpartum period, HIV-positive women face elevated susceptibility to severe infections and complications, including sepsis and anemia, and may experience postpartum hemorrhage indirectly through coagulopathy, coinfections, and overall physiological vulnerability. Beyond mortality, HIV is linked to major obstetric complications, such as preterm labor, low birth weight (LBW), and intrauterine growth restriction (IUGR), reflecting both maternal disease effects and health-system constraints that delay timely interventions [16]. In some settings, HIV is also associated with higher cesarean delivery rates, driven by clinical decision-making around maternal condition and prevention of vertical transmission. Mental health burdens are also pronounced: HIV-positive pregnant women report higher rates of depression and anxiety, stigma-related psychological distress, and fear of disclosure. These psychosocial pressures can undermine ART adherence and influence infant feeding and breastfeeding practices, creating a feedback loop that further threatens maternal and neonatal outcomes [17].

Mother-to-Child Transmission (MTCT)

Mother-to-child transmission (MTCT) of HIV can occur at three key periods: in utero, during labor and delivery (intrapartum), and through breastfeeding. In the absence of prevention measures, the overall risk of transmission is substantial, typically ranging from 15% to 45%. However, this risk drops dramatically with effective antiretroviral therapy (ART), falling to below 5% and often below 2% in well-functioning prevention programs [18]. In East Africa, prevention of mother-to-child transmission (PMTCT) strategies commonly include universal HIV testing during antenatal care (ANC) to identify maternal infection early, immediate initiation of lifelong ART for all pregnant and breastfeeding women (Option B+), and early infant diagnosis (EID) to detect infection promptly and start treatment without delay. Programs also promote safe breastfeeding practices supported by sustained maternal ART to minimize postnatal transmission while preserving infant nutrition benefits [19]. Despite these interventions, important challenges persist, including loss to follow-up across the ANC–postnatal continuum, suboptimal viral suppression during pregnancy and breastfeeding, heightened vulnerability among adolescent mothers, inequities in rural service access, and disruptions in conflict-affected settings that weaken continuity of care.

Effects on Neonatal and Child Health

HIV affects neonatal and child health through both direct infection and indirect exposure. Perinatally HIV-infected infants experience high early mortality without antiretroviral therapy (ART), alongside growth failure, recurrent infections, and neurodevelopmental delays; however, early ART initiation markedly improves survival and overall outcomes. In parallel, HIV-exposed uninfected (HEU) children constitute a rapidly expanding group in East Africa, and emerging evidence suggests they may face elevated risks of infections, impaired immune maturation, higher hospitalization rates, growth faltering, and possible neurodevelopmental vulnerability [20]. These risks are likely multifactorial, reflecting in utero exposure to HIV and inflammatory cytokines, ART exposure during gestation or breastfeeding, socioeconomic disadvantage, and microbiome alterations that may influence immune function and metabolism. HIV also contributes to malnutrition-related pathways by worsening maternal nutritional status, reducing breastfeeding confidence, and exacerbating household food insecurity. The downstream consequences for children include stunting, wasting, and micronutrient deficiencies, which can compound susceptibility to illness and impair developmental trajectories [21]. Overall, optimizing maternal care, ensuring early infant diagnosis, and strengthening ART access and nutrition support are critical to improving outcomes.

Breastfeeding in the Context of HIV

In the context of HIV, breastfeeding guidance emphasizes both infant nutrition and prevention of mother-to-child transmission (MTCT). The WHO recommends exclusive breastfeeding for the first 6 months, followed by continued breastfeeding up to 12–24 months, provided the mother is on effective antiretroviral therapy (ART) and maintains viral suppression. In East Africa, however, optimal feeding practices are shaped by social norms and practical constraints [22]. Mixed feeding combining breastmilk with other liquids or foods before 6 months remains a concern because it is associated with higher MTCT risk compared with exclusive breastfeeding. Cultural practices, family influence, and community expectations can strongly affect feeding choices, while fear of HIV transmission may lead some mothers to shorten breastfeeding duration or avoid exclusive breastfeeding even when ART is available. Across settings, maternal viral suppression is the central protective factor, underscoring the importance of early ART initiation, adherence support, and regular viral load monitoring [23]. Beyond biology, HIV outcomes

are also driven by socioeconomic and structural determinants, including poverty, gender-based violence, limited education, stigma and discrimination, weak health systems, and rural–urban disparities in service access and quality. Adolescents who are pregnant and living with HIV face especially high risk due to compounded vulnerabilities and barriers to consistent care.

Health System Challenges in East Africa

East African health systems continue to face persistent constraints that limit optimal HIV outcomes for mothers and infants. Key challenges include limited capacity for routine viral load monitoring, periodic stock-outs of antiretroviral therapy (ART) in some settings, and chronic health workforce shortages that affect service delivery quality and continuity. Integration of maternal and child health (MCH) with HIV services especially across antenatal care (ANC), prevention of mother-to-child transmission (PMTCT), and pediatric HIV platforms—remains inadequate and inconsistently implemented, while postpartum retention systems are often weak, leading to loss to follow-up during a high-risk period [24]. Despite these gaps, the region has recorded notable progress: mother-to-child transmission (MTCT) rates have fallen substantially, ART coverage has expanded, and maternal survival has improved alongside broader access to early infant diagnosis. Many countries have also adopted Option B+, enabling lifelong ART for pregnant and breastfeeding women and strengthening programmatic momentum toward elimination goals [25]. However, major disparities persist across and within countries, driven by uneven infrastructure, supply chain reliability, staffing, and service integration, underscoring the need for targeted investments to close implementation gaps and sustain gains toward MTCT elimination.

Future Directions

Future efforts to improve maternal and child outcomes in HIV-affected populations should prioritize stronger, more integrated service delivery across the pregnancy–postpartum continuum. Viral load monitoring during pregnancy needs to be strengthened through timely testing, rapid result turnaround, and prompt clinical action to reduce vertical transmission risk. Postpartum retention should be improved by reducing missed visits, supporting continuity of ART, and aligning maternal and infant follow-up schedules [26]. Adolescent-focused HIV services must be expanded to address age-specific barriers such as confidentiality concerns, low autonomy, and heightened stigma. Integrating mental health screening and care into ANC/PMTCT is essential, given the links between depression, adherence, and engagement in care. Greater attention is also required for HIV-exposed uninfected (HEU) children, who may face elevated risks of morbidity, growth faltering, and developmental delays. Nutrition programs should be strengthened to support maternal health and infant growth through counseling, supplementation where appropriate, and food security linkages. Surveillance systems must be improved in conflict and displacement settings to maintain continuity of prevention and treatment services. Finally, community-based stigma reduction should be enhanced to increase testing, disclosure support, and sustained care-seeking. Implementation science is needed to identify what works, for whom, and how to scale effectively [27].

CONCLUSION

In conclusion, improving maternal and child outcomes in HIV-affected populations requires closing persistent gaps across the ANC–delivery–postpartum continuum through integrated, patient-centered care. Timely viral load testing, rapid return of results, and prompt clinical response are central to sustaining maternal viral suppression and preventing vertical transmission. Strengthening postpartum retention by simplifying visit schedules, supporting uninterrupted ART, and integrating mother–infant services remains critical to reducing loss to follow-up. Adolescents require differentiated, stigma-sensitive models that safeguard confidentiality and address structural and social barriers to adherence. Embedding routine mental health screening and brief interventions within ANC/PMTCT platforms can enhance engagement and treatment success. HIV-exposed uninfected children warrant proactive monitoring for infections, growth faltering, and neurodevelopmental delay, supported by strengthened nutrition counseling and social protection linkages. In fragile and conflict-affected settings, resilient surveillance and community outreach systems are essential to maintain service continuity. Ultimately, implementation science should drive context-specific adaptation, ensure fidelity, promote equity, and support sustainable scale-up of high-impact interventions.

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CITE AS: Abaho Areeba Fortunate (2026). Effect of HIV/AIDS on Maternal and Child Health in East Africa: A Narrative Review. *IDOSR JOURNAL OF BIOCHEMISTRY, BIOTECHNOLOGY AND ALLIED FIELDS* 11(3):36-41. <https://doi.org/10.59298/IDOSR/JBBAF/2026/1133641>