

Integrating PMCT in RH / MCH services in Myanmar



6 November 2006
At Kuala Lumpur



Country profile

14 states and divisions, 63 districts,
and 325 townships

Population in 2005 was 55.40 million (estimated)

70% of the population resides in rural areas

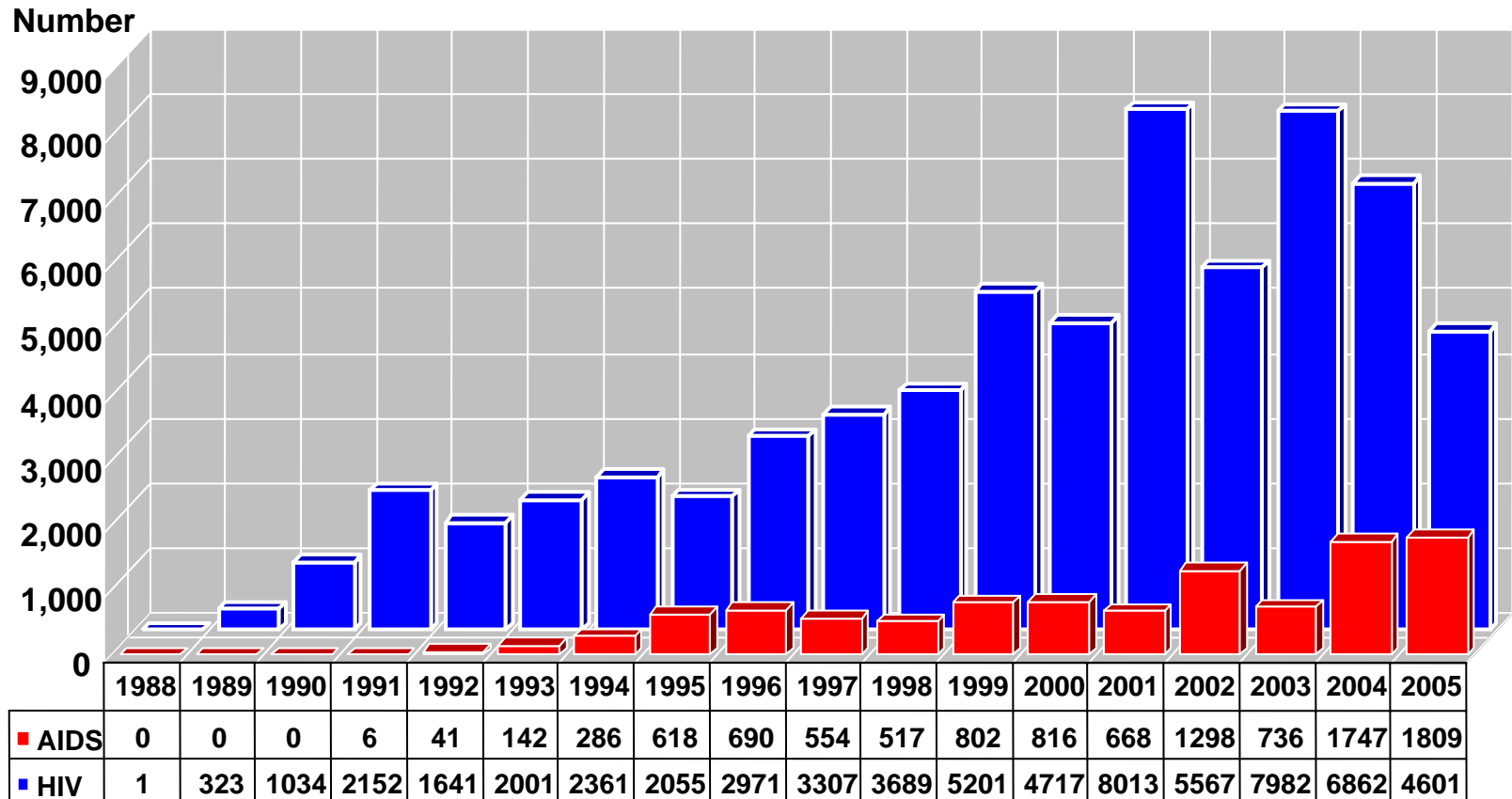
Population growth rate was 2.02 (2000)

Background – RH/MCH

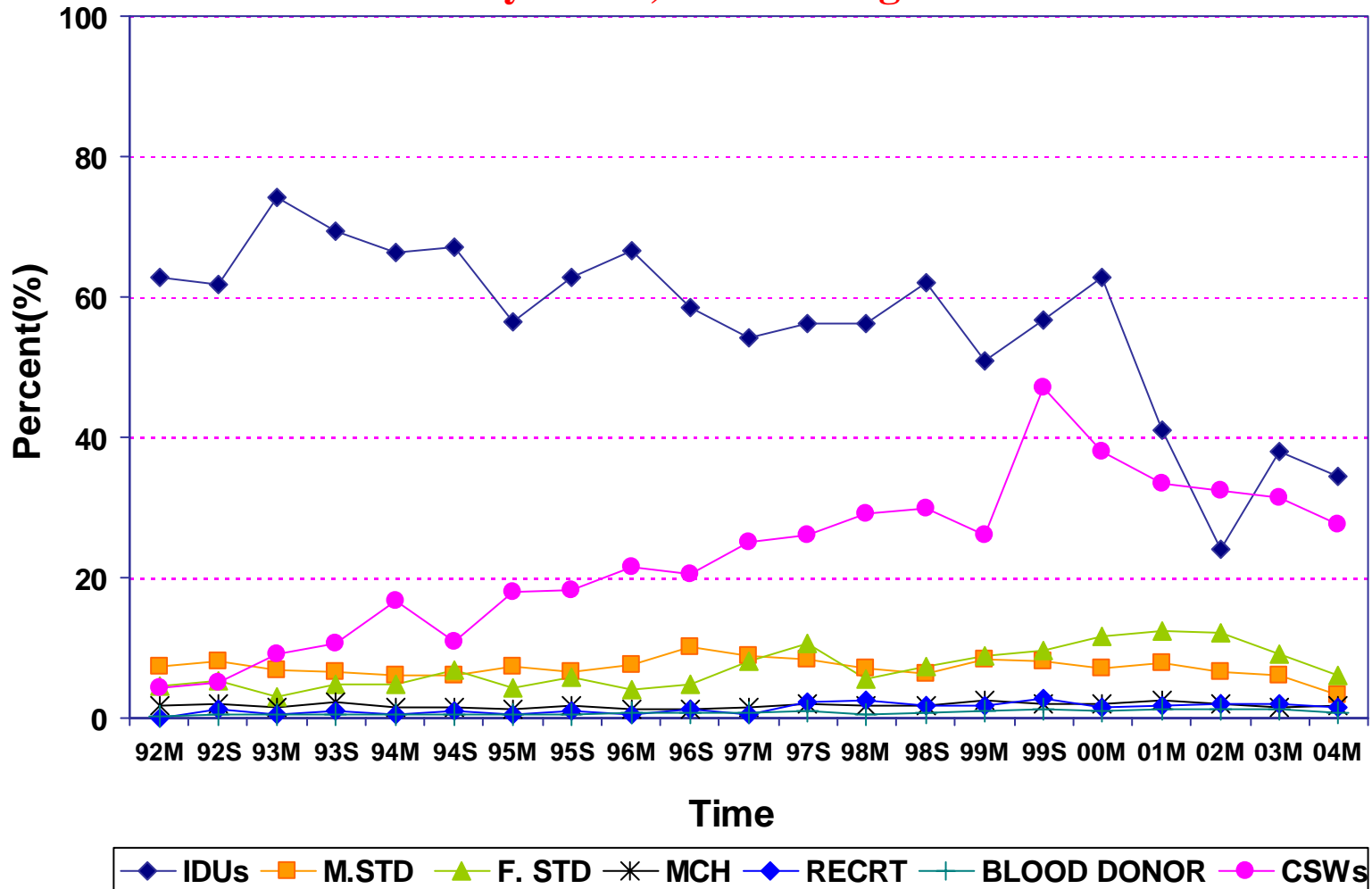
- Total Fertility rate- 2.21 (2003)
- Estimated number of births-1303800 (2003)
- ANC coverage- 63% (2005)
- Infant Mortality Rate-
 - Urban-45.3/1000 live birth (2003)
 - Rural- 47.1/ 1000 live birth (2003)
- U5 Mortality Rate- 62.1/1000 live births(2003)

HIV/AIDS SITUATION IN MYANMAR

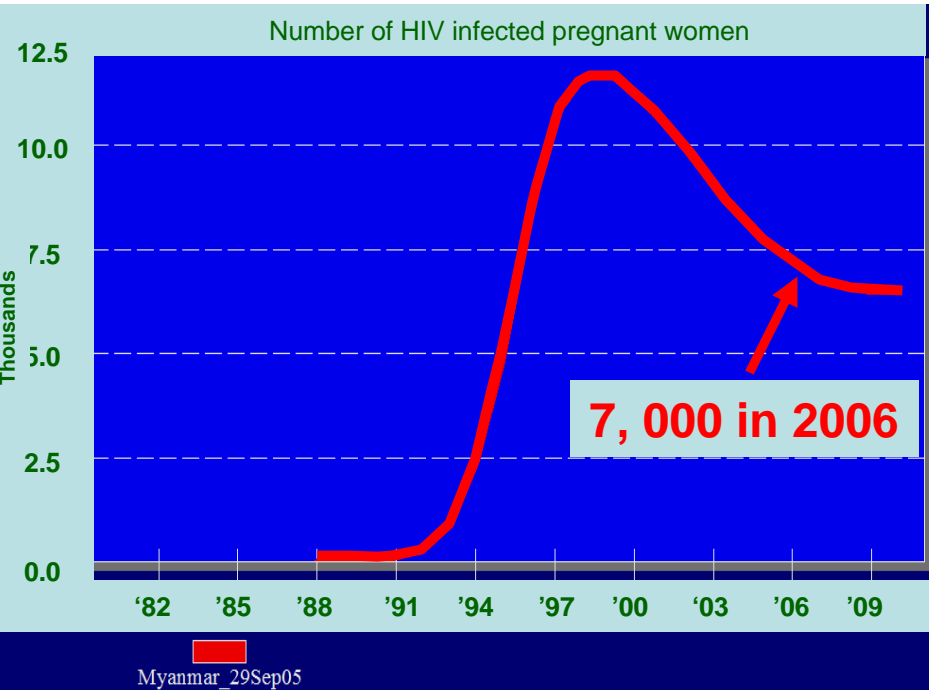
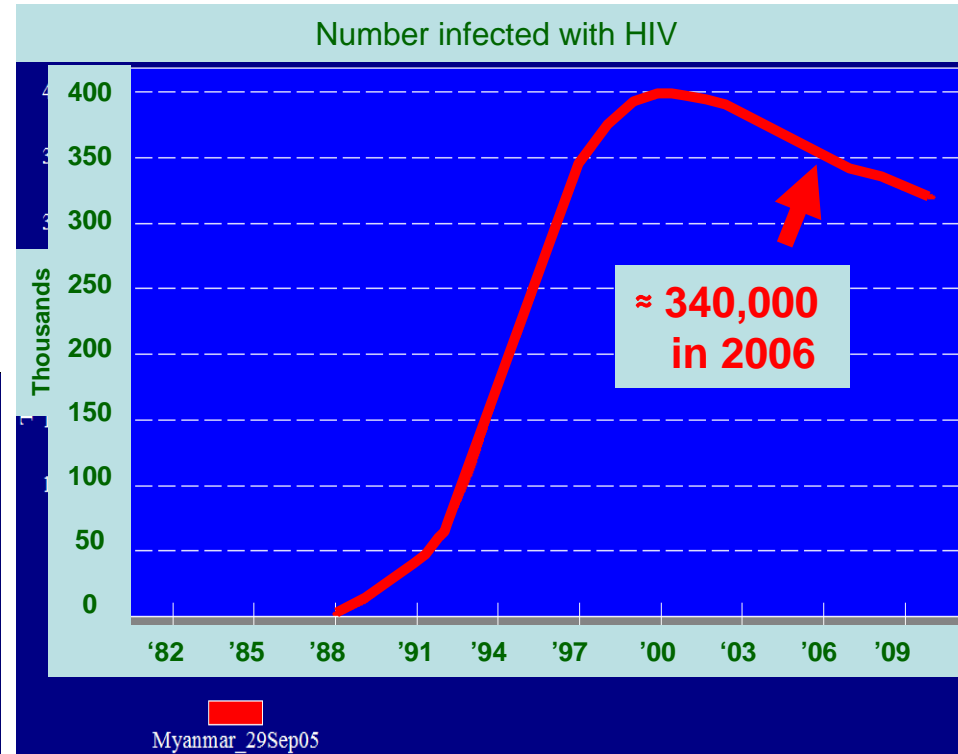
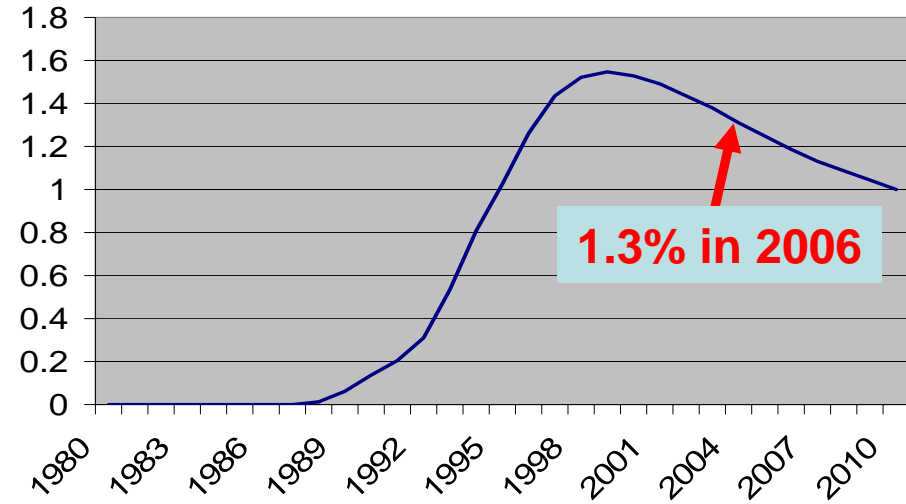
HIV +ve recorded = 64,478 (cumulative up to Dec. 2005)
AIDS Cases (Reported) = 10,730 (cumulative up to Dec. 2005)
Deaths due to AIDS (Reported) = 4,785 (cumulative up to Dec. 2005)
PLWHA (estimates) = 338,911 (2004)



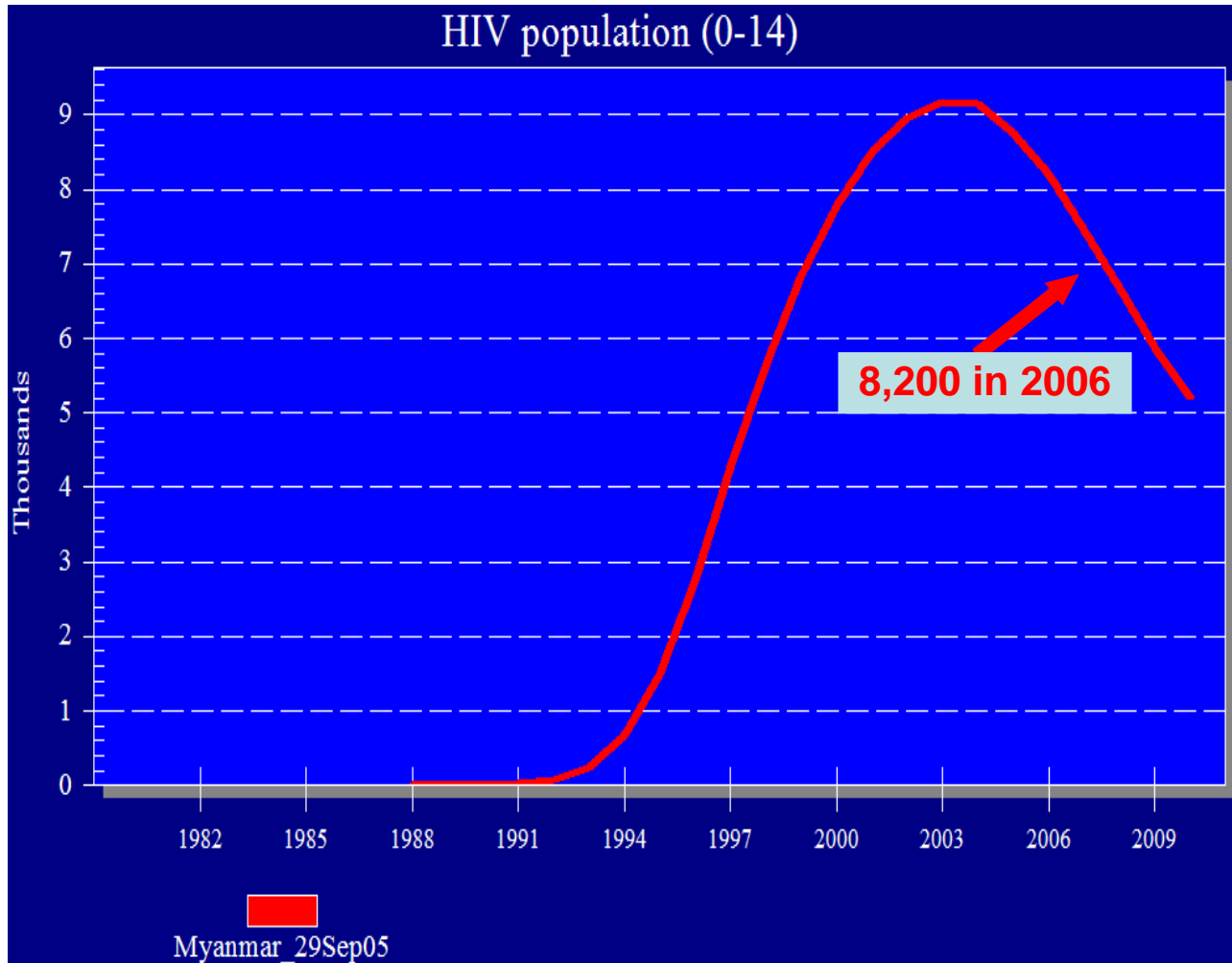
Trends of HIV prevalence among the Urban Institution-based subpopulation group of the HIV sentinel surveillance, Myanmar, 1992 through 2004



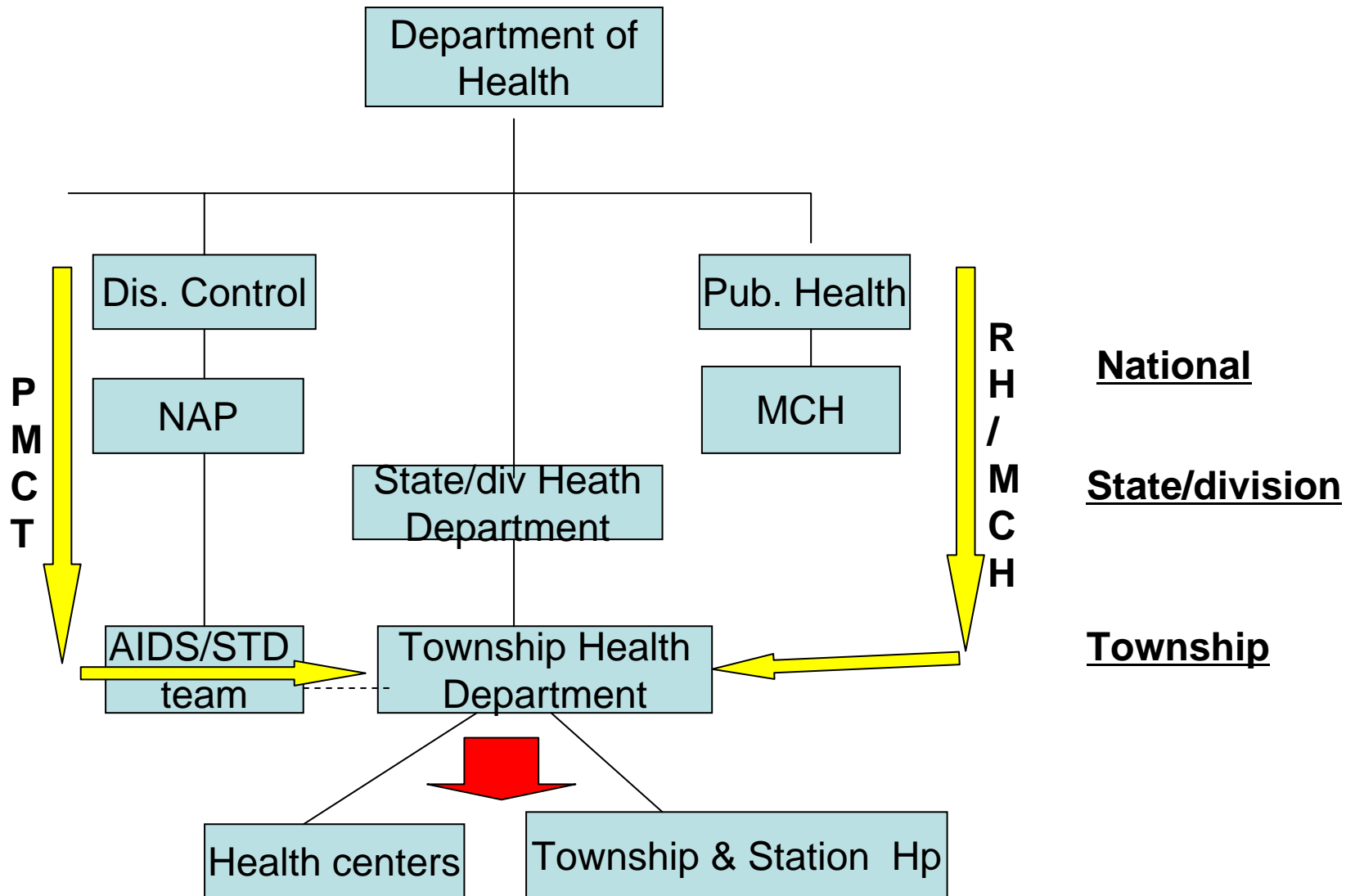
Estimate of national HIV prevalence trend and number of PLHA in Myanmar



No of HIV infected children (0-14)

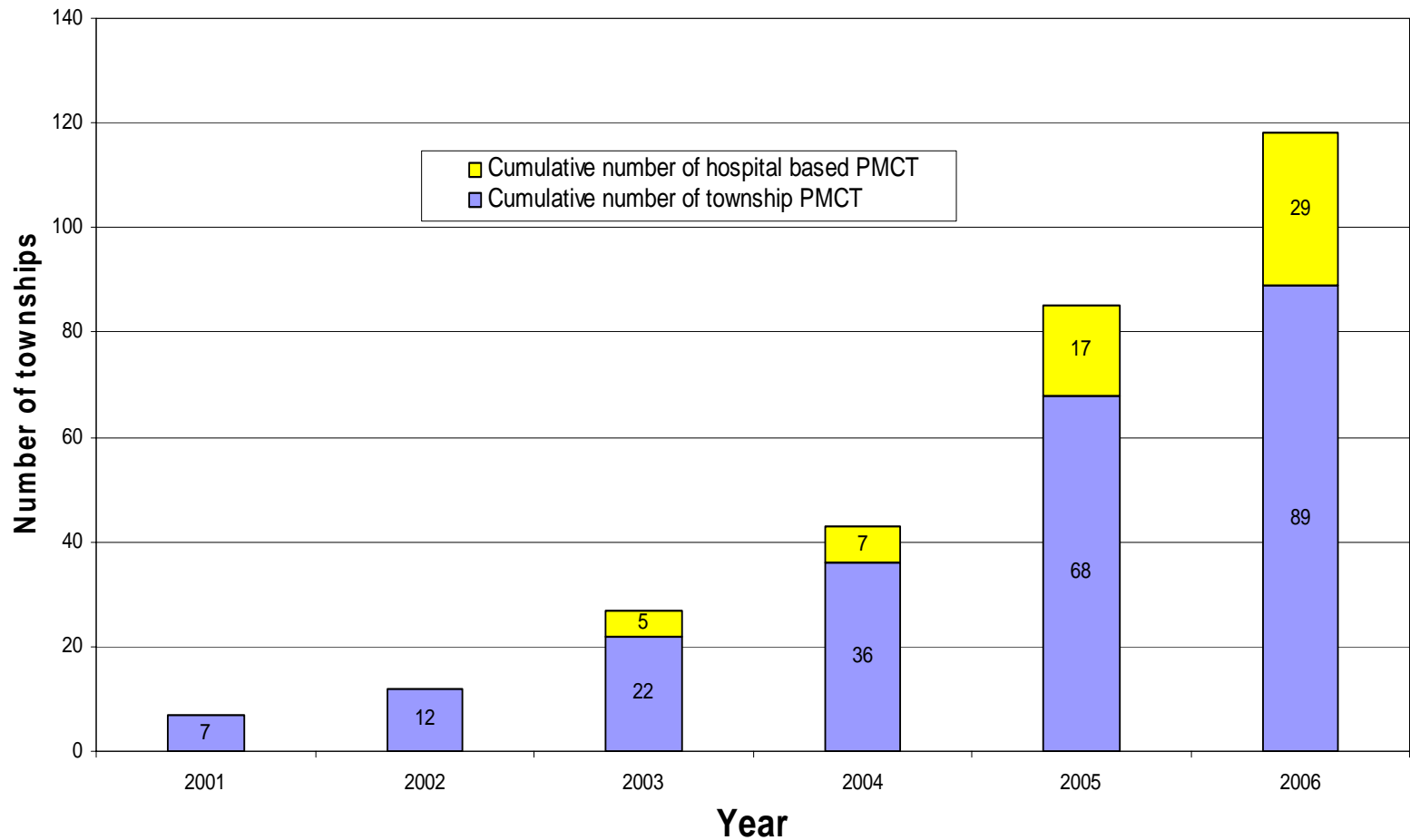


Health service structure



PMCT Programme

PMCT implementing areas



Approach

- Phase 1(2000-2005) - Community based approach (focus on 70% of population residing at Rural area, 80% deliveries at home, 60% ANC at RHC)
- Phase 2 – (2005-) township (Hospital) & Urban MCH based approach at the township level & Institutional (Hospital) based approach at tertiary and S/D level (Focus on case load & facilities, logistic ease, easy for M&S, high prevalence)

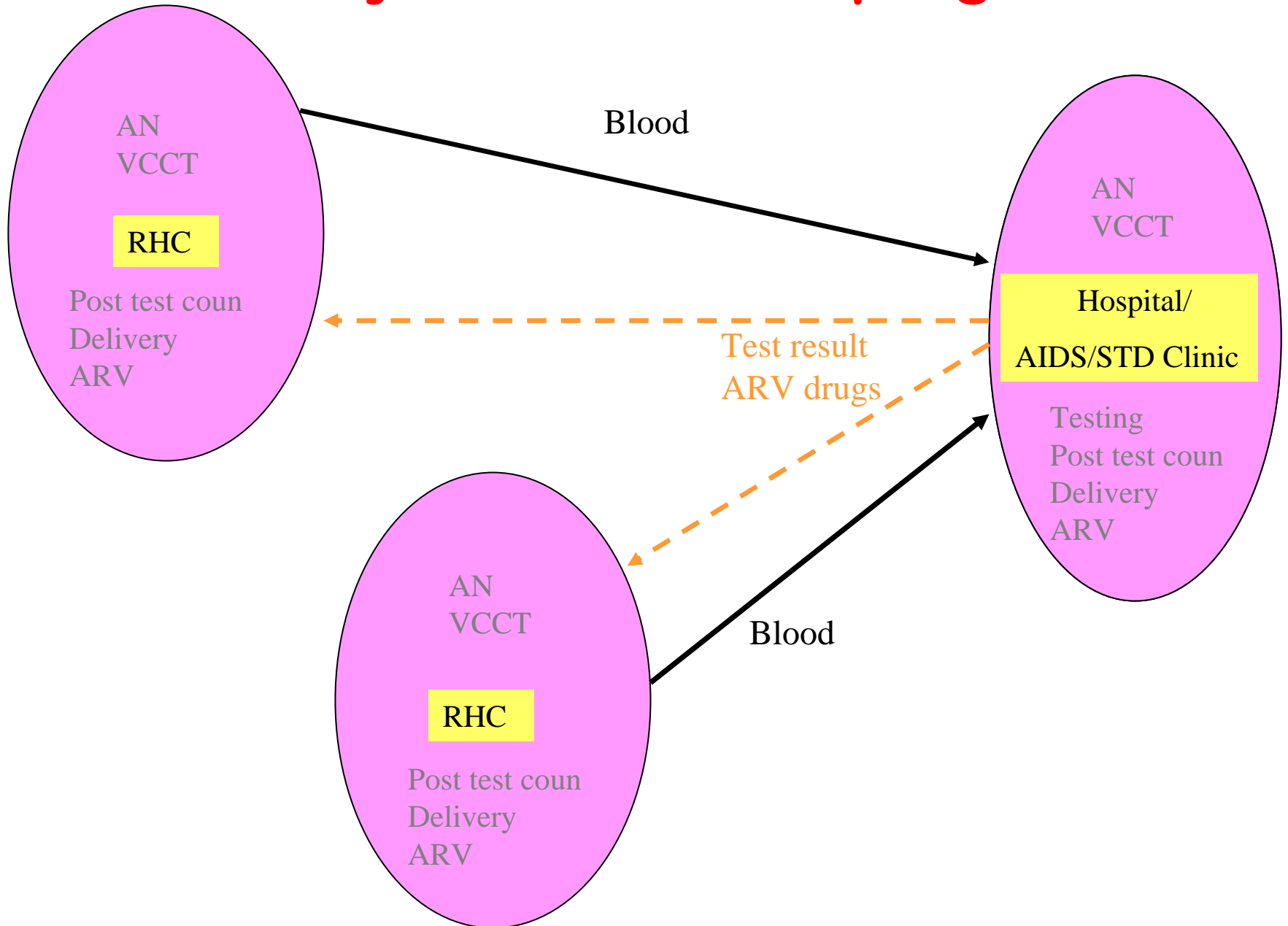
To be start with areas where

- potential of target population exist: evidenced by epidemiological data
- existing infrastructure and manpower is feasible to implement the PMCT programme

“Community based” PMCT

- Model (up to Rural Health Centre level done by Basic Health Staff except testing)
 - Pre-test
 - Group routine ANC education includes PMCT
 - Followed by individual counseling (Opt-in)
 - Taking blood
 - Send blood sample to urban lab (hospital, STD clinic)
 - Post-test
 - Post-test counseling
 - NVP for preg women and/or midwife
 - Safe Delivery either at home or hospital
 - Infant feeding counseling
 - Follow up, care and support

Community based PMTCT programme



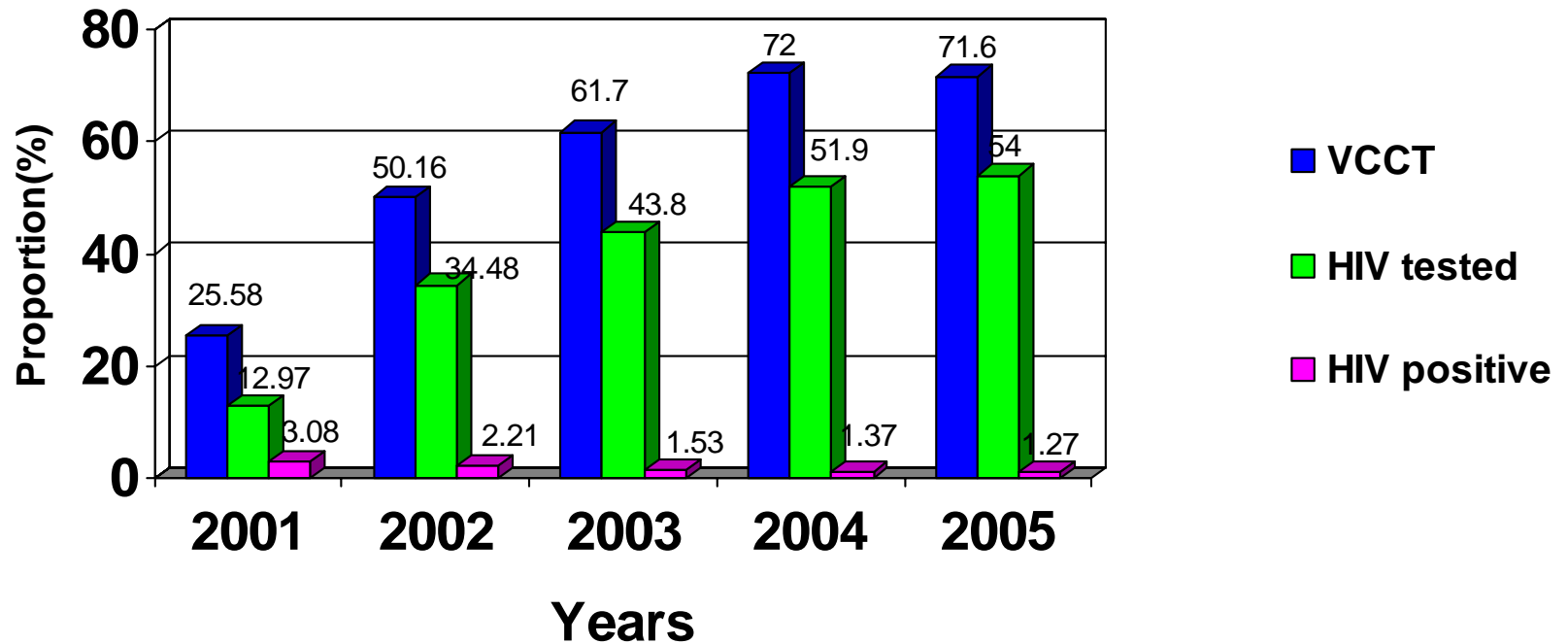
**ANC education session
with PMCT messages**



Results - Service utilization

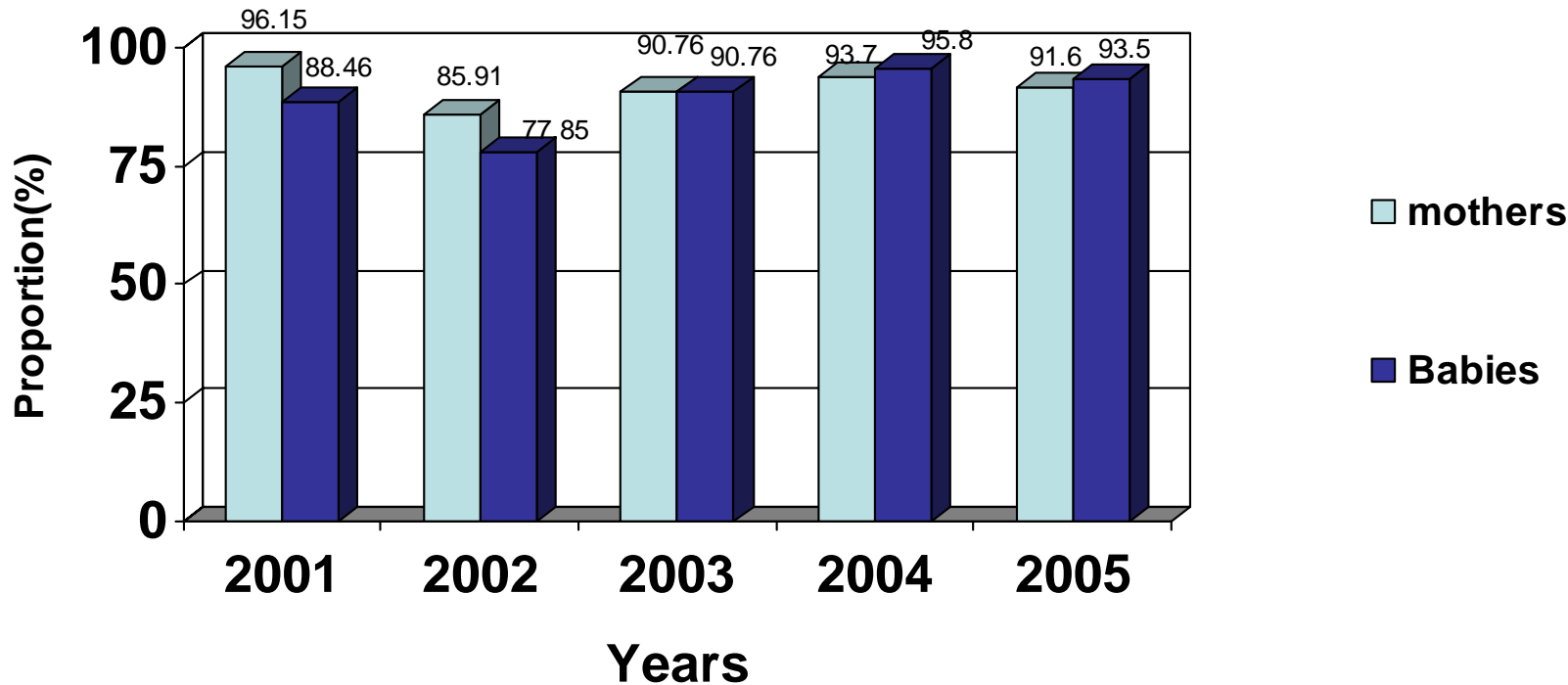
PMTCT at a glance:

service utilization rate increased,
seroprevalence rate reduced



Results –ARV therapy

PMTCT at a glance: most of the deliveries of HIV infected pregnant women were covered by Nevirapine



Lessons learned from Community Based PMCT

Advantage

- Can cover home deliveries
- BHS's knowledge and experience of HIV
- Easy access to VCT for pregnant women
- Good follow up after delivery

Challenge

- Logistical challenge
 - Transport of blood samples/report
- Technical challenge
 - Difficulty of supervision to large number of RHC
 - Difficulty in improving counseling skills of Midwives (as low prevalence in rural area)

Future activities for comprehensive PMCT

- New things
 - Regimen
 - Cotrimoxazol
 - Opt-out
 - Lay counselor for individual pre-test information
 - Continuum of care (support group, CHBC, ART)
- Strengthen linkage with
 - RH/MCH
 - CoC (as an entry point)

Integration of PMCT in RH/MCH services

- Implementing staff (Basic health staff/ midwife)
- HIV/PMCT information as a part of routine ANC
- Training (knowledge, theory)
 - MCH training includes PMCT knowledge (PCPNC)
 - Pre-service training includes PMCT knowledge

Future Plan

- Scale up PMCT up to nation wide coverage
 - Limited funding is a bottleneck for scale up
- Township hospitals to provide comprehensive PMCT
- Identify modalities of PMCT to be a part of routine AN services
 - Coordinated training
 - Coordinated reporting (HMIS, HBMR)
- Strengthen coordination through regular coordination meeting among stakeholders

Thank You

