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Delivering HIV Services to Pregnant Drug Users in Low-Resource Settings

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BACKGROUND

Pregnant women who use drugs require access to key HIV services-testing and counselling, ART for preventing mother-to-child transmission for pregnant IDU who are HIV-positive, ART postpartum for women who require treatment, HIV testing for the newborn, and ART for children who are born HIV-positive. In low-resources settings, many of these services may not be available or may be prohibitively difficult to access. Outreach workers can provide key HIV-services to pregnant IDU in the home settings, and can also support women to access those HIV services that are available in country. This information brief outlines the key HIV services pregnant IDU require and provides guidance on ways in which service providers can improve women IDUs access to these services.

WHAT ARE THE ISSUES?

Women IDU of child-bearing age are at particularly high risk of HIV infection:
The vast majority of women IDU are of child-bearing age, and women IDU tend to have significantly higher HIV infection rates than their male counterparts. Studies in nine European countries found that the average HIV prevalence rate was more than 50 percent higher among women IDUs than it was among men IDUs.[1] Similarly, studies in Yunnan Province, China, found HIV prevalence to be significantly higher among women IDUs than among men,[2] comparative analysis in Mombasa, Kenya, found that the prevalence of HIV was 50 percent among all IDUs, but 85 percent among women IDUs,[3] and a study in Kazakhstan found that women IDU were 2.5 time more likely to be HIV positive than male IDU.[4]

HIV-positive pregnant IDU have exceptionally high mother-to-child transmission rates compared with HIV-positive women with no history of IDU: Although few studies have compared mother-to-child transmission rates among HIV-positive IDU and non-IDU, the existing data suggests a severe disparity: Data from Ukraine found that women with a history of drug use were at a 42 percent increased risk of transmitting HIV to their babies compared to HIV-positive women with no history of drug use.[5]

HIV-positive women IDU have exceptionally poor access to PMTCT compared with HIV-positive women with no history of drug use: Few studies have compared access to PMTCT among HIV-positive IDU and non-IDU, but the existing data suggests that IDU women are significantly less likely to access PMTCT. A study in Russia found that 46 percent of HIV-positive IDU received no PMTCT, compared to only 16 percent of HIV-positive non-IDU women.[6]

Pregnant women who use drugs tend to access HIV testing very late in their pregnancies compared with pregnant women who are not IDU: The existing data suggests that women IDU have significantly poorer access to HIV testing during pregnancy. A study in Ukraine found that among women who did not know their HIV status at the start of their pregnancy, women with an IDU history were 3.5 times more likely to be diagnosed during delivery than were non-IDU women. When women are diagnosed late in the pregnancy, they are not in a position to access more effective ART regiments for PMTCT and are thus at increased risk of transmitting HIV to their babies. The same study found that IDU women diagnosed with HIV during pregnancy were significantly more likely to have symptoms of advanced HIV: 13 percent of HIV-positive pregnant women with an IDU history had severe or advanced clinical symptoms versus only 5 percent in non-IDU women.[7]

HIV-positive IDU women are at risk of transmitting HIV to their newborns, due to lack of access to information on mother-to-child transmission, lack of infant feeding options besides breast feeding, and poor access to post-natal care.

[1] European Monitoring Centre for Drugs and Drug Addiction Annual Report 2006: the state of the drug problem in Europe, http://ar2006.emcdda.europa.eu/en/home-en.html
[2] Choi, S.Y.P., Cheung, Y.W., Chen, K. 2006, Gender and HIV risk behaviour among intravenous drug users in Sichuan Province, China. Social Science and Medicine, 62, 1672-1684
[3] Ndetei, D. 2004, UNODC study on the linkages between drug use, injecting drug use and HIV/AIDS in Kenya, University of Nairobi, 2004, in UNODC World Drug Report 2005
[4] Bronzan R, Zhussupov B, Favorov M, Kryukova V, Muratbaeva G, Kuznetsov N, Shakarishvili A, and Ryan C., Risk Factors for HIV infection among injecting drug users in Kazakhstan: implications for prevention intervention, Proceedings of the XVth International AIDS Conference. Bangkok 2004
[5] Claire Thorne, University College London, Access of IDU women to PMTCT services in Ukraine. Data from a 9 year prospective cohort study, Presentation the High-Level Consultation on Pregnancy, Drug Addiction and HIV in Eastern Europe and Central Asia: New viewpoints on service-provision for mother and child, UNICEF, UNODC, UNAIDS, WHO-Europe, 1-3 July 2009, Yalta
[6] Nazarova O.A., G.R. Khasanova, L.M. Mukharyanova, V.A. Anokhin. 2008. Medical-social aspects of providing antenatal HIV care to women who inject drugs, Presentation at the Conference on HIV, Pregnancy and Drug Use, Kazan, Russia, November 10-11, 2008.
[7] Claire Thorne, University College London, Access of IDU women to PMTCT services in Ukraine. Data from a 9 year prospective cohort study, Presentation the High-Level Consultation on Pregnancy, Drug Addiction and HIV in Eastern Europe and Central Asia: New viewpoints on service-provision for mother and child, UNICEF, UNODC, UNAIDS, WHO-Europe, 1-3 July 2009, Yalta

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EVIDENCE: GOOD PRACTICES

Although good guidelines exist for providing HIV services to pregnant and parenting IDU in developed countries, there is little research on good practices for delivering HIV services to pregnant IDU in low-resource settings, and no research in this area in South Asia. Some aspects of existing HIV service delivery practices for pregnant IDU do, however, have broad applicability:

Home pregnancy testing:
A number of programs that work with women drug users provide home pregnancy tests as well as counselling and support on family planning and reproductive health, and home gynaecological check-ups. [8]Early detection of pregnancy allows for provision of HIV testing and counselling services at an early stage of pregnancy.

HIV testing and PMTCT are offered as part of a larger package of antenatal services:
Most services for pregnant drug users integrate HIV testing into a larger comprehensive package that includes addressing issues of poverty, housing, partner violence, sexual abuse, legal issues, and mental illness.

PMTCT for HIV-positive IDUs is provided in conjunction with supportive drug treatment:
Ideally, this means integrating antenatal care into drug treatment services[9] or integrating drug treatment into antenatal care services.[10]

Postpartum care:
includes providing information about contraception options to prevent unwanted pregnancies, as well as supporting women to care for their babies and to bring their babies for HIV-testing and treatment if necessary.[11]

Infant care:
The Australian National Clinical Guidelines for the Management of Drug Use during Pregnancy, Birth and the Early Development Years of the Newborn recommend that babies born to HIV+ women commence ARVs as soon as possible following birth and for the first 6 weeks of life. Monitoring of the baby's HIV status by PCR should be extended for the first 18 months of life.

POLICY AND PROGRAMMING IMPLICATIONS

While some important HIV-related services require attendance at medical facilities, many services can be provided via outreach workers and home visits, and outreach workers can also provide key support to assist pregnant IDU to attend and adhere to HIV services.

Provide free home pregnancy tests combined with information and education about pregnancy, drug use, HIV, and PMTCT. It is important to emphasize that although women drug users may have irregular menses, they can become pregnant, and regular home pregnancy testing is important to detect pregnancy at an early stage.

As much as possible, provide free home express HIV testing in conjunction with counselling. When express tests are not available, support pregnant IDU to attend HIV testing and if possible, accompany women for the HIV test.

Provide condoms and advise IDU women to continue to use condoms during pregnancy. IDU women are at risk of HIV infection through needle sharing and many also have high-risk IDU husbands / partners. It is important for women in these high-risk situations to continue to use condoms during pregnancy: Research has found high rates of sero-conversion during pregnancy, because couples are less likely to use a condom during this time and recent seroconverters are more likely to transmit HIV to their infants.[12]

For women IDU who are pregnant and test HIV-positive, support access to ART for PMTCT.

Provide condoms, reproductive health support and family planning instruction to women post-partum.

Support HIV-positive women IDU to access HIV services for newborns.

[8]IHRD, Making Harm Reduction Work for Women: The Ukrainian Experience, March 2010.
[9]See, for example, Bilangi, Richard J., Pregnant addict care in Methadone Treatment Programs. Heroin Addiction and Related Clinical Problems, 2(2), 43-50, 2000.
[10]See, for example, Hepburn, Mary. 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.
[11]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.

[12]WHO. 2008. Towards Universal Access: Scaling up HIV services for women and children in the health sector. Progress Report.