Message Brief (B): (i) Infant and Maternal Health Care

Season Twelve

Infant and maternal health care involves the health of pregnant women, new mothers and babies under 5 years old. This is one of the B Themes of the series, but which fits in with, and is indeed an integral part of, re-engineering primary health care (PHC).

Overview and Introduction

South Africa is one of several African counties who will not meet the internationally-accepted Millennium Development Goals (MDG) #'s 4 and 5. These state respectively that by 2015, under-5 mortality should decrease by two thirds from what it was in 1990, and that maternal mortality (MMR) should decrease by 75% of its levels in 1990.

Maternal and under-5 mortality remain very high in South Africa. The National Department of Health's Report of the Health Data Advisory and Coordination Committee (2011) – shows that MMR is 310 per 100 000 and the under-5 mortality rate is 56 per 1000 live births. By comparison, the 2015 MDG targets are 38 per 100 000 for MMR and 20 per 1000 live births for under-5 mortality.

The leading cause of maternal deaths in South Africa are infections (such as AIDS), and complications from excessive bleeding and high blood pressure. Overall, 40% of all maternal deaths are avoidable, and are due to community, administrative and clinical factors. Maternal deaths have attendant consequences on the families, communities and the children left behind, often increasing the likelihood that they themselves will die. Women most at risk of maternal death are older women especially women over 35 years and older, women in their first pregnancy or who had five or more pregnancies. The commonest causes of Under 5 mortality in the country are deaths related to AIDS, including infections (TB, diarrhoeal diseases and pneumonia) and malnutrition.

One of the key approaches of the Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa (CARMMA) is to mobilize communities to let them know that everyone has a role to play in improving maternal and child health and to accelerate actions aimed at the reduction of maternal and child mortality in Africa. And important aspects related to this community mobilization will be advocacy and health promotion for early antenatal care and attendance/ booking; empowering civil organisations and communities to demand services and; building the capacity of community health workers to support the communities and health services.

HIV/AIDS and the Prevention of Mother to Child Transmission (PMTCT)

It is a common misunderstanding that pregnant women who are HIV-positive automatically pass the disease to their babies. This is not true. Only one out of every three children born to HIV-positive

mothers will become infected with HIV. In other words two out of every three babies will be born healthy. With an appropriate PMTCT programme this risk can be reduced substantially so that less than 5% of babies (1 out of 20) become infected via their mothers. PMTCT is one of the most crucial issues in the current struggle against HIV infection.

HIV prevalence among 15 - 24 year old pregnant women was at 20.5 % in 2011, a decline of 1.3% from the previous year. However, HIV prevalence was on the increase in pregnant women aged over 35 years. In 35-39 year-old women the 2011 estimated prevalence was 39.5%, compared to a rate of 35.4% in 2009.

The latest national PMTCT survey found a 3.5% mother-to-child transmission (MTCT) rate in pregnancy and child birth, and this had a greater than 4-fold differential range of rates across the nine provinces. The sharp provincial variations in MTCT is probably due to the differences in 'effective coverage' and quality of PMTCT programmes including uptake of C4 cell count testing results, repeat HIV testing at 32 weeks, appropriate ARV prophylaxis/HAART for HIV-positive women, and adherence to PMTCT regimens. MTCT of HIV can occur during pregnancy, labour, delivery, and mixed methods of infant feeding. It is also called "vertical transmission" because the mother does not intentionally transmit the virus to the baby. Many women find out at pregnancy that they are HIV positive.

Maternal HIV acquisition since the last HIV test was potentially high at 4.1% and therefore repeat HIV testing at 32 weeks pregnancy and couples testing are critical, along with safer sex during pregnancy. Nevertheless, uptake of PMTCT services around the country is high, with more than 98% of women getting HIV tested during pregnancy and 91.7% of HIV-positive mothers receiving ARV treatment or prophylaxis. However CD4 (78.3%) testing and early infant diagnosis (EID) (35.1%) uptake are lower and represent on-going missed opportunities in the PMTCT programmes. The same survey found that early infant HIV testing uptake is high if offered to all infants (94%) at six-week immunisation visits, indicating that EID strategies that routinely offer infant HIV testing only to known HIV-exposed infants should be reviewed.

Given the measured MTCT rate in the early implementation phase of the revised 2010 South African PMTCT guidelines, virtual elimination of paediatric HIV infection is possible with intensified effort. This was quite unthinkable just a few years ago.

Only 20% of HIV-positive women were exclusively breastfeeding, 62% were formula feeding and 18% were practicing high-risk mixed feeding, suggesting a need for increased attention to infant feeding. The poor feeding practices during the first 6 weeks after delivery highlights the need to strengthen infant feeding counselling, adherence to postnatal prophylaxis and to monitor MTCT and HIV- free survival from 6 weeks to 18 months and HIV-free survival beyond six weeks.

Although the data suggests a greater than 80% reduction in MTCT from 25% - 30% (without PMTCT interventions) to 3.5% currently, virtual paediatric HIV elimination will only be possible with intensified efforts and a change in approach towards infant feeding. Estimated targets to reach the 2015 South African national targets would be MTCT rates of less than 2% at 6 weeks and less than 5% at 18 months. Gaps in effective PMTCT coverage for all steps in the PMTCT cascade need to be

addressed, and postnatal MTCT must be prevented through improved infant feeding and expanded coverage of the postnatal prophylaxis programme.

Infant Feeding – a Basic Overview

Counselling and advice on infant feeding for HIV-positive mothers is provided as part of the PMTCT programme.

- The promotion, protection and support of breastfeeding should continue to be the primary focus. Exclusive breastfeeding should be practised during the first six months of life and continued breastfeeding up to two years of age or beyond.
- Exclusive breastfeeding means that the baby must only receive breast milk. The baby must not be given any tea, juice, infant formula or even water during this period. Breast milk is the best food for the baby and helps the baby develop a strong immune system. This helps to protect the baby from developing HIV disease. However if other foods are introduced at the same time it weakens the digestive system making it easier for the HIV virus to get into the baby's blood.
- Health care personnel should not recommend formula feeding as an alternative to breastfeeding, unless there are legitimate medical reasons to do so namely: in rare cases of metabolic disorders of the infant, such as galactosaemia, and when a mother makes an informed decision not to breastfeed.
- Exclusive formula feeding means only giving the baby formula feed, prepared strictly according to the instructions. The water must be clean and freshly boiled and the bottles and teats must be properly sterilised, otherwise the baby can get very sick and even die.
- Health advisors need to take into account local conditions. If clean water is not readily available or if the clinic has problems supplying regular infant formula, women should be encouraged to rather choose the exclusive breastfeeding option.
- In some communities there is a stigma attached to formula feeding because some people think that it identifies the mothers who are HIV-positive. Many mothers are therefore reluctant to choose this option. It is important that the mothers who choose to formula feed are properly supported by the clinic staff, their families and the community in order for this option to be successful.
- In some cases a 'wet' nurse who is HIV-negative can be found to feed the baby. This is not always practical but it offers an ideal solution as the baby receives all the benefits of breast milk without any risk.

Fertility Management

The ability to control the number, spacing and timing of children is basic for women's health and rights. Currently there is strong social pressure on women to fall pregnant and to fall pregnant

earlier than the age of 25. Falling pregnant is seen as a qualification for becoming recognized as a 'real woman'. This social drive encourages risky sexual behaviour which leads to HIV infection.

Although teenage pregnancy is an important public health concern, reports of unwanted pregnancies are higher amongst older women. The percentage of births reported as unwanted rises with age, 13% of women aged 19 and younger reporting unwanted births compared to 43% of women 40 and older.

Primary Health Care for Mothers and Infants

The public health sector provides free health services to pregnant and lactating women, and children below the age of six years, who are not members of medical aid schemes.

In addition, South Africa's PMTCT programme now guarantees every pregnant woman and mother the right to:

- HIV Counselling and Testing (HCT) on her first antenatal clinic visit, which should be before 14 weeks.
- ***If she is HIV-negative***, she should be offered a second test at around 34 weeks.
- ***If she is HIV-positive***, she should be enrolled immediately in a PMTCT programme.

  – All women diagnosed are placed on a Fixed Dose Combination treatment immediately if there is a contraindication to FDC then use of AZT is recommended and the FDC continues until end of breastfeeding. The baby then gets NVP at birth and then daily for 6 weeks.
- Good guidance on infant feeding, including information about weaning and the benefits of exclusive breastfeeding while on ARV treatment.
- Access a child support grant if she does not have enough income.

And every new-born baby has the right to:

- Daily Nevirapine for six weeks from birth if the mother is HIV-positive;
- Daily Nevirapine beyond six weeks while breastfeeding, until one week after breastfeeding stops if the mother is not on ARVs;
- Be tested for HIV at six weeks using PCR testing, six weeks after stopping breastfeeding, and at 18 months;
- Be initiated on ARV treatment immediately if they test HIV-positive under one year of age;
- Prompt referral for management of HIV if HIV-positive;
- Have his/her birth registered.

Challenges and preferred areas of advocacy

- ★ Two thirds of women and girls have their first antenatal visit too late. They come to the clinic after 20 weeks, although they should be taking ARVs before that if they are HIV positive.
- ★ An estimated 25% of pregnant women have never had an HIV test.
- ★ Low male involvement in PMTCT programmes limits women and children's access to PMTCT services.
- ★ Stigma and discrimination often stop women from testing and/or accessing PMTCT programmes.
- ★ Mixed feeding, which increases the chance of infecting a baby, remains high.
- ★ There is a lack of post-natal care – this is one of the major obstacles to effective PMTCT.
- ★ PMTCT programmes often fail to link mothers, babies and families to treatment, care and support.
- ★ Several thousand babies are not identified as HIV exposed and hence are not tested for HIV, nor are they placed on Cotrimoxazole, which prevents death from a severe form of pneumonia.
- ★ There are major socio-economic constraints that limit the ability of women to access and adhere to PMTCT services and practices like regular-follow up visits. In certain contexts (particularly rural areas), poor telecommunications, poor transportation infrastructure, and people's inability to access grants can make it impossible for women to benefit from PMTCT services. It's important to consider the appropriateness of formula feeding in contexts of poverty, and that counselling on infant feeding options should be contextualised to particular socio-cultural circumstances of the individual mother.
- ★ Additional key strategies aimed at addressing maternal health:
    - Show that women and men can gain respect from their family and community without having to fall pregnant or have a child.
    - Demonstrate how to control your fertility as a woman and as a man.
    - Demonstrate the benefits of a planned pregnancy, with the advantages of early and regular ante natal care and a planned birthing experience.
    - Show communities how to make pregnancy a happy, healthy and safe birthing experience for women.
    - Show health care workers how to improve and enhance the quality of caring at their facilities and not to take out their frustrations on patients.

Audiences

- ★ Pregnant women
- ★ Young and first-time pregnant women
- ★ HIV+ mothers
- ★ Couples
- ★ Male partners
- ★ Health care workers working in maternity and neo natal care.

Messages & Messaging

Pregnancy and infant care

- Visit the ante- clinic before 14 weeks if you suspect or know you are pregnant. It can save your life and that of your baby.
- Alcohol use in pregnancy will harm your baby and can result in Foetal Alcohol Syndrome.
- Smoking during pregnancy will harm your baby
- Attend regular check-ups at the Ante-Natal Clinic
- Always use a condom when you have sex while you are pregnant. They will prevent infections, including HIV. Your chances of getting HIV are higher during pregnancy. If you contact HIV during your pregnancy there is a greater chance that your baby will become HIV+.
- Talk to someone you trust if you are pregnant and HIV positive to get help and support
- It is good for the health of the mother and child for men to support and provide for their partners during pregnancy.
- Make sure you have a transport plan for emergencies during your pregnancy
- We need to change our cultural beliefs about childbearing and childrearing in order to save our children from HIV
- All women have a right to adequate health care and access to credible and relevant information about their health in order to make informed choices and decisions
- Feeding your baby correctly can prevent him/her getting HIV if you are HIV positive
- Exclusive breastfeeding is the safest way to feed your baby for the first six months.

Fertility Management

- Family planning delays the first birth, prevents unintended pregnancies and promotes proper birth spacing. This gives women time to recover between pregnancies and promotes infant survival.
    - *Having children is a personal choice*

- *Women and men should be encouraged to take joint responsibility for: Using contraception and practising safe sex. If the couple decide to use the injectable contraceptive or the pill, they should still use condoms to protect themselves from STDs.*
- *Bringing up children is difficult if you are young and broke. Plan to have children when you and your partner feel ready both emotionally and financially.*

- You are worthwhile and have value in society even if you have no children
  - *Men and woman can gain respect in other ways, such as economic success, dedication to a community cause and by caring for others.*
  - *Communities should encourage women to look after Orphan's and Vulnerable Children rather than having more children themselves.*
- A planned pregnancy with a planned birthing experience will result in a happy, healthy and safe birthing experience
  - *It is safe to fall pregnant later than 25 years of age. This will give you a chance to finish your education and to have a career. A career will enable you to look after your children financially.*
  - *Test yourself and your partner before planning a pregnancy.*
- Clear messages around baby care:
  - *Understanding oral rehydration and diarrhoea*
  - *Recognising breathing problems*
  - *Understanding the Road to Health chart*
- It is a myth that women fall pregnant for the child support grant.
  - *Men and Women are responsible for falling pregnant.*
  - *Many pregnancies occur because the partners did not plan and many men abdicate their responsibility.*