Prevention of Mother-to-Child Transmission (PMCT) in Myanmar

Guided by the UNGASS Goal to reduce the number of infants infected with HIV, UNICEF has the prevention of Parent-to-Child Transmission of HIV as one of the organizational priorities. Prevention of Parent-to-Child Transmission in Myanmar includes more broad-reaching activities such as in improving overall maternal and child health services for antenatal care, delivery services and postnatal care.

I. Background of PMCT in Myanmar

Though PMCT in Myanmar started only at the end of 2000, initial discussions on PMCT interventions in Myanmar have been started since 1998. After strong presence and participation in 5th International Conference on AIDS in Asia and Pacific held in Kuala Lumpur October 1999, National AIDS Program (NAP) and UNAIDS partners in Myanmar received a high-level support from Ministry of Health to start PMCT in Myanmar. With the endorsement of National AIDS Program, UNICEF and UNFPA/UNAIDS supported a multi-agency collaborative process to conduct an assessment on feasibility of PMCT interventions in two townships where HFV infection among pregnant women is thought to be highest in Myanmar. The first assessment was carried out in Tachileik of Eastern Shan State from 21 January to 18 February 2000. Elizabeth Preble, UNICEF consultant on PMCT, led the team composed of members from NAP, WHO, UNICEF, Myanmar Maternal and Child Welfare Association (MMCWA), and Myanmar Red Cross (MRC). A second assessment was carried out by NAP using the same assessment tool (adapted module of WHO/UNICEF) in Kawthaung of Tanintharyi Division during March 2000.

The PMCT assessment, which includes baseline data collection, field trips to the high-risk areas of Mother-to-Child transmission, group discussions, meetings and workshops, elicited concrete intervention recommendations to be followed up by NAP, UNICEF and other UNAIDS partners. This assessment also provided a significant opportunity for primary prevention targeting women of reproductive age in sexual relationship, development of counseling and voluntary testing services and care & support for the women and children affected or infected.

Based on the analysis of all possible PMCT interventions, the team recommended Tachileik and Kawthaung to undertake a package of PMCT pilot interventions including:

♦ strengthening of primary prevention, introduction of voluntary counseling and testing (VCT)
♦ provision of anti-retroviral (ARV) therapy (Nevirapine) for HIV-positive pregnant women and her newborn baby, improving obstetric and postnatal care, counseling on infant feeding practices
♦ improving birth spacing.
II. Current PMCT intervention in Myanmar

After the assessment missions, NAP and UNICEF worked together for a realistic workplan, budget and additional human resources required to implement PMCT package. Laying the groundwork for PMTCT, modification of counseling manual, preparing HIV testing protocols, PMCT training packages and procurement of supplies & equipment was carried out during the year 2000.

Communication Strategy for PMCT developed in March 2001 with the support from Shari Cohen (UNICEF Communication Specialist on PMCT Communication and Social Mobilization). UNICEF, National AIDS Program, Central Health Education Bureau (CHEB), International NGOs and National NGOs working on HP/AIDS participated in the workshop. As a result of the workshop, an advocacy package, social mobilization and different communication materials (IEC) for general population and pregnant women on benefits of PMCT/VCT developed.

PMCT pilot projects started in Kawthaung and Tachileik townships - Myanmar-Thailand border - in December 2000 and expended in 5 additional townships (Lashio, Muse, Monywa, Myitkyina and Dawei) during 2001. UNICEF and NAP is expanding PMCT programs in additional 5 townships - Taunggyi, Magway, Pokokku, Meikhtila, Myeik in 2002 - and 5 additional townships will be added to PMCT programme each year, totaling 27 townships at the end of 2005 (UNICEF Myanmar five year country programme is from 2001 to 2005).

III. Community-based PMCT intervention in Myanmar

The uniqueness of PMCT intervention in Myanmar is its nature of being community-based, whereas other countries' experiences are hospital-based. The activities need to be community based since most of the pregnant women in Myanmar receive antenatal care in a rural health center (RHC), and access to hospitals is limited due to lack of transport and resources. Therefore all the PMCT services have been made available at the rural health centers, maternal and child health clinics, township and station hospitals in the pilot project areas to make sure that women in the rural community have access to the services.

The current PMCT/VCT offers pre-test counseling for pregnant women living in rural areas by health staff in the RHC. The blood samples are taken in the RHC and transported to the AIDS/STI team at the township hospital. Pregnant women, except for those who have obstetrical indication for hospital delivery, have the choice to receive post-test counseling, AN care, administration of ARV and delivery in the township hospital or in RHC. Confidentiality is ensured within the health system in providing PMCT services. Collaboration between Township Medical Officer (TMO), OBGYN and hospital doctors, Township AIDS/STD Team Leader and BHS is the most important for successful PMCT programme.

IV. Activities

Voluntary Counseling and Testing (VCT) of pregnant mothers has been the initial entry point for implementing PMCT in addition to primary prevention - education and practicing safer sex to women of reproductive age. Counseling manual for PMCT developed and counseling training has been conducted for basic health staffs in PMCT pilot townships to introduce voluntary counseling and testing for pregnant women at antenatal visits. Counseling training has also been conducted for community health workers and auxiliary midwives to
understand the concept of counseling in order to support women in the community to raise their awareness in prevention of HIV infection and PMCT information and to provide psychological support to HIV infected families in the communities.

Safe delivery and Universal Precaution training conducted for all midwives and lady health visitors in project townships and nurses in townships hospital to make sure that women are delivered safe and the staff practice universal precaution to every delivery.

Infant feeding counseling training conducted for lady health visitors, midwives in rural health centers and MCH centers and nurses from township hospital so that they could discuss about the most appropriate and acceptable infant feeding practices especially for HIV infected mothers to meet their individual needs.

Home care and management of opportunistic infection training equipped all basic health staff in the project townships with the knowledge to cope with the AIDS related symptoms and treatment of opportunistic infection.

Laboratory technicians from project sites are trained for HIV testing in order to provide efficacy and effectiveness of testing procedure.

In addition, UNICEF provides instruments for safe delivery at the township hospital, clean delivery kits for midwives and lady health visitors, to make sure the every delivery are attended safe and the staff practice universal precaution. HIV test kits and laboratory equipment and anti-retroviral drugs (Nevirapine) provided by UNICEF. Proper reporting and monitoring system has established in all pilot townships.

V. Actual results and success of PMCT in Myanmar

During the period of PMCT implementation more than 300 basic health staff were trained for counseling, infant feeding practices, universal precaution and safe delivery and home care. More than 150 volunteers in high prevalence areas were trained for home based care for people with HIV.

During the year 2001, a total of 17902 new pregnant women attended antenatal care in the PMCT townships. Number of pre-test counseled pregnant women in group were 12,571 (70%) and 2,333 (19%) pregnant women tested for HIV and 73 were HIV positive (3%). During this period, total deliveries were 8757, and 25 out of 29 HIV positive mothers and 24 newborn babies received Nevirapine (one stillbirth). Four HIV positive women and babies were lost to follow-up. Out of 24 babies born to HIV positive mothers, 22 babies received exclusive breastfeeding and only two received formula feeding.

VI. Constraints and Lessons learned

♦ Low acceptance of VCT by pregnant women is one of the significant findings throughout all three pilot sites. Around 72% of pregnant women coming to AN service have access to VCT.

However, only 18% choose to take the test. The programme is still new in Myanmar and community mobilization should be initiated and expanded to increase community awareness on PMCT and its benefits.

♦ Breastfeeding is nearly universal in Myanmar. While this is generally a positive factor for child health, the fact that average duration of breastfeeding is long and rates of exclusive breastfeeding are low (16%), increasing the risk of HP transmission through breastmilk. Exclusive breastfeeding should be strengthened and sustained.
There is a large unmet demand for modern family planning methods such as injection, oral contraceptive, male and female sterilization and condoms resulting in unsafe and illegal abortion, a major contributor to high maternal mortality rate (MMR).

PMCT cannot be effective as an entirely vertical effort, but must also relate to, and be supportive of primary prevention activities and care and support activities for persons and families affected by AIDS. While many other efforts are already underway in primary prevention, there is still a large unmet need for care, compassion and support towards persons, families and children either infected or affected.

VII. How do we respond to these challenges

Advocacy, social mobilization and communication to general population, communities and pregnant women will play a key role in increasing PCT/VCT acceptance.

Built PMCT into ANC system where midwives and other basic health staff can play an important role in referring persons and families affected by AIDS to appropriate care and support services.

Develop a risk assessment tool used by BHS and pregnant mother together in selecting infant feeding options, which are acceptable, feasible, affordable, sustainable and safe. Expand and sustain exclusive breastfeeding in country.

Link with safe motherhood and essential steps for safe delivery (ESSD) activities to improve obstetric care and universal precaution practices.

Work closely with other partners in birth spacing activities offering a variety of choices.
UNICEF MTCT Monitoring Form (Myanmar)

Month /Year: January -December 2001
Center or Country: Myanmar

A. Pregnant women -ANC/VCT
#ANC clients: 17,902
#pre-test counseled: 12,571
#HIV tested: 2,333
#HIV-positive: 73

B. Pregnant women -MTCT ARV
#started on AZT this month -
#started on NVP this month 25

C. Pregnant women -Deliveries
#deliveries Overall 8,757
HIV positive 29
HIV negative 1,330
Unknown HFV status 7,398

D. Infants
#started on AZT this month -
#started on NVP this month 24
#started on breast feeding this month: 22

E. Key activities during the month
#started on replacement feeding this month (from birth): 2

F. Key Constraints during the month
Some HIV positive mothers lost to-follow up at me time trf'delivery especially in Tachileik as some of them visit AN Care on Thailand side. Sometimes, health staff do not write down the HIV status if women are HFV negative which lead us less HIV negative women deliveries reported compared to testing.
**UNICEF MTCT Monitoring Form (Myanmar)**

Month /Year: January-July 2002  
Center or Country: Myanmar

**A. Pregnant women -ANC/VCT**
- #ANC clients: 12,900
- #pre-test counseled: 12,073
- #HIV tested: 4,139
- #HIV-positive: 88

**B. Pregnant women -MTCT ARV**
- #started on AZT this month: -
- #started on NVP this month: 22

**C. Pregnant women -Deliveries**
- #deliveries: Overall 6,846  
  - HIV positive: 28
  - HIV negative: 2,342
  - Unknown HIV status: 4,476

**D. Infants**
- #started on AZT this month: -
- #started on NVP this month: 25
- #started on breast feeding this month: 17
- #started on replacement feeding this month (from birth): 8

**E. Key activities during the month**
PMTCT is fully operational in all 12 pilot townships.

**F. Key Constraints during the month**
Some HIV positive mothers lost to follow up at the time of delivery.