Providing Services to Pregnant Drug Users in Low-Resource Settings

BACKGROUND

Pregnant women who use drugs can have safe pregnancies and deliver healthy babies-provided they receive proper antenatal care and drug treatment services. However, in low resource settings, key elements of proper care for pregnant drug users may not be available: The gold-standard of care for pregnant women who use opiates is methadone maintenance therapy-offered most effectively together with psychosocial support and antenatal care-but in many countries, methadone is not available for drug treatment. Existing drug treatment services may not be equipped to treat pregnant women or may simply not accept women who are pregnant. In addition, the available data shows that pregnant women who use drugs tend to have comparatively poor access to antenatal care. For these reasons, pregnant drug-users and their babies are likely to have more health problems than non-drug using women. Service providers who work with pregnant drug users in settings where drug treatment is not provided to pregnant women or where methadone maintenance treatment is not available, require guidance on ways they can support the health of pregnant drug users. This information brief provides basic information and guidance on important steps services providers can take to support pregnant drug users in low resource settings.

WHAT ARE THE ISSUES?

Women who use drugs may not be fully aware of the impact of drugs on their foetus, and may hold a number of misperceptions about drug use and pregnancy. Service providers-including outreach workers, harm reduction services, drug treatment providers, and antenatal care services, may also be inadequately informed about drug use and pregnancy, and may therefore provide inadequate or inaccurate information to pregnant women who use drugs. In many settings, there are high levels of stigma surround drug use and that stigma is amplified in the case of a pregnant woman who is using drugs. Stigma in health care settings discourages pregnant drug users from seeking services and lack of accurate information among service providers can endanger the health of the mother and the life of the foetus.

Key facts to know about pregnancy and drug use are:

Women who use drugs may experiences interrupted menses-amenorrhea, and may therefore not realise that they are pregnant until late into their second or even in their third trimester. Some women may incorrectly believe that they cannot get pregnant when they are using drugs or when they do not have their period.

Heroin use can have an adverse physical impact on foetal development:
Using opioids during pregnancy is associated with placental abruption, in utero withdrawal, perinatal asphyxia, meconium aspiration, and perinatal infection.[1]

But, quitting opioids abruptly can be extremely dangerous to foetal development:
Pregnancy can often be a powerful motivator for a woman to quit drugs. However, quitting drugs abruptly can endanger the life of the foetus. Without proper support or drug treatment, pregnant women who quit drugs are at a high risk of relapse, and it is this dynamic of withdrawal followed by relapse that most endangers the foetus. Dramatic fluctuations in opioid concentration in the mother's blood stream can lead to foetal withdrawal or overdose-highly damaging to foetal development, and possibly life-threatening to the foetus.

And, other drugs can have greater adverse effects on pregnancy than heroin:
Compared with the effects of alcohol, cocaine and benzodiazepine during pregnancy, opioid use does not have teratogenic or cytotoxic effect.[2] Heavy tobacco and alcohol use during pregnancy have been shown to have permanent developmental effects on children.

Use of tobacco, including heavy exposure to second-hand smoke, can be more damaging to pregnancy outcomes than heroin use:
Estimates indicate that 90 percent of opioid-dependent women are heavy smokers.[3] Studies have found that cigarette smoke reduces blood flow through the placenta by 38 percent.[4] Tobacco increases the risk of spontaneous abortion, increases the risk of vaginal bleeding and premature delivery, increases the risk of lower birth weight, and increases the risk of sudden infant death syndrome, as well as bronchitis and pneumonia in children.

[1] Ostrea E.M. Jr. 1978. The care of the drug dependent woman and her infant. Lansing, Michigan. Michigan Department of Public Health, cited in Ben Shaw, Maternal Drug Use:
[2] Consequences for the Child, in Catherine Siney ed.. 1999. Pregnancy and Drug Misuse, Edinburgh: Books for Midwives. Channoff I.J., Burns W.J. and Scholl S.H. 1984. Perinatal addiction: the effects of maternal narcotic and non-narcotic substance abuse on the fetus and neonate. NIDA Res Monogr 49, 220-226.
[3] Finnegan, Loretta, Pregnancy, Drug Addiction and HIV in Eastern Europe and Central Asia: _
New Viewpoints on Service -Provision for Mother and Child, Technical Consultation UNICEF, WHO, UNODC, and UNAIDS, Yalta, Ukraine, July 1-3, 2009.
[4] Finnegan, Loretta, Pregnancy, Drug Addiction and HIV in Eastern Europe and Central Asia.

POLICY AND PROGRAMMING IMPLICATIONS

Although pregnant drug users are unlikely to access mainstream medical services, harm reduction service providers operating via outreach can and do access these women. In South Asia in particular, where women may have limited access to services outside the home, female outreach workers are in a position to provide important services to pregnant drug users and their babies at home. In the absence of evidence-based drug treatment options appropriate to pregnant women, such as methadone maintenance therapy, outreach workers can offer women services that can improve the health of both mother and child:

Advise women on the dangers of abruptly stopping drug use during pregnancy and support them to draw down their dose in a controlled manner. While no drug use is the ideal for pregnant women, be aware that this may not be a realistic option for every woman. Support women who continue to use drugs or who relapse, in a non-judgemental manner.

Offer key services to improve maternal health during pregnancy, especially **nutritional support** and support to **decrease smoking and alcohol consumption.** Eliminating alcohol consumption and decreasing cigarettes to less than 10 per day significantly improves the health of both mother and child.

Support women to attend HIV testing, advise them on mother-to-child transmission, and support them to access PMTCT.

Support women to access antenatal care by helping them to make doctors' appointments and accompanying them to doctors' appointments.

Provide harm reduction services including condoms and NSP to pregnant drug users as needed.

Provide access to safe and discrete pregnancy termination services as needed.

Provide home pregnancy tests to women and advise women that they can become pregnant even if they are not menstruating.

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There is no safe level of alcohol consumption during pregnancy:
Alcohol passes through the placenta and the foetus has limited ability to metabolize alcohol. Alcohol use during pregnancy can result in an increased risk of spontaneous abortion and stillbirth and an increased risk of foetal alcohol spectrum disorder.[5]

HIV-positive women who inject drugs during pregnancy have disproportionately high rates of mother-to-child transmission compared to HIV-positive women with no history of drug use: Mother-to-child HIV transmission rates among HIV-positive drug users have been found to be markedly higher than among HIV-positive non-drug using women.[6]

The health of pregnant opioid users is impacted by a complex range of circumstances including poverty, lack of prenatal care, unwanted pregnancy, sexually transmitted infections, poor nutrition, physical abuse, stress, depression, and lack of support.

EVIDENCE: GOOD PRACTICES

Opiate substitution therapy:
OST with methadone or buprenorphine-is the most effective and safest treatment for pregnant women who use drugs. If these treatments are available, support women to access them.

Detoxification:
Detoxification during pregnancy is generally not recommended, due to the danger of continued illicit substance use and relapse.[7] However, a number of programs in the U.K.,[8] U.S.[9] and Australia[10] do provide detoxification for pregnant women using methadone or buprenorphine. Where methadone is not available, medically prescribed slow-acting morphine can be safely used to manage maternal withdrawal.[11] Naloxone and naltrexone should not be administered to pregnant women as this can result in the rapid onset of withdrawal and seizures.[12] Detoxification is most safely undertaken in the second trimester. Attempting detoxification during the first trimester may incur an elevated risk of miscarriage, and during the third trimester-of premature delivery. Opioid detoxification during pregnancy on an outpatient basis has been found to have low success rates.

A supportive and non-judgemental approach:
Programs have universally found that providing services in a supportive and non-judgemental manner is critical to program success. Few populations experience greater stigma than pregnant drug-using women, and women who are injecting drugs during pregnancy are likely to feel guilty about their drug use and concerned about the health of their baby. A punishing approach only serves to reinforce women's feelings of inadequacy and undermine receptivity and adherence to services.

Treating the whole woman:
The most effective programs for pregnant opioid users address the complex range of pregnant women's needs. These programs have found that addressing the full range of drug-using women's needs, rather than focusing exclusively on their drug use, attracts women to services, improves adherence to antenatal care, supports reduced drug use, and improves health outcomes for mother and child.

Key services include:[13]

- Nutritional support for both mother and child such as hot lunches, food bags, and baby formula. Provision of supplements such as prenatal vitamins with folic acid and B12 when necessary
- Support for reducing or stopping smoking as needed
- Support for reducing or stopping alcohol use as needed
- Clothing, household items, infant clothes and toys
- Child care support when needed
- Pre and post-natal health care
- Accompaniment to doctors appointments
- Accompaniment for HIV testing and support for access to PMTCT for women who test positive
- Transportation assistance (bus tickets, car service)
- Assistance with securing safe housing when needed
- Counselling
- Domestic violence counselling and support
- Breastfeeding instruction
- Parenting classes
- Home pregnancy tests for parenting women
- Wellness and safety plans with parenting women
- Infant health checks
- Contraception
- Relapse prevention support after delivery for women who have stopped using drugs

NSP for pregnant opioid users:
Women who continue to inject drugs during pregnancy require access to needle and syringe programs offered in a supportive and non-judgemental manner. NSP is key to reducing HIV transmission and should be provided to pregnant women as needed. Programs have found that women who continue to use illicit drugs and inject in the groin may have problems as their abdomen enlarges and alternative injecting sites need to be suggested.[14]

Condom programs:
Pregnant women who inject drugs require access to condom programs for the prevention of HIV infection. Programs have found that pregnant women injectors are vulnerable to HIV infection via sexual transmission because they are less likely to use condoms during pregnancy.

[5] Koren G, Nulman I, Chudley AE, Loock C. Fetal alcohol spectrum disorder, CMAJ 2003; 169 (11): 1181-1185; Chudley AE, Conry J, Cook JL, Loock C, Rosales T, LeBlanc N. Fetal alcohol spectrum disorder: Canadian guidelines for diagnosis, CMAJ 2005; 172 (5suppl.): S1-S21.
[6] Malyuta, Ruslan and Claire Thorne, Eastern Europe and Central Asia: IDU, HIV and PMTCT in the Context of Drug Use, Presentation at the XVII International AIDS Conference, Mexico City, August 3, 2008.
[7] Center for Substance Abuse Treatment. 2005. Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs. Treatment Improvement Protocol (TIP) Series 43. DHHS Publication No. (SMA) 05-4048. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005 Chapter 13: Medication-Assisted Treatment for Opioid Addiction Treatment during Pregnancy. http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.section.83488; Australian National Clinical Guidelines for the Management of Drug Use during Pregnancy, Birth and the Early Development Years of the Newborn. 2006 March. www.health.nsw.gov.au/pubs/2006/ncg_druguse.html.
[8] The Glasgow Women's Reproductive Health Service. Hepburn, Mary. 2002. Providing care for pregnant women who use drugs: The Glasgow Women's Reproductive Health Service, in Klee, Hilary, Marcia Jackson and Susan Lewis. 2002. Drug Misuse and Motherhood, Routlidge: London and New York, pp. 250-260
[9] Johns Hopkins Bayview Medical Center, Baltimore, http://www.hopkinsmedicine.org/Psychiatry/bayview/substance_abuse/center_addiction_pregnancy.html
[10] In New South Wales, Australia
[11] Fischer, G., Jagsch R., Eder H., Gombas, W., Etzersdorfer, P., Schmidl-Mohl, K., Schatten, C., Weninger, M. and Aschauer, H.N., (1999), Comparison of methadone and slow-release morphine maintenance in pregnant addicts, Addiction, 94 (2), 231-239.
[12] Australian National Clinical Guidelines. p. 46.
[13] List developed on the basis of the following sources: Australian National Clinical Guidelines; Boyd, Susan C. and Lenora Marcellus, eds., With Child: Substance Use During Pregnancy: A Woman-Centred Approach, Fernwood Publishing, Halifax, 2004; Poole, Nancy, Evaluation Report of the Sheway Project for High-Risk Pregnant and Parenting Women. British Columbia Centre of Excellence for Women's Health, 2000.
[14] Ruben, Susan and Frances Fitzgerald. 2002. The role of drug services for pregnant drug users: The Liverpool approach, in Klee, Hilary, Marcia Jackson and Susan Lewis, Drug Misuse and Motherhood, Routlidge: London and New York, 2002, pp. 224-238.