

**YANGON UNIVERSITY OF ECONOMICS
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**A STUDY ON EFFECTIVENESS OF PEER
COUNSELING FOR HIV PATIENTS IN YANGON**

**MIN SAN TUN
EMDEVS - 42 (14th BATCH)**

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MASTER OF DEVELOPMENT STUDIES PROGRAMME

**A STUDY ON EFFECTIVENESS OF PEER
COUNSELING FOR HIV PATIENTS IN YANGON**

A research paper submitted as a partial fulfillment towards the requirements for the
degree of Master of Development Studies (MDevS)

Supervised by

Daw Mie Mie Soe
Lecturer
Department of Economics
Yangon Institute of Economics

Submitted by

Min San Tun
Roll No, 42
EMDevS (14th Batch)
(2017-19)

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This is to certify that this thesis entitled “**A Study on Effectiveness of Peer Counseling for HIV Patients in Yangon**” submitted as a partial fulfillment of the requirements of the degree of Master of Development Studies has been accepted by Board of Examiners.

BOARD OF EXAMINERS

1. Dr. Tin Win
Rector
Yangon University of Economics (Chief Examiner)

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Yangon University of Economics (Examiner)

4. Dr. Cho Cho Thein
Professor and Head
Department of Economics
Yangon University of Economics (Examiner)

5. Dr. Khin Thida Nyein
Professor
Department of Economics
Yangon University of Economics (Examiner)

August 2019

ABSTRACT

In Myanmar, peer counselling approach is employed as a means of providing a cost-effective, trusting, and understanding environment for sharing of sensitive information between the patient and the counsellor. However, its effectiveness has not been assessed to consider potential modifications. The objectives of this study are to assess the community perception on knowledge, attitude, and practice (KAP) relating on peer to peer HIV counselling model in Yangon and to identify the effectiveness on performance of peer counselors in their counseling session providing for HIV knowledge, stigma, social support, barriers to care, medication adherence, and subjective attitudes regarding HIV counseling among People Living with HIV patients. This thesis is based on primary data, in quantitative method, structured questionnaires concerned knowledge, attitude and practice to HIV patients. A sample size of 150 HIV patients who received Anti Retro-viral Therapy (ART) treatment was chosen by purposive sampling method. The limitations of this study were selected geographical areas of 9 ART initiation sites out of 45 in Yangon Region with limited number of respondents. The result of this study highlighted the technical skill for peer counselors still need to be improved but patients satisfied on counseling experience with peer counselors, the practice of HIV patients for adherence on Anti-retroviral Therapy is good because of the receiving of counseling from peer HIV counselors. The attitude on Stigma and Discrimination of HIV patients felt self-stigma avoid from social relationship among community and family. This study highlights that the peer counselor need to support more information about stigma and discrimination with the Human Rights approach.

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LIST OF ABBREVIATION

3MDG Fund	A multi-donor trust fund that pools the contributions of seven bilateral donors
ADB	Asian Development Bank
AIDS	Acquired Immuno-Deficiency Syndrome
APN+	Asia Pacific Network of People Living with HIV/AIDS
ART	Anti-retroviral Therapy
CBO	community-based organization
CD4	immune system, specifically the T cells
FDC	Fixed Dose Combination
FSW	female sex workers
GDP	Gross Domestic Product
HIV	Human Immuno-Deficiency Virus
HTC	HIV testing and counseling
HTS	HIV testing Services
LGBT	Lesbian Gay Bisexual Transgender
LMIC	Lower Middle Income Country
MPG	Myanmar Positive Group (National Network of PLHIV)
MSF	Medicines Sans Frontiers
MSM	Men who have sex with men
NGO	Non-government Organization
NSP	National Strategic Plan
PEP	Post-exposure Prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PrEP	Pre-exposure Prophylaxis
PWID	People who Inject Drugs
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

CHAPTER I

INTRODUCTION

1.1 Rationale of the Study

Similar to other countries, HIV/AIDS problem affects Myanmar's prospects for growth and development, the epidemic has definitely had an adverse impact on the Myanmar economy and will continue to do so at a macro, regional, and household level. Generally speaking, and this is true for other countries as well, there will be four layers of impacts:

- The direct costs of prevention and treatment are high although some of the costs can be borne by external assistance.
- Indirect costs due to loss in productivity, higher wages, and loss of skills and institutional knowledge can be very high.

The distribution of these impacts is quite uneven. There are some population groups, geographical areas, and age groups that are more affected than others. It is the poor who suffer the most since they have the least access to services and information and the least ability to protect themselves or obtain treatment.

In the long term, savings and investment levels will be affected, and there are also intergenerational impacts at the household level. If it is tough for a child to be brought up by a single parent in a poor household, it is tougher when both parents are lost to the disease and he/she is brought up by grandparents who themselves are not materially well off. There are thousands of these cases all over Southeast Asia, including Myanmar.

Strategic Information and M&E Working Group, Technical and Strategy Group on AIDS (2010), HIV Estimates and Projections Asian Epidemiological Model (AEM) Myanmar 2010-2015 said that the HIV global epidemic began more than three decades ago, and the first case of HIV in Myanmar was detected in 1988. At a national level the prevalence of HIV among adults 15 years and older seems to have stabilized at below 1% and there has recently been a significant decline in deaths

(from 15601 in 2011 to 9675 in 2015). The Myanmar HIV Technical Strategic Group (2017), the National Strategic Plan on HIV and AIDS (2016-2020) said that it was estimated that there were 220,000 people adults and children living with HIV, prevalence rate of adult aged of 15 to 49 is 0.7, adult and children newly infected with HIV is 11,000 and adult and children death due to AIDS is 6,700 with the epidemic heavily affecting the key populations of people who inject drugs (PWID), female sex workers (FSW), men who have sex with men (MSM) and the intimate partners of these groups. The Avert, UNAIDS data 2017, Global information and education on HIV and AIDS mentioned that National level HIV prevalence was estimated to be 34.9% among people who inject drugs among estimated population 93,000, and 5.4% among female sex workers estimated population 66,000 and 6.4% among men who have sex with men estimated population 252,000 in 2017.

Any people of all different classes who has risk behaviours can easily to get HIV infection. Due to occurrence of HIV infection in all classes, socioeconomic status was affected by the disease. If a person is infected with HIV, his/her community, relative, neighbour and family will encounter the consequences of infection, i.e (medical, financial, job, social, family and psychosocial). In this way, fight against HIV/AIDS has been one of the priority disease, it necessary to deal with problem and fight against infection in a multi sectorial approach.

National AIDS Program, Department of Public Health, Ministry of Health and Sport Myanmar (2017), the Guidelines for Clinical Management of HIV infection in Myanmar said that HIV is now treatable condition and majority of people who have HIV remain fit and well on treatment. Despite this, significant numbers of people are unaware of their HIV infection and remain at risk to their own health and of unknowingly passing their virus on to others. Late diagnosis is the most important factor associated with HIV related morbidity and mortality. Patient should therefore be offered and encouraged to accept HIV testing in a wider range in setting.

The Myanmar HIV Technical Strategic Group (2017), the National Strategic Plan on HIV and AIDS (2016-2020) stated as strategic result; to increase in number of people living with HIV engaged in HIV prevention, testing and treatment program and at least 30% of all services delivery is community led by 2020. Currently, the ART provision services of international and local NGOs is being transferred HIV patients to public sector during the transition period of 2017 to 2020. So, the public health sector tries to cover for all ART patients in public care setting rapidly

extending the ART centres and ART Decentralized Sites across the country but it still have many challenges on Human Resources and Infrastructures. National AIDS program of department of public health is promoting the peer counselling in its service provision points by collaboration with Myanmar Positive Group, National PLHIV Network and other NGOs.

In Myanmar, peer counselling is employed as a means of providing a cost-effective, trusting, and understanding environment for sharing of sensitive information between the patient and the counsellor. However, its effectiveness has not been assessed to consider potential modifications, hence the purpose of this study.

1.2 Objectives of the Study

Objectives of this study are to assess the community perception on knowledge, attitude, and practice (KAP) relating on peer to peer counselling HIV counselling model in Yangon and to identify the effectiveness on performance of peer counselors in their counseling session providing for HIV knowledge, stigma, social support, barriers to care, medication adherence, and subjective attitudes regarding HIV counseling among People Living with HIV patients.

1.3 Method of Study

In this study is based on primary data, in quantitative method, structured questionnaires concerned knowledge, attitude and practice to HIV patients. A sample size of 150 HIV patients who received Anti Retro-viral Therapy (ART) treatment was chosen by purposive sampling method.

1.4 Scope and Limitation of the study

The study area chosen was Yangon Region specifically at (9) HIV service centers where peer counselors are working on counseling services for HIV patents. The sample size of 150 HIV patients receiving antiretroviral therapy (ART) who also received counselling from peer HIV counsellors was chosen by purposive sampling method with reasonable amount in (9) HIV service centers.

The limitations of this study were selected geographical areas of 9 ART initiation sites out of 45 in Yangon Region with limited number of respondents and times on period of research were we done from May 2019 to August 2019.

1.5 Organizing of the study

The thesis divided into five chapters. Chapter I introduced the Rational of thesis, Objective, Method of Study, Scope and Limitation, and Organizing of the thesis. Chapter II presents Literature Review concerning nature of HIV and Chapter III mentions Overview of HIV Treatment Care and Support in Myanmar. In Chapter IV, Empirical Analysis of knowledge Attitude and practice on Peer Counselling for HIV Patents study results are described. And Chapter V is the Conclusion.

CHAPTER II

LITERATURE REVIEW

2.1 HIV/AIDS

HIV stands for human immunodeficiency virus. It is the virus that can lead to acquired immunodeficiency syndrome or AIDS if not treated. Unlike some other viruses, the human body can't get rid of HIV completely, even with treatment. So once you get HIV, you have it for life.

HIV attacks the body's immune system, specifically the CD4 cells (T cells), which help the immune system fight off infections. Untreated, HIV reduces the number of CD4 cells (T cells) in the body, making the person more likely to get other infections or infection-related cancers. Over time, HIV can destroy so many of these cells that the body can't fight off infections and disease. These opportunistic infections or cancers take advantage of a very weak immune system and signal that the person has AIDS, the last stage of HIV infection.

No effective cure currently exists, but with proper medical care, HIV can be controlled. The medicine used to treat HIV is called antiretroviral therapy or ART. If people with HIV take ART as prescribed, their viral load (amount of HIV in their blood) can become undetectable. If it stays undetectable, they can live long, healthy lives and have effectively no risk of transmitting HIV to an HIV-negative partner through sex. Before the introduction of ART in the mid-1990s, people with HIV could progress to AIDS in just a few years. Today, someone diagnosed with HIV and treated before the disease is far advanced can live nearly as long as someone who does not have HIV.

Only certain body fluids—blood, semen (cum), pre-seminal fluid (pre-cum), rectal fluids, vaginal fluids, and breast milk—from a person who has HIV can transmit HIV. These fluids must come in contact with a mucous membrane or damaged tissue or be directly injected into the bloodstream (from a needle or syringe) for transmission to occur. Mucous membranes are found inside the rectum, vagina, penis, and mouth.

Having anal or vaginal sex with someone who has HIV without using a condom or taking medicines to prevent or treat HIV. For the HIV-negative partner, receptive anal sex (bottoming) is the highest-risk sexual behaviour, but you can also get HIV from inserted anal sex (topping). Either partner can get HIV through vaginal sex, though it is less risky for getting HIV than receptive anal sex. Sharing needles or syringes, rinse water, or other equipment (works) used to prepare drugs for injection with someone who has HIV. HIV can live in a used needle up to 42 days depending on temperature and other factors; from mother to child during pregnancy, birth, or breastfeeding. Although the risk can be high if a mother is living with HIV and not taking medicine, recommendations to test all pregnant women for HIV and start HIV treatment immediately have lowered the number of babies who are born with HIV and by being stuck with an HIV-contaminated needle or other sharp object. This is a risk mainly for health care workers.

Today, more tools than ever are available to prevent HIV. You can use strategies such as abstinence (not having sex), limiting your number of sexual partners, never sharing needles, and using condoms the right way every time you have sex. You may also be able to take advantage of newer HIV prevention medicines such as pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP).

If you have HIV, there are many actions you can take to prevent transmitting it to others. The most important is taking HIV medicine (called antiretroviral therapy, or ART) as prescribed. If you take HIV medicine as prescribed and get and keep an undetectable viral load (or stay virally suppressed), you can stay healthy and have effectively no risk of transmitting HIV to an HIV-negative sex partner. (UNAIDS, 2017)

2.1.1 Changes of lives in People

Ever since the beginning of AIDS epidemic in 1981, the number of people infected and affected by HIV/AIDS is on the rise. During the course of infection, a broad range of physical, social and psychological needs and problems is experienced. Changing nature of the illness imposes a variety of psychological and emotional strains on individuals and those closest to them. Taking into account the dilemmas associated with it, the effects of HIV epidemic are enormous. AIDS, in fact, is seen more as a psychosocial phenomenon than a disease. HIV/AIDS counseling assists people to make informed decisions, cope better with their condition, lead more

positive lives, and prevent HIV transmission. HIV/AIDS counselling is important because infection with HIV is life-long. Role of counselling in HIV/AIDS is perhaps more important than in any other disease.

2.1.2 Antiretroviral Therapy (ART)

Antiretroviral Therapy (ART) is the use of HIV medicines to treat HIV infection. People on ART take a combination of HIV medicines called an HIV treatment regimen every day. ART is recommended for everyone who has HIV. ART can't cure HIV but HIV medicines helps people with HIV live longer, healthier lives. ART also reduce the risk of HIV transmission. HIV attacks and destroys the infection-fighting CD4 cells of the immune system. Loss of CD4 cells makes it hard for the body to fight off infections and certain HIV-related cancers. HIV medicines prevent HIV from multiplying, making copies of itself, which reduces the amount of HIV in the body, also called viral load, with having less of HIV in the body gives the immune system a chance to recover Even though there is still some HIV in the body, the immune system is strong enough to fight off infections and certain HIV-related cancers. By reducing the amount of HIV in the body, HIV medicines also reduce the risk of HIV transmission. A main goal of ART is to reduce a person's viral load to an undetectable level. An undetectable viral load means that the level of HIV in the blood is too low to be detected by a viral load test. People with HIV who maintain an undetectable viral load have effectively non risk of transmitting HIV to their HIV negative partner through sex.

There are many HIV medicines available to HIV regimens. The HIV medicines are grouped into seven drug classes according to how they fight HIV. A person's initial HIV regimen usually includes three HIV medicines from at least two different HIV drug classes. Selection of an HIV regimen depends on several factors, including possible side effects of HIV medicines and potential drug interactions between medicines. Because the needs of people with HIV vary, there are several HIV regimens to choose.

Sometimes HIV medicines can cause side effects. Most of effects from HIV medicines are manageable, but a few can be serious. Overall, the benefits of HIV medicines far outweigh the risk of side effects. In addition, newer HIV regimens cause fewer side effects than regimens used in the past. As HIV treatment options continue to improve, people are less likely to experience side effects from their HIV medicines.

HIV medicines can interact with other HIV medicines in an HIV regimen. They can also interact with other medicines, vitamins, nutritional supplements, and herbal products. A drug interaction can reduce or increase a medicine's effect on the body. Drug interactions can also cause unwanted side effects. When HIV multiplies in the body, the virus sometimes mutates, changes form, and makes variations itself. Variations of HIV that developed while a person is taking HIV medicines can lead to drug-resistant strains of HIV. HIV medicines that previously controlled a person's HIV are not effective against the new, drug-resistant HIV. In other words, the person's HIV continues to multiply. Poor adherence to an HIV regimen, not taking HIV medicines every day and exactly as prescribed increases the risk of drug resistance and treatment failure. (UNAIDS, 2017)

2.2 Global Situation on HIV/AIDS

World Health Organization, 2018, Global Health Observatory (GHO) data, Summary of the global HIV epidemic indicated that since the beginning of the epidemic, more than 70 million people have been infected with the HIV virus and about 35 million people have died of HIV. Globally, 36.9 million [31.1–43.9 million] people were living with HIV at the end of 2017. An estimated 0.8% [0.6-0.9%] of adults aged 15–49 years worldwide is living with HIV, although the burden of the epidemic continues to vary considerably between countries and regions. 940 000 [670 000–1 300 000] people died of HIV-related illnesses worldwide in 2017. A total of 115 low-and- middle-income countries submitted data on the availability of HIV testing and counseling services in health facilities in 2014. HIV testing and counseling services were provided by more than 174 000 health facilities compared to 143 000 health facilities in 2011 (129 countries). The WHO African region remains most severely affected, with nearly 1 in every 25 adults (4.1%) living with HIV and accounting for nearly two-thirds of the people living with HIV worldwide.

HIV.gov Mission and Team, 2018, Global HIV/AIDS Overview, PEPFAR and Global AIDS, November 20, 2018 indicated that HIV, the virus that causes AIDS, is one of the world's most serious public health challenges. But there is a global commitment to stop new HIV infections and ensuring that everyone living with HIV has access to HIV treatment.

According to UNAIDS, an estimated 1.8 million individuals worldwide became newly infected with HIV in 2017 – about 5,000 new infections per day. This

includes 180,000 children (<15 years). Most of these children live in sub-Saharan Africa and were infected by their HIV-positive mothers during pregnancy, childbirth or breastfeeding.

Approximately 75% of people living with HIV globally were aware of their HIV status in 2017. The remaining 25% (over 9 million people) still need access to HIV testing services. HIV testing is an essential gateway to HIV prevention, treatment, care and support services.

In 2017, 21.7 million people living with HIV (59%) were accessing antiretroviral therapy (ART) globally, an increase of 2.3 million since 2016 and up from 8 million in 2010. HIV treatment access is key to the global effort to end AIDS as a public health threat. People living with HIV who are aware of their status, take ART daily as prescribed, and get and keep an undetectable viral load can live long, healthy lives. There is also a major prevention benefit. People living with HIV who adhere to HIV treatment and get and keep an undetectable viral load have effectively no risk of sexually transmitting HIV to their HIV-negative partners.

AIDS-related deaths have been reduced by more than 51% since the peak in 2004. In 2017, 940 000 people died from AIDS-related illnesses worldwide, compared to 1.4 million in 2010 and 1.9 million in 2004. The vast majority of people living with HIV are in low- and middle-income countries.

In 2017, there were 19.6 million people living with HIV (53%) in eastern and southern Africa, 6.1 million (16%) in western and central Africa, 5.2 million (14%) in Asia and the Pacific, and 2.2 million (6%) in Western and Central Europe and North America.

Despite advances in our scientific understanding of HIV and its prevention and treatment as well as years of significant effort by the global health community and leading government and civil society organizations, too many people living with HIV or at risk for HIV still do not have access to prevention, care, and treatment, and there is still no cure. However, effective treatment with antiretroviral drugs can control the virus so that people with HIV can enjoy healthy lives and reduce the risk of transmitting the virus to others.

The HIV epidemic not only affects the health of individuals, it impacts households, communities, and the development and economic growth of nations. Many of the countries hardest hit by HIV also suffer from other infectious diseases, food insecurity, and other serious problems.

Despite these challenges, there have been successes and promising signs. New global efforts have been mounted to address the epidemic, particularly in the last decade. The number of people newly infected with HIV has declined over the years. In addition, the number of people with HIV receiving treatment in resource-poor countries has dramatically increased in the past decade.

Progress also has been made in preventing mother-to-child transmission of HIV and keeping mothers alive. In 2017, 80% [61– >95%] of pregnant women living with HIV had access to antiretroviral medicines to prevent transmission of HIV to their babies, up from 47% in 2010.

However, despite the availability of this widening array of effective HIV prevention tools and methods and a massive scale-up of HIV treatment in recent years, new infections among adults globally have not decreased sufficiently. (UNAIDS, 2017)

2.3 Element of HIV Counseling

Various studies throughout the world suggest that HIV/AIDS counselling assists people to make informed decisions, cope better with their condition, lead more positive lives, and prevent HIV transmission. HIV/AIDS counselling is important because infection with HIV is a life-long phenomenon and during the course of the infection, a broad range of physical, social and psychological needs and problems are likely to be experienced. The changing nature of the illness imposes a variety of psychological and emotional strains on individuals and those closest to them. HIV/AIDS counselling is a dialogue between a client and a care provider aimed at enabling the client to cope with stress and to make personal decisions related to HIV/AIDS. The counselling process includes the evaluation of personal risk of HIV transmission and the facilitation of preventive behaviour. HIV/AIDS counselling is a process that begins with the client's first contact either with an HIV/AIDS counselling service or with the care system for HIV-related needs. In the context of HIV/AIDS, the care system includes all health and social service facilities, both governmental and non-governmental, where individuals receive care and social support. The counselling process continues through a referral network to various community and social support agencies, according to the need of the individual and the family affected by or worried about HIV. Main goals of counselling are to provide psychosocial support to those whose lives have been affected by HIV and to prevent HIV infection and its

transmission to other people and counselling is vital important to adherence of HIV treatment, Antiretroviral Therapy (ART).

2.3.1 HIV Counselling

The BMJ, (2001) HIV counselling and the psychosocial management of patients with HIV or AIDS said that counselling helps people to define for themselves the nature of the problems they are facing. They can then make realistic decisions about what they can do to reduce the impact of these problems on themselves, their family and friends. Helping people to achieve the confidence to make lifestyle changes is an integral part of the counselling relationship. Effective counselling should occur where people most need it and should not be. So, HIV/AIDS counselling is important in HIV prevention, care and treatment sectors such as Pre-test and Post-test of HIV testing and Services, notifying past and current partners, sexually transmitted Infections (STI) and Hepatitis C testing, Pre-exposure Prophylaxis (PrEP), Post-exposure Prophylaxis (PEP), disclosure to children on HIV status, Adolescent preparedness, Prevention of Mother to Child Transmission (PMTCT) and HIV treatment adherence counselling.

A wide range of people can play a role in the provision of HIV/AIDS counselling. These people include: Doctors, nurses, community health workers, social workers, and other care-providers who have been specially trained in HIV/AIDS counselling. Some of these trained individuals may also act as "focal points" and educators for counselling services in their province, district, or community; Full-time counsellors (e.g. psychologists, psychiatrists, and therapists) who have been trained in HIV/AIDS counselling, and who may receive clients directly, or who may receive clients through referral by other care-providers; Religious leaders and other community-based workers who work consistently with people in confidential situations and with emotional concerns; Trained community members, members of AIDS support groups, and other people living with HIV/AIDS.

2.3.2 Diagnosis of HIV infection

HIV testing services (HTS) is the initial diagnose for HIV infection. The overarching goals of HIV testing services are to: identify people with HIV through the provision of quality services for individuals, couples and families, link individuals and their families to appropriate HIV treatment, care and support, as well as HIV

prevention services, based upon their Cero status, support the scale-up of high impact interventions in Myanmar to reduce HIV transmission, morbidity and mortality, including early access to antiretroviral therapy (ART), prevention of mother-to-child transmission (PMTCT), post-exposure prophylaxis (PEP), Pre-exposure Prophylaxis (PrEP) and other interventions.

2.3.3 Principles to all HIV Testing Services

The 5 Cs are principles that apply to all HIV Testing Services and in all circumstances:

Consent: People receiving HTS must give informed consent to be tested and counselled. (Verbal consent is sufficient; written consent is not required.) They should be informed of the process for HIV testing and counselling and of their right to decline testing.

Confidentiality: HTS must be confidential, meaning that what the HTS provider and the client discuss will not be disclosed to anyone else without the expressed consent of the person being tested. Although confidentiality should be respected, it should not be allowed to reinforce secrecy, stigma or shame. Counsellors should discuss, among other issues, whom else the person may wish to inform of their sero-status and how they would like this to be done. Shared confidentiality with a partner or family members - trusted others - and health-care providers are often highly beneficial.

Counselling: Pre-test information can be provided in a group setting if appropriate, but all persons should have the opportunity to ask questions in a private setting if they request. All HTS must be accompanied by appropriate and high-quality post-test counselling, based on HIV test results. Quality assurance (QA) mechanisms as well as supportive supervision and mentoring systems should be in place to ensure the provision of high-quality counselling.

Correct: Providers of HTS should strive to provide high-quality testing services, and QA mechanisms should ensure that people receive a correct diagnosis. QA may include both internal and external measures and should include support from the national reference laboratory. All people who receive a positive HIV diagnosis should be retested to verify their diagnosis before initiation on ART or engagement in HIV care.

Connection: Linkage to prevention, care and treatment services should include the provision of effective and appropriate follow-up as indicated, including long-term prevention and treatment support.

2.4 Factors of influencing on HIV counselling

Counselling in HIV and AIDS has become a core element in a holistic model of health care, in which psychological issues are recognised as integral to patient management. HIV and AIDS counselling has two general aims: (1) the prevention of HIV transmission and (2) the support of those affected directly and indirectly by HIV. It is vital that HIV counselling should have these dual aims because the spread of HIV can be prevented by changes in behaviour. One to one prevention counselling has a particular contribution in that it enables frank discussion of sensitive aspects of a patient's life—such discussion may be hampered in other settings by the patient's concern for confidentiality or anxiety about a judgmental response. Also, when patients know that they have HIV infection or disease, they may suffer great psychosocial and psychological stresses through a fear of rejection, social stigma, disease progression, and the uncertainties associated with future management of HIV. Good clinical management requires that such issues be managed with consistency and professionalism, and counselling can both minimise morbidity and reduce its occurrence. All counsellors in this field should have formal counselling training and receive regular clinical supervision as part of adherence to good standards of clinical practice. (The Avert, UNAIDS data, 2017)

2.5 HIV peer Counseling

Kanters S, Park JJ, Chan K, Ford N, Forrest J, Thorlund K, Nachega JB, Mills EJ, (2016) Use of peers to improve adherence to antiretroviral therapy: a global network meta-analysis said the people, who are respected by the community, engender a sense of trust and respect with the people with whom they are working, and are willing to receive the specialized counselling training are the ideal selection to become HIV/AIDS counsellors. Our analysis showed that peer support leads to modest improvement in adherence. These modest effects may be due to the fact that in many settings, particularly in LMICs, program already includes peer supporters, adherence clubs and family disclosures for treatment support. Rather than introducing

new interventions, a focus on improving the quality in the delivery of existing services may be a more practical and effective way to improve adherence to ART.

HIV service providers utilize peer-to-peer HIV counselling. They employ HIV positive individuals as paid counsellors and volunteers. To mitigate the consequences of social stigma and to provide HIV positive individuals with work opportunity, the peer-to-peer HIV counselling serves to allow patients to comfortably discuss at-risk behaviours and ask questions pertaining to their illness and lifestyle in a non-judgmental, understanding environment. HIV counselling is free of charge but mandatory before a patient may be assessed and referred for ART at these organizations and after the Antiretroviral Treatment (ART) for treatment adherence to avoid lost to follow up and being defaulter.

Asia Pacific Network of People Living with HIV/AIDS (APN+, 2009) Access to HIV-related health services in positive women, MSM, transgender and IDU, research finding highlights, August 2009 Report mentioned that research done in other countries has shown that barriers to HIV treatment access include a lack of adequate knowledge about ART, poor information on the availability of ART services in their local areas, limited financial resources (for treatment, laboratory testing and transportation), distance to ART facilities, provider attitudes, denial of health services and fear of drug interactions and side-effects. Although PLHIV network and self-help groups may not have much medical expertise, they can play strategic roles in encouraging and supporting PLHIVs to obtain proper treatment and to adhere to their treatment regimens. Also, no one is in a more suitable position than they are, as peers, to gather information about the treatment, care and support needs of spouses and partners. PLHIV peer can play a vital role in positive prevention strategies. PLHIV networks and self-help groups are, therefore, an excellent resource for the scale up of HIV treatment and care. A guide note from the Asia Pacific Network of People Living with HIV/AIDS (APN+) recommended government institutions, non-government organizations (NGOs), community-based organizations (CBOs), donors, and other institutions forge stronger partnerships with PLHIV organizations and groups.

Asia Pacific Network of People Living with HIV/AIDS (APN+, UNDP, 2016) Working in partnership with networks of people living with HIV in Asia and the Pacific, a guidance note for development practitioners noted that experiences in other countries have demonstrated that partnerships and coalitions between positive communities and other stakeholders benefit both sides and create effective

collaborative responses to HIV. In South Africa, for instance, the existence of extensive networks of community-based treatment monitors from different geographical areas significantly reduced loss to follow-up of ART patients and strengthened ART adherence.⁶ Moreover, PLHIV networks and SHGs can provide links between HIV positive people seeking treatment, and existing service providers, thereby leading to improved target group access, follow-up and feedback in care and support initiatives. For example, in Pakistan, the New Light AIDS Control and Awareness Society (a HIV positive people's network) acts as a bridge between positive people seeking treatment and service providers.

2.6 Reviews on Previous Study

Wai Myint (2015) studied fruitful benefit on HIV response in Prevention of Mother to Child Transmission of HIV/AIDS (PMCT) Program in “A study on the effectiveness of Myanmar Maternal and Child Welfare Association volunteer's performance in Prevention of Mother to Child Transmission of HIV/AIDS”. The main objective of this study is to assess the knowledge, attitude and practice of pregnant women, spouses and family members in the community where PMCT project were implemented regarding HIV/AIDS. It was found that by giving proper antenatal care, institutional safe delivery, post natal care and infant feeding can reduce HIV infection in their infants. The study reveals the Knowledge, Attitude and Practice of pregnant women, their spouses and family members become HIV/AIDS more positive effect on behavior change.

Khin Thuzar Win (2008) studied on the status of knowledge, attitude and behavior of young people toward HIV/AIDS in “A study of young people's knowledge on HIV/AIDS in Myanmar”. The main objective of this study was to identify knowledge, attitude and behavior (KAB) of young people towards HIV/AIDS in Myanmar and specific objectives were to know the status of Knowledge, Attitude and Behavior (KAB) of young people toward HIV/AIDS in selected area and to utilize the information and data collected for implementing HIV prevention programmes for young people. This study found that respondents have heard about HIV/AIDS knowledgeable on HIV prevention and transmission. But the practice on three ways of prevention in sexual related on HIV, ABC; abstinence from sex, being faithful to single uninfected partner and consistent condom use that the significant percentage of respondents shown on not practicing for two ways of prevention on

sexual transmission among three for abstinence and consistent condom use. Their knowledge on correctly rejecting the common misconception of HIV is also very high. But there is need for awareness programmes on prevention. Young people need to increase their health seeking behavior. School teacher need to be trained to acquire skill to teach HIV/AIDS issue more comfortably and parents also need to be encouraged to discuss more openly about HIV/AIDS.

Su Aung, Priya Hirway, Fai Zervou, Htun Nyan, Aung Kyaw, Min San Tun, Khaymar Win Aung, Rami Kantor, and Aadia Rana (2016), conducted a research on effectiveness of peer to peer counseling on HIV comparing with standard counseling by assessing on people living with HIV community in Myanmar for their knowledge, attitude and barriers in a study “Effectiveness of Peer-To-Peer HIV Counseling in Myanmar: A Measure of Knowledge, Attitudes, and Barriers”. The main objective of this study is to perform a knowledge, attitude, and barrier to care assessment among peer HIV counselors and HIV patients via a self-administered questionnaire in Yangon; Myanmar. This will assess the overall understanding of disease, the importance of follow-up care and compliance to therapy, and satisfaction with the counseling experience. The goal of the study is to determine if there is a need to enhance training amongst the counselors based on the results of their knowledge assessments and to evaluate if peer-to-peer counseling leads to a better understanding of the disease and adherence to treatment. This study founded that the knowledge scores were slightly higher for the respondents group who received peer to peer counseling compared to patients in the standard counseling. The treatment adherence of ART clients reported clients in peer to peer counseling loops are better than the clients in standard counseling. The level of stigma was low in internalized among clients of peer counseling and the externally enacted stigma is nearly the same. The patients of peer counseling report the highest level of satisfaction with their social support compared to standard counseling patients.

CHAPTER III

OVERVIEW OF HIV TREATMENT, CARE AND SUPPORT IN MYANMAR

3.1 HIV Situation in Myanmar

The Avert, UNAIDS data (2017), Global information and education on HIV and AIDS, HIV AIDS in Myanmar 2018 indicated that Myanmar has a population of 53 million people, of which UNAIDS estimates there were 220,000 people living with HIV in 2017. A further 6,700 people died from AIDS-related illnesses in the same year. Between 2010 and 2017, the number of AIDS-related deaths has fallen by an estimated 49% as a result of antiretroviral treatment coverage in Myanmar. After Thailand, Myanmar has the second highest prevalence in Southeast Asia at 0.7% and shares similar key populations of people most affected by HIV. These include men who have sex with men, male and female sex workers and people who inject drugs and their intimate partners. Despite a general decline in new infections across Asia, gains in some countries have been offset by rising epidemics in places such as Myanmar where funding of effective primary HIV prevention has been insufficient.

Table (3.1) HIV Country Profile in Myanmar (2017)

Indicators	Values
People Living with HIV	220,000
Adult HIV prevalence (age 15-49)	0.7%
New HIV infections	11,000
AIDS-related deaths	6,700
Adult on antiretroviral treatment*	65%
Children on antiretroviral treatment*	91%
*All adults/children living with HIV	

(Source: UNAIDS Data 2018)

This table has shown by UNAIDS Data (2018), the HIV country profile in Myanmar for 2017 indicated that in 2017, a total number of People Living with HIV in Myanmar is 220,000, the HIV prevalence rate among adult age between 15 and 49 is 0.7%, the new HIV infection cases in one year is 11,000, the number of cases on AIDS related deaths within one year is 6,700, the percentage of adult on antiretroviral treatment among all adults living with HIV in 2017 is 65% and the percentage of children on antiretroviral treatment among children living with HIV in 2017 is 91%.

As such, Myanmar is now one of 35 countries which together account for 90% of new infections globally. Myanmar had 11,000 new infections reported (approximately 30 infections per day) in 2017. Although this number of new infections remains steady compared to the two years before, observations show that the annual rate of infections is no longer declining at the same rate it did between 2000 and 2010. New infections are mostly found in urban areas or areas where drug use is endemic. For example in the country’s largest city, Yangon (formerly known as Rangoon), there appears to be a higher rate of partner change, a higher rate of buying sex and injecting drugs, lower knowledge on HIV transmission and prevention, lower contact by outreach workers and a lower rate of condom use, all resulting in higher HIV prevalence.

3.1.1 Key affected populations in Myanmar

Table (3.2) HIV population among key population groups in Myanmar (2017)

Key Population Groups on HIV	Prevalence
People who Inject Drugs	27.9%
Men who have Sex with Men	6.4%
Prisoners	5.6%
Female Sex Workers	5.4%

Source: UNAIDS Data 2018, Avert, www.avert.org

This table mentioned the HIV population among key population groups on HIV in Myanmar for 2017 that the prevalence of People who inject drugs is 27.9%, the Men who have sex with men is 6,4%, the prevalence among prisoners is 5.6% and the rate of prevalence among Female Sex Workers is 5.4%. (UNAIDS Data 2018)

(a) People who inject drugs (PWID)

In 2017, HIV prevalence among people who inject drugs (sometimes referred to as PWID) was by far the highest out of all of the key affected populations at 34.9%. In the previous year, people who inject drugs also presented the highest HIV incidence, accounting for 20–65% of adults, aged 15 to 49, and testing positive for new infections. Analysis suggests that infection occurs at an early age among those who inject drugs, with 16.8% of those under the age of 25 already testing positive. These findings have bolstered the argument that the risk associated with injecting drug use and HIV vulnerability should make the case for developing more youth-targeted programs. Although the burden of HIV prevalence has been limited to urban towns and cities, injectable opium use is endemic with rates of high HIV prevalence evident in the more rural northern and north-eastern areas of the country where the drug is produced. For example, in Waingmaw in Kachin State, HIV prevalence among people who inject drugs was particularly high at 47% during 2014. Distribution of drugs from this region also has contributed to new HIV infections developing in more remote areas of the country, providing additional challenges to expanding the coverage of harm reduction and HIV services. Less than 50% of people who inject drugs report regular testing for HIV and less than a quarter of those asked in 2016 reported consistent condom use. However, 90.8% of people who inject drugs report using sterile injection equipment for their last injection.

(b) Men who have sex with men (MSM)

HIV prevalence (6.4%) among gay men and other men who have sex with men (sometimes referred to as MSM) has continued to remain a concern in Myanmar, with rates particularly high in many cities and urban areas such as Yangon (26.6%). This is highest recorded rate of prevalence for this group in the Southeast Asia region, even higher than Bangkok, Thailand (24.4%). Myanmar's National Strategy Plan recognizes that these rates are alarming and present an immediate call to scale up targeted services in high burden geographical locations. There appears to be an increased risk of HIV infection within the most sexually active age group (25-49 year olds) where prevalence of HIV is significantly higher than average. Prevalence peaks at 25% for the 35-39 age group. Stigma and discrimination continues to contribute to the low levels of access to HIV services, with just 50%-75% of men who have sex with men reporting having an HIV test in 2015. Consequently, in 2017, just over half

(52.4%) of those living with HIV knew their status. Most recent statistics record 77% of gay men and other men who have sex with men reporting condom use with their last male partner. However, male-to-male sexual dynamics are complex in Myanmar, and risk behaviors can vary between self-categorized groups of men who have sex with men. Although Myanmar has a relatively visible LGBT community, existing laws which criminalize same sex behavior in Myanmar keep many people hidden from the reach of healthcare service providers. Moreover, a lack of legal gender identity recognition in the country often means that transgender people are wrongly categorized as men who have sex with men and are commonly not offered the appropriate link to targeted HIV services. These observations have informed the country's National Strategic Plan to develop a more appropriate future framework for effective responses to intertwined gender identities, sexual orientations and behaviors. By 2020 the new strategy aims to reach more 'non-disclosed' men who have sex with men by expanding services through innovative social media, test-and-treat campaigns and proactive community-led outreach linked to services which are friendly towards men who have sex with men and transgender persons.

(c) Sex workers

Sex workers who knew their status stood at 44.6% and HIV prevalence among female sex workers was over 5.4% in Myanmar in 2017. In Myanmar's major cities, HIV prevalence was much higher - 24.6% and 13.7% in Yangon and Mandalay respectively - representing some of the highest HIV prevalence locations in the Southeast Asia and Pacific region.

(d) Migrants

Myanmar is home to over 100 different ethnic groups and shares its borders with two of the most populated countries in the world, India and China, in addition to Bangladesh, Laos and Thailand. The last census (2014) estimated that over 11 million residents have migrated internally or externally. Some critics are concerned that increasingly open borders make Myanmar more vulnerable to HIV incidence with the increase of migrants coming from bordering high-prevalence countries. As HIV testing is not a condition for entry, work or residence in Myanmar, there is not much comprehensive information available on HIV prevalence or risk behaviors associated with the migrant population. Nevertheless, in 2014, the IOM data project did find that

18% of people identifying as migrants in Mon and Kayin states were HIV positive - although it is difficult to assess if the point of infection happened within country. However, it is broadly assumed that migrants might face residency and social restrictions that limit their access to HIV programming services, as well as other general forms of healthcare. Since 2014, HIV awareness campaigns that target large migrant populations have been created to address these issues. The National Strategic Plan proposes developing specific packages for people near transit points in addition to cross-border referral mechanisms and agreements to strengthen access to health services in destination countries.

3.1.2 HIV testing and counseling (HTC) in Myanmar

Unfortunately, there has been no new behavioral data on HIV testing among the general population in Myanmar since 2007 when it was recorded at 11.3%. As such, there is an urgent need for strengthening the involvement of community networks in the planning and monitoring of testing services. In 2014, among key affected populations, the estimated testing coverage was also still far from optimal with only 34% of female sex workers, 27% of people who inject drugs, and 20% of men who have sex with men accessing testing services. Myanmar's most recent National Strategic Plan, launched in 2016, aims to promote early HIV testing and counseling in line with WHO recommendations, and to close the testing gap by prioritizing townships with a high epidemic burden and centralizing the provision of HIV counseling and testing to become a local public health sector concern.

3.1.3 HIV prevention program in Myanmar

(a) Harm reduction

Research consistently shows that harm reduction program - such as needle and syringe exchange program and opioid substitution therapy – are the most effective ways of reducing the spread of HIV among people who inject drugs. However, because the scale of drug use in Myanmar is particularly extensive, existing harm reduction services fail to meet the escalating demand by people who inject drugs. For example, in response to a 2014 study which estimated that the reported re-use of needles varied from 16% in Mandalay to 63% in other areas, there were 18 million sterile needles and syringes distributed free of charge during the next year. Despite

these efforts, the coverage of additional needles was not enough. Based on typical injecting practices involving 2-3 daily injections, around 60-90 million additional needles would be needed. So there continues to be a major gap for the 93,000 people who inject drugs in Myanmar. The government has recognized this need to scale up their commitment to strengthening harm reduction services, and has since allocated an additional US\$1 million (as part of the US\$11 million domestic funding commitment towards HIV services) for methadone as a form of opioid substitution. However, critics suggest that this sum will not be enough to curtail the growing dependency on drug use within the country.

3.1.4 Preventing mother-to-child transmission (PMTCT)

HIV counseling and testing services for all pregnant women have been integrated into antenatal services across the country, which presents a much more successful model of implementation compared to other countries within the Southeast Asia region. As a result, more than 900,000 pregnant women received pre-test counseling and more than 700,000 took an HIV test and received post-test counseling during 2015. In 2015, 3,923 HIV-positive pregnant women received ART to reduce the risk of mother-to-child transmission, but only 39% of these were put on lifelong treatment (Option B+) as recommended by the WHO, with the rest only put on treatment while pregnant and breastfeeding. In 2017, overall ART coverage among pregnant women living with HIV to prevent mother-to-child transmission was estimated to be 78%, with 4,383 women receiving antiretroviral therapy and a further 5,600 women in need. Routine monitoring continues to be an area of weakness - as it is across most testing, prevention and treatment services in Myanmar. Early infant diagnosis stands at just 28% with less than 1,000 new HIV infections averted due to PMTCT care. Myanmar's National Strategic Plan suggests that there is a critical need for better collaboration between health services to integrate early infant diagnosis into post-birth care in order to establish a fully comprehensive PMTCT cascade.

3.1.5 Antiretroviral Therapy (ART) availability in Myanmar

According to UNAIDS, 146,826 (or 66%) of all people living with HIV in Myanmar have access to antiretroviral treatment (ART). It is worth noting that this figure has more than doubled (from 24%) in 2012 (NSP), and has brought the country up to speed with the treatment rate of people living with HIV in the rest of the

Southeast Asia region (41%). As a result, the country has witnessed the number of AIDS-related deaths fall by an estimated 49% to 6,700 in 2017 as ART coverage has expanded in the last six years. Nevertheless, despite improvements in treatment access, Myanmar is still a high burden country with limited availability of viral load testing and HIV drug resistance testing for monitoring patients who are on first-line as well as second-line ART.

3.1.6 Civil society's role and HIV in Myanmar

The legacy of military rule and restrictions on the financing and operations of civil society in Myanmar hinder efforts to provide support to people living with HIV and populations at risk of HIV but progress is being made. The Myanmar Positive Group-MPG, a national network of people living with HIV, promotes networking between individuals and self-help groups, works to reduce stigma and discrimination, and advocates for peoples' rights to access treatment and quality services. In 2015, there were 177 networked self-help groups of people living with HIV; there was no update as of September 2018.

3.1.7 HIV and tuberculosis (TB) co-infection in Myanmar

Myanmar is one of 14 countries that carry a high burden of TB/HIV co-infection (of 30 countries globally) as well as multi-drug resistant TB and TB infection. The number of TB-related deaths among people with HIV was 4,900 in 2016 up 2,000 from 2015. In 2016 the World Health Organization (WHO) and UNAIDS carried out an in-depth review of the status of tuberculosis and HIV co-infection in Myanmar. Co-infection of TB and HIV remains a serious public health issue and was responsible for around 4,100 deaths in Myanmar in 2014 (of the estimated 32,000 deaths for all TB forms). The key recommendations of the 2016 review shared with the Ministry of Health focused on the importance of strengthening collaboration between HIV and TB National Program, through improved information sharing, joint procurement and adequate deployment of human resources. Furthermore, increasing and decentralizing the number of health facilities which provide joint screenings and treatment of patients for HIV and TB at all levels of the health system (through scaling up of services and employing mobile teams particularly in high burden areas) are central to ensuring that these diseases and co-infections are detected early, properly treated and further reduced.

3.1.8 Barriers to the HIV response in Myanmar

(a) Financial barriers

Total health expenditure in Myanmar (2-2.4% of its GDP) is among the lowest in the Southeast Asia and Western Pacific regions, which goes some way to explaining the country's HIV incidence. An analysis of countries from different regions, and with varying epidemic patterns, found that Myanmar was among the countries where funding of effective and focused primary HIV prevention was insufficient. In 2015, the country committed US\$ 11 million in domestic funding towards HIV program while relying on an additional US\$ 71.8 million from international donors. Further findings from the National AIDS Spending Assessment (NASA) indicate that while more than 20 donors provide additional financial support for healthcare in Myanmar, only a few are committed to funding HIV-specific program. Of these, the Global Fund provides around half of the existing funding towards such program (investing a total of US\$ 266 million between 2009 and 2017).

(b) Structural barriers

There are plans to move HIV treatment services to government have not yet addressed critical supply chain and human resource needs in order to make such transitions viable. This means that key affected populations, such as people who inject drugs, are being left behind in terms of service reach. As well as these limitations, service delivery and supply chains are set up to operate separately within the healthcare system which means that human resources such as community health workers and service delivery at health facilities remain distinct from one another. The above are compounded by lack of assurance and oversight by the Principal Recipients, Country Coordinating Mechanism and Local Fund Agent.

(c) Legal barriers for sex workers

Sex work in Myanmar is illegal. Fear of prosecution, harassment and blackmail all reduce access to services such as HIV testing which, in 2016, was only accessed by 50% of sex workers in the country. Until 2011, even carrying a condom could be used as circumstantial evidence if a sex worker was detained by the police. More recent records from 2017 still indicate that just 81% of sex workers reported condom use with last client.

One day, the police detained me and I had to pay a MMK 50,000 fine for my release next day. If I did not pay, I could be detained, sued and jailed. - *Sex worker, Myanmar*

Legal penalties for commercial sex work are just one of many social and structural barriers alongside cultural stigma, discrimination and violence – preventing sex workers accessing necessary HIV prevention and treatment services.

(d) Stigma and discrimination

There is currently no welfare or job support for people living with HIV in Myanmar, and many face family or community rejection as a result of their status. Stigma within communities largely appears to stem from a lack of public health education and misconceptions on how the infection is spread.

We've seen cases where if someone looking after a patient with HIV dies while the patient is unwell, other people don't want to take care of the person with HIV anymore. - *Soe Yadanar, Medecins Sans Frontieres (MSF)*

This stigma also persists within healthcare systems themselves, with reports of institutional neglect by nurses and doctors also being cited by patients living with HIV. For example, in one 2015 report assessing hospital conditions of people living with HIV in Myanmar and Cambodia, it was found that some patients were relegated to segregated waiting areas and bed spaces after their status was discovered. The same report also discovered much more serious allegations by women living with HIV who were forced by healthcare providers into making sterilization a condition for accessing pregnancy-related services. In one instance in the city of Yangon, they also found that one woman was sterilized without her knowledge or consent.

3.1.9 Funding for HIV in Myanmar

Myanmar is a UNAIDS fast-track country with a severe epidemic. Historically, the private sector -through international and local NGOs - has played a major role in service delivery. The current national strategic plan (NSP III 2016-2020) is focused on the development of sustainable partnerships which calls for the public and private sector, and communities to jointly design, deliver, monitor and evaluate services. Resource need is estimated at US\$460 million, a 16% decrease from the total funding need of the previous plan. The decrease is due to, 'streamlined costs that will enable efficient strategic scale-up of priority needs and strengthening of cross-cutting components'. The single largest external financing source of the HIV response

in Myanmar has been the Global Fund, amounting to 50% of total funding (external and domestic sources) in 2015. Other more limited external sources include the 3MDG Fund (a multi-donor trust fund that pools the contributions of seven bilateral donors), PEPFAR, Asian Development Bank (ADB), and international and local NGOs. The decreasing trend in external funding for HIV in Myanmar continues. In 2015, the Government of Australia withdrew support to the health sector and in 2017, the 3MDG Fund wound up, leaving a large gap in resources for HIV prevention, particularly for one of the most key affected populations: people who inject drugs. In 2018, increased financial commitments and management responsibility from the Government to a more integrated HIV response and a rapid expansion of services have also raised concerns about how to optimize resources and bridge gaps in service quality. Successful implementation requires an increase in national resources that is beyond the capacity of the Government and donor commitments.

3.1.10 The future of HIV in Myanmar

The Avert, UNAIDS data 2017, Global information and education on HIV and AIDS, HIV AIDS in Myanmar 2018 indicated that there are plans for Myanmar to develop a model for pre-exposure prophylaxis (PrEP) as a prevention method for populations at substantial risk of HIV infection. However, some critics suggest that treatment access for those living with HIV should be prioritized first before implementing new methods in prevention.

Myanmar is a country where only 60% of people living with HIV can access treatment; WHO describe universal access to treatment as minimum 80% coverage. It's a heavily resource-constrained setting and there isn't the capacity to deliver PrEP appropriately. *Associate Professor Mark Stoové from the Burnet Institute*

An initial assessment testing the acceptability of PrEP in Myanmar during 2016 found that although 39% of men would be willing to use it, the cost of the drug was a barrier. The report also suggested that, because sex between men is still illegal in Myanmar, it is unlikely that PrEP would be accessed through government systems and would instead have to be administered in safer social environments by NGOs or community-led services. Like many other low- and middle-income countries, there is a long way to go if Myanmar is come close to the UNAIDS targets for ending the epidemic by 2030. However, there is some optimism that targets for reducing

transmission and increasing treatment can be achieved with increased national and international funding and support.

3.2 Current HIV Counseling in Myanmar

Historically, the private sector through international and local NGOs has played a major role in HIV service delivery in Myanmar. However, in recent years the Government has become a stronger and more active provider of HIV services, managing 27% or more than US\$22 million in 2015. A major transition is planned during the National Strategic Plan on HIV and AIDS Myanmar III (2016-2020) - NSP III, with the Government taking a larger leadership role in implementation and management. The Government plans to increase its role with an aim to support a large increase in number of ART patients receiving care in the public sector. So, the role of peer PLHIV counselors will be critical in treatment adherence of clients in public sector, ART service centres.

Myanmar has been a 63% increase in the availability of ART facilities with 82 public sector ART initiation sites and 137 decentralized sites providing ART maintenance. ART coverage has doubled, reaching over 47% of estimated number of people living with HIV in 2015, or 106490 individuals.

3.3 National Strategic Plan on HIV and AIDS Myanmar (2016 – 2020)

The Republic of the Union of Myanmar, Ministry of Health and Sports, (2017), the National Strategic Plan on HIV and AIDS (2016-2020) published that the Republic of the Union of Myanmar's National Strategic Plan on HIV/AIDS 2016–2020 is the strategic guide for the country's response to HIV at national, state/regional and local levels. The Ministry of Health and Sports of Myanmar launched the country's latest five-year HIV plan on 2017 May. The plan provides a road map on how to Fast-Track the national HIV response and end the AIDS epidemic as a public health threat by 2030. Myanmar is one of the 35 countries accounting for 90% of new HIV infections globally. The new plan adapts global Fast-Track Targets to the local context to ensure an effective, cost-effective and high-impact HIV response. Locations are prioritized based on their HIV epidemic and risk of new HIV infections and service delivery approaches are tailored to reach priority populations and speed up access to services. The ambitious plan aims to ensure the 90–90–90 targets whereby 90% of people living with HIV know their HIV status, 90% of people who

know their HIV-positive status are accessing treatment and 90% of people on treatment have suppressed viral loads are met by 2020. The plan also aims to ensure that 90% of key population access HIV prevention services and that 90% of people living with and affected by HIV report zero discrimination, especially in health, education and workplace settings.

This strategy builds upon Myanmar's political commitment and the achievements of the previous HIV NSP II, and is aligned with the Three Ones principles and guides the country to focus on geographical, population and intervention priorities to ensure the greatest impact. The strategy aims to promote and protect human rights and gender equity particularly for those key populations most affected by the epidemic including people living with HIV, people who inject drugs, men who have sex with men, sex workers, and their intimate partners. The strategy aims to eliminate stigma and discrimination and ensure maximum access to essential HIV services and social protection. Despite significant progress, challenges remain: a large proportion of people living with HIV in Myanmar do not know their HIV status, while stigma and discrimination and late diagnosis present substantial barriers to improving health outcomes. Approximately half of the people living with HIV are still not receiving life-sustaining antiretroviral therapy (ART). NSP III describes an operational model that prioritizes townships based upon a thorough analysis of the geographical distribution of epidemic burden and those at risk of HIV infection. Three township categories are described with tailored service delivery packages based upon epidemic burden and the opportunity to reduce risk of new infections. NSP III is a highly focused, cost efficient strategy to ensure that the right interventions are implemented in the right places for the right people. NSP III will support resource development and its allocation to ensure the greatest impact. This strategy will build sustainable partnerships through the public, community and private sectors to ensure maximum involvement of priority populations and to optimize access to HIV prevention, care and treatment. A significant transition is planned to bolster the Government's leadership role in collaboration with affected communities and in partnership with the NGO, community and private sectors. Innovation will be supported to ensure cost efficiency and effectiveness in the context of available resources. NSP III will support Myanmar in reaching its sustainable development goals and will support universal access to health through evidence informed and results oriented approach based upon local epidemic dynamics. It is driven by the vision to end HIV as a public health

threat by 2030 and is in line with Myanmar's economic and development goals to ensure prosperity and a greater quality of life for all.

The NSP III (2016-2020) mentioned as Priority Intervention 3.3 for its strategic direction 3 that Strengthen the community to be engaged in service delivery, including reducing stigma and discrimination and improving legal and policy frameworks people living with HIV (PLHIV) support each other and services such as health facilities, drop-in centres and other community settings to reinforce positive prevention, ART adherence and case management. In addition, PLHIV groups often jointly organize and implement economic activities, such as income-generation and vocational training. Community-based ART distribution schemes will be piloted. Civil society will also be supported to be actively involved in the formulation of HIV plans, policies and program; in research; in reducing HIV-related stigma and discrimination; and in supporting legal and HIV-related human rights.

3.4 Guideline for Clinical Management of HIV Infection in Myanmar

Department of Public Health, Ministry of Health and Sports, Myanmar (2017), the *Guidelines for the Clinical Management of HIV Infection in Myanmar* as Fifth Edition stated that HIV is now a treatable condition and the majorities of people who have HIV remain fit and well on treatment. Despite this, a significant number of people are unaware of their HIV status and remain at risk to their own health and unknowingly passing their virus to others. Late diagnosis is the most important factor associated with HIV related morbidity and mortality. Patients should therefore be offered and encouraged to accept HIV testing in a wider range of settings.

In 2016, extensive consultations and discussions were held in Naypyitaw and Yangon on the adaptation of the Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach (WHO, 2016), with active participation of all stakeholders. Under the leadership of the National AIDS Programme, the core writing group was formed and drafted these Guidelines for the clinical management of HIV infection in Myanmar: Fifth Edition. These guidelines aim to guide all health care providers in Myanmar, accommodating the situation of different settings in the context of progressive decentralization of HIV services. Notable changes from the previous edition include:

- diagnosis of HIV

- update on the initiation of ART
- new ARV drugs and regimens
- new recommendation on infant prophylaxis
- PrEP and PEP updates
- updates on co-infections and comorbidities management

This Clinical Management Guideline guidance on Adherence of Anti-retroviral Therapy (ART) in HIV counseling - important measure when started ART. Patient should understand that

- ART is suppressive therapy
- ART is life-long
- near perfect adherence is necessary to prevent ART resistance
- there are possibilities of side effects

Assessment of patient readiness should be carried out before starting ART (ART should never be prescribed casually at the first visit). Treatment adherence counseling need to make sure for following points; such as 1) Establish trusting relationship, 2) Provide necessary information and advice, 3) Identify and encourage peer/family/friends/community/support groups' participation, 4) Try to fit in ART into patients' lifestyle and daily events, 5) Discuss cost if patient/family/friends have to pay, 6) Discuss need for regular follow up; patient's address, how he will attend clinic, who will help, cost of travel, 7) Assess readiness and commitment of patients for ART, 8) past ability to attend clinic regularly, 9) past ability to take drugs regularly, e.g. cotri-moxazole prophylaxis, past ability to complete full course of TB treatment if relevant, adequate understanding of what is involved, 10) Treatment adherence, at least 95% to the recommended regimens, should be emphasized. This means that missing more than 3 doses per month (with 1 BD regimens) is associated with risk of developing drug resistance.

If regular doses are missed or late, reinforce adherence counseling may need to enlist help from peers, family etc. Timing of drug intake is crucial. E.g. BD drugs are taken every 12 hours +/- one hour. Missed doses can be taken up to 6 hours in a BD regimen. If > 6 hours late, skip dose and take next normal dose. If the patient is on OD dose, drug is taken every 24 hours. Missed dose can be taken up to 12 hours in OD regimen. If >12 hours late, skip dose and take next normal dose. Drug side effects have to be understood and explained in advance. Do not acquire drugs only when the

supply runs out. Always keep some spare pills for emergencies. People on ART still need to use condoms. Herbal products may interact with ART. Regular clinic attendance for monitoring of efficacy and adherence is essential. Treatment regimen should be simplified by reducing the number of pills, reducing the number of dosing and minimizing side effects. Fixed dose combinations are very useful. At every clinic visit, check the following: 1) Number of doses missed in last 3 days, 2) Number of doses missed since last visit, 3) If correct doses are taken at correct time, Reason for poor adherence, Reinforce adherence, Use fixed dose combination (FDC) pills if possible. Use of FDCs reduces pill burden and improves adherence. In children, there are also fixed dose combinations. The details of the pediatric regimens based on weight bands and the dispensing guidance is enclosed. Goals of Antiretroviral therapy (ART) is improvement of quality of life and prolongation of life -Reduction of HIV related morbidity and mortality -Greatest possible reduction in viral load (< 50 copies/ml) for as long as possible to stop or delay disease progression -Restoration and preservation of immune function -Minimization of drug side effects -Reduction of HIV transmission.

CHAPTER IV

EMPIRICAL ANALYSIS OF KNOWLEDGE ATTITUDE AND PRACTICE ON PEER COUNSELING FOR HIV PATENTS

4.1 Survey Profile

4.1.1 Area and Sample

A survey was conducted in (9) selected sites of Yangon Region among (45) sites of HIV service centers where peer counselors are working on counseling services for HIV patents.

The participants are HIV positive patients receiving peer HIV counselling at (9) selected sites and age range is 18-70 years with sample size is N = 150 (Patients). Criteria for HIV positive patient respondents are as followings; patients must be aged 18 years or older. They may or may not be completed their peer counselling curriculum offered to them prior to evaluation and referral for receiving anti-retroviral therapy (ART). Patients must be utilizing the services for peer counselling at ART centres. Patients must have decisional capacity to consent for the study. If reading literacy is inadequate to self-administer the questionnaire, patients must understand the questions and answers of the questionnaire if read out loud to them for participation.

In this survey, Requested Participant Description is on Gender, age, level of education, area of residence (rural, sub-rural, sub-urban, or urban for reporting), and approximate date of HIV diagnosis (year).

Table (4.1) Selected sites distribution

Selected sites on HIV Counselling Service	Estimated population of HIV patient	Number of Selected Respondent	Percentage of Selected Respondents
East Yangon District ART centre	320	9	2.81%
Insein ART centre	4376	16	0.37%
Kyimyindaing ART centre	580	6	1.03%

Latha ART center	3030	7	0.23%
Mingalardon ART centre	8658	38	0.44%
Mingalartaungnyunt ART Decentralize Site	547	20	3.66%
North Okkalapa ART centre	858	29	3.38%
Thingangyun ART centre	639	7	1.10%
North Okkalapa Waibargi ART center	1603	18	1.12%

Source: ART facilities with peer supporter, volunteer mapping 2017, UNAIDS

Table (4.1) mentioned that among (9) sites, respondents are selected with purposive sampling method and Mingalardon ART Centre is highest prevalence of HIV patient then other HIV service sites. Insein ART center has secondly highest number of patients and Latha ART Centre is third highest sites among (9) selected HIV service provision Centre.

4.2 Survey Design

This research method design was qualitative method design and a participatory enhancement approach was used to involve people living with HIV from the designing of the research study to the analysis of data to inform an ongoing cycle of participation and reflection.

4.2.1 Questionnaire

In terms of quantitative method design, the questionnaires were developed another intended for patients to evaluate basic HIV knowledge, attitude on the peer counselling and practise to care. The questionnaire was referenced from the permission of researcher for the research of Su Aung, MD, MPH, Jerome Larkin, MD, Htun Nyan, MBBS, Aung Kyaw, BSc., Min San Tun, BSc., Khaymar, MBBS, October 2016, study on “Effectiveness of Peer-To-Peer HIV Counseling in Myanmar: A Measure of Knowledge, Attitudes, and Barriers”. The questionnaire was modify in content by chosen based on guidelines published by the World Health Organization and the Guideline for the clinical management of HIV infection in Myanmar, 5th Edition, National AIDS Program, Ministry of Health and Sports, 2017. No personal identifiers will be collected. If a patient is unable to complete the questionnaire due to literacy level, arrangements will be made to have assistant from researcher for read

the questions to the patient word-for-word. The researcher will then circle the answer verbally provided by the patient.

For the Knowledge assessment on HIV patients, respondents, the percentage of correct answers are being reported. Greater than 90% correct among the knowledge assessment questions will be considered the adequate cut-off in determining the basic knowledge level of an HIV patient attaining from peer to peer counselling sessions. The responses will be stratified by the length of time since diagnosis, level of education, gender, age, general location of residence (rural, sub-rural, sub-urban, or urban), subjective mode of transmission and level of social support. Significant variations within any of these strata will be reported.

Attitude on the peer counseling assessment was depended variables justification to implement modifications to the counselling training in any of the following areas: HIV knowledge, interpersonal skills, duration of training, psychosocial support training, provision of referrals to helpful resources, and so forth. This will serve to enhance knowledge and attitudes among the patients receiving counselling, build morale, and decrease barriers to receiving appropriate care.

Practice on care assessment is mainly collected HIV knowledge assessment scores will effect to attitudes and practise of HIV patients regarding the counselling experience from the receiving end, and identification of their practise and barriers to care.

4.2.1 Data Collection

For Data Collection, recruitment of patients was done by distribution of the flyers regarding the study informed to patients while they come for counselling services from peer counsellors at ART service centres and ask if the patient would participate by completing an anonymous questionnaire. Patients will be recruited during their scheduled of visits over a period of 2 months May and June 2019. As patients arrive to their visit, they will be given a study information flyer as well as the recruitment statement. Upon receipt of verbal consent, the questionnaire will be administered in a private location within the hospital. Expected duration of survey is 30 minutes to 1 hour.

Completed self-report measures are described as tabulated. For questions measuring knowledge assessment, a single point will be allotted to each question. No single question will be weighed higher than others.

The study involves minimal risk. Participants will be explained that voluntary non-participation in the study will not affect their employment or services in any way. Participants may withdraw from the study at any time prior to submission of completed questionnaires.

The duration of the entire study, including data analysis and submission for publication, is 4 months and duration of data collection was approximately 2 months from May to June 2019 and the duration on data analysis and submission for publication was done by at the end of August 2019.

4.3 Survey Data Analysis

The respondents were interviewed by using structured questionnaires including the questions concerning basic characteristics of age, sex, education, ART status, CD4 count and year on HIV status.

4.3.1 Characteristics of Respondents

Table (4.2) Distribution on Age (Year) for Respondents

Age (year)	Male		Female		Total	
Age 17-35	32	42%	27	37%	59	39%
Age 36-60	43	56%	44	60%	87	58%
Age above 60	2	3%	2	3%	4	3%
Total	77	49%	73	51%	150	100%

Source: Survey Data May 2019

The table (4.2) shown that a total of 150 respondents participated in the study that the 51 per cent of them were female and 49 per cent were male. A majority of the respondents were aged between 36 and 60 years with 58%, 87 respondents that the 60 per cent of them were female, 44 respondents and 56 per cent of them were male, 43 respondents. The 39 per cent of total the respondents, 59 respondents were young people between 17 to 35 years that the second largest number of respondents in this study. There were only 3 per cent as a lowest number of respondents aged above 60 years.

Table (4.3) Distribution on selected HIV service centres and number for Respondents

Selected sites on HIV Counselling Service	Male		Female		Grand Total	
	Number	%	Number	%	Number	%
East Yangon District ART Centre	3	4%	6	8%	9	6%
Insein ART Centre	7	9%	9	12%	16	11%
Kyimyindaing ART Centre	4	5%	2	3%	6	4%
Latha ART Centre	5	6%	2	3%	7	5%
Mingalardon ART Centre	17	22%	21	29%	38	25%
Mingalartaungnyunt ART Decentralize Site	11	14%	9	12%	20	13%
North Okkalapa ART Centre	17	22%	12	16%	29	19%
Thingangyun ART Centre	5	6%	2	3%	7	5%
North Okkalapa Waibargi ART Centre	8	10%	10	14%	18	12%
Total	77	49%	73	51%	150	100%

Source: Survey Data May 2019

Among the total respondents of 150, Table (4.3) has shown the number of respondents on 9 selected HIV service centres with sex. The highest numbers of respondents were 25 per cent from Mingalardon ART Centre, 19 per cent from North Okkalapa ART Centre, 13 per cent from Mingalar Taungnyunt ART Decentralize Site, 12 per cent from North Okkalapa Waibargi ART Centre, 11 per cent from Insein ART Centre, 6 per cent from East Yangon District ART Centre, 5 per cent each from Latha ART Centre and Thingangyun ART Centre and 4 per cent from Kyemyindaing ART Centre.

Table (4.4) Distribution on approximate year of HIV diagnosis

approximate year of HIV diagnosis	Number of respondent	% of respondent
Above 10 Yrs	17	11%
Between 3 - 10 Yrs	47	31%
Between 1.5 - 3 Yrs	19	13%
Under 1.5 Yrs	63	42%
Not answer	4	3%
Grand Total	150	100%

Source: Survey Data May 2019

This survey does not provide the range of knowing their HIV status and Table (4.4) shown the years when patients known his or her HIV status. A total of 150 respondents participated in the study, 5 groups is categorized on years of known on their HIV status. A majority of the respondents nearly 42 percent, 63 respondents were known their HIV status on diagnose for period of under 1.5 years, nearly 31 percent of clients were known their status between 3 to 10 years, nearly 13 percent were known between 1.5 to 3 years, nearly 11 percent were known above 10 years and nearly 3 percent were not answer this question.

Table (4.5) Distribution on Education Level of Respondents

Education	Number of respondent	% of respondent
Unschooler	5	3%
Basic Education (grade 10 or below)	123	82%
Passed high school	11	7%
Vocational School	1	1%
Diploma	2	1%
Obtained Bachelor Degree	6	4%
Obtained Higher than Bachelor Degree	2	1%
Total	150	100%

Source: Survey Data May 2019

This table (4.5) Education Level of Respondents mentioned the highest number of respondents in this survey were middle and primary school levels with nearly 82 percent, 123 respondents of total respondents, nearly 7 percent, 11 respondents passed the 10th Standard, nearly 4 percent, 6 respondents obtained Bachelor Degree and nearly 3 percent did not attend school. Each of Vocational School, some Collage and obtained higher than Bachelor Degree were only 1 percent.

Table (4.6) Distribution on general area of residence of Respondents

General Area of Residence	Number of respondent	% of respondent
Inter City Urban	83	55%
Sub-urban	54	36%
Rural	11	7%
Other	2	1%
Total	150	100%

Source: Survey Data May 2019

Table (4.6) has shown the General area of residence of Respondents that the majority of the respondents in this survey come from the urban city area of 55 percent, 83 respondents and 36 percent, 54 respondents are living in sub-urban area for their residence, 7 percent from rural area and 1 percent from farms in forest.

Table (4.7) Respondents by ART Status and Current CD4 Count

Current CD4 Count	ART Status					
	On ART Number	On ART %	No ART Number	No ART %	Total Number	Total %
Less Than 200	4	4%	7	7%	11	11%
200 – 350	27	27%	20	20%	47	47%
351 – 500	42	42%	5	5%	47	47%
Over 500	37	37%	1	1%	38	38%
Not Sure	5	5%	1	1%	6	6%
Not yet having to CD4 count			1	1%	1	1%
Total	115	77%	35	23%	150	100%

Source: Survey Data May 2019

The table (4.7) has shown ART Status and Current immune system, specifically the number of T cells (CD4) Count in blood that 77% of respondents, 115 patients are being on the Anti-retroviral Therapy (ART) and 23%, 35 clients still in process to initiate ART. Among respondents who are on ART, majority of respondents 42%, 42 clients had their CD4 counts are between 351 and 500. The obvious data indicated in this table are 5%, 5 clients of respondents did not remember their CD4 counts and 4%, 4 clients of respondents had the CD4 count less than 200

even they are on ART. Among the respondents who are still in process to initiate ART, the highest percentage of patients, nearly 20%, 20 clients have CD4 count between 200 and 350 and 7%, 7 clients have the CD4 count less than 200.

Table (4.8) Distribution on attended number of counselling session and completeness of require counselling

Attended number of Counseling Session	Number of respondents completeness on required counseling			
	Yes	No	Don't know	Grand Total
0-3	52	1	2	55
4-6	49			49
7-9	27			27
10-12	11			11
>12	7		1	8
Grand Total	146	1	3	150

Source: Survey Data May 2019

This table (4.8) has shown on comparing of the attended number of counselling session and completeness of require counselling for respondents. The majority of respondent clients who attended the number of counselling session for maximum 3 times are 55 respondents and perception of 52 respondents are regarding on required counselling for them are completed. Then 49 respondents were received 4 to 6 times for counselling session, 27 respondents were received 7 to 9 times for counselling session

Table (4.9) The Most receiving knowledge regarding HIV

The most receiving knowledge regarding HIV	Number of respondent	% of respondent
My peer Counselor	111	74%
My Doctor	21	14%
My Friends	11	7%
My Family	3	2%
Myself	4	3%
Total	150	100%

Source: Survey Data May 2019

The table (4.9) referred to the Most receiving knowledge regarding HIV that a large amount of respondent 74%, 111 respondents said they get most of the knowledge regarding on HIV from their peer counsellor, 14% received their HIV knowledge from doctors and some percentages of respondents received their HIV knowledge 7% from friends, 2% from family and 3% learnt by self-study. Improving their skill of sharing knowledge about HIV can improve the efficiency on counselling that can change attitude and practise regarding HIV.

This survey finding are measured based on the knowledge, attitude and practise of respondents regarding on perception of their HIV status, getting proper Anti-retroviral Therapy, perception on psychosocial support, social communication and self-stigmatization.

4.3.2 Knowledge

Table (4.10) Knowledge on HIV/AIDS acquired from Counselling sessions

	Particulars		Correct	Incorrect	Unknown
1	Coughing Sneezing do not spread HIV	Number	115	32	3
		%	77%	21%	2%
2	A person can get HIV by sharing a glass of water with someone who has HIV	Number	139	11	0
		%	93%	7%	0%
3	People who have been infected with HIV quickly show serious signs of being infected	Number	128	16	6
		%	85%	11%	4%
4	A woman can get HIV if she has anal sex with a man.	Number	144	0	6
		%	96%	0%	4%
5	Showering, or washing one's genitals/private parts, after sex keeps a person from getting HIV	Number	124	17	9
		%	83%	11%	6%
6	All pregnant women infected with HIV will have babies born with AIDS	Number	117	20	13
		%	78%	13%	9%
7	Eating healthy foods can keep a person from getting HIV	Number	140	6	4
		%	93%	4%	3%
8	There is a vaccine that can stop	Number	89	56	5

	adults from getting HIV	%	59%	37%	3%
9	A person can get HIV even if he or she has sex with another person only one time	Number	108	41	1
		%	72%	27%	1%
10	A woman cannot get HIV if she has sex during her period	Number	126	17	7
		%	84%	11%	5%
11	A person can get HIV through contact with saliva, tears, sweat, or urine.	Number	146	2	2
		%	97%	1%	1%
12	A person will not get HIV if she or he is taking antibiotics.	Number	148	1	1
		%	99%	1%	1%
13	Having sex with more than one partner can increase a person's chance of being infected with HIV	Number	142	5	3
		%	95%	3%	2%
14	Taking a test for HIV one week after having sex will tell a person if she or he has HIV	Number	133	8	9
		%	89%	5%	6%
15	A person can get HIV by sitting in a hot tub or a swimming pool with a person who has HIV.	Number	145	4	1
		%	97%	3%	1%
16	A person can get HIV from oral sex.	Number	48	85	17
		%	32%	57%	11%
17	Washing drug use equipment with cold water kills HIV.	Number	126	13	11
		%	84%	9%	7%
18	A person can be infected with HIV for 5 years or more without getting AIDS	Number	109	27	14
		%	73%	18%	9%

Source: Survey Data May 2019

The table (4.10) mentioned that Knowledge on HIV/AIDS acquired from counselling session provided from peer counsellors that average of 123 (82%) out of total respondents 150 could answer correct on knowledge assessment questions can be considered the adequate cut-off in determining the basic knowledge level of an HIV patient who has completed all counselling sessions. According to the data, most of the respondents, 61% could not give correct answer on question number (8) “there is a

vaccine that can stop adults from getting HIV” and 68% could not give correct answer on question (16) “a person can get HIV from oral sex”.

Table (4.11) Knowledge Level on respondents

Knowledge Level	Number of Respondents	Percentage of Respondents
Low Knowledge (score <7)	1	0.67%
Medium Knowledge <13	17	11.33%
High Knowledge >13	132	88%
Total	150	100%

Source: Survey Data May 2019

Table (4.11) indicated the level of knowledge identify on respondents who received individual total score in questionnaires on knowledge assessment for HIV/AIDS acquired from counselling session provided by peer counsellors with classify on three classes with total score of individual participants. The Low Level of Knowledge is defined on score under 6, the Medium Level of Knowledge is under 13 and the High Level of Knowledge is above 13. According to the result, 132 respondents 88% of total are being found in High Level of Knowledge. So, this study said the peer to peer counselling is highly effective on giving HIV knowledge for HIV patients.

4.3.2 Attitude

Table (4.12) Attitude on Adherence of HIV Treatment

Adherence of HIV Treatment	No Problem	Very slight Problem	Somewhat of problem	Major Problem	Not Answer
Long distances to medical facilities and personnel	120	21	7	1	1
	80%	14%	5%	1%	1%
Medical personnel (e.g., physicians, nurses), who decline to provide direct care to persons with HIV/AIDS	91	35	4	19	1
	61%	23%	3%	13%	1%
The lack of health care professionals who are adequately trained and competent in AIDS care.	74	44	8	23	1
	49%	29%	5%	15%	1%

Lack of refer to access for other required services	106	5	6	32	1
	71%	3%	4%	21%	1%
Do not have enough on psychologists, social workers, and mental health counselors who can help address mental health issues.	64	46	13	25	2
	43%	31%	9%	17%	1%
The lack of psychological support groups for persons with HIV/AIDS.	68	8	37	36	1
	45%	5%	25%	24%	1%
The level of knowledge about HIV/AIDS among residents in the community	47	56	9	37	1
	31%	37%	6%	25%	1%
Community residents' stigma against persons living with HIV/AIDS	55	31	5	59	0
	37%	21%	3%	39%	0%
The lack of employment opportunities for people Living with HIV/AIDS	64	22	5	59	0
	43%	15%	3%	39%	0%
The lack of supportive and understanding at work environments for people living with HIV/AIDS	58	15	7	70	0
	39%	10%	5%	47%	0%
My personal financial resources	48	26	38	38	0
	32%	17%	25%	25%	0%
Lack of adequate and affordable housing.	48	26	39	36	1
	32%	17%	26%	24%	1%

Source: Survey Data May 2019

The table (4.12) has shown the attitude of HIV patients on treatment adherence that among the total respondent of 150, the majority of the respondents 120 respondents (80%) feel comfortable on distance to get medical facilities but 19 patients (13%) feel as major problem on decline to provide direct care by medial person, 75 respondents (75%) feel problem on the lack of health care professionals who are adequately trained and competent in AIDS care, one third of respondents, 49

person (35%) said they did not get the proper referral to access for other required services, 84 respondents (57%) over the half of total respondent did not get the adequate service from psychologists, social workers, and mental health counsellors who can help address mental health issues, over 54% of total respondent 81 respondents said they do not have psychological support groups for persons with HIV/AIDS, 102 respondents 68% of total respondents said they have problem on low level of knowledge about HIV/AIDS among residents in the community, 95 respondents (63%) faced as problem on stigma against persons living with HIV/AIDS by Community residents, 86 respondents (57%) faced the lack of job opportunity on the reason of being people living with HIV, 92 respondents (62%) mentioned that lack of supportive and understanding at work environments for people living with HIV/AIDS, 102 respondents (67%) faced the problem on personal financial resources and 102 respondents (67%) also faced burden on Lack of adequate and affordable housing.

Table (4.13) Attitude on Stigma and Discrimination to HIV patients

Stigma and Discrimination to HIV patients	Not at all	A little	A fair amount	A great deal	not answer
Feeling that you should avoid holding a new infant because of your HIV	140	6	3	1	0
	93%	4%	2%	1%	0
Feeling that you should avoid feeding children because of your HIV	97	3	48	1	1
	65%	2%	32%	1%	1%
Feeling that you should avoid sharing dishes or glasses just in case someone might catch HIV from you	145	4	0	1	0
	97%	3%	0	1%	0
Feeling that you have brought shame to your family because you have HIV	49	48	39	13	1
	33%	32%	26%	9%	1%
Feeling that you have HIV because you have done wrong behaviors	59	81	3	7	0
	39%	54%	2%	5%	0
Feeling that you should avoid cooking for people because you have HIV	142	4	3	1	0
	95%	3%	2%	1%	0
Feeling guilty about having HIV	47	81	18	4	0
	31%	54%	12%	3%	0

Feeling disgusting because of your HIV	47	81	18	4	0
	59%	36%	3%	1%	1%
Feeling that you are paying for previous demerit because you have HIV	73	55	6	16	0
	49%	37%	4%	11%	0

Source: Survey Data May 2019

The table (4.13) has shown the Attitude on perception of Stigma and Discrimination that 93% of total respondents did not have feeling they should avoid holding a new infant because of HIV but 35% have feeling that they should avoid feeding children because of their HIV, 97% of respondent understand that they do not need to avoid from sharing dishes or glasses might not be infected HIV to others, 67% of respondent felt sorry they made shame to family because of their HIV status, 61% of respondents felt they have infected HIV because they have done wrong behaviors, 87% of respondents they can do cooking for others even they have HIV, nearly 70% of respondent feel guilty about having HIV, 40% of respondents felt disgust because of their HIV and 52% of respondents felt that they are paying for previous demerit with having HIV.

Table (4.14) Attitude on Counseling Experience

Counseling Experience	Yes	No	Not Sure
The same counselor throughout all counseling sessions	118	32	0
	79%	21%	0%
Feeling comfortable talking to counselor during counseling sessions	149	1	0
	99%	1%	0%
Counseling sessions done one on one between counselor and client	144	6	0
	96%	4%	0%
Feeling comfortable talking about at-risk behaviors with counselor	147	1	2
	98%	1%	1%
Enable to ask questions during counseling session to counselor	148	2	0
	99%	1%	0%
Feeling comfortable on asking questions during counseling sessions	146	3	1
	97%	2%	1%
Afraid of or uncomfortable with, asking counselor during	69	78	3

counseling sessions	46%	52%	2%
Counselor was not able to answer during counseling experience	69	78	3
	46%	53%	1%
Having call or visit to a counselor or a healthcare worker on having more questions or concerns after the completion of counseling sessions	149	1	0
	99%	1%	0%
Feeling on understanding of counselor how hard life is living with HIV	144	3	3
	96%	2%	2%

Source: Survey Data May 2019

The table (4.14) shown that Attitude on Perception of Counselling Session that 21% of respondents did not get the same counselor throughout all counseling sessions, 99% of respondent felt comfortable talking to counselor during counseling sessions, 96% of respondents felt counseling sessions done one on one between counselor and client, 98% of respondents felt comfortable talking about at-risk behaviors with counselor, 99% of respondent enable to ask questions during counseling session to counselor, 97% of respondents felt comfortable on asking questions during counseling sessions, 46% of respondents felt afraid of or uncomfortable with, asking counselor during counseling sessions and also counselor was not able to answer during counseling experience, 99% of respondent have a chance to call and visit to counselor to ask more questions or concerns after the completion of counseling sessions and 96% of respondents felt on understanding of counselor how hard life is living with HIV.

4.3.3 Practices

Table (4.15) Adherence practice on Anti-retroviral Therapy

Adherence on Anti-retroviral Therapy	Yes		No		Not answer	
	Count	Percentage	Count	Percentage	Count	Percentage
Forgot to take ART medicines	10	7%	105	70%	35	23%
Late for taking ART medicine	29	19%	86	58%	35	23%
Stop taking ART medicine	6	4%	109	73%	35	23%
Forgot to take ART drug in holidays	6	4%	109	73%	35	23%

Source: Survey Data May 2019

The table (4.15) has shown the practise of clients for adherence on Anti-retroviral Therapy that 70%, 105 respondents of total respondents do not have forget to take medicines, 58%, 86 respondents had on time for taking ART medicines and 73%, 109 respondents had never stop taking ART medicines and forget to take ART drug in holiday. So, most of the clients have consistent for treatment adherence because of their knowledge on HIV treatment received from counselling sessions supported from peer HIV counsellors.

Table (4.16) Numbers of days don't taking medicines at all

Numbers of days don't taking medicines at all	Respondent	% of respondent
Under 2 days and do not have absent day	146	97%
Above 2 days	4	3%
Total	150	100%

Source: Survey Data May 2019

The table (4.16) showed the practise on HIV treatment adherence because of the receiving of counselling from peer HIV counsellors at HIV service sites. According to the survey data the 97%, 146 respondents had don't take medicine at all for under two days and don't have absent day and just only 3%, 4 respondents had above 2 days.

Table (4.17) Satisfaction on support practices from friends and family members

Satisfaction on support practices	Number of Respondent	% of respondent
Very Dissatisfied	6	4%
Somewhat Dissatisfied	3	2%
Somewhat Satisfied	78	52%
Very Satisfied	63	42%
Total	150	100%

Source: Survey Data May 2019

The table (4.17) mentions the satisfaction on support from friends and family members that 42%, 63 respondents have very satisfied, 78 respondents have

somewhat satisfied, only 3 respondents (2%) have somewhat dissatisfied and 6 respondents (4%) have very dissatisfied.

Table (4.18) Practise on supporters who supported biggest support on HIV

Supporters to HIV client	Number of Respondent	% of Respondent
Family Member(s)	44	29%
Friend(s)	10	7%
Neighbor(s)	2	1%
Co-worker(s)	3	2%
My peer HIV Counselor(s)	60	40%
My Doctor(s)/ Nurse(s)	8	5%
Religious contact(s) (monks, nuns, etc	1	1%
Do not have any one	22	15%
Total	150	100%

Source: Survey Data May 2019

The table (4.18) has shown the practise on supporters who supported biggest support on HIV that the majority of respondents 60 (40%) said they received the biggest support from their peer counsellors, 44 respondents (29%) received from family members and 22 respondents (15%) did not have support from any one.

Table (4.19) Practice on Stigma and Discrimination to HIV patients

Practice on Stigma and Discrimination	Yes	No	Total n=150
Having a medical provider or hospital worker mistreated you because of your HIV	4	146	150
	3%	97%	100%
Having people looked at you differently because you have HIV	26	124	150
	17%	83%	100%
Having a healthcare worker not wanted to touch you because you have HIV	3	147	150
	2%	98%	100%
Having you been told not to share your food or utensils with family because of your HIV	9	141	150
	6%	94%	100%

Having you been asked not to touch or care for children because of your HIV	54	96	150
	36%	64%	100%
Having you been refused medical care or denied hospital services because of your HIV	3	147	150
	2%	98%	100%
Having family members forced you to move out of your home because you have HIV	1	149	150
	1%	99%	100%
Having a hospital worker made your HIV infection publicly known by marking HIV on your medical record	14	136	150
	9%	91%	100%
Having someone threatened to hurt you physically because you have HIV	5	145	150
	3%	97%	100%
Having you been refused housing because people suspect you have HIV	5	145	150
	3%	97%	100%

Source: Survey Data May 2019

Table (4.19) has shown the practise on Stigma and Discrimination that 97% of total respondents, 146 did not have experience on mistreated by a medical provider or hospital worker because of HIV, 17% of total respondents 26 respondents have people looked at them differently because of HIV, 98% of respondents 147 respondents did not have experience on a healthcare worker not wanted to touch because of HIV, 94% of total respondents 141 respondents did not have experience on telling not to share his or her food or utensils with family because of HIV, 36% one third of total respondents, 54 have experience on been asked not to touch or care for children because of HIV, 98% of total respondents 147 did not have experience on refused medical care or denied hospital services because of HIV but only 2%, 3 respondents faced refused for medical care and hospital services, almost every respondent over 99% did not have experience on family members forced to move out of home because of having HIV, 91%, 136 of respondents did not have experience on practise of a hospital worker made his or her HIV infection publicly known by marking HIV on medical record and still 9%, 14 respondents have experience like this, this study found the case for someone threatened to hurt physically because of having HIV and been refused housing because people suspect on having HIV on each of 5 patients 3% of total respondents.

Table (4.20) Practise of counselling session

Experience on counseling session	Yes	No	Not Sure
Feeling on counselor give support for coping with the challenges of living with HIV	143	7	0
	95%	5%	0%
Notify to someone if unable to take medications as prescribed, or if cannot make follow-up appointment	141	2	7
	94%	1%	5%
Understanding more about illness (HIV) after counseling sessions	148	1	1
	99%	1%	1%
Feeling on understanding of taking medications and making follow-up appointments is increased after counseling sessions	150	0	0
	100%	0%	0%
Prefer to be counseled from HIV counselor instead of a healthcare worker such as a nurse or a doctor	117	30	3
	78%	20%	2%
A healthcare worker such as a nurse or a doctor would be better able to answer on questions	113	26	11
	75%	17%	7%
Feeling comfortable to share personal information and at-risk behavior to health care worker than counselor	93	45	12
	62%	30%	8%
Feeling good along counseling experience	149	0	1
	99%	0%	1%
Prefer to have the same HIV counselor for another counseling sessions	126	22	2
	85%	15%	1%
Felt mistreated or looked down upon during any of counseling sessions	25	123	2
	17%	82%	1%
The counseling sessions made feel more comfortable with illness and talking to partner or other close persons about illness	125	1	0
	83%	1%	16%
Knowing who to call should feel sick and have questions about symptoms	144	3	3
	96%	2%	2%
Knowing a place can comfortably go to get evaluation and treatment if feel ill	147	2	1
	98%	1%	1%

Source: Survey Data May 2019

The table (4.20) shown the Practise on perception of counselling session that 95% of respondents felt on counsellor give support for coping with the challenges of living with HIV, 94% of respondents had a chance to notify when they unable to take medications as prescribed, or if cannot make follow-up appointment, 99% felt understanding more about illness (HIV) after counselling sessions, 100% of respondents felt on understanding of taking medications and making follow-up appointments is increased after counselling sessions, 78% of respondents prefer to get counseled from HIV counsellor instead of a healthcare worker such as a nurse or a doctor but they know a healthcare worker such as a nurse or a doctor would be better able to answer on questions, 62% of respondents felt comfortable to share personal information and at-risk behaviour to health care worker than counsellor, 99% of respondents felt good along counselling experience, 85% of respondents felt prefer to have the same HIV counsellor for another counselling sessions, only 17% felt mistreated or looked down upon during any of counselling sessions, 83% of respondents felt the counselling sessions made feel more comfortable with illness and talking to partner or other close persons about illness, 96% of respondents has known who to call should feel sick and have questions about symptoms and 98% of respondents has known for a place can comfortably go to get evaluation and treatment if feel ill.

CHAPTER V

CONCLUSION

5.1 Findings

Alastair Ashley, Alexander Brown, The international health policies, September 18 2018, SDG 3.3 on HIV – A noble target with a dangerous blind spot said that the Sustainable Development Goals (SDGs) address the shift from the Millennium Development Goals (MDGs) to the UN’s 2030 Agenda and the 17 interconnected goals and 169 targets were developed with the mantra “no one left behind,” setting a standard for both high- and low-income countries and avoiding placing an undue burden on countries within the “global south.” No one goal can be achieved in isolation from other complementary goals. The AIDS response has long led the way in making inclusive, multi stakeholder and multi-sectorial development a reality. We have much to offer in terms of lessons learned that will be key to informing progress across all the SDGs. Ending the HIV epidemic by 2030 is undoubtedly a noble endeavor, and is the aim put forward by the UN in SDG 3.3. In full, the target states: “*By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases*”. We must meet this challenge going forward, or risk leaving behind vulnerable people who we should be bringing with us into a bright new ‘post-AIDS’ future.

The study could measure the effectiveness of the counseling services by evaluating the basic knowledge level, attitudes regarding peer HIV counseling, as well as identification of practice to receiving recommended HIV care, social support, perceived stigma, and adherence to therapy. The responses will help determine whether the provision of currently available HIV counseling is adequate. If there are gaps identified in basic knowledge, or if there are negative attitudes expressed against peer HIV counseling, or if patients are experiencing certain barriers in receiving care, then these data will serve as evidence to make specific modifications to the counseling experience to augment overall care. This survey result could help determine the effectiveness of the peer HIV counseling system in relation to the above

variables of interest. In general, this will help to reduce the rate of loss to follow-up and offer more referrals to services that can help reduce identified barriers in receiving recommended care.

HIV counseling is free of charge but mandatory before initiation of Anti-retroviral Therapy. Peer-to-peer HIV counseling is commonly utilized to provide patients with the opportunity to comfortably discuss at-risk behaviors and ask questions in a non-judgmental environment. Although theoretically sound, the effectiveness of this counseling method has not been formally assessed in Myanmar. Results of the 150 patients who participated from (9) selected sites of Yangon Region among (45) sites of HIV service centers where peer counselors are working on counseling services for HIV patients.

The characteristics of respondents in this study found that there were 150 eligible PLHIV who completed questionnaires, a majority of the respondents were aged between 36 and 60 years with 58%, 87 respondents, the 39 per cent of total the respondents, 59 respondents were young people between 17 to 35 years that the second largest number of respondents in this study. A majority of the respondents nearly 42 percent, 63 respondents were known their HIV status on diagnose for period of under 1.5 years. Education Level of Respondents mentioned the highest number of respondent in this survey were middle and primary school levels with nearly 82 percent, 123 respondents of total respondents, nearly 7 percent, 11 respondents passed the 10th Standard, nearly 4 percent, 6 respondents obtained Bachelor Degree and nearly 3 percent did not attend school. The majority of the respondents in this survey comes from the urban city area of 55 percent, 83 respondents. ART Status and Current immune system, specifically the number of T cells (CD4) Count in blood that 23%, 35 clients still in process to initiate ART. Among the respondents who are still in process to initiate ART, the highest percentage of patients, nearly 20%, 20 clients have CD4 count between 200 and 350 and 7%, 7 clients have the CD4 count less than 200. the Most receiving knowledge regarding HIV that a large amount of respondent 74%, 111 respondents said they get most of the knowledge regarding on HIV from their peer counselor.

The result on Knowledge assessment on HIV patients, respondents, in this study found that Knowledge on HIV/AIDS acquired form counselling session provided from peer counsellors that average of 123 (82%) out of total respondents 150 could answer correct on knowledge assessment questions can be considered the

adequate cut-off in determining the basic knowledge level of an HIV patient who has completed all counselling sessions. According to the data, most of the respondents, 61% could not give correct answer on question number (8) “there is a vaccine that can stop adults from getting HIV” and 68% could not give correct answer on question (16) “a person can get HIV from oral sex”. There are 132 respondents 88% of total respondent in this study are being found in High Level of Knowledge. So, this study said the peer to peer counselling is highly effective on giving HIV knowledge for HIV patients.

The result of Attitude on the peer counseling assessment in this study found that the attitude of HIV patients on treatment adherence that among the total respondent of 150, the majority of the respondents 120 respondents (80%) feel comfortable on distance to get medical facilities but 19 patients (13%) feel as major problem on decline to provide direct care by medial person, 75 respondents (75%) feel problem on the lack of health care professionals who are adequately trained and competent in AIDS care, one third of respondents, 49 person (35%) said they did not get the proper referral to access for other required services, 84 respondents (57%) over the half of total respondent did not get the adequate service from psychologists, social workers, and mental health counsellors who can help address mental health issues, over 54% of total respondent 81 respondents said they do not have psychological support groups for persons with HIV/AIDS, 102 respondents 68% of total respondents said they have problem on low level of knowledge about HIV/AIDS among residents in the community, 95 respondents (63%) faced as problem on stigma against persons living with HIV/AIDS by Community residents, 86 respondents (57%) faced the lack of job opportunity on the reason of being people living with HIV, 92 respondents (62%) mentioned that lack of supportive and understanding at work environments for people living with HIV/AIDS, 102 respondents (67%) faced the problem on personal financial resources and 102 respondents (67%) also faced burden on Lack of adequate and affordable housing. the Attitude on perception of Stigma and Discrimination that 93% of total respondents did not have feeling they should avoid holding a new infant because of HIV but 35% have feeling that they should avoid feeding children because of their HIV, 67% of respondent felt sorry they made shame to family because of their HIV status, 61% of respondents felt they have infected HIV because they have done wrong behaviors, 87% of respondents they can do cooking for others even they have HIV, nearly 70% of respondent feel guilty about

having HIV, 40% of respondents felt disgust because of their HIV and 52% of respondents felt that they are paying for previous demerit with having HIV. Attitude on Perception of Counselling Session that 21% of respondents did not get the same counselor throughout all counseling sessions, 99% of respondent felt comfortable talking to counselor during counseling sessions, 96% of respondents felt counseling sessions done one on one between counselor and client, 98% of respondents felt comfortable talking about at-risk behaviors with counselor, 99% of respondent enable to ask questions during counseling session to counselor, 97% of respondents felt comfortable on asking questions during counseling sessions, 96% of respondents felt on understanding of counselor how hard life is living with HIV.

The Practice assessment is mainly collected based on HIV knowledge acquired from counselling sessions of HIV patients regarding the counselling experience from the receiving properly and identification of the practise of counselors and barriers to care. This study found that the practise of clients for adherence on Anti-retroviral Therapy that 70%, 105 respondents of total respondents do not have forget to take medicines, 58%, 86 respondents had on time for taking ART medicines and 73%, 109 respondents had never stop taking ART medicines and forget to take ART drug in holiday. So, most of the clients have consistent for treatment adherence because of their knowledge on HIV treatment received from counselling sessions supported from peer HIV counselors. According to the survey data the 97%, 146 respondents had don't take medicine at all for under two days and don't have ever and just only 3%, 4 respondents had above 2 days. The satisfaction on support from friends and family members that 42%, 63 respondents have very satisfied, 78 respondents have somewhat satisfied the practise on supporters who supported biggest support on HIV that the majority of respondents 60 (40%) said they received the biggest support from their peer counsellors, 44 respondents (29%) received from family members and 22 respondents (15%) did not have support from any one. 17% of total respondents 26 respondents have people looked at them differently because of HIV, 36% one third of total respondents, 54 have experience on been asked not to touch or care for children because of HIV, still 9%, 14 respondents have experience on practise of a hospital worker made his or her HIV infection publicly known by marking HIV on medical record. The Practice on perception of counselling session that 95% of respondents felt on counsellor give support for coping with the challenges of living with HIV, 94% of respondents had a chance to notify when they unable to

take medications as prescribed, or if cannot make follow-up appointment, 99% felt understanding more about illness (HIV) after counselling sessions, 100% of respondents felt on understanding of taking medications and making follow-up appointments is increased after counselling sessions, 78% of respondents prefer to get counseled from HIV counsellor instead of a healthcare worker such as a nurse or a doctor but they know a healthcare worker such as a nurse or a doctor would be better able to answer on questions, 99% of respondents felt good along counseling experience, 17% felt mistreated or looked down upon during any of counseling sessions. The most of respondents prefer to get counseled from HIV counselor instead of a healthcare worker such as a nurse or a doctor but they know a healthcare worker such as a nurse or a doctor would be better able to answer on questions.

5.2 Suggestions

The above results sustained after stratifying for age, gender, education level, and duration of illness. Peer HIV counseling effectively supported to a higher level of HIV knowledge, increased adherence to therapy, and lower internalized stigma. Despite this, providing on basic information for ways of HIV infection and update need to be more specifically, lower satisfaction with social support and higher levels of barriers to care are reported in the peer counseling group. This suggests that while peer-to-peer HIV counseling may be more effective in improving HIV knowledge, reducing stigma, and enhancing adherence, mitigating other social barriers remain challenging.

The peer counseling to HIV patients is crucial for effectiveness to support improving HIV knowledge to patients, ART treatment adherence and reduction of stigma and discrimination. The above result of this study the technical skill for peer counselors still need to be improved but patients satisfied on counseling experience with peer counselors, the practice of HIV patients for adherence on Anti-retroviral Therapy is good because of the receiving of counseling from peer HIV counselors The attitude on Stigma and Discrimination of HIV patients felt self-stigma avoid from social relationship among community and family that they felt they made shame to family, they have done wrong behaviors, guilty about having HIV and they regarding as they are paying for previous demerit with having HIV. This study highlights that the peer counselor need to support more information about stigma and discrimination with the Human Rights approach. But the enabling environment for receiving health

care services still need to be improved and the community and workplace needs more awareness not to do stigma and discrimination to People Living with HIV/AIDS.

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Appendix I

“ရန်ကုန်မြို့တွင် ဘဝတူချင်း အိပ်ချ်အိုင်စီ နှစ်သိမ့်ဆွေးနွေးအကြံပေးခြင်းဖြင့် ရရှိသော အကျိုးသက်ရောက်မှု အတွက်၊ အသိပညာ၊ သဘောထားနှင့် အလေ့အကျင့်များအား လေ့လာစမ်းစစ်ခြင်း”

မင်းဆန်းထွန်း၊ EMDevS 14th Batch

အိပ်ချ်အိုင်စီပိုးကူးစက်ခံထားရသူများနှင့်ပတ်သက်သည့်မေးခွန်းလွှာ

အမှတ်စဉ်။

အထွေထွေ

အသက် _____

ကျား၊ မ (ပိုင်းပေးရန်)

အိပ်ချ်အိုင်စီအသိပညာများကို နှစ်သိမ့်ဆွေးနွေးအကြံပေးခြင်း ရရှိခဲ့သည့်နေရာ _____

၁) သင်လိုအပ်သည့် နှစ်သိမ့်ဆွေးနွေးအကြံပေးမှုများအား ပြီးပြည့်စုံစွာရရှိခဲ့ပါသလား။

- က) ရရှိပါသည်။
- ခ) မရရှိခဲ့ပါ။
- ဂ) မသိပါ။

၂) သင်သည် ဘဝတူနှစ်သိမ့်ဆွေးနွေးအကြံပေးသူနှင့် လုံလောက်သောအချိန်ပေးပြီး ဆွေးနွေးပြီးဖြစ်ပါသလား။

- က) ဆွေးနွေးပြီးပါပြီ။
- ခ) မပြီးသေးပါ။
- ဂ) မသိပါ။

၃) ယခုအချိန်ထိ ခန့်မှန်းခြေအားဖြင့် နှစ်သိမ့်ဆွေးနွေးအကြံပေးမှု ဘယ်နှစ်ကြိမ်ရရှိခဲ့ပါသလဲ။

- က) ၀-၃ ကြိမ်
- ခ) ၄-၆ ကြိမ်
- ဂ) ၇-၉ ကြိမ်
- ဃ) ၁၀-၁၂ ကြိမ်
- င) ၁၂ ကြိမ်ထက်ပိုသော

၄) သင်နောက်ဆုံတက်ရောက်ခဲ့သည့် ပညာအရည်အချင်း

- က) ကျောင်းမတက်ခဲ့ရပါ
- ခ) အခြေခံပညာအထက်တန်းကျောင်း (၁၀တန်းနှင့်အောက်)
- ဂ) ၁၀ တန်းအောင်
- ဃ) အသက်မွေးပညာသင်ကျောင်း
- င) ဒီပလိုမာ
- စ) ကော်လိပ်ကျောင်း(သို့) တက္ကသိုလ်
- ဆ) ကောလိပ်(သို့) တက္ကသိုလ်မှ ဘွဲ့တစ်ခုခုရရှိပြီး
- ဇ) ဘွဲ့ထက်ပိုမြင့်သော မာစတာဘွဲ့(သို့) အခြားဘွဲ့ရရှိခြင်း
- ဈ) အထက်ပါအကြောင်းအရာများမှ လွဲ၍

၅) သင်နေထိုင်သည့်နေရာ

က) မြို့တွင်း

ခ) မြို့ပြင်(ဆင်ခြေဖုံး)

ဂ) ကျေးရွာ

ဃ) အထက်အကြောင်းအရာများမှလွဲ၍ အခြား _____

၆) သင့်တွင် HIV ပိုးရှိသည်ကို ခန့်မှန်းခြေ ဘယ်နှစ်က စတင်သိရှိခဲ့သနည်း။

(၁၉____)/(၂၀____)

၇) သင့်အား HIV ပိုးကူးစက်ခံရသည့်အကြောင်းရင်းအား ရွေးချယ်ပေးပါ။

(အောက်ပါတို့မှ အသေချာသော်လည်း ဖြစ်နိုင်ချေအရှိဆုံးကို ရွေးချယ်နိုင်ပါသည်။)

က) HIV ပိုးကူးစက်ခံထားရသည့် ယောက်ျားနှင့် အကာအကွယ်မဲ့လိင်ဆက်ဆံခြင်း

ခ) HIV ပိုးကူးစက်ခံထားရသည့် မိန်းမနှင့် အကာအကွယ်မဲ့လိင်ဆက်ဆံခြင်း

ဂ) HIV ပိုးကူးစက်ခံထားရသည့် အခြားသူနှင့် ဆေးထိုးအပ်၊ ဆေးထိုးပြန် မျှဝေသုံးစွဲခြင်း

ဃ) ဆေးကုသမှုအတွက် သွေးသွင်းခြင်း

င) လုပ်ငန်းခွင်တွင် အပ်စူးခြင်း

စ) မေးခွန်းအားမဖြေလိုပါ

ဆ) အထက်ပါအကြောင်းအရာများမှလွဲ၍ အခြား _____

၈) သင်၏နောက်ဆုံး CD4 အရေအတွက်

က) ၂၀၀ အောက်

ခ) ၂၀၀-၃၅၀ အတွင်း

ဂ) ၃၅၀-၅၀၀ အတွင်း

စ) ၅၀၀နှင့် အထက်

င) မသေချာ

စ) CD4 မစစ်ခဲ့ဖူးပါ။

၉) HIV ပိုးထိန်းချုပ်ဆေးဝါးများ (ART) သောက်နေပါသလား။

က) သောက်နေပါသည်။

ခ) မသောက်ပါ။

ဂ) မသိပါ။

၁၀) HIV နှင့်ပတ်သက်ပြီး မည်သူကသင့်အား အများဆုံးအသိပညာပေးခဲ့သနည်း။

က) HIV နှစ်သိမ့်ဆွေးနွေးအကြံပေးသူ (HIV peer Counselor)

ခ) ဆရာဝန်

ဂ) သူငယ်ချင်း

ဃ) မိသားစု

င) ကိုယ်တိုင်လေ့လာခြင်း

အသိပညာ (Knowledge)

HIV/AIDS အသိပညာအကဲဖြတ်ခြင်း

ဟုတ်၊ မဟုတ် နှင့် မသိရှိပါ အကွက်များတွင် တစ်ခုအား အမှန်ဖြစ် တစ်ခုသာဖြစ်ရန်။

		ဟုတ်	မဟုတ်	မသိပါ
၁။	ချောင်းဆိုးခြင်း၊ နှာခြေခြင်းတို့မှ တဆင့် HIV မကူးစက်နိုင်ပါ။			
၂။	HIV ပိုးရှိသူနှင့်အတူ သောက်ရေခွက် အတူတူမျှဝေသုံးစွဲမိပါက HIV ပိုးကူးစက်ခံရနိုင်ပါသည်။			
၃။	HIV ပိုးကူးစက်ခံရသူသည် ချက်ခြင်းAIDSလက္ခဏာများ ပေါ်ပေါက်လာပါမည်။			
၄။	မိန်းမတစ်ယောက်သည် ယောက်ျားတစ်ယောက်နှင့် စအိုမှအကာအကွယ်မဲ့လိင်ဆက်ဆံပါက HIV ပိုးကူးစက်ခံရနိုင်ပါသည်။			
၅။	လိင်ဆက်ဆံပြီးနောက် ရေအတူတူချိုးခြင်း၊ အချင်းချင်းကိုယ်အင်္ဂါအစိတ်အပိုင်းများအား ဆေးကြောသန့်စင်ပေးခြင်းသည် HIVပိုးကူးစက်ခြင်းမှ ကာကွယ်နိုင်ပါသည်။			
၆။	HIVပိုးကူးစက်ခံထားရသော ကိုယ်ဝန်ဆောင်အမျိုးသမီးမှ မွေးဖွားလာမည့် ကလေးများသည် မွေးရာပါ AIDS ရောဂါရှိပါသည်။			
၇။	ကျန်းမာရေးနှင့်ညီညွတ်သည့် အစားအသောက်များစားသုံးပေးပါက HIV ပိုးကူးစက်ခြင်းမှ ကာကွယ်နိုင်ပါသည်။			
၈။	HIVပိုးကူးစက်မခံရအောင် လူကြီးများအတွက် ကာကွယ်ရန်ဆေးဝါးများရှိပါသည်။			
၉။	လူတစ်ယောက်သည် အခြားသူနှင့် အကာအကွယ်မဲ့ (ကွန်ဒုံးမသုံးပဲ) တစ်ကြိမ်တစ်ခါသာ လိင်ဆက်ဆံမိပါက HIVပိုးကူးစက်ခံရနိုင်ပါသည်။			
၁၀။	မိန်းမတစ်ယောက် ရာသီလာနေစဉ်အတွင်း လိင်ဆက်ဆံပါက HIVပိုးတစ်ဦးမှတစ်ဦးသို့ မကူးစက်နိုင်ပါ။			
၁၁။	HIVပိုးရှိသူ၏ တံတွေး၊ ချွေး၊ မျက်ရည်နှင့် ဆီးတို့အား ထိတွေ့မိလျှင် HIVပိုးကူးစက်ခံရနိုင်ပါသည်။			
၁၂။	လူတစ်ယောက်သည် ရောဂါပိုးသတ်ဆေး (ပဋိဇီဝဆေး)များ သုံးစွဲနေလျှင် HIVပိုးမကူးစက်နိုင်ပါ။			
၁၃။	လိင်ဆက်ဆံဖက်များလေ ထိုသူ၏HIVပိုးကူးစက်ခံရနိုင်ခြေများလေ ဖြစ်ပါသည်။			
၁၄။	လိင်ဆက်ဆံပြီး တစ်ပတ်အကြာတွင် HIVပိုး ရှိမရှိစစ်ဆေးပါက HIVပိုး ကူးစက်ခံရခြင်း ရှိမရှိ သိနိုင်ပါသည်။			
၁၅။	HIVပိုးကူးစက်ခံရသူနှင့် အတူတကွ ရေကူးကန်(သို့) ရေပူစမ်းတစ်ခုထဲတွင် ထိုင်မိပါက HIV ကူးစက်ခံရနိုင်ပါသည်။			
၁၆။	ပါးစပ်ဖြင့် လိင်ဆက်ဆံခြင်း(ပါးစပ်ဖြင့် ယောက်ျားအင်္ဂါ(သို့) မိန်းမအင်္ဂါနှင့်ထိတွေ့ လိင်ဆက်ဆံခြင်း) သည် HIVပိုးကူးစက်ခံရနိုင်ပါသည်။			
၁၇။	မူးယစ်ဆေးဝါးထိုးသွင်းသုံးစွဲထားသော ဆေးထိုးအပ်များကို ရေအေးဖြင့်ဆေးကြောပါက HIV ပိုးအား သေစေနိုင်ပါသည်။			
၁၈။	HIV ပိုးရှိသူသည် ၅နှစ်နှင့်အထက် AIDSရောဂါလက္ခဏာမပြဘဲ ရှိနေနိုင်ပါသည်။			

HIVကုသမှုနှင့် ပတ်သက်သော စိတ်နေသဘောထား။ (စိတ်နေသဘောထား)

ဖြေဆိုသူများအနေဖြင့် အောက်ပါမေးခွန်းတိုင်းအတွက် အဖြေမှန်တစ်ခုကိုသာ ရွေးချယ်ဖြေဆိုပေးပါရန်။

(မေးခွန်းတိုင်း၏ အခြေအနေများတွင် သင့်အနေဖြင့် HIV ဆေးကုသမှုများ၊ ကျန်းမာရေးဝန်ဆောင်မှုများ ရယူရာတွင် လမ်းညွှန်ချက်များအတိုင်း လက်တွေ့ကျင့်သုံးလိုက်နာမှု အတိုင်းအတာများကို ဖော်ပြပေးပါရန်)

		လုံးဝ ပြဿနာမရှိပါ	ပြဿနာ အနည်းငယ်ရှိ	ပြဿနာ ရှိသည်	ပြဿနာကြီးကြီး မားမားရှိသည်
၁။	ဆေးကုသမှုခံယူနိုင်သည့်နေရာသည် လက်ရှိနေထိုင်သည့်နေရာနှင့် ဝေးကွာနေခြင်း	၁	၂	၃	၄
၂။	ဆေးကုသပေးသည့် ဆရာဝန်များ၊ သူနာပြုများသည် HIVရှိသူများအား ကိုင်တွယ်စမ်းသပ် ကုသပေးရန် ငြင်းပယ်ခြင်း	၁	၂	၃	၄
၃။	AIDS ရောဂါနှင့် ပတ်သက်၍ အရည်အချင်း ပြည့်မီသော၊ လေ့ကျင့်သင်ကြားပေးထားသော၊ ကျွမ်းကျင်သည့် ကျန်းမာရေးစောင့်ရှောက်မှု ဝန်ထမ်းများ မရှိခြင်း	၁	၂	၃	၄
၄။	အခြားလိုအပ်သည့် ကျန်းမာရေးစောင့်ရှောက်မှု များရရှိနိုင်သည့်နေရာသို့ တိကျသော ညွှန်းပို့မှု မရှိခြင်း။	၁	၂	၃	၄
၅။	စိတ်ပိုင်းဆိုင်ရာ ကိစ္စရပ်များ အတွက် စိတ်ရောဂါ ပညာရှင်များ၊ ဆေးလူမှုဝန်ထမ်းများ၊ စိတ်ပိုင်းဆိုင်ရာ အကြံပေးဆွေးနွေးပေးသူများ လုံလောက်စွာ မရှိခြင်း	၁	၂	၃	၄
၆။	HIVပိုးရှိသူများကို စိတ်ပိုင်းဆိုင်ရာ အားပေးပြီး ပိုင်းဝန်းကူညီပေးမည့် အဖွဲ့များမရှိခြင်း	၁	၂	၃	၄
၇။	သင်နေထိုင်ရာ ပတ်ဝန်းကျင်ရှိ နေထိုင်သူများ ၏ HIV/AIDS အကြောင်းဗဟုသုတ မရှိခြင်း	၁	၂	၃	၄
၈။	ပတ်ဝန်းကျင်ရှိနေထိုင်သူများမှ HIVပိုးရှိသူအား ပစ်ပယ်ထားခြင်း။	၁	၂	၃	၄
၉။	HIVပိုးရှိသူများအား အလုပ်အကိုင်မပေးခြင်း	၁	၂	၃	၄
၁၀။	လုပ်ငန်းခွင်တွင် HIVပိုးရှိသူများအား ခွဲခြားဆက်ဆံခြင်း။	၁	၂	၃	၄
၁၁။	ကိုယ်ပိုင် ဝင်ငွေလုံလောက်မှုမရှိခြင်း	၁	၂	၃	၄
၁၂။	ကိုယ်တိုင်ပိုင်ဆိုင်သော နေအိမ်မရှိခြင်း	၁	၂	၃	၄

ကဲ့ရဲ့ပစ်တင်ခံရခြင်းနှင့် ခွဲခြားနှိမ်ချဆက်ဆံခံရခြင်း (စိတ်နေသဘောထား)

ဖြေဆိုသူများအနေဖြင့် အောက်ပါမေးခွန်းများအား သင့်တော်သည့်အဖြေကို ရွေးချယ်ဖြေဆိုပေးပါရန်။

	လူနာ၏ခံစားချက်	လုံးဝမထင်	အနည်း ငယ်မျှသာ	ထိုက်သင့် သလောက်	အများ အပြား
၁။	သင့်တွင် HIVပိုးရှိ၍ မွေးကင်းစကလေးငယ်များအား ထိတွေ့ ကိုင်တွယ်ခြင်းကို ဘယ်လောက် အတိုင်းအတာအထိ				

	ရှောင်ရှားရမည် ဟုထင်သနည်း။				
၂။	သင့်တွင် HIVပိုးရှိ၍ ကလေးငယ်များအား အစားအစာကျွေးခြင်းကို ဘယ်လောက်အတိုင်းအတာအထိ ရှောင်ရမည်ဟု ထင်ပါသလဲ။				
၃။	အခြားသူထံသို့ သင့်ထံမှ HIVပိုးကူးစက်နိုင်သဖြင့် ပန်းကန်များ ဖန်ခွက်များ မျှဝေသုံးစွဲခြင်းကို ဘယ်လောက်အတိုင်းအတာအထိ ရှောင်ရှားရမည်ဟုထင်ပါသလဲ။				
၄။	သင့်တွင် HIVပိုးရှိ၍ သင့်မိသားစုအား ဘယ်လောက်အတိုင်းအတာအထိ ဂုဏ်သိက္ခာ ကျဆင်းစေသည်ဟု ထင်ပါသလဲ။				
၅။	သင့်တွင် HIVပိုးရှိခြင်းသည် ယခင်က မှားယွင်းသော အပြုအမူများ ပြုလုပ်ခဲ့ခြင်းကြောင့်ဖြစ်သည်ဟု ဘယ်လောက်အတိုင်းအတာအထိထင်သနည်း။				
၆။	သင့်တွင် HIVပိုးရှိ၍ အခြားသူများအတွက် အစားအသောက် ချက်ပေးခြင်းကို ဘယ်လောက်အတိုင်းအတာအထိ ရှောင်ရှားရမည်ဟု ထင်သနည်း။				
၇။	သင့်တွင် HIVပိုးရှိ၍ ကိုယ့်ကိုယ်ကို အပြစ်ရှိသည်ဟု ဘယ်လောက်အတိုင်းအတာအထိ ထင်သနည်း။				
၈။	သင့်တွင် HIVပိုးရှိ၍ ကိုယ့်ကိုယ်ကို ရွံစရာကောင်းသည်ဟု ဘယ်လောက်အတိုင်းအတာအထိ ထင်သနည်း။				
၉။	သင့်တွင် HIVပိုးရှိခြင်းသည် ပြုလုပ်မိသည့်အပြစ်များ၊ ဝဋ်ကြွေးများကြောင့်ဟု ဘယ်လောက်အတိုင်းအတာအထိ ထင်သနည်း။				

HIV လူနာများ နှစ်သိမ့်ဆွေးနွေးအကြံပေးမှု အတွေ့အကြုံများ။ (စိတ်နေသဘောထား)

ဖြေဆိုသူများအနေဖြင့် အောက်ပါမေးခွန်းတိုင်းအား ဟုတ်၊ မဟုတ်၊ မသေချာ အကွက်များတွင် ခြစ်ပြီး ဖြေဆိုပါ။

		ဟုတ်	မဟုတ်	မသေချာ
၁။	နှစ်သိမ့်ဆွေးနွေးအကြံပေးသည့် အချိန်တစ်လျှောက်လုံး အကြံပေးသူ (Counselor) တစ်ယောက်တည်းနှင့်သာ ဆွေးနွေးတိုင်ပင်ခဲ့သလား။			
၂။	နှစ်သိမ့်ဆွေးနွေးအကြံပေးသည့်အချိန်များတွင် အကြံပေးသူ (Counselor) နှင့် စကားပြောသည့်အခါ သက်တောင့်သက်သာ ရှိသလား။			
၃။	နှစ်သိမ့်ဆွေးနွေးအကြံပေးသည့် အချိန်များတွင် အကြံပေးသူ (counselor) နှင့်သာ နှစ်ယောက်ထံ ဆွေးနွေးခဲ့သလား။			
၄။	အဖော်များစွာနှင့် လိင်ဆက်ဆံမှုပြုခြင်း၊ ဆေးထိုးအပ်များ မျှဝေသုံးစွဲခြင်း၊ အမြဲတစေ ကွန်ဒုံးမသုံးခြင်း အစရှိသည့် အန္တရာယ်များသည့် လုပ်ရပ်များအား နှစ်သိမ့်ဆွေးနွေးအကြံပေးသူ (counselor) ကိုပြောပြရာတွင် သက်တောင့်သက်သာ ရှိသလား။			
၅။	နှစ်သိမ့်ဆွေးနွေး အကြံပေးသည့်အချိန်များတွင် မေးခွန်းများမေးခွင့် ရခဲ့ပါသလား။			
၆။	နှစ်သိမ့်ဆွေးနွေး အကြံပေးသည့်အချိန်များတွင် သင့်အားအကြံပေးသူ(counselor) က မေးခွန်းများမေးသည့်အခါ သက်တောင့်သက်သာ ရှိသလား။			
၇။	နှစ်သိမ့်ဆွေးနွေးအကြံပေးသည့် အချိန်များတွင် အကြံပေးသူ (counselor) အား မေးခွန်းများမေးရန် ကြောက်ရွံ့ခြင်း၊ သက်တောင့်သက်သာမရှိခြင်း ဖြစ်သလား။			

၈။	နှစ်သိမ့်ဆွေးနွေးအကြံပေးသည့်အချိန်များတွင် အကြံပေးသူ (counselor)သည် HIVနှစ်သိမ့်ဆွေးနွေးခြင်းနှင့် ပတ်သက်ပြီး မဖြေနိုင်ခဲ့သည့် မေးခွန်းများရှိပါသလား။			
၉။	နှစ်သိမ့်ဆွေးနွေးအကြံပေးသည့်အချိန်များ ပြီးဆုံးသည့်နောက်ပိုင်း မေးစရာမေးခွန်းများရှိခဲ့ပါက မေးရန်အကြံပေးသူ (counselor) သို့မဟုတ် ကျန်းမာရေးစောင့်ရှောက်မှုပေးသူ ဝန်ထမ်းများထံမေးခွင့်ရပါသလား။			
၁၀။	သင့်ဘဝသည် HIVပိုးရှိနေ၍ ခက်ခဲကြမ်းတမ်းသည်ကို သင့်အားနှစ်သိမ့်ဆွေးနွေးအကြံပေးသူများသည် သိရှိနားလည်သည်ဟု ထင်ပါသလား။			

အေအာတီဆေးစွဲမြဲစွာကုသမှုကိုလိုက်နာခြင်း (အလေ့အကျင့်များ)

ဖြေဆိုသူများအနေဖြင့် အောက်ပါမေးခွန်းတိုင်းအတွက် အဖြေများကို ရွေးချယ် ဖြေဆိုပေးပါရန်။
(သင့်အနေဖြင့် HIVပိုးထိန်းဆေးဝါးများ (ART) သုံးစွဲခြင်းမရှိပါက မေးခွန်း ၁ မှ ၆ အားကျော်ကာ နောက်တစ်ပိုဒ်ဆက်၍ ဖြေဆိုနိုင်ပါသည်။)

၁။	သင့်အနေဖြင့် ARTဆေးသောက်ရန် မေ့လျော့ပြီး အသောက်မိခြင်း ရှိပါသလား။	ရှိ	မရှိ
၂။	သင့်အနေဖြင့် ARTဆေးသောက်ရန် တစ်ခါတစ်ရံ သတိမေ့ပြီး အချိန်နောက်ကျမှ သောက်မိခြင်း ရှိပါသလား။	ရှိ	မရှိ
၃။	သင့်အနေဖြင့် တခါတရံ နေထိုင်မကောင်းသည့်အခါ ARTဆေးသောက်ခြင်းအား ရပ်တန့်ဖူးခြင်း ရှိပါသလား။	ရှိ	မရှိ
၄။	သင့်အနေဖြင့် ပြီးခဲ့သည့်တစ်ပတ်အတွင်း ဘယ်နှစ်ကြိမ် ARTဆေးသောက်ရန် ပျက်ကွက်ဖူးခဲ့ပါသလဲ။ က) တစ်ကြိမ်မှ မပျက်ကွက်ဖူးပါ။ ခ) ၁-၂ ကြိမ် ဂ) ၃-၅ ကြိမ် ဃ) ၆-၁၀ကြိမ် င) ၁၀ ကြိမ်နှင့် အထက်		
၅။	သင့်အနေဖြင့် ပြီးခဲ့သည့် အလုပ်ပိတ်ရက်များ၊ ခရီးသွားလာသောရက်များတွင် ဆေးသောက်ရန် ပျက်ကွက်မှုရှိခဲ့ပါသလား။	ရှိ	မရှိ
၆။	သင့်အနေဖြင့် ပြီးခဲ့သည့် ၃လအတွင်း ART ဆေးလုံးဝအသောက်မိသောရက် ဘယ်နှစ်ရက်ရှိပါသလဲ။ က) ၂ရက်နှင့်အောက် ခ) ၂ရက်ထက်ကျော်လွန်		

ကဲ့ရဲ့ပစ်တင်ခံရခြင်းနှင့် ခွဲခြားနှိမ့်ချထက်ဆံခံရခြင်း (အလေ့အကျင့်)

ဖြေဆိုသူများအနေဖြင့် အောက်ပါမေးခွန်းတိုင်းအတွက် အဖြေနံပါတ်များကို ရွေးချယ်ဖြေဆိုပေးပါရန်။

		လုံးဝ မကျေနပ်ပါ	နည်းနည်း မကျေနပ်ပါ	နည်းနည်း ကျေနပ်သည်	လုံးဝ ကျေနပ်သည်
၁။	သင်၏သူငယ်ချင်း၊ မိသားစုဝင်များမှ ကူညီပံ့ပိုးမှုအား ဘယ်လောက်အထိကျေနပ်မှု ရရှိပါသလဲ။	၀	၁	၂	၃

၂။ သင့်အား ကူညီပံ့ပိုးပေးသူများထဲတွင် မည်သူက သင့်အား အများဆုံးထောက်ပံ့ပေးခဲ့ပါသနည်း။
(အဖြေတစ်ခုတည်းအားရွေးချယ်ပေးပါရန်။)

- က) မိသားစုဝင်များ
- ခ) သူငယ်ချင်းများ

- ဂ) အိမ်နီးနားချင်းများ
- ဃ) လုပ်ဖော်ကိုင်ဖက်များ
- င) HIVအသိပညာများကို နှစ်သိမ့်ဆွေးနွေးအကြံပေးသူများ
- စ) ကျန်းမာရေးဝန်ဆောင်မှုပေးသူများ (ဆရာဝန်များ၊ သူနာပြုများ)
- ဆ) နေအိမ်ပတ်ဝန်းကျင်ရှိ လူကြီးသူမများ
- ဇ) ဘာသာရေးဆိုင်ရာ- ဘုန်းကြီးများ၊ သီလရှင်များ၊ ခရစ်ယာန်ကျောင်းများ၊ ဗလီကျောင်းများ စသည်တို့
- ဈ) တစ်ယောက်မျှ မထောက်ပံ့ပေးပါ

ဖြေဆိုသူများအနေဖြင့် အောက်ပါမေးခွန်းတိုင်းအား မှန်လျှင် (✓)၊ မှားလျှင် (X) ခြစ်ပါ။

	HIV ပိုးရှိနေ၍ အခြားသူများမှ ပစ်ပယ်ခံရခြင်း	✓	X
၁။	ကျန်းမာရေးဝန်ဆောင်မှုပေးသူများ၊ ဆေးရုံဝန်ထမ်းများမှ သင့်တွင် HIV ပိုးရှိ၍ မတူမတန် မလေးမစား ဆက်ဆံခြင်းများရှိခဲ့သည်။		
၂။	သင့်တွင် HIV ပိုးရှိ၍ အခြားသူများမှ သင့်အားခွဲခြင်းဆက်ဆံခြင်းပြုလုပ်ခဲ့သည်။		
၃။	သင့်တွင် HIV ပိုးရှိ၍ ကျန်းမာရေးစောင့်ရှောက်မှုဝန်ထမ်းသည် သင့်အားမထိမတွေ့ မစမ်းသပ်လိုခြင်းများ ရှိခဲ့သည်။		
၄။	သင့်တွင် HIV ပိုးရှိ၍ အစားအသောက်များ၊ အသုံးအဆောင်ပစ္စည်းများအား မျှဝေသုံးစွဲခြင်း မပြုရန် မိသားစုဝင်များမှ တားမြစ်ခြင်း ရှိသည်။		
၅။	သင့်တွင် HIV ပိုးရှိ၍ ကလေးသူငယ်များအား ထိတွေ့ခြင်း၊ ကလေးထိန်းပေးခြင်း ကိစ္စရပ်များ အား မပြုလုပ်ရန်ပြောခဲ့သည်။		
၆။	သင့်တွင် HIV ပိုးရှိ၍ ကျန်းမာရေးစောင့်ရှောက်မှုများ၊ ဆေးရုံမှ ဝန်ဆောင်မှုပေးရန် ငြင်းပယ်ခြင်း ခံခဲ့ရသည်။		
၇။	သင့်တွင် HIV ပိုးရှိ၍ သင့်မိသားစုများက နေအိမ်တွင် ဆက်မနေရန် ပြောခဲ့သည်။		
၈။	သင့်တွင် HIV ပိုးရှိနေကြောင်း လူအများသိစေရန် ဆေးရုံဝန်ထမ်းသည် သင့်ဆေးမှတ်တမ်း တွင် HIV ရှိကြောင်း ထင်ရှားစွာရေးသားခဲ့သည်။		
၉။	သင့်တွင် HIV ပိုးရှိသည်ကို အကြောင်းပြ၍ သင့်အား အခြားတစ်ယောက်မှ ကိုယ်ထိရောက် ဖော်ကားခြင်းပြုရန် ခြိမ်းခြောက်ခြင်းခံခဲ့ရသည်။		
၁၀။	သင့်တွင် HIV ပိုးရှိကြောင်း သံသယရှိသဖြင့် သင့်အား နေထိုင်ရန် နေရာပေးရန် ငြင်းပယ်ခံ ရခြင်း(ဥပမာ - တည်းခိုခန်း၊ အိမ်ငှား)		

HIV လူနာများ နှစ်သိမ့်ဆွေးနွေးအကြံပေးမှု အတွေ့အကြုံများ။ (အလေ့အကျင့်)

ဖြေဆိုသူများအနေဖြင့် အောက်ပါမေးခွန်းတိုင်းအား ဟုတ်၊ မဟုတ်၊ မသေချာ အကွက်များတွင် ခြစ်ပြီး ဖြေဆိုပါ။

		ဟုတ်	မဟုတ်	မသေချာ
၁။	နှစ်သိမ့်ဆွေးနွေးအကြံပေးသူများအနေဖြင့် သင့်အား HIV ပိုးရှိခြင်းကြောင့် ဖြစ်ပေါ်လာသည့် စိန်ခေါ်မှုများအားရင်ဆိုင်နိုင်ရန် စိတ်ပိုင်းဆိုင်ရာ ပံ့ပိုးမှုများ ပေးသလား။			
၂။	အကယ်၍ ဆရာဝန်ညွှန်ကြားထားသည့်ဆေးဝါးများ-(ART) အပါအဝင် ဆေးဝါးများ အား မသောက်သုံးနိုင်ခြင်း၊ ဆရာဝန်နှင့်တွေ့ဆုံရန် ရက်ချိန်းပျက်ကွက်ခြင်းကဲ့သို့ ကိစ္စများရှိပါက အကြောင်းကြားရန် တစ်ယောက်ယောက်ရှိပါသလား။			
၃။	နှစ်သိမ့်ဆွေးနွေးအကြံပေးသည့် အချိန်များကြောင့် သင့်ရောဂါအကြောင်း ပိုမိုသိရှိ လာခဲ့သလား။			
၄။	နှစ်သိမ့်ဆွေးနွေးအကြံပေးခြင်းများကြောင့် ဆရာဝန်ညွှန်ကြားသည့်ဆေးများမှီဝဲ			

	ခြင်း၊ ဆရာဝန်နှင့်ရက်ချိန်းအတိုင်းတွေ့ဆုံခြင်း စသည့်ကိစ္စများပို၍ ဂရုစိုက်လုပ်ဆောင်လာသည်ဟု ထင်ပါသလား။			
၅။	HIVနှစ်သိမ့်ဆွေးနွေးအကြံပေးသူထက် ဆရာဝန်၊ သူနာပြုကဲ့သို့သော ကျန်းမာရေးစောင့်ရှောက်မှုပေးသူဝန်ထမ်းများထံမှ အကြံပေးခြင်းကို အလိုရှိပါသလား။			
၆။	ဆရာဝန်၊ သူနာပြုကဲ့သို့သော ကျန်းမာရေး စောင့်ရှောက်မှုပေးသူဝန်ထမ်းများက သင့်မေးခွန်းများကို ပိုမိုဖြေဆိုအကြံပေးနိုင်မည်ဟု ထင်ပါသလား။			
၇။	သင်၏အန္တရာယ်များသည့်အပြုအမူများ၊ ကိုယ်ရေးကိုယ်တာအချက်အလက်များအား HIVနှစ်သိမ့်ဆွေးနွေးအကြံပေးသူထက် ဆရာဝန်၊ သူနာပြုကဲ့သို့သော ကျန်းမာရေးစောင့်ရှောက်မှု ဝန်ထမ်းများကို ပြောပြခြင်းက ပိုမိုသက်တောင့်သက်သာရှိသည်ဟု ထင်ပါသလား။			
၈။	ခြုံငုံပြောရလျှင် နှစ်သိမ့်ဆွေးနွေးအကြံပေးခြင်းခံယူရသည့် အတွေ့အကြုံသည် သင့်အတွက် အကောင်းဘက်တွင် ရှိသလား။			
၉။	အကယ်၍ နှစ်သိမ့်ဆွေးနွေးအကြံပေးခြင်းကို နောက်တစ်ရက်မည်ဆိုလျှင် ယခင်အကြံပေးသူနှင့်သာ ထပ်မံဆွေးနွေးလိုပါသလား။			
၁၀။	နှစ်သိမ့်ဆွေးနွေးအကြံပေးသည့်အချိန်များတွင် သင့်အားအချေမငံဆက်ဆံခြင်း၊ အထင်မမြင်သေးခံခြင်းကဲ့သို့သော အပြုအမူများရှိသည်ဟု ခံစားချက်ရှိခဲ့ဖူးပါသလား။			
၁၁။	နှစ်သိမ့်ဆွေးနွေးအကြံပေးသည့်အချိန်များတွင် သင့်အဖော်သို့မဟုတ် အခြားရင်းနှီးသည့်မိတ်ဆွေအား သင့်ရောဂါအခြေအနေကို ပြောပြရန် အထောက်အပံ့ဖြစ်ပါသလား။			
၁၂။	သင့်ရောဂါအခြေအနေအား သိရှိလိုခြင်း သို့မဟုတ် နေထိုင်မကောင်းဖြစ်သည့်အခါ မည်သူထံသို့ သွားရမည်ကို သိရှိပါသလား။			
၁၃။	သင်နေထိုင်မကောင်းဖြစ်သည့်အခါ ဆေးကုသမှုခံယူရန် သင့်အနေဖြင့် စိတ်သက်တောင့်သက်သာ သွားပြရမည့်နေရာရှိပါသလား။			

Appendix II

“Effectiveness of Peer Counseling for HIV Patients in Yangon; a Measure of Knowledge, Attitude and Practices”

Min San Tun, EMDevS 14th Batch

Questionnaire for HIV Patients

No.;

General

Age: _____

Gender (circle): M F

Clinic/agency where you received HIV counseling: _____

- 1) Have you completed all your required counseling sessions?
 - a.) Yes
 - b.) No
 - c.) Don't know
- 2) Did you receiving counseling from a peer HIV positive counselor?
 - a.) Yes
 - b.) No
 - c.) Don't know
- 3) Approximately how many counseling sessions have you attended?
 - a.) 0-3
 - b.) 4-6
 - c.) 7-9
 - d.) 10-12
 - e.) > 12 sessions
- 4) What is the highest level of education you have completed?
 - a.) unschooled
 - b.) Basic Education (grade 10 or below)
 - c.) Passed high school
 - d.) Vocational school
 - e.) Diploma
 - f.) Obtained Bachelor degree
 - g.) Obtained higher than Bachelor degree
 - i.) Other (please explain)_____

- 5) General area of residence:
- a.) Intercity/urban
 - b.) Sub-urban
 - c.) Rural
 - d.) Other _____
- 6) When did you first learn you were HIV-positive (estimate year)?
(19___)/(20___)
- 7) What is the most likely way that you became infected with HIV? Select the most likely way, even if you are uncertain
- a.) Sex with a man who was HIV-positive
 - b.) Sex with a woman who was HIV-positive
 - c.) Shared needles or other injection equipment with a person who was HIV positive
 - d) Blood transfusion or other medical exposure
 - e.) Needle stick or other exposure while at work (occupational exposure)
 - f.) Refuse to answer
 - g.) Other (please specify) _____
- 8) What was your last CD4 count?
- a.) Less than 200
 - b.) 200 – 350
 - c.) 351 - 500
 - d.) Over 500
 - e.) Not sure
 - f.) Have not had a CD4 count
- 9) Are you taking HIV medications?
- a.) Yes
 - b.) No
 - c.) Don't know
- 10) Who do you feel taught you the most regarding HIV?
- a.) My HIV counselor
 - b.) My doctor
 - c.) My friend
 - d.) My family
 - e.) I self-taught myself

Knowledge

HIV/AIDS Knowledge Assessment

Please check True, False, or don't know

	True	False	Don't Know
1. Coughing and sneezing, DO NOT spread HIV.			
2. A person can get HIV by sharing a glass of water with someone who has HIV.			
3. People who have been infected with HIV quickly show serious signs of being infected.			
4. A woman can get HIV if she has anal sex with a man.			
5. Showering, or washing one's genitals/private parts, after sex keeps a person from getting HIV.			
6. All pregnant women infected with HIV will have babies born with AIDS.			
7. Eating healthy foods can keep a person from getting HIV.			
8. There is a vaccine that can stop adults from getting HIV.			
9. A person can get HIV even if he or she has sex with another person only one time.			
10. A woman cannot get HIV if she has sex during her period.			
11. A person can get HIV through contact with saliva, tears, sweat, or urine.			
12. A person will not get HIV if she or he is taking antibiotics.			
13. Having sex with more than one partner can increase a person's chance of being infected with HIV.			
14. Taking a test for HIV one week after having sex will tell a person if she or he has HIV.			
15. A person can get HIV by sitting in a hot tub or a swimming pool with a person who has HIV.			
16. A person can get HIV from oral sex.			
17. Washing drug use equipment with cold water kills HIV.			
18. A person can be infected with HIV for 5 years or more without getting AIDS.			

Adherence of HIV Treatment (Attitude)

For each question, please circle your answer.

For each question, please indicate to what extent each of the following situations make you to receive the HIV treatment, services or opportunities on your experience are being on client satisfaction (please circle one response).

	No problem at all	Very slight problem	Somewhat of a problem	Major problem
1. Long distances to medical facilities and personnel.	1	2	3	4
2. Medical personnel (e.g., physicians, nurses, who decline to provide direct care to persons with HIV/AIDS	1	2	3	4
3. The lack of health care professionals who are adequately trained and competent in AIDS care.	1	2	3	4
4. The lack of transportation to access the services I need.	1	2	3	4
5. The shortages of psychologists, social workers, and mental health counselors who can help address mental health issues.	1	2	3	4
6. The lack of psychological support groups for persons with HIV/AIDS.	1	2	3	4
7. The level of knowledge about HIV/AIDS among residents in the community	1	2	3	4
8. Community residents' stigma against persons living with HIV/AIDS	1	2	3	4
9. The lack of employment opportunities for people living with HIV/AIDS	1	2	3	4
10. The lack of supportive and understanding work environments for people living with HIV/AIDS.	1	2	3	4
11. My personal financial resource	1	2	3	4
12. Lack of adequate and affordable housing.	1	2	3	4

Stigma and Discrimination to HIV patients (Attitude)

For the following questions, please check Not at all, A little, A fair amount, or A great deal.

Internalized Stigma	Not at All	A little	A fair amount	A great deal
1. How much do you feel that you should avoid holding a new infant because of your HIV?				
2. How much do you feel that you should avoid feeding children because of your HIV?				
3. How much do you feel that you should avoid sharing dishes or glasses just in case someone might catch HIV from you?				
4. How much do you feel that you have brought shame to your family because you have HIV?				
5. How much do you feel that you have HIV because you have done wrong behaviors?				
6. How much do you feel that you should avoid cooking for people because you have HIV?				
7. How much do you feel guilty about having HIV?				
8. How much do you feel disgusting because of your HIV?				
9. How much do you feel that you are paying for karma or sins because you have HIV?				

Counseling Experience (Attitude)

HIV Patient- Centered Questions: For each question, please mark Yes, No, or Not sure.

	Yes	No	Not sure
1. Did you have the same counselor throughout all your counseling sessions?			
2. Did you feel comfortable talking to your counselor during your counseling sessions?			
3. Were each of your counseling sessions done one-on-one between you and your counselor?			

4. Did you feel comfortable talking about your at-risk behaviors with your counselor (e.g., having sex with multiple partners, sharing needles, not using condoms all the time, etc.)?			
5. Were you able to ask questions during your counseling session?			
6. Did you feel comfortable asking questions during your counseling sessions?			
7. Were there questions that you were afraid of or uncomfortable with, asking your counselor during your counseling sessions?			
8. Were there questions you had during your, counseling experience related to your disease that your counselor was not able to answer during your counseling experience?			
9. Is there a counselor or a healthcare worker that you call or visit if you have more questions or concerns after the completion of your counseling sessions?			
10. Do you feel the counselor(s) you have worked with understand how hard your life is living with HIV?			

Adherence on HIV Treatment (Practices)

For each question, please circle your response. If you are not taking HIV medications, please skip this questions; from No.1 to 6 and skip to next section.

1. Do you ever forget to take your medicine?	Yes	No
2. Are you careless at times about taking your medicine?	Yes	No
3. Sometimes if you feel worse, do you stop taking your medicines?	Yes	No
4. Thinking about the last week. a.) Never b.) 1-2 times c.) 3-5 times d.) 6-10 times e.) > 10 times		
5. Did you not take any of your medicine over the past weekend?	Yes	No
6. Over the past 3 months, how may days have you not taken any medicine at all? a.) < 2 days b.) > 2 days		

Stigma and Discrimination to HIV patients (Practices)

For each question, please circle the number under your response.

		Very Dissatisfied	Somewhat Dissatisfied	Somewhat satisfied	Very satisfied
1.	In general, how satisfied are you with the overall support you get from your friends and family members?	1	2	3	4

2. Overall, within your support system, who gives you the biggest support regarding your HIV (choose one answer, your top choice)?

- a. Family member(s)
- b. Friend(s)
- c. Neighbor(s)
- d. Co-worker(s)
- e. My HIV counselor(s)
- f. My doctor[s] and/or nurse(s)
- g. Community elders
- h. Religious contacts monks, nuns, church, etc.
- i. I have not had anyone who supports me

For each question, please check if Yes (√) or if No (X)

Discrimination to HIV patients	√	X
1. Has a medical provider or hospital worker mistreated you because of your HIV?		
2. Have people looked at you differently because you have HIV?		
3. Has a healthcare worker not wanted to touch you because you have HIV?		
4. Have you been told not to share your food or utensils with family because of your HIV?		
5. Have you been asked not to touch or care for children because of your HIV?		
6. Have you been refused medical care or denied hospital services because of your HIV?		
7. Have family members forced you to move out of your home because you have HIV?		
8. Has a hospital worker made your HIV infection publicly known by marking HIV on your medical record?		
9. Has someone threatened to hurt you physically because you have HIV?		
10. Have you been refused housing because people suspect you have HIV?		

Counseling Experience (Practices)

HIV Patient- Centered Questions: For each question, please mark Yes, No, or Not sure.

	Yes	No	Not sure
1. Do you feel that your counselor(s) give you support for coping with the challenges of Living with HIV?			
2. If you are unable to take your medications as prescribed, or if you cannot make your follow-up appointment, is there someone you notify?			
3. Do you feel you understand more about your illness (HIV) after your counseling sessions?			
4. Do you feel that your understanding of taking medications and making follow-up appointments is increased after your counseling sessions?			
5. Would you prefer to be counseled from a healthcare worker such as a nurse or a doctor instead of your HIV counselor?			
6. Do you think a healthcare worker such as a nurse or a doctor would be better able to answer your questions?			
7. Would you feel comfortable sharing your personal information, such as any at-risk behaviors, to a healthcare worker such as a nurse or a doctor compared to your HIV counselor?			
8. Overall, was your counseling experience positive?			
9. Overall, if you were to have another counseling session, would you prefer to have the same HIV counselor?			
10. Have you ever felt mistreated or felt you were looked down upon during any of your counseling sessions?			
11. Have the counseling sessions made you feel more comfortable with your illness and talking to your partner or other close persons in your life about your illness?			
12. Do you know who to call should you feel sick and have questions about your symptoms?			
13. Do you know a place you can comfortably go to get evaluation and treatment if you feel ill?			