Evaluation Report

Myanmar NGO Consortium on HIV/AIDS Prevention and Care Programme (FHAM Round II)

CARE Myanmar

March 2007

Executive Summary

Myanmar NGO Consortium on HIV/AIDS Prevention and Care Programme (FHAM Round II) is the logical continuation of FHAM Round I programme, up-scaling the responses to HIV/AIDS and integrating other activities into one coordinated programme. The programme aims to build community resilience and mitigate the impact of AIDS through focusing on behaviour change, care and support services and enabling environment. The goal of the project is to reduce HIV transmission and enhance the quality of life of PLWHA.

CARE implements its part in 19 townships across the length and breadth of the country. During the course of implementation, CARE entered into agreement with three implementing partners – UNFPA for provision of reproductive health and HIV/AIDS education in the communities in five townships, UNICEF for care and support for orphans and vulnerable children and International HIV/AIDS Alliance for development of safer sex norms among MSM in Monywa.

The evaluation was conducted from 15 February to 31 March 2007, both quantitative and qualitative aspects, highlighting the processes that bring about the results. KAP study was convened in six townships to compare the changes over the baseline situation. Findings of the focus group discussions, clients' satisfaction and SWOC analysis were triangulated with the quantitative achievements. Staffs feelings, perceptions and experiences were presented in 'Our Stresses' to reveal the insight of the staffs.

Overall, all the planned targets were achieved and even surpassed majority of the targets. For behavioural change, 298,874 IEC materials were distributed, 51,720 people were reached through health education sessions and 73,893 beneficiaries were involved in life skills training and education. Reflective learning tool was introduced in February 2006 and found to be effective in one on one discussion.

Nearly 3,000 beneficiaries were provided with VCCT services – 2923 pre-test counseling, 2450 testing and 2655 post-test counseling. The number of people undergoing post-test counseling was greater than those of testing because HIV positive people were referred from other implementing partners for counseling and of course to receive support. Home based care was delivered to 2992 PLWHAs of which 1872 are still alive. 2099 OVC received nutrition, education and health support. Referral system supported 4534 beneficiaries for quality treatment – 86 percent for OIs and 8.6 percent for TB. Altogether 19 Self Help Groups were formed – 13 PLWHA-SHG, 2 SW-SHG and 4 MSM-SHG – and are functioning.

Findings of the KAP study demonstrated improvement in knowledge, attitude and practices among youth aged 15 to 24 years over baseline data. The percentage of youth who can name three common modes of transmission increases from 75.3 to 90.9. Regarding the number of youth who can name three common ways of prevention there is only slight increase, from 42.4 to 47.8 percents. Incorrect beliefs about transmission fall from 82.2 percent to 39.8 percent. Correct knowledge (UNGASS indicator) increases from 18.8 to 59.8 percents. The comprehensive correct knowledge (transmission, prevention, rejection of misconceptions) improves from 7.8 to 28.2 percents. 71.1 percent of youth shows right attitude compare to 33.7 percent in baseline. The percentage of youth with multiple partner last 12 months and sex with SW decreases. The condom use rates are raised in all occasions – sex with non-regular partner (27.8% to 80.2%) and sex with SW (27.3% to 93.1%).

Beneficiaries – PLWHAs, MSMs and SWs – were more open up and they overcome stigma and discrimination. They involved in many activities – dissemination of knowledge and information, referral, care and support – to other beneficiaries. Formation of SHGs provides encouragement to beneficiaries to be self reliance and lead a productive life. This in turn, if fully functional, could contribute to sustainability.

The strengths of the project are the dedication, commitment, and skills of the staffs, and the presence of CARE's project in the locality with its credibility. Communication gap between central and field level, deficient transportation facilities in the light of nature of the project, changing formats and over workload are some of the weaknesses. Understanding and cooperation of the local authority, presence of other implementing partners and other CARE's project(s) and functioning SHGs are opportunities for the project to deliver services effectively and efficiently and to be sustainable. However, due to too much close relationship between beneficiaries and staffs and sympathy and empathy of staffs signals the emergence of dependency among some beneficiaries. Some beneficiaries already regard that these are the responsibility of CARE and they make undue demand beyond the mandate and limits of the project capability.

It was learnt that many townships situated far apart imposed administrative, technical, quality control and logistic difficulties. Different set or activities for different township cause confusion among staffs and beneficiaries. There is deficiency in feed back and follow up to the recommendations of the mid-term evaluation and as well as the monthly progressive reports and the Consortium quarterly reports. Change of reporting formats results in difficulty compilation of the data. The field level staffs need training on the recording and utilization of data.

Development of project with cluster townships will facilitate easy monitoring and support. Communication gap between central and field level requires improvement. It is critical, during the project inception period, to create common understanding of the project, to build capacity, to develop monitoring and evaluation plan and logical framework and to set criteria, guidelines and procedures to ensure delivery of services effectively and efficiently. These procedures, criteria and guidelines and planned targets are subject to change depending upon the situation and experience gained. The standardization of the support across the projects is crucial as well to avoid misunderstanding among beneficiaries. Any assistance and support to the beneficiaries should be judged from the perspective of 'dependency syndrome'. Exit strategy for sustainability needs to be considered during the course of implementation of the project, not at the end of the project. Capacity building and empowerment is necessary together with assignment of specific roles and responsibility to the concerned party is essential. This requires participatory trial and assessment and revision whenever necessary.

In conclusion, the objective of the project is achieved to an acceptable level. Behavioural change and improvement in quality of life of PLWHAs is observed. Sustainability of some activities to some extent can be anticipated.

Abbreviations

ART	: Anti-Retrovial Therapy
EW	: Entertainment Worker
FGD	: Focus Group Discussion
FHAM	: Fund for HIV/AIDS in Myanmar
GF	: Global Fund
HBC	: Home Based Care
HE	: Health Education
IEC	: Information Education Communication
KAP	: Knowledge Attitude Practice
LS	: Life Skills
MSM	: Men having Sex with Men
MWMP	: Men with Multiple Partner
OVC	: Orphans and Vulnerable Children
OW	: Outreach Worker
PAR	: Participatory Action Research
PE	: Peer Educator
PIT	: Project Implementation Team
PLWHA	: People Living With HIV/AIDS (PWHA)
SHG	: Self Help Group
SW	: Sex Worker (Working Women)
SWOC	: Strengths Weaknesses Opportunities Challenges
TOT	: Training of Trainers
VCCT	: Voluntary Confidential Counselling and Testing

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Evaluation Report
Myanmar NGO Consortium on HIV/AIDS Prevention and Care Programme 2004/5 – 2006/7 (FHAM Round II)

1. Project Summary[1]

The Myanmar NGO Consortium on HIV/AIDS (Consortium) was established in 2002 by five experienced and committed Non-Governmental Organizations: CARE Myanmar (CARE), Marie Stopes International (MSI), Myanmar Nurses Association (MNA), Save the Children UL (SC UK) and World Vision Myanmar (WVM) to build a more comprehensive higher quality response to HIV/AIDS in Myanmar by its members. The FHAM Round I was implemented from January 2003 to July 2004. The first year of shared FHAM funding has allowed members to upscale their response to HIV/AIDS considerably.

The Consortium has seek, for Round II, an increase in funding around 60% on the Year 1 budget to integrate other activities, previously funded elsewhere, into one, coordinated programme. In addition, and in response to the alarming shortfall in support for reproductive health services and STI treatment in Myanmar, increasing priority was being given to improving access for young people to quality reproductive health services. The Round II proposal seek to support and expand ongoing HIV/AIDS programmes of member agencies which aim to build community resilience and mitigate the impact of AIDS, through focusing on three programme priorities: behaviour change, care and support services and enabling environment. The main beneficiaries were young people (10-24 years), high risk populations, people living with HIV/AIDS (PLWHA), community influencers, broad population, STI care providers, project and partner staff.

The programme covered the 20 months duration from August 2004 to March 2006 addressed the Component 1: Sexual transmission of HIV, Component 3: Knowledge and attitudes, Component 4: Care, treatment and support for PLWHA, and Component 5: Enabling environment of Joint Programme in Myanmar, covering 35 townships in 9 states/divisions.

CARE Myanmar utilized FHAM funding in 19 townships. The project has extended two times: one from April 2006 to November 2006 and another from December 2006 to March 2007, for a total of one year. Therefore, the total duration of the project becomes 3 years. During the course of implementation, in the third phase of FHAM funding, the number of PLHA and OVC is increasing month by month while current funding is not anticipated to cover all the expense of the emerging PLHA and OVC in the program. UNICEF agreed to provide fund to meet this growing demand for one year, July 2006 to June 2007[2].

CARE came into agreement with UNFPA regarding provision of reproductive health and HIV/AIDS education in the communities in selected townships with effect from 1 May 2005 and ended in December 2006.[3]

[1] Myanmar NGO Consortium on HIV/AIDS. Proposal Application for FHAM Round II (2204/5 – 2005/6)

[2] CARE Myanmar. Project proposal, Care and support program for orphans and vulnerable children (OVC). May 2006

[3] Field Level Agreement between United Nations Population Fund (UNFPA) and CARE Myanmar.

In March 2006, CARE agreed to act as the Collaborating Agency in the tripartite agreement between International HIV/AIDS Alliance, Rose Group / Khaing Hnin Si and CARE Myanmar to carry out three sets of participatory discussion groups in order to support the development of safer sex norms among MSM in Monywa from March 2006 to September 2006. As a Collaborating Agency, CARE has to provide technical support in financial and accounting matters.[4] The agreement was able to start only in January 2007 and CARE staffs has to provide, in addition to financial and accounting matters, technical and administrative support as there is no staff from Alliance.

2. The Evaluation Process

The evaluation of the project was done in the light of quantitative and qualitative achievements and highlighted the process that brings about these results. The perceptions and opinions of beneficiaries and staffs were triangulated with the achievements taking into consideration the relevance, effectiveness, efficiency, impact and sustainability of activities whenever possible. The 'stresses' experienced by staffs that are usually taken for granted and never bring into light are valuable and important for future implementation. Then lessons learned were drawn from the experiences of all stakeholders and recommendations are made based on the lessons learned.

3 Achievements against Targets

The achievements of the project are evaluated according to the Monitoring and Evaluation Plan explicitly spelled out in the M&E Plan revised in April 2006. Planned targets are calculated as a cumulative total targets FHAM targets incorporating the targets for two extension periods.[5,6,7,8,9] In the M&E plan, targets are mentioned only at activity level. However, during the evaluation, some data that are not included in the objective and output levels are filled up to facilitate visualization of the project comprehensive picture. Achievements were the cumulative total of monthly progressive reports[10] Consortium quarterly reports.[11]

Table 1: Monitoring and Evaluation Plan

	Indicators	Data Needed	Planned Targets	Achievements
Goal To reduce HIV transmission and enhance quality of life of PLWHA	• % of young people aged 15-24 who are infected • % of Sex Workers who are infected • % of Infants born to mothers who are infected • Orphans' school attendance	# of youths infected # of SWs infected # of infants infected # of orphans attending school		

[4] MOU between International HIV/AIDS Alliance, Myanmar and Rose Group/Khaing Hnin Si in collaboration with CARE, Myanmar. Grant No. GR-2006-016.

	Indicators	Data Needed	Planned Targets	Achievements
Objective To change behaviour to reduce transmission of HIV and to improve the health of PLWHA	• % of young people aged 15-24 reporting use of condoms during sexual intercourse with a non-regular partner • % of Sex Workers who report using condom with most recent client • % of MWMP reporting condom use at last anal sex • % of youths (15-24) expressing accepting attitudes towards PLWHA	# of youths using condoms \# of SWs using condom \# of MWMP using condom at last anal sex \# of youths expressing accepting attitudes towards PLWHA	Baseline: T 27.8% M 44.3% F 11.3% Baseline: T 33.7% M 33.3% F 34.1%	End-of project: T 79.2% M 76.0% F 86.4% End-of project: T 71.1% M 70.1% F 72.0%
Component 1 (Sexual Transmission of HIV) Output 1.1 Improved access to affordable condoms	• Condom distribution	\# of condoms distributed		
Output 1. 2 Increased access to quality treatment and care of STIs (Quality STI management)	• Clients referred to STI services	\# of clients referred to STI services		
Component 3 (Awareness raising) Output 3.1 Increase awareness of HIV/AIDS among general population	• Awareness raising events including supporting World AIDS Day	\# of awareness raising events		
Output 3.2 Increased awareness of HIV / AIDS among young people and specific target groups	• IEC / BDCC materials distributed to youths, SWs , MWMPs • PEs / OWs / Volunteers involved in the project	\# of IEC / BDCC materials distributed to youths, SWs, MWMPs \# of PEs / OWs / Volunteers		493

	Indicators	Data Needed	Planned Targets	Achievements
Output 3.3 Increased awareness of HIV/AIDS among young people and enhanced capacity of young people to manage their reproductive health	• Life Skills trainings provided to young people	# of Life Skills trainings conducted # of youths involved in Life Skills trainings		
	• % of youths identifying 3 most common ways of preventing HIV / AIDS transmission	# of youths correctly identifying common ways of preventing	BL: M 46.0% F 39.0%	EOP: M 45.9% F 49.6%
	• % of youths correctly rejecting major misconceptions about HIV/AIDS transmission	# of youths correctly rejecting major misconceptions about HIV / AIDS transmission	BL: M 19.8% F 17.9%	EOP: M 57.7% F 61.8%
	• % of youth correctly identifying 3 most common ways of HIV/AIDS transmission	# of youths correctly identifying common ways of transmission	BL: M 79.6% F 71.0%	EOP: M 90.8% F 91.0%
<u>Component 4 Care , treatment and support for PLWHA</u> Output 4.1 Improved access to quality care and treatment services for PLWHA	• PLWHA receiving Home Based Care	# of PLWHAs receiving Home Based Care		
	Townships with community Home Based Care	# of townships (new + existing)		12
Output 4.2 Increased awareness and access to VCCT	• Establish VCCT proper referral system referring people	# of people referred for VCCT		
	• People receiving pre test counselling	# of people received pre test counselling # of people receiving HIV testing # of people receiving post-test counseling		
Output 4.3 More supportive environment created in programme townships	• OVC support provided in townships where CHBC is implemented	# of OVC provided support		
	• Townships where OVC support is implemented	# of townships with OVC support		12

	Indicators	Data Needed	Planned Targets	Achievements
Component 5 Enabling Environment Output 5.1 Enhanced support of opinion leaders for programme activities	• Youth , SWs , MWMPs and PLWHAs advocacy events conducted at all levels	# of advocacy events conducted at all levels		
Output 5.2 Coordinated and strengthened partnership	• Co-ordination meetings to develop a comprehensive responsive t o HIV / AIDS	# of Co-ordination meetings		
Output 5.4 Improved capacity for implementation at all levels	• Trainings on STI management for providers • Trainings on HBC for volunteers • Trainings for self help groups	# of trainings on STI mgt # of trainings on HBC # of trainings for SHGs		
Activities 1.1 Distribution of condoms	Condoms distributed	# of Condoms distributed	3,959,600	M 4,182,859 F 6,766 T 4,189,625
1.2 Access to quality treatment and care of STIs	Clients referred for management (quality treatment and care of STIs)	# of clients referred	440 STI patients	MSI = 115 Other = 279 Total = 394
3.1 HIV / AIDS information booths	Booths conducted at annual events , new year , religious festival , Thingyan Festival and other exhibitions	# of booths conducted	2	32
3.2 Distribution of IEC materials such as pamphlets , posters , cartoons , and promotional gifts to reinforce behaviour change among specific target groups	IEC materials distributed	# of IEC materials distributed	139,900	298,874
3.3 Awareness raising on HIV / AIDS among general population	General population involved in HE sessions	# of participants involved in HE sessions	13,035	51,720
3.4 Improving life skill activities of young persons	Youths involved in Life Skill Trainings	# of youths involved in Life Skill trainings	18,470	73,693
4.1 PLWHA receiving Home Based Care	New and existing PLWHA receiving Home Based Care	# of New and existing PLWHA receiving Home Based Care	960	2,992
4.2 VCCT	Pre-test Counselling Testing Post Test Counselling	# of people receiving pre-test counselling # of people who voluntarily tested for HIV # of people receiving post test counselling	2,885 1,765 3,165	2,923 2,450 2,655
4.3 OVC Support	OVC receiving support	# of OVC receiving support	1300 existing and 120 total new OVCs	2,099

	Indicators	Data Needed	Planned Targets	Achievements
5.1 Home Based Care training for volunteers	• Number of volunteers attended • Number of training conducted	# of attendees # of training conducted	80 volunteers 5 Trainings	 9
5.2 Advocacy conducted at all levels for Youths , SWs , MWMPs , PLWHA	Advocacy events conducted at all levels for Youths , SWs , MWMPs , PLWHA	# of Advocacy events	10 advocacy events	158
5.3 Coordination meetings to develop a comprehensive response to HIV / AIDS	Coordination meetings	# of coordination meetings	44 Coordination Meetings	136
5.4 Training of Self Help Groups	Self Help Group Trainings	# of trainings	Total 4 trainings	2
5.5 Training of GPs for quality care and treatment of STIs and TOT for teachers and religious leaders ??	# of trainings conducted for GPs on quality care and treatment of STIs	# of trainings conducted	2 trainings for GPs 3 TOT trainings	OI and ART management
5.6 Monitoring of Quality of services	Monitoring of quality of services by each respective staff	Information in Checklist		

For the assessment of program quality, FHAM senior staff will access during their field trip, FGD, KII, IDI with staff and stakeholders including beneficiaries, studying MSC stories, etc;

It can be seen that almost all of the planned targets were achieved and surpassed in many instances. The deficiencies in recording and reporting system failed to get the necessary data, for example number of attendees for trainings. The Project has to submit two kinds of report – monthly progress report for CARE and Consortium quarterly report and there is different in requirements for each report. The confounding confusion and burden with reporting was the change of reporting format for both reports. This is vividly evident when total cumulative achievements are calculated at the end of project causing difficulty in deriving a consistent data. (Annex A: Joint Programme Component-wise Achievements)

4. Behaviour Change

The project aims to reduce HIV transmission and enhance the quality of life of PLWHA. To achieve this objective behavioure change is the critical element of the project activities. For the behaviour change, many tools were employed – IEC materials, health education, life skills, reflective learning.

IEC materials

298,874 IEC materials have been distributed already. Majority of IEC materials go to special events booths, youths, migrant and transport workers. (Annex A: Table 3). Altogether, 314,313 number of IEC materials were produced. It comprises of 88,800 promotional materials (10 items) and 225,500 printed materials distributed individually (13 items). There is one item for larger audience (13 billboards) (Annex A: Table 4). Staffs noted that some IEC materials are not targeted and staffs from Northern Shan also suggested to produce IEC in local dialect. In general, for any language, it is found that the percentage of people who understand written language is much less than those who understand spoken language depending upon literacy rate. Moreover, even for Shan language, there are two major languages.

Health Education

At first, since FHAM I period, PITs (Project Implementation Teams) were formed with volunteers from the community / beneficiaries provided them with TOT (Training of Trainers) on HIV/AIDS. They organized health education sessions at their respective locality with the assistance of Outreach Workers (OW). Health education session was conducted using flip charts and distributed IEC materials and demonstrated condom use. The benefit of health education is that participants gain knowledge and some skills in condom use. Sensitivity surrounding sex and sexuality is lessened although some regards talking about condom as sex provocative. They accept condom as a health commodity. In fact, health education is the entry point to reach beneficiaries especially marginalized people. The disadvantage is that being a large group, it does not favours discussion and those who want to ask question are also reluctant to speak out in front of large crowd. Some people think that HE is not for them and it is only for those who are notorious. Altogether 51720 people were given HE. Out of which students comprised of 32.8 percent. (Annex A: Table 6)

Life Skills

Life skills training were conducted for staffs, altogether 8 trainings, and started implementing in November 2004. The main target for life skills training is youth and vulnerable groups like sex workers, MSMs, IDUs, entertainment workers, migrants, transport workers. Life skills training are usually given in small group of five participants and encourage two-way discussion. The draw back is that it is difficult to meet the same participants for three times to cover all seven skills. Besides, the stories in the modules are not relevant to the local context and staffs have to adapt and revise to meet the local situation. The whole session is evaluated with the prescribed form. The life skills education was so well accepted by the beneficiaries that project received invitation even from parents and warm welcome by authorities and factories. Some youth came to the project office and discussed on their issues/problems. (Annex B: Life skills)

> *"One PIT volunteer is a delinquent, drinker, gambler and womanizer and always blames his parents. After receiving life skills training, he becomes polite, get along well with everybody and help his parents". (Staff)*

> *"In the past money is our priority. Now we know what is more important. We care our health. We use condom always and refuse without condom even if they pay more money." (SW)*

Altogether 73,693 beneficiaries were involved in life skills education – 34.6 percents were youths (students) and 17.7 percent were migrant workers. (Annex A: Table 6)

Reflective Learning

Reflective learning/PAR tool was introduced in February 2006. PAR is more flexible as there is no prescribed procedure and discusses on issues coming out of talking based on their own experience. Staffs observed that by doing PAR, they gained more confidence from beneficiaries (SW). In PAR, they are able to discuss not only HIV/AIDS but also other issues encountered in their life time. For PAR to be successful, it requires mutual trust and confidence and good inter-personal relationship.

> *"PAR has wider scope than HE and LS. It enables to probe deeper into their habit and practices. Open and frank discussion is possible. Because of frequent contact, changes can be observed."*

Self-reported evidence of behavioural changes was revealed by many beneficiaries during focus group discussions. Sex workers reported that about 70 percent of them uses condom and more and more SW become using condoms. In the past money is their priority and use what ever they earn in gambling and for nothing, but now they care their health. However, there are some SWs who think that young and handsome boys are clean and thus they do not use condoms.

> *"Previously, I think of money only and work in the face of money. If the client pays more money for plain sex (without condom) I accept. Now I never go without condom and refuse even they offer more money."*
>
> *"In the past, money from the mat is spent on the mat (gambling). Now I save money and send to my parents."*
>
> *"If they (clients) do not want to use condoms, I use female condoms."*
>
> *"I did not use condom with my boy friend in the past. I only used with clients. Now I use with my boy friend too."*
>
> *"I witnessed future bright light of one colleague who quits from this work."*

MSM also reported that almost all MSMs now use condoms consistently, estimated to be 70 - 80 percent. One MSM regards condom as life saving instrument. They also impart the knowledge they acquired to fellows particularly to those who have limited access to IEC services. They persuade their clients who refuse to use condoms by telling the pros and cons of using condoms. Some also reduce the number of clients.

> *"When this HIV/AIDS appears I think it is a bad omen for our earning. After knowing about it I know it is near to my arm's length. If I contract the disease my life will be finished. So I always use condom and reduce my clients from 10 to 5."*
>
> *"I always keep condom with me, for me and to give to those in need."*

It is surprising to note that in some areas, especially in rural areas, there are people who do not know condoms, may be due to different vocabulary.

> *"During school holiday, I went to* Asin *village and gave talks on HIV/AIDS. When I talked about condom they did not understand it. When I said 'law-ra-ki ah-soot' then they knew it. They are* 'ah-pone' *by day and* 'ah-pwint' *by night."*

Many PLWHAs are no longer ashamed of to be known by other people of their infection and they try to lead a normal life, helping and assisting fellow PLWHAs.

> *"At first, I was afraid and ashamed of being known by others. Now, I have sympathy for fellow PLWHAs and give encouragement to them. I go out as usual." (female PLWHA)*

> *"If someone asks me whether I have HIV/AIDS, I dare to say 'YES'. (female PLWHA)*
>
> *"My family understands me now. Previously, even my friends discarded me. I change psychologically and I do not think myself as a patient." (male PLWHA)*
>
> *"Before having contact with CARE, I did not know how to prevent and how to protect myself and so unknowingly I passed on* 'yaw-gar-poe' *(HIV) to others. Now I behave myself." (male PLWHA)*

There is a dilemma among staffs comparing the effectiveness of each tool in behaviour change. Some beliefs that flip chart and IEC materials are not necessary for behavioral change. In fact, each tool has its own merit, effectiveness and efficacy depend upon the situation and level of knowledge and willingness of beneficiaries to change and readiness of the environment conducive for change and the trust and confidence of beneficiaries on the staffs. Every body agrees that knowledge only is not enough to change the behaviour but it is an essential element towards behaviour change. Without skills, the knowledge gained cannot be applied and utilized in making decision for real life situation. Moreover, if the person does not learn reflecting his/her or others' experiences he/she may not able to choose a correct option.

5. Voluntary Confidential Testing and Counselling (VCCT)

Voluntary Confidential Testing and Counselling is an entry point for comprehensive home based care and support programme. (Annex C: VCCT). Previously, people were reluctant to go for HIV testing because of concern over confidentiality and stigma and discrimination. Staffs exercised every possible effort to maintain confidentiality and thus clients always requested staffs to take the results on behalf of them. This facilitates post-test counselling. As the project carries on, people have confidence in staffs and understand the value of counselling and as such more and more people are open enough to undergo HIV testing.

Out of 2923 beneficiaries undergoing pre-test counseling, 2450 accepted HIV testing and 2655 people came for post-test counseling. (Annex A: Table 8). The overall positive rate is 29.7 percent. It can be seen that the number of people coming for post-test counseling surpassed the number of people going for testing. The counselling service provided by CARE is well accepted that clients are sent to CARE for post-test counselling by many health providers when they found positive. It is peculiar and not logical to note that in the plan targets the number of people receiving post-test counseling was 3165 compare to the number of people receiving HIV testing, 1765.

VCCT helps PLWHA to lead a positive life. Staff from Mudon recounted her experience:

> *"One girl was going to marry one returnee from Thailand. The couple agreed to undergo VCCT. Unfortunately the bridegroom-to-be was found to be positive and was given post-test counselling. I suggested to use condom as a option. The bridegroom replied that he loved his bride-to-be and he did not want her to get infected and so he decided not to marry her. The girl also understood him. They remained as close friends."*

Staffs observed that there were more and more marriage counselling and testing. The practical programmatic constraint is that, for each township, target is set and staffs are, sometimes, in a difficult situation to cope with the growing demand. In some townships, VCCT service without access to ART make PLWHAs depress. With the aim of meeting the set target, staffs sometimes suggest rather than providing options for HIV testing that might infringe on 'voluntary' testing.

6. Enhancing the Quality of Life

Many efforts are endeavoured to enhance the quality of life of PLWHAs. In addition to counseling, they are provided with HBC, Referral service, Nutritional support, Psycho-moral support, Social support, Income-related support and Capacity building to be self reliance. Self help groups are formed. The main reasons for making contact with CARE are: to get VCCT, to be healthy and to prolong life, to reduce stress and to get moral support, refer from PMCT programme, GPs and friends, and of course to receive support.

> *"I thought I was the only person who suffers from this disease and I usually cried with down-hearted. Now I am a member of* Haung-kyo-mei (PLWHA-SHG) *and I met fellow sufferers. We help solving each other's problems. Life becomes meaningful."*

> *"I got married by my parents. He worked in Thailand and returned back when he was sick and died. I was worried that I also got this disease. I was ashamed and afraid less my family and neighbours know my condition. I contacted CARE through my friend and I received all services. Now I can withstand the censure by environment. I know that I may not die instantly. I have my children and I have to educate them."*

> *"Now I don't want to die. I see life is beautiful. I take care of my health. When SHG perform* 'shin-pyu-pwe' *(novitiate ceremony) I am very happy."*

Most of the PLWHAs are not longer feel dejected, lonely and helpless. They become part of the community they belong and lead as much as possible a normal life. There are some who are so depended on CARE that they request to meet all their demands and requirements. Some PLWHAs call out the staff for every issue they face and expect to receive all support. It necessitates leveling out the understanding between the project and beneficiaries in the light of limitations of project mandate.

6.1 Home Based Care

During the project period, the project was able to provide HBC to 2992 PLWHAs. Out of which, 946 expired, 42 are referred out and 125 lost in follow up and 1872 remains alive. It is worth noted that 8 PLWHAs said that they do not need further support. (Annex A: Table 7). Criteria for eligibility for HBC and contents of HBC kit were standardized. (Annex D-1: HBC). However, there was slight variation between townships. (Annex D-2: Contents of BHC kit). Nutrition support worth 4000 Kyats were provide monthly and it consisted of vitamins and quaker oats, noodles, cooking oil and eggs depending on township to township based on beneficiaries preference.

Because of HBC, stigma and discrimination was reduced among family members. They even provide care to fellow PLWHAs. They felt that they were not abandoned and HBC uplift the

psychology of PLWHAs. There were instances where some poor PLWHAs sold quaker oats to buy medicines. As the number of PLWHAs increased by time, staffs were hardly able to pay regular home visits, and are compounded by insufficient transportation facility.

6.2 Support for Orphans and Vulnerable Children (OVC)

Altogether 2099 OVCs are supported; out of which 95 are HIV positive. (Annex A:Table 9) They are provided with monthly nutrition support and health and education assistance. Child protection kit and one-time supply are also provided. Other services like family counseling, entertainment activities, cross visits are also conducted. (Annex E). Journey of Life training attracts OVCs and family members as well. Vocational training like sewing, weaving and mechanical workshop is also given. By working together on mobility mapping, psychological aspects of children are better understand and can provide needed supports.

Role of Septrin in PLWHAs

Findings from Mon state (Mawlamyine and Mudon) regarding the role of Septrin among PLWHAs are encouraging in terms of survival. Out of 1359 PLWHAs, 161 (11.8%) take Septrin. Overall survival rate after 3 years for Septrin group is 76.4 percent and that of without Septrin is 63.4 percent. Among the asymptomatic PLWHAs, survival rate among Septrin group is 100 percent and 89.6 percent in without Septrin group. The corresponding rates among symptomatic PLWHAs are 68.6 percent and 53.1 percent respectively.

Table 2: Survival of PLWHAs with and without Septrin in Mon state

Condition		Number of PLWHAs														
		< 1 year			1 – 2 year			2 – 3 year			> 3 years			TOTAL		
		A	D	T	A	D	T	A	D	T	A	D	T	A	D	T
Asymptomatic	Septrin	19	0	19	10	0	10	8	0	8	3	0	3	40	0	40
	No Septrin	76	20	96	66	1	67	48	6	54	2	3	5	192	30	222
	TOTAL	95	20	115	76	1	77	56	6	62	5	3	8	32	0	262
Symptomatic	Septrin	32	21	53	33	13	46	16	3	19	2	1	3	83	38	121
	No Septrin	214	253	467	135	46	181	58	13	71	26	0	26	433	312	745
	TOTAL	246	274	520	168	59	227	74	16	90	28	1	29	516	350	866

Fig. 1: Survival rate of asymptomatics PLWHAs

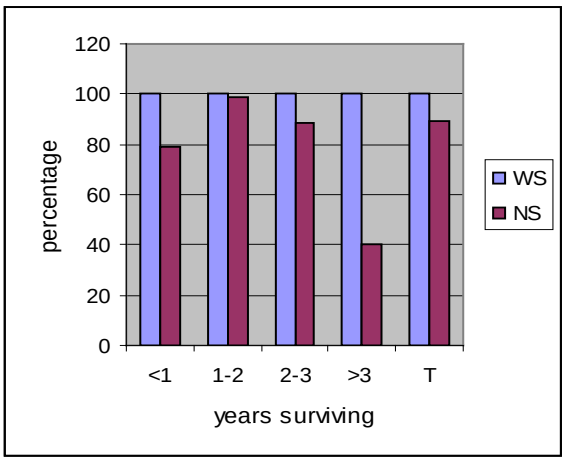
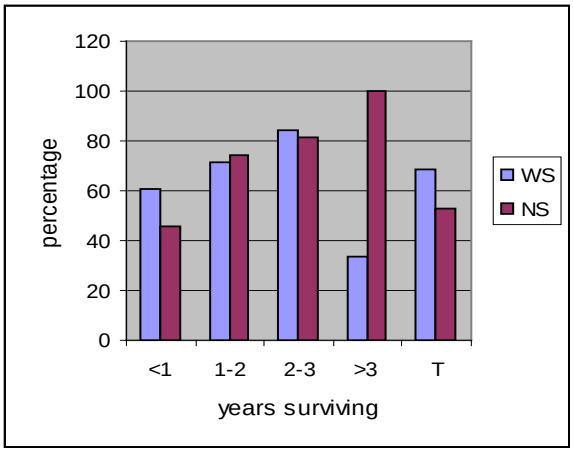


Fig. 2: Survival rate of symptomatics PLWHAs



WS = With Septrin NS = No Septrin T = Total

Septrin has some effects on survival years by preventing occurrence of opportunistic infections provided that all other conditions affecting survival remains the equal. The effect is more pronounced among asymptomatic than symptomatic PLWHAs.

6.3 Referral System: Improving access to quality care, subsidizing for treatment cost

Referral system aims to provide quality health services and to reduce financial burden on infected and affected family and to encourage PLWHAs to take prompt and adequate treatment when sick. (Annex F). As one PLWHA pointed out that the message that expressed *'there is no cure for AIDS, sure to die'* desist them from taking treatment for any illnesses in the past. By treating OIs health of PLWHA is improved and they can pursue productive life. Altogether 4534 persons were referred to hospital, NAP, TB team, GP, NGOs: 3899 for OIs, 390 for TB, 48 for PMCT and 197 for other support.

Nearly 86 percent (85.99%) of people were referred for OIs and 8.6 percent for TB. Majority of the people (74%) were referred to GPs. (Table 3)

The current reimbursement procedure does not permit to assess the validity of vouchers. Some guardians (pimps) do not allow their girls (SWs) to seek medical treatment.

Table 3: Number of persons referred by type of institution and purpose of referral

Purpose of referral	Number of persons referred						
	Hospital	NAP	TB team	GPs	NGOs	Others	TOTAL
OIs	152	174	10	3326	211	26	3899 (85.99%)
TB	7	4	327	10	41	1	390 (8.6%)
PMCT	37	7	0	3	1	0	48
Others	9	29	1	18	133	7	197
TOTAL	205	214	338	3357	386	34	4534

6.4 Self help groups

Altogether 19 self help groups (SHG) were formed – 13 for PLWHAs, 2 for SW and 4 for MSM (Table 4). Later on one MSM-SHG (*Ah-lin-young*) originally formed by PSI in Mandalay participated in CARE's activities. SHGs are formed to be self reliance, to pursue a productive life and for the sustainability of activities. (Annex H).

Table 4: List of self help groups

No.	Name of township	Name of Self Help Group
PLWHAs		
1	Mawlamyine	1. Phyu-sin-myitta Bawa-than-thara; 2. Myitta-sone-see
2	Mudon	1. Nhaung-kyo-mei (5 SHGs – Mudon, Kawkhapon, Nyaungkone, Naingpyaing, Kwantar)
3	Yay	1. Ma-nwan-thaw-pan (Kawdut); 2. Phyu-sin-myitta (Lamine)
4	Monywa	1. Phyu-sin-myitta; 2. Yin-nyein-pan
5	Lashio	1. Ah-lin-yaung
6	Muse	1. Maw-Cherry
	T O T A L	13 SHGs

SWs		
1	Mawlamyine	1. Myitta-sone-see
2	Pyay	1. Myitta-sone-see
	T O T A L	2 SHGs
MSMs		
1	Mawlamyine	1. Sa-na-mhu-setana
2	Monywa	1. Pyit-taing-htaung
3	Pyay	1. Khit-ta-yar Swe-taw-oo
4	Bago	1. Setana Arr-man
	T O T A L	4 SHGs

PLWHA-SHG

In the past, PLWHAs were afraid of being known by other people about their sero-status because of concern over ostracism exercised by community and even by family members. Now days, not only the stigma and discrimination are reduced but also the infected and affected people gain confidence enough to face and encounter these negative attitude. PLWHAs initiated to form group who have same understanding and feeling to help each other and to support each other.

Each SHG has its own objectives of about 4-5 objectives. The objectives of PLWHA-SHGs are listed below:

- To provide health, knowledge and psychological support among PLWHAs
- To improve capacity of PLWHAs
- To participate in HIV/AIDS prevention activities
- To create a brighter future for OVCs
- To have friendships among PLWHAs
- To provide home based care among PLWHAs
- To discuss openly about social and family affairs and assist each other
- To establish and carry out income generation activities
- To assist PLWHAs and OVC financially

One SHG aims to live normal life span (*Yin-nyein-pan*). One SHG wants to reduce stigma and discrimination on PLWHAs (*Myitta-sone-see*). There are many similarities in between SHGs. All PLWHA-SHGs aim for assisting each other and also OVC in health, psychological and financial matters, overcoming stigma and discrimination and developing self reliance. In summary they are trying to improve the quality of their life.

The activities of SHG range from providing care and support to fellow PLWHA to doing income generating activities. SHG members usually meet once a month, sharing experience and solving problems encountered. Although there is no written agreement, they help CARE in provision of HBC, referral, distribution of condom, nutrition packages and medicines and supplement financial support for funeral grant, render helping hands at DIC and library. Activities are listed below:

- Home visit and care to sick PLWHAs
- Condom education and distribution
- Peer education
- Assist OVC
- Assist in referral for HIV testing, consultation for TB, and treatment of OIs, counselling

- Referral for vocational training (sewing at AFXB)
- Income generating activities (money lending with interest, selling fire woods, household goods)
- Social activities (novitiate OVC)

SW-SHG
Two SW-SHGs were formed, one in Mawlamyine and one in Pyay, in 2006. The objectives of the SHGs are to help members in case of distress (arrest), to support when taking treatment for illnesses, to disseminate health knowledge and to participate in HIV/AIDS prevention activities. Members save 1000 Kyats per month and meet once a month at CARE office. During the meeting members share their experience and staff facilitate for reflective learning.

MSM-SHG
In fact, *'sana-hmu setana'* group was formed way back in 1995 in Mawlamyine by a group of MSMs to give empathy to fellow MSM, to assist in case of health and social affairs and to provide funeral support. Two SHGs were established in 2006 and one in 2007. In general, the main objectives are: to assist infected and affected family, to share information to lead a healthy life and to help fight against stigma and discrimination. Members provide peer education, home based care, condom distribution and assist in referral for health care.

7. Findings of Focus Group Discussions [12]

PLHAs

Out of services provided by CARE, PLWHAs expressed that they are most satisfied with home based care, nutrition support, home visits, referral for treatment of illnesses, counseling, and support for OVC, forum, and cross visits. They also appreciated for helping to get ART. They wish every positive people access to ART. They are no longer afraid of community to be discriminated and they tried to live a normal life.

"In the past it is very difficult to meet with PLWHA each other. No body let other people know us as PLWHA and we dare not open even to our family. Now we have a group and meet each other frequently, at least once a month."

"I feel safe and secure. Mentally I become stronger. I acquire the chance to live."

It was noted that beneficiaries regarded that CARE has all the responsibility to take care of them. There is gap of understanding between beneficiaries and staff. This may be due to the fact that beneficiaries are not fully informed about the project mandate and procedures or some staff might go beyond the project limits on their own out of empathy for the beneficiaries.

"Money given for referral treatment is of small amount and is not enough".
"I do not satisfy when I go to office for reimbursement of treatment cost and I do not get it because of absent of staff."
"All the children (OVC) who should attend the (vocational) training do not get the chance to attend the training."

They observed many changes. They understand how to deliver home based care and they help each others. They attend patients when hospitalized. Family has more understanding on them. Even the teachers pay more attention to the children (OVC).

"I counsel fellow PLWHA, refer and guide them where to go for sickness. Sometimes, I accompany them to clinics."

The needs expressed by PLWHAs are well beyond the limits of the project capability. They asked for bicycle for travel to look after the patients and raincoat, umbrella and gloves too; school uniform and travel bag; house rent; delivery cost for positive mother; all hospitalization cost including attendant; financial support for children (OVC) till they become engineers and doctors; etc.

MSM

They valued the good relation by staff as brothers and sisters. Improved health literacy makes them how to take care of their health by themselves. Because of home based care, cost of treatment is much reduced and also the family burden of hospitalization.

"My friends died of this disease (AIDS). We did not have health knowledge on AIDS and we did not how to live in good health. I always discuss about health with my colleagues and use condom now. That's why I can live alive till now."

"I know about AIDS and STIs – chancre, wart, herpes. In the community, they treat with folk-medicine because they are shy. When the disease becomes wither they think that it is cured. I understand about sex and I know how to protect myself. I always use condoms. I reduce sexual partner and I also meditate."

They suggested cooperating with writers, musicians and theatrical performers to get the education messages to wider audience. They pointed out that factories and workplaces should be the next targets because there are many workers there. They said that there are many *'apone'* (hidden MSM) who are not reached by any programme because they are afraid and shy to be known by others as MSM and they impose great risk of transmitting diseases. As they found out that some people sold the condoms they received and therefore they cautioned free distribution of condoms.

SW (Working Women)

Warm welcome and relation, patience and give time listening to their issues, keeping confidentiality by the staffs are scored as high apart from condom distribution and referral for treatment. They are able to take care of themselves. They use condoms systematically and consistently and refuse without sex so that as one SW told she lost some clients. They educate each other and go for HIV testing if condom breaks. Moreover, they buy condom sometimes. Most of the SWs suggested to run a DIC and a clinic run by a female doctor and to contact street based SWs. In Tamu and Kalay there is no referral clinic.

8. SWOC Analysis

The SWOC analysis was conducted at each township and in the workshop participants were grouped into 6 groups according to the geographical locations: Mandalay, Mon, Northern Shan, Sagaing, Chin, and Bago – and group discussion were made.[13] The outcomes of group works and township findings were summarized below.

Strengths

The capacity, accountability, responsibility, and empathy of the staffs are the key elements in the success of the project. The greatest strength is the dedication and commitment of staffs towards the project and beneficiaries. The long working experience with CARE, from one project to the next, provides staffs with increasing knowledge and skills acquired through capacity building activities and field works and familiarity with beneficiaries and stakeholders and the locality facilitates start up and implementation of the project. The employment of local staffs ensures smooth relationship with beneficiaries overcoming the language problems. The long presence of CARE's projects in the area with its credibility intensifies confidence and trust of beneficiaries and authority. The presence of CARE's other projects in the area enables to provide services to beneficiaries that the project cannot offer. The mentality of the staffs, not the least, is a crucial factor for the success of the project. Staffs collectively try to meet the planned targets in spite of shortage of staffs and insufficient transportation facilities (use own motorcycle). Introducing life skills and reflective learning after health education promotes behavioural change.

Weaknesses

Insufficient facilities (transport, computers) create some difficulties in delivering services. Variation in services between townships (HBC in 12 townships, condom promotion alone in Hlaingtharyar) makes staffs feel a bit not to their heart's content. They also wish to help their community as much as possible. Too many target groups (12-13) consume time in advocacy and causes inaccuracy in recording and reporting of activities. Different in format for Consortium and CARE and change of reporting formats produces confusion in recording and calculation of total achievements. Every staffs does not have the chance to attend training. There is weakness in coordination between CARE's projects in the same area. Keeping strict confidentiality of PLWHAs sometimes lend up in double counting difficulty to make hand over. Changes in benefits provided to beneficiaries creates misunderstand and confusion of beneficiaries on staffs. As the project continues the workload increases and ends up in overload on staffs (about 50 PLWHA per staff). The current reimbursement system is difficult to verify the validity of vouchers in referral.

Opportunities

The presence of other NGOs in the area enables the project to make available of services to beneficiaries that the project cannot offer. Good cooperation with NAP makes accessibility to ART for PLWHAs. Organization of SHGs and conducting forum facilitates self confidence and self reliance of beneficiaries. Cooperation of GPs and health institutions favours effective referral system. One GP from Monywa offers his services free of charge for PLWHAs (cost of medicines only) when the project finishes. Participation of volunteers (magician, artists, teachers, community leaders, youths) permits CARE to expand and extend its activities with success. PLWHAs provide counseling and home visits to fellow PLWHAs and they also assist in referral. Income generating activities of PLWHA-SHGs help supporting the family (children). Through PLWHA peers more PLWHAs made contact to CARE.

Challenges

To implement any activity, it requires to seek approval and permission from authority. The project has to face delay in getting approval or sometimes not getting at all. Although, stakeholders are advocated, stigma and discrimination are observed in some instances.

Sometimes confidentiality is leaked. Undue demands from beneficiaries are received by staffs. There is a thin red line in dealing with SW because of legal constraints. Staffs experienced request by SWs to meet one of them in jail and make contact with her family. The inflation and rising cost of commodity results in less amount of nutrition support with the same allotted budget. Some PLWHAs are so attached to CARE that they refuse to go to other NGOs for referral. There is increasing chance of transmission of infection because PLWHAs do not fully understand and accept using universal precaution.

9. Projects Riding Pick-a-back on FHAM

One significant feature of this FHAM project is that three projects are incorporating into the project. First of all, CARE came into field level agreement with United Nations Population Fund (UNFPA) regarding provision of reproductive health and HIV/AIDS education in the communities in selected townships. Activities were implemented in Mandalay, Lashio, Monywa, Tiddim and Mawlamyine from May 2005 to December 2006. Community Educators employed by UNFPA provides education and medicines – ferrous sulphate, folic acid and vitazone - to targeted communities. Although CARE has neither administrative nor technical control, CARE has to take responsibility in the area because the activities were implemented in the name of CARE.

"Care and Support Programme for Orphans and Vulnerable Children (OVC)" was initiated from April 2006 to March 2007 with funding from UNICEF. The project aims to improve the quality of life of HIV affected and infected OVC in 8 townships and to increase their participation within communities in a sustainable manner. The programme focuses on the most vulnerable children and the capacity of the people within their environment. The activities included strengthening and capacity building of staff and community volunteers, advocacy and coordination, care and support for HIV/AIDS affected and infected OVC and community activities and participation. This project created opportunities for OVCs. UNFPA appointed 12 Outreach Workers. But CARE has to undertake activities as required by UNCEF.

CARE served as the Collaborating Agency in the joint project implemented by International HIV/AIDS Alliance and Rose Group/Khaing Hnin Si that supports the development of safer sex among MSM in Monywa. The project period is from March to September 2006. CARE was entrusted to oversee the financial matter and to provide support to ensure compliance with the procedures. As Rose Group has no experience in managing the project they always made request whatever they have to do so much so that they thought this the CARE's responsibility.

There are advantages and disadvantages of these piggy-back projects. There is expansion of opportunities for beneficiaries for the additional support. Staffs capacity is improved through training from UNICEF – Journey of Life, Mobility Mapping. CARE reputation among beneficiaries is heightened because of ability to provide more support particularly for OVCs. The activities to be carried out for these projects put extra burden on staffs already overloaded.

10. KAP Study

Baseline KAP among youth, 15 – 24 years, was conducted in 2002 in 8 townships.[14] At the end-of project, KAP was conducted in February 2007 in 6 townships (5 baseline townships – Mawlamyine, Moywa, Lashio, Bago, Pyay - plus Mandalay) using the same baseline questionnaire.[15] The questionnaire consists of four sections – profile of respondents, knowledge on HIV/AIDS/STI, attitude, and personal experience, practice, perception about the community. Convenience sampling method was applied and each outreach workers had to interview a minimum of 25 youths of roughly equal sex proportion. Some key parameters[16] were compared between baseline and end-of project findings. (Annex G).

Profile of respondents

Altogether 1372 youths, 662 males (48.3%) and 710 females (51.7%), were interviewed.

Table 5: Number of respondents by sex and location

Name of township	**Male**	**Female**	**Total**
Monywa	205	195	400
Mandalay	100	136	236
Bago	82	68	150
Mawlamyine	119	135	254
Lashio	100	100	200
Pyay	56	76	132
T O T A L	**662**	**710**	**1372**

Majority of the respondents (70.3%) passed middle school education, 8th standard and education level between males and females was almost the same in all level of education. Most of the interviewees (35.6%) attained high school level education and 24.1 percent were in higher education (colleges and universities). Illiterate constituted 2 percent overall and females comprised of 3.2 percent.

Table 6: Educational level of respondents

Educational level	Male		Female		Total	
	N	%	N	%	N	%
Illiterate	5	0.8	23	3.2	28	2.0
Monastic Education	9	1.4	7	1.0	16	1.2
Primary school	53	8.0	87	12.3	140	10.2
Secondary school	123	18.6	99	13.9	222	16.2
High school	239	36.1	249	35.1	488	35.6
Higher education	161	24.3	169	23.8	330	24.1
Graduate	72	10.9	73	10.3	145	10.6
Others	-	-	3	0.4	3	0.2
T O T A L	662	100.0	710	100.0	1372	100.0

Knowledge

Fig. 3: Knowledge on common modes of transmission

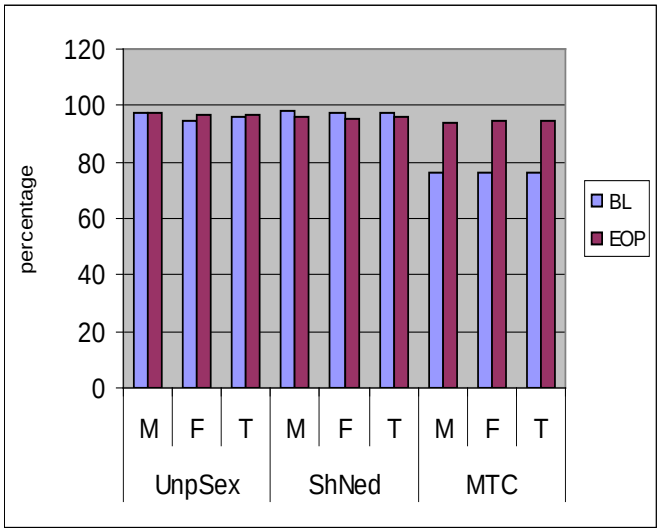
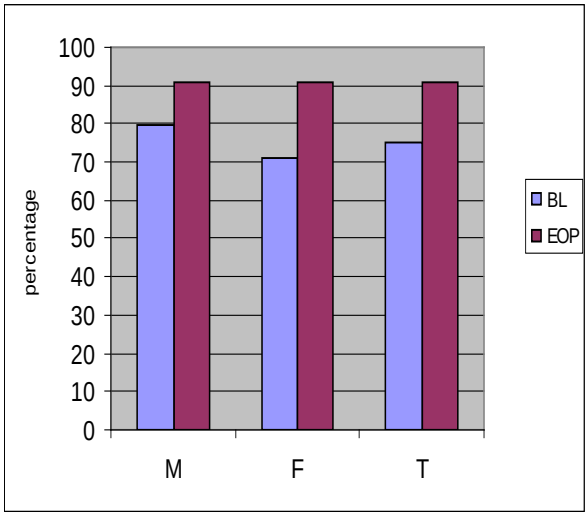


Fig. 4: Know 3 common modes of transmission



UnpSex = unprotected sex with infected partner ShNed = sharing needle MTC = mother-to-child

Regarding knowledge of common modes of HIV transmission, percentage of youths who can identify all 3 modes of transmission is increased in both sexes, from 75.3 to 90.9 percents. While knowledge on "unprotected sex" and "sharing needles" is almost the same between baseline and EOP, knowledge on "mother-to-child transmission" is increased. More pre-marriage counseling and testing sought be beneficiaries especially in Mon state where there is a lot of returnees may possibly be the reflection of this increased knowledge.

Fog. 5: Knowledge on common ways of prevention

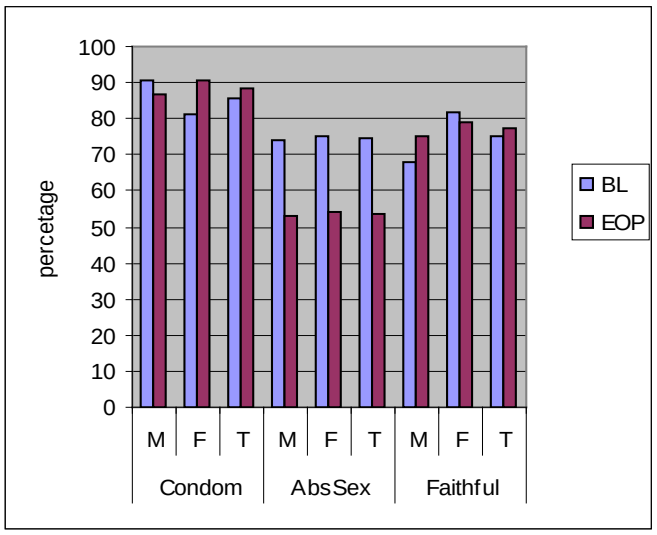
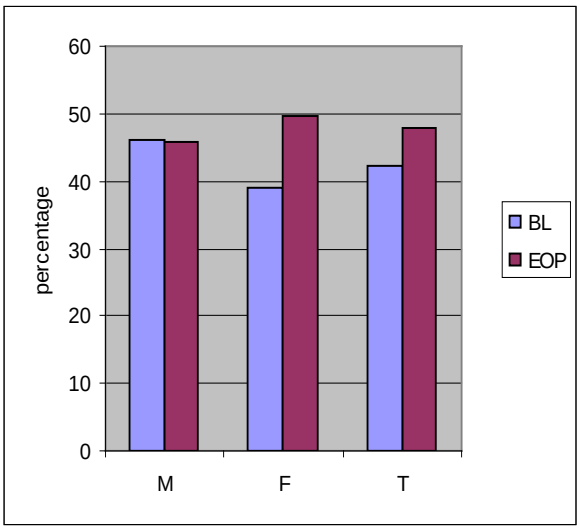


Fig. 6: Know 3 common ways of prevention

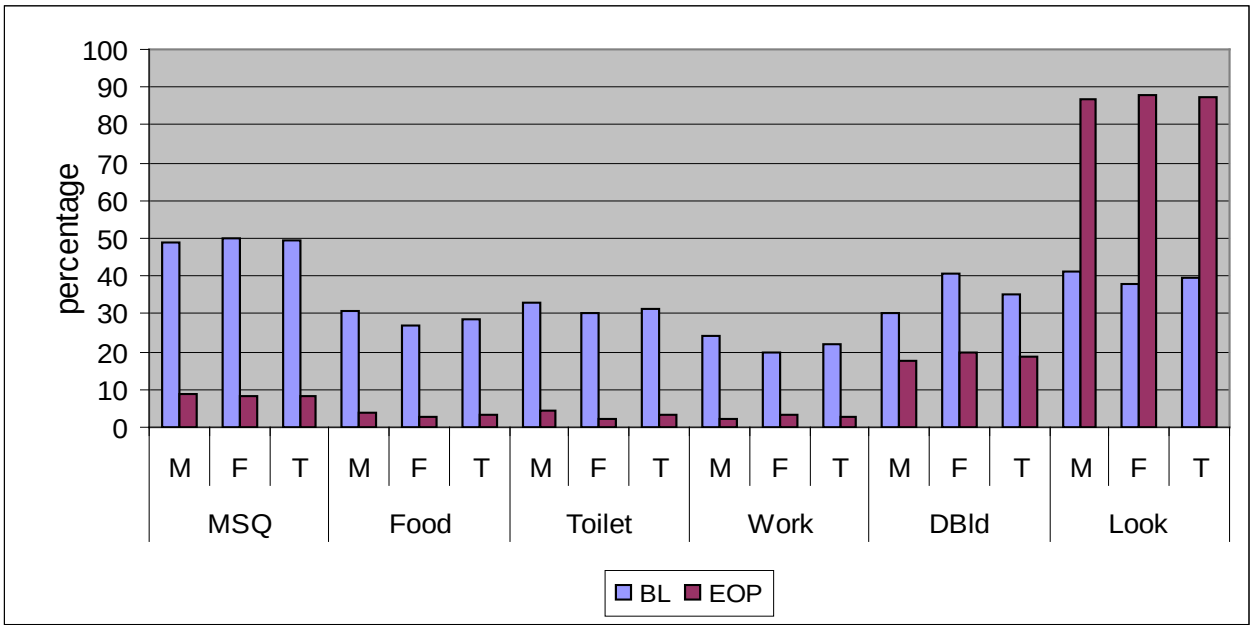


Condom = using condoms correctly every time AbsSex = abstinence from sexual intercourse
Faithful = having one uninfected faithful partner

Regarding knowledge on common ways of prevention, percentage of youth who knows 3 common ways of prevention is increased among females but no difference among males. In total it increases from 42.4 percent to 47.8 percent. Comparing to baseline data, it is interesting to note that both males and females who believes that 'abstinence from sexual

intercourse prevents HIV/AIDS' decreases. Deeper probe into this response reveals that respondents think that 'abstinence from sexual intercourse' is not realistic for majority of people and there are other modes of transmission apart from sexual transmission. Some interviewers designate this phenomenon as 'over educated' and 'far-fetched in thought'.

Fig. 7: Percentage having misconception about transmission



MSQ = mosquito bites; Food = sharing meals with PLWHA; Toilet = using public toilet also used by PLWHA; Work = working with PLWHA; DBld = donating blood; Look = healthy-looking person can have HIV/AIDS

Common misconceptions about transmission are 'mosquito bites' and 'donating blood'. Misconceptions about HIV/AIDS are significantly reduced in both sexes for each misconception. However, 'donating blood' remains as the most common misconception about transmission still at the end of project. The percentage who believe that 'healthy-looking person can have HIV/AIDS increased from 39.7 percent to 87.3 percent. Overall, percentage of youths who have incorrect beliefs/misconceptions for all misconceptions is also reduced, from 82.2 to 39.8 percents.

Fig. 8: Percentage having incorrect beliefs

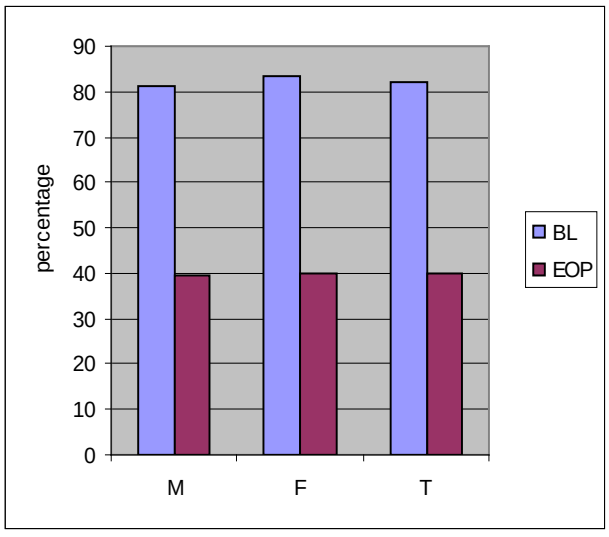


Fig.9: Percentage with correct knowledge UNGASS indicator

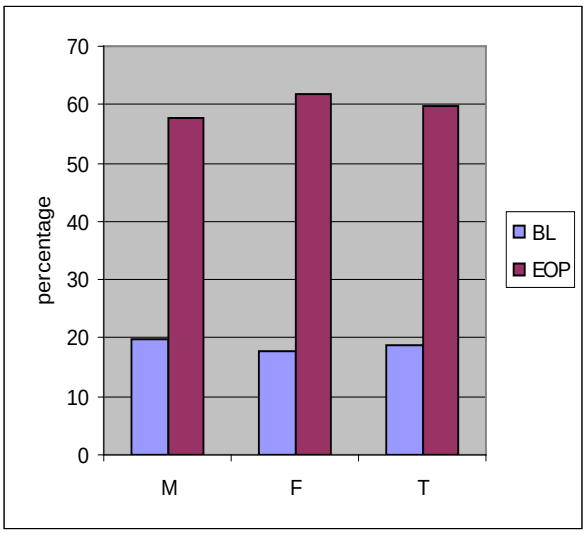
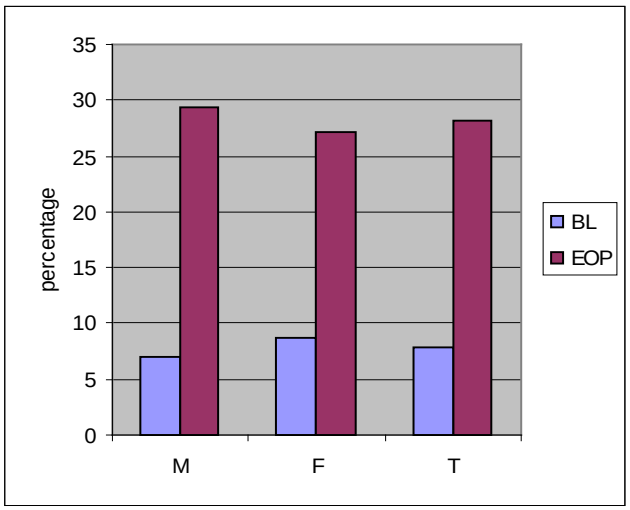


Fig. 10: Percentage with comprehensive correct knowledge



Conversely, percentage of youths with correct knowledge on transmission and prevention is increased, 18.8 to 59.8 percents

It is encouraging to found that the percentage of youth, both males and females, who know three common modes of transmission, three common ways of prevention and rejecting common misconceptions are increased by about 20 percent from baseline, 7.8 to 28.2.

Attitude

Fig. 11: Attitude towards PLWHAs

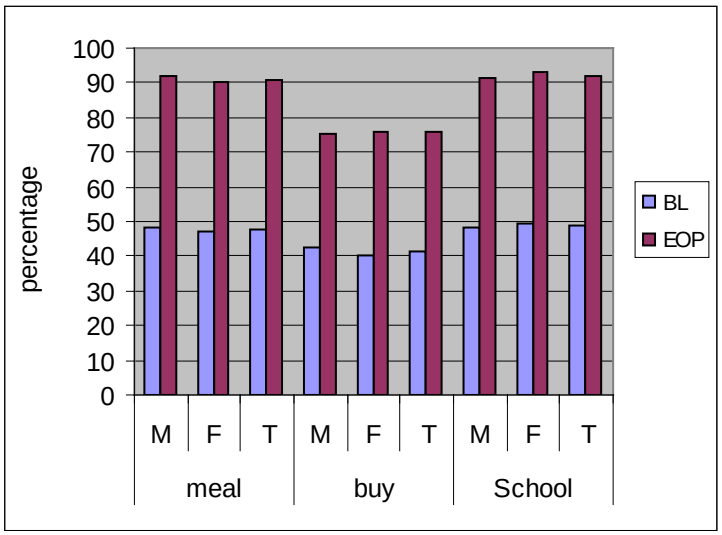
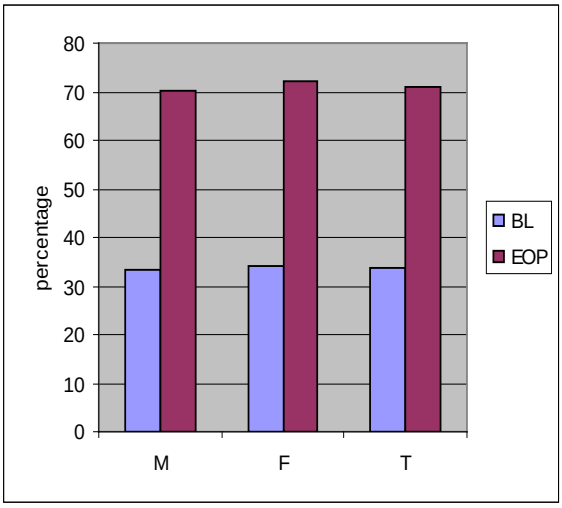


Fig. 12: Percentage with right attitude



meal = willing to share meal with PLWHA
buy = willing to buy food from HIV+ vendor
School = HIV+ student should attend school

Attitude towards PLWHA is very positive among both sexes in all aspects and percentage with right attitude rises from 33.7 percent baseline to 71.7 percent. The percentages who answered that they are willing to share meal with PLWHA increase from 47.8 percent to 90.9 percent, and the number of youths 'willing to buy food from HIV+ vendor increase from 41.3 to 75.6 percents. Ninety two percent of youths favours that 'HIV+ student should attend school' compare to 48.9 percent in the baseline.

Practice

Males having multiple partners last 12 months drop from 49.5 percent to 14.2 percent, but increases from 5.3 percent to 6.9 percent in females. Sex with CSW last 12 months is also decreases, 85.1 to 51.2 percents.

The salient finding is that reported condom use is improving in all occasions in both sexes – condom use first sex, condom use last sex, condom use with non-regular partner and condom use with SW. Condom use with non-regular partner increases from 27.2 to 79.2 percents and that with SW 51.3 to 93.1 percents.

Fig. 13: Multiple partners last 12 months

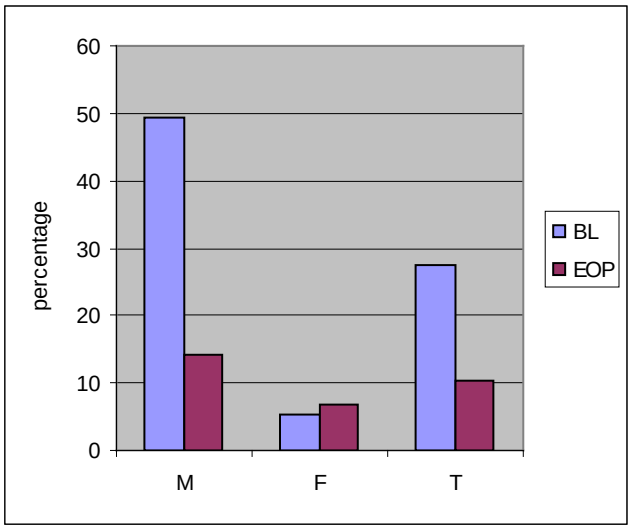


Fig. 14: Percentage of condom use first sex

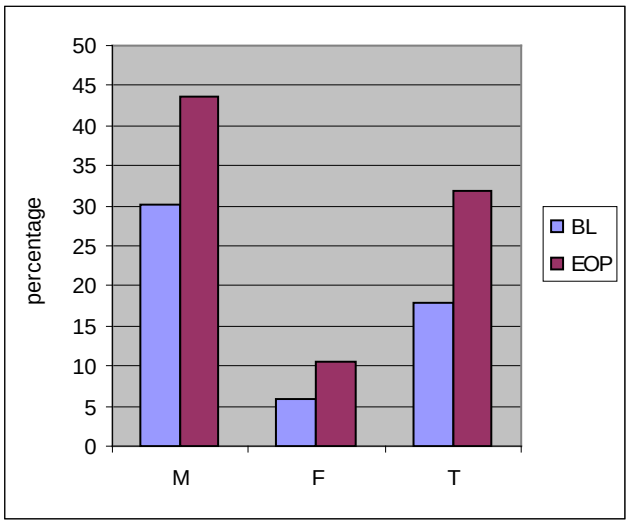


Fig. 15: Percentage of condom use last sex

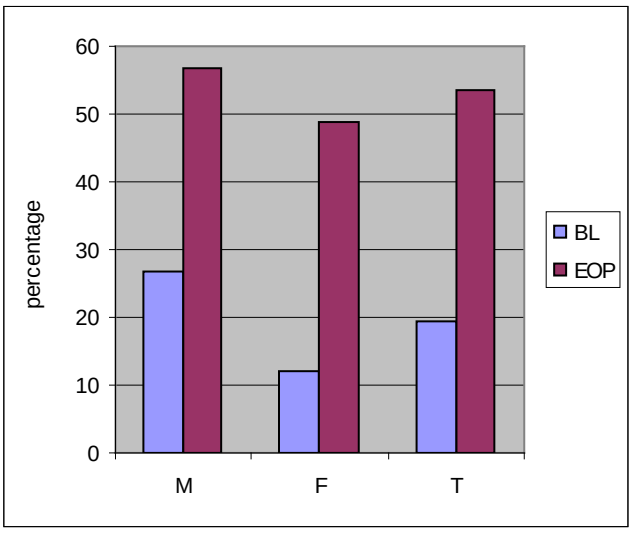


Fig. 16: Condom use with non-regular partner

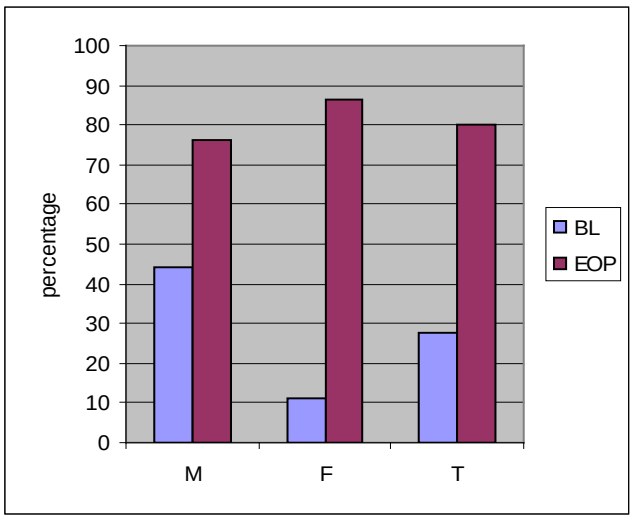
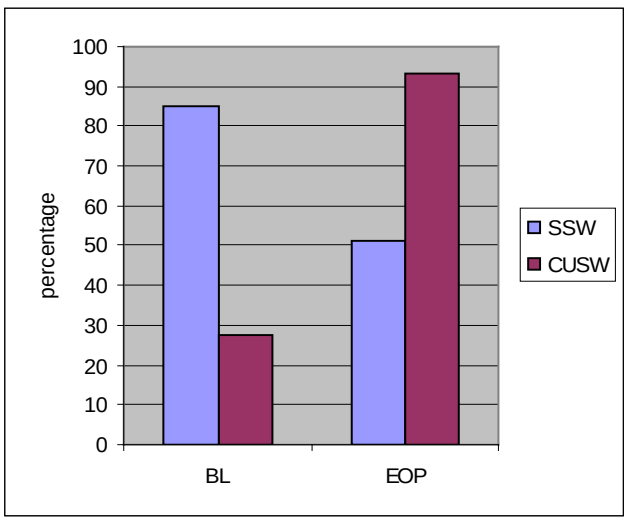


Fig. 17: Sex with SW and condom use



11. Conclusion

The activities implemented are relevant to the purpose objective – "to change behaviour to reduce the transmission of HIV and to improve the health of PLWHA" - and to some extent contribute to the achievement of the goal objective – "reduce HIV transmission and enhance the quality of life of PLWHA".

Results-based evaluation is conducted, both quantitative and quality assessment, within user-friendly environment. All the planned targets were achieved more than 100 percent for several indicators. Exploiting health education as an entry point to the community including target groups follow by life skills training and reflective learning approach proves to be effective in change the concept, attitudes and behaviour.

Improvement in knowledge, attitude and practices were reported by beneficiaries and youths. KAP study among youths aged 15-24 years revealed youth with comprehensive correct knowledge and right attitudes are increased compare to baseline study. The percentage with risk behaviour is also reduced and condom use is remarkably increased.

PLWHAs are provided with care and support, medical, nutritional, financial and psycho-social. More PLWHAs are accessible to ART and quality treatment for OIs and STIs. Self help groups are formed to be self reliance and to return to productive life and ensure integration into community. OVCs, both HIV positive and negative, are supported with nutrition, care for illnesses and education. They are also provided with vocational training to be able to lead a normal life. Formation and operation of SHGs could contribute to the sustainability of the activities.

12. Our Stress

Meeting planned targets cannot be taken easily and lightly especially when working with HIV/AIDS infected and affected people and people with high risk behaviours. It is to be noted that the results achieved are done with staffs head and heart. Being dealing with the marginalized group of people, depressed with the disease and discrimination, people with risk behaviour, socially and culturally not accepted, walking on a tight rope of legal barrier, unable to meet all the demands, misery, dejection and down-heartedness of people witnessing almost every day affects on staffs psychologically. Their emotion swings along the up and down wind of beneficiaries' wellbeing. They are happy when beneficiary's health improves. They feel sorry when their beneficiary dies.

They are excited to know the HIV testing result just like the person concerned. Staffs have great concern when they are handling with PLWHAs with psychological problems. Some SWs and MSMs hug, touch, kiss and sometimes bite staffs. Sometimes male staffs received sexual harassment when they work with MSMs. Female staffs are sometimes mistaken as SWs when they are doing work at brothel house in the SW's room. Staffs are in danger of being arrest when working with SWs. Some pimps thought that female staffs are peers of SW. Some staffs encountered harm imposed by pimps and MSM.

Beneficiaries dislike them when they refuse to take food and drinks offered by the beneficiaries thinking this as discrimination. In fact staffs are reluctant to take food because it is not prepared clean. But staffs relent to their request and have to take with feeling of embarrassment. There is risk getting infection especially TB. As a universal precaution, staffs wear mask and gloves in home based care, but PLWHAs misunderstand that this is a form of

discrimination. Staffs also received request to adopt OVCs. Some beneficiaries borrow money.

13. Lessons learned

- There is inconsistency in following the criteria and guidelines within and across the projects. The upper limit of age for OVC is set at 15 years, but in reality it ranges from 14 to 18 years (exceptional). The nutritional package for beneficiaries differs between FHAM and IDU projects. So also financial support for referral and hospitalization is not the same between FHAM and Global Fund projects. This might cause confusion and misunderstanding on the part of beneficiaries who know CARE and not by project-wise. Adaptation and flexibility to the changing trend and experience is practiced to guarantee delivery of services effectively and efficiently. Transparency and accountability is the key to minimize inadvertent negative consequences.
- Many townships located far apart for the project locations impose administrative and logistic constraints. There is gap in knowledge, information and understanding of procedures between central and the field staffs. The project covers 19 townships located across the country – south to north, east to west – and not all townships are equipped with communication facilities.
- Activities implemented by the project can be categorized into two – comprehensive activities package and minimal activity package. Those townships with minimal package are curious about the reasons for the discrepancy and they would like to implement the comprehensive activities package for their beneficiaries as well.
- Many tools or approaches are employed for behavioural change – IEC materials, health education, life skills and reflective learning (participatory action research) at different period of the length of project. With little explanation and information, this creates complications and confusion and debated over the superiority of each approach. The stories in the life skill modules are not suitable with the local target people.
- Staffs as well as the beneficiary groups expressed that IEC materials are not targeted and some drawings are not conform to the social cultural context. Staffs from Northern Shan state suggested producing in local ethnic language for better understanding.
- Staffs seem to be over burden towards the later part of the project period. Possible explanations are failure to replace attrition and addition of new assignments through additional projects piggy back on the FHAM project and actual increase of beneficiaries load. Moreover, TB Team Leaders usually confer staffs as supervisors for ‘dots’ treatment. At first staffs are emotionally elated and well satisfied with their achievements. Distress signal has started flashing out due to the burden and stressful condition imposed upon them along the course of implementation.
- Transport facilities are limited and deficient compare to the staff daily assigned tasks. Some staffs use their own motorcycle but it is not possible and practical in the long run.
- Forum and cross visits, workshops and training for beneficiaries are well accepted by and valuable for beneficiaries. However, staffs have to take responsibility for health, accidents and social issues on top of organizing these activities. Frequent such events inflict stress and burden for the staffs.
- Some staffs, out of sympathy and empathy for the beneficiaries, render help and assistance beyond the limitations of the project. Beneficiaries do not understand whether this is personal or project assistance. The inconsistency of assistance between staffs creates misunderstanding.
- Employment of PLWHA as outreach workers sounds good in theory and principle. However, they usually behave as advocate for PLWHAs rather than a staff.

- Mid-term evaluation workshop[17] was held to share experiences and lessons learned and to prepare for the future but the outcomes of the workshop were not following up to the project benefits in the later half. DME Coordinator pointed out that more than 75 percent of the lessons learned at the end-of project evaluation are the same as that of mid-term evaluation.
- Empowerment of beneficiaries is witnessed to some extent but it is not systematic and clear cut about the role and responsibility of concerned parties.
- Dedication and motivation of staffs ensure successful implementation of the project.
- Effective advocacy and good interpersonal relationship build trust and confidence that lead to involvement and participation of all stakeholders.
- Presence of CARE's previous project(s) in the area(s) with high credibility renders smooth implementation of the project

14. Recommendations

- It is preferably to have a cluster of townships nearby to facilitate effective supervision and easy logistics support.
- During the inception phase/period of the project, all staffs need to be informed about the project and provide with task-oriented trainings. Then with their participation, logical framework, procedures and guidelines, recording and reporting formats monitoring and evaluation plan be developed.
- Segmented audience research and pre-test are necessary for the development of targeted IEC materials follow by post-test to improve effectiveness whenever necessary.
- In the initial phase and also through out the course of implementation, it is of critical to level out the understanding between staffs, beneficiaries and other stakeholders to erase doubts, confusion and misunderstanding and also to lessen or abolish any undue demand. Any changes accrue also be informed to parties concerned.
- The involvement of PLWHAs and other beneficiaries (MSM and SW) in the project as staff, though theoretically sound, requires serious consideration.
- Recording and reporting formats and the monitoring and evaluation plan should reflect the objectives, outputs and activities of the project. Staffs need training in analyzing and utilization the data. The person who collects the data is the user. Without utilization the validity of the data may suffer. Timely feed back on the monthly report is an essential element in monitoring the project and in improving the quality of the project implementation.
- Staffs should be well informed about the limits of project activities. Even if they want to help or provide support on their own will out of their pocket money, it is necessary to inform and get approval from senior staff to avoid negative implications in future.
- Monitoring trip by senior staffs should look into technical, administrative, financial and human resource aspect of the project and follow up in subsequent visit.
- Every effort should be attempted to delivery standardized services across projects, even from different donors, particularly in the same locality/township, to avoid confusion and misunderstanding.
- It is necessary to bear in mind that humanitarian charity activity sometimes ends up in dependency.
- Exit strategy for sustainability needs to be considered during the course of implementation of the project, not at the end of the project. Capacity building and empowerment is necessary together with assignment of specific roles and

responsibility to the concerned party is essential. This requires participatory trial and assessment and revision whenever necessary.

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Annex A

Joint Programme Component-wise achievements

Table 1: Condom distribution by type of beneficiaries (Output 1.1)

No.	Type of beneficiaries	No. beneficiaries	Male condom	Female condom	Gel tube
1.	SW	7869	853257	891	322
2.	MSM	4101	263619	517	463
3.	IDU	701	31893	0	0
4.	PLWHA	1585	105969	3	1
5.	Sex worker clients	2577	53610	0	0
6.	Entertainment workers	924	38206	6	3
7.	Gatekeepers	3668	234430	627	11
8.	Boaters	3855	103840	260	0
9.	Transport workers	42268	662063	2895	2
10.	Migrant workers	23776	373740	1227	1
11.	Uniformed services	10923	220328	201	57
12.	Students	18461	186333	25	3
13.	CBO/NGO	1028	44274	9	0
14.	Special events, booths	51687	185096	18	20
15.	Condom box	5782	206686	9	0
16.	Condom advocate	4125	99001	0	0
17.	Others	26870	520514	78	14
	T O T A L	210,200	4,182,859	6,766	897

Table 2: Beneficiaries referred for STI management by institution (Output 1.2)

No.	Type of beneficiaries	Type of institutions															
		Hosp.		NAP		GP		MSI		PSI		AZG		Others		Total	
		n	f	n	f	n	f	n	f	n	f	n	f	n	f	n	f
1.	SW	0	0	22	24	9	13	63	99	1	1	1	1	0	0	96	138
2.	MSM	0	0	11	20	5	10	0	0	0	0	0	0	0	0	16	30
3.	IDU	0	0	0	0	0	0	0	0	1	1	0	0	0	0	1	1
4.	PLWHA	0	0	16	19	10	20	35	48	0	1	1	1	0	0	62	89
5.	Sex worker clients	0	0	0	0	0	0	1	1	0	0	0	0	0	0	1	1
6.	Entertainment workers	0	0	10	12	0	0	0	0	0	0	1	0	0	0	11	13
7.	Gatekeepers	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
8.	Boaters	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
9.	Transport workers	0	0	12	15	2	4	4	6	0	0	1	1	0	0	19	26
10.	Migrant workers	0	0	2	2	2	2	8	15	0	0	2	2	0	0	14	21
11.	Uniformed services	0	0	0	0	0	0	1	3	0	0	0	0	0	0	1	3
12.	Students	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0
13.	Others	1	0	1	1	0	0	2	1	0	0	0	0	0	0	4	2
	T O T A L	1	0	74	93	28	49	115	173	2	3	6	6	0	0	226	324

n : number f : frequency

Table 3: IEC distribution by type of beneficiaries (Output 3.2.1)

No.	Type of beneficiaries	Type of IEC							
		Pamphlet	Notebook	Q & A	Cartoons	Comb	About Us	Others	Total
1.	SW	1082	405	111	15	286	1040	4409	7348
2.	MSM	344	155	119	0	40	2794	3243	6695
3.	IDU	599	61	35	9	27	37	69	837
4.	PLWHA	804	155	110	33	82	386	4090	5660
5.	Sex worker clients	2490	11	1	0	25	30	915	3472
6.	Entertainment workers	230	86	18	33	101	27	2092	2587
7.	Gatekeepers	647	620	25	51	379	180	2404	4306
8.	Boaters	2068	205	56	76	74	460	664	3603
9.	Transport workers	6089	2684	649	809	1042	2514	9393	23180
10.	Migrant workers	7623	2532	406	615	1438	3634	8541	24789
11.	Uniformed services	3980	1365	315	193	340	1073	3095	10361
12.	Students	9517	6453	630	722	2223	11498	18757	49800
13.	CBO/NGO	10233	415	20	8	87	409	1040	12212
14.	Special events, booths	19401	10974	1267	443	715	1907	48037	82844
15.	Others	14043	7686	3175	925	2634	5463	27254	61180
	T O T A L	79150	33807	6937	3932	9493	31452	134103	298874

Table 4: Category of IEC materials produced (Output 3.2.2)

Category	Type	Number produced
Promotional materials	1. Note book	40,000
	2. Key chain	15,500
	3. Comb	12,000
	4. T-shirt	1,500
	5. Ball pen	10,000
	6. Wallet	6,500
	7. Sport shirt (WAD)	100
	8. HBC bag	1,000
	9. GP bag, Advocacy bag	1,000
	10. Bags WAD	1,200
	TOTAL	**88,800**
Printed material distributed individually	1. Pamphlet	110,000
	2. RH book	8,000
	3. Positive women	2,000
	4. Positive Faces in Zambia	7,000
	5. Red book (Basic information on HIV/AIDS)	26,000
	6. Red book in Mon	5,000
	7. Red ribbon cards WAD	10,000
	8. Pocket calendar WAD	10,000
	9. Post card WAD	20,000
	10. Booklets WAD	20,000
	11. Ko-Gyi-Kyaw comic WAD	3,000
	12. Q & A booklets WAD	3,000
	13. HBC booklet	1,500
	TOTAL	**225,500**
Visual printed material for larger audience	1. Billboard	13
	TOTAL	**13**
	Grand Total	**314,313**

Table 5: Number of PEs/OWs/Volunteers involved in the project (Output 3.2.3)

No.	Township	PE/Volunteer	OW	Total
1.	Mandalay	65	17	82
2.	Monywa	32	11	43
3.	Lashio	36	6	42
4.	Muse	13	6	19
5.	Namkham	4	2	6
6.	Mawlamyine	109	11	120
7.	Mudon	67	7	74
8.	Yay	58	7	65
9.	Kalay	20	2	22
10.	Pyay	1	4	5
11.	Bago	10	5	15
	T O T A L	415	78	495

Table 6: Number of beneficiaries provided with health education and life skills (Output 3.3)

No.	Type of beneficiaries	Health education			Life skills		
		Male	Female	Total	Male	Female	Total
1.	SW	18	1408	1426	8	1197	1205
2.	MSM	503	0	503	509	0	509
3.	IDU	509	23	532	139	1	140
4.	PLWHA	245	326	571	268	272	540
5.	Sex worker clients	261	0	261	52	0	52
6.	Entertainment workers	176	421	597	94	469	563
7.	Gatekeepers	63	121	184	29	23	52
8.	Boaters	266	17	283	112	10	122
9.	Transport workers	3510	863	4373	1183	548	1731
10.	Migrant workers	5575	3973	9548	2397	1758	4155
11.	Uniformed services	1460	847	2307	284	258	542
12.	Students	8144	8824	16968	3727	4812	8539
13.	Others	5829	8348	14167	1611	2212	3823
	T O T A L	26549	25171	51720	10411	11562	21973

Table 7: Number of PLWHA receiving home based care by age and sex (Output 4.1)

	<15			15-24			25-49			=>50			TOTAL		
	F	M	T	F	M	T	F	M	T	F	M	T	F	M	T
Total	59	76	135	186	131	317	1148	1289	2437	41	52	103	1434	1558	2992
Expired	12	15	27	40	29	69	306	493	799	20	31	51	378	568	946
Referred	0	0	0	3	4	7	6	28	34	0	0	0	9	32	41
Lost	2	3	5	14	10	24	37	58	95	0	1	1	53	72	125
Stop	0	0	0	0	1	1	2	5	7	0	0	0	2	6	8
Alive	45	58	103	129	87	216	797	705	1502	21	30	51	992	880	1872

Table 8: Voluntary confidential counseling and testing by type of beneficiaries (Output 4.2)

No.	Type of beneficiaries	Pre-test counselling			HIV testing			HIV positive			Post-test counselling		
		M	F	T	M	F	T	M	F	T	M	F	T
1.	SW	14	350	364	11	305	316	4	106	110	11	306	317
2.	MSM	64	0	64	48	0	48	16	0	16	55	0	55
3.	IDU	38	1	39	25	1	26	10	1	11	25	1	26
4.	PLWHA	25	47	72	14	27	41	3	9	12	31	56	87
5.	Sex worker clients	24	0	24	20	0	20	4	0	4	14	0	14
6.	Entertainment workers	40	205	245	24	172	196	2	11	13	22	172	194
7.	Gatekeepers	1	3	4	4	2	6	1	1	2	2	1	3
8.	Boaters	32	1	33	21	2	23	6	1	7	24	1	25
9.	Transport workers	174	21	195	119	17	136	42	4	46	156	16	172
10.	Migrant workers	454	207	661	334	153	487	113	56	169	429	176	605
11.	Uniformed services	23	5	28	17	5	22	5	1	6	22	11	33
12.	Students	101	57	158	90	69	159	17	17	34	87	63	150
13.	Others	448	588	1036	387	487	874	114	179	293	438	536	974
	TOTAL	1436	1487	2923	1112	1242	2454	336	387	723	1314	1341	2655

Table 9: Number of OVC receiving home based care by age and sex (Output 4.3.1)

	<2 yr			2-4 yr			5-9 yr			10-15 yr			>15			Total		
	F	M	T	F	M	T	F	M	T	F	M	T	F	M	T	F	M	T
Total	122	94	216	194	220	414	423	443	866	289	288	577	14	12	26	1042	1057	2099
Expired	9	7	16	0	3	3	3	5	8	0	1	1	0	0	0	12	16	28
Referred	0	0	0	2	0	2	0	0	0	0	0	0	0	0	0	2	0	2
Lost	9	5	14	11	18	29	22	18	40	12	8	20	7	7	14	61	56	117
Stop	0	0	0	0	0	0	0	1	1	2	1	3	1	0	1	3	2	5
Alive	104	82	186	181	199	380	398	419	817	275	278	553	6	5	11	964	983	1947

Table 10: Number of OVC positive receiving home based care by age and sex (Output 4.3.2)

	<2 yr			2-4 yr			5-9 yr			10-15 yr			>15			Total		
	F	M	T	F	M	T	F	M	T	F	M	T	F	M	T	F	M	T
Total	122	94	216	194	220	414	423	443	866	289	288	577	14	12	26	1042	1057	2099
Positive	7	2	9	20	10	30	21	21	42	6	8	14				54	41	95
Negative	105	84	189	149	187	336	366	382	748	259	261	520	14	12	26	893	926	1819
No test	5	5	10	13	18	31	19	28	47	18	8	26				55	59	114
Unknown	5	3	8	12	5	17	17	12	29	6	11	17				40	31	71

Table 11: Number of trainings conducted (Output 5.4)

Type of Training	No. of Training
A. Township level training	
1. Life Skills	10
2. TOT – HIV/AIDS	8
3. VCCT	4
4. HBC	9
5. SHG	2
6. Journey of Life	4
7. Social mobilization	6
8. Personal Management	4
9. First aid	5
10. OI management	1
11. ART management and counselling	1
12. Gender awareness	1
13. Peer education	1
14. Legal awareness	1
15. SW literacy	1
16. Universal precaution	1
B. Central level training	
1. Sex workers (Working women)	1
2. BCC and sexuality	1
3. Management and leadership	1
4. Journey of life, Mobility mapping and Memory book	1

Annex B

Life skills Training

CARE Myanmar started to implement life skills discussion with youth activity in MMR041 project in FHAM round II. But the actual activities could start only in November 2004 in the project townships.
This activity was implemented in all 19 townships of CARE Myanmar, MMR041 project.

Objectives

1. To raise awareness on HIV/AIDS among youth.
2. To change the risky behaviour of youth to prevent HIV transmission by themselves.
3. To equip youths with life skills to be able to use for their life.

Target group

The main target group of this activity is youth who can be out-school or in-school. But the people from vulnerable group such as entertainment workers, sex workers, MSMs, migrants, transport workers and IDUs were also covered mostly for those who were youth.

How we get contact with clients for this activity?

- Through volunteers (PIT members) help project staffs to make contact with clients in their local community.
- Through Self-help group members
- Information sharing among the clients
- Through advocacy with restaurant mangers, hostel in-charge, pimps, owners of private business, leaders of MSMs, tuition teachers and others.
- Some voluntary contact by the mothers who heard about this activity to do LS discussion with their children.

Process of LS education activity implementation in this project

Strategy

The strategy for implementation of life skills is different from the strategies using in other organizations.
We give LS education through individual or in small groups of not more than five people. At first our target is to be able to meet with each beneficiaries for three times. But later it was found out that it is impossible for most of the cases to meet with them for three times because many of the clients are moving frequently and cannot get contact with them later. But there were some clients with whom we can meet often and so second time/ third time discussions can be done with them. There are some youths who invite or came to the staffs very often to discuss issues related to LS reflecting with their own problems/issues. In some cases staffs cannot even count the frequency (>15 times).

We also give health education to those who have not got HE on HIV/AIDS and STI before LS discussion. Each discussion usually takes about 45-60 min and sometimes up to 2-3 hours.
References we took for the discussion were the manuals from Save the Children and UNICEF.
We use seven facts of life skills in discussion. (Self awareness, Empathy, Critical and creative thinking, Effective Communication, Decision Making, Interpersonal skill and Dealing with stress)

Preparatory phase

1. Discussion on the strategy to guide.
2. Collection of short stories/ events to use in the discussions.
3. Distribution of these stories to all staff who are going to do LS discussion.
4. Preparation of reporting format
5. Training workshops to all existing staffs by project senior staffs. (8 trainings: 2 in MLM, 2 in MDY, 2 in Monywa, 1 in Kalay and 1 in Lashio)
6. Attending trainings from other organizations – Save the children, UNDP
7. Preparation of life skills checklist

Implementation phase

- After preparatory phase, we started to do LS education among staffs, volunteer youths and then with the little brothers and sisters and their friends of staffs.
- Review and discussion on the activity was done among the staffs. The life skills guideline checklist was done according to lessons learned and the finalized checklist is used from then on.
- Then they started to do the activity in the community. All the discussions were noted down in the LS form.
- Telling about a case story or about the staff's previous problem or difficulty experience and the client's view on the case. Then continue the discussion incorporating life skills facts.
- Sometimes not all seven LS facts were covered in one discussion and continue in the follow-up discussions.
- Continuously after that or in the next time, they discuss the life skills in relation with the client's own experiences/ issues.
- For the cases of second time/ third time discussion which may be after about one week or more, the staffs asked clients if there were any decisions made using some of the factors of life skills and then to discuss again about that issue.

Monitoring and evaluation phase

- Client satisfaction – Life skills evaluation form is used for evaluation purpose.
- Difficulties, entry point (how to start the subject), successes and the new ways were discussed usually in the staff meetings.
- Procedures were also discussed in the mid-term review and also in cross learning visits.

Support for this activity

- IEC materials usually ballpen, pamphlet and sometimes keychain were provided to the client.
- Refreshment costing up to 400 Kyats per person (Actual).
- IEC materials

Life skill checklist

1. rdrf|uj|ci f
   - ujr|efm0ef rf emn f?ujr|efmt aMurif?ujr|efm-armf NkdKf&Ddv|kyfaqmifaerIt ukdS|f/
   - awGq|&lb n f l , l t rn f?t ou f?usm;?ae&yf/ydpnf?t v|kf uldf?ar;jrefjci f/
2. v ma&mufawGq|Ndl&b n ft aMurif&if ul&d½Sfyjci f?o |Hmudt x daxwGq|Ml &Ekdf?&Ekdf
3. y|kyf^ Znmvf rf wpf|kfulaijymjci f(o |lfzwfckdfjci f(o |lfv wfvav mvGfawG|kf&Sdao m jyó em^t cuf cul/pf&y&yf½Sd½Sdar;jrefjci f/
4. x kyfjrif x r$jyó emulaib i f aeEESfq|uk Cifrn fudb lbaijz½Sfygn fen f/
5. rddd|kd fu|kd fo jidi f t aeEESfb mawpGCifpm;v Nkf rv /D (Self awareness)
   - rddb mawGpm;ae&v /D rdpdrf Sb mawjzpfaev /D
   - rdd b mudkawefzJk m;o v /D
   - rddSb mt m;en f csufawG&Sdv /D
   - rddSb mt m;omcsufawGaumif fwbi csuf?ujRfusi f?v |kEkdf lawG o lrsm;x uf b mwbi csufaw)G&Sdv /D
6. rdckdUwefzJk m;rIt ay: uGjyDJmjym;o bdSdv m;/ rddb muawefzJk m;o v /D rdckdUwefzJk m;rIu kd rdd , fv x ekfo drfrv /D (Value Clarification)
7. u|kd fcsifpmemjpmrfb , fv kd m;jci f jzi fjyó emulaijyv n fapEkdf v /D wjcm;o Lu kdb , fv kd u|kd fcsifpmo i fb v /D wpfzuf v L b , fv |kdCifpm;rv /D b , fv kdpm;ae&rv /D o lae&mSu|kd fo mq|kdi f b , fv kaijymv /D b , fv kaijz½Sfrv /D wpfzuf v L rQyrl½Sdv m;/ (Empathy)
8. ' kjyó emulaijz½SfEkdfzJb , fv kaMurif us|Cq u fyjpCifpm;rv /D (Critical and creative thinking)
   - jyó enjzpfapwbi t aMurif&if u b mv /D
   - t "d jyó emu b mv /D
   - ' kjyó emaMurifb mawGq u fzpEkdfb v /D
   - jyó emaijyv n f b Gt mifaijz½SfzJwGifb , fv kd wi ft csuf v ufawGukdv /D Cyrm- t ydcsf kd^Dykd aMurif?u|pu fen fr sm;t aMurif ao ao csmcsmo ekt mif v |kfzJv kdv m;/
   - v kdyfwbi wi ft csuf v ufawGukdb , fb |D o b&½Sdkdf v /D
   - ' Dn feUaijz½Sfv kdfv kbMwfjyó em[maijyv n f b G&Sdv m;/
   - t jcm;en f b , fv kd n fawGaijz½Sfv bEkdfao ;o v /D
9. y|kyf x l v [mb , fv kbl|Kpdrfzpd|D awGpm;ae&o v /D cpm;ae&wdpdrfzpd|D u kdb , fv k&if q|kdf v /D pdrfzpd|D av sh o Gt mifb mv |k&ifaumifrv /D b mv |kfv kd &if pdrfzpd|D awGav sh o G rv /D (Coping with Stress)
10. jyó emulaijz½Sfwuke&mSb , fv kbJaijym&if x ek&mu f½Sdv /D (Effective Communication)
    - pu m;aijymq|kJcn fv rf - b , fv kaijym&if aumifrv J?
    - b , f csdf Saijym&if aumifrv J?
    - u|kdfwkdaijym&if t q i faijyEkdf v m;?
    - o lrsm;ulaijymukd fr S t q i faijyEkdf Sv m;/
11. x ek&mu f eGuefwbq |kjewfcsufcs&Sfjci f/ b mudk |kjewfv kd f v /D rddd wGifa&mo lrsm;awGwGifyg t aumifq|k?t rGufeq|k?t x ek&muf q|kd |kjewfcsuf b mv /D (Decision Making)
12. aijymx m;wbi csuf v u fsm;ukd u$fcs|kfjyefv n faijymjci f/ o ab mayguf½Sd½Sdar;jrefjci f/
13. b 0wGifwmu Rfusi f lrsm;ukd rddd aeyCib 0wGi t o |kbSEkdfykdq u fyfaijymjci f/
14. au $Zl;wi fpu m;aijymMumjci f EESfaemufwpfBudfawGef&uf?t csdfjyefv n fcsdfq|kdi f/

Annex C

Voluntary Confidential Testing and Counselling

CARE Myanmar started to do this activity since early 2004 in its Promoting Voluntary and Confidential Counseling and Testing Project (UNICEF). So in this project, we took the lessons learned from the previous project and the formats and criteria were modified and used in this project.

Objectives:

- To get the early diagnosis of HIV/AIDS and get HBC and in-time treatment
- To reduce further transmission of HIV from them
- To give them psychological support/ to relieve their stress
- To help them plan for their future

Entry Points

In the early phase of project

1. Promotion of VCCT activities through health education sessions, life skills discussions, booth shows and by distribution of information, education and communication materials.
2. Advocacy with the health service providers, vulnerable groups (MSMs, SWs, Entertainment girls- restaurants, migrants, etc.) and others.
3. VCCT information giving stickers sticked at the hotels, guest houses and restaurants.
4. Information sharing among vulnerable people by their peers

Present condition

1. Promotion of VCCT activities through HE, LS discussions.
2. Referral from other places: hospitals, GPs, Specialists, basic health staffs, TB, STI campaigns, PMCT project, other INGO/ NGOs, other people
3. Referral from peers: MSMs, SWs, EWs, PLHAs, etc.

Process and strategies

Pre-test counseling

- We give pre-test counseling to all those who seek our service using pre-test counseling guideline which is modified from the format of National AIDS Program, AIDS Counseling Team (NAP- ACT).
- Most of the pre-test counseling take place in the office but sometimes in the beneficiaries' house or tea-shop or some friend's house or many other places the beneficiaries feel convenient.
- After the counseling, the staff write down in the counseling report.

HIV testing

- If the client decided to do HIV testing, they were referred to government AIDS team (STI team) for testing. Sometimes, laboratory technician come to office or sometimes to the clients' house to take blood sample. The beneficiary was appointed to come back next day or other day.
- Referral for testing form is used: one is given to the beneficiary and the other is kept at the office for record.
- The referral records are provided at the laboratory and the responsible person fill in the form and the charges are usually disbursed two-weekly or sometimes monthly.

- We got the result usually on the next day. Mostly staff took the result paper and keep at the office.

Post-test counseling

- The clients are appointed for post-test counseling usually at the office or sometimes at other places as stated in the pre-test counseling.
- Post test counseling is given to every client who tested for HIV: either positive or negative result.
- Post-test counseling guideline is used.
- After that, the staff has to fill in the counseling form.
- If the client is found to be HIV positive, we transfer him into home-based care program.
- There are many cases whom HIV testing was done at the GPs/ hospital or other places and referred to CARE Myanmar for post-test counseling and home-based care.

Type of support

- Transport fee up to 800 kyats per beneficiary.
- Testing fee up to 1500-2000 Kyats per beneficiary.
- IEC – pamphlet, booklets

Checklist for VCCT (Voluntary and Confidential Counseling and Testing)

yg0ifaomvkyfief;rsm;

1. aoG;rppfaq;rD ESpfodrfhaqG;aEG;jcif; Pre-test counseling
2. aoG;ppfaq;NyD; ESpfodrfhaqG;aEG;jcif; Post-test counseling
3. aoG;ppfaq;&eftwGuf "gwfcGJcef;odkY vTJydkYay;jcif;? Referral to the laboratory for testing
4. Positive jzpfvQif HBC ay;jcif;? Giving HBC to positive people.

Types of support in relation to VCCT (Client wpfOD;vQif 2000/usyf EIef;)

1. vrf;p&dwf 500/usyftxday;jcif;/
2. aoG;ppfaq;c wpfOD;vQif 1500 - 2000usyfay;onf/

Points to note

1. Counseling vkyfwdkif;vkyfwdkif;? Client vmonfhtMudrfwdkif; ESpfodrfhaqG;aEG;jcif; tpD&ifcHpm wGif jznfh&rnf/
2. Testing vkyfolwdkif;udk Post-test Counseling vkyf&rnf/ (ydk;awGUonfjzpfap? rawGYonfjzpfap)
3. Client wpfOD;udk Pre-test Counseling vkyfxm;olomvQif Post-test Counseling udk ay;yg/
4. Testing vkyfvQif Testing Referral form ESpfckjznfhyg/ wpfckudk "gwfcGJcef;odkY ay;vkduf&rnfjzpfNyD; usefwpfckudk rdrdxHwGif vufcHtjzpf odrf;xm;&rnfjzpfonf/
5. "gwfcGJcef;wGif Referral record udk ay;xm;&rnf jzpfNyD; aoG;vmppfolrsm;udk xdkpm½GufxJwGif "gwfcGJcef;rS rSwfxm;ay;&ef jzpfonf/ tenf;qHk; ESpfygwfwpfBudrf oGm;a&muf ydkufqH½Sif;ay;NyD; Refer record pm½Gufudk abmufcsmtaeESifh jyef,lcJh&rnf/
6. Pre-test Counseling ay;jcif;onf aoG;ppfaq;atmif wdkufwGef;jcif; r[kwfaMumif; owdjyKyg/ ESpfodrfhaqG;aEG;rIcH,lNyD;olwdkif; aoG;ppfaq;&rnf[k owfrSwfcsufr½Sdyg/

7. vlwpfOD;vQif aoG;rppfaq;rD ESpfodrfhaqG;aEG;jcif; tMudrfaygif;rsm;pGm vkyf&onfvnf; ½SdEdkifygonf/
8. ayghpwpfjzpfolwdkif;udk HBC ay;&ygrnf/
9. tjcm;ae&mrsm;rS (Oyrm- aq;cef;? aq;½Hkrsm;) aoG;ppfaq;NyD;í vTJydkYvmolrsm;udk aoG;ppfaq;cJhjcif; twGuf ydkufqH axmufyHhrI ray;Edkifaomfvnf;? Post-test Counseling ay;Edkifygonf/

Annex D-1

Home-based Care

HIV/AIDS, being a chronic illness, needs HBC definitely. So CARE Myanmar started to implement HBC activity about six years ago. On implementing this activity, we found out that HBC is very effective and essential to increase the quality of life of people living with HIV/AIDS and also in prevention of HIV transmission. At first HBC was done as a pilot project and later continue to implement replicating the lessons learned from the pilot project.

Entry points: The main difficulty at the start of the implementation of HBC is to get contact with PLHAs. So various means were used as entry point.

1. Promotion of HBC activities to general population through health education sessions, life skills discussion sessions, booth shows and IECs.
2. Advocacy with health service providers (Basic Health Staffs, GPs, hospital), health authorities and local authorities.
3. Peer to peer information sharing and referral.
4. Establishment of referral network with health service centers, other INGO, NGOs and laboratories.

Aims of the activity:

1. To help PLHAs build the capacity (knowledge and skills) on self-care.
2. To help PLHA family members and care givers build the capacity in home-based care to be able to give care to PLHAs and also for themselves.
3. To reduce frequency of OI incidences and to shorten the period of illness so that to increase the life span of PLHAs.
4. To provide moral, physical and social support to PLHAs and to increase the quality of life of PLHAs.
5. To raise the health seeking behaviour of PLHAs.
6. To create enabling environment for PLHAs- family, environment, health centers.
7. To reduce stigma and discrimination related to HIV/AIDS.
8. To prevent further transmission of HIV from PLHAs.

Strategies and procedures

- Use criteria for HBC guideline for selection of beneficiaries for HBC, to provide HBC kit and HBC manual. (Attached)
- Use criteria for selection of beneficiaries for nutritional support. (Attached)
- To do HBC according to the guideline which involve activities for HBC. (Attached)
- Use monitoring checklist for OWs by supervisors for quality HBC. (Attached)
- Use monitoring and evaluation checklist (HBC) occasionally for monitoring and evaluation purpose. (Attached)
- Outreach workers use care giver's notes to note events of every home visits.

- Nutrition is supplied monthly. In most towns, nutrition is supplied door to door but in some towns, it is supplied at the office and so PHAs and/or family members has to come to office.
- To use referral forms and referral record for OI refer.

Types of support

- HBC kit to every positive cases and teaching PLHAs and/or care givers how to use kit contents. Instruction pamphlet how to use kit content is also included in the kit. (Attached)
- HBC manual and teaching PLHAs and/or care givers how to use the manual.
- Monthly nutritional support – nutritious materials costing equivalent to 4000kyats per month which varies according to project site, availability of the goods and the cost of the goods. Usually we give vitamin enough for one month (Nutrivita, Plus, Provimin, ---), quaker oats, cooking oil/ eggs.
- Referral for opportunistic infection and subsidize cost for consultation (2000Kyats per visit) and travel cost (800Kyats per visit).
- Support of cost for hospitalization cases (2000Kyats for every day of hospitalization and 800Kyats for travel during hospitalization)
- Supply of Septrin for those who were prescribed for prophylaxis by referral network.
- Occasional one-time supply (mosquito net, slippers)

Other activities for the moral and psychosocial support of PLHAs

1. Establishment of PLHA SHGs.
2. Capacity building of SHG members.
3. Meditation and pagoda visit activities
4. Forums and cross visits

Establishment of Drop-in Centers

5. (DIC) for regular gathering, meeting and to get contact.

Criteria of beneficiaries for HBC **HBC ay;rnfholrsm;owfrSwfcsuf**

1. HIV tested positive asymptomatic (HIV cases)
   HIV ydk;½SdNyD; vu©Pm rjyao;olrsm;
2. HIV tested positive symptomatic (AIDS cases)
   HIV ydk;½SdNyD; vu©Pm ½Sdolrsm; (attdkif'Dtufpfa0'em½Sifrsm;)
3. Untested symptomatic (AIDS related complex)
   ydk;½Sdr½Sd aoG;rppfaq;&ao;aom a&m*gvu©Pm ½Sdolrsm;

Criteria for nutritional support (tm[m& axmufyHhrlay;rnfholrsm; owfrSwfcsuf)

1. All symptomatic cases a&m*gvu©Pm½Sdoltm;vHk;
2. Nutritional deficiency cases tm[m&csdKUwJhrI cHpm;ae&oltm;vHk;
3. Very poor cases tvGefqif;&Jaom vlemrsm;tm;vHk;
4. People who are in need of nutritional support e.g. PMCT, Breast feeding mothers, Weight loss
   ydk;½Sdaeaom udk,f0efaqmifrsm;? EdkYwdkufrdcifrsm;? tm[m& vdktyfaeaomolrsm;? udk,ftav;csdef tvGefusaeolrsm;

HBC activities

1. Home visits tdrfwdkif,ma&muf oGm;a&mufvnfywfjcif;
2. Psychological support pdwfydkif;qdkif&m tm;ay;ulnDjcif;
3. HBC books emrusef;olrsm;tm;
   aetdrfwGif;jyKpkapmihfa½Smufjcif;pmtkyf ay;jcif;
4. HBC knowledge teaching/ discussion with the PLHA and his family

HBC ESifh ygwfoufaom A[kokwESifh vkyfyHkudkifyHkudk PLHA ESifh rdom;pktm; ½Sif;vif;ajymjy&ef

5. Monitoring the knowledge and usage of HBC book and HBC kit
   HBC pmtkyfESifh kit tdwf toHk;jyKyHkudk odrod ESihf oHk;roHk; udk qef;ppfjcif;
6. Nutritional support given according to the above criteria
   owfrSwfxm;aom owfrSwfcsufrsm;ESifh udkufnDolrsm;udk vpOftm[m&ay;jcif;
7. HBC kit and the knowledge to use the contents given to
   atmufygvlemrsm;tm; HBC kit tdwfay;jcif;ESifh toHk;jyKyHkudk ½Sif;vif;oifjyay;jcif;
   - all symptomatic cases attdkif'Dtufpfvu©Pm½Sdoltm;vHk;
   - all cases with any kind of illness e.g. minor illness tao;pm;emrusef;rI tygt0if emrusef;rItm;vHk; Oyrm- ESmap;acsmif;qdk;
8. Supporting with the medicine as necessary
   tcgtm;avsmfpGm vdktyfovdk tdrfoHk;aq;0g;rsm;ay;jcif;
   - ORS,
   - Burmeton
   - Paracetamol
   - Gentian Violet
   - Mezincal lotion
   - Glove
   - Antiseptic solution
9. Referral vdktyfovkdvTJajymif;nTef;ydkYjcif;

HBC Kit twGif;wGif yg0ifaom aq;rsm; ESifh ypönf;rsm; toHk;jyK&ef vrf;nTef

1/ yg&mpDwarm aq;jym; Paracetamol tudkuftcJESifh udk,ftylcsdefwufjcif; twGuf toHk;jyKEdkifonf/ vlBuD;wpfa,muftwGuf wpfBudrfvQif (1) jym; rS (2) jym; txd pm;Ekdifonf/ wpfaeY (3) Budrftxd aomufEdkifonf/

2/ bmrDwGefaq;jym; Burmeton udk,fcE¨m ,m;,Hjcif;? aq;rwnfhjcif;ESifh ESmap;jcif;wdkY twGuf toHk;jyKEkdifonf/ vlBuD;wpfa,muftwGuf wpfBudrfvQif (1) jym; rS (2) jym;? wpfaeY (3) Budrftxd pm;EdkifNyD; 4if;aq;onf vludk xdkif;rSdKif;aponf/

3/ rufZifu,f vdrf;aq;&nf Mezincal udk,fcE¨m ,m;,Hjcif;? tzktydefYrsm;xjcif; wdkYtwGuf vdrf;&efjzpfonf/

4/ zef&nfrSKefY KMnO4 (Potassium Permanganate) trSKefYtenf;i,fudk yef;a&mifEkEkt&nf &onhfwdkif a&jzifh azsmfyg/ t&nfudk *Grf;wGifqGwfí temudk zef&nfaq;ay;Edkifonf/ ykvif;udk tzHk;vHkvHk tkyfxm;&ef ta&;BuD;ygonf/

5/ c&rf;a&mifaq;&nf Gentian Violet a&,kefaygufaomtcgESifh yg;pyfxJwGif rufc½kaygufygu okwfvdrf;&ef jzpfonf/ *Grf;wGif vdrf;aq;&nfqGwfNyD; okwfvdrf;ay;Ekdifonf/

6/ bDwm'if;vdrf;aq;&nf Betadine xdcdkufyGef;yJh½Semrsm; ESifh temrsm;wGif xnfhEdkifonf/ ydk;rsm;udkaoaponf/ t&ufysHuJhodkY rpyfyg/ uav;rsm;wGif

bDwm'if;oHk;vQif rpyfonfhtwGuf ydkoifhavsmfonf/ aq;&nfudk
*Grf;wGifqGwfí temay:wGif vdrf;Edkifonf/
7/ omrdkrDwm Thermometer
udk,ftylcsdef wdkif;wm&efjzpfonf/ jy'g;wdkifudk vQmatmuf (odkY)
csdKif;Mum;wGif 2-rdepfxm;NyD; wkdif;wmEdkifonf/
8/ <uyf<uyfvuftdwf Plastic Glove
temaq;xnfh&mwGifvnf;aumif;? tnpftaMu;rsm;udk
udkifwG,f&mwGifvnf;aumif; toHk;jyKEkdifonf/ wpfcgoHk;NyD;vQif
pGefYypf&efjzpfonf/

9/ &mbmvuftdwf Rubber glove
temaq;xnfh&mwGifvnf;aumif;? tnpftaMu;rsm;udk
udkifwG,f&mwGifvnf;aumif; toHk;jyKEkdifonf/ NyD;vQif a&aq;?
aevSrf;NyD; jyefvnftoHk;jyKEdkifonf/
10/ "gwfqm;xkwf ORS (Oral Rehydration Salt)
0rf;avQmaeaom vlemtm;½kwfw&ufaoqHk;jcif;rS umuG,f&ef?
a&"gwfcef;ajcmufjcif;? tm;tif,kwfavsmhjcif;rS umuG,f&ef
wdkufauR;Edkifonf/ "gwfqm;xkwf wpfxkwfudk wpfaxmifpDpD (odkY)
a&oefYykvif; wpfykvif;pm½Sd a&oefY (odkY) a&usufat;jzifh azsmf&rnf/
"gwfqm;&nfudk azsmfNyD; (24) em&D txdom aomufoHk;Ekdifonf/
11/ yvmpwm Plaster
temaq;aMumoefYpifjcif;? aq;xnfhjcif;wdkYwGif toHk;jyK&efjzpfonf/
12/ *Grf; Cotton
temaq;aMumoefYpifjcif;? aq;xnfhjcif;wdkYwGif toHk;jyK&efjzpfonf/
13/ ywfwD; Bandage
temaq;aMumoefYpifjcif;? aq;xnfhjcif;wdkYwGif toHk;jyK&efjzpfonf/
14/ t&ufysH Spirit
temaq;aMumoefYpifjcif;? aq;xnfhjcif;wdkYwGif toHk;jyK&efjzpfonf/
15/ uyfaus; Scissor
16/ bDppf B6 (Behexavit)
acgif;rl;ajyaq; wpfcgaomufwpfvHk; wpfaeY ESpfBudrf
17/ pwD;cGuf Steel bowl
temaq;xnfhonhf ypönf;rsm;xnfh&ef? zef&nfazsmf&ef
toHk;jyKEkdifonf/
18/ a&oefY Purified water
1000 pDpD (odkY) wpfvDwmyg0ifonf/
19/ Zm*em Forcep
20/ Condom

Monitoring checklist for OWs by supervisors for Quality HBC

Name of OW ..... Township .....
Supervisor name ..... Date .....

Number of PLHA

All registered PLHA ----------
All expired cases ----------
All alive PLHA ---------- Symptomatic cases ---------- Asymptomatic cases ----------
HBC kits have been given to ----------
HBC manuals have been given to ----------
HBC education have been done ---------- (PLHA and/or family members/ care giver)
Counseling have been given to ----------
(family, psychological, social, health related csl, RH, breast feeding, PMCT, discrimination.)
HE have been given to ----------
who are referred for TB ----------
who are taking Septrin Prophylaxis ----------
who are taking ART ----------

of PHA to whom you can pay home visits ----------
Highest number of visits to one PLHA ----------
Lowest number of visits to a PLHA ----------

Monitoring and Evaluation Checklist (HBC)

Name: ---------- PLHA No. ----------
Position: ---------- Date: ----------
Township: ---------- Quarter: ----------

um,uH½Sif ESifh jyKpkapmifha½Smufol udkar;jref;jcif;

1. vGefcJhonfh ESpfvtwGif; emrusef;jzpfcJhovm;/ bmjzpfcJhovJ/ ----------
2. xdkemrusef;jzpfcJhonhftwGuf bmvkyfcJhovJ/----------
3. vpOfay;aom tm[m& ESifh tm;aq;udk vlem udk,fwdkifpm;oHk;jzpfovm;/ xda&mufrSK&Sdonf [kxifygovm;/ ----------
4. emrusef;jzpfjcif;aMumihf aq;cef;odkUvTJydkYay;rSK cH,lbl;ygovm;/ tqifajyygovm;/ ----------

Munfh½SKtuJcwfjcif; ESifh rdrd\ 0efxrf;udk ar;jref;jcif;

5. HBC pmtkyfudk vlemtem;wGif^ vlemtdrfwGif awGUcJhonf/--------- rawGUcJhyg/---------
6. um,uH½Sifonf HBC pmtkyfudk toHk;jyKwwfovm;/ aumif;rGefpGmoHk;wwfonf---toifhtwifhoHk;wwfonf---tenf;i,foHk;wwfonf---roHk;wwfyg---
7. tdrfom;rsm;xJrS b,fESpfOD;onf þpmtkyfudk toHk;jyKwwfoenf;/ 0 ---- 1---- 2 ---- 3 ---- 4 ---- 5 ----

8. HBC Kit tdwfudk tdrfwGif awGYcJhygovm;/ awGUcJhonf/----- rawGUcJhyg-----/
9. HBC Kit tdwfxJrS ypönf;rsm;udk um,uH½SifrS toHk;cswwfonf[k xifygovm;/

aumif;rGefpGmoHk;wwfonf---toifhtwifhoHk;wwfonf---tenf;i,foHk;wwfonf---roHk;wwfyg---

10. rdom;pk0ifrsm;rS toHk;cswwfonf[k xifygovm;/

aumif;rGefpGmoHk;wwfonf---toifhtwifhoHk;wwfonf---tenf;i,foHk;wwfonf---roHk;wwfyg---

11. atmufygwdkUteuf rnfonfh taMumif;t&mrsm;udk usef;rma&;ynmay;NyD;jzpfoenf;/

HIV/AIDS -------- STI ---------- Birth spacing om;qufjcm; ---------- HBC ----------

12. atmufygwdkYteuf rnfonfh taMumif;t&mrsm;ESifh ygwfoufí ESpfodrfhaqG;aEG;ay;cJhzl;oenf;/

ART ------ Socioeconomic Problems ------- PMCT ------- Others ----

13. um,uH½Sif\ ywf0ef;usifwGif Stigma and Discrimination ½Sdaeovm;/ tJ'DtwGuf bmvkyfay;cJhovJ/----------

---

Annex D-2

List of contents of HBC kit by township

No.	Items	Mdy	Mwa	Muse	Lso	Nkm	Mlm	Ye	Mdn
1	HBC bag	1	1	1	1	1	1	1	1
2	HBC book	1	1	1	1	1	1	1	1
3	Plastic Glove	1	1	1	1	1	1	1	1
4	Rubber glove						3		
5	Forceps	1			1		1	1	1
6	Scissors	1		1	1	1	1	1	1
7	Bowl							1	1
8	Plastic basket								1
9	Bandage 2” roll	1	1	1	1	1	1	1	1
10	Plaster	1			1	1		1	
11	Paper tape			1			1		1
12	Cotton (packet)	6	3	3		3	1		
13	Spirit bottle	1	2	1	1	1	1	1	1
14	Thermometer	1		1	1	1	1	1	1
15	Burmeton tablets	20	10	10	10	10	20	10	20
16	Paracetamol tablets	20	10	20	20	20	20	20	20
17	B6 tablest	20	10		10			10	20
18	Cevit tablets	100	10	10					
19	Provimin tablets (bottle)				1	1		1`	
20	ORS packet	5-10	5	5	2	5	5	5	5
21	Potassium permanganate		1				1	1	
22	Gentian violet	1	1	1	1	1	1	1	1
23	Septidine	1	1	1		1			1

24	Mezincal	1	1	1		1	1		1
25	Condom	6	3	3		3	1		
26	Small towel						1	1	1
27	Note book			1		1			
28	Pen			1		1			
29	Soap	1							

Mdy = Mandalay Mwa = Monywa Mso = Lashio Nkm – Namkham
Mlm = Mawlamyine Mdn = Mudon

Annex E

Support for Orphans and Vulnerable Children

CARE Myanmar started to do care and support activities related to orphans and vulnerable children since 2004 in twelve townships. All OVCs are identified through our home-based care program. So all of them are HIV infected or affected children. Most of them are affected and only some are infected. Starting from July 2006, UNICEF and CARE jointly implement the OVC activities by in-cooperating the OVC activities in the current care and support program for people with HIV/AIDS.

Objectives:

1. To be able to give health care to HIV affected orphans and vulnerable children.
2. To reduce the burden of the families of people with HIV/AIDS.
3. To help those children who cannot afford to attend school.
4. To give psychosocial support to OVCs and to reduce stigma and discrimination for OVCs

Entry points

Only those children identified from existing HBC program are included in the project.

Strategies and procedures

- Use criteria for selection of beneficiaries for OVCs, type and amount of support and points to note.
- Use monitoring checklist for OWs by supervisors for OVC.
- Use monitoring and evaluation checklist (OVC) occasionally for monitoring and evaluation purpose.
- Outreach workers used to note down events of every home visits in their note books.

- Nutrition is supplied monthly. In some towns, nutrition is supplied door to door but in some towns, it is supplied at the office and so OVCs and/or family members has to come to office.
- To use referral forms and referral record for referral for any kind of illness.
- HIV infected OVCs are given care and support the same as for PLHAs and also they got educational and other types of support given for other OVCs.

Types of support

- Monthly nutritional support – nutritious materials costing equivalent to 4000kyats per month which varies according to project site, availability of the goods and the cost of the goods. Usually we give quaker oats and cooking oil/ eggs for non-infected children and vitamin syrup + quaker oats +/- cooking oil for infected children.
- Referral for opportunistic infection and subsidize cost for consultation (2000Kyats per visit) and travel cost (800Kyats per visit) for infected children and the same amount of support for non-infected children for any kind of illness.
- Support of cost for hospitalization cases (2000Kyats for every day of hospitalization and 800Kyats for travel during hospitalization).
- Supply of Septrin for those HIV infected OVCs who were prescribed for prophylaxis by referral network.
- Support for school enrollment with average amount of 6000 Kyats per child (to give actual cost) which may vary from less than 2000 Kyats up to 10000 Kyats according to the level of standard.
- Occasional one-time supply (mosquito net, slippers)
- Distribution of child protection kits.

Activities for the moral and psychosocial support of OVCs

1. Participation of PLHA SHGs for care and support of OVCs.
2. OVC entertainment activities
3. Family counseling
4. Forums and cross visits
5. Drop-in centers- libraries, gathering weekly/ monthly to play together with other children, telling education stories, singing songs, etc.
6. Doing workshops on journey of life, mobility mapping and memory book with the children and their family members.

Criteria for Orphan and Vulnerable Children (OVC)

Criteria for OVC

- AIDS Orphans –rdbESpfyg;vHk; (odkU) rdbwpfOD; AIDS a&m*gjzifh qHk;yg;oGm;NyD; usef&pfaom om;orD;rsm;
- Vulnerable Children – rdbESpfyg;vHk; odkYr[kwf rdbwpfOD; AIDS a&m*gaMumihf emwm½Snfa0'em cHpm;ae&vQif (odkYr[kwf) tdyf,mxJvJaevQif olwdkY\ om;orD;rsm;

Children –- touf 15 ESpf ESifh atmuf uav;i,frsm;? tu,fí roefrpGrf; (odkYr[kwf) tm[m&csdKUwJaevQif (odkYr[kwf) tvkyfvkyfrpm;Edkifaomolrsm; jzpfaevQif touf (18) ESpf txd tusHK;0ifonf/

Type of support

1. Monthly nutritional support (Quaker oats one large package – 30 sachets + 20 eggs or any nutrition with cash amount equivalent to 2000-2500 Kyats per month)

vpOf tm[m&axmufyHhrIay;jcif; - auGumtkyf txkyfao; (30) + MuufO tvHk; (20) odkYr[kwf aiGaMu; (usyfaiG) 4000 usyf wefaom tm[m& trsdK;tpm; wpfrsdK;rsdK;

2. Health related support – subsidy system for referral for illness
   usef;rma&;qdkif&m axmufyHhay;rI -– emrusef;jzpfrIrsm;twGuf aq;½Hk? aq;cef; ydkYay;jcif;wGif wpfMudrfvQif uJjrefrmrS 2000usyftxdESifh vrf;p&dwf 800usyfEIef;uscHjcif;/
3. Educational support ynma&;? ausmif;aea&;qdkif&m axmufyHhrI – - ausmif;tyfp&dwfaxmufyHhjcif;? (wpfOD;vQif ysrf;rQ 6000usyf) ausmmif;0wfpHktygt0if? pmtkyf? cJwH? avmpmtkyftwGuf 7000usyfzdk;/

Points to note (rSwfom;&ef)

- Only AIDS orphans and vulnerable children will be counted.
  attdkif'Dtufpfa&m*gaMumifh rdbrJh ESifh Vulnerable jzpfoGm;aom uav;i,frsm;om yg0ifygonf/
- We will not actively find OVCs.
  OVC rsm;udk vdkufr½Smyg/
- Only AIDS OVCs found during HBC activity will be counted.
  HBC vkyf&if; awGUBuHKvm&aom OVC rsm;udkom axmufyHHhrIay;ygrnf/

Monitoring checklist for OWs by supervisors for Quality OVC care and support

Name of OW ..... Township .....
Supervisor name ..... Date .....

Number of OVC

All registered OVC ----------
All expired cases ----------
All alive OVC ---------- In-school OVC ----------Out-of school OVC ----------
JOL training given to ---------- OVCs
School support given to ---------- OVCs
Vocational training support to ---------- OVCs
Family counseling given to ---------- families
Psychosocial support given to ---------- OVCs
HE have been given to ---------- families
who are referred for TB ---------- OVCs
whom Nutrition giving (at present) ---------- OVCs
Child protection kits given to ---------- OVCs
Income generation support to ---------- families
who are taking referral service ---------- OVCs
JOL training given to ---------- community members

Annex F

Referral System

CARE Myanmar has established the referral network in the project townships where home-based care activity is implementing.

Objectives:

1. To promote the health seeking behaviour of people living with HIV/AIDS.
2. To promote the quality of life of PLHAs.
3. To prolong the survival of PLHAs.
4. To reduce the burden of PLHAs and their families physically and financially.
5. To establish the enabling environment for PLHAs.
6. To reduce stigma and discrimination in the community.

Supporting points for development of a successful referral system

- Advocacy with health service providers –GPs, specialist, health authorities
- Systematic referral procedures
- Clear guideline for referral process and level of support
- Review and feedback mechanism with the doctors and regular disbursement of the costs
- Enthusiasm and hard-working of staffs

- Occasional Continuous Medical Education Programs with doctors
- Provision of Medical books related to HIV/AIDS (Management guidelines for adult and child HIV/AIDS, infectious diseases color guide books, dermatology, BNF, etc)

Referral system

1. Criteria for illness referral guidelines is used. (Attached)
2. Responsible outreach worker or the beneficiary decides the time to go to clinic.
3. The doctors are provided with referral forms and referral record forms in advance.
4. The responsible OW has to fill in two referral forms for one client: one is given to the patient and the other is kept for record.
5. Mostly the outreach worker accompanies the patient to the clinic but sometimes patient go by themselves.
6. The doctor took the referral form from the patient and gave treatment. If the consultation fee is more than the limit, the doctor will charge the extra cost from the patient. The doctor fill in the referral record form in which the cost is also stated which is also used as a voucher to reimburse to the doctor.
7. There is no exact limit for frequency of clinic visit. But for the cases where many visits per each PHA is needed, outreach workers need to consult with their supervisors.
8. We also provide support for hospitalization.

Payment system

1. CARE provides 2000 Kyats per visit for the consultation at the upper limit and actual cost for cases below 2000 Kyats.
2. Provides 800 Kyats per visit for travel cost.
3. For hospitalization cases, CARE provides 2000 Kyats for consultation or medicine cost and 800 Kyats for transportation per admitted day up to 10 days.
4. Outreach workers shared responsibility to reimburse at the clinics usually every two weeks. They collect the referral records back after reimbursement and use them as vouchers.
5. Previously the project had bought some OI drugs which were distributed to the clinics. The doctors use the drugs and only charge for consultation and for other medicine they use. We used 50% subsidy system but the doctors complained and so we changed our system as mentioned above.

Referral network

Beneficiaries are referred to referral centers for the following reasons

1. Opportunistic infection
2. ART
3. Other types of support

The following health service providers and centers are involved in our established referral network. The list is arranged in chronological order.

Referral for opportunistic infection

1. Local private general practitioners
2. TB campaign
3. STI campaign
4. General and maternity and child hospitals
5. INGO/NGOs – MSI for STI, MNA for nursing care, IOM for drugs
6. Specialist clinics
7. Health center for skin diseases (Leprosy mission hospital)

Referral for STI

1. MSI – Marie Stopes International
2. Government STI clinic
3. Local GP
4. Sun clinic GPs

Referral for other types of support

1. AFXB
2. Save the Children
3. MSI
4. MNA
5. IOM
6. World Vision
7. Other local NGOs

Referral for ART

1. ART selection committee
2. AIDS specialists, Local physician
3. Waibargi Communicable Disease Hospital
4. AZG – Yangoon

Capacity building activities done for referral system

For staffs- Home-based care trainings
Lecture/ Discussion about TB
Knowledge on HIV/AIDS and STI
Other knowledge sharing – nutrition, RH

For service providers
CMEs (Continuous Medical Education Program)
Distribution of medical books
HBC training to BHS

Referral system

9. Criteria for illness referral guideline is used. (Attached)
10. Responsible outreach worker or the beneficiary himself decide the time to go to clinic.
11. The doctors are provided with referral forms and referral record forms in advance.
12. The responsible OW has to fill in two referral forms for one client: one is given to the patient and the other is kept for record.
13. Mostly the outreach worker accompany the patient to the clinic but sometimes patient go by themselves.
14. The doctor took the referral form from the patient and gave treatment. If the consultation fee is more than the limit, the doctor will charge the extra cost from the patient. The doctor fill in the referral record form in which the cost is also stated which is also used as a voucher to reimburse to the doctor.
15. There is no exact limit for frequency of clinic visit. But for the cases where many visits per each PHA is needed, outreach workers need to consult with their supervisors.
16. We also provide support for hospitalization.

Payment system

6. CARE provide 2000Kyats per visit for the consultation at the upper limit and actual cost for cases below 2000Kyats.
7. We also provide 800Kyats per visit for travel cost.
8. For hospitalization cases, CARE provide 2000Kyats for consultation or medicine cost and 800Kyats for transportation per admitted day. But again if there is continuous admission more than 10 days.
9. Outreach workers shared responsibility to reimburse at the clinics usually every two weeks. They collect the referral records back after reimbursement and use them as vouchers.
10. Previously the project had bought some OI drugs which were distributed to the clinics. The doctors use the drugs and only charge for consultation and for other medicine they use. We used 50% subsidy system but the doctors complained and so we changed our system as mentioned above.

Annex G

Selected findings of KAP study among youth aged 15-24 years

Description	Male		Female		Both sexes	
	BL	EOP	BL	EOP	BL	EOP
Number of respondents	732	662	727	710	1459	1372
	%	%	%	%	%	%
Modes of Transmission						
HIV/AIDS transmission through unprotected sex with infected person	97.3	97.1	94.6	96.6	95.9	96.9
HIV/AIDS transmission through sharing needles	97.9	95.8	97.6	95.6	97.7	95.7
HIV/AIDS transmission mother-to-child	76.1	94.0	76.4	94.8	76.2	94.4
Can name 3 correct modes of transmission	**79.6**	**90.8**	**71.0**	**91.0**	**75.3**	**90.9**
Ways of prevention						
Using condom correctly every time prevents HIV/AIDS	90.4	86.7	81.1	90.4	85.7	88.6
Abstinence from sexual intercourse prevents HIV/AIDS	74.2	53.0	75.3	53.9	74.7	53.5
Having one uninfected faithful partner prevents HIV/AIDS	68.0	75.1	81.9	79.2	74.9	77.2
Can name 3 ways of prevention	**46.0**	**45.9**	**39.0**	**49.6**	**42.2**	**47.8**
Misconceptions						

HIV/AIDS transmission through mosquito bite	49.0	8.6	50.0	8.0	49.5	8.3
HIV/AIDS transmission by sharing meals with PLWHA	30.9	3.6	26.7	2.8	28.8	3.2
HIV/AIDS transmission by using public toilet also used by PLWHA	32.9	4.4	30.0	2.3	31.4	3.3
HIV/AIDS transmission through working with PLWHA	24.3	2.3	20.0	3.4	22.1	2.8
HIV/AIDS transmission through donating blood	30.0	17.7	40.7	19.9	35.3	18.8
Healthy-looking person can have HIV/AIDS	41.4	86.9	38.0	87.7	39.7	87.3
Incorrect beliefs	**81.3**	**39.4**	**83.3**	**40.1**	**82.2**	**37.8**
Correct knowledge UNGASS indicator	**19.8**	**57.7**	**17.9**	**61.8**	**18.8**	**59.8**
Comprehensive correct knowledge	**7.0**	**29.3**	**8.7**	**27.2**	**7.8**	**28.2**
Attitudes						
Wiiling to share meal with PLWHA	48.3	91.8	47.3	90.0	47.8	90.9
Wiiling to buy food from HIV+ vendor	42.4	75.4	40.3	75.8	41.3	75.6
HIV+ student should atten school	48.4	91.2	49.5	93.0	48.9	92.1
Right attitudes UNAIDS indicator	**33.3**	**70.1**	**34.1**	**72.0**	**33.7**	**71.1**
Practice						
Condom use at first sex	30.1	43.7	5.8	10.8	17.9	31.9
Condo use last sex	26.9	56.8	12.0	48.7	19.4	53.6
Multiple partner last 12 months	49.5	14.2	5.3	6.9	27.4	10.4
Condom use last sex with non-marital, non-regular/non-cohabitating partner	44.3	76.0	11.3	86.4	27.8	80.2
Sex with CSW last 12 months	85.1	51.2	NA	NA		
Condom use with CSW last sex	27.3	93.1	NA	NA		

Annex H

SHG Background Information

I. PHA SHG

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4/ OVC uav;rsm; tem*gwf om,mvSyap&ef/

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vkyfaqmifaeaom vkyfief;rsm;
1. Home Based Care visit
2. Family counselling
3. Referral
4. Monthly meeting/ forum
5. Income generation
6. Peer Education about HIV/AIDS
7. Sometimes assisit in member's funeral

+++
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zGJUpnf;aomaeU - (20.06.2006)
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2. Counselling
3. Referral

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&nf&G,fcsuf
1/ b0wltcsif;csif; udk,fcsif;pmemrIxm;&ef/
2/ usef;rma&;^vlrIa&;ESifh ywfoufNyD; ulnDrIay;&ef/
3/ ema&;jzpfvQif wlnD0wfpHk0wfí ulnDaxmufyhH&ef/

vkyfaqmifaeaom vkyfief;rsm;
1/ aw;o&kyfazmfESifh ynmay;jcif;/
2/ Condom udk vljrifatmif csdwfqGJNyD; oHk;enf;udk jyojcif;/
3/ Condom a0iSjcif;/
4/ Transmission taMumif; ynmay;jcif;/

++++
2/ rHk&Gm (MSM SHG)
tzGJUtrnf -]] ypfwdkif;axmif}}
zGJUpnf;aomaeU - (9.01.2007)
tzGJU0ifOD;a& - 5

&nf&G,fcsuf
1/ HIV ul;pufcHae&ol tygt0if 4if;wdkUESifh ywfoufqufEG,faeaom rdom;pk0ifrsm;tm; ulnD&ef/
2/ HIV ydk; ul;pufcHae&aomfvnf; a&m*gonf tqifhqDra&mufatmif usef;rmpGmaexdkifoGm; Edkif&efESifh rdrdod&Sdxm;aom owif;tcsuftvufrsm;udk tcsif;csif; ajymjy&ef/

3/ PHA rsm; tygt0if MSM rsm;udk cGJjcm; ypfy,frI r&Sd&ef/
4/ vlrIa&;tzGJUtpnf;rsm; r&Sdonfh aemufydkif; usef;rma&;? vlrIa&; aqmif&GufrIrsm;udk qufvuf vkyfaqmifoGm;&ef/

vkyfaqmifaeaom vkyfief;rsm;

1. Peer Education
2. Home Based Care
3. Condom distribution/IEC distribution
4. Regular Meeting

+++

3/ jynf (MSM SHG)
tzGJUtrnf -]] cwåå&m pG,fawmfOD;}}
zGJUpnf;aomaeU - (25.11.2006)
tzGJU0ifOD;a& - 20 ausmf

&nf&G,fcsuf

HIV/AIDS usef;rma&; ynmay;ESifh tcsif;csif; jyKpkapmifha&Smuf&ef twGuf OD;wnfqufoG,frnfh tzGJUudk zGJUpnf;ygonf/ (jynfc&dkif 6 NrdKUe,f)

vkyfaqmifaeaom vkyfief;rsm;

1/ tzGJU&SdaMumif; today; wqifhpum;ajymMum;rnf/
2/ tpnf;ta0;udk wpfvwpfBudrfvkyfrnf/
3/ vkyfcJhwmawGudk jyefajymNyD; rSwfwrf;rSwfr,f/ (pkrdwJhae&mawGrSm ajymjyr,f)
4/ uGef'Hk; oHk;enf; ? &EdkifwJhae&mawGudk ajymjyr,f/
5/ uGef'Hk; a0wJh pm&if;udk rSwfxm;r,f/
6/ aq;cef;jyp&mae&mawGudk csdwfqufay;r,f/
&/ &yfwnfp&m ae&m&atmif azsmfajza&;awGvkyfr,f/ ynmay;wmawG vkyfr,f/
8/ &HyHkaiGxm;rnf/ tzGJU0ifaMu; wpfv (200) usyfaumufrnf/
9/ tzGJU0ifrsm;udk OD;pm;ay; aiGacs;ay;rnf/
10/ tvGJoHk;pm;vkyfvQif ta&;,lrnf/

++++++

4/ yJcl; (MSM SHG)
tzGJUtrnf -]] apwemh tm;rmef}}
zGJUpnf;aomaeU - (16.12.2006)
tzGJU0ifOD;a& - 13

&nf&G,fcsuf

1/ usef;rma&; csdKUwJhaom MSM rsm;udk ulnD&ef/
2/ MSM r[kwfaomfvnf; HIV jzpfaeaom tjcm;olrsm;udk ulnD&ef/
3/ HIV r[kwfaomfvnf; tjcm;a&m*gjzpfaom qif;&JEGrf;yg;olrsm;udk ulnD&ef/
4/ rdef;rvsmrsm; tm;vHk; nDnDnGwfnGwfjzpf&ef/
5/ oufqHk;wdkif þtzGJUBuD; wnf&Sdap&ef/

vkyfaqmifaeaom vkyfief;rsm;
1/ tzGJU&SdaMumif; vufqifhurf;ajymMur,f/
2/ wpfvwpfBudrf yHkrSef tpnf;ta0;awGvkyfMur,f/
3/ Condom toHk;jyKyHkESifh Condom &Edkifaom ae&mrsm;udk ajymjyr,f/
4/ usef;rma&; aqmif&GufrIay;aom tzGJUawGudk qufoG,fvrf;nTefay;r,f/
5/ &HyHkaiGxJrS usef;rma&;csdKUwJholrsm;udk axmufyhHay;r,f/
6/ vpOf&HyHkaiG (200) usyfay;r,f/
(ulnD&mwGif HIV jzpfaeoludk OD;pm;ay;r,f/ &yfuGufxJu tzGJU0ifawGodwJh csdKUwJh EGrf;yg;olawGudk OD;pm;ay;r,f)
+++++

III. SW SHG
1/ armfvNrdKif (SW SHG)
tzGJUtrnf -]] arwÅmqHkqnf;}}
zGJUpnf;aomaeU - (16.03.2006)
tzGJU0ifOD;a& - 10

&nf&G,fcsuf
1/ tzGJU0ifoli,fcsif;awG 'ku©a&mufwJhtcg ulnDEdkifatmif/ (tzrf;cHxd&if pkxm;wJhaiGeJU a&G;Edkifatmif)
2/ zsm;em&if aq;ukorIay;Edkifatmif/
3/ usef;rma&;eJU vkyfief;cGifA[kowawG ydkwkd;yGm;vmatmif/

vkyfaqmifaeaom vkyfief;rsm;
1/ wpfvwpfcg uJ&f&Hk;rSm tzGJU0ifawGpkjzpfMuw,f/ pkNyD;&if udk,fh&JUtawGUtBuHKawGjyefajym Muw,f/ tcuftcJawGajymMuw,f/
2/ usef;rma&;taMumif;awG? aq;cef;taMumif;awG ajymjyjzpfMuw,f/ pum;0dkif;av;uaeNyD; tcsif;csif; avhvmoif,ljzpfw,f/ ajz&Sif;&rJhenf;vrf;awGudk pOf;pm;jzpfMuw,f/
3/ wpfvudk wpfa,mufudk wpfaxmifpDpkMuw,f/ tcktzGJU0if (12) a,muftxd&SdvmNyD/ tzrf;cHxdvdkU a&G;&&if wpfa,mufudk (30000) uae (50000) avmuftxdukefw,f/ wpfa,mufcsif;qdk&if vufxJrSm aiGpkrdwJholu r&SdoavmufyJ/ 'gaMumifh 'DrSm wpfvwpfaxmif aiGpkxm;wm/ uJ&fuq&mrawGem;rSmpkxm;w,f/ tJ'DaiGudk oHk;&if wpfvtwGif;aMuatmif jyefqyf&r,f/
4/ aemifrSm tzGJUpkaiGwdk;vmatmif b,fvdkvkyf&rvJqdkwmvnf; pOf;pm;aew,f/

++++
1/ jynf (SW SHG)
tzGJUtrnf -]] arwÅmtiftm;}}
zGJUpnf;aomaeU - (26.11.2006)
tzGJU0ifOD;a& - 20

&nf&G,fcsuf
1/ HIV/AIDS a&m*g umuG,fa&;wGif wpfwyfwpftm; yl;aygif; yg0ifulnDEdkif&ef/

2/ b0wltcsif;csif; ulnD,dkif;yif;Edkif&ef/

vkyfaqmifaeaom vkyfief;rsm;

1/ HIV/AIDS a&m*gESifhywfoufaom usef;rma&;taMumif;aqG;aEG;Murnf/
2/ awGUBuHK&wJhtcuftcJawGudk tcsif;csif;aqG;aEG;wdkifyifr,f/
(tmPmydkiftzGJUeJUywfoufNyD;? usef;rma&;
jyoemawGeJUywfoufNyD;)
3/ udk,f&&Sdxm;wJh owif;awG zvS,fr,f/ (NGO , aq;cef;)
4/ tcsif;csif; ulnDapmifha&Smufr,f/
5/ wpfvwpfcg qHkMur,f/ t*Fvdyfvdk vqef; wpf&ufaeU/
(qHkrnfhae&mudk uJ&f&Hk;rS pDpOfay;&ef/ Catholic Church)