

Barriers to Access to PMTCT Services by Female Sex Workers

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and
UNICEF Myanmar

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LIST OF ABBREVIATIONS

ANC	Ante-natal care
ART	Anti-retroviral therapy
ARV	Anti-retroviral
CBO	Community based organization
FSW	Female sex worker
IDI	Individual Depth Interview
IDU	intra-venous drug user
INGO	International Non-governmental Organization
KAP	Key affected population
MOH	Ministry of Health
MTCT	Mother-to-child transmission
MSM	Men having sex with men
NGO	Non-governmental Organization
PMTCT	Prevention of mother-to-child transmission
PWID	People who inject drug
RTD	Round Table Discussion
SEM	Socio-ecological Model
TBA	Traditional birth attendant
UNICEF	United Nations Children Fund
UNFPA	United Nations Population Fund
WHO	World Health Organization

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EXECUTIVE SUMMARY

The study was conducted with objectives to explore the barriers to access and utilization of PMCT services by pregnant key populations and describe the factors of not accessing PMTCT services. Because of non-availability of pregnant key populations other than FSWs for participation in the study, the study exploration focused only on the FSWs. An exploratory qualitative research design was applied where Round Table Discussions with Key Informants and Individual Depth Interviews (IDIs) with FSWs. During IDIs, short quantitative questions were also posed to this non-random sample to be able to quantify some of the key variables of interest.

The study findings highlighted that at an individual level, there is a need for further improving mother-to-child HIV transmission knowledge among pregnant FSWs. Among the 102 FSWs interviewed, only 64 (64%) could identify MTCT as one of the modes of HIV transmission. Out of these 64, only 10 (15.6%) could identify all the three periods during which MTCT could take place. If being able to indicate “breast feeding as one of the periods during which HIV transmission could take place” alone is taken into consideration, there were 42 (65.6%) interviewees who could provide this answer. Indicating condom use as a mean for HIV transmission is high (98%). However, condom use in practice still has limitations. Violence during sex acts and paying more money for sex acts without condom use are found to be factors associating no-condom use. From this study, un-intended pregnancies are found to be less with most of the pregnancies were the intended ones of both the FSWs and their husbands. About 76% of the FSWs interviewed got pregnant with their husbands. FSWs might not be using condom with husbands intentionally to get a child.

In this study, it was found that about 78% of pregnant FSWs took ANC though majority of them went for ANC at a later stage of pregnancy, i.e., in second or in third trimester. FSWs had to engage in sex work even while pregnant so as to earn to meet their daily needs. This is one reason for not going for ANC at an early stage of pregnancy. Costs, for travels and for payments to be made at health facilities, and being shameful of having pregnancy without having a husband, are among reasons that deter FSWs from taking ANC. Though payments to be made at government health facilities were revealed by some FSWs, some other FSW interviewees said they received free ANC. Reports were made that their blood had been taken without proper explanation about the test and getting their agreement; needing to make payments for the blood test; and breaking of confidentiality of their HIV status in the ways of giving test results.

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About half of the FSW interviewees said they made their deliveries at health facilities. TBAs were found to be playing key roles and this is due to financial barriers for making deliveries at health facilities. Some of the TBAs also are abortionists. At community level, HIV stigma is still high. Being a FSW and being HIV positive posed the FSWs to bear double burden of discrimination in the community as well as at health facilities, though the latter situation is found to be to a lesser extent.

Taking into consideration of the key findings of the study, the following recommendations are made: introducing financing and social protection schemes for poor families (in which FSWs' families will be included) to overcome financial barriers; enhancing participatory education for the community as a whole, to reduce HIV stigma, and this could be undertaken by NGOs and community based organizations (CBOs); and conducting a study addressing health facility issues focusing on PMTCT services.

INTRODUCTION

Mother-to-child transmission (MTCT) refers to a situation where HIV infection is transmitted from an HIV-infected mother to her child during pregnancy, labour, delivery or breastfeeding. The prevention of mother-to-child transmission (PMTCT) is a highly effective intervention and has enormous prospective to advance both maternal and child health. PMTCT has four basic components, involving prevention of primary infection among women; prevention of unintended pregnancies among HIV positive women; provision of specific interventions to reduce the risk of mother-to-child transmission; and provision of care, treatment and support to HIV infected women, their infants and families (WHO, 2007; WHO, 2010a). Viral replication and viral load during pregnancy will be reduced by providing highly active antiretroviral therapy to a woman, and infection in newborns prevented by a post-exposure prophylaxis (WHO, 2007; Siegfried, N, van der Merwe, L, *et al*, 2011; Dabis, F, Newell, M L, *et al*, 2000).

To ensure PMTCT programmes successfully prevent HIV transmission from mother-to-child, PMTCT and antenatal services must be available, efficient and accessible; mothers must be able to access antenatal services early and be retained on PMTCT programmes from beginning to end. In reality, however, and due to a range of interacting factors, explored below, many women do not follow this essential pathway. The diagram below (**Figure (1)**) shows the number of different stages that a woman must progress through to complete a PMTCT programme.



Figure (1) Different stages to complete a PMTCT programme.

In spite of the availability of the highly effective intervention, experiences in many countries suggested that anti-retroviral (ARV) prophylaxis for PMTCT alone had only limited impact. A number of pregnant women dropped out at different steps of the health care process even in facilities where ARV prophylaxis was available (WHO, 2003). The most important barrier to use the services was found to be fear of stigma and discrimination among HIV positive pregnant women (Gridassova, O, 2003; Painter TM, Diaby KL, Matia DM, *et al*, 2004; JR Busza, 2001; Rogers

A, Meundi A, *et al.*, 2006). Access to PMTCT services by HIV positive pregnant women is also limited by lack of awareness on PMTCT opportunities by them (Hyodo C, Tanaka T, Kobayashi M, 2000; Koniz-Booher P, Burkhalter B, *et al.*, 2004). As revealed by some studies health staffs were not willing to provide appropriate care for HIV positive pregnant women, because of their own fear or lack of knowledge (Morch E, Thu Anh N, Ha DQ, Hanh NTT 2006; Stringer JS, Stringer EM, Phanuphak P, 1999).

A study in Tallinn indicated that 34% of FSWs never have had a previous HIV test and 81% of those infected were unaware of their HIV status, and studies in Russian Federation and Serbia have identified a reluctance of intra-venous drug users (IDUs) to access HIV testing because of concerns regarding confidentiality, lack of trust in services and previous experience of stigma during health services contact (Thorne, C, Malyuta, R, Ferencic, N, *et al.*, 2011). Findings in some Eastern European countries showed concerns about separation from their children and loss of child custody and objections by partners as barriers preventing pregnant IDUs or those with children from accessing drug treatment programmes (Burns, K, 2009).

Among the seven strategic directions identified by the World Health Organization (WHO) for its focus on PMTCT, “ensuring reliable and equitable access for all women, including the most vulnerable” is described as one direction (WHO, 2010b). Female sex workers and female drug users are among the vulnerable needing special focus.

In Myanmar, people who inject drug (PWID) are the highest risk group for HIV infection, followed by female sex workers (FSWs) and their clients (MOH, 2012). They are to be referred to as key affected population (KAP). The majority of HIV infections in Myanmar have been in men. The male to female ratio declined from 8 to 1 in 1993 to 1.9 to 1 in 2009. Projection made for 2015 as regards this ratio is 1.6:1, and these women are largely sex partners of current and former FSW clients, PWID, and Men having sex with Men (MSM) (MOH, 2011).

PMTCT was initiated in Myanmar since 2001 and currently it reaches 253 townships and 38 hospitals through support from United Nations Children Fund (UNICEF), United Nations Fund for Population Activities (UNFPA) and Global Fund. However, there is still a huge gap in achieving universal access targets for PMTCT. According to 2011 data, fewer than 25% of estimated pregnant women were tested for HIV and received post-test counseling (MOH, NAP, 2011a). The late access of women to ante-natal care (ANC) is a major concern for the provision of effective PMTCT services. Earlier service seeking and higher retention of post-counseling will reduce mother-baby transmission. Despite good coverage and commitment, PMTCT services can be

difficult for pregnant women to access and utilize. Besides, pregnant women who engage in sex work and drug use are at higher risk of HIV infection.

In the Myanmar National Strategic Plan and Operational Plan on HIV and AIDS (2011-2015), among the priority key populations identified to scale up essential HIV prevention services include female sex workers and people who inject drugs and their partners (MOH, NAP, 2011b). Since Myanmar literatures on barriers to access by pregnant key populations or partners of key populations are sketchy, it is important to identify these barriers. Understanding the factors that pose as barriers for access to PMTCT by these vulnerable groups will contribute valuable information that will aid in developing strategies and policies towards targets of PMTCT access.

OBJECTIVES

The study objectives are to explore the barriers to access and utilization of PMCT services by pregnant key populations and describe the factors of not accessing PMTCT services. Because of non-availability of pregnant key populations other than FSWs for participation in the study, the study exploration focused only on the FSWs.

CONCEPTUAL FRAMEWORK

The study is based on the Socio-ecological Model (SEM), which recognizes the intertwined relationship existing between an individual and their environment (see **Figure (2)**).

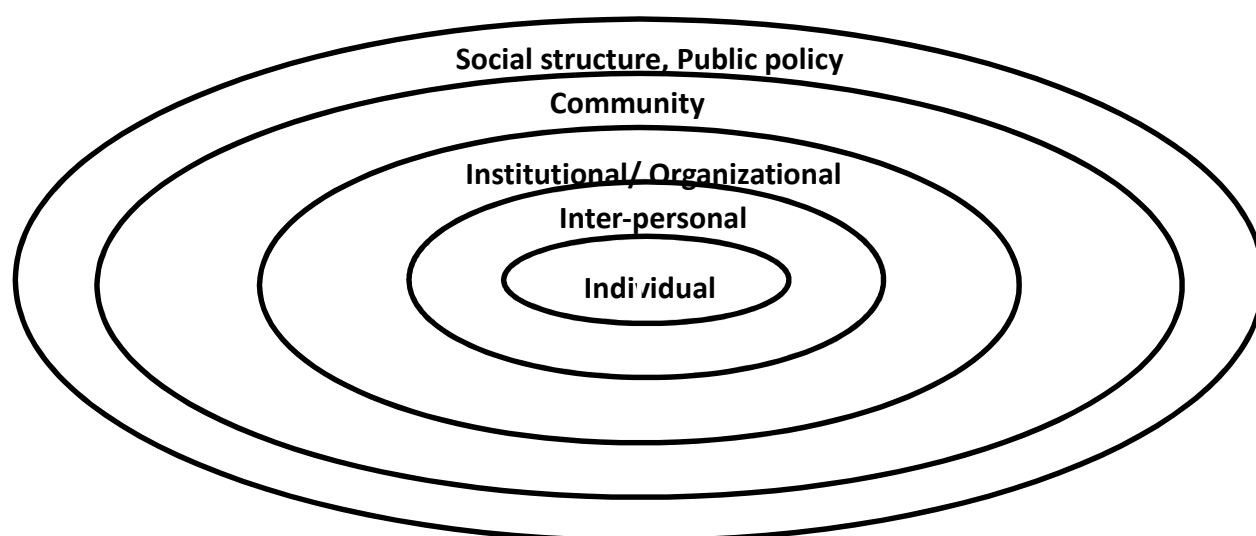


Figure (2) Socio-ecological Model

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Source: McElroy, KR, Bibeau, D, Steckler, A, Glanz, K. An ecological perspective on health promotion programs, *Health Education Quarterly*, 15:351-177, 1988.

The SEM can be represented by an onion, with one level wrapping around another. At the center of the model is the **individual**, where the internal determinants of behavior, such as knowledge, attitudes, beliefs, and skills exist. The next level of SEM considers **interpersonal** processes. This level involves primary groups of social interaction such as family and friends, and this is the level where social norms operate. In many interpersonal relationships there are some individuals in social roles, which are seen as key decision makers, or influential persons.

Institutions and organizations are composed of assemblies of primary interpersonal associations, like workplace, church, or a volunteer organization to which each individual belongs. These operate under a common set of rules and policies that guide behavior. The **institutional/organization** level of SEM considers these rules and policies. The next level of SEM to consider is the **community**. This level includes all those individuals, businesses, institutions and organizations, which collectively comprise the larger societal compositions. These larger social constructs can be defined in many ways, such as by geographic location, membership in a particular group, or possession of certain beliefs that produce affiliations. Finally, the outermost level of SEM is the **social structure/ public policy** level. Public policy is defined as an authoritative decision made by a local, state, or federal governing body.

Exploration in this study will focus only on **individual** (knowledge and attitudes), **interpersonal** (support from family, peers, social networks), **organizational** (relationships with informal structures, if any) and/or **community** (social networks) layers. Thus these three outer layers indicated will have overlaps. Public policy layer will not be addressed in this study. Recently, a separate study has been conducted to explore policy barriers preventing scale-up of HIV services for Most at Risk Populations in Myanmar (USAID/Asia, PSI/Myanmar and Save the Children, year not indicated).

METHODOLOGY

A qualitative approach is considered most appropriate for this exploration. This is due to the fact that there is very little existing research that has been conducted thus far among the population groups specified (see selection criteria under sub-section 4.3) relating specifically to access to PMTCT services. In addition, the exploration of the barriers to accessing PMTCT services by the target samples specified involves sensitive, emotive, and personal topics that can be best captured through careful probing using the qualitative data collection methods. Questions for collecting quantitative data were also posed to each interviewee during qualitative interviews.

Study setting

The study settings involved Yangon City, Mandalay City and Muse-Lashio Towns. The cities and town were purposively chosen because of availability and access to FSW, Drug User and MSM networks. The study samples, meeting the set criteria, were recruited through these networks.

Study type and data collection techniques

An exploratory qualitative research design was applied where Round Table Discussions (RTDs) with Key Informants from FSW, IVDU and MSM Networks and Individual Depth Interviews (IDIs) with FSWs were the data collection methods applied. RTDs were performed to get preliminary information of the situation to be studied and also on feasibility of getting samples meeting set criteria. During IDIs, short quantitative questions were also posed to this non-random sample to be able to quantify some of the key variables of interest.

Sample, sampling procedures and data collection

The study population planned included FSWs, women who inject drugs, and partners of IDU and MSM; they needed to be currently pregnant or who had delivered a baby during last two years. Because of the sensitive nature and related difficulties to get enough samples meeting the specified criteria, sample size was not calculated. As already stated, qualitative study was considered most appropriate for this exploration.

Though various sampling approaches like targeted sampling, time-location sampling and respondent-driven sampling exist (Magnani, R, Sabin, K, *et al.*, 2005; Johnston, LG and Sabin K,

2010), non-random sampling, though with inherent biases, is considered the most relevant for this particular study. The other sampling approaches are considered not applicable to this study.

Existing networks of FSW, MSM and injecting drug users were approached. RTDs were held with representatives of these networks. During the RTDs, awareness of and availability of PMTCT services, barriers to utilization of PMTCT services by pregnant sex workers and injecting drug users were generated. Then, these participants were requested to identify pregnant sex workers, injecting drug users (or wives of IDUs) and women who had had sex with MSMs (or wives of MSMs) meeting the criteria specified for IDIs.

In real practice, only two women who were wives of drug users and who met the set criteria could be recruited. No women having had sex with MSMs (or wives of MSMs) meeting the set criteria could be recruited. All the remaining recruits were FSWs. Quantitative data analysis was made only with FSW data and qualitative data obtained from the wives of drug users were considered not optimal enough for triangulation and was excluded from including in the study.

IDIs were conducted with the samples meeting the criteria specified, and performed to the possible extent of achieving optimum information. IDIs allowed exploring issues deeper and being interactive in nature enabled clarification of issues during the interview. They also allowed further probing and modification of interview guides in the course of the study. The IDI guide developed for this study comprised of a section on demographic characteristics and open-ended questions covering awareness and use of PMTCT services among other areas.

Explorations involved issues such as whether they are able to negotiate sex or contraceptive use, or to access contraceptives, which could prevent leading to unplanned pregnancies; whether women are able to access pre-natal health services for a variety of reasons, including because their partners controlled the household financial or transportation resources, because they could not take time off work, or because they could not leave their dependents to travel to a clinic or hospital; and whether fear of rejection, stigmatization, violence or abuse prevent women from utilizing PMTCT, accessing PMTCT programs, or engaging in alternative infant feeding practices. Other issues explored encompass: psychological issues following HIV diagnosis; stigma and fear of status disclosure to partners, family or community members; the extent of partner/community support; cultural traditions including preferences for traditional birth attendants (TBAs); and staff-client interactions when taking PMTCT services. One added theme was the delivery process when delivered with a TBA.

Data processing and analysis

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All interviews will be recorded, transcribed and then inductively coded line-by-line using Atlas-ti software. Initial codes were drawn from the question themes. Further emergent codes and sub-codes were added as appropriate. When new codes were developed, all transcripts were reviewed to see whether the new codes were also relevant. The coding process remained iterative during analysis, while also drawing on the general structure provided by the SEM. The interviews were read through several times to obtain a sense of the whole. Then the texts concerning the awareness and utilization of PMTCT services were extracted.

Quantitative data was analyzed using SPSS and Excel soft-wares. Only descriptive data showing frequencies for key variables of interest were calculated. These variables included: **basic information** on sample characteristics (age; education); **knowledge** of HIV/ART/vertical transmission; **ANC seeking behaviors in relation to PMTCT** (No. of ANC visits; facility attended); **use of and access to PMTCT services** (HIV testing and counseling; post-test counseling; ARV prophylaxis for mother); **delivery** method and place; ARV prophylaxis for child; and provision of free infant formula.

Ethical considerations

Ethical clearance was obtained from the Ethical Review Committee of the Department of Medical Research (Lower Myanmar). Confidentiality and anonymity were assured to all participants of the study, using information sheets and consent forms.

FINDINGS

Background characteristics

There were 102 FSWs who participated in the study, with their ages ranging from 18-44 years (mean age 26.6, SD 6.3); about 26% are illiterate; and 52% are married at the time of study. See **Table (1)** for the findings.

Table (1) Age, educational level and marital status of FSWs interviewed

Background characteristic	Findings	
	No.	%
Age (in years) (N = 102)		
- Mean = 26.6		
- SD = 6.3		
- Range: 18-44		
Level of Education (N = 76)		
- Primary	43	56.6
- Middle school	17	22.4
- High school	14	18.4
- University	2	2.6
Marital Status at the Time of Interview (N = 102)		
- Married	53	52.0
- Divorced	32	31.4
- Widowed	4	3.9
- Not married	13	12.7

Knowledge on HIV vertical transmission and ART

1. MTCT

Out of the total 102 FSWs interviewed, 100 (98%) said they had ever heard of HIV/AIDS. Among them, 64 (64%) could identify mother-to-child transmission as one of the modes through which HIV could spread (see **Figure (3)**).

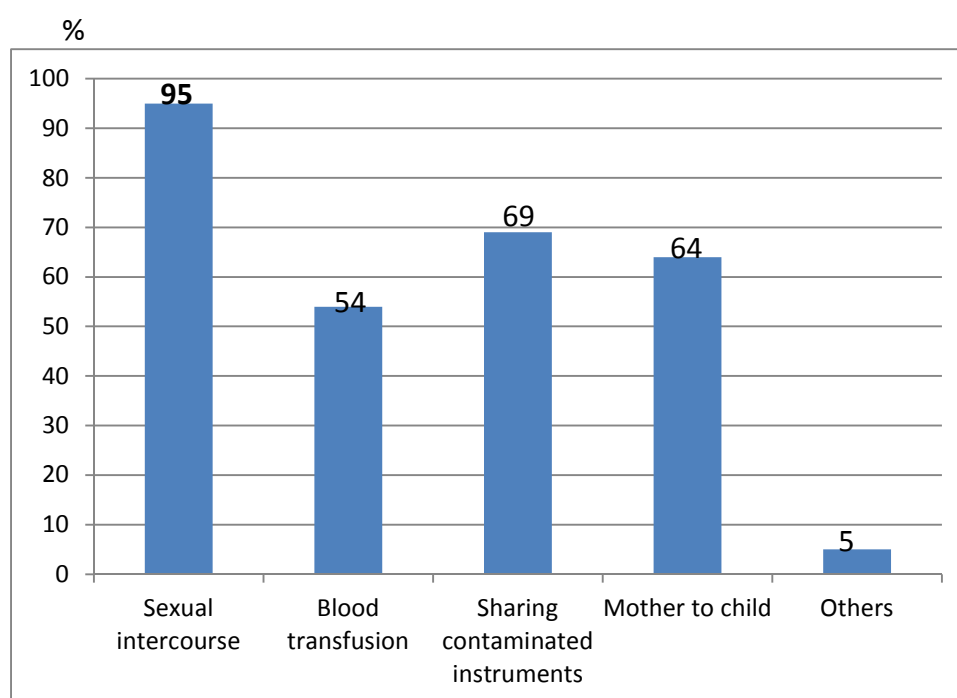


Figure (3) Modes of transmission of HIV answered by FSWs

On further probing the timing when this transmission could take place from the mother to a baby,

- 10 interviewees could identify all the three periods, i.e., while pregnant, while delivery, and while *breast feeding*;
- 9 mentioned only two periods, i.e., while pregnant and while *breast feeding*;
- 2 mentioned during delivery and *breast feeding*; and
- 21 mentioned that transmission of HIV could take place during *breast feeding*.

The rest, though they mentioned mother-to-transmission, could only identify that the transmission took place while pregnant or during delivery.

2. Condom use for prevention of HIV transmission

From **Figure (4)**, it could be observed that about 98% of FSWs interviewed mentioned condom use to prevent HIV transmission. There were few FSWs who spoke of unusual sex practices as means to prevent HIV transmission. They referred to these as *gyar-thone-gyar* practice (literally meaning sex practice in three cleavages). These three cleavages are said to be between the two breasts, in the arm pits and between thighs.

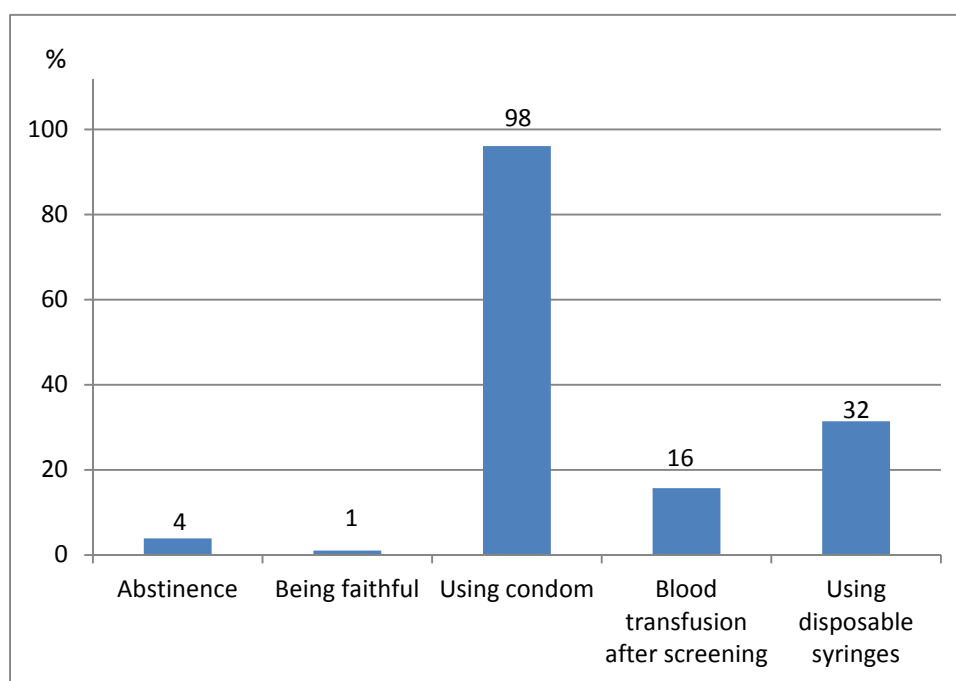


Figure (4) Main methods of preventing HIV transmission answered by FSWs

3. Awareness of anti-retroviral therapy (ART)

From **Figure (5)**, it could be observed that 80% of the FSW interviewees said they heard of ART for treating HIV.

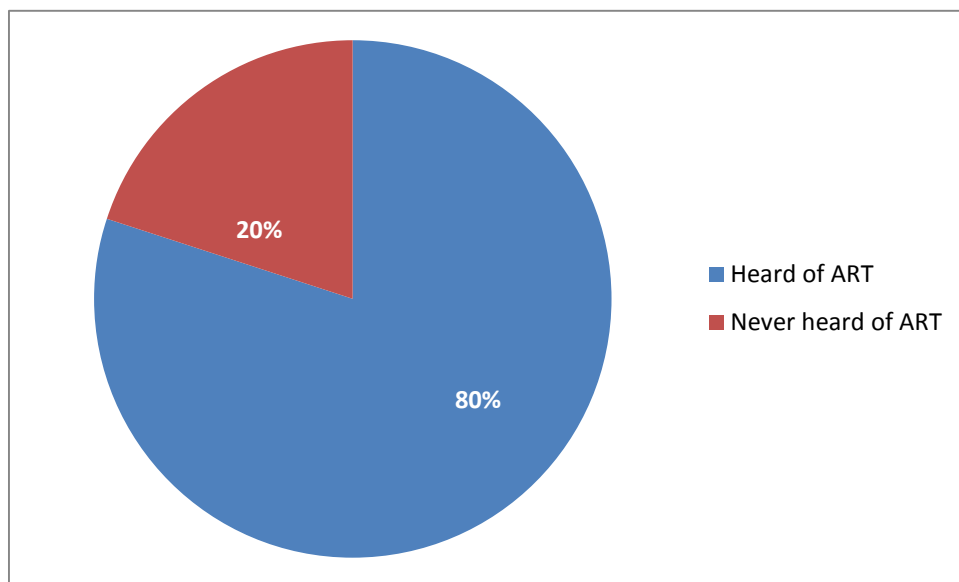


Figure (5) Percentages of those who had heard of ART

Sources of information varied as follows:

- Heard of ART because a relative is HIV positive and taking ART (4 interviewees responded);
- Heard about ART when she visited an INGO clinic (2 FSWs responded);
- Heard about ART from friends (9 FSWs responded).

"My daughter, also a sex worker like me, is HIV positive and she is taking ART" (33-year old FSW, Yangon)

"I was informed by my friend that someone with HIV could live like a normal person if ART is taken regularly" (25-year old FSW, Mandalay)

Out of the 102 interviewees, only 12 (11.8%) said they had ever used ART, and among them, 10 (83.3%) were current users at the time of interview. Out of the 10 current users, 4 said they had ever missed taking ART. Almost all the interviewees expressed the seriousness they attached on taking ART regularly.

"I regularly take my ART, 9 in the morning and 9 in the evening. I have no watch or clock at home. I looked at the clock of my neighbor for 9 O'clock in the morning. For 9 O'clock in the

evening, I listened to the tone-kauk-than (the sound of beating a wooden stump) of the monastery near my house. My survival is more important for my baby than for myself" (33-year old FSW, Yangon)

How the last pregnancy was conceived

1. Views of key informants

According to the key informants during RTDs, about 45% of FSWs were said to have got unintended pregnancies. They might be either HIV positive or negative, and might be either married or unmarried. The key informants said the FSWs were unable to use condoms because either condoms were not available, the clients or FSWs were careless in using condoms, condoms were damaged, or being forced by clients not to use condoms. The FSWs did not know for sure whether the clients who did not use condoms were HIV positive or not. However, *"those who engage in violence forcing not to use condoms were the ones who were HIV positive, and they did this intentionally to let other also acquire HIV infection"* said a FSW Peer Educator during RTD.

"FSWs were unable to refuse to make sex without condom, and were unable to resist violence. They are in need of money for our daily living ... they have to pay for house rental, for tuition fees for children ..." (Key informant during RTD)

Key informants said that a FSW could earn money while she was pregnant even in the late stage: *"There are instances of FSWs who were pregnant and received clients, even few days before giving birth"*.

2. Not using condoms with their husbands

Table (2) Person last pregnancy was conceived, awareness of HIV status and condom use

N = 102

Variable	No.	%
Person with who the last pregnancy was conceived		
- Spouse	77	75.5
- Boy friend	3	2.9
- Casual acquaintance	21	20.6
- Don't know	1	1.0
HIV status of the sex partner		

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- Positive	5	4.9
- Negative	61	59.8
- Don't know	34	33.3
- No Response	2	2.0
HIS status of the interviewee		
- Positive	14	13.7
- Negative	80	78.4
- Don't know	6	5.9
- No Response	2	2.0
Using condom with the person with who last pregnancy was conceived		
- YES	9	8.8
- NO (or used sometimes)	93	91.2

About 76% of the FSW interviewees said they got the pregnancy with their husbands; about 33% of the interviewees said that they did not know the HIV status of the person with who they got pregnant; about 6% said they did not know their HIV status before getting pregnant; and 91% said they did not use condom when making sex with the person with who the last pregnancy was conceived (see **Table (2)**).

Most of the married FSWs said that their husbands knew they were sex workers. They took a child just because both their husbands and they themselves wanted to have a baby even if their husbands knew they were HIV positive. Most of these FSW interviewees said they did not use condom with their husbands, and they used condoms regularly with their customers. There was only one interviewee who said she got pregnant because she did not know that using a condom would prevent her from getting a conception.

"My husband and I wanted a baby, and so we did not use condom" (25-year old FSW, Yangon; 25-year old FSW, Mandalay; 21-year old FSW, Muse)

"My current husband is my second husband and he knows that I am HIV positive and a FSW. I got HIV from my first husband. My husband wanted a child and I asked him whether he wanted a child as I am HIV positive. He said he wanted" (21-year old FSW, Yangon)

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“I told my husband to use condom because I am HIV positive. He said he would not use and he did not mind dying of HIV. He did not test his blood as well” (35-year old FSW, Yangon)

“I entered the sex word one year ago. In the initial stage, I did not know that I should use condom, and I did not use it and got pregnant” (26-year old FSW, Yangon)

Most of the interviewees said that because their husbands knew they were FSWs and because they were regularly contacted by Peer Educators for testing their blood regularly, their husbands were also tested for HIV. Both the husband’s and FSW’s HIV status being negative is one condition that made them feel safe not to use condom.

“Both my husband and I tested our blood regularly. I informed the health staffs at the government health clinic that I was a sex worker. They do not discriminate me. They advised me to bring my husband as well for regular testing of blood. Because both my husband and I are HIV negative, I do not use condom with my husband but I use it regularly with clients” (22-year old FSW, Mandalay)

There was one interviewee who said about her husband who concealed his HIV positive status, refused to use condom, and how she found out only after she and her baby got the infection:

“My husband did not tell me that he was HIV positive. I found him taking drugs but he said he was taking these for kidney problems. Because of this, I did not use condom with him. When I was tested for HIV while pregnant and found to be HIV positive, he still concealed his condition. When my baby reached 18 days old, then only he said he was HIV positive. He also had TB and was taking drugs for TB as well. We are now divorced. I met him at the (INGO) clinic, but I dared not go near him because I am afraid of getting TB infection from him” (22-year old FSW, Yangon)

Used condoms but ...

Even though FSWs, married or unmarried, used condoms with their clients, there were occasions where:

- The condom was ruptured;
- They forgot to bring condoms with them and their customers also did not bring any condom, and getting money was given priority;
- The customer demanded for not using condom and at the same time giving more money for the sex act without using condom; and
- They were drunk and forgot to use condom.

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“When I was called in a hurry, I did not have time to take condoms; the customer also said he did not bring any condom. I am in need of money as I am taking care of my blind mother, and so I agreed to make sex without using a condom” (26-year old FSW, Yangon)

“Sometimes I did not use condom because it was not available. It costs about Kyat 500 per piece. Sometimes, the customers gave me extra pocket money about Kyat 3,000-5,000 if I did not use condom” (36-year old FSW, Yangon)

“I know that I should use condom. I was drunk during the water festival, and forgot to use it. I got pregnant with one of the clients” (24-year old FSW, Yangon)

“Sometimes I had sex with my clients on a road-side in a bush and in such situations condom was not used” (28-year old FSW, Lasho)

“Though I have no husband, I got pregnant three times with my clients and I could not identify who specifically the person was. I used condoms, but they sometimes ruptured, or being in a hurry I forgot to use condom, or being paid more money I did not use condom” (20-year old FSW, Mandalay)

“Some of the clients are very rude and harsh ... they pulled down all our clothes and no time for me to ask for using condom” (29-year old FSW, Lasho)

There are said to be three categories of clients: a casual client; a “boy-friend”, a person with whom a FSW fell in love; and a “sponsor”, usually a well-to-do person, married, who visits regularly and giving a huge payment. Some FSWs said they were promised to be married by their boy-friend clients. So, they sometimes did not use condoms. However, when got pregnant these clients got away from them. Some of the FSW interviewees said that they did not use condoms with their sponsors because they trusted them to be HIV free because they have their own families. They denied experiences of becoming pregnant with these sponsors.

“One of my regular customers was a manual laborer. We fell into love, and he said he would marry me. I did not use any condom with him. When I got pregnant, he disappeared. I was a bit downhearted at first. Later I decided to take the pregnancy” (30-year old FSW, Mandalay)

Those who were HIV positive said they always used condoms after knowing their HIV status.

3. Availability of condoms

Condoms were supplied free by INGOs. There were also few complaints made as regards availability of condoms.

“Though condoms are provided free by an INGO, these are not enough and we had to buy ourselves sometimes” (28-year-old FSW, Yangon)

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“Condom was provided by the INGOs and I got them regularly every 15 days. I do not need to buy myself” (31-year old FSW, Yangon)

“Most of the clients do agree to use condom when asked for. When there are many clients, all the condoms carried were used up, and the clients also do not keep condoms with them and in such situations sex was made without using condom. Condoms are provided free by INGOs, but not sufficient. About 10 days before the end of a month for receiving new supply of condoms, the old ones are already gone away” (28-year old FSW, Yangon)

“I always keep 1-2 boxes of condoms with me. If these become used up, I buy from a shop. I have to pay about Kyat 500 for each box” (23-year old FSW, Yangon)

Reports were also made by few FSW interviewees that they use contraceptives other than condoms with their husbands or boy-friends. Sometimes they missed taking contraceptive pills or forgot to take an injection on due date making them got pregnant.

4. Unwanted pregnancy

When got pregnant unwantedly, some made abortions and sometimes when it was too late to be aborted, they took the baby, said the interviewees during qualitative interviews. There were also cases who decided not to abort, but to keep the baby because having a baby would provide a companion for them. There was one interviewee who said she got herself pregnant because one of the clients requested her to get a baby for him. This person falls into sponsor category.

“I did not abort it because I wanted to have a companion” (28-year-old FSW, Yangon)

“When I knew that I was pregnant, the baby was already 3 months and I did not want to abort it” (18-year-old FSW, Yangon)

“One of my regular customers is an old man (around 60 years) whose wife is also an old woman. They do not have any child. The man wanted me to have a pregnancy and deliver a child for him. I agreed. However, I did not agree to give the child to that man. Whatever kind of job I have to do, I cannot give my son to the man” (31-year old FSW, Yangon)

Abortion fees ranged from 20,000 to 50,000 depending on the stage of pregnancy. Most of these abortionists are TBAs.

“I paid only Kyat 3,000 to the TBA when I aborted one of my previous pregnancies. The TBA is a close friend of me and she knows that I am poor” (31-year old FSW, Mandalay)

5. Engaging in sex work while pregnant

Few of the FSWs revealed they had to engage in sex even after getting pregnant to earn for their livelihood.

"I stopped work only when I was seven months pregnant" (20-year old FSW, Mandalay)

"There are instances of FSWs who were pregnant and received clients, few days before giving birth" (Key informants during the RTD)

ANC seeking behavior

Table (3) ANC seeking during last pregnancy

Variable	No.	%
ANC sought (N = 102)		
- YES	80	78.4
- NO	22	21.6
Stage of pregnancy when ANC took place (N = 80)		
- During first three months	12	15.0
- During second three months	55	68.8
- During the last three months	13	16.3
Place where ANC taken (N = 80)		
- Government Hospital/Clinic	69	86.3
- Private Hospital/Clinic	1	1.3
- INGO/NGO Clinic	7	8.8
- Others	3	3.8
Times ANC taken (N = 80)		
- Mean = 4.3		
- SD = 3.5		
- Range = 1-22		

It can be seen from **Table (3)** above that 78.4% of the interviewees took ANC, and among them about 69% initiated going for ANC in the second trimester and about 86% visited government hospital/clinic for ANC. The mean ANC visits made was 4.3.

1. Views of key informants

Key informants said that about 90% of those who got pregnant were said to have ended in abortions, mostly with TBAs. Those who did not resort to abortions were because while they

were taking time to save enough money for abortion, the pregnancy entered the late stage. The abortion fees were said to be ranged from Kyat 20,000 to 300,000 depending on pregnancy stage.

The key informants said that except those who received prior information from INGOs/NGOs, the remaining majority did not go for ANC. The reasons are: the FSWs had to work for their daily earnings; they are unable to afford for the travel costs; unable to bear the costs for the charges made at public and private hospitals; did not want to let their family members know their HIV status in case it is revealed during the ANC.

“When we went to a government health center or hospital, the first thing we had to pay was for the registration book fees, which was Kyat 1,000. For blood testing, we had to pay Kyat 6,000, and so on. If we do not have Kyat 10,000 in hands, we could not go to a public hospital”
(A Peer Educator during RTD)

With regards to financial control by husbands, it may depend on the type of husband said the key informants. Generally, the husband may be the pimp or gate keeper, and one from outside world. The first category was said to be exploitative, keeping away almost all the incomes of a FSW, controlling financial access as well as access to health care.

“If the husband is a pimp or a gate keeper, he even may himself perform abortion using massaging the abdomen, pushing down the baby inside, or other harmful ways. Or, he may take the pregnant FSW to a TBA for abortion” (Peer Educator during RTD).

“I got married to my current husband after having four children and entering the life of a FSW. With him, I have no problem spending my own income” (Peer Educator during RTD).

2. Cost, a deterring factor for taking ANC as expressed by FSWs

Being not able to afford for the costs incurred in taking ante-natal care at the public health facilities is said to be a factor that deterred some of the interviewees from taking care. One interviewee said she had to pay about Kyat 3,000 for registration book, blood test and urine examination, totaling to about Kyat 3,000 at the government clinic, and that she also could not afford for paying trishaw fare. Another interviewee from the same township said she had to pay about Kyat 6,000.

“I had to pay about Kyat 6,000 for tests and examinations during my AN visit to the government clinic” (a 22-year old FSW)

“I took my ANC at a late stage because I came to know that I was pregnant late. At the (government) ANC clinic they asked for Kyat 1,500 to donate. I got only Kyat 500 at that time, and I was quite ashamed in front of many others” (33-year old FSW)

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"I went to the (government) clinic only once because I could not afford to make donations there" (33-year old FSW)

3. Being shameful

Being shameful for making a visit to a clinic is another factor as expressed by some interviewees. A sex worker getting pregnant without having husband encounters discrimination by neighbors. One interviewee said though she was looked down by neighbors when she got pregnant, local authorities were supportive of her. Few FSWs said some of their friends who got pregnant with a client aborted the pregnancies.

"I did not take any antenatal care because one reason was that I could not afford for it. Another reason was that the community censures me because I got pregnant without a husband, and the clinic staffs don't discriminate me when I go to the clinic. What is now happening is that people are calling my child 'hpar-thare-ma-thar (whoreson)'. I do not mind calling me whatever they like, but I do not want my son to be called this way. All my neighbors, all of who are manual laborers, are doing like this. However, some senior citizens and local authorities are quite supportive of me" (18-year-old FSW, Yangon)

"I did not take any antenatal care because I was shameful to inform the clinic staff that I got pregnant without having a husband" (28-year-old FSW, Yangon)

4. Perspectives of FSWs on getting ANC

There were also interviewees who said they received ANC services free of charge. Generally, they went to the clinic in groups. One interviewee said she and her husband wanted a child and they took great care of the baby in the womb when she got pregnant making her visit the government ANC clinic regularly.

"I followed other pregnant mothers to the government ANC clinic. I did not need to give any fees there" (26-year old FSW, Yangon)

Some of the FSWs made regular blood testing in accordance with the advice given by volunteers of INGOs whether they were pregnant or not. One volunteer said her pimp always provided them good advises how to keep themselves healthy and to test their bloods regularly.

"When volunteers came and took us for blood testing, we tested our blood" (18-year old FSW, Yangon)

"I had to make blood tests every three months. This is as suggested by my pimp (a female). She used to give us health talks such as to use condoms regularly with all the clients, to test

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blood regularly to know HIV status, to keep one-self healthy, and so on. I thank her very much for such advices given” (36-year old FSW, Yangon)

According to majority of the FSW interviewees, since their husbands are not bread earners but those who depended on the incomes of FSWs, they could use their own money for their needs. Even then, affordability plays a key role in getting access to ANC according to the interviewees.

PMTCT services

Table (4) Receiving PMTCT services

N = 80

Variable	No.	%
Pre-test Counseling received (N = 80)		
- YES	55	68.8
- NO	22	27.5
- Do not remember	3	3.8
HIV test done (N = 80)		
- YES	70	87.5
- NO	8	10.0
- Do not remember	2	2.5
HIV status informed (N = 70)		
- YES	64	91.4
- NO	6	8.6
Post-test Counseling received (N = 70)		
- YES	19	27.1
- NO	7	9.9
- Do not remember	1	1.5
- Missing	43	61.5

From **Table (4)** above, it could be noted that among those who took ANC (80), about 69% received pre-test counseling; and HIV test was done on 88% of them. Among those who were tested for HIV (70), 91% were informed of their HIV status; and 27% said they received post-test counseling.

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In the quantitative interview, the interviewees were not asked for their HIV status for ethical reasons unless they revealed their status by themselves. However, one question was posed asking the reaction of health staffs on knowing their HIV positive status. For this question, 17 gave their answers, and among them, only 2 said she was treated bad or very badly by health staffs.

1. Views of key informants

Majority of FSWs, except those who were HIV positive and were having regular contacts with International Non-governmental Organizations/ Non-governmental Organizations (INGOs/NGOs) for regular receipt of ART, is said to be unaware of PMTCT services, according to the key informants. Among those who received PMTCT services and HIV status revealed, they were said to have complied with the follow-up services relating to PMTCT. The same holds true also for those who had already known their HIV status and were having prior contacts with INGOs/NGOs. Most of the FSWs do not reveal their HIV status in the community where they live, said the key informants, for possibilities of encountering discrimination.

2. Perspectives of FSWs

As already stated under the previous theme, FSWs went to clinics for ANC or for blood testing in groups when volunteers from INGOs came and called them. Some went there with their own consciousness just because they wanted to know their blood to be tested.

“I am a sex worker, and I want to know my HIV status” (21-year old HIV positive FSW, Yangon)

Most of the interviewees said their blood had been taken without proper explanation about the test and getting their agreement. They also complained of needing to make payments for the blood test. This was said to have happened at the public clinics.

“There was no explanation whatsoever on why blood testing should be made. All the pregnant mothers made a queue and each one’s blood was taken” (26-year old FSW, Yangon)

“On arrival at the hospital, the staff started saying that I had to make a blood test, took blood from me, and asked for a payment of Kyat 3,000. I got only Kyat 1,000 and paid it. They did not call me to get the result. My result was told only when I was there again for delivery” (34-year old FSW, Yangon)

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“They took blood from me without any proper explanation and asked Kyat 4,000 from me. I had nothing to pay, and told them I did not want to know the test result. They said nothing” (19-year old FSW, Yangon)

Those who went to INGO clinics and few who went to the public health facilities said they were properly explained and taken their consents before testing their blood.

“I went to Tun Clinic (an INGO clinic). They explained me thoroughly why I should make a blood test. Then only they took blood from me when I agreed. They also reported back to me my test result” (26-year old FSW, Yangon)

“I was properly explained the reasons why I should test my blood. Then they asked me my consent. Only when I agreed, they took my blood. I also wanted to know my HIV status” (33-year old FSW, Yangon)

Most of the interviewees said they were not afraid of their test results and they wanted to know it since they were engaged in sex work and they were aware of the possibility of getting the infection. Even then, on knowing the positive test result, they became down-hearted at first. Then, they tried to elate their spirit and decided to take treatment regularly.

“I had no fear to know my result. Everyone has to die one day. However, on knowing the result that I was HIV positive, I was at first down-hearted. However, I pulled myself together and decided to take treatment regularly” (33-year old FSW, Yangon)

Few made complaints as regards the ways their test results were reported and breaking confidentiality at some of the government health facilities. On the day of providing feedback on the test results, all the pregnant mothers waited together at the clinic. Then the staffs asked some of the mothers to follow them for a separate discussion, and these are those who were HIV positive. Other mothers knew at that point that who were HIV positive and who were not. By this, confidentiality was broken.

Different stories were reported as regards reactions of their spouses, family members and neighbors towards their HIV positive status. Some encountered harsh treatment by the husband and family members and some got moral support. In both situations, social stigma could be observed from their narrations.

“I revealed my husband about my HIV status, and he also tested his blood and found to be positive. From that day onwards he used to beat me very often saying that I had pulled down his life. I let my neighbors know about my HIV status, and there was no discrimination from them. One of the local authorities of our ward is very supportive of persons like me” (31-year old FSW, Yangon)

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"When I told my husband about my HIV status, my husband said words of support to me and asked me to keep away the worries. My mother also did the same way to me. I did not let my neighbors and friends know about it. If they know, they will surely discriminate me. Even when my child had a quarrel with his friends, parents of the other child called my son 'son of a bitch'. When I made my delivery at the government hospital, the staffs there did not make any discrimination towards me in spite of knowing that I was HIV positive" (21-year old FSW, HIV positive, Yangon)

"My parents and my brothers and sisters all know that I am HIV positive. They are all OK towards me. My neighbors also know this, but there is no discrimination. They dared not fight with me, because they were afraid that they would get infection from me. I do not go to ceremonies when I am invited because I feel ashamed to be there" (22-year old FSW, Yangon)

"All my family members knew I am HIV positive. They treated me as usual. They said my health is bad and gave moral support to make myself healthy. Few neighbors are good but majority looked down at me. When my elder children had a fight with their children, they called my children 'children of a prostitute'. As we stay in slum area, this is one factor that people around here discriminate our families" (35-year old FSW, HIV positive, Yangon)

3. On posing a scenario that she was HIV positive

When a scenario was posed what they would feel and what probabilities would be the reactions of their husbands, family members and neighbours, similar responses to those given by HIV positive FSWs were reported.

"If I am found to be HIV positive, I will not have any feeling. I will take treatment. However, in my community, people will shun away from me if I am positive" (31-year old FSW, Yangon)

"If I am found to have HIV positive, I will take treatment. I will inform my husband and ask him to have a blood test as well. My husband knows my sex work. I will be shunned away by my relatives and my friends in my community if they know I am HIV positive" (26-year old FSW, Yangon)

"I will not be downhearted. I will take drugs given by health staffs and follow their instructions" (30-year old FSW, Mandalay)

"If my relatives and my neighbors know that I have HIV, they will stay aloof from me" (25-year old FSW, Mandalay)

Delivery

1. Views of key informants

Deliveries had to take place at public hospitals to where the INGOs/NGOs referred, said the key informants. Bitter experiences were revealed by the interviewees relating to these deliveries.

“The nurses blamed us why we were taking babies because we were FSWs and HIV positive”
(Peer Educator at RTD)

“All the poor are treated very harshly by the staffs at the public hospitals. The situation worsened if they found out that we were FSWs and HIV positive” (Peer Educator at RTD)

“The hospital staffs sometimes, with a loud voice and in front of many people, told us not to be disappointed any more though we were HIV positive because we were provided with ART. This made a great shame for us” (Peer Educator at RTD)

2. Home deliveries

Out of 102 interviewees, 13 were still pregnant at the time of interview. Out of the remaining 89 interviewees, 43 (48.3%) said they made their deliveries at their government hospitals/clinics. The remaining 52.7% delivered at their homes (See **Figure (6)**). There are 14 HIV positive FSWs in this study. Among them, government hospital deliveries and home deliveries were found to be the same percentage (50% respectively).

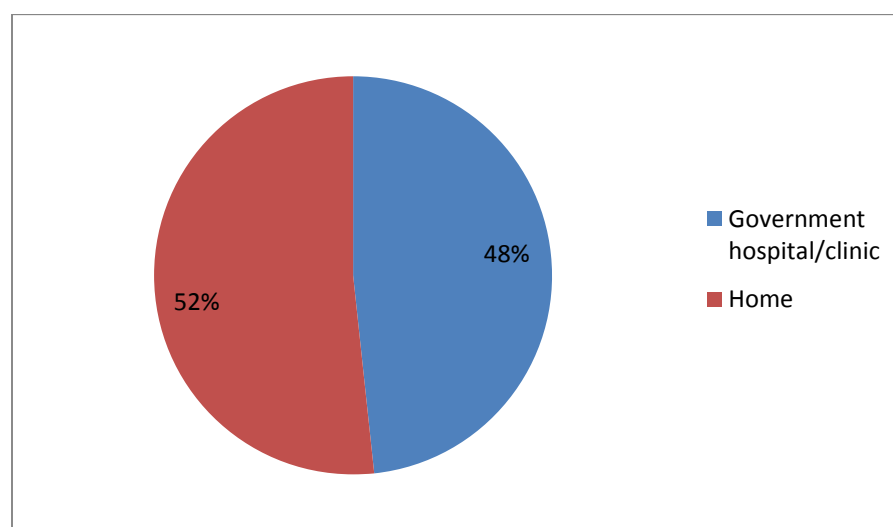


Figure (6) Delivery place

3. TBAs play key roles

Quantitative data showed that 52% of the deliveries were made at homes. Traditional birth attendant (TBA) is found to be the key birth attendant for majority of the FSWs interviewed. Cost of delivery was the key factor expressed by majority of interviewees that deterred them away from making a delivery at a hospital. Other factors mentioned included far distance from a hospital, unaffordability of transport cost, TBA staying close to their residence, delivery fees with a TBA is cheaper and parents persuading to make the delivery at home.

“The delivery fee for a TBA is about Kyat 45,000 and it could be paid back with installments. If a delivery is made at the hospital, it may cost about Kyat 100,000. For me, what I earned during a night’s work are almost all gone after paying back debts the next morning” (22-year old FSW, Yangon)

“I first called a TBA, but because of difficulties in delivery I was sent to Shwe Pyi Thar hospital. Normal delivery was made at the hospital. The total cost was about Kyat 40,000” (26-year old FSW, Yangon)

The most common reason given for making deliveries at the hospital was encountering a difficult labor and being referred by the TBA. Some FSWs said they were provided by the INGO clinics as well as the public hospitals gloves, plastic sheets, cotton wools, clean blades for cutting baby’s umbilical cord and a thread for tying it; when they made deliveries with TBAs, the TBAs used these provisions. There was one interviewee who said she purposely went to the hospital for her delivery because she considered the hospital to be a safe place. Another FSW said she got a discount for her delivery fees at the hospital.

“I attempted to make my delivery with a TBA at home. However, because of difficult labor and because of my age as well, I was told to make my delivery at the hospital” (35-year old FSW, Yangon)

“I delivered my twins at Insein hospital. It was a normal delivery. It cost me about Kyat 100,000. I had to borrow money from my friends” (36-year old FSW, Yangon)

“I would go to the hospital only when I encounter any problem. I delivered with a TBA. The (government) hospital has provided gloves, a blade for cutting and a thread for tying umbilicus. The TBA used them” (33-year old FSW, Yangon)

“I made my delivery at the government hospital because this is my first child and I am afraid something might happen to him. There are equipment available at the government hospital to take care of danger conditions” (24-year old FSW, Yangon)

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“I made my deliver at the (government) hospital. I was charged only Kyat 30,000 and they told me that they discounted me because they knew I was a FSW” (31-year old FSW, Yangon)

“I delivered my baby at the hospital because of breech presentation. It cost me Kyat 200,000. I had to borrow money with an interest rate of 10% per month. I could not clear my debts yet. When my baby is 4 months old, I returned back to my sex work” (21-year old FSW, Mandalay)

4. Delivery process with TBA

TBA made deliveries on mothers who were HIV positive, using materials provided to the mother by the INGOs or government hospitals. Some TBAs even used injections to expedite deliveries.

The kit provided to a HIV positive mother includes a blade for cutting umbilical cord; a clip to cut the cord; and three pieces of napkins. The HIV positive mother was also provided Kyat 30,000 for use when making delivery at a hospital. Though planned to deliver at a hospital, the baby was delivered at home with a TBA and the TBA used the materials in the kit. Few HIV positive mothers who made deliveries at the hospital said that though they brought the kit provided by the INGO to the government hospital, the staffs there used their own.

“I made my delivery with a TBA because I have no money to go to the hospital though I was told to go there. I paid Kyat 25,000 to the TBA. At hospital, it will cost me more. The TBA used the gloves provided to me by the INGO. I receive ART regularly for me and my baby from the INGO” (35-year old HIV positive FSW, Yangon)

“I am provided with Kyat 30,000 and a kit containing sterile gloves and a razor for cutting the baby’s umbilicus by the INGO. I took them with me when I made my delivery at the government hospital. They used their own” (22-year old HIV positive FSW, Yangon)

Most of the interviewees did not receive any provision from the INGOs or from public health facilities. For them, they had to buy new blades, cotton wools and threads for use by TBAs. TBAs used their own gloves during deliveries.

Opinions for improving PMTCT services to make access for the Key Affected Mothers

1. Views of key informants

The following views were given by the key informants during RTDs:

- NAP, UN agencies, INGOs/NGOs should train peer educators and through them to disseminate birth spacing methods and PMTCT services to FSWs;

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- To target poor and marginalized female population specifically on birth spacing methods and PMTCT services.

2. Opinions of FSWs

On asking for suggestions and opinions as regards how to improve FSWs access to PMTCT, majority of the FSWs were unable to provide any. The most common answer given was that they would provide information to their friends the importance about it. Few said pamphlets should be disseminated as regards availability of services and location of the health facility the way an INGO is doing. Most of the FSWs do not want to go to the ANC alone because of feeling ashamed. They prefer to go there with friends in groups. One key factor making them keeping away from public health facilities is the discrimination they faced there.

“I will explain to my fellow sex workers the importance about it” (38-year old FSW, Yangon)

“Should disseminate pamphlets the way Tun Clinic (an INGO clinic) is doing, informing about the services available and the address” (36-year old FSW, Yangon)

“Some FSWs did not go to any ANC or make deliveries at hospitals because they were afraid that they would be belittled if they were found out to be FSWs” (31-year old FSW, Yangon)

Few suggested to provide training to FSWs regularly imparting with required knowledge relating to condom use for contraception and for preventing disease transmission, for regular testing of blood and taking ANC and PMTCT at INGO or government health facilities. They said such knowledge dissemination should be made at karaoke bars as well.

DISCUSSION

In this study, study population was FSWs becoming pregnant and making deliveries during past two years, or who were pregnant in late stages (either second or third trimester), were recruited and interviewed. Though qualitative in-depth interview was the key approach of data collection applied, quantitative data collection was also done for each interviewee. A total of 102 FSWs, irrespective of their HIV status, participated in the study. This study focused on access to PMTCT services and did not look into adherence of ARVs for PMTCT or quality of counseling services.

Previous international studies had identified that poor knowledge of HIV transmission and ARV drugs being common reasons for dropping out of PMTCT services (Peltzer, K, Mlambo, M, et al, 2010; Varga, C, Brookes, H, 2008; Duff, P, Kipp, W, *et al*, 2010; Chinkonde JR, Sundby J, Martison, F, 2009). The FSWs need to have high awareness of HIV transmission modes in general and more particularly the mode of vertical mother-to-child transmission. They need to have high levels of awareness and knowledge related to using PMTCT services to prevent maternal transmission of HIV to their children. This, in the first place, could promote utilization of PMTCT services by pregnant FSWs.

Among the 102 FSWs interviewed, only 64 (64%) could identify MTCT as one of the modes of HIV transmission. Out of these 64, only 10 (15.6%) could identify all the three periods during which MTCT could take place. If being able to indicate “breast feeding as one of the periods during which HIV transmission could take place” alone is taken into consideration, there were 42 (65.6%) interviewees who could provide this answer. This situation shows the need for further improving HIV transmission knowledge among pregnant FSWs.

Indicating condom use as a mean for HIV prevention is high (98%) and awareness of ART can also be considered high (80%). In spite of the high awareness to use condom for preventing HIV transmission, this did not take place with some of the FSWs especially with their husbands, with clients considered their “boy-friends” and with those who paid more for using condoms. There were said to be instances, according to the interviewees, where condoms ruptured or they were forced to have sex without using condoms. According to the FSW interviewees, condoms are supplied free by INGOs, though few said they did not have enough condoms.

The study showed that about 52% of the FSWs were married at the time of interview. About 76% of the FSWs interviewed got pregnant with their husbands. FSWs might not be using condom with husbands intentionally to get a child. Even though one of them (FSW or her husband) may

be HIV positive, and even knowing that their child might become infected as well, some of them wanted a child.

Thus, not all pregnancies were un-intentional. Some of the un-intended pregnancies would have been aborted and did not enter into the recruitment as interviewees. The findings showed that some FSWs thought of aborting the unwanted baby, however, had to carry on with the pregnancy because the stage was too late.

Being accessible to ANC services is another factor that would facilitate FSWs to be accessible to PMTCT services available at the health facilities. In this study, it was found that about 78% of pregnant FSWs took ANC though majority (82%) of them went for ANC at a later stage of pregnancy, i.e., in second or in third trimester.

FSWs had to engage in sex work even while pregnant so as to earn to meet their daily needs. This is one reason for not going for ANC at an early stage of pregnancy. Costs, for travels and for payments to be made at health facilities, and being shameful of having pregnancy without having a husband, are among reasons that deter FSWs from taking ANC. Though payments to be made at government health facilities were revealed by some FSWs, some other FSW interviewees said they received free ANC.

In most of the study places, it was found that with the support of peer volunteers or peer health educators, FSWs went for HIV testing regularly. The same also held true when they became pregnant and seeking ANC. In this context, peer health educators/ peer volunteers play an important role in increasing the uptake of HIV testing and ANC services by providing information and supporting and encouraging for the use of services. Though assessing the quality of PMTCT services was not the objective of this study, information was acquired whether key components of PMTCT --- pre-test counseling, volunteer blood testing, confidentiality in providing test results and post-test counseling for positive mothers --- had taken place or not. Study findings showed that PMTCT services were not taking place as they should be at some of the health facilities, especially at the public facilities. Reports were made that their blood had been taken without proper explanation about the test and getting their agreement; needing to make payments for the blood test; and breaking of confidentiality of their HIV status in the ways of giving test results.

Discrimination towards HIV positive persons, especially among the community members, was highly evident from the responses given by the FSW interviewees. Being a FSW is under discrimination, and having HIV infection further worsened the discrimination. At the same time,

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few revelations were made as regards how local authorities in some wards provided necessary support to them.

Deliveries made by pregnant FSWs at health facilities are found to be about half of all the deliveries. Few FSWs made expressions of discrimination against them by health staffs when making deliveries there, in case they were found out to be FSWs, and more so if they were HIV positive.

TBAs are found to be playing key roles in providing home deliveries. Though cost of delivery at health facilities was said to be a key factor for using TBAs, making deliveries with TBAs was not free of charge. Some of the INGOs provided clean delivery kits to pregnant FSWs so that they could let TBAs to use them. TBAs, when given these kits, they made use of them. Study findings identified that some of the TBAs also are abortionists.

CONCLUSION AND RECOMMENDATIONS

Since the sample selection approach was based on contacts of existing FSW networks, all the FSWs came from lower social group, the ones who could be considered in most need of access to ANC and PMTCT services. At the same time, this approach of study has limitations to reveal the true situation of access to PMTCT services by FSWs, as the samples are biased towards those having contacts with existing FSW networks.

The study findings highlighted that at an individual level, there is a need for further improving mother-to-child HIV transmission knowledge among pregnant FSWs. The coverage for ANC and HIV testing during pregnancy is high among FSWs. Awareness of condom use is high and its availability also has no serious problems. However, condom use in practice still has limitations. Violence during sex acts and paying more money for sex acts without condom use are found to be factors associating no-condom use.

From this study, un-intended pregnancies are found to be less with most of the pregnancies the intended ones. This probably could have been due to most of the un-intended pregnancies being ended in abortions and not included in the study.

Financial barriers for accessing to ANC and PMTCT services had been revealed in this study. TBAs were found to be playing key roles and this is due to financial berries for making deliveries at health facilities. Some of the TBAs also are abortionists.

At community level, HIV stigma is still high. Being a FSW and being HIV positive posed the FSWs to bear double burden of discrimination in the community as well as at health facilities, though the latter situation is found to be to a lesser extent.

Taking into consideration of the key findings of the study, the following recommendations are made:

- Existing PMTCT programs are adequate to ensure reasonable coverage for pregnant FSW;
- Introducing financing and social protection schemes for poor families (in which FSWs' families will be included) to overcome financial barriers;
- Ensuring antenatal care, labour and delivery, and postpartum services provide a user-friendly environment for women living with HIV who are from key population groups.
- Enhancing participatory education for the community as a whole, to reduce HIV stigma, and this could be undertaken by NGOs and community based organizations (CBOs); and
- Conducting a study addressing health facility issues focusing on PMTCT services.

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Annex (1)Quantitative Data Collection Tool for the Study:
PMTCT Services

Barriers to Access to

(A) Background Characteristics																				
1	Age (in years) How old were you at your last birthday? ____ ____ Enter 99 if don't know	AGE [] []																		
2	Education Have you ever attended school? 1. YES 2. NO (GO TO QUESTION No. 4)	EDU []																		
3	Level of Education 1. Primary 2. Middle school 3. High school 4. University	EDUL []																		
4	Marital status at the time of interview Are you married? 1. YES 2. Divorced 3. Widowed 4. Never married 5. Others (Specify) _____	MARI []																		
(B) Knowledge on HIV vertical transmission and ART																				
5	Modes of HIV transmission Have you heard of HIV or AIDS (<i>use local terms</i>)? 1. YES 2. NO (GO TO SECTION C)	HIVAIDS []																		
6	What are the main modes of HIV transmission? <table border="0"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>1. Sexual intercourse</td> <td>1</td> <td>2</td> </tr> <tr> <td>2. Blood transfusion</td> <td>1</td> <td>2</td> </tr> <tr> <td>3. Sharing contaminated instruments</td> <td>1</td> <td>2</td> </tr> <tr> <td>4. From infected mother to child</td> <td>1</td> <td>2</td> </tr> <tr> <td>5. Others (specify) _____</td> <td>1</td> <td>2</td> </tr> </tbody> </table>		Yes	No	1. Sexual intercourse	1	2	2. Blood transfusion	1	2	3. Sharing contaminated instruments	1	2	4. From infected mother to child	1	2	5. Others (specify) _____	1	2	MODE1 [] MODE2 [] MODE3 [] MODE4 [] MODE5 []
	Yes	No																		
1. Sexual intercourse	1	2																		
2. Blood transfusion	1	2																		
3. Sharing contaminated instruments	1	2																		
4. From infected mother to child	1	2																		
5. Others (specify) _____	1	2																		

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7	<p>Do you know the main methods of preventing HIV infection?</p> <table border="0"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>1. Abstinence</td> <td>1</td> <td>2</td> </tr> <tr> <td>2. Being faithful to each other's partner</td> <td>1</td> <td>2</td> </tr> <tr> <td>3. Using condom</td> <td>1</td> <td>2</td> </tr> <tr> <td>4. Blood transfusion after screening</td> <td>1</td> <td>2</td> </tr> <tr> <td>5. Using disposable or sterile instruments (injection needles, skin piercing instruments, etc)</td> <td>1</td> <td>2</td> </tr> <tr> <td>6. Others (specify) _____</td> <td>1</td> <td>2</td> </tr> </tbody> </table>		Yes	No	1. Abstinence	1	2	2. Being faithful to each other's partner	1	2	3. Using condom	1	2	4. Blood transfusion after screening	1	2	5. Using disposable or sterile instruments (injection needles, skin piercing instruments, etc)	1	2	6. Others (specify) _____	1	2	<p>PREV1 []</p> <p>PREV1 []</p> <p>PREV1 []</p> <p>PREV1 []</p> <p>PREV1 []</p> <p>PREV1 []</p>
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6. Others (specify) _____	1	2																					
8	<p>Ever heard of ART</p> <p>Have you ever heard of anti-retroviral therapy (Treatment for HIV)?</p> <p>1. YES 2. NO</p>	ART []																					
9	<p>Have you ever taken ART treatment?</p> <p>1. YES 2. NO (GO TO QUESTION No. 14)</p> <p>3. NO RESPONSE (GO TO QUESTION No. 14)</p>	ARTT []																					
10	<p>What kind of user you are?</p> <p>1. Current user 2. Past user only (GO TO QUESTION No. 13)</p>	ARTU []																					
11	<p>Have you ever missed taking ART treatment?</p> <p>1. YES 2. NO</p>	ARTM []																					
12	<p>What are the reasons for missing ART treatment?</p>	REASON1																					
13	<p>What are the reasons for stopping ART treatment?</p>	REASON2																					
<p>(C) How the last pregnancy was conceived</p>																							
14	<p>Can you please tell me with whom the last pregnancy was conceived?</p> <p>1. Spouse</p> <p>2. Boy friend</p> <p>3. Casual acquaintance</p> <p>4. MSM</p>	PREG []																					



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	5. No Response 6. Others (specify) _____	
15	What was the HIV status of the sex partner? 1. Positive 2. Negative 3. Don't know 4. No Response	HIVP []
16	What was your HIV status at that time? 1. Positive 2. Negative 3. Don't know 4. No Response	HIVR []
17	Did you use condom when you had had sex with the one with whom you got pregnant? 1. YES (Always) (GO TO QUESTION No. 19) 2. NO (or used sometimes)	CONDOM []
18	What were the reasons that you did not use condom?	CONNO
(D) ANC seeking behaviour		
19	Did you go for ANC during your last pregnancy? 1. YES 2. NO (GO TO QUESTION No. 29)	ANC []
20	At what stage of your pregnancy did you go for ANC? 1. During first three months 2. During second three months 3. During the last three months	ANCWHEN []
21	Where did you go for your ANC? 1. Government Hospital/Clinic 2. Private Hospital/Clinic 3. INGO/NGO Clinic 4. Others (specify) _____	ANCWHERE []

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22	How many total visits did you make for ANC? _____ times	ANCTIMES [][]
(E) Use of PMTCT services		
23	Did you receive counseling on prevention of mother-to-child transmission of HIV during your ANC visits? (<i>Explain what PMCT counseling is</i>) 1. YES 2. NO 3. Do not remember	COUNSEL []
24	Was HIV testing done? 1. YES 2. NO (GO TO QUESTION No. 29) 3. YES, but refused (GO TO QUESTION No. 29) 4. Do not remember (GO TO QUESTION No. 29)	HIVTEST []
25	Was HIV status informed? 1. YES 2. NO 3. Not Relevant because HIV status already known before	HIVSTATUS []
26	Was ART prophylaxis given (if the HIV status was found to be positive)? 1. YES 2. NO, even the HIV status was found to be positive 3. NO, because HIV status was found to be negative 4. Not Relevant because the respondent was already on ART	ARTP []
27	Was Post-test Counseling given after HIV testing was found to be positive? 1. YES 2. NO 3. Do not remember	POSTTEST []

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28	<p>What was your perception as regards the ways health staffs treated you after knowing that you were HIV positive?</p> <ol style="list-style-type: none"> 1. Very Good 2. Good 3. Bad 4. Very Bad 5. Not Relevant because HIV testing was found to be negative 	STAFF []
(F) Delivery		
29	<p>Where did you deliver your baby?</p> <ol style="list-style-type: none"> 1. Government Hospital/Clinic 2. Private Hospital/Clinic 3. INGO/NGO Clinic 4. At home 5. Pregnant 6. Others (specify) _____ 	DELIVERY []
30	<p>Did you receive ARV prophylaxis for your baby?</p> <ol style="list-style-type: none"> 1. YES 2. NO 3. Not relevant 	ARVB []
31	<p>Did you receive free infant formula?</p> <ol style="list-style-type: none"> 1. YES 2. NO 3. Not relevant 	INFANTF []

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Quantitative Data Collection Tool for the Study: Barriers to Access to PMTCT Services

(G) Background Characteristics		
၁	အသက် (နှစ်) သင်ရဲ့အသက်ပြည့်နှစ် ____ နှစ် မသိလျှင် ၉၉ ဖြည့်ပါ။	Age[][]
၂	ပညာရေး ကျောင်းနေဖူးလား? (၁) နေဖူးပါသည်။ (၂) မနေဖူးပါ။ (မေးခွန်း(၄)သို့သွားပါ။)	EDU[]
၃	နေဖူးလျှင် ဘယ်နှစ်တန်းထိနေဖူးပါသလဲ? (၁) မူလတန်း (၂) အလယ်တန်း (၃) အထက်တန်း (၄) တက္ကသိုလ်	SCU[]
၄	(မေးမြန်းစဉ်) အိမ်ထောင်ရေး အခြေအနေ အိမ်ထောင်ရှိပါသလား ? (၁) ရှိ (၂) ကွဲ/တစ်ခုလပ် (၃) မုဆိုးမ (၄) အခြား(ဖော်ပြပါ)_____	MARI []
(H) Knowledge on HIV vertical transmission and ART		
၅	အိပ်ချ်အိုင်စီကူးစက်ပုံ အိပ်ချ်အိုင်စီ/အေအိုင်စီအကပ်/လေးလုံးရောဂါကြားဖူးလား? (၁) ကြားဖူး (၂) မကြားဖူး (Section C သို့သွားပါ)	HIVAIDS []

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၆	<p>အိပ်ချ်အိုင်စွဲကူးစက်ပုံများပြောပြပါ။</p> <table border="0" style="width: 100%;"> <tr> <td></td> <td style="text-align: center;">ဖြေ</td> <td style="text-align: center;">မဖြေ</td> <td></td> </tr> <tr> <td>၁.(ပိုးရှိသူနှင့်) လိင်ဆက်ဆံခြင်း</td> <td style="text-align: center;">၁</td> <td style="text-align: center;">၂</td> <td>MODE1 []</td> </tr> <tr> <td>၂.(ပိုးပါသော) သွေးသွင်းခြင်း</td> <td style="text-align: center;">၁</td> <td style="text-align: center;">၂</td> <td>MODE2 []</td> </tr> <tr> <td>၃.(ပိုးပါသော) ပစ္စည်းကိရိယာများသုံးခြင်း</td> <td style="text-align: center;">၁</td> <td style="text-align: center;">၂</td> <td>MODE3 []</td> </tr> <tr> <td>၄. ပိုးရှိသောမိခင်မှ ကလေးသို့ကူးခြင်း</td> <td style="text-align: center;">၁</td> <td style="text-align: center;">၂</td> <td>MODE4 []</td> </tr> <tr> <td>၅. အခြား (ဖော်ပြပါ)</td> <td style="text-align: center;">၁</td> <td style="text-align: center;">၂</td> <td>MODE5 []</td> </tr> <tr> <td colspan="4">_____</td> </tr> </table>		ဖြေ	မဖြေ		၁.(ပိုးရှိသူနှင့်) လိင်ဆက်ဆံခြင်း	၁	၂	MODE1 []	၂.(ပိုးပါသော) သွေးသွင်းခြင်း	၁	၂	MODE2 []	၃.(ပိုးပါသော) ပစ္စည်းကိရိယာများသုံးခြင်း	၁	၂	MODE3 []	၄. ပိုးရှိသောမိခင်မှ ကလေးသို့ကူးခြင်း	၁	၂	MODE4 []	၅. အခြား (ဖော်ပြပါ)	၁	၂	MODE5 []	_____								
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၁. လိင်ဆက်ဆံမှုရှောင်ကျဉ်ခြင်း	၁	၂	PREV1 []																															
၂. မိမိကြင်ဖော်အပေါ်သစ္စာရှိခြင်း	၁	၂	PREV1 []																															
၃. ကွန်ဒုံးသုံးခြင်း	၁	၂	PREV1 []																															
၄. ပိုးစစ်ပြီးသောသွေးကိုသာအသွင်းခံခြင်း	၁	၂	PREV1 []																															
၅. တခါသုံး(သို့မဟုတ်) ပိုးသန့်စင်ထားသော ပစ္စည်းကိရိယာများ (ဆေးထိုးအပ်၊စသည်)အသုံးပြုခြင်း	၁	၂	PREV1 []																															
၆. အခြား(ဖော်ပြပါ)	၁	၂	PREV1 []																															

၈	<p>ART ဆေးဆီတာကြားဖူးလား (အိပ်ချ်အိုင်စွဲပိုးရှိသူကို ကုတဲ့ဆေးကြားဖူးလား) ?</p> <p>(၁) ကြားဖူး (၂) မကြားဖူး</p>	ART []																																
၉	<p>ART ဆေးသောက်သုံးဖူးလား ?</p> <p>(၁) သောက်သုံးဖူး (၂) မသောက်သုံးဖူး(မေးခွန်း ၁၄ သို့သွားပါ)</p> <p>(၃) ဖြေဆိုခြင်းမရှိ (မေးခွန်း ၁၄သို့သွားပါ)</p>	ARTT []																																

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၁၀	ART သုံးစွဲနေပုံအမျိုးအစား (လက်ရှိ/ယခင်က) (၁) လက်ရှိသုံးစွဲနေသည် (၂) ယခင်ကသုံးစွဲဖူးသည် (မေးခွန်း သုသို့သွားပါ)	ARTU []
၁၁	ART အချိန်မှန်သုံးစွဲဖို့ မေ့လျော့သွားတာမျိုးဖြစ်ဖူးလား ? (၁) ဖြစ်ဖူးပါ (၂) မဖြစ်ဖူးပါ	ARTM []
၁၂	ဘာကြောင့် ART အချိန်မှန်သုံးစွဲဖို့ မေ့လျော့သွားရတယ်ဆိုတဲ့ အကြောင်း ပြောပြပါ။	REASON1
၁၃	ART ဆက်မသောက်ဖြစ်တော့တဲ့ အကြောင်းပြောပြပါ။	REASON2
(I) How the last pregnancy was conceived		
၁၄	နောက်ဆုံးကိုယ်ဝန် ဘယ်သူနဲ့ရခဲ့တာလဲ? (၁) ခင်ပွန်း (၂) သမီးရည်းစား (၃) အပျော်အဖော် (၄) လိင်တူဆက်ဆံသူ (၅) မသိပါ (၆) မဖြေဆိုပါ (၇) အခြား (ရှင်းပြပါ) _____	PREG []
၁၅	လိင်ဆက်ဆံဖက်မှာ အိပ်ချ်အိုက်စွဲပိုးရှိလား ? (၁) ရှိ (၂) မရှိ (၃) မသိ (၄) မဖြေ	HIVP []

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၁၆	သင်မှာ အိပ်ချ်အိုင်ဗွီပိုးရှိပါသလား ? (၁) ရှိ (၂) မရှိ (၃) မသိ (၄) မဖြေ	HIVR []
၁၇	ကိုယ်ဝန်ရှိခဲ့သူနှင့် လိင်ဆက်ဆံစဉ်က ကွန်ဒုံးသုံးခဲ့ပါသလား ? (၁) အမြဲသုံး (မေးခွန်း ၁၉သို့သွားပါ) (၂) မသုံး(သို့) တခါတရံသုံး	CONDOM []
၁၈	ကွန်ဒုံးမသုံးဖြစ်ခဲ့ရသည့် အကြောင်းများပြောပြပါ	CONNO
(J) ANC seeking behavior		
၁၉	သင်ရဲ့နောက်ဆုံးကိုယ်ဝန်ရရှိစဉ်က ကိုယ်ဝန်အပ်ပြီးစောင့်ရှောက်မှုခံယူ ခဲ့ပါသလား ? (၁) ခံယူ (၂) မခံယူ (မေးခွန်း ၂၉သို့ သွားပါ)	ANC []
၂၀	ကိုယ်ဝန်ဘယ်နှစ်လမှာ ကိုယ်ဝန်သွားအပ်ခဲ့ပါသလဲ? (၁) ပထမ ၃လတွင်း (၂) ဒုတိယ ၃လတွင်း (၃) နောက်ဆုံး ၃လတွင်း	ANCWHEN []

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၂၆	အိပ်ချ်အိုင်စီပိုး ကလေးကို မကူးစက်ဖို့အတွက် ဆေး(အေ-အာရ်-တီ) တိုက်ကျွေးခဲ့ပါသလား (အကယ်၍ အိပ်ချ်အိုင်စီပိုးရှိလျှင်)? (၁) တိုက်ကျွေးသည် (၂) ပိုးရှိကြောင်းသိရသော်လည်း ဆေးမတိုက်ခဲ့ပါ (၃) ပိုးမရှိသဖြင့် ဆေးမတိုက်ခဲ့ပါ (၄) (ART ဆေးသောက်နေသူဖြစ်၍ မသက်ဆိုင်ပါ)	ARTP []
၂၇	အိပ်ချ်အိုင်စီပိုး ရှိကြောင်းပြောပြီးသည့် အခါနှစ်သိမ့်ဆွေးနွေးတာ လုပ်ခဲ့ပါသလား? (၁) ဆွေးနွေးသည် (၂) မဆွေးနွေးပါ (၃) မမှတ်မိပါ (၄) (ပိုးမရှိသဖြင့် မသက်ဆိုင်ပါ)	POSTTEST []
၂၈	သင့်မှာ အိပ်ချ်အိုင်စီပိုးရှိကြောင်း သိရှိရပြီးသည့်အခါ ၊ ကျန်းမာရေးဝန်ထမ်း များက သင့်ကို ဆက်ဆံပုံနှင့် ပတ်သက်၍ မည်သို့ထင်ပါသလဲ ? (၁) အင်မတန်ကောင်း (၂) ကောင်း (၃) ဆိုး (၄) အင်မတန်ဆိုး (၅) (အိပ်ချ်အိုင်စီပိုးမရှိသဖြင့် မသက်ဆိုင်ပါ)	STAFF []

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(L) Delivery		
၂၉	<p>သင့်နောက်ဆုံး ကလေးကို ဘယ်မှာ မီးဖွားခဲ့ပါသလဲ ?</p> <p>(၁) အစိုးရဆေးရုံ/ဆေးခန်း (၂) ပုဂ္ဂလိက ဆေးရုံ/ဆေးခန်း (၃) INGO/NGO ဆေးခန်း (၄) အိမ်မှာ (၅) အခြား (ရှင်းပြပါ) _____</p>	<p>DELIVERY []</p>
၃၀	<p>သင့်ကလေးအတွက် အိပ်ချ်အိုင်စီမကူးစက်ရန် ကာကွယ်ပေးမည့် သောက်ဆေး ရရှိခဲ့ပါသလား ?</p> <p>(၁) ရရှိခဲ့သည် (၂) မရရှိခဲ့ပါ</p>	<p>ARVB []</p>
၃၁	<p>တစ်လအတွက် နို့မှုန့်အခမဲ့ရရှိခဲ့ပါသလား?</p> <p>(၁) ရရှိခဲ့သည် (၂) မရရှိခဲ့ပါ</p>	<p>INFANTF []</p>

Annex (2)

FDG

Focus Group Discussion Guide for the Study: Barriers to Access to PMTCT Services

Theme 1: Background information of the respondents

Name

Age

Marital status

Theme 2: Conceiving pregnancies among FSWs, Women who inject drugs and female partners of IVDU

Invite the participants to discuss, according to their awareness, whether are female sex workers, women who injects drug, female partners of IVDU and MSM who had been pregnant and had delivered a baby during last one year, or are currently pregnant.

Probe: With whom? What the HIV positive status of the partner and the women was? Whether the women were able to negotiate sex or contraceptive use, or to access contraceptives (which can prevent leading to unplanned pregnancy)?

Theme 3: ANC seeking behavior

Basing on their opinions, ask the participants to discuss;

Where the women took ANC for their pregnancy;

At what stage of pregnancy they went there and how many times they visited;

The reasons in case there were any pregnant woman who did not go for ANC.

Probe: whether women are able to access pre-natal health services for a variety of reasons, including because their partners control the household financial or transportation resources, because they cannot take time off work, or because they cannot leave their dependents to travel to a clinic or hospital; cultural traditions including preferences for traditional healers and birth attendants.

Theme 4: Use of PMTCT services

In their opinions, ask whether the pregnant women receive counseling on prevention of mother-to-child transmission of HIV during your ANC visits?

Probe: Whether fear of rejection, stigmatization, violence or abuse prevent women from utilizing PMTCT, accessing PMTCT programs.

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Probe:

- Psychological issues following HIV diagnosis
- Stigma and fear of status disclosure to partners, family or community members
- The extent of partner
- The extent community support
- Receipt of post-test counseling
- ART prophylaxis for mother
- Staff-client interactions when taking PMTCT services

Theme 5: Delivery

Ask, according to their awareness, where these pregnant women made their deliveries and the reasons for making at those places.

Probe: ARV prophylaxis for child; provision of free infant formula; staff-client interactions when taking PMTCT services.

Theme 6: Opinions for improving PMTCT services to make access for the Key Affected Mothers

Ask for their opinions how PMTCT services should be organized so as to improve access to the Key Affected Mothers.

**Focus Group Discussion Guide for the Study:
Barriers to Access to PMTCT Services**

အပိုင်း(၁) ဆွေးနွေးဖြေဆိုသူများ၏ နောက်ခံအချက်အလက်များ

အမည် -----

အသက်(နှစ်) [] []

အိမ်ထောင်ရေး -----

အပိုင်း(၂) အဓိက ခံစားနေရသည့်အုပ်စုများဖြစ်သောအမျိုးသမီးလိင်လုပ်သားများအမျိုးသမီး မူးယစ်ဆေးသုံးစွဲသူများနှင့် မူးယစ်ဆေးသုံးစွဲသူများ၏ လိင်ဆက်ဆံဖော်များအကြား ကိုယ်ဝန်ရရှိခဲ့ခြင်း

- မည်သို့သောသူများနှင့်ကိုယ်ဝန်ရခဲ့ကြတာလဲ? သူမတို့နှင့်ထိုလိင်ဆက်ဆံဖက်များ၏ HIV ရောဂါပိုးရှိမရှိ။ ထိုသူနှင့်လိင်ဆက်ဆံရာတွင်ညှိနှိုင်းမှုပြုလုပ်လို့ရသလား၊ ကိုယ်ဝန်တားဆေးသုံးစွဲရန်အတွက်ညှိနှိုင်းပြောဆိုခြင်း၊ခွင့်ပြုခြင်းများရှိသလား။

အပိုင်း(၃) ကိုယ်ဝန်စောင့်ရှောက်မှုခံယူခြင်း

သင်တို့၏အတွေ့အကြုံအရ ထိုအမျိုးသမီးများသည် ကိုယ်ဝန်အပ်ပြီး စောင့်ရှောက်မှု ခံယူကြပါသလား။

ကိုယ်ဝန်အပ်ပြီးစောင့်ရှောက်မှုခံယူခဲ့ခြင်းမရှိပါက အကြောင်းရင်းကို သေချာစွာ မေးရန်။
(ကိုယ်ဝန်စောင့်ရှောက်မှုဝန်ဆောင်မှုလုပ်ငန်းများကို ရရှိရန်အတွက်အဟန့်အတားဖြစ်စေသော အကြောင်းအရင်းများကိုပြောပြပေးပါ။ (ဥပမာ-

လိင်ဆက်ဆံဖက်သည်မိသားစု၏စီးပွားရှာသူ(အိမ်ထောင်ဦးစီး)ဖြစ်ခြင်း(သို့)ခရီးစရိတ်ထောက်ပံ့မည် သူဖြစ်ခြင်း။ မိမိတို့အလုပ်မှ ခွင့်ယူရန်မဖြစ်နိုင်ခြင်း၊မိမိတို့၏ မှီခိုသူများကို ဆေးရုံ/ဆေးခန်းသွားနေစဉ် ထားခဲ့ဖို့မဖြစ်နိုင်ခြင်း၊ တိုင်းရင်းဆေးကုသသူများနှင့်လက်သည်များကိုကြိုက်သည့် လေ့ထုံးစံကြောင့်)

အပိုင်း(၄) မိခင်မှ ကလေးကို အိပ်ချ်အိုင်ဗွီပိုး မကူးအောင် ကာကွယ်ခြင်းနှင့် သက်ဆိုင်သည့်ဝန်ဆောင်မှု ကို ရယူခြင်း

သင်တို့၏အတွေ့အကြုံအရ ထိုအမျိုးသမီးများသည်ကိုယ်ဝန်စောင့်ရှောက်မှုခံယူစဉ်က မိခင်က ကလေးကို အိပ်ချ်အိုင်ဗွီပိုး မကူးအောင် ကာကွယ်နည်းအကြောင်းဆွေးနွေးမှုခံယူရရှိကြပါသလား။

မိခင်က ကလေးကို အိပ်ချ်အိုင်ဗွီပိုး မကူးအောင် ကာကွယ်ခြင်း ဝန်ဆောင်မှုကို သုံးခြင်းနှင့် ပတ်သက်ပြီးအဟန့်အတားရှိသလား။ (ဥပမာ-ဆေးထိုးကြောက်ခြင်း၊ ခွဲခြားဆက်ဆံခံရမှုကြောက်ခြင်း၊အကြမ်းဖက်ခံရမှုကြောက်ခြင်း)

အပိုင်း(၅) ကလေးမီးဖွားခြင်း

သင်တို့၏အတွေ့အကြုံအရ ထိုအမျိုးသမီးများဘယ်မှာ မီးဖွားကြပါသလဲ။ဘာကြောင့်ထိုနေရာတွင်မွေးဖွားခဲ့ပါသလဲ။

(ကလေးအတွက် အိပ်ချ်အိုင်ဗွီမကူးစက်ရန် ကာကွယ်ပေးမည့် သောက်ဆေးရရှိသောကြောင့်၊ နို့နှင့်အမဲရရှိသောကြောင့်(သို့) ကျန်းမာရေးဝန်ထမ်း များကသင့်ကို ဆက်ဆံပုံနှင့် ပတ်သက်၍)

အပိုင်း(၆) AIDS ကြောင့် အဓိကခံစားနေရသည့်မိခင်များ "မိခင်က ကလေးကို အိပ်ချ်အိုင်ဗွီပိုး မကူးအောင် ကာကွယ်ခြင်း" ဝန်ဆောင်မှုကို ရယူရာတွင်တိုးတက်မှုရှိစေရန် အကြံပြုချက်

AIDS ကြောင့် အဓိကခံစားနေရသည့်မိခင်များ "မိခင်က ကလေးကို အိပ်ချ်အိုင်ဗွီပိုး မကူးအောင် ကာကွယ်ခြင်း" ဝန်ဆောင်မှုကို ရယူရာတွင်တိုးတက်မှုရှိစေရန်အတွက် မည်သည့်အကြံဉာဏ်များပေးလိုပါသလဲ။

IDI

Qualitative (IDI) Interview Guide for the Study: Barriers to Access to PMTCT Services

Theme 1: Background Characteristics

Age (in years)

Education

Marital status at the time of interview

Theme 2: Knowledge on HIV vertical transmission and ART

Can you please explain me how HIV is spread?

Can you tell me how HIV transmission could be prevented?

If you anything about treating HIV, can you please describe about these to me?

Have you ever taken ART treatment?

If so, have you ever missed ART treatment? What are the reasons for missing ART treatment?

Probe: Forget to take? Financial problem? Difficulty in going to the clinic? Health condition? Afraid of side effects? Shortage of drugs at the clinic? Clinic is closed? Other reasons? *Ask in-depths for each probing question.*

If you are a past user of ART, what are the reasons for stopping treatment?

Probe: Financial problem? Difficulty in going to the clinic? Health condition? Afraid of side effects? Shortage of drugs at the clinic? Other reasons? *Ask in-depths for each probing question.*

Theme 3: How the last pregnancy was conceived

Can you please tell me with whom the last pregnancy was conceived?

Probe: With whom? The HIV positive status of the partner. Whether they were able to negotiate sex or contraceptive use, or to access contraceptives, which can prevent leading to unplanned pregnancy.

Theme 4: ANC seeking behavior

Can you please tell me where you took ANC for your last pregnancy, at what stage of pregnancy you went there and how many times you visited.

Ask the reasons in case anyone responded that she did not go for ANC.

Probe: whether women are able to access pre-natal health services for a variety of reasons, including because their partners control the household financial or transportation resources,

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because they cannot take time off work, or because they cannot leave their dependents to travel to a clinic or hospital; cultural traditions including preferences for traditional healers and birth attendants.

Theme 5: Use of PMTCT services

(*Explain what PMCT counseling is first*). Did you receive counseling on prevention of mother-to-child transmission of HIV during your ANC visits?

Probe: Whether fear of rejection, stigmatization, violence or abuse prevent women from utilizing PMTCT, accessing PMTCT programs.

Probe the followings and the ways of posing the probes will depend on specific characteristics of the respondents (previous HIV positives; came to know about HIV positive status during last ANC; came to know that she was not a HIV positive after HIV testing during last ANC; did not take any ANC; etc.):

- Psychological issues following HIV diagnosis
- Stigma and fear of status disclosure to partners, family or community members
- The extent of partner
- The extent community support
- Receipt of post-test counseling

Note: In applying the above probes, for those who are HIV negative, a scenario may have to be posed saying that in case they were found out to be HIV positive after HIV testing.

Further probe the followings for those who were HIV positives:

- ART prophylaxis for mother
- Staff-client interactions when taking PMTCT services.

Theme 6: Delivery

Please tell me where you made your last delivery and the reasons for choosing the place.

Probe: ARV prophylaxis for child; provision of free infant formula; staff-client interactions when taking PMTCT services.

Theme 7: Opinions for improving PMTCT services to make access for the Key Affected Mothers

(Ask for their opinions how PMTCT services should be organized so as to improve access to mothers like them).

Qualitative (IDI) Interview Guide for the Study: Barriers to Access to PMTCT Services

အပိုင်း (၁) ဖြေဆိုသူ၏ နောက်ခံ အချက်အလက်များ

အသက်(နှစ်) [][]

ပညာအရည်အချင်း -----

အိမ်ထောင်ရေးအခြေအနေ -----

အပိုင်း (၂) HIV/ ART တို့နှင့် ပတ်သက်သော ဗဟုသုတများ

- အိပ်ချ်အိုင်ဗွီကူးစက်ပုံအကြောင်းပြောပြပေးပါ။
- အိပ်ချ်အိုင်ဗွီမကူးစက်ရန် အဓိကကာကွယ်နည်းများအကြောင်းပြောပြပေးပါ။
- အိပ်ချ်အိုင်ဗွီပိုးရှိသူကိုကုတဲ့ဆေးအကြောင်းကြားဖူးသလား။ပြောပြပေးပါ။
- ART ဆေးသောက်ဖူးသလား။
- ART အချိန်မှန်သုံးစွဲဖို့ မေ့လျော့သွားတာမျိုးဖြစ်ဖူးလား ? ဘာကြောင့် ART အချိန်မှန်သုံးစွဲဖို့ မေ့လျော့သွားရတယ်ဆိုတဲ့ အကြောင်း ပြောပြပါ။
(မေ့သွားတာလား၊ စီးပွားရေးအခက်အခဲတွေကြောင့်လား၊ ဆေးခန်းသွားရတာလေး/
အခက်အခဲရှိလို့လား၊ ကျန်းမာရေး အခြေအနေကြောင့်လား၊ ဆေးရုံဘေးထွက်
ဆိုးကျိုးကိုကြောက်လို့လား၊ ဆေးခန်းမှာဆေးပြတ်သွားလို့လား၊
ဆေးခန်းပိတ်လို့လား၊အခြားအကြောင်းရှိလား။)
- သင်သည် ယခင်ကARTဆေးသုံးခဲ့ဖူးခဲ့လျှင် ART ဆက်မသောက်ဖြစ်တော့တဲ့
အကြောင်းပြောပြပါ။
စကားရပ်သမီး (မေ့သွားတာလား၊ စီးပွားရေးအခက်အခဲတွေကြောင့်လား၊
ဆေးခန်းသွားရတာလေး/ အခက်အခဲရှိလို့လား၊ ကျန်းမာရေး အခြေအနေကြောင့်လား၊
ဆေးရုံဘေးထွက် ဆိုးကျိုးကိုကြောက်လို့လား၊ ဆေးခန်းမှာဆေးပြတ်သွားလို့လား၊
ဆေးခန်းပိတ်လို့လား၊အခြားအကြောင်းရှိလား။)

အပိုင်း(၃) နောက်ဆုံးကိုယ်ဝန်ရရှိခဲ့ခြင်း

- နောက်ဆုံးကိုယ်ဝန် ဘယ်သူနဲ့ရခဲ့တာလဲ? ထိုသူ၏ HIV ရောဂါပိုးရှိမရှိ။
စကားရပ်သမီး (ထိုသူနှင့်လိင်ဆက်ဆံရာတွင်ညှိနှိုင်းမှုပြုလုပ်လို့ ရသလား၊

ကိုယ်ဝန်တားဆေးသုံးစွဲရန်အတွက်ညှိနှိုင်းပြောဆိုခြင်း၊ခွင့်ပြုခြင်းများရှိသလား။)

အပိုင်း(၄): ကိုယ်ဝန်စောင့်ရှောက်မှုခံယူခြင်း

- သင်ရဲ့နောက်ဆုံးကိုယ်ဝန်ရရှိစဉ်က ကိုယ်ဝန်အပ်ပြီးစောင့်ရှောက်မှုခံယူခဲ့ပါသလား ?
- ကိုယ်ဝန်ဘယ်နှစ်လမှာ ကိုယ်ဝန်သွားအပ်ခဲ့ပါသလဲ?

(၁) ပထမ ၃လတွင်း

(၂) ဒုတိယ ၃လတွင်း

(၃) နောက်ဆုံး ၃လတွင်း

- ကိုယ်ဝန်စောင့်ရှောက်မှု ဘယ်နှစ်ကြိမ်သွားယူခဲ့ဖြစ်ခဲ့ပါသလဲ ?

စကားရပ်သမီး ကိုယ်ဝန်အပ်ပြီးစောင့်ရှောက်မှုခံယူခဲ့ခြင်းမရှိပါက အကြောင်းရင်းကို သေချာစွာ မေးရန်။ (ကိုယ်ဝန်စောင့်ရှောက်မှုဝန်ဆောင်မှုလုပ်ငန်းများကို ရရှိရန်အတွက်အဟန့်အတားဖြစ်စေသော အကြောင်းအရင်းများကိုပြောပြပေးပါ။ (ဥပမာ- လိင်ဆက်ဆံဖက်သည်မိသားစု၏စီးပွားရှာသူ(အိမ်ထောင်ဦးစီး)/ဖြစ်ခြင်း(သို့)ခရီးစရိတ်ထောက်ပံ့မည် သူဖြစ်ခြင်း။ မိမိတို့အလုပ်မှ ခွင့်ယူရန်မဖြစ်နိုင်ခြင်း၊မိမိတို့၏ မှီခိုသူများကို ဆေးရုံ/ဆေးခန်းသွားနေစဉ် ထားခဲ့ဖူးဖြစ်နိုင်ခြင်း၊ တိုင်းရင်းဆေးကုသသူများနှင့်လက်သည်များကိုကြိုက်သည့် ဓလေ့ထုံးစံကြောင့်)

အပိုင်း(၅): မိခင်က ကလေးကို အိပ်ချ်အိုင်စွဲပိုး မကူးအောင် ကာကွယ်ခြင်းနှင့် သက်ဆိုင်သည့်ဝန်ဆောင်မှု

မိခင်က ကလေးကို အိပ်ချ်အိုင်စွဲပိုး မကူးအောင် ကာကွယ်နည်းအကြောင်း ဆွေးနွေးခြင်း အကြောင်းဦးစွာအရင်ရှင်းပြပါ။

- သင်ကိုယ်ဝန်စောင့်ရှောက်မှုခံယူစဉ်က မိခင်က ကလေးကို အိပ်ချ်အိုင်စွဲပိုး မကူးအောင် ကာကွယ်နည်းအကြောင်းဆွေးနွေးပါသလား ?
- မိခင်က ကလေးကို အိပ်ချ်အိုင်စွဲပိုး မကူးအောင် ကာကွယ်ခြင်း ဝန်ဆောင်မှုကို သုံးခြင်းနှင့် ပါတ်သက်ပြီးအဟန့်အတားရှိသလား ။

(ဥပမာ-ဆေးထိုးကြောက်ခြင်း၊ခွဲခြားဆက်ဆံခံရမှုကြောက်ခြင်း၊
အကြမ်းဖက်ခံရမှုကြောက်ခြင်း)

အပိုင်း(၆): ကလေးမီးဖွားခြင်း

သင့်နောက်ဆုံး ကလေးကို ဘယ်မှာ မီးဖွားခဲ့ပါသလဲ ? ဘာကြောင့်ထိုနေရာတွင်မွေးဖွားခဲ့ပါသလဲ။

(၁) အစိုးရဆေးရုံ/ဆေးခန်း

(၂) ပုဂ္ဂလိက ဆေးရုံ/ဆေးခန်း

(၃) INGO/NGO ဆေးခန်း

(၄) အိမ်မှာ

စကားရိပ်သမ်း (သင့်ကလေးအတွက် အိပ်ချ်အိုင်ဗွီမကူးစက်ရန် ကာကွယ်ပေးမည့်
သောက်ဆေးရရှိသောကြောင့်၊ နို့မှုန့်အခမဲ့ရရှိသောကြောင့်(သို့) ကျန်းမာရေးဝန်ထမ်း များကသင့်ကို
ဆက်ဆံပုံနှင့် ပတ်သက်၍)

**အပိုင်း(၇): AIDS ကြောင့် အဓိကခံစားနေရသည့်မိခင်များ "မိခင်က ကလေးကို အိပ်ချ်အိုင်ဗွီပိုး
မကူးအောင် ကာကွယ်ခြင်း" ဝန်ဆောင်မှုကို ရယူရာတွင်တိုးတက်မှုရှိစေရန် အကြံပြုချက်**

AIDS ကြောင့် အဓိကခံစားနေရသည့်မိခင်များ "မိခင်က ကလေးကို အိပ်ချ်အိုင်ဗွီပိုး မကူးအောင်
ကာကွယ်ခြင်း" ဝန်ဆောင်မှုကို ရယူရာတွင်တိုးတက်မှုရှိစေရန်အတွက်
မည်သည့်အကြံဉာဏ်များပေးလိုပါသလဲ။