

**YANGON UNIVERSITY OF ECONOMICS
DEPARTMENT OF APPLIED ECONOMICS
MASTER OF PUBLIC ADMINISTRATION PROGRAMME**

**A STUDY ON THE IMPACT OF HIV / AIDS ON QUALITY OF
LIFE IN HLAING TOWNSHIP, YANGON, MYANMAR**

**NAN SU KHAING
MPA – 48 (22nd BATCH)**

JUNE, 2025

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**A STUDY ON THE IMPACT OF HIV / AIDS ON QUALITY OF
LIFE IN HLAING TOWNSHIP, YANGON, MYANMAR**

A thesis paper submitted in partial fulfillment of the requirements for the
Master of Public Administration (MPA) degree

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YANGON UNIVERSITY OF ECONOMICS
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MASTER OF PUBLIC ADMINISTRATION PROGRAM

This is to certify that this thesis entitled "**A STUDY ON THE IMPACT OF HIV / AIDS ON QUALITY OF LIFE IN HLAING TOWNSHIP, YANGON, MYANMAR** " submitted as a partial fulfilment towards the requirements for the Degree of Master of Public Administration (MPA) has been accepted by the Board of Examiners.

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ABSTRACT

HIV/AIDS continues to pose significant public health challenges in urban Myanmar, particularly in densely populated areas such as Hlaing Township. Understanding the quality of life (QoL) among people living with HIV/AIDS is essential for developing responsive and inclusive health interventions. This study aims to examine the multidimensional factors influencing QoL among HIV-positive individuals in Hlaing Township, focusing on physical, psychological, social, and environmental domains. A quantitative research approach was employed, utilizing survey data from 120 respondents collected through the WHOQOL-HIV BREF instrument. Descriptive statistics were used to analyze and interpret the quantitative findings. Descriptive statistics and thematic analysis were used to interpret the findings. Descriptive statistics and thematic analysis were used to interpret the findings. Results indicate that while ART adherence is generally high, psychological distress, stigma, and economic hardship significantly affect QoL. Social support emerged as a protective factor, while gaps in mental health services and health literacy remain. The study recommends targeted, community-based strategies to improve QoL and reduce structural and social barriers to care.

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LIST OF ABBREVIATIONS

AHF	AIDS Healthcare Foundation
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
CHV	Community Health Volunteer
CPI	Community Partners International
EQ-5D	EuroQol 5 Dimensions Questionnaire
FSW	Female Sex Workers
HIV	Human Immunodeficiency Virus
IPT	Isoniazid Preventive Therapy
MAM	Medical Action Myanmar
MMK	Myanmar Kyat (Currency)
MOH	Ministry of Health
MPG	Myanmar Positive Group
MSM	Men who have Sex with Men
NAP	National AIDS Program
NGO	Non-Governmental Organization
PLHIV	People Living with HIV
PrEP	Pre-Exposure Prophylaxis
PWID	People Who Inject Drugs
QoL	Quality of Life
SF-36	Short Form-36 Health Survey
TB	Tuberculosis
U=U	Undetectable = Untransmittable
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
WHOQOL-HIV BREF	World Health Organization Quality of Life HIV Brief Instrument

CHAPTER I

INTRODUCTION

1.1 Rationale of the Study

The HIV/AIDS epidemic continues to pose significant challenges to public health and individual well-being globally. While advancements in antiretroviral therapy (ART) have significantly improved life expectancy for HIV patients, the impact of the virus extends beyond physical health, significantly affecting their overall quality of life.

Despite significant progress in HIV/AIDS prevention and treatment, many HIV patients continue to experience challenges in various aspects of their lives. These challenges may include physical and mental health complications, social stigma and discrimination, economic hardship, and limited access to quality healthcare and social support services. Understanding the lived experiences of HIV patients and the factors that influence their quality of life is crucial for developing effective interventions that address their specific needs and improve their overall well-being. (UNDP Myanmar - 2023)

The Human Immunodeficiency Virus (HIV) and acquired immunodeficiency syndrome (AIDS) epidemic remains one of the most profound public health challenges of the 21st century. While biomedical advances such as antiretroviral therapy (ART) have transformed HIV into a manageable chronic condition, the experience of living with HIV transcends clinical boundaries. In particular, the social well-being of individuals living with HIV in densely populated urban environments like Hlaing township, Yangon demands more focused scholarly attention. Social well-being encompasses individuals' ability to form and maintain meaningful relationships, access emotional support, and participate in their communities without fear of rejection or stigma. As individuals navigate the complexities of disclosure, discrimination, and social isolation, HIV increasingly becomes not just a medical condition, but a fundamentally social one. (WHOQOL-BREF framework – 2011)

Despite healthcare delivery improvements in Myanmar, especially in townships like Hlaing, HIV patients face persistent social challenges that compromise their quality of life. These include loss of intimacy, family conflict, and alienation from community life. Such stressors significantly worsen mental health and delay treatment-seeking behaviors. Conversely, strong interpersonal relationships, peer acceptance, and safe social spaces have been linked to improved health outcomes and sustained ART adherence. The magnitude of this social dimension of HIV calls for a dedicated inquiry into how personal networks, cultural values, and community structures interact with the lived experiences of HIV patients in Yangon. (Myanmar Positive Group - 2022)

Through a combination of structured surveys and open-ended questions, this research gathers first-hand accounts of individuals navigating life with HIV—from their ability to maintain friendships and romantic relationships, to whether they feel accepted in their families, religious institutions, or workplaces.

1.2 Objective of the Study

The objective of this study is to investigate the factors that influence the quality of life of HIV patients in Hlaing Township, Yangon, Myanmar.

1.3 Method of Study

This study uses a descriptive method approach by using collected primary and secondary data to explore the quality of life among HIV patients in Yangon. The main method involves collecting survey data from HIV to assess their physical, emotional, social, and economic well-being. The survey also includes questions about demographics, health status, and access to healthcare services. The data will be analyzed using basic statistics such as averages and comparisons.

1.4 Scope and Limitations

This study focuses on examining the quality of life among HIV patients living in Hlaing Township, Yangon, Myanmar. Data was collected between mid-March and the end of May through an online assessment form. This method was chosen because most participants preferred not to show their faces or participate in in-person interviews due to privacy concerns and social stigma associated with HIV. While the online format provided anonymity and convenience, it may have limited participation from individuals without internet access or digital literacy. The study's scope is confined to

Hlaing Township, and its findings may not be applicable to HIV patients in rural areas or in other regions of Myanmar with different cultural or socioeconomic conditions.

1.5 Organization of the Study

This thesis is structured into five chapters. Chapter One outlines objectives, methods, and structure. Chapter Two reviews global and regional literature on the relationship between HIV and social well-being. Chapter Three situates the epidemic within the Yangon context, including demographic patterns and cultural dimensions of stigma. Chapter Four presents the analysis of survey results.

Finally, Chapter Five synthesizes these findings and offers recommendations for fostering inclusive communities, strengthening support networks, and reducing HIV-related discrimination in Myanmar.

CHAPTER II

LITERATURE REVIEW

2.1 Quality of Life

Quality of life (QoL) encompasses an individual's physical, psychological, social, and environmental well-being. WHO defines QoL as “an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns” (WHOQOL Group, 1995). This approach highlights QoL's subjective character, shaped by personal and cultural experiences.

The WHOQOL-HIV BREF is frequently used to assess HIV/AIDS patients' QoL. The 2002 WHO tool evaluates physical health, psychological well-being, independence, social interactions, environment, and spirituality/ religion/personal views. Each domain is assessed using Likert-scale items for individual and comparative analysis. Other validated tools include the SF-36 Health Survey (Ware & Sherbourne, 1992) and the EuroQol EQ-5D (EuroQol Group, 1990), which assess HRQoL and functional status.

In the context of HIV/AIDS, QoL measurement is essential not only for clinical assessment but also for evaluating the effectiveness of public health interventions and social support systems (UNAIDS, 2023). These tools provide a framework for understanding how individuals adapt to chronic illness and how external factors influence their well-being.

Table (2.1) Measurement Instruments for HIV/AIDS Quality of Life

Instrument	Developer/Year	Domains Covered	Focus
WHOQOL-HIV BREF	WHO, 2002	Physical, psychological, independence, social, environment, spirituality	Multidimensional HIV-specific QoL
SF-36 Health Survey	Ware & Sherbourne, 1992	Physical functioning, pain, general health, vitality, social, mental health	Health-related QoL
EuroQol EQ-5D	EuroQol Group, 1990	Mobility, self-care, usual activities, pain/discomfort, anxiety/depression	Functional status and health utility

Source: UNAIDS

In HIV/AIDS, QoL measurement is essential not only for clinical assessment but also for evaluating public health interventions and social support systems (UNAIDS, 2023). These tools help understand adaptation to chronic illness and external influences on well-being.

2.2 Impact of HIV/AIDS on Individuals

HIV/AIDS affects individuals across multiple dimensions, each contributing to a complex and often fluctuating experience of living with the disease. The physical dimension includes symptoms such as fatigue, pain, weight loss, and susceptibility to opportunistic infections, which can impair daily functioning and reduce independence (MOHS, 2022). The psychological dimension encompasses emotional distress, depression, anxiety, and internalized stigma, all of which are prevalent among HIV-positive populations (Phoenix Association, 2022).

The social dimension is shaped by interpersonal relationships, community acceptance, and access to support networks. Many individuals face social isolation,

discrimination, and breakdowns in family or intimate relationships due to their HIV status (Myanmar Positive Group, 2023). The economic dimension includes loss of employment, reduced income, and increased healthcare-related expenses, which can exacerbate poverty and limit access to essential services (UNAIDS, 2023).

Globally, HIV/AIDS has multidimensional effects on those infected, and these effects often evolve over time. Physical complications can include opportunistic infections, side effects from ART, and chronic comorbidities like cardiovascular disease and diabetes. Mental health is frequently impacted, with studies showing elevated levels of depression, anxiety, and post-traumatic stress disorder among HIV-positive individuals.

HIV/AIDS has a profound and multidimensional impact on individuals, extending far beyond its clinical implications. At the physical level, HIV patients often contend with co-infections such as tuberculosis, hepatitis, and various opportunistic infections, along with long-term side effects of antiretroviral therapy (ART), including fatigue, gastrointestinal issues, and neuropathy. These health complications can reduce mobility, disrupt routines, and erode physical comfort. However, the psychological burden is equally significant. Studies have shown that HIV-positive individuals frequently experience depression, anxiety, and feelings of hopelessness—particularly in contexts where stigma and discrimination are prevalent. According to the 2020 study published by Steven Safren in *The Lancet HIV*, global prevalence of depression among HIV patients ranges from 35% to 50%, indicating a widespread psychological vulnerability across diverse populations. These emotional challenges often stem from fear of disclosure, loss of social identity, and internalized shame.

Beyond mental health, HIV/AIDS disrupts the social fabric of individuals' lives. Relationships may suffer due to perceived stigma or fear of contagion, leading to isolation, fractured family ties, and strained romantic partnerships. In many cultures, being HIV-positive is associated with moral judgment or social exclusion, further compounding emotional distress. Carla Obermeyer's 2011 research article, "*Facilitating HIV Disclosure: Social Patterns Across Six Countries*", found that reluctance to disclose one's HIV status frequently led to withdrawal from community engagement, contributing to loneliness and reduced help-seeking behavior. Additionally, economic consequences arise as individuals with HIV may lose employment due to discrimination or health-related limitations. Job insecurity, reduced

income, and lack of social insurance can compromise housing, food access, and the ability to afford complementary health care. These intersecting hardships make it clear that HIV/AIDS is not only a medical condition, but a life-altering experience that reshapes how individuals perceive themselves and relate to the world around them.

Table (2.2) Multidimensional Impact of HIV/AIDS

HIV/AIDS affects individuals across multiple dimensions with complex, fluctuating experiences.

Dimension	Description
Physical	Fatigue, pain, weight loss, opportunistic infections impair functioning and independence.
Psychological	Emotional distress, depression, anxiety, internalized stigma prevalent among HIV-positive people.
Social	Isolation, discrimination, loss of relationships, community exclusion.
Economic	Employment loss, reduced income, increased healthcare costs, poverty, food insecurity.

Source: WHO

Physical complications include opportunistic infections, ART side effects, and chronic comorbidities like cardiovascular disease. Mental health impacts are significant—with depression prevalence between 35% and 50% globally (Safren, 2020). Emotional challenges stem from fear of disclosure, loss of social identity, and internalized shame.

Socially, HIV disrupts relationships due to stigma and contamination fears. Moral judgment and exclusion amplify emotional distress (Obermeyer, 2011). Economic consequences follow with job loss and healthcare expense burdens.

2.3 Quality of Life Dimensions of HIV/AIDS Patients

The concept of quality of life in HIV/AIDS studies is commonly broken down into several interrelated dimensions.

Mental Health

HIV patients experience high rates of depression and anxiety due to both biological and psychosocial factors. Studies have shown that mental distress in HIV-positive individuals often results from fear of discrimination, social isolation, and shame associated with diagnosis. These conditions not only worsen emotional well-being but also contribute to nonadherence to ART and neglect of self-care.

Social Well-being

Social well-being refers to the ability to form and maintain meaningful relationships and to feel accepted and included in society. HIV patients frequently suffer from disrupted family bonds, rejection by friends or partners, and exclusion from community events. Social support, especially from peers and family members, has been shown to protect against these harms and improve health outcomes.

Economic Stability

Economic hardships are widespread among HIV-positive individuals, particularly in lower-income settings. Insecure employment, lack of health insurance, transportation costs, and housing challenges all contribute to reduced access to treatment and diminished overall well-being. Patients who face financial stress are more likely to experience food insecurity, treatment interruptions, and emotional fatigue.

These dimensions interact closely with each other, for example, financial instability can worsen mental health, and social stigma can limit economic mobility. Thus, understanding QoL in HIV/AIDS patients requires a holistic and intersectional approach.

Table (2.3) Quality of Life Dimensions for HIV/AIDS Patients

QoL in HIV/AIDS is broadly divided into these interrelated dimensions.

Dimension	Characteristics
Mental Health	High rates of depression and anxiety caused by discrimination, isolation, and shame.
Social Well-being	Ability to maintain relationships and feel included. Social support mitigates harm.
Economic Stability	Insecure employment, lack of insurance, transportation, and housing difficulties reducing care access.

Source: WHO

These interact closely; financial instability worsens mental health; social stigma limits economic mobility. Holistic, intersectional understanding of QoL is needed.

2.4 Reviews on Previous Studies

Li Li et al 2007 research paper titled “*Social Support and ART Adherence in Chinese HIV Patients*”, conducted a large-scale study in several provinces of China. Their findings revealed that HIV-positive individuals who had consistent social support were 95% more likely to adhere to treatment protocols. Both emotional and practical assistance—from family, friends, or peer groups—had a measurable impact on mental health and medical consistency. The study emphasized the protective role of peer-led organizations and recommended that governments and NGOs invest in community engagement models.

Sengupta’s 2011 titled “*Stigma, Social Support, and Mental Health among HIV-Positive Adults*”, found that stigma was a leading contributor to poor ART adherence and delayed diagnosis. The study examined how perceived discrimination and fear of rejection directly discouraged patients from seeking timely healthcare services. Over 45% of respondents across multiple countries reported emotional distress linked to stigma, and this influenced both psychological health and physical outcomes. Sengupta concluded that reducing community stigma must be a priority in global HIV prevention strategies to protect mental health and ensure early treatment.

Obermeyer’s 2011 article “*Facilitating HIV Disclosure: Experiences from Six Countries*” explored disclosure patterns among HIV-positive individuals in both high- and low-income settings. The study found that only 30%–40% of patients disclosed

their HIV status to family or community members due to fear of retaliation or shame. However, among those who did disclose, access to social support improved significantly, leading to stronger ART adherence and emotional resilience. Obermeyer stressed the importance of disclosure counseling and culturally tailored support programs to enable safe and empowering disclosure experiences.

Vyavaharkar et al 2011, in the article *“HIV Disclosure, Social Support, and Depression Among HIV-Infected African American Women Living in the Rural Southeastern United States,”* published in 2011, Jyotsna Vyavaharkar and her co-authors examined how social support and disclosure affected depression among HIV-positive women in rural settings. In a sample of 340 participants, women who disclosed their status and had strong social support networks reported significantly fewer depressive symptoms. The research highlighted the emotional benefits of disclosing HIV status in trusting environments, but also warned against the risks of doing so in stigmatizing or unsupportive contexts. The authors concluded that mental health and social interventions should focus on increasing both the availability and the quality of support systems, particularly among vulnerable populations.

Ssewamala (2020), the study titled *“Factors Associated With HIV Disclosure and HIV-Related Stigma Among Adolescents Living With HIV in Southwestern Uganda”* conducted by Fred M. Ssewamala and his team in 2020 explored how family relationships and social support influence HIV disclosure and internalized stigma among adolescents. Drawing from a sample of 702 participants in the study, they found that open family communication and perceived school-based support were key in lowering emotional distress and encouraging safe disclosure. Adolescents with stronger caregiver bonds were more likely to discuss their HIV status and less likely to experience shame or self-blame. The findings underscored the importance of strengthening family and institutional support systems to enhance the psychological well-being of young HIV patients.

Ko Aung Myo Wai’s thesis submitted in 2021 at the University of Public Health Yangon, titled *“Psychosocial Impacts of HIV/AIDS among Urban Myanmar Adults”*, explored spiritual stigma in Buddhist-majority communities. The study found that 43% of participants had been excluded from family religious ceremonies, and 37% believed their diagnosis was a form of divine punishment. These perceptions contributed to significant emotional distress, social withdrawal, and reduced treatment adherence. Ko

Aung Myo Wai concluded that mental health services must engage with religious leaders and integrate culturally sensitive counseling to address spiritual stigma and foster acceptance.

The *Myanmar Positive Group Annual Report (2023)* presented findings from peer-support pilot programs across urban centers in Myanmar. Among participants in Yangon, depression scores decreased by an average of 25% after six months of group involvement. Furthermore, the report stated that 32% more individuals felt confident disclosing their HIV status safely. These results echoed global trends and highlighted the success of community-based interventions that go beyond clinical treatment. The report recommended expanding peer-group initiatives to underserved townships and integrating psychosocial support into formal healthcare systems.

This global and regional understanding of HIV/AIDS and quality of life sets the stage for an in-depth examination of the epidemic's specific dynamics in Yangon and Hlaing Township, as presented in the next chapter.

CHAPTER III

OVERVIEW OF THE HIV/AIDS EPIDEMIC IN HLAING TOWNSHIP

3.1 Overview of HIV/AIDS in Myanmar

HIV/AIDS in Myanmar is a multidimensional and dynamic phenomenon that has become apparent due to a concurrent alliance of the actions undertaken to combat the issue within the framework of social forces and the dynamic political environment. The initial response of the country, beginning in the late 1980s, was narrow and targeted in terms of resources and scope in blood safety as well as basic surveillance. However, as the epidemic was spreading in the 1990s, particularly among the key populations and in the metropolitan regions, a more concerted effort was badly needed. By 2025, the projected figures of individuals living with HIV in Myanmar by the Ministry of Health and UNAIDS were 280,000. The national disease burden of HIV among adults is about 0.7, and this figure could be deemed irrelevant, but it conceals a very dense and acute epidemic in the risk group and areas. The burden is disproportionately among men who have sex with men (MSM), people who inject drugs (PWID), female sex workers (FSWs), and transgender persons. In this case, the national HIV prevalence rate is 8.6 among MSM, and up to 30 percent or more in the hyper-concentrated cities like Yangon. (UNAIDS,2023)

The age group of 25 - 49 is also the most economically active, socially active group affected by the epidemic. The implications of this population trend extend widely into the employment and family structure of the nation. Myanmar has made commendably good progress during the past 10 years in relation to low new HIV infections. In 2010, the incidence was 17000 cases per year and in 2023, the incidence was 11000 cases per year. The major contributions to this success are the amplified response at nationwide level that has aimed at widening accessibility to antiretroviral therapy (ART), raising awareness initiatives, and targeting priority populations. ART has been covered more and about 75 percent of HIV patients sufferers are being treated. It is an epic success especially considering the socio-political issues. But there is also a

range of systemic problems that do not permit the country to reach the final stages of epidemic management. Conflict-afflicted and resource-strained regions have had disproportionate rates of retention in care and rates of viral suppression. The most recent addition to the national response to HIV is the National Strategic Plan on HIV/AIDS (2021-2025) that endorses the concept of decentralization, community engagement, and integration of HIV services within the whole healthcare system. However, old problems related to the irregular international financing, structural limitations, and institutionalized stigma continue to face the health system, hampering the success of prevention and care goals.

3.2 HIV/AIDS Epidemiology in Yangon

Yangon is the largest city in Myanmar and the economic hub of the country therefore it will be central in the national HIV response. The epidemiology of the city is distinctly determined by the large concentration of the population, a fast process of internal migration, and a significant socioeconomic inequality. As surveillance data of sentinel sites and ART clinics show, there is an appalling truth about HIV among MSM in Yangon: the prevalence rate of the disease among them is nearly 30 percent, which is much higher than the national average and speaks of a concentrated epidemic. Young MSM are especially susceptible to inadequate access to full protection measures, including condoms, lubricants, and pre-exposure prophylaxis (PrEP). Another significant cause of the epidemic is injecting drug use, and an estimated 33 percent of new HIV infections in the country are due to needle sharing. The hotspots of drug use are located in highly populated urban townships in Yangon, such as Hlaingthaya, Shwepyithar, and Dagon Seikkan, where harm reduction services are not well distributed and have a high operational burden. The physical location of these hotspots, mostly in informal settlements and in the industrial areas, makes it difficult to provide stable and available care. (UNAIDS, 2023; Ministry of Health Myanmar, 2022)

In this work, a particular and intentional emphasis is laid on Hlaing Township. Being one of the giant peri-urban and industrial areas on the outskirts of Yangon, it houses a large number of internal migrants and daily wage workers, who form the backbone of the manufacturing and construction industries in the city. Such people tend to reside in unstable dwellings, have low social support circles, and experience high obstacles to obtaining stable medical care. Their work and living arrangements are temporary; hence, they find it hard to build long-term relationships with healthcare

providers. Whereas the central clinics of Yangon could be proud of their fantastic ART coverage rates, townships such as the Hlaing townships have a different set of issues. The long-distance residents have to cover to centralized hospitals can take hours, and is prohibitively expensive, which may result in missed appointments and treatment interruptions. Moreover, ignorance of existing local services and the overload of the local clinic system may pose substantial entry barriers among new patients. The information gathered in this research, as described in a following chapter, affirm that people living in Hlaing, as well as in other townships, experience higher incidences of treatment interruption, often through lack of flexibility in their work hours, engagement in expensive travel, and lack of flexibility in transportation as the main factors. Thus, the knowledge of the unique context of a given region, Hlaing Township, is not merely a geographical fact; it is important in designing the specific interventions that can be developed in response to the logistical and social context of the peri-urban communities. A review of clinical data in large hospitals like Waibargi Specialist Hospital and Insein General Hospital indicates that patients do not regularly show up in Yangon with early disease. (UN-Habitat Myanmar, 2022; Myanmar Positive Group, 2023)

Only 23% of patients are diagnosed at World Health Organization (WHO) stage III or IV, which suggests that the virus is at an advanced stage with severe symptoms prior to its diagnosis. This observation is also buttressed by the fact that the median CD4 count upon registration is alarmingly low at 169 cells/mm³. To give some background, healthy CD4 count ranges between 500 and 1,500 cells/mm³. Such a low count signifies that an individual has a very weak immune system which exposes them to opportunistic attacks. This vulnerability is clearly pronounced in the high prevalence of co-infection with tuberculosis (TB) where 41 percent of patients are already on TB treatment when they initiate ART. TB is a major cause of death among the HIV patients, and uptake of isoniazid preventive therapy (IPT) that can help prevent the onset of active TB is critically low at only 0.8%. These patterns reflect a systemic inability to find cases early, test, and integrate HIV/TB. Most of these delays are not caused by medical reasons but rather social ones. The fear of disclosure and stigma remains a strong deterrent and makes people avoid seeking early care and letting the epidemic develop in urban areas. (World Health Organization, 2021; Ministry of Health Myanmar, 2023)

3.3 Initiatives of Ministry of Health (MOH)

Since 1989, the Ministry of Health (MOH) has led the HIV response in Myanmar via its national AIDS Programme (NAP). The strategic framework of the NAP has been shaped over many years and adapted to changing epidemic dynamics. The MOH has more than 100 ART clinics in Yangon; among these, there are high-volume referral centers, including the Waibargi Hospital that focuses on the management of infectious diseases. Decentralization of

ART services, incorporation of HIV care into general health systems and the growth of the capacity to monitor viral load in laboratories are strategic priorities of the government. The Integrated HIV Care Programme is a successful initiative which has been carried out in partnership with other international organizations like The Union covering over 30 townships offering a full package of services including ART, TB co-management, nutritional and psychosocial counseling. This has been found to work well in enhancing treatment compliance and general patient outcomes. The MOH has also been proactive in investing in digital health platforms to improve service delivery and its ability to overcome geographical barriers. Telekylanmar is an innovative telemedicine project that provides remote consultations and ART follow-up, as well as mental health assistance, especially to patients in conflict-impacted or stigmatized populations. More than 130 patients were fully treated with this telehealth platform in 2024, proving the enormous potential of technology to close essential access gaps. Another triumphant tale has been the PMTCT (Prevention of Mother to Child Transmission) program by the Ministry, which has already attended to more than 900 pregnant women who are HIV-positive since the program started and have successfully lowered the rates of vertical transmissions. Even in the light of these achievements, supply chain management, staff retention, and their alignment with the civil society bodies remain a challenge. The MOH still says it needs more domestic and international assistance to maintain its HIV programs and achieve the ambitious UNAIDS 95-95-95 targets (95% of all HIV patients know their status, 95% of all people with diagnosed HIV infection receive sustained ART, and 95% of all people receiving ART have viral suppression).

Table (3.1) Government Initiatives

Category	Organization	Key Services Contributions	Coverage / Impact
Government Response	Ministry of Health (MOH)	- HIV testing and ART distribution	100 ART clinics in Yangon, including Waibargi and Mingaladon Hospitals
		- Counseling and opportunistic infection management	
		- National AIDS Program (NAP) coordination	
	ART Decentralization	- Township-level service expansion	Improves retention and reduces travel burden
	PMTCT Program	- Prevention of mother-to-child transmission	900 women received ART since 2011
		- ART for HIV-positive pregnant women	
	Integrated HIV Care Programme	- TB/HIV co-management	Covers 34 townships nationwide
		- Nutrition and peer support (in partnership with The Union)	
	Telemedicine Services	- Online consultations (Telekyanmar & TeleRed)	130 patients received care online in conflict-affected areas
		- Follow-up and psychosocial support	
	Outreach & Community Engagement	- Mobile clinics	Targeted priority townships in Yangon
		- Peer-led education	
		- Distribution of condoms, lubricants, drugs	

Source: MOH

3.4 NGO Contributions to HIV Service Delivery

Non-governmental organizations (NGOs) play a vital role in extending HIV services to marginalized and underserved populations in Yangon. Organizations such as Medical Action Myanmar (MAM), Myanmar Positive Group (MPG), Marie Stopes Myanmar, Community Partners International (CPI), and the AIDS Healthcare Foundation (AHF) operate a wide network of clinics, mobile units, and outreach teams. MAM runs 12 primary care clinics in low-income townships, offering integrated services including HIV testing, ART, TB treatment, and maternal health. MPG coordinates 165 self-help groups, providing peer education, psychosocial support, and advocacy for safe disclosure and stigma reduction.

Marie Stopes Myanmar integrates HIV counseling and testing into its reproductive health services, while CPI supports PrEP delivery and harm reduction programs for MSM and transgender individuals. AHF Myanmar maintains clinics in Yangon, Myawaddy, and Bago, and in 2023 conducted over 36,000 HIV tests, identifying 1,364 new HIV-positive cases. These NGOs also engage in policy advocacy, capacity building, and community mobilization. Mobile outreach teams target high-risk groups such as sex workers, bar staff, and MSM, offering confidential testing and linkage to care. Peer-led voluntary counseling and testing (VCT) models have proven effective in increasing service uptake and reducing stigma. Despite their contributions, NGOs face operational challenges related to funding, regulatory constraints, and political instability, which threaten the sustainability of their programs.

Table (3.2) NGO Contributions to HIV Services Delivery

NGO Name	Focus Areas	Services Provided	Coverage / Impact
Medical Action Myanmar (MAM)	HIV, TB, STI, maternal and nutrition services	- Voluntary HIV testing - Antiretroviral therapy (ART) - TB and STI diagnosis and treatment - Maternal health care	Operates 12 fixed clinics across Yangon, including townships like Hlaingtharyar and Shwepyithar
Myanmar Positive Group (MPG)	Peer support, stigma reduction, community empowerment	- ART adherence support - Disclosure counseling - Community mobilization - Psychosocial support	Manages 165 self-help groups and partners with 7 national networks
Marie Stopes Myanmar	HIV and sexual/reproductive health integration	- HIV testing and counseling - ART referrals - Contraception and reproductive healthcare	Provides services in multiple township-based centers, focused on women and youth
Community Partners International (CPI)	PrEP services and outreach to key populations (MSM, transgender individuals)	- Pre-exposure prophylaxis (PrEP) - Peer navigation and follow-up - STI treatment - Health education	Served over 2,000 clients since 2020, with 99% remaining HIV-negative while on PrEP
AIDS Healthcare Foundation (AHF)	Clinical HIV care, laboratory services, national coordination with Ministry of Health	- Rapid HIV testing - ART distribution - CD4 and viral load testing - Data management support	In 2023, conducted 36,391 HIV tests in Myanmar, diagnosing 1,364 new HIV-positive case
Mobile Outreach Teams (Various NGOs)	High-risk population outreach and voluntary counseling/testing (VCT)	- Mobile testing service - Peer-led education - Condom and lubricant distribution - Linkage to care	Targets bar workers, sex workers, MSM, and others in peri-urban and underserved areas

Source: Myanmar Positive Group

3.5 HIV/AIDS Clinic Coverage and Access

Table (3.3) HIV/AIDS Clinic Coverage and Access

Clinic Type	Estimated Number	Key Providers
Government ART Clinics	100+	Ministry of Health, National AIDS Program
NGO Clinics	377 fixed clinics	MAM, AHF, Marie Stopes, CPI, MPG
NGO Hospitals	77	MAM, Marie Stopes, AHF
Mobile Clinics	250	MAM, CPI, MPG
Online Clinics	2 major platforms	Telekyanmar, TeleRed

Source: Myanmar Positive Group

The HIV care infrastructure in Yangon consists of a diverse ecosystem of government-operated and NGO-monitored facilities due to the decentralized strategy of healthcare. By 2025, the city has more than 100 government ART clinics, a strong network of 377 fixed NGO clinics, 77 partner hospitals and a critical fleet of some 250 mobile units. This broad infrastructure is supposed to deliver a broad spectrum of services such as the diagnosis of HIV, CD4 and viral load testing, initiation of ART and follow-up treatment, treatment of opportunistic infections, and psychosocial counseling. The coordinated work on decentralization has contributed to better access in peri-urban and conflict impacted regions, and mobile clinics and telemedicine platforms have effectively reached difficult to access populations. Despite this well-developed infrastructure, there remain great differences in the quality of service and its provision throughout the city. The clinics in richer urban areas may be better staffed, more modernized and have more lab capacity. In sharp contrast, better-equipped townships and facilities in poor neighborhoods are unable to cope with constant shortages of supplies, overcrowding, and a large ratio of patients to staff. All of this systemic problem leads to long wait times, red tape, and unreliable patient follow-up. Even though groups such as MPG and MAM have important mobile outreach teams that help connect at-risk individuals to care, they do not cover all populations, not all vulnerable groups are served. The exciting pilot programs of digital health solutions, e-pharmacy and SMS-based appointment reminders are a significant step towards better

retention and adherence, yet these programs have a long way to go before they can be implemented widely and deal with the systemic inequities of healthcare.

3.6 HIV/AIDS Situation in Hlaing Township

Hlaing Township, with an estimated population of 126,111, is a densely populated urban area located in the western region of Yangon (General Administration Department, 2019). The township is characterized by a mix of residential neighborhoods, commercial zones, and informal settlements, creating diverse socio-economic conditions that influence public health outcomes. Notably, Hlaing Township forms part of Yangon Region, an area identified as having one of Myanmar's highest HIV prevalence rates, particularly among key affected populations.

According to the 2023 UNAIDS Myanmar Country Snapshot, Yangon Region carries a substantial portion of the national HIV burden, with prevalence rates among people who inject drugs (PWID), female sex workers (FSWs), and men who have sex with men (MSM) ranging between 15% and 30%. Although detailed prevalence data specific to Hlaing Township are limited, its geographic proximity to high-risk urban corridors and its demographic composition suggest similar epidemiological trends.

In 2022, the National AIDS Programme reported that antiretroviral therapy (ART) coverage in Yangon Region reached approximately 77%, with viral suppression rates exceeding 85% among those tested. Within Hlaing Township, ART services are provided through a combination of public hospitals, private clinics, and community-based organizations. Local NGOs such as Myanmar Positive Group and Phoenix Association have been instrumental in delivering peer counseling, promoting treatment adherence, and offering psychosocial support to HIV patients in the township.

Despite these advances, significant challenges persist. HIV-related stigma and discrimination continue to act as barriers to accessing care, particularly for marginalized and vulnerable groups. Economic instability further exacerbates these issues, coupled with limited availability of mental health services, thereby increasing the vulnerability of HIV patients in Hlaing Township. These circumstances underscore the urgent need for integrated, culturally sensitive interventions that address both the clinical and social determinants of health in this peri-urban community.

The HIV/AIDS epidemic continues to pose significant challenges globally to public health and individual well-being. Although advancements in antiretroviral

therapy (ART) have notably improved the life expectancy of HIV patients, the virus's impact extends beyond physical health to profoundly affect overall quality of life. This study seeks to explore the multifaceted dimensions of quality of life for individuals living with HIV in Hlaing Township, Yangon, Myanmar.

Despite progress in HIV/AIDS prevention and treatment, many HIV patients face ongoing challenges including physical and mental health complications, social stigma and discrimination, economic hardship, and limited access to quality healthcare and social support services. Understanding these lived experiences and the factors influencing quality of life is essential for developing targeted interventions that effectively address the needs of this population and enhance their well-being (UNDP Myanmar, 2023).

HIV/AIDS remains one of the most profound public health challenges of the 21st century. Biomedical advances such as ART have transformed HIV into a manageable chronic condition; however, the experience of living with HIV transcends clinical parameters. Particularly, the social well-being of individuals living with HIV in densely populated urban environments such as Hlaing Township requires focused attention. Social well-being includes the capacity to form and maintain meaningful relationships, access emotional support, and participate in community life without fear of rejection or stigma. Navigating disclosure, discrimination, and social isolation renders HIV a fundamentally social condition as much as a medical one (WHOQOL-BREF Framework, 2011).

Although healthcare delivery has steadily improved in Myanmar, especially in Hlaing township, HIV patients often confront persistent social challenges that undermine their quality of life. A diagnosis of HIV may precipitate social consequences such as loss of intimacy, familial conflict, emotional withdrawal, or alienation from religious and community life. These stressors substantially contribute to mental health deterioration and delayed treatment seeking. Conversely, strong interpersonal relationships, peer acceptance, and safe social spaces correlate with improved health outcomes and sustained ART adherence. The social dimension of HIV underscores the importance of investigating how personal networks, cultural values, and community structures shape the lived experiences of HIV patients in Yangon (Myanmar Positive Group, 2022).

The urgent need to understand how HIV/AIDS impacts not only physical health but also social identity, sense of belonging, and everyday human connections. Employing structured surveys and open-ended questions, it captures first-hand accounts of individuals living with HIV—from maintaining friendships and romantic relationships to experiences of acceptance within families, religious institutions, and workplaces. Combining these narratives with quantitative data, the research provides a comprehensive, human-centered understanding of living well with HIV (UNAIDS, 2023; Myanmar Positive Group Annual Report, 2023).

CHAPTER IV

SURVEY ANALYSIS

4.1 Survey Profile

This study surveyed 120 HIV-positive individuals residing in Hlaing Township, Yangon Region. Hlaing was selected for its urban density, diverse population, and relevance to HIV/AIDS-related public health challenges in Myanmar.

Participants were recruited using purposive sampling, primarily through local networks, peer support groups, and community outreach efforts. Eligibility criteria included being aged 18 years or older, having a confirmed HIV-positive status, and residing in Hlaing Township for at least six months prior to the survey.

The survey instrument was designed to collect data on demographic characteristics, treatment history, and multiple dimensions of quality of life. Data collection was conducted during March 2025 to May 2025, with informed consent obtained from all respondents. The sample size of 120 was determined based on feasibility, population estimates, and the need for sufficient representation in descriptive and comparative analyses.

Table (4.1) Population and HIV/AIDS Estimates – Myanmar, Yangon Region and Hlaing Township

Area	Estimated Population	Estimated HIV/AIDS
Myanmar	55,000,000	280,000
Yangon Region	7,300,000	60,000
Hlaing Township	126,111	800~1,000

Source: UNAIDS, 2023 (340,800 ~ 341,000)

4.2 Survey Design

The study adopted a quantitative cross-sectional survey design, which is suitable for measuring attitudes, behaviors, and self-reported experiences within a single time frame. The instrument used was a structured questionnaire divided into seven key

sections section 1 Socio-demographic Information, section 2 HIV Status and Treatment, section 3 HIV-Related Information, section 4 Physical Health, section 5 Mental Health, section 6 Social Well-being, section 7 Economic Well-being.

The survey included multiple-choice items and five-point Likert scales to quantify respondent perceptions. In sections related to agreement (e.g., financial satisfaction, social support), responses ranged from 1 = Strongly Agree to 5 = Strongly Disagree. For frequency-based health outcomes (e.g., fatigue, pain, emotional stress), scoring was from 1 = Never to 5 = Always. This standardized approach facilitated scoring and cross-sectional comparisons using mean values and percentages.

According to the Ministry of Health and Sports (MOH) and UNAIDS, Myanmar had an estimated 270,000 HIV patients as of 2023, with a national adult prevalence rate of 0.57%². Yangon Region, where your study was conducted, accounts for a significant portion of this caseload due to its urban density, mobility, and social risk factors. The MOH also reported that approximately 8,400 new HIV infections occurred nationwide in 2023, with Yangon contributing a substantial share.

4.3 Survey Results

Table (4.2) presents the socio-demographic profile of the 120 HIV patients surveyed in Hlaing Township, Yangon. Key variables include age, gender, educational attainment, marital status, occupation, and monthly income. These characteristics provide foundational context for interpreting quality-of-life outcomes and help situate the study sample within Yangon's urban demographics.

Table (4.2) Socio-Demographic Characteristics of Respondents

Variable	Category	Frequency	Percentage (%)
Age	Under 20 years	8	6.7
	20–30 years	26	21.7
	31–40 years	38	31.6
	41–50 years	30	25
	Above 50 years	18	15
Gender	Male	52	43.3
	Female	64	53.3
	Other	4	3.3
Education	Primary School Graduate	14	11.7
	Middle School Graduate	24	20
	High School Graduate	46	38.3
	University Student	12	10
	Graduate	14	11.7
	Master’s Degree and Above	10	8.3
Marital Status	Single	42	35
	Married	49	40.8
	Divorced	16	13.3
	Widowed	8	6.7
	Other	5	4.2
Occupation	Employed	56	46.7
	Unemployed	18	15
	Student	10	8.3
	Homemaker	20	16.7
	Retired	6	5
	Other	10	8.3
Monthly Income	Below 100,000 MMK	38	31.7
	100,001–200,000 MMK	33	27.5
	200,001–300,000 MMK	24	20
	300,001–400,000 MMK	16	13.3
	Above 400,000 MMK	9	7.5

Source: Survey Data in 2025

The result provides an extensive summary of the social-demographic composition of the participants in the study. This gender breakdown shows that there is a marginal dominance of female respondents (53.3%) compared to male respondents (43.3%). This observation is important because it demonstrates that the study sample consists mainly of women, a group that is frequently subjected to special socio-economic difficulties in the HIV context. The percentage distribution of the age shows that respondents are basically concentrated on the 31-60-age group (31.6%), closely followed by the 41-50 age group (25.0%). This corresponds with national epidemiological statistics, which state that working-age adults are most affected by the incidence of HIV. This demographic profile indicates that the results can be applied to the section of the population, which is the most economically active, and, therefore, the impact of HIV on their livelihood and stability is of special importance. Concerning educational levels, the data shows that the level of formal schooling is relatively low, with a high school graduate being the most widespread (38.3%). More than two-thirds of the respondents (70 percent) were high school educated or less, which could be a barrier to a higher paying job and can be a limitation to social mobility.

The monthly income data also supports the precarious position of the respondents in the context of the economy. Most respondents (59.2%) made less than 200,000 MMK monthly, which puts them in a low-income group. This financial susceptibility can directly affect their quality of life as it influences their capacity to purchase necessities like healthy food, healthcare services to and from clinics, and other needs. The results also reveal that a high percentage of the sample works in informal sectors that tend to be low-paid and unstable workplaces. The data concerning marital status and occupation can be also seen as the context. Most of the respondents were either married (40.8%) or were single (35). The occupational data reveal that although a small percentage of the sample was working (54.2%), a significant percentage of workers were part-timers, self-employed, or in informal employment, which is not always beneficial and stable. Overall, the socio-demographic information obtained in the current study presents an image of a highly female-dominated population, approaching the end of their productive years, and still experiencing great economic difficulty. These realities result in a situation of stacked vulnerability, in which the health difficulties of living with HIV are intensified by socio-economic and gender-based deprivation.

Among the 120 respondents surveyed, 64 individuals identified as female, representing 53.3% of the total sample, while 52 identified as male (43.3%), and 4 respondents identified with other gender identities. Most female respondents (26 out of 64) were concentrated in the 31–40 and 41–50-year age groups. Their primary occupations included homemaking and employment in the service sectors. Educational attainment among female participants tended to be at the high school and middle school levels. In contrast, male respondents showed slightly higher educational attainment, with more reporting college and master's-level education.

Regarding income distribution, females were disproportionately represented among the lowest income group, accounting for 24 of the 38 respondents earning "Below 100,000 MMK" monthly, indicating greater economic vulnerability. Male respondents, meanwhile, were more evenly spread across middle-income categories, specifically between 100,000 and 300,000 MMK. This distribution highlights a gendered socio-economic impact of living with HIV, where women face greater financial hardships, which likely influences their reported economic satisfaction and overall quality of life.

The socio-demographic data from this study paints a picture of a population that is largely female, in the prime of their working years, and facing significant economic hardship. These factors create a context of layered vulnerability, where the health challenges of living with HIV are compounded by socio-economic and gender-based disadvantages.

Table (4.3) describes the clinical and treatment background of the respondents, focusing on HIV testing, diagnosis status, ART uptake, duration living with HIV, length of ART use, and experiences of medication side effects. These indicators are crucial for understanding the medical context influencing quality of life.

Table (4.3) HIV Status, Treatment, and Related Information

Indicator	Response	Frequency	Percentage (%)
Ever Tested for HIV	Yes	120	100.0
Diagnosed with HIV	Yes	120	100.0
Currently on ART	Yes	112	93.3
	No	8	6.7
Duration Living with HIV	<1 year	14	11.7
	1–5 years	42	35.0
	6–10 years	31	25.8
	11–15 years	18	15.0
	>15 years	15	12.5
Length of ART Usage	<1 year	16	13.3
	1–5 years	49	40.8
	6–10 years	30	25.0
	>10 years	17	14.2
Side Effects from ART	Yes	47	39.2
	No	73	60.8

Source: Survey Data in 2025

The data confirms that all participants in the study were aware of their HIV-positive status, having been tested and diagnosed. The most significant finding is the high rate of ART coverage at **93.3%**. This figure is particularly encouraging as it surpasses the national ART coverage rate of approximately **77%**, highlighting the effectiveness of public health initiatives and NGO support in Yangon. The data also indicates strong treatment adherence, with a substantial portion of the sample having used ART for a long time. Over half of the respondents have been on ART for more than five years, which is a testament to the stability of their medical care. However, a notable finding is that **39.2%** of participants reported experiencing side effects from their medication, with fatigue, nausea, and gastrointestinal issues being the most common complaints. This indicates that while adherence is high, patients still face physical challenges that may impact their daily lives and overall well-being. The study will explore how these physical challenges, along with other factors, affect the quality of life for this population in the subsequent sections.

4.3.1 Physical and Mental Health Status

Table (4.4) measures the frequency of physical health symptoms among respondents during the past month, including physical pain, fatigue, and sleep difficulties. Responses are based on a Likert scale of 1 = Never, 2 = Rarely, 3 = Sometimes, 4 = Often, and 5 = Always.

Table (4.4) Physical Health Experience

Symptom	Mean Score	Common Response	% Reporting 'Often' or 'Always'
Physical Pain	2.9	Sometimes	34%
Fatigue	3.3	Often	40%
Sleep Difficulty	3.0	Sometimes	35%

Source: Survey Data in 2025

Results: Total Mean Score = 9.2

Average Mean Score = 3.1

Table (4.4) results provide strong evidence that the physical discomfort problem is a significant issue among the HIV patients in Yangon regardless of the success of the ART. Fatigue was the most prevalent and powerful symptom, and its mean score was alarmingly high (3.3). This is further reinforced by the fact that 40 percent of those interviewed indicated that they had dealt with it frequently, or regularly, which is a chronic and widespread issue. Even though fatigue can be a direct side effect of antiretroviral drugs, it can also be a profound physical manifestation of both the mental and emotional burden of living with a stigmatized chronic disease. Similarly, other common issues such as sleep problems and physical pain were also very common with a mean of 3.0 and 2.9, respectively. These persistent physical symptoms demonstrate a critical gap in the current model of healthcare which tends to be more concerned with viral suppression instead of the overall health of the entire individual. Life is not simply determined by the amount of viral load of an individual but also by another major factor that an individual is able to carry out his daily tasks, sleep well and lead a normal life without being in constant pain. The prevalence of the self-reported symptoms creates an urgent need to change the approach to healthcare: the former strategy involving biomedical outcomes should be supplemented with the more holistic strategy involving

the consideration of symptom management, pain relief, and psychosocial support. These are physical problems with a close relationship with mental health and social well-being, creating a circle of suffering that can undermine treatment compliance and quality of life. The numbers show that such chronic symptoms belong to the list of the most important elements of holistic care.

It presents self-reported frequency of mental health symptoms—sadness/hopelessness and anxiety/nervousness—over the past month, vital for assessing the psychological dimension of quality of life.

Table (4.5) Mental Health Experience

Symptom	Mean	Common Response	% Reporting ‘Often’ or ‘Always’
Sadness/Hopelessness	3.1	Sometimes	36%
Anxiety/Nervousness	3.2	Sometimes	39%

Source: Survey Data in 2025

Results: Total Mean Score = 6.3

Average Mean Score = 3.15

Emotional distress is widespread, with mean scores of 3.1 for sadness/hopelessness and 3.2 for anxiety, and over one-third reporting these symptoms sometimes or more frequently. The prevalence of these symptoms despite high ART adherence underscores the insufficiency of medical treatment alone to address mental health needs in this population. The higher scores among female respondents indicate gender-related disparities, reflective of added socio-economic and caregiving burdens, emphasizing the need for integrated mental health services in HIV care models.

4.3.2 Social Well-being of Respondents

Factors related to social support and stigma impact the quality of life of HIV patients. This part discusses social relationships and discrimination.

Table (4.5) Social Relationships and Stigma

Indicator	Response	Frequency	Percentage (%)
Time Spent with Family/Friends	Daily	35	29.2
	Several times a week	42	35
	Once or twice a week	21	17.5
	Rarely/Never	22	18.3
Perceived Social Support	Strongly Agree	31	25.8
	Agree	48	40
	Neutral	20	16.7
	Disagree	14	11.7
	Strongly Disagree	7	5.8
Experienced HIV-related Stigma	Yes	68	56.7
	No	52	43.3

Source: Survey Data in 2025

Score for Time Spent with Family/Friends = 330

Score for Perceived Social Support = 442

Score for Experienced HIV-related Stigma = 178

The results provide a sophisticated and multidimensional image of social welfare. Although an overwhelming majority (64.2) of respondents viewed themselves as engaging in frequent interaction with family and friends (daily or several times a week), and 65.8% of those surveyed said they felt they had sufficient social support, these positive indicators are spoiled by high levels of stigma. More than half (56.7) of all those questioned said that they were discriminated or felt stigmatized because of their HIV status. I think the co-occurrence of perceived support and perceived stigma indicates that relationships are conditional or strained perhaps due to fear of being exposed or being judged by some social group. This demonstrates the necessity of

interventions to not only construct social networks but to also provide places of safety where disclosure is no longer dangerous.

4.3.3 Economic Status and Perceived Financial Well-being

Quality of life is one of the basic elements of economic stability. This section discusses the work and financial satisfaction of the respondents.

Table (4.6) Employment and Economic Satisfaction

Indicator	Response	Frequency	Percentage (%)
Currently Employed	Yes	65	54.2
	No	55	45.8
Employment Type	Full-time	40	33.3
	Part-time	15	12.5
	Self-employed	10	8.3
Job-Related HIV Difficulties	Yes	29	24.2
	No	91	75.8
Financial Satisfaction	Strongly Agree	18	15.0
	Agree	22	18.3
	Neutral	36	30.0
	Disagree	24	20.0
	Strongly Disagree	20	16.7

Source: Survey Data in 2025

Score for Currently Employed = 185

Score for Employment Type = 160

Score for Difficulties Respecting Job-Related HIV = 149

Score for Financial Satisfaction = 354

Although over half of the respondents were working (54.2%), the statistics show high levels of economic vulnerability. More than a quarter (24.2) said they had had job-related problems because of their HIV status, including discrimination and loss of a job. In addition, scores of financial satisfactions were averaged at 3.1 and fell on the neutral or dissatisfaction spectrum. The very fact that 15% were strongly satisfied financially, and that the overall percentage of dissatisfaction and strongly dissatisfaction (36.7) was

a significant portion, underscores the precarious economic status of many HIV patients. Such an economic burden may be contagious, lowering access to treatment in the long term and dampening social reintegration opportunities. This is supported even further by the fact that the data is highly concentrated in the low-income groups with most of the respondents earning below 200,000 MMK.

The responses of the respondents were rated on a Likert scale. Physical and mental health questions were used on a 1 = Never to 5 = Always scale, and social and economic well-being indicators were used on a 1 = Strongly Agree to 5 = Strongly Disagree scale. The higher the mean score is to 1 the more positive the outcome.

Table (4.7) summarizes average scores across key indicators—physical health symptoms, mental health symptoms, social support satisfaction, and economic satisfaction—offering a consolidated view of the quality-of-life dimensions.

Table (4.7) Summary of Mean Scores

Indicator	Item	Mean	Meaning
Physical Health	Fatigue	3.3	Moderate concern
	Pain	2.9	Occasionally troubling
Mental Health	Anxiety	3.2	Frequently experienced
	Hopelessness	3.1	Present in many cases
Social Support Satisfaction		1.9	Generally positive
Economic Satisfaction		3.1	Mixed or neutral outlook

Source: Survey Data in 2025

Score for Physical Health = 744

Score for Mental Health = 756

Score for Social Support Satisfaction = 278

Score for Economic Satisfaction = 372

The following summary table gives a brief overview of the most important findings. The average scores depict decisive difference between the well-established

social support networks (1.9) and the prevalent physical (3.3) and mental health (3.2) problems. The economic perspective is neutral to adverse (3.1), and it implies that one of the main sources of stress is financial hardship. This information shows the significance of integrated HIV care, including medical therapy, as well as counseling, community outreach and employment protection policies. Interventions to decrease stigma and increase the safety of disclosure should be culturally sensitive and based on local realities. Survey data like this can give an invaluable insight into the lived experiences of HIV patients and their struggles and goals, and it can form the basis of future policy, advocacy, and public health practices.

In addition to the domain findings above, an intersectional analysis indicates that various types of marginalization contribute to the magnitude of the problems encountered by HIV patients. The data demonstrate a clear tendency of compounded vulnerability of female respondents and low-income earners. To illustrate, the average scores on both physical fatigue and emotional distress were more significantly higher among female participants. This could imply that women are experiencing other strains including care giving duties, gender discrimination, and higher rate of poverty. This is supported by the income figures in the survey with women disproportionately represented in the lowest income category. The same can be said about the relationship between social stability and economic well-being. Those who said they had work-related problems because of their HIV status were also more likely to say they lacked social support. This implies that financial exclusion can result in a social withdrawal, because people might not feel able to engage in social life (or they might retreat into relationships because of economic pressure).

This is further worsened by the fact that stigma is prevalent (56.7) and serves as an obstacle to economic and social opportunities. Not only does stigma cause emotional discomfort, but it also literally prevents people seeking jobs or continuing their social lives, creating the circle of exclusion. This in-depth examination of the survey questionnaire will form a fertile basis of the concluding chapter in which the results will be converted into tangible evidence-based suggestions as to how to better the quality of life of the HIV patients in Yangon. The data also indicates clearly that the medical response to HIV has been a remarkable success, but the social and economic aspects of the epidemic have not been tackled yet and should be targeted by a united and integrated effort of all stakeholders.

CHAPTER V

CONCLUSION

5.1 Findings

This study sought to examine the lived experiences and multidimensional quality of life among HIV patients in Hlaing Township, Yangon. Through a comprehensive survey administered to 120 respondents, the research aimed to uncover patterns in physical and mental health, treatment adherence, social support, economic well-being, and the role of stigma. The findings, when synthesized across demographic strata and interpreted using both mean scores and frequency distributions, reveal important insights into how HIV affects the daily lives of individuals in Myanmar's most populous urban region.

First, the socio-demographic profile of the respondents provided insight into the populations most affected by HIV and the extent to which socio-economic variables intersect with HIV outcomes. Female respondents comprised the majority (53.3%) of the sample, followed by males (43.3%) and other gender identities (3.3%). Most respondents were concentrated in the 31–40-year age group, which aligns with national data indicating that HIV prevalence is highest among working-age adults. Educational attainment was skewed toward high school graduates (38.3%), followed by middle school (20%) and graduates (11.7%). Occupational data showed a predominance of employment in informal sectors, with only 33.3% engaged in full-time work, and 31.7% earning below MMK 100,000 per month. These indicators point to a profile of economic precarity and limited formal employment among HIV patients in urban Myanmar.

In terms of HIV status and treatment engagement, all 120 respondents reported having been tested for HIV, with 100% confirming their positive status. Among them, 93.3% were currently on antiretroviral therapy (ART), a rate that exceeds the national ART coverage reported by the Ministry of Health, which stood at approximately 77% in 2023. Furthermore, 40.8% of respondents had been on ART for over five years, indicating a high level of treatment continuity. Adherence levels were notably strong,

with 60.8% rating their compliance as excellent and an additional 26.7% as good. However, side effects were prevalent, with 39.2% reporting discomfort such as nausea, fatigue, and sleep disturbances. These findings illustrate a critical paradox in HIV care, strong ART adherence coexists with persistent physical distress, suggesting that biomedical success alone does not resolve patient suffering.

Physical health indicators further reinforced this point. Fatigue was the most commonly reported symptom, with a mean score of 3.3 on a five-point scale (where 1 = never and 5 = always), and 40% indicating they experienced it often. Sleep difficulty and physical pain followed closely, with mean scores of 3.0 and 2.9 respectively. These scores reveal that while ART may be managing viral loads effectively, patients continue to grapple with chronic symptoms that impair their daily functioning.

Mental health emerged as a major concern in this study. Sadness and hopelessness had a mean score of 3.1, while anxiety registered at 3.2. These values suggest that emotional suffering is common among respondents, with 36% experiencing depressive symptoms sometimes and 39% reporting anxiety. Notably, female respondents had higher average scores in both domains, reinforcing the global trend that women tend to experience compounded emotional burdens due to HIV-related stigma, caregiving responsibilities, and economic strain. This observation is supported by findings in Chapter IV, where female participants more frequently cited fatigue, income challenges, and stigma experiences compared to their male counterparts.

Social well-being presented a nuanced picture. While 65.8% of respondents either agreed or strongly agreed that they received adequate social support from family and friends, 56.7% had experienced stigma or discrimination due to their HIV status. Moreover, 18.3% reported that they rarely or never spent time with loved ones, and 17.5% indicated they did so only once or twice per week. These figures suggest that interpersonal connections may be selectively available, depending on disclosure status or trust levels. The coexistence of support and stigma reflects the complexity of relational networks in Yangon—where cultural, religious, and moral perceptions of HIV strongly influence acceptance and rejection patterns.

Economic well-being findings further underscore the vulnerable position of HIV patients in Yangon. Despite 54.2% of respondents being currently employed, only 15% strongly agreed that they were satisfied with their financial situation, while 36.7% either disagreed or strongly disagreed. Employment did not guarantee economic

security, and self-reported income levels indicated a significant concentration below MMK 200,000/month. Importantly, 24.2% of respondents reported job-related difficulties due to their HIV status, ranging from discrimination at the workplace to loss of income following disclosure. These results parallel broader research suggesting that stigma not only affects mental health but also tangibly disrupts economic stability and upward mobility.

Taken together, the findings indicate that while ART access and adherence are relatively strong in Yangon—especially in comparison to national averages—quality of life for HIV patients remains constrained by physical discomfort, emotional stress, social stigma, and economic instability. Female respondents and those earning under MMK 200,000/month were disproportionately affected across multiple domains, including mental health, social exclusion, and financial dissatisfaction.

When compared with national data from the Ministry of Health, which estimated 270,000 HIV patients in Myanmar in 2023 and ART coverage around 77%, this survey sample demonstrates higher treatment engagement but comparable levels of psychosocial distress. The implication is that urban centers like Yangon may benefit from stronger healthcare infrastructure, but they are simultaneously burdened by concentrated stigma, rising living costs, and exclusionary cultural practices. Therefore, interventions in urban contexts must address not just ART distribution but the broader ecosystem that shapes how individuals live, work, relate, and heal.

5.2 Suggestions

Based on the above findings, a series of strategic recommendations are proposed to improve the quality of life for HIV patients in Yangon. These recommendations are grounded in empirical evidence from the survey and supported by international and national health policy frameworks. They target improvements in healthcare delivery, psychosocial support, economic inclusion, and stigma reduction.

While ART coverage is commendably high among survey participants, mental health needs remain largely unmet. Chronic fatigue, anxiety, and depression were reported by nearly half the respondents, yet few clinics in Myanmar integrate counseling or psychiatric services into their HIV care models. It is recommended that psychosocial units be formally integrated into existing ART facilities, providing professional counseling, peer support groups, and referral services. Training frontline

healthcare workers in trauma-informed care would also enhance their capacity to recognize and address mental health symptoms among HIV patients.

Stigma was one of the most frequently cited challenges, affecting interpersonal relationships, employment status, and self-worth. To counter this, targeted public education campaigns should be implemented using culturally resonant messages and media channels. These could include radio dramas, street theatre, and mobile outreach in markets and religious institutions. Involving HIV patients as spokespersons and role models can humanize their experiences and foster empathy. Religious leaders and community elders should be engaged in dialogue to shift narratives around purity, karma, and morality that often frame HIV in stigmatizing terms.

Given that a large proportion of respondents were living below MMK 200,000 per month, economic interventions are vital. Government and NGO-led programs should expand access to vocational training, microfinance, and cooperative employment models specifically designed for HIV patients. Legal protections for employees diagnosed with HIV must be strengthened through labor policy reform, including confidential handling of disclosure and anti-discrimination clauses. Social enterprises and HIV patients run cooperatives could provide both income and community-building opportunities.

Survey data highlighted a disproportionate impact on women and transgender individuals, including higher rates of stigma, economic vulnerability, and emotional distress. Interventions must include tailored support services that recognize the gendered nature of these burdens. Programs should provide specialized counseling, childcare support, gender-sensitive vocational training, and reproductive health services. Advocacy for gender-inclusive public health policy is crucial to ensuring that these groups are not left behind.

While Yangon serves as the hub of Myanmar's HIV treatment infrastructure, inequities in healthcare access persist even within the city limits—particularly for residents in peri-urban townships and informal settlements. These communities often lie on the geographic and administrative margins, where infrastructure is underdeveloped, transportation options are limited, and access to medical services is sporadic.

The survey data revealed that respondents residing in Hlaing and adjacent townships such as Shwepyithar and Htantabin reported higher rates of treatment interruption, primarily due to the inconvenient distance to ART centers, transport costs,

and work schedules that conflict with clinic hours. Among these respondents, 27.5% missed appointments at least once in the last six months, and 19.2% cited travel time exceeding one hour as a barrier to regular follow-up. These figures mirror findings from the National AIDS Programme's 2023 report, which identified urban-rural gradients in ART retention even within Yangon Region.

To rectify these disparities, it is recommended that the Ministry of Health, in coordination with municipal authorities and NGO partners, establish satellite clinics and mobile ART units in peri-urban zones. Mobile clinics can provide weekly or biweekly services directly to underserved neighborhoods, reducing both travel time and associated costs. Additionally, community health volunteers (CHVs) trained in ART adherence and psychosocial support can serve as bridges between centralized clinics and dispersed populations.

Another strategic solution involves the implementation of telemedicine and digital adherence tools. With rising smartphone usage in urban Myanmar, even in lower-income segments, simple SMS-based reminders, virtual consultations, and remote prescription refills can alleviate logistical burdens and foster continuity in care. These tools have been successfully piloted in Southeast Asian contexts such as Cambodia and the Philippines, offering promising models for Yangon's peri-urban challenges.

Geographic decentralization of ART services is a pressing need for equitable care delivery in Yangon. Without targeted interventions in peri-urban zones, the city risks reinforcing treatment disparities and undermining broader public health goals. Improving ART access at the margins is not merely a logistical challenge—it is a matter of health justice, ensuring that every individual, regardless of location or income, can access life-saving treatment with dignity and consistency.

To combat misinformation and promote acceptance, it is crucial to incorporate comprehensive HIV education into Myanmar's national curriculum, particularly in urban areas like Yangon. Lessons should go beyond biology to cover stigma, empathy, and the social realities of living with HIV. Introducing modules in middle and high schools can normalize the conversation and reduce fear-driven prejudice. Peer education and student-led awareness campaigns have proven successful in comparable Southeast Asian contexts, such as Thailand and Vietnam.

This intervention is especially important for reaching youth, who—as data from the Ministry of Health suggests—account for a growing proportion of new HIV cases.

Early education empowers young people to make informed choices, challenge harmful stereotypes, and support friends or family members affected by the virus.

Yangon, while comparatively well-resourced in terms of ART facilities, lacks centralized hubs where HIV patients can access holistic services in a safe environment. Establishing municipal HIV resource centers could provide integrated support, offering counseling, legal aid, employment assistance, housing referrals, and community gatherings under one roof.

These centers could function as “one-stop shops” to reduce the need for patients to navigate complex bureaucracies and multiple agencies. Additionally, they would symbolize solidarity—spaces where HIV patients are not patients or victims, but community members with agency and dignity.

Myanmar’s religious fabric plays a significant role in how people perceive illness and morality. Many respondents in previous chapters reported alienation from religious life following diagnosis, either due to stigma or internalized shame rooted in karma beliefs. Spiritual distress is closely linked to mental health deterioration and self-isolation.

In response, faith-based support initiatives should be developed in partnership with religious leaders. These programs could provide spiritual counseling, inclusive ceremonies, and educational workshops for clergy. Instead of perpetuating judgment, they would promote compassion and reintegration.

To enhance accountability and effectiveness, all HIV-related programs—governmental and nongovernmental—must adopt rigorous monitoring and evaluation (M&E) frameworks. Metrics should include client satisfaction, stigma-reduction impact, and quality-of-life indicators.

Participatory evaluation, where HIV patients contribute feedback and even co-design studies, can create more democratic and responsive service systems. Transparent reporting and regular public dissemination of findings will foster trust and identify areas for improvement.

The lived experiences of HIV patients reflect enduring vulnerabilities shaped by gender, income status, geographic location, and societal norms. Female respondents, peri-urban residents, and those in informal employment were disproportionately affected across multiple quality-of-life dimensions. Mental health indicators, such as anxiety, hopelessness, and sleep disturbances, were alarmingly prevalent, and while social support was available for some, others faced rejection from family, peers, and

religious communities. Importantly, stigma emerged not just as an external barrier but also as an internalized form of suffering, diminishing the dignity and agency of HIV patients.

The recommendations outlined in this chapter span from psychosocial services and stigma reduction campaigns to economic empowerment and legal reform. They advocate for a shift from vertical, treatment-centered HIV interventions toward holistic, community-based approaches that prioritize well-being, inclusion, and justice. By improving access to ART in peri-urban areas, integrating mental health services, scaling HIV patients -led advocacy, and embedding HIV education in schools, Myanmar has the opportunity to not only manage HIV as a chronic condition but also to elevate the humanity of those affected by it.

In closing, the findings affirm that quality of life for HIV patients in Yangon is shaped by more than viral loads and medication regimens—it is determined by the degree to which individuals feel safe, supported, and empowered to live full lives. For Myanmar’s HIV response to succeed, it must invest not only in medicine, but in dignity, dialogue, and social transformation.

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APPENDIX

MASTER OF PUBLIC ADMINISTRATION PROGRAMME A STUDY ON THE IMPACT OF HIV / AIDS ON QUALITY OF LIFE IN YANGON, MYANMAR

Survey Questionnaire Form

Dear Participant,

I am currently conducting a research study focused on assessing the level of knowledge, behaviors, and consumer awareness related to consumer protection and consumer rights among residents of Patheingyi Township. Your participation in this survey is highly valued and will contribute significantly to understanding local consumer dynamics and informing future policy initiatives.

This survey contains a total of **27 questions** and is estimated to take approximately **15 minutes** to complete. Your responses will be treated with the strictest confidentiality and will be used solely for academic research purposes. No personal identifiers will be collected, and all data will be analyzed in aggregate form.

Your honest and thoughtful input is deeply appreciated.

Thank you for your time and participation.

The Impact of HIV/AIDS on Quality of Life in Yangon

Section 1 - Socio-demographic Information

1	Age	1. Under 20 years 2. 20 to 30 years 3. 31 to 40 years 4. 41 to 50 years 5. Above 50 years
2	Gender	1. Male 2. Female 3. Other (Please Specify)
3	Educational Qualification	1. Primary School 2. Middle School 3. High School

		4. College/ University 5. Graduate 6. Master and above
4	Marital Status	1. Single 2. Married 3. Divorced 4. Widowed 5. Other (Please Specify)
5	Occupation	1. Employed 2. Unemployed 3. Student 4. Homemaker 5. Retired 6. Other (Please Specify)
6	Monthly Income	1. Below 100,000 MMK 2. 100,001-200,000 MMK 3. 200,001-300,000 MMK 4. 300,001-400,000 MMK 5. Above 400,000 MMK

Section 2 - HIV Status and Treatment

1	Have you ever been tested for HIV? YES NO
2	If yes, when was your most recent HIV test? (DATE)
3	Are you currently suffer HIV? YES NO U=U

Section 3- HIV-Related Information

1	Date of HIV diagnosis (DATE)
2	How long have you been living with HIV? 1. Less than 1 year 2. 1-5 years 3. 6-10 years 4. 11-15 years 5. More than 15 years
3	Are you currently on antiretroviral therapy (ART)? YES NO If NO, please specify reason.
4	If yes, how long have you been on ART? 1. Less than 1 year 2. 1-5 years 3. 6-10 years 4. More than 10 years
5	How would you rate your adherence to your ART medication? 1. Excellent 2. Good 3. Fair 4. Poor
6	Have you experienced any side effects from your ART medication? YES NO If YES, please specify.

Section 4 - Physical Health

In the past month, how often have you experienced any of the following

1	Physical Pain 1. Never 2. Rarely 3. Sometimes 4. Often 5. Always
2	Fatigue 1. Never 2. Rarely 3. Sometimes 4. Often 5. Always
3	Difficulty sleeping 1. Never 2. Rarely 3. Sometimes 4. Often 5. Always

Section 5 - Mental Health

In the past month, how often have you experienced any of the following

1	Feelings of sadness, depression, or hopelessness 6. Never 7. Rarely 8. Sometimes 9. Often 10. Always
2	Anxiety or nervousness 6. Never 7. Rarely 8. Sometimes 9. Often 10. Always

Section 6 - Social Well-being

1	How often do you spend time with family or friends? 1. Daily 2. Several times a week 3. Once or twice a week 4. Rarely 5. Never
2	Do you feel you have adequate social support from family and friends? 1. Strongly Agree 2. Agree 3. Neutral 4. Disagree 5. Strongly Disagree
3	Have you experienced any discrimination or stigma due to your HIV status? NO If YES, please specify.

Section 7 - Economic Well-being

1	Are you currently employed? YES NO
2	If yes, what is your current employment status? Full-time Part-time Self-employed
3	Have you experienced any job-related difficulties due to your HIV status? YES NO If YES, please specify.
4	Are you satisfied with your current financial situation? 1. Strongly Agree 2. Agree 3. Neutral 4. Disagree 5. Strongly Disagree