



labour, but our attempts to purchase isotonic sports drinks for our labour ward through the hospital have been unsuccessful. We were concerned that almost all women in labour at Coronation Hospital were requiring intravenous fluids, at considerable expense to the hospital and discomfort to the women.

We therefore asked our hospital kitchen to prepare a home brew of chilled lemon rooibos tea. The initial recipe tried was 3 teabags, 2 lemons and 200 g sugar per 10 litres of water. Of 26 women in labour surveyed, only 13 (50%) liked the drink. Suggestions from the remainder were that they would prefer more sugar (4 women), more lemon (1 woman), and a stronger rooibos flavour (6 women). The recipe was therefore revised.

Now 4 rooibos teabags, 4 sliced lemons and 400 g sugar are boiled in 10 litres of water. The tea is cooled and supplied to the labour ward in used plastic 1-litre sterile water bottles from theatre.

Of 40 women surveyed, 34 (85%) liked this mixture. Two would have preferred more sugar, 2 less sugar, 1 less lemon, 2 a stronger rooibos flavour and 2 a weaker rooibos flavour. The drink has become routine in our labour ward, and the number of women requiring intravenous fluids has fallen. The cost of the constituents (not electricity and labour) is as follows:

Rooibos tea, 4 bags	R0.40
4 lemons	R0.40
Sugar, 400 g	R2.80
Total (for 10 litres)	R3.60
Cost per glass (250 ml)	R0.09

We recommend the following guidelines for hydration during labour:

1. All women in labour except those with a specific, evidence-based reason to restrict oral fluids should have a suitable carbohydrate-containing drink at the bedside, and be encouraged to drink at least 250 ml per hour.
2. Intravenous hydration should be limited to women with specific complications of pregnancy, those receiving epidural analgesia, and those who become dehydrated despite attempts at oral hydration.
3. Women who require venous access but not intravenous fluids (e.g. for administration of medication or as a precaution because of an increased risk of postpartum haemorrhage) should have an intravenous catheter with a non-return side-port (e.g. Optiva or Venolit) inserted. The open end is closed with the cap and 0.5 ml saline is injected through the side-port to fill the catheter and prevent clotting.

Introduction of an oral hydration programme may achieve considerable savings in terms of reduced use of intravenous fluids and giving sets. We wish to thank our labour ward staff, superintendent and hospital kitchen staff, particularly Ms Gloria Mogotsi, for their enthusiasm and support.

We appeal to the health authorities to allow greater budgetary autonomy to hospital management so that cost-

saving exercises of this sort can be implemented without an uphill battle.

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THE MOTHER-TO-CHILD HIV TRANSMISSION DEBATE

To the Editor: In a recent editorial in the *SAMJ* Wilkinson and McIntyre¹ present a balanced view on the issue of reducing perinatal transmission of HIV in the South African context. They specifically recommend a three-stage parallel process which includes national consultation and consensus building around the development of a policy, the establishment of pilot study sites, and further research. The development of pilot programmes is underway in some parts of the country. However, Dr Nkosazana Zuma, Minister of Health, recently announced that such initiatives in South Africa were to cease, the argument being that they are too costly and the money would be more wisely spent on primary preventive measures such as vaccine development and behavioural modification strategies.

We wish to challenge the Minister's decision. We are also concerned that she has made a decision without consultation with relevant role-players such as academic and service personnel and community-based and non-governmental organisations. The strongest arguments in favour of implementation of a programme to reduce mother-to-child transmission of HIV are cost-efficacy, its potential for enhancing preventive strategies and our moral obligation. We contend that implementation of such a programme will be beneficial and cost-effective. One study² estimated the cost per infection averted at approximately R5 000 and the cost per potential life gained at R450, which was likened to other cost-effective public health interventions such as immunisation. In another study,³ it is argued that the cost of preventing vertical transmission is far less than the cost of treating the complications of HIV infection in children. This retrospective 5-year study concluded that it cost R1.4 million to treat 91 HIV-infected children. It was suggested that this money would have prevented infection in 187 - 435 infants if utilised to reduce vertical transmission.⁴ Another study in the Western Cape (G McGillivray, G Hussey — unpublished data, 1998) estimated that the direct costs of the programme (which includes



screening and testing all pregnant women, counselling, AZT for infected women, milk formula feeds for infants of infected women for 6 months, prophylactic co-trimoxazole therapy for the infant) will range from R8 to R12 million.

Theoretically the programme will prevent 750 infants becoming infected in the Western Cape (given 75 000 public sector births, a 10% seroprevalence rate and a 20% transmission rate). The benefits obtained if these children do not require hospitalisation as a consequence of HIV infection are considerable. We have estimated that the cost of hospitalisation to a secondary-level hospital in Cape Town over a 2-year period amounts to R16 million (given that an HIV-infected child has at least two admissions per child per year with an average length of stay of 11 days; G Hussey — unpublished data, 1998).

Besides being cost-effective, compared with the other interventions the AZT programme is the one that is most tangible and likely to succeed if implemented systematically. Other interventions aimed at behaviour modification are important but do not have the visibility and the immediate impact of the AZT programme. Through its visibility the programme may enable (or kick-start) other preventive and promotive strategies. For the first time large-scale voluntary HIV screening and counselling will be implemented, which will lead to greater awareness among the population, setting the basis for greater uptake of existing primary prevention interventions. The implementation of this intervention may become the vehicle for entrenching a primary health care approach. In order to be successful, implementation requires the health care worker to allow the patient to be an active partner in health care. It can further provide an opportunity for counselling with regard to other reproductive health issues.

Withholding the only direct and effective intervention to reduce mother-to-child transmission of HIV at a stage of exponential progression of the epidemic will add yet another item to the list of missed intervention opportunities in this country. Some may very well argue that withholding intervention could be regarded as unethical and perhaps even unconstitutional practice. The United Nations Convention on the Rights of the Child (CRC), ratified by South Africa in 1995, specifies that 'In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration'. Our Bill of Rights makes the best interests of the child *paramount* in every action concerning a child. If Dr Zuma has not taken the best interests of children into account, she is in violation of both the CRC and our Constitution.

We acknowledge that there are obstacles to implementation. These include economic, environmental and social problems. Overloaded primary care services will not cope unless additional resources are provided. Lack of access to a clean, safe water supply and financial hardship will prevent many

women from being able to provide milk formula for their infants. There is also the possibility that bottle-feeding will undermine and reverse the gains that the breast-feeding lobby has made over the last decade. There are also ethical concerns, for example, identifying the mother who is HIV-positive in order to possibly prevent her unborn child from a similar fate, while neglecting to provide follow-up care for the woman thereafter. Continued discrimination in a community or environment that is hostile to persons living with HIV may undermine the programme, which hinges on screening and thus identification of HIV-infected individuals.

These obstacles are not insurmountable. We call upon the Minister to review and rescind her decision not to allow the initiative to proceed. Dr Zuma must fulfil her obligations to children's rights in terms of the CRC and the Constitution by allowing implementation of the intervention programme on a national basis and, at the very least, supporting the pilot initiatives that were enthusiastically planned in a number of settings and were specifically designed to identify any impediments to the programme. The information obtained from these activities can contribute to informed decision making.

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2. Wilkinson D. Reducing the transmission of HIV from mother to child in South Africa. MRC Policy Brief, No. 1, May 1998 pp. 1-2.
3. Cotton MF, Schaaf HS, Van Veenendaal M, Janse van Rensburg A, Janse van Rensburg E. The burden of mother-to-child transmission of HIV-1 disease in a low prevalence region — a five-year study of hospitalised children. *S Afr J Epidemiol Infect* 1998; **13**: 46-49.
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To the Editor: We read the letter from Dr Van der Wal¹ relating to the prevention of perinatal vertical HIV transmission with concern and disappointment. The authoritarian and dictatorial approach he appears to advocate can have no place in policy founded upon ethics and respect for human rights. Furthermore, any attempt to invoke parliamentary authority in seeking a solution to difficult and complex issues in which the subject is already enmeshed will serve only to introduce a stigma of criminality into the subject. In many instances affected individuals already have to bear an insupportable burden of rejection by their families and communities. The