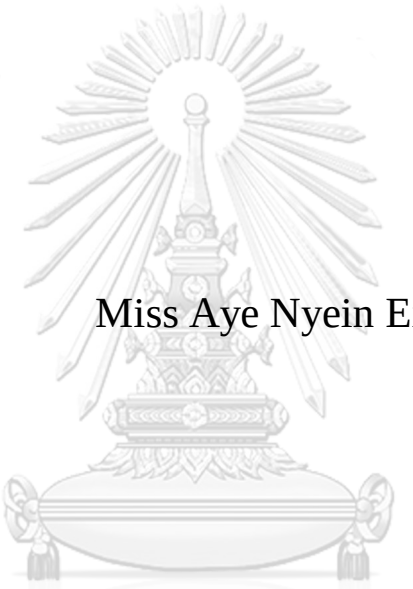
Knowledge, Attitude and Health Care Practices for Gender-Based Violence Cases in Yangon, Myanmar

Miss Aye Nyein Ei



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และการให้บริการสุขภาพสำหรับผู้ได้รับความรุนแรงบนฐานเพศภาวะในเมืองย่างกุ้ง
ประเทศเมียนมา

น.ส.เอ เนียน อิ

วิทยานิพนธ์นี้เป็นส่วนหนึ่งของการศึกษาตามหลักสูตรปริญญาสาธารณสุขศาสตรมหาบัณฑิต
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เอ เนียน อิ : ความรู้ ทัศนคติ และการให้บริการสุขภาพสำหรับผู้ได้รับความรุนแรงบนฐานเพศภาวะในเมืองย่างกุ้ง ประเทศเมียนมา. (Knowledge, Attitude and Health Care Practices for Gender-Based Violence Cases in Yangon, Myanmar) อ.ที่ปรึกษาหลัก : มนทกานติ์ เชื่อมชิต

ความรุนแรงบนฐานเพศภาวะส่งผลกระทบต่อสุขภาพกาย จิต และสังคมของผู้ถูกกระทำ การตอบสนองและการช่วยเหลือตั้งแต่เต้นสามารถลดขนาดของปัญหาความรุนแรงได้ ดังนั้นความพร้อมของบุคลากรทางการแพทย์ต่อการตอบสนองปัญหาความรุนแรงจึงเป็นสิ่งสำคัญ การศึกษาครั้งนี้มีวัตถุประสงค์ในการสำรวจความรู้ ทัศนคติ และการปฏิบัติเกี่ยวกับการตอบสนองต่อความรุนแรงบนฐานเพศภาวะของบุคลากรทางการแพทย์

การวิจัยครั้งนี้เป็นการศึกษาภาคตัดขวางโดยศึกษาในโรงพยาบาล 48 แห่งในเมืองย่างกุ้ง ประเทศเมียนมา ระหว่างเดือนเมษายน-พฤษภาคม 2562 ในกลุ่มบุคลากรทางการแพทย์ (แพทย์และพยาบาล) รวมทั้งสิ้น 398 คน โดยการตอบแบบแบบสอบถามด้วยตนเองในหัวข้อลักษณะประชากรและสังคม ความรู้ ทัศนคติ ปัจจัยแวดล้อมที่สนับสนุน และการปฏิบัติ ในส่วนของการวิเคราะห์ข้อมูลนั้น ได้ใช้สถิติการวิเคราะห์ตัวแปรเดียว ตัวแปรสองตัว และตัวแปรหลายตัว ที่ระดับความเชื่อมั่นร้อยละ 95 งานวิจัยนี้ได้ผ่านการพิจารณาจริยธรรมจากจุฬาลงกรณ์มหาวิทยาลัย

ผลการวิจัยพบว่า จากกลุ่มตัวอย่าง 398 คน มีอายุเฉลี่ย 35.01±8.265 ปี มีประสบการณ์การทำงานเฉลี่ย 9.91±6.82 ปี ร้อยละ 86.2% เป็นเพศหญิง ผู้มีส่วนร่วมการวิจัยส่วนใหญ่มีความรู้และทัศนคติในระดับปานกลาง ร้อยละ 66.1 และร้อยละ 73.9 ตามลำดับ มากกว่าครึ่ง (54.3%) รายงานว่ามีปัจจัยสนับสนุนในระดับปานกลาง ในจำนวนนี้พบว่ามีเพียงร้อยละ 12.8 เคยมีประสบการณ์ในการให้บริการสุขภาพสำหรับผู้ได้รับความรุนแรงบนฐานเพศภาวะ ในกลุ่มคนที่เคยมีประสบการณ์การให้บริการนั้นพบว่า ร้อยละ 24.9 มีการปฏิบัติในระดับที่สูง ร้อยละ 54.9 มีการปฏิบัติในระดับปานกลาง ร้อยละ 15.7 มีการปฏิบัติในระดับต่ำ ในส่วนของความสัมพันธ์พบว่า ปัจจัยที่มีผลต่อการให้บริการสุขภาพแก่ผู้ได้รับความรุนแรงบนฐานเพศภาวะ อย่างมีนัยยะสำคัญ ($P < 0.05$) คือ อายุ การศึกษา ประเภทโรงพยาบาล ตำแหน่งที่รับผิดชอบ ระดับความรู้ การเข้ารับการฝึกอบรมเรื่องความรุนแรงบนฐานเพศภาวะ การอบรมเกี่ยวกับการจัดการโรคติดต่อทางเพศสัมพันธ์ การอบรมสหสาขาวิชาชีพ และการอบรมทักษะการสื่อสาร นอกจากนี้ ผลการศึกษายังพบว่า บุคลากรที่สำเร็จการศึกษาในระดับประกาศนียบัตรจะให้บริการน้อยกว่าบุคคลที่สำเร็จการศึกษาระดับปริญญาบัณฑิต 3.768 เท่า บุคลากรที่ทำงานในโรงพยาบาลศูนย์มีแนวโน้มการให้บริการน้อยกว่าบุคคลที่ทำงานในโรงพยาบาลระดับชุมชน 69.6% แพทย์มีการให้บริการมากกว่าพยาบาลระดับปฏิบัติการ และบุคคลากรที่ผ่านการฝึกอบรมงานที่เกี่ยวข้องมีการให้บริการที่ดีกว่าบุคคลที่ไม่ผ่านการฝึกอบรม ข้อแนะนำจากงานวิจัยนี้ คือ การเพิ่มความพร้อมในการตอบสนองต่อความรุนแรงบนฐานเพศภาวะนั้น จำเป็นต้องมีการฝึกอบรมบุคลากรทางการแพทย์ในทุกระดับ และควรมีการเพิ่มพูนความรู้และการฝึกอบรมเกี่ยวกับความรุนแรงบนฐานเพศภาวะ

สาขาวิชา	สาธารณสุขศาสตร์	ลายมือชื่อนิสิต .....
ปีการศึกษา	2561	ลายมือชื่อ อ.ที่ปรึกษาหลัก .....

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KEYWORD: Knowledge Attitude Practices Health Care Gender-based violence

Aye Nyein Ei : Knowledge, Attitude and Health Care Practices for Gender-Based Violence Cases in Yangon, Myanmar. Advisor: MONTAKARN CHUEMCHIT, Ph.D.

Gender-based violence has negative impact on physical, psychological and social wellbeing of the survivor. The initial response can lessen the magnitude of the effect and thus the health care sector's readiness to response GBV cases is important. Hence, a study to explore the knowledge, attitude and practice level regarding GBV response among health care personnel was conducted.

A cross-sectional study was conducted in 48 public hospitals in Yangon, Myanmar during April and May 2019 involving 398 health care personnel (doctors and nurses). The measurement tool is self-administered structured questionnaires for demographic assessment, knowledge, attitude, supportive environmental factors and practice. Analysis of the variables was done using univariate, bivariate, and multivariate analysis at 95% confidence level. Ethical approval from Chulalongkorn University was obtained.

A total 398 participants (mean of age 35.01±8.265, mean of working experience 9.91±6.82), 86.2% accounting for female involved in this study. Most of the participants have moderate knowledge (66.1%) and attitude (73.9%) level. More than a half (54.3%) have the moderate level of supportive environmental factors. Among them, 0nly 12.8% have experienced practice and 87.2% have never experienced GBV management. Among those who have ever managed GBV cases, 29.4% have the high practice level, more than a half 54.9% have moderate and 15.7% have poor practice level. From the chi square tests, age, education (diploma, bachelor or master), workplace (the level of the hospital), working position (doctor/nurse, senior/junior), the level of knowledge, the completeness of GBV response training, STIs management training, multidisciplinary teamwork training and communication skills training are found to be associated with the level of practice on GBV response. And then from the binary logistic regression, the study found out that the health care personnel who got the diploma degree tend to do less practice then the higher education level, bachelor degree (OR=3.768, CI=1.854-7.659, p<0.001). The participants who are working in regional hospitals tend to have 69.6% less practice than those working in station hospitals. The medical officers and senior medical officers are found to have more practices than the junior nurses. Like that, the participants who already attended the GBV response training and STI management training had a better practice than who have not.

It is suggested that in order to raise the readiness for GBV response, the health care personnel of various working position should be trained for GBV response and their knowledge regarding GBV should be improved through specific trainings.

Field of Study: Public Health Student's Signature .....
Academic Year: 2018 Advisor's Signature .....

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Aye Nyein Ei

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List of Abbreviation

GBV	Gender-based violence
IPV	Intimate partner violence
LGBT	Lesbian, Gay, Bisexual and Transgender
PTSD	Posttraumatic stress disorder
OBGYN	Obstetrics and Gynecology
STI	Sexually transmitted diseases
EC	Emergency contraceptives
IUCD	Intra-uterine device
PEP	Post exposure prophylaxis
OSCC	One stop crisis center

CHAPTER 1: INTRODUCTION

The introduction describes the brief explanation about the gender-based violence, its magnitude as well as the reason for the researcher's intention to focus on the health care provision. The research objectives, hypothesis, framework, and operational definitions are also mentioned in this section.

1.1 Background and Rationale

Gender- based violence against women has been defined as "any act that results in, or is likely to result in physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life"[1].

Gender-based violence (GBV) includes all physical, sexual and psychological violence occurring within the family household or in the general community [1]. GBV varies from sexual harassment and domestic violence to sexual assault and human trafficking. It can be experienced in everywhere, anytime with various forms by both female, male or LGBTs [2, 3]. In 2002, the 49th World Health Assembly declares GBV as a priority public health problem [4].

Globally, 35% of women have experienced GBV and 7% of them have been sexually assaulted. The rate of intimate partner violence (both physical and sexual) and lifetime non-partner violence among women above 15 years old is reported according to the region. The data for the first category shows there are 37.7% for South-East Asia followed by 37% in Eastern Mediterranean, 36.6% in Africa, 29.8% in Americas, 25.4% in Europe, 24.6% I Western Pacific and 23.2% in high- income countries. The latter data describes that the high- income countries have the highest

rate (12.6%) and 11.9% for Africa, 10.7% in Americas, 6.8% in Western Pacific, 5.2% in Europe and 4.9% in South-East Asia [5].

In one small study conducted among 600 participants from five townships of Yangon Region, 19% said they have faced intimate partner violence and 53% mentioned they know women who have been violated by their family. And only 40% of the direct violence was reported [6]. Another study carried out among 286 women at Mandalay Region in 2005 reported that 69% of them have experienced domestic violence within 12 months before the study. Among them, 69% experienced psychological abuse and 27% includes physical violence and 93% of them did not respond for an action [6].

According to the data from the Ministry of Home Affairs, Myanmar, in 2016, there were 1100 total sexual assault cases for both adult and children (429 and 671 respectively). In 2017, the number rose to 1405 with 508 and 897 correspondingly [7]. Because of the rising number of cases, the Myanmar society is starting to aware the GBV cases, especially for sexual violence, in these years. But these are only the recorded cases. According to the study conducted among women from 24 countries, only 39.86 % of cases are reported in both formal and informal ways but the remaining percentage is not reported because of many reasons [8]. From the global rate of reporting, there must be unreported cases in Myanmar also.

A report form EI (Educational Initiatives) and AJAR (Asia Justice and Rights) stated that various types of supportive services for gender-based violence survivors exist in main townships and can be easily accessed by road. But the survivors from remote areas found difficulties to access those services due to lack of safe and secure transport services [6].

Among these various services, health care facilities can be their first choice to seek help from (6). But health service facilities are often lacking in gender sensitivity as the health care personnel will not consider the gender-based violence as a health problem and reluctant to give services for the survivors. Other reasons include limited resources and staff trained for this issue makes health care facilities to recognize the problem (6).

So, if the health care personnel in various regions including both urban and rural area are competent how to manage the health problems of GBV survivors may improve the rate of awareness and action about access to health care services. Strengthening the health care personnel's competence and service delivery for survivors is the most basic thing we can change for better response to gender-based violence (6).

The clinical care for a GBV survivor includes (i) informed consent which is an important first step to help increase the client's autonomy and confidence (ii) history taking and physical examination to determine what treatments should be given (iii) forensic specimen collection for legal support, (iv) prevention of pregnancy and diseases including STIs, HIV, Hepatitis B (v) psychosocial support with non-judgmental behavior and keeping confidentiality to support the disclosure of the client and referral to social services to support the client's ability to continue her life and (vi) follow-up visits to ensure the completeness and effectiveness of the treatments and support and (vii) referral .

There are some studies conducted in Myanmar about barriers to seeking help for survivors from GBV. But there are limited studies on the factors that can determine the capacity of health professionals on the health care for the GBV cases. Therefore, it

is important to explore knowledge, attitude, and practice of health care personnel on health care management towards GBV survivors, to be able to manage such cases and the results are hoped to be a supportive data for health system strengthening for the response of GBV cases.

1.2 Research Questions

- What are the sociodemographic characteristics, knowledge, attitude, and supportive environmental factors of health care personnel and health care practices for gender-based violence cases in Myanmar?
- Is there any association between the sociodemographic characteristics, knowledge, attitude, supportive environmental factors of health care personnel, and health care practices for gender-based violence cases in Myanmar?

1.3 Research Objectives

1.3.1 General Objective

- To examine knowledge, attitude, supportive environmental factors of health care personnel and health care practices for Gender-Based Violence Cases in Myanmar.

1.3.2 Specific Objective

- To determine the percentage of health care personnel who have experienced health care practices for survivors from gender-based violence in Myanmar.
- To describe the socio-demographic characteristics, knowledge, attitude, supportive environmental factors of health care personnel and health care practices for gender-based violence cases in Myanmar.

- To identify the association between the sociodemographic characteristics, knowledge, attitude, supportive environmental factors of health care personnel and health care practices for gender-based violence cases in Myanmar.

1.4 Research Hypothesis

Null Hypothesis

There is no association between the sociodemographic characteristics, knowledge, attitude, and supportive environmental factors of health care personnel and health care practices for gender-based violence cases.

Alternative Hypothesis

There is an association between the sociodemographic characteristics, knowledge, attitude, and supportive environmental factors of health care personnel and health care practices for gender-based violence cases.

1.5 Operational Definitions

a. **Gender-based violence**: Any act of gender-based violence which leads to, or may lead to, physical, sexual or psychological harm, against a person on the basis of gender or social role in a society or culture, GBV can be also experienced by men and LGBTs

b. **Health care personnel**: Health service providers from various fields and include nurses (junior nurse, senior nurse, and head nurse) and doctors (senior medical officer, medical officer, and house officer) working in emergency and out-patient departments at government hospitals

c. **Violence:** The premeditated use of force or the threat of its use against the self, another person, a group of persons, or society as a whole, which may lead to

serious injuries, death, harm, or growth problems. The definition is tied to premeditation upon the commission of the act, which differentiates it from injury or accidents. However, it is necessarily tied to causing harm

d. Victim: The person directly affected by violence

e. Survivor: The person who reacts actively and effectively towards the violence he /she is subject to

f. GBV cases: Both victim and survivor who is seeking help for GBV related illness

g. Abuse: whether physical, sexual, emotional or economic, or a combination of these, which may cause death, or which causes or may cause serious physical or psychological harm, or significant harm to a person's property

h. Perpetrator: a person, group or institution that commits violence or supports its commission, or assists other forms of abuse against others, in support of or against free will, other words used to give the same meaning: abuser, executioner, criminal.

i. Health care practices: All steps and procedures necessary to provide for GBV cases, listening and screening, informed consent, history taking and physical examination, forensic specimen collection, prevention of pregnancy and diseases, appropriate treatment and follow up, referral, psychosocial support

j. Health consequences: Health problems derived from GBV

k. Socio-demographic characteristics: The social and demographical facts of the service providers

l. Age: Age in years of the health care personnel

m. Sex: Sex of the service providers (male or female) as this can affect the comfortability of the survivor to disclose

n. **Education level**: The different educational attainment by the service providers ["Diploma in Midwifery and Nursing", "Bachelor of Nursing Science" (B.N.Sc), "M.B., B.S", or Post-graduate level]

o. **Workplace**: This include three level of hospitals, regional level (200-500 beds), township level (25-100 beds) and station level (16-25 beds)

p. **Working experience**: Total years of providing and practicing medical services to clients

q. **Position**: The level of working (senior medical officer, medical officer, house-surgeon, junior nurse, senior nurse, head nurse)

r. **Training**: Basic training, new training and refresher training on updated information and guidelines regarding managing GBV cases

s. **Gender sensitivities**: Accepting, recognizing and awareness that gender-based violence has health consequences

t. **Refusal to police case**: Refuse to provide care and management for a sexual assault survivor because of legal complications and unwanted witness position

u. **Guidelines/policies**: current direction and process on how to manage the sexual assault cases and the path to follow in the referral process

v. **Confidentiality**: Maintaining all information and records on history taking, physical examination, treatment provided and counseling as private (Ethical concern)

w. **Referral**: Appropriate referral to higher level care, mental health counseling services and other sectors such as social support or legal service

x. **Follow-up**: Proper appointment to recheck the improved health status and completeness of treatment course

1.6 Conceptual Framework

The conceptual framework is based on the knowledge-attitude-practice model by Schwartz 1976.

Knowledge means the capacity to acquire, retain and use information; a mixture of comprehension, experience, discernment, and skills. Attitude is defined as inclinations to react in a certain way to certain situations; to see and interpret events according to certain dispositions or to organize coherent and interrelated structures. The practice is the application of rules and knowledge that leads to action [9].

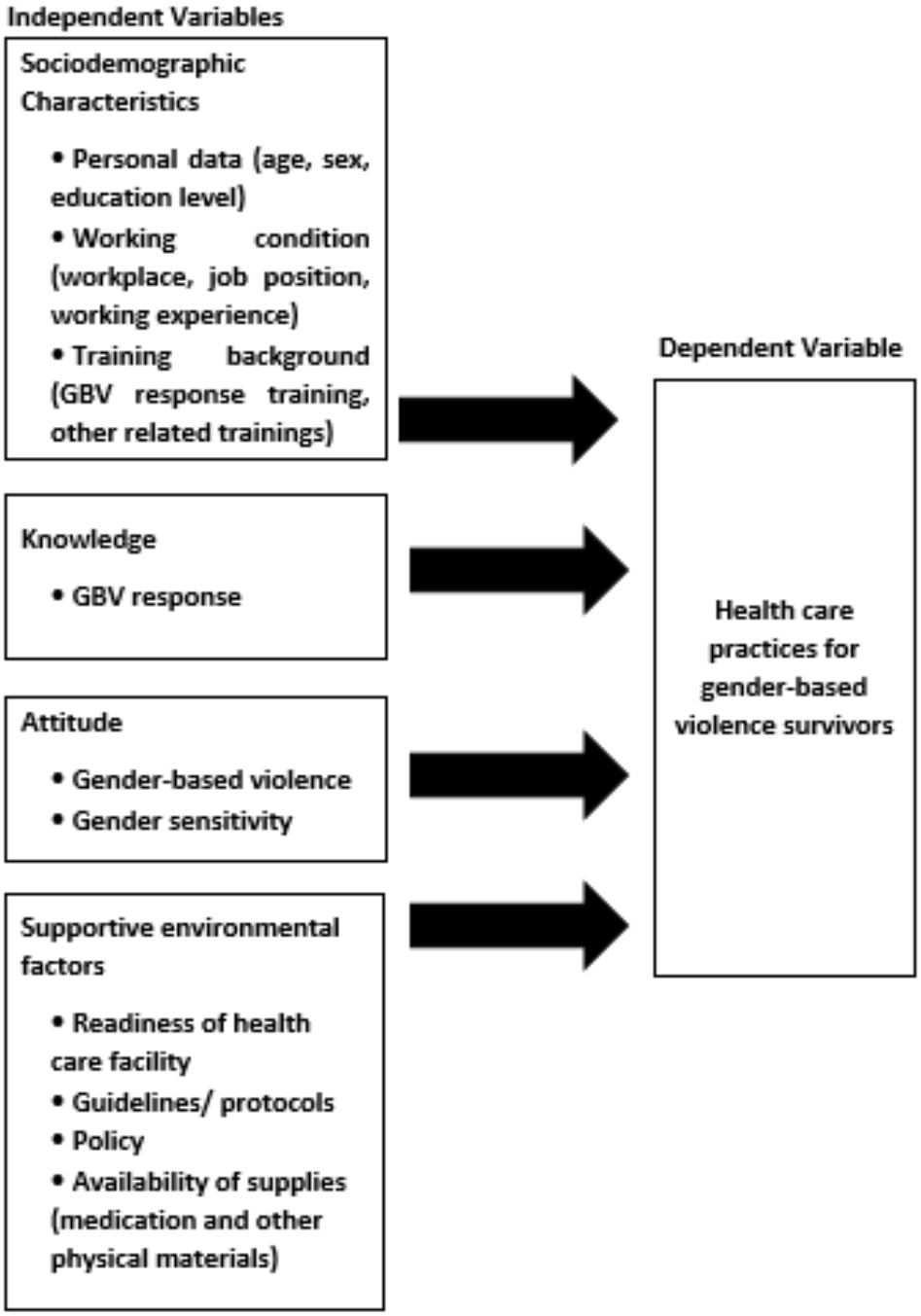


Figure 1: Conceptual Framework

CHAPTER 2: LITERATURE REVIEW

The literature review contains explanations about the various types of gender-based violence, its negative impact on health and the health service provision for GBV cases. This section also has a brief description of the health care system for GBV cases in Myanmar and some similar studies.

2.1 Definitions

Gender-based violence against women has been defined as “any act that results in, or is likely to result in physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life” [1].

There are two kinds of GBV, directly and indirectly. Direct violence includes 1.physical_violence in close relationships, sexual assault, sexual harassment, rape, exploitation ,slavery, human trafficking, forced marriages, child marriages, female genital mutilation, cyber exploitation or bullying and various forms of sexual abuse using the information or communication from technological resources 2.psychological_mocking, threats, humiliation, and controlling behaviors 3.economic violence_ deny access to financial resource, property, health care, education or labor market and denying from making economic decisions.

Physical violence is the intentional use of physical force with the potential for causing death, disability, injury, or harm. Physical violence includes, but is not limited to, scratching; pushing; shoving; throwing; grabbing; biting; choking; shaking; slapping; punching; burning; use of a weapon; and use of restraints or one’s body, size, or strength against another person [10].

Psychological abuse which includes behaviour that is intended to intimidate and persecute, and takes the form of threats of abandonment or abuse, confinement to the home, surveillance, threats to take away custody of the children, destruction of objects, isolation, verbal aggression, and constant humiliation [10].

Sexual violence is defined as any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home or work [11].

Intimate partner violence is defined as behaviors within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviors [12]. IPV is also used interchangeably with domestic violence.

2.2 Global and Local Situation

Globally, 15 million girls have experienced forced sex between age 15 and 19. In 38 low and middle-income countries, 17 million women said they have experienced forced sex in their adolescence [13]. The Cambodia Demographic and Health Survey in 2014 reported that 22% of women experienced physical or sexual violence and 6% have experienced sexual violence in their lifetime. The Indonesian National Women's Life Experience Survey in 2016 stated that 42% of ever-partnered women faced one out of four (physical, psychological, sexual or economic) forms of violence in their life and 33% accounted for physical or sexual violence. The Lao National Survey on Women's Health and Life Experiences 2014: A Study on Violence against Women

reported that non-partner sexual violence occurred in 5% of women and 1% of women have suffered forced sex in their lifetime [14].

According to Myanmar Demographic and Health Survey 2015-2016, ever-married women 15-49 who have ever experienced emotional, physical, or sexual violence committed by their husband accounted for 21% and women 15-49 who have ever experienced sexual violence since age 15 is 3% [15].

2.3 Impact on Health

The impact of gender-based violence on health may vary depending on the magnitude of the abuse, the personal data of the perpetrator (whether he is a stranger or not), the magnitude of physical injuries, the support of the survivor's family and friends and other sectors as health and legal systems [16] The health impact got from sexual assault ranges from physical illness to social problems. The physical illness includes musculoskeletal injury, soft tissue injury, genital organs trauma and other injuries, unwanted pregnancy, unsafe abortion which leads to increased maternal and fetal mortality, mental health problems as anxiety, hopelessness, helplessness, guilt and self-blame, fear and shame, mood swings, depression and substance abuse, social problems as victim blaming and community stigma which can lead to disability, suicide or death [5]. Women who faced violence have higher risks as twice to depression and alcohol abuse disorders, 16% to have low birth weight baby and 1.5 times to acquire HIV and to contact syphilis each [5]. The women experienced the violence can also experience other forms of socio-economic lost such as uncompleted education, stopping the status of participation in the economic workforce and bearing additional cost on health care [14].

2.4 Health Care Services for Survivors from Gender-Based Violence

Most of the victims of GBV represents these conditions; physical injuries such as cuts, fractures, burns, wounds, partial or permanent disability, ear/eye injury, dislocations; reproductive health problems such as STIs, HIV/AIDS, pregnancy complications (miscarriage, preterm delivery, low birth weight, fetal injury) or other gynecological problems; mental illness such as depression, anxiety, sexual dysfunction, eating and sleeping disorders, chronic conditions including chronic pelvic pain, persistent headaches, chest pain, irritable bowel syndrome, PTSD, anxiety disorders or fatigue [17].

The survivors usually seek help at primary health care services such as family planning clinics, antenatal care or STI clinics, secondary care such as polyclinic or hospitals in these potential departments like emergency, OBGYN, OPD, mental health/psychiatric, orthopedic, ENT (ear, nose, throat) and other government and non-government sectors, e.g. police, social welfare or women's support group [17].

Before assessing the suspected gender-based violence cases, ensuring that the patient is alone and in a private room where others cannot see or hear the patient is important. Then, the health care provider should carefully initiate a conversation by using the general statements about gender-based violence before asking about his/own experience. It is inappropriate to force the patient to talk about his/her own GBV experience. If the patient is crying during counseling, he/she should be given enough time [18].

Health care services for survivors from gender-based violence include:

a. Informed consent form

b. History taking and physical examination

c. Forensic specimen collection

d. Prevention of pregnancy and diseases including STIs, HIV, Hepatitis B

e. Psychosocial support

f. Follow up visits

g. Referral

Every health care personnel should obtain an informed consent form that gives information on every step of the following procedures to get the client's permission to perform those. Then the general health history and reproductive health history should be taken along with the physical examination including the pelvic and anal region. If the forensic specimen is to be collected, it would be done during the physical examination to promote the survivor's comfortability. The main things in the treatment process include injuries treatment, STIs prevention, prevention of pregnancy, anti-tetanus, prevention of HIV and Hepatitis B infection and psychosocial support and counseling. Follow-up visits should be also appointed to assess the completion and side effects of treatment and the improvement in health. Accessibility, security, cleanliness, privacy and proper documentation are the features of these services [19].

The health care personnel should know the rights of the survivor. He/she has the rights- to high-quality health care for both physical and psychological comfort, to receive respectful health care regardless of their age, sex , race, national or socioeconomic status, to privacy so that he/she should be examined and cared in a separate room, to be well informed about all options for the treatment, to confidentiality so that all medical and health information about her should be kept

even from the family members and to autonomy so that the survivor can choose the kind of care he/she wants. The health care personnel should not force the survivor to do anything that he/she does not want to do.

2.4.1 Obtaining Informed Consent [19]

Every health care personnel should obtain informed consent from the survivor before the management process starts. The informed consent must include every step of each process and the survivor's permission to perform those. She should be examined and cared in a separate room in order to keep confidentiality.

2.4.2 Health History and Physical Examination [19]

The history and physical examination are taken to decide which treatments should be given. They include past medical history, vaccination history, information on current medication and medication allergies, reproductive health history (last menstrual period, current contraceptive use, pregnancy and recent sexual history), information on violence (when did it take place, how long does it take, any vaginal or anal penetration, any use of physical force, any use of foreign object, how many assailants, whether the assailant is a stranger or not) and physical examination including thorough assessment on pelvic and anal region.

2.4.3 Forensic Specimen Collection [19, 20]

If the samples are to be collected, it should be within 72 hours as the passing of time can reduce the evidence considerably. The specimen should be collected during the physical examination so that the survivor does not need to be exposed repeatedly. The specimen collection sites include clothing, hair, nails, skin, mouth, blood, urine, sanitary pads/ tampons, genitalia and anus/ rectum. The samples and specimen must

be labeled accurately and handled carefully. All findings including injuries and emotional state should be written precisely in technical terminologies without the service provider's opinion.

2.4.4 Injuries Treatment [19]

Clean the wound or tears and suture if needed. Provide anti-tetanus according to the survivor's vaccination status.

2.4.5 Prevention of Pregnancy [21]

Emergency Contraceptive Pills

Dedicated ECP products (1.5mg LNG/0.75mg LNG) or Oral Contraceptive Pills as EC, Combined oral contraceptives (EE+LNG) where LNG=levonorgestrel EE=ethinyl estradiol

If the client vomits within 2 hours after taking drugs, give another dose gain.

Intra-uterine Devices as Emergency Contraceptives

Should be inserted within 5 days after unprotected sex. If the date of ovulation can be estimated, the IUCD can be inserted within 5 days after ovulation.

2.4.6 Prevention of STIs [22]

The most common infections acquired from sexual abuse include gonorrhea, chlamydia, trichomoniasis, syphilis, herpes simplex type 2 and human papillomavirus (HPV). The antibiotics are administered considering that the assailant has the infection and transmitted during the sexual violence. The antibiotics are given according to the guidelines.

2.4.7 Prevention of HIV Infection [13, 20, 23]

Post-exposure prophylaxis for HIV includes counseling, HIV testing, risk assessment, and prophylaxis treatment administration. It is not recommended for a survivor with known HIV positive. If the assailant's HIV status is unknown, all cases should be considered as positive. If the assailant is known to be HIV-negative, the prophylaxis is not needed.

The PEP should be started within 72 hours. If providing PEP is delayed, the service provider should weigh the benefits and risks of the administration. Any health care personnel can provide PEP without training according to the following guideline. The 4 weeks' regimen is proved to be protective.

Recommended regimen: Tenofovir (TDF)+3TC(Lamivudine)

The use of this regimen can encourage treatment completion [24].

2.4.8 Prevention of Hepatitis B [20]

Hepatitis B vaccine should be given to survivors of all unvaccinated or inadequately vaccinated. The vaccine must be given within 48 hours and not more than 14 days of exposure. If the client is fully vaccinated but the anti-HBs status is not known, test anti-HBs urgently.

2.4.9 Psychological Support

The psychological management also includes assessment, treatment and, follow-up. A private environment is required to promote open communication. The survivor should be treated with dignity and non-judgmental behavior. Explain the survivors that it is difficult to disclose the information and the information will remain confidential [13]. She should be reminded that this is the perpetrator's fault but not because of her

dressing manner or behavior. Thoroughly explain that if orgasm occurred during the assault, it is a physiological response and not to be guilty (12).

2.4.10 Follow-Up Visit [19, 20]

On follow-up visits, check the adherence and side effects of the medications and PEP regimens. Provide an additional supply of drugs as needed. Evaluate the condition of STI and mental health status. Check for the healing of the injuries and completion of treatment course for STIs. Re-evaluate the status of STIs and signs of pregnancy. Assess for the emotional and mental status and counsel if needed.

Checking status for HIV, Hepatitis B and Syphilis may be required to do again in the following 12 weeks and 6 months and complete the vaccination as needed.

2.4.11 Referral [20]

The survivors may need a certain amount of social support and it should be determined based on the individual status of each survivor. Social support services can help the survivor to feel less isolated, boost sharing experiences and build a supportive environment by themselves. Those services include mental health counseling, legal aid, shelters for survivors, financial and social service agencies.

2.4.12 Myanmar Context

In Myanmar, the Ministry of Health and Sports already had a well-formed guideline based on the WHO and UNFPA guidelines. The book contains five sections; background, initial support for the survivor from sexual or intimate partner violence, clinical care for a sexual violence survivor, psychosocial support and forensic specimen collection for legal support [25].

In the first section, the definitions, types, and forms of violence were explained along with the illustrations as well as the data and fallacies about GBV were described. The second section composed of the signs and symptoms of suspected violence victim/survivor, ways of interviewing the client about the client and the record keeping, and steps and guidelines for the initial support, “listen, inquire, validate, enhance safety and support”. The details of each step are explained in the following sections [25].

For clinical care, the book mentioned the importance of privacy, confidentiality, and respect for the dignity of the survivor. The following flow chart shows the detailed steps of clinical care for a female sexual violence survivor in Myanmar. Besides, the care for the elderly, male and child victims are also included in the guidelines [25].

The law on the support, care, and treatment for emergency conditions was declared in 2014. It states that everyone has a duty to help and support a client in emergency conditions and every health care facility must prepare for the needs for emergency health care as well as the multi-sectoral service provision including police, the local administrators and other organizations. In law, the financial statement was clearly mentioned. The transportation fees for any emergency cases can be claimed from the police department and the health care expenses can be claimed from the relevant township medical administration office [25].

These are some places that can be contacted; public or private hospitals, INGO clinics, Ministry of Social Welfare, Myanmar Women’s Affairs Federation, Myanmar Maternal and Child Welfare Association, and other legal, religious or community-based organizations [25].

The UNFPA described Myanmar's response to GBV as "initial, small scale response such as capacity building" in 2010 [17]. The OSCC center was opened in Naypyidaw 1000 Bedded Hospital on 26 February 2019 [26].

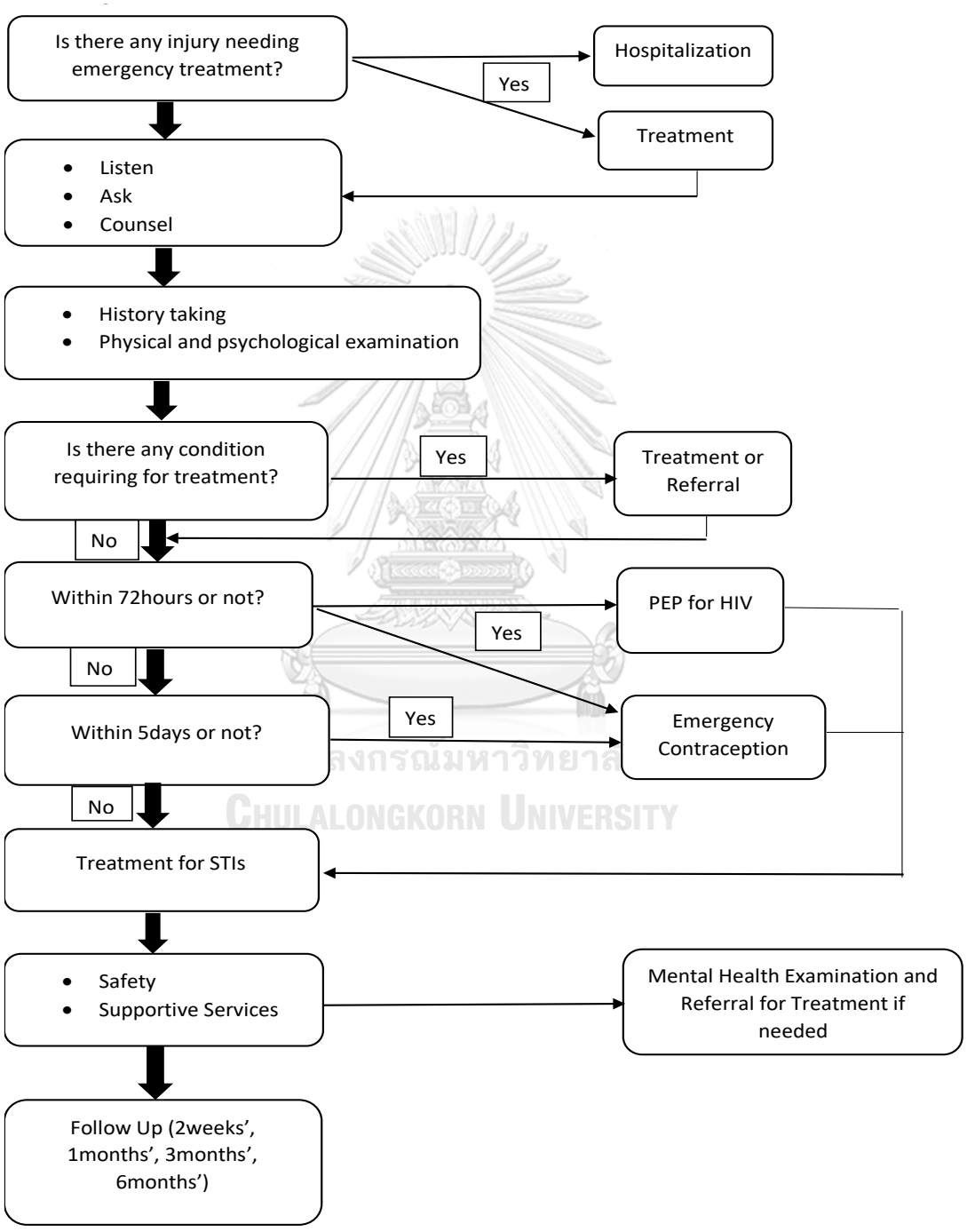


Figure 2: Clinical Management for a sexual violence survivor in Myanmar

2.5 Related Studies

The related studies show the various situation of service provisions, the knowledge, attitude and practices of health care providers towards GBV from some previous studies.

One qualitative study designed with in-depth interviews and focus group discussions were carried out among women clients seeking for RH services and the service providers in Yangon and Mandalay in 2015 by Population Service Myanmar.

It says that most of the health care providers accept that GBV has certain health consequences and the mutual trust between the client and the provider can encourage the disclosure of private life. But some service providers mentioned their lack of counseling capability concerning violence and some accept intimate partner violence as a usual problem between husband and wife.

From the view of clients, the trusting relationship with their health care providers, together with the providers' ability to support the survivors in choosing options and knowing their rights can enhance their care-seeking behavior [27].

One qualitative study carried by the Gender Equality Network Myanmar among gender-based violence survivors in October 2015 says places of services existing too far away to go, accessed services being unhelpful, and knowledge about how to seek services are the barriers in accessibility to services [28].

A cross-sectional study done at Emergency Department, Hospital Universiti Sains Malaysia in One Stop Crisis Centre (OSCC) to assess the knowledge, attitude and practice of towards rape victim claims that most of our emergency healthcare providers have adequate knowledge on rape management in OSCC, possess positive

attitudes towards rape victims as well as adhere to acceptable practices in management of rape victims in OSCC. But this study also shows some differences between the various groups of healthcare providers. In particular, despite the finding that the SNs group demonstrated better knowledge in OSCC care [29].

A cross-sectional study among 124 South African health care providers regarding post-rape care in 2007 states that trained service providers have more knowledge and higher knowledge is associated with the more appropriate attitude towards rape but not with the higher confidence. Health personnel working for a longer period has more confidence regardless of less knowledge [30].

A descriptive study among emergency nurses in Korea on awareness of abuse said that only 14.4% of suspected sexual and domestic violence were reported and the reasons for un-reporting included the case was not severe/ did not have sufficient evidence, too much workload and some answered that they don't know how to report/no action was taken after the reporting. Among the respondents, about 70% answered that they have to report for further legal actions but 45% didn't know whose duty to report [31].

In a qualitative study on barriers of health care provision in Iran, the participants described various barriers for providing services to the survivors. The survivor hiding the violence from the health care personnel because of trust issues, most survivors worrying about the virginity other than HIV/ STI transmission and the victims complaining unmet expectations such as hymenoplasty [32].

CHAPTER 3: RESEARCH METHODOLOGY

In this chapter, there are plans to conduct the study such as study design, study area, and population sampling and estimated budget.

3.1 Study Design

Quantitative cross-sectional study design was used in this study.

3.2 Study Area

This study was carried out in Yangon where the amount of reported cases of sexual assaults was the highest in Myanmar.

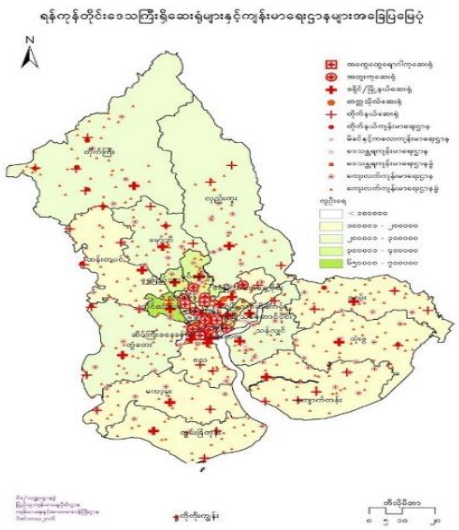


Figure 3: The location of Government Health Care Facilities in Yangon Region, Myanmar
Source: Ministry of Health and Sports, Myanmar

3.3 Study Population

Health care personnel, doctors and nurses in Yangon region in government setting.

3.4 Sample Size

Cochran formula will be used to calculate the sample size for this study.

n = desired number of sample size

z = the reliability coefficient at the 95% CI = (1.96)

p = the population proportion of health care personnel having good practice level to gender-based violence survivor in Yangon region (assumed to be 0.5)

d = expected error at 5% = 0.05

$n = Z^2 P (1-P)/ (d)^2$

$= 1.96^2 \times 0.5 (1-0.5)/0.05^2$

$= 384$

The calculated sample size was 422 (384+ 10% of expected refusals data).

p was assumed to be 0.5 (50%) to get the most appropriate sample size as the population was unknown and there was no similar study.

3.5 Sampling Technique

Multistage sampling technique was used.

First stage, the Yangon region was selected from 14 regions by purposive sampling as it had the highest reported sexual assault cases.

Second stage, 15 townships was selected from 45 townships by stratified sampling to cover the various levels of hospitals and to cover the sample size.

Third stage, among 15 townships, 4 have one regional level hospital each and the remaining 11 townships have 1 township level hospital and 3-6 station level hospitals from which 3 of them were randomly selected.

Regional Hospitals

1. West Yangon Hospital
2. East Yangon Hospital
3. Thingungyun General Hospital

4. North Okkalapa General Hospital

Township and Station Hospitals,

1. Hmawbi
2. Htantabin
3. Tike Kyee
4. Ton Te
5. Kayan
6. Dala
7. Thanlyin
8. Seik Gyi Kha Naung To
9. North Dagon
10. Dagon Myothit Seikkan
11. North Dagon Myothit were chosen randomly.

From 11 townships, every single township hospital was included and 3 station hospitals were randomly selected.

Fourth stage, participants eligible were selected by convenience sampling from each hospital. The estimated number of participants was about 20 from regional hospital, 10 from township hospital and 7 from station hospital which are about 15% of the total health service providers working in each emergency and OPD department.

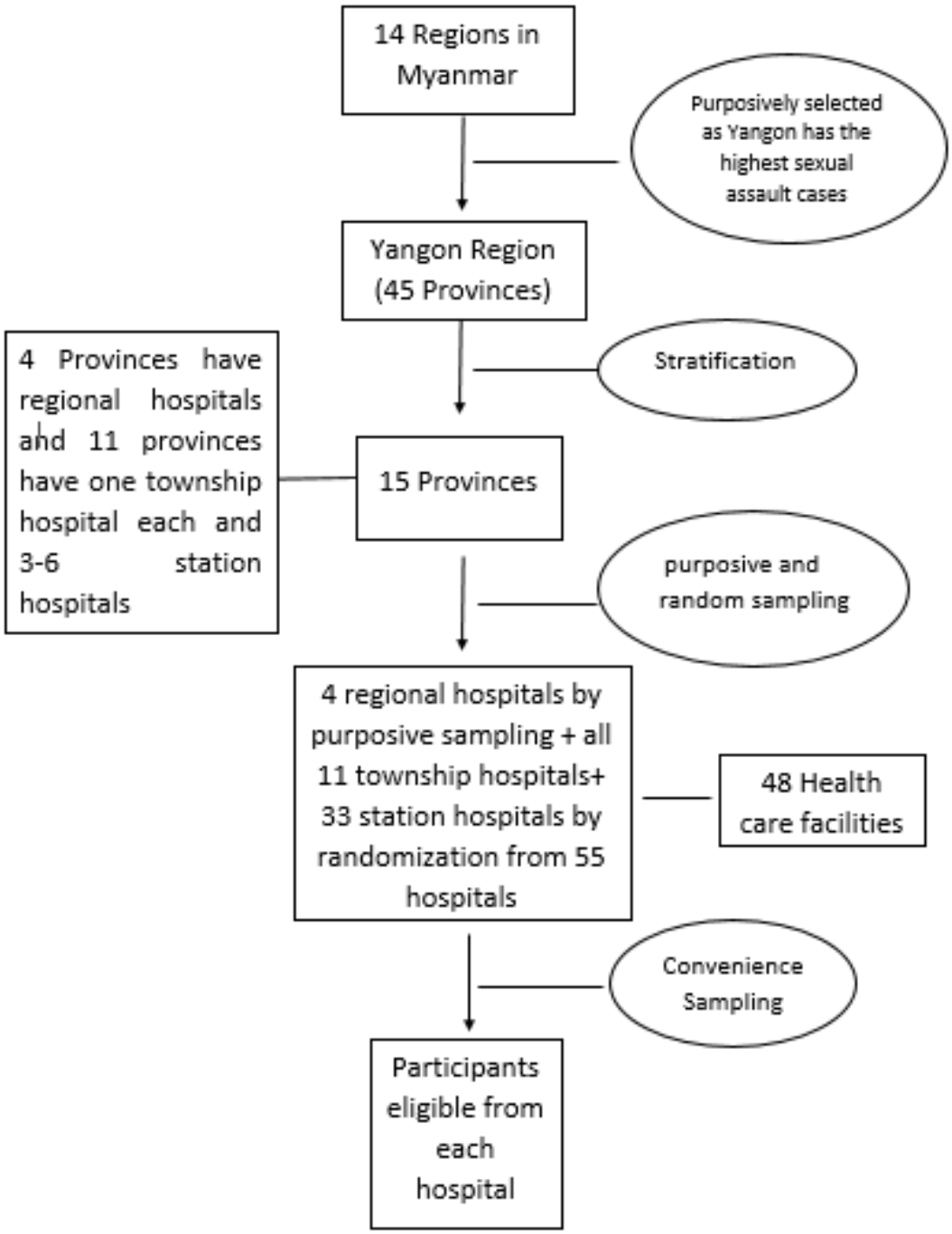


Figure 4: Flow Chart for Sampling

3.5.1 Inclusion Criteria

Male and female health care personnel, currently providing health care services in a hospital setting (emergency and out-patient department) in Yangon Region who were willing to participate and gave the written informed consent was included.

3.5.2 Exclusion Criteria

Health care personnel who works in the preferred health care setting less than six months were excluded.

3.6 Measurement Tools

The data was collected using self-administered structured questionnaires. The questionnaires were developed referring to many studies. The questionnaires had five sections;

a. Sociodemographic characteristics of the health care personnel

b. Knowledge on management of gender-based violence cases

c. Attitude towards the gender-based violence cases

d. Supportive environmental factors

e. Health care practices

3.6.1 Sociodemographic characteristics

This section included 10 questions about general information of the health care personnel on age, gender, education level, workplace, position in the job and the working experience in years and the background on training received. These variables were based on “The Harmonized Questionnaire for Sociodemographic Measures” [33].

3.6.2 Knowledge on health care for gender-based violence cases

This was about the information on the health care personnel's knowledge regarding the health care procedures for the gender-based violence survivor. There were 9 questions (Q.11-Q.19).

The answers were categorized into multiple-choice, a correct answer was given 1 score and the wrong answer was given 0. So, the total score was varied from 0-45 points.

Total scores were classified into three levels with Bloom's cut-off point. [34]

Level of Knowledge	**Cut off Point**	**Scores**
Low	<60%	<27
Moderate	60%-80%	27-36
High	>80%	>36

3.6.3 Attitude towards gender-based violence cases

This section contains 8 items (Q.20-Q.27) which allowed choosing between "Agree/Disagree/Neutral". The rating scale was measured as follows.

Positive Statements		**Negative Statements**	
Choice	Score	Choice	Score
Agree	3	Agree	1
Not sure	2	Not sure	2

Disagree	1	Disagree	3

Total attitude scores were classified into three levels with a cut-off point of the mean (SD). The standard point of the skill was the mean ± standard deviation. All participants' answer was accounted by the mean and standard deviation.

Negative attitude = point ≤ mean – SD (≤16)

Neutral attitude = mean – SD < point < mean + SD (17-21)

Positive attitude = point ≥ mean + SD (≥22)

3.6.4 Supportive environmental factors

This section contained 7 questions (Q.28-Q.34) to explore whether there are guidelines, policies, and readiness of materials required to manage gender-based violence cases in the workplace. The questions provided three responses "Yes/No/Not Sure" scoring 1 point for answering "Yes" and 0 points for "No" and "Not Sure".

The possible minimum score was 0 and the possible maximum score accounted for 7 points.

Total scores were classified into three levels with a cut-off point of the mean (SD). The standard point was the mean ± standard deviation. All participants' answer was accounted by the mean and standard deviation.

Low supportive environmental factors = point ≤ mean – SD (≤3)

Moderate supportive environmental factors = mean – SD < point < mean + SD (4-6)

High supportive environmental factors = point ≥ mean + SD (≥7)

3.6.5 Health care practices

This part was to explore the health care staff's experience in managing gender-based violence cases. There were 13 questions with two answers "Never or Yes". The respondents who answered 'yes' had to also categorize the practice into "always/ sometimes/ often /rare" along with the frequency.

The rating scale was as follows.

Practice	
Choice	**Score**
Never	0
Rare	1
Sometimes	2
Often	3
Always	4

Total practices scores were classified into three levels with a cut-off point of the mean (SD). The standard point of the skill was the mean ± standard deviation. All participants' answer was accounted by the mean and standard deviation.

Low level of practice = point ≤ mean – SD

Moderate level of practice = mean – SD < point < mean + SD

High level of practice = point ≥ mean + SD

3.7 Validity and Reliability

3.7.1 Validity Test

The questionnaire was developed by reviewing various literature and articles. Following that, a panel of three experts were invited to evaluate the content and construct validity of the questionnaire according to Item Objective Congruence Index (IOC). The criteria for IOC scoring are as follows;

- -1 means the wording and meaning of question is not consistent with operational definition and conceptual framework.
- 0 means uncertain whether the wording and meaning of question corresponds to operational definition and conceptual framework or not.
- +1 means the wording and meaning of question is consistent operational definition and conceptual framework.

The acceptable score is ≥0.5 and then questions will be revised accordingly [35].

The total IOC scores for the whole package of questionnaires was 0.94.

3.7.2 Pilot Test

The reliability of the questionnaire was examined by conducting a pilot test on 40 people who match with the inclusion criteria of the study. Then the Cronbach's alpha test will be run to test the reliability. The alpha value ranges from 0 to 1 and the acceptable value is ≥0.7. [36] The questions will be revised accordingly after the pre-test.

The questionnaires were pretested in 40 health care personnel from various hospitals in Myanmar excluding the Yangon region. The Cronbach's alpha results 0.783 for the

9 knowledge questions, 0.814 for 8 attitude questions, 0.741 for 7 items on supportive environmental factors and 0.792 for 13 practice questions.

3.8 Data Collection

Permission for conducting the study was requested from the Yangon Regional Health Department (Ministry of Public Health) and the Medical Superintendents from each hospital. With the official permission letter and the cooperation from the hospital administrates, the research team could initiate communication and approach with the potential participants.

The research team was included the researcher herself and three students from University of Medicine 2, Yangon, who were trained for explaining the information sheet and to answer any unclear points from the respondents.

After explaining the information regarding with the study, the participants were requested to sign in the written informed consent and then take part in the study.

Data collection was performed through self- administered questionnaires as the target population is the health care personnel who were already familiar with the terms.

Monitoring the completeness of data was performed by the trained research assistants by checking the coverage of response to each questions. All hospitals selected will be participated as the permission has given from the Regional administration.

3.9 Data Analysis

After data collection, all the data were entered, cleaned, coded and scored using SPSS version 22.0.

3.9.1 Descriptive Statistics

Descriptive statistics such as percentage, mean, standard deviation, median and range were used for analyzing the general characteristics of the respondents as well as knowledge, attitude, supportive environmental factors and practices.

3.9.2 Inferential Statistics

Bivariate analysis

Chi-square test was used to find out the relationship between the categorical variables and the level of practice in clinical management.

Pearson's chi-square test was used to find the association between the socio-demographic characteristics, training background of the respondents, level of knowledge, attitude, the situation of the supportive environmental factors and the level of practice on GBV response. Each independent variable was coded into categorical variables for bivariate analysis using Chi-square test. The Fisher's Exact test was used for those variables with a frequency less than 5 in more than 20% of cells.

Multivariate analysis

Binary logistic regression was used to construct the multivariate analysis model to find out the factors associated with Health Care Practices for Gender-based Violence Cases. The variables which had the value of $p < 0.2$ in bivariate analysis were selected for multivariate analysis.

3.10 Ethical Consideration

Ethical approval to conduct the research was obtained from the Ethical Review Committee of Chulalongkorn University. Permission to conduct the research in

selected provinces was taken from the District Medical Officer, the Township Medical Officer and the In-charges of selected hospitals. Then, the written consents will be taken from the respondents who are health care personnel from selected areas and willing to participate in the study. The privacy and confidentiality of the respondent information will be carefully kept up. The consent forms and the questionnaires will be kept apart after the interview so that it cannot be traced back to the participant's answer. The survey date and time will be chosen by the convenience of the respondents. As respondents' participation is voluntary, no compensation for participation in this study was done and the respondent can withdraw from participation with no complications. However, the researcher treated the respondents with water and snacks during answering the questions which may take about 10-20 minutes.

3.11 Limitation

There are some limitations to this study. As the GBV cases are rarely reported to health service facilities and due to limited time and budget, the practical part cannot be really observed. The practical skill of the health care personnel is determined through whether he or she knows the guidelines or not. The results will not be generalizable to the whole population as this study is focused only on Yangon Region.

3.12 Expected Benefit and Application

This research was expected to be useful for the health care personnel in increasing gender sensitivity, to provide baseline information in developing appropriate training models for strengthening their competencies in managing gender-based violence cases. Moreover, it also provided essential information for the researcher to conduct further study such as intervention studies among health care personnel.

Chapter 4: Results

In this study, a total 398 health care personnel took part as some of them refused to answer the questionnaire because they were uncomfortable or they were too busy to answer. The total sample size needed was 422 including 10% refusal data. But the minimum required amount was 384. So, the number covered the minimum number.

Part 1: Descriptive Findings

4.1 Socio-demographic Characteristics

Table 1 shows the socio-demographic characteristics of the health care personnel (doctors and nurses) who took part in this study. They are working in various positions at various public hospitals around Yangon Region, Myanmar. The mean age of the respondents was 35 years old with a range of 20-57. Most of the participants are aged between 31-40 accounted for 43.2% followed by 20-30 years of age (32.7%). The remaining respondents are 41-50 years old (20.4%) and 51-60 years old (3.8%). The majority of the participants are female (86.2%) and most of them are senior nurses (57%).

For the education level, only 6% of the respondents have completed the postgraduate level. Around 94% of them have the diploma and bachelor degree equally. The equal proportion of respondents worked at each level of hospitals; station, township and regional and most of them have worked for 1-10 years in total. The mean of the total years of working experience is 9.91 with a range of 1-34 years.

Concerning the training background, this study assessed four training regarding gender-based violence response, management of sexually transmitted infections,

multidisciplinary teamwork and communication skills. The vast majority, 94.5% and 92.5% of the participants responded that they have never attended the GBV response training and the multidisciplinary teamwork training respectively. For the training on management of STIs and the communication skills training, 34.9% said they have completed the former training and only about 20% have finished the latter one.

Table 1: Socio-Demographic Characteristics of the Participants

Socio-demographic Characteristics (n=398)	**Number (n)**	**Percentage (%)**
Age (Years)		
20-30	130	32.7
31-40	172	43.2
41-50	81	20.4
51-60	15	3.8
Mean (±Std. Deviation)	35.01 (±8.265)	
Median	35.00	
Minimum	20	
Maximum	57	
Std. Deviation		
Sex		
Male	55	13.8
Female	343	86.2

Education Level		
Diploma	186	46.7
Bachelor	188	47.2
Master	24	6.0
Workplace		
Station	138	34.7
Township	127	31.9
Regional	133	33.4
Job Position		
Junior Nurse	79	19.8
Senior Nurse	227	57.0
Head Nurse	17	4.3
Medical Officer	30	7.5
Senior Medical Officer	45	11.3
Working Experience (Total Period since Graduation)		
1-10	222	55.8
11-20	139	34.9
≥21	37	9.3

Mean (±Std. Deviation)	9.91 (±6.82)
Median	9.00
Minimum	1
Maximum	34

Ever attended a training on gender-based violence response		
No	376	94.5
Yes	22	5.5
Ever attended a training on management of STIs		
No	259	65.1
Yes	139	34.9
Ever attended a training on the multidisciplinary teamwork		
No	368	92.5
Yes	30	7.5
Ever attended a training related to communication skill		
No	317	79.6
Yes	81	20.4

Knowledge of the Participants towards GBV Cases

The knowledge was assessed using 9 questions which included one statement and five answers. The respondents had to choose whether each answer is right or wrong. Each

correct answer is given one score and the score ranges from 0-45. The level of knowledge is determined as low if the score is less than 60% of the total score (0-26), moderate between 60-80% of the total score (27-36) and high if the respondent gets more than 80% of the total score ((37-45). Table 2 shows the level of knowledge of the health care personnel towards GBV cases. Around 28% of the respondents have a high knowledge level, majority of them shows the moderate while 5.5% have low knowledge level.

Table 2: Respondents by Level of Knowledge towards health care for GBV Cases

Level of Knowledge (n=398)	**Number (n)**	**Percentage (%)**
Low (<60%) (0-26)	22	5.5
Moderate (60-80%) (27-36)	263	66.1
High (>80%) (37-45)	113	28.4
Mean	34.07±4.348	
Minimum	18	
Maximum	42	

Attitude of the Participants towards GBV Cases

Table 3 represents the level of attitude among health care personnel. The mean score of attitude is 18.65 with the standard deviation of 2.313. The level of attitude is defined with the score 0-16 as negative, 17-21 as neutral and 22-24 as positive attitude. According to the frequency distribution, 17.1% of the participants have a negative attitude, 73.9% are neutral and only 9% of them have a positive attitude.

Table 4 shows the responses for each attitude statement. 63.3% of the respondents accepted that sex workers can also experience sexual violence. 7% of the health care staff disagreed and about 80% of them agreed that rape case is serious and urgent. The majority 83.4% of the respondents admitted that GBV can be happened to all gender other than only females. The results indicated that nearly 60% of the respondents thought the patient should follow every procedure according to the service provider's decision while only 17.6% thought of the patients' right for autonomy.

Table 3: Respondents by Level of Attitude towards GBV Cases

Level of Attitude	**Number (n)**	**Percentage (%)**
Negative (0-16)	68	17.1
Neutral (17-21)	294	73.9
Positive (22-24)	36	9.0
Mean (±Std. Deviation)	18.65±2.313	
Minimum	12	
Maximum	24	

Table 4: Respondents by Attitude towards GBV Cases

Statement (n=398)	**Disagree n(%)**	**Not Sure n(%)**	**Agree n(%)**
1. Health providers have the responsibility to interview clients with musculoskeletal injuries about the violence.	50 (12.6)	83 (20.9)	265 (66.6)

2. Domestic violence is a private matter. No third party should not interfere.*	224 (56.3)	76 (19.1)	98 (24.6)
3. The client might feel offended if you ask them directly about the domestic violence.	53 (13.3)	189 (47.5)	156 (39.2)
4. A sex-worker cannot be a victim of sexual violence.*	252 (63.3)	117 (29.4)	29 (7.3)
5. A client complaining insomnia can be a GBV victim.	121 (30.4)	205 (51.5)	72 (18.1)
6. A rape case is a serious case and need urgent care.	28 (7)	51 (12.8)	319 (80.2)
7. The gender-based violence can be experienced by all males, females and LGBTs. (lesbians, gays, bisexuals, trans-genders)	21 (5.3)	45 (11.3)	332 (83.4)
8. survivor has to follow all treatment procedures as the service provider is doing for his/her own benefit.*	70 (17.6)	91 (22.9)	237 (59.5)

Negative Statement

Supportive Environmental Factors

The supportive environmental factors contain facilities and infrastructures such as guidelines/protocols for GBV response, required documents, room for GBV counselling, HIV test kit and essential medications.

The table 5 shows the level of the completeness of supportive environmental factors. The mean score is 4.29 and the standard deviation is 1.643. The level is high with the score 7, moderate if 4-6 and low between 1-3.

About 40% of the participants answered that they have protocol/ guideline for GBV cases in their workplace and the record form for post-rape care. Nearly 90% of the participants answered that their workplace has a private room for counselling and physical examination. The vast majority 92.5% said there is HIV test kit and 61.3% answered they have emergency contraceptive pills in their workplace. More than a half (56.5%) of the participated health care personnel said they are not sure that they can claim the cost for post-rape care from the relevant health administrators although the Ministry of Health have already mentioned that they can in the GBV guideline. To refer a GBV patient for psychosocial support, 59% of the participants answered that they know where to contact while 41% don't know. The details were shown in table 6

Table 5: Respondents by Level of Supportive Environmental Factors

Level of Supportive Environmental Factors	**Number (n)**	**Percentage (%)**
Poor (1-3)	140	35.2
Moderate (4-6)	216	54.3
High (7)	42	10.6
Mean (±Std. Deviation)	4.29±1.643	
Minimum	0	
Maximum	7	

Table 6: Respondents by Supportive Environmental Factors

Statement (n=398)	**No/Not Sure n (%)**	**Yes n (%)**
1. Protocol or guideline regarding the management of GBV survivor is available in your workplace.	228 (57.3)	170 (42.7)
2. Do you have a private room (i.e. the patient cannot be heard or seen from outside) for history taking and physical assessment in your department?	40 (10.1)	358 (89.9)
3. Record form for history taking and physical examination for sexual violence survivor is available in your workplace.	239 (60.1)	159 (39.9)
4. Do you have rapid diagnostic test kit for HIV in your workplace?	30 (7.5)	368 (92.5)
5. Can you provide health care to a rape victim free of charge and then claim back from the relevant health administrators?	225 (56.5)	173 (43.5)
6. Do you have emergency pills (which is not expired) in handy?	154 (38.7)	244 (61.3)
7. Do you know any contact to refer a survivor for psychosocial support?	163 (41)	235 (59)

Health Care Practices

For the practice on GBV case management, only 12.8% of the participants had experience within the past two years. Among them 2.3% have experienced four cases,

1.5% have experienced 3 cases, 3% have experienced 2 cases and 6% have experienced managing only one case. The cases include 73 sexual violence (i.e. rape), 11 physical violence, 9 physical and sexual violence, 4 psychological and sexual violence, 4 physical and psychological violence and 1 psychological violence. The type of cases, gender of the survivors and the type of perpetrators were presented in table 8.

Table 7: Respondents by Experience of GBV Response and Number of Cases Managed

Have you ever experienced managing a GBV case within last two years? (n=398)	**Yes** **n** **(%)**	**No** **n** **(%)**	**Number of cases**	**Number (n)**	**Percentage (%)**
	51 (12.8)	347 (87.2)	0	347	87.2
			1	24	6.0
			2	12	3.0
			3	6	1.5
			4	9	2.3

Table 8: Types of Managed Cases

n (%) N=102	Sexual Violence	Physical Violence	Psychological Violence
73 (71.57)	√		
11 (10.78)		√	
9 (8.82)	√	√	
4 (3.92)	√		√
4 (3.92)		√	√
1 (0.98)		√	

Table 9: Details of Managed Cases

Type of Cases (N=102)	Number of Cases n (%)	Gender of Survivor		Type of Perpetrator			
		Male	Female	Unknown	Stranger	Intimate Partner	Family Member
Sexual Violence	73 (71.57)	1	72	7	64	2	-
Physical Violence	11 (10.78)	-	11	-	-	9	2

Physical and sexual violence	9 (8.82)	-	9	-	6	3	-
Psychological and sexual violence	4 (3.92)	-	4	-	4	-	-
Physical and psychological violence	4 (3.92)	-	4	-	2	1	1
Psychological violence	1 (0.98)	-	1	-	1	-	-

Among them (n=51), 29.4% of them had good, 54.9% had moderate and the 15.7% had poor practice level.

Table 10: Respondents by Level of Health Care Practices

Level of Health Care Practices	**Number (n)**	**Percentage (%)**
Poor	8	15.7
Moderate	28	54.9
High	15	29.4

Mean (±Std. Deviation)	12.90±7.452
Minimum	0
Maximum	34

Among the participants who have experienced GBV response, 27.5% of participants have never screened the injured patients for suspected GBV and 88% have not used a GBV protocol. But 33% of them always ask an injured patient for proposing GBV and 11.8% of the participant have ever used a GBV protocol.

For the question to assess maintaining the confidentiality of the patient, 68.6% of the respondents answered that they have taken history of a GBV patient with a family member staying near them and have explained about the health care procedures before providing to the patient. Among 51 participants, 68.6% haven ever given counselling for HIV testing and post-exposure prophylaxis for HIV infection to a GBV patient. Next, only 9.8% of them answered that they always call a GBV patient for follow-up and further treatment.

In liaising a GBV patient for social and legal support, only 9.8% of the respondents have assisted for legal support and only 17.7% have helped for social support such as contacting the non-governmental organizations. The respondents said that some cases were referred to the hospital for medical treatment from social organizations.

Table 11: Respondents by Health Care Practices for GBV Cases

Statement (n=398)	Number (n)	Percentage (%)
1. Ever asked an injured patient for suspected GBV		
Never	14	27.5
Rare	4	7.8
Sometimes	13	25.5
Often	3	5.9
Always	17	33.3
2. Ever used a GBV protocol		
Never	45	88.2
Rare	1	2.0
Often	1	2.0
Always	4	7.8
3. Ever spent time to console or calm a GBV survivor who is hysterical or crying		
Never	16	31.4
Rare	2	3.9
Sometimes	9	17.6
Always	24	47.1
4. Ever taken history of a GBV client at the presence of his/her family member*		
Never	16	31.4
Rare	1	2.0
Sometimes	15	29.4
Always	19	37.2

5. Ever given enough time listening to a GBV client and pay attention about the details of the violence

Never	4	7.8
Rare	6	11.8
Sometimes	10	19.6
Often	1	2.0
Always	28	54.9

6. Ever briefed the GBV cases regarding the health care procedures

Never	24	47.0
Rare	4	7.8
Sometimes	4	7.8
Always	19	37.3

7. Ever counsel a GBV client for HIV testing and post-exposure prophylaxis

Never	35	68.6
Rare	6	11.8
Sometimes	4	7.8
Always	6	11.8

8. Ever made an appointment for follow-up with a GBV survivor

Never	32	62.7
Rare	5	9.8
Sometimes	4	7.8
Always	10	19.6

9. Ever involved in referring a GBV survivor for legal support (e.g. informing the

police)		
Never	38	74.5
Sometimes	8	15.7
Always	5	9.8
10. Ever involved in referring a GBV survivor for social support (e.g. contacting with women's support organizations)		
Never	42	82.3
Rare	1	2.0
Sometimes	6	11.8
Always	2	3.9
11. Ever made sure that the survivor was in a safe place (e.g. in a shelter)		
Never	39	80.4
Rare	1	2.0
Sometimes	7	13.7
Always	2	3.9

Negative Statement

Part 2: Bivariate Analysis

Association between Socio-Demographic Characteristics and Health Care Practices for Gender-Based Violence Cases

Table 11 shows the association between socio-demographic characteristics and health care practices on GBV patients in the past two years.

The health care practices for GBV was not associated with the age (p=0.165) and sex (p=0.514).

The health care practice towards GBV cases is found to be associated with the education level (p-value=0.001). More health care personnel who are the diploma degree holders had no experience on GBV practice (50.4%) followed by the bachelor degree holders (43.8%). On the other hand, the bachelor degree holders tend to have more experience on health care for GBV cases (70.6%).

Another factor associated with the health care practices is the workplace. More participants working in the township hospitals have no experience on health care practice for GBV response comparing with those working in the station and the regional level. Among the participants who have experience GBV response, 47.1% were from the station level hospital, 37.3% were from the township level and 15.7% are from the regional level hospitals.

The job position was also associated with the health care practices ($p<0.001$). The participants who had health practices on GBV response were 37.3% senior nurses, 25.5% senior medical officers, 19.6% medical officer and 17.6% junior nurses.

The working experience was not found affecting the health care practices (p=0.762).

The GBV response training (p=0.001), STIs management training ($p<0.001$) and multidisciplinary teamwork training (p=0.040) were found to be associated with the health care practices.

Table 12: Association between Socio-Demographic Characteristics and the Health Care Practices

Socio-demographic Characteristics (n=398)	**Health Care Practices n (%)**		**P-value**
	No	**Yes**	
Age (Years)			
20-30	118 (34.0)	12 (23.5)	
31-40	146 (42.1)	26 (51)	0.165
41-50	72 (20.7)	9 (17.6)	
51-60	11 (3.2)	4 (7.8)	
Sex			
Male	46 (13.3)	9 (17.6)	0.514
Female	301 (86.7)	42 (82.4)	
Education Level			
Diploma	175 (50.4)	11 (21.6)	0.001*
Bachelor	152 (43.8)	36 (70.6)	

Master	20 (5.8)	4 (7.8)	
Workplace			
Station	114 (32.9)	24 (47.1)	
Township	108 (85.0)	19 (37.3)	0.013*
Regional	125 (36.0)	8 (15.7)	
Job Position			
Junior Nurse	70 (20.2)	9 (17.6)	
Senior Nurse	208 (59.9)	19 (37.3)	
Head Nurse	17 (4.9)	0 (0.0)	#<0.001*
Medical Officer	20 (5.8)	10 (19.6)	
Senior Medical Officer	32 (9.2)	13 (25.5)	
Working Experience (Total Years)			
1-10	194 (55.9)	28 (54.9)	#0.762

11-20	122 (35.2)	17 (33.3)	
21-30	29 (8.4)	6 (11.8)	
31-40	2 (0.6)	0 (0.0)	
GBV Response Training			
No	334 (86.3)	42 (82.4)	#0.001*
Yes	13 (3.7)	9 (17.6)	
STI Management Training			
No	238 (68.6)	21 (41.2)	<0.001*
Yes	109 (31.4)	30 (58.8)	
Multidisciplinary Teamwork Training			
No	325 (93.7)	43 (84.3)	#0.040*
Yes	22 (6.3)	8 (15.7)	

Communication Skills Training			
No	280	37	
	(80.7)	(72.5)	0.193
Yes	67	14	
	(19.3)	(27.5)	

#***Fisher's Exact Test***

****P-value<0.05***

Association between Level of Knowledge and Health Care Practices

According to the results, the level of knowledge is significantly associated with the level of health care practices. All participants with low level of knowledge (6.3%) had no practice. The participants with moderate level of knowledge tend to have more practices (58.8%).

Table 13: Association between Level of Knowledge and Health Care Practices

Level of Knowledge (n=398)	**Health Care Practices n (%)**		**P-value**
	No	**Yes**	
Low	22	0	
	(6.3)	(0.0)	
Moderate	233	30	0.029*
	(67.1)	(58.8)	
High	92	21	
	(26.5)	(41.2)	

****P-value<0.05***

Association between Level of Attitude and Health Care Practices

According to the results, the level of attitude is not significantly associated with the level of health care practices.

Table 14: Association between Level of Attitude and Health Care Practices

Level of Attitude (n=398)	Health Care Practices n (%)		P-value
	No	Yes	
Low	60 (17.3)	8 (15.7)	0.907
Moderate	255 (73.5)	39 (76.5)	
High	32 (9.2)	4 (7.8)	

Association between Level of Supportive Environmental Factors and Health Care Practices

According to the results, the level of supportive environmental factors is not significantly associated with the level of health care practices.

Table 15: Association between Level of Supportive Environmental Factors and Health Care Practices

Level of Supportive Environmental Factors (n=398)	Health Care Practices n (%)		P-value
	No	Yes	
Poor	125 (36.0)	15 (29.4)	0.562
Moderate	187 (53.9)	29 (56.9)	
High	35 (10.1)	7 (13.7)	

Part 3: Multi-variable Logistic Regression Analysis

Binary logistic regression was used to find out whether there is statistically significant relationship between the dependent variable and the independent variables which have p-value less than 0.2 in bivariate analysis.

Binary Logistic Regression Analysis for the Association between Socio-demographic Characteristics and Health Care Practices for Gender-Based Violence Cases in the Past Two Years

Table 15 shows the binary logistic regression analysis of each independent sociodemographic characteristic variable associated with health care practices for GBV cases in the past two years. Eight variables which have p-value less than 0.2 (age, education level, workplace, job position, completion of GBV response training, STI management training, multidisciplinary teamwork training and communication

skills training) were put into logistic regression analysis to find association with the health care practices. The level of knowledge (p=0.290), the level of attitude (p=0.907) and level of supportive environmental factors (p=0.562) were left as they were found not to be significantly associated with the health care practices in the chi-square test. After the first step of logistic regression the variables which have p-value 0.05 were excluded from the analysis to get the final model as below.

From the results, the education level is found to be positively associated with the health care practices (p-value<0.001). Health care staff with a bachelor degree tended to have 3.768 times more practice (p<0.001).

The workplace is also found to be negatively associated with the health care practices. The participants who are working in the regional hospitals have 69.6% less likely to have practice than those who were working in the station level hospitals (p=0.005).

Another association factor is the job position. The medical officers have 3.889 times and senior medical officers have 3.16 times more practice than the junior nurses. But there is no difference between the experiences of junior nurses, senior nurses and head nurses.

The completion of attending GBV response training, STI management training and multidisciplinary teamwork training are also associated with the health care practices level (p-value<0.001). The participants who have completed the GBV response training have 5.505 times likelihood to have more practice The participants who have completed the STI management training have 3.119 times likelihood to have more practice. The multidisciplinary teamwork training attended participants tended to have 2.748times more practice for GBV patients.

The knowledge was combined into two levels, low and moderate as the low level of knowledge and the high level of knowledge. The health care personal with high knowledge level tends to have 1.94 times more practice than the participants with low and moderate level of knowledge.

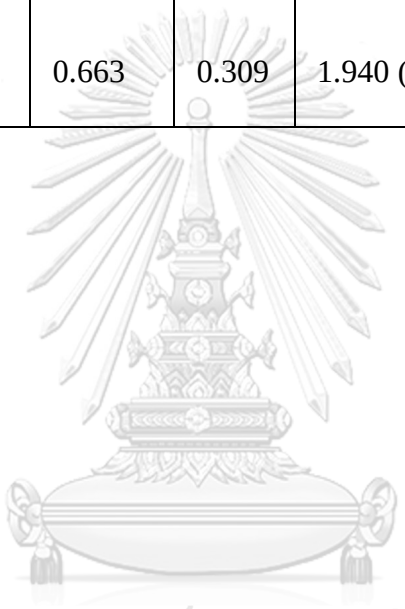
Table 16: Binary Logistic Regression Analysis of Socio-demographic Characteristics associated with Health Care Practices for GBV Cases in the Past Two Years

Variables	Health Care Practices			
	B	S.E	Crude OR (95% CI)	P-Value
Age Group				
20-30 (ref:)				0.183
31-40	0.560	0.370	1.751 (0.847-3.618)	0.130
41-50	0.206	0.466	1.229 (0.493-3.062)	0.658
51-60	1..572	0.658	3.576 (0.985-12.981)	0.053
Education Level				
Diploma (ref:)				<0.001*
Bachelor	1.327	0.362	3.768 (1.854-7.659)	<0.001
Master	1.157	.630	3.182 (0.926-10.933)	0.066
Workplace				
Station (ref:)				0.019*
Township	-0.180	0.335	0.836 (0.433-1.612)	0.592
Regional	-1.191	0.428	0.304 (0.131-0.704)	0.005

Job Position				
Junior Nurse (ref:)				<0.001*
Senior Nurse	-0.342	0.428	0.710 (0.307-1.643)	0.424
Head Nurse	-19.152	9748.22	0.000 (0.000)	0.998
Medical Officer	1.358	0.525	3.889 (1.390-10.877)	0.010
Senior Medical Officer	1.150	0.483	3.160 (1.225-8.148)	0.017
Ever attended GBV Response Training				
No (ref:)				<0.001*
Yes	1.706	0.464	5.505 (2.220-13.656)	<0.001
Ever attended STIs Management Training				
No (ref:)				<0.001*
Yes	1.138	0.307	3.119 (1.709-5.695)	<0.001
Ever attended Multidisciplinary Teamwork Training				
No (ref:)				<0.001*
Yes	1.011	0.444	2.748 (1.152-6.557)	0.023

Ever attended Communication Skills Training				
No (ref:)				<0.001*
Yes	0.458	0.342	1.581 (0.809-3.091)	0.180
Level of Knowledge				
Low and Moderate				<0.001*
High	0.663	0.309	1.940 (1.058-3.558)	0.032*

*p-value<0.05



Chapter 5: Discussion, Conclusion and Recommendation

5.1 Discussion

This cross-sectional study was conducted on 398 health care personnel (doctors and nurses) who are working in various levels of hospitals in Yangon Region, Myanmar. The total sample size needed was 422 including the 10% refusal data. The minimum sample size required was 384. So, the collected sample size covers the minimum requirement. This study was carried out to describe the socio-demographic characteristics of the health care personnel, their knowledge, attitude, health care practices for GBV cases and the association between these independent variables and the dependent variable (health care practices).

The principal finding of the health care practices for GBV cases among 398 health care personnel indicated that only 12.8% (n=51) had ever managed GBV cases and 6% of them have managed only one case within the past two years. The maximum cases encountered was 4 cases. Most of the cases are the rape cases. This is because Myanmar community sees only rape cases as GBV and need medical attention, but other forms of GBV as normal [28]. A similar study conducted in Turkey had more, 66.1% of doctors and nurses who have experienced at least one intimate partner violence patient as professional experience[37].

Among them (n=51), 29.4% of them had good, 54.9% had moderate and the 15.7% had poor practice level on GBV response within previous two years. However, from the scoring 0-34 points, the mean score was 12.90±7.452 which indicates that even the participants in this study got high practice level, the score for the practice is low and they didn't practice well in the real situation. This finding matches with the study conducted by Gender Equality Network, which said that in Myanmar health system,

there is no established GBV response program and the services are more focusing on the forensic medicine rather than the GBV specific response [28].

For awareness of GBV screening, 27.5% of the respondents answered that they never asked for suspected GBV for an injured patient and only 11.8% had ever used a GBV protocol. However, another study conducted among 215 Turkish nurses and physicians showed a reverse result that 63.9% of them screened for an injured patient for intimate partner violence and 25% of them did screening as a routine procedure[37]. In another study in Oxfordshire among 692 health care workers, only 3% have ever used a protocol for domestic violence which is much lower than the rate in this study [38].

For the confidentiality of the patients, 68.6% had taken health history of a GBV patient with the presence of their family member every time. Only 31.4% of the health care personnel who have experienced GBV management never let another person to be around during the history taking.

For the communication skills, about 54.9% of the health care personnel had always given enough time and attention listening to a GBV patient and 31.4% had briefed about the health care procedures to the patient for informed consent.

Among the respondents, only 31.4% had ever counselled a GBV client for post exposure prophylaxis for HIV transmission. Nearly 70% of the respondents who have experienced the GBV management have never counseled for PEP. Excluding the physical and psychological abuse which are not in need for the PEP, the rate is still low comparing with the number of sexual violence cases described in section 4.5, health care practices. In the National Strategic Plan on HIV and AIDS- Myanmar (2016-2020), the plan for post exposure prophylaxis was mentioned. But there so very

limited implementation program [39]. A similar study in Guinea in 2012 said only 11% of the health care personnel have given post-exposure prophylaxis to a rape survivor which has a bit higher percentage comparing with this study [40].

For legal and social support, around 3% of the health care personnel had ever referred to the relevant organization. But from the informal conversation with the participants, they said most cases go to the police or NGOs from which referred to the hospital, so that the respondents did not need to refer.

5.1.1 Socio-demographic Characteristics

In this study, the majority of the respondents were age between 31-40 years old and 86.2% were female. Only a few proportion of the participants had completed the master degree and around 47% were diploma and bachelor degree holders.

They were from various levels of hospitals (station, township and regional) in Yangon Region, Myanmar. The vast majority were the senior nurses and the other positions included were junior nurses, head nurses, medical officers and senior medical officers. House officers were included in the eligible criteria but as all of them were worked less than 6 months and thus excluded. More than half of the respondents had worked for 1-10 years and the working experience ranged from 1 to 34 years.

About 95% of the respondents had not attended the GBV response training. The remaining 5% were transferred from Naypyidaw. The Ministry of Health and Sports had hold Dissemination of Guideline on Health Care Response for GBV Survivors and Training of Trainers in October, 2018 in Naypyidaw[41]. The participants of this events are from the administrative levels from each region in Myanmar. The training was aimed to be provided to the implementation level from each of them. In a study in

Guinia in 2012 stated more health care providers received the GBV training (28%) which was mentioned to be inadequate[40].

The last updated information from MOHS website says that "Advocacy and Training on Health Sector Response for GBV Survivors" for doctors and nurses who are working at the hospitals was given in Kachin state only. The training contents included are basic concept of GBV, first-line support for GBV survivor, post-rape care, psycho-social support, collecting medico-legal evidence and so on[41].

The Yangon Regional Health Department gave GBV response training on 19-25 June 2019 with the coordination of Gender-Equality Network which is a local NGO [42]. Among the respondents, 34.9% had attended training on STIs management and 7.5% had finished attending communication skills training.

In bivariate analysis, age, education level, workplace, job position, GBV response training, STI management training, multidisciplinary teamwork training and communication skills training are found to be associated with the health care practices.

Next, in the multi-variate analysis, the education level is found to be associated with the level of health care practices. The higher the education level the participants have completed, the better health care practice they have. Like that, health care personnel who have completed the GBV response training, STIs management and multidisciplinary teamwork training had more practice than who have not attended those trainings. In a quasi-experimental study, the practice of the health care workers on post-rape care was also found to be increased about 50% after the intervention training [43]. The positive association between STI management training and health

care practices was also found in a similar study conducted in four humanitarian settings in Africa (Kenya, Jorden, Ethiopia and DRC) in 2010-2012 [44].

5.1.2 Knowledge on Health Care for GBV cases

The knowledge part contained 9 questions, one statement with 5 answers which the respondents had to choose whether match or not with the statement. The maximum score was 5 for each question. Most of the respondents had a moderate knowledge level. Only 22.6% got full 5 scores for the forms of GBV and 1.8% got zero. Next, 71.6% chose the right and wrong answers perfectly for the adverse effects of GBV on health.

For the question on health care procedures to be provided to a sexually violated patient, about 74% of the respondents got 4 to 5 scores. However, most of the participants answered screening for cervical cancer as one health care procedure for post rape care. About the history taking and physical examination as well as the collectable specimen for forensic purpose, the majority of the health care personnel got 3 scores. 47.7% got 5 scores for the statement regarding the behavior to be stick with while providing psychological support. Subsequently, 61.6% got 4 points for follow-up care as most of them wrongly answered that to give extra contraceptives as further management for a GBV survivor. Lastly, around 55% of the respondents knew the names of the organizations they can contact for legal or social support for a GBV survivor.

The results directed that the participants should be educated and trained on every aspect of the knowledge towards both understanding the gender based violence cases and health care response.

From the bivariate analysis, the level of knowledge was found to be statistically associated with the health care practice. Participants with a higher knowledge tended to have more practices. In a training assessment in Kabul, Afganistan, WHO found out that after the training, with increasing knowledge on GBV, the participants were found to practice the identification, counseling, examining, treating and referring the GBV cares more often [45].

5.1.3 Attitude towards GBV Cases

Attitude assessment section included 8 statements with three likert scales (Disagree/ Not Sure/ Agree). Generally, most of the participants had a neutral attitude. 66.6% of the respondents agreed that health care personnel are responsible to be aware of screening suspected GBV cases. In a study carried out in Brazil in 2006 says that 12% answered management of GBV is not for health professional's role [46]. But in another study conducted in Oxfordshire among 685 health care providers, 69% thought they should involve in screening domestic violence more [38]. More than half of the participants (56.3%) disagreed that domestic violence is a private matter whereas 70% of respondents from a study on IPV carried out in Turkey in 2007 said this is not interfering the private family matter [37]. So, the average respondents in this study knew that domestic violence is a public issue and it is also a human right violation as described in the GBV guideline distributed by MOHS.

Only a few participants (7.3%) agreed that a sex worker cannot be a victim of sexual violence and a majority 83.4% agreed that GBV can be experienced by all gender; male, female and LGBTs. The obvious answer regarding the patient's autonomy is that 59.5% of the health care personnel agreed that the patient has to follow every treatment as the health care provider is in the leading role. However, in the GBV

guideline, MOHS mentioned that respect is one of the essential thing in providing health care for a GBV survivor and autonomy as a human right.

From the bivariate analysis, the level of attitude is not statistically associated with the level of health care practice. However, another study conducted in Iran shows that the health care providers with a positive attitude was found to have better practices towards domestic violence response [47].

5.1.4 Supportive Environmental Factors

Supportive environmental factors include the infrastructure and the readiness of the health care facility. 10.1% of the participants answered that there is no private room in their workplace. This may be because some doctors and nurses are working in both OPD and the inpatient department. For example, the obstetrics and gynecology department has both hospitalized patients and a special outpatient appointment schedule such as Monday and Thursday only. So, the in-patient department does not have a private room besides a screening is used for privacy. The baseline assessment in Guinea hospitals in 2012 showed that only 52% of them have a private room for both visual and audio confidentiality[40].

For the availability of other materials, 42.7% answered they have GBV guideline or protocol and 39.9% said they have special record form for documents on sexual assault survivors in their workplace. This match with the result of previous study on all available services for GBV survivors in Myanmar mentioning lack of protocol in health care services [28]. An assessment done in Guinea hospitals in 2012, 69% of the participants answered that there are SOPs or guidelines in their workplace[40]. However, only 40% answered that they have a special record form for documenting the findings from rape survivor in their workplace.

n the GBV response guideline, it is described that a rape victim will be provided the health care services free of charge and the cost can be claimed back from the relevant health administrators. However, 56.5% of the health care providers did not know this information.

For the readiness of the medication supplies, this study only assessed the availability of rapid HIV test kit and the emergency contraceptive pills. More than a half (61.3%) said they have ECP inn handy whereas a similar study in Guinea said only 19 % answered they have ECP in their work place [40]. For the referral for psychosocial support, 59% of health care personnel knew the referral contacts of relevant organizations. In a study carried out among 463 doctors and nurses in Bristol and Hackney in 2012 shows 18% of health care providers had the contact resource[48].

The results showed that approximately half of the participants have an average completeness of supplies to be able to provide services for GBV survivors (Protocol, private room, emergency contraception, HIV test kit and contact for psychosocial support).

The level of completeness of supportive environmental factors was not found to be associated in statistical analysis.

5.2 Conclusion and Recommendation

In this study, age, education level, workplace, job position, completion of GBV response training, STI management training, multidisciplinary teamwork training, communication skills training and level of knowledge were found to be associated in binary logistic regression analysis. But after processing the multivariate analysis, only education level, job position, GBV response training, STI management training and

multidisciplinary teamwork training and level of knowledge were statistically, significantly and positively associated with the level of health care practices.

However, this study cannot be generalized to the whole population. Besides, as most of the participants knew GBV as a rape case, the number of GBV cases they have encountered in the past two years cannot be exactly correct and recall bias can also be happened. Very few, but a recognizable number of participants didn't even know what a GBV is and this can also be a cofounder. The social desirability bias can be also occurred in the practical part even the researcher explained that the responses are confidential.

The findings from this study helped advocate and guide the public health manager in strengthening the readiness for GBV response at service provider level. The results indicated that the general knowledge on both gender-based violence and health facility response for gender-based violence of the health service providers should be improved as well as the readiness of the health care facility should be strengthened more. As many GBV victims usually seek help from the health care services and early detection of the violence by the health care providers can reduce or eliminate the negative impacts of the GBV and prevent the further occasions[46, 49]. Next, the awareness of GBV can be enhanced among the health care providers who can act as the awareness promotors and thus spread the information on accessible services for GBV clients to the community members and encourage community participation in GBV response and prevention[50, 51]. The final hope is to prevent the GBV by sharing information.

The results in this study indicates that the future studies should focus on all aspects on knowledge and practice towards GBV response. Furthermore, as a training on GBV

response was given to the health care providers in Yangon region following this study, it is recommended to take a post intervention study. Finally, the Ministry of Health and Sports should also establish specific programs for GBV response and should promote health care practices regarding health sector response for GBV cases.

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Appendix A: Certificate of Ethical Approval

AF 02-12

The Research Ethics Review Committee for Research Involving Human Research Participants, Health Sciences Group, Chulalongkorn University
Jamjuree 1 Building, 2nd Floor, Phyathai Rd., Patumwan district, Bangkok 10330, Thailand.
Tel/Fax 0-2218-3202, 0-2218-3409 E-mail: eccu@chula.ac.th

COA No. 142/2019

Certificate of Approval

Study Title No. 080.1/62 : KNOWLEDGE, ATTITUDE, AND HEALTH CARE PRACTICES FOR GENDER-BASED VIOLENCE CASES IN YANGON, MYANMAR

Principal Investigator : MS. AYE NYEIN EI

Place of Proposed Study/Institution : College of Public Health Sciences, Chulalongkorn University

The Research Ethics Review Committee for Research Involving Human Research Participants, Health Sciences Group, Chulalongkorn University, Thailand, has approved constituted in accordance with Belmont Report 1979, Declaration of Helsinki 2013, Council for International Organizations of Medical Sciences (CIOM) 2016, Standards of Research Ethics Committee (SREC) 2013, and National Policy and guidelines for Human Research 2015.

Signature: ..... Signature: .....
(Associate Prof. Prida Tasanapradit, M.D.) (Assistant Prof. Nuntaree Chaichanawongsaroj, Ph.D.)
Chairman Secretary

Date of Approval : 27 May 2019 Approval Expire date : 26 May 2020

The approval documents including:

1) Research proposal
2) Participant Information Sheet and Consent Form
3) Researcher
4) Questionnaire

Protocol No. 080.1/62
Date of Approval 27 MAY 2019
Approval Expire Date 26 MAY 2020

The approved investigator must comply with the following conditions:

1. *The research/project activities must end on the approval expired date of the Research Ethics Review Committee for Research Involving Human Research Participants, Health Sciences Group, Chulalongkorn University (REC.CU). In case the research/project is unable to complete within that date, the project extension can be applied one month prior to the REC.CU approval expired date.*
2. *Strictly conduct the research/project activities as written in the proposal.*
3. *Using only the documents that bearing the REC.CU's seal of approval with the subjects/volunteers (including subject information sheet, consent form, invitation letter for project/research participation (if available).*
4. *Report to the REC.CU for any serious adverse events within 5 working days.*
5. *Report to the REC.CU for any change of the research/project activities prior to conduct the activities.*
6. *Final report (AF 02-14) and abstract is required for a one year (or less) research/project and report within 30 days after the completion of the research/project. For thesis, abstract is required and report within 30 days after the completion of the research/project.*
7. *Annual progress report is needed for a two- year (or more) research/project and submit the progress report before the expire date of certificate. After the completion of the research/project processes as No. 6.*

Appendix B: Permission Letter for Data Collection in Yangon

ပြည်ထောင်စုသမ္မတမြန်မာနိုင်ငံတော်အစိုးရ
ရန်ကုန်တိုင်းဒေသကြီးကျန်းမာရေးဦးစီးဌာန
ရန်ကုန်မြို့

စာအမှတ်- ၄၀၆၃ /ရကတ-ပက/ သုတေသန
ရက်စွဲ - ၂၀၁၉ ခုနှစ်၊ ဧပြီ လ (၂၂) ရက်

သို့

ဆေးရုံအုပ်ကြီး/မြို့နယ်ကျန်းမာရေးဦးစီးဌာနမှူး
_____ ဆေးရုံ/မြို့နယ်။

အကြောင်းအရာ။ သုတေသနစစ်တမ်းကောက်ယူရန်ကိစ္စ။

ထိုင်းနိုင်ငံ၊ ချူလာလောင်ကွမ်းတက္ကသိုလ်တွင် Master of Public Health တက်ရောက်သင်ကြားနေသော မအေးငြိမ်းအိသည် "Knowledge, Attitude & Health Care Practices for Gender-Based Violence Cases in Yangon,Myanmar." ခေါင်းစဉ်ဖြင့် သုတေသနစာတမ်းကို ရန်ကုန်တိုင်းဒေသကြီးအတွင်းရှိ ပူးတွဲပါ ဆေးရုံကြီးများ၊ မြို့နယ်ဆေးရုံများ၊ တိုက်နယ်ဆေးရုံများတွင် ကောက်ယူမည်ဖြစ်ပါသည်။

သို့ဖြစ်ပါ၍ အဆိုပါ သုတေသနစာတမ်းကို လူကြီးမင်းတို့၏ ဆေးရုံကြီးများ၊ မြို့နယ်ဆေးရုံများ၊ တိုက်နယ်ဆေးရုံများ၌ ကောက်ယူရာတွင် လိုအပ်သည်များကို ကူညီပံ့ပိုးပေးနိုင်ပါရန် ညှိနှိုင်းအကြောင်းကြားပါသည်။

ဒေါက်တာထွန်းမြင့်
တိုင်းဒေသကြီးကျန်းမာရေးဦးစီးဌာနမှူး
ရန်ကုန်တိုင်းဒေသကြီး

မိတ္တူကို-
၁။ ညွှန်ကြားရေးမှူးချုပ်၊ ပြည်သူ့ကျန်းမာရေး/ကုသရေးဦးစီးဌာန၊ နေပြည်တော်။
၂။ မျှော်စာတွဲ။
၃။ ရုံးလက်ခံ။

Appendix C: Participant Information Sheet

Title of Research Project

Knowledge, Attitude and Health Care Practices for Gender-Based Violence Cases in Yangon, Myanmar

Principal Researcher's Name **Position**

Miss Aye Nyein Ei Student at Master of Public Health Program

College of Public Health Sciences

Chulalongkorn University

Address

58; 13th Street; Lanmadaw Township, Yangon

Phone Number:095414009

Email:nyeinnyein.feb.nn93@gmail.com

1. You are warmly being invited to participate in this research project. Before you decide to participate, it is important to understand why the research is being done and what it will involve. Please take time to read the following information carefully and do not hesitate to ask if anything is unclear or if you would like more information.
2. This research project is aimed to explore the knowledge, attitude and health care practices of the health care personnel in Yangon on Gender-based Violence cases.

3. In this research, the participants will be health care personnel in government hospital setting in Yangon Region. Participants who meet inclusion criteria and who do not meet the exclusion criteria will be involved in this study. You will be one of about 400 participants from around 50 hospitals in this research.

Inclusion Criteria	Exclusion Criteria
Male and female health care personnel, currently providing health care services in hospital setting (emergency and out-patient department) in Yangon Region who are willing to participate and give oral and written informed consent is included.	Health care personnel who works in health care setting less than six months will be excluded.

4. The permission to conduct this research was received from the Deputy Director General in Yangon Regional Health Department and the Medical Superintendent of the hospital.

5. After the research team explain you regarding the study using participant information sheets, you will be asked to participate in this study using an informed consent form. If you do not want to participate, you do not need to give consents and you do not need to give an explanation.
6. The data will be collected using self-administered structured questionnaires. The questionnaires have five sections with total 47 questions and it will take 10-15 minutes to answer.

7. Any information directly related to you will be kept confidentially. Even though the study will be published, the participants' names or other identifying information will not be mentioned in the report or summaries of the study.
8. The final report can be available from principal researcher and the report will not be used with another intension. The data will be kept confidentially during the process of report and research and all data files together with the participants' answer on questionnaires will be destroyed after final report has been done.
9. The study will not give benefit directly to you as it provides the baseline information for institute and country to develop a trainings regarding gender based violence case management and for the researcher to develop the further study. However, your participation will be beneficial for your community showing that the need of specialized training on clinical management on gender-based violence cases. As your participation is voluntary and no special compensation for participation in this study will be done. Nevertheless, small present will be given as appreciation for your participation.
10. You have the right to choose or refuse for giving consent and participating in this study. Even after giving consent, you can withdraw from the study at any time. There will not be any bad consequence to you for this reason. You can also ask anything you want to know before, during and after the study conduct any time you have any questions or complaints about this study.
11. *No harms and/or risks of any kind can be inflicted upon participants. You can refuse to answer any questions if you feel too personal or uncomfortable to answer.*

12. You can make report to the Research Ethics Review Committee for Research involving Human Research Participants, Chulalongkorn University (RECCU)., Jamjuree 1 Bldg., 2nd floor., 254 Phayathai Road., Pathuwam District, Bangkok 10330, Thailand, Tel/Fax +662218-3202 E-mail: eccu@chula.ac.th at any time if the researcher does not treat the participant according to the items.

Appendix D: Letter of Consent for Participation in Interview Research

Address:

Date: /

/

Title of Research Project

Knowledge, Attitude and Health Care Practices for Gender-Based Violence Cases in Yangon, Myanmar

Principal Researcher's Name

Miss Aye Nyein Ei

Address

58; 13th Street; Lanmadaw Township, Yangon

Phone Number:095414009

Email:nyeinnyein.feb.nn93@gmail.com

I have been notified of the detail of the research rationale and the research objectives, details of the stages that I must go through or must be treated, as well as the risks/ dangers and the benefits to be obtained from this research. I have thoroughly read the details in the document providing information for the research participants and have received explanations from the researcher so that I am able to clearly understand the information.

I understand that the project is designed to gather information about socio-demographic factors and factors influencing heath care practices on for gender-based violence cases. l will be one of approximately 400 people participating in this

research. Participation involves to answer self-administered questionnaires. The answering time will last approximately 10-20 minutes.

I understand that the researcher will not identify me by name in any reports using information obtained from this questionnaires, and that my confidentiality as a participant in this study will remain secure. Subsequent uses of data will be subject to standard data use policies which protect the anonymity of individuals and institutions. The information about the participants will be destroyed after the study is done

I understand that this research study has been reviewed and approved by the Ethical Review Committee from Chulalongkorn University and permission to conduct has been given by the director of the hospital. For research problems or questions regarding subjects, the researcher may be contacted through the mentioned address.

I have read and understand the information provided to me. I have had all my questions answered to my satisfaction, and I voluntarily agree to participate in this study.

_____

Signature of the Investigator

Ms. Aye Nyein Ei

0995414009

nyeinnyein.feb.nn93@gmail.com

_____

_____

Signature of Participant

Signature of the Witness

_____

Code Number

Appendix E: Questionnaire

Questionnaires on Knowledge, Attitude and Health Care Practices for Gender-Based Violence Cases in Yangon, Myanmar **Code-**	
Section (1) **Socio-Demographic Characteristics**	
1.	Age _____Years
2.	Sex □ Male □ Female
3.	Education level □ Diploma □ Bachelor's Degree □ Master's Degree □ Postdoctoral Degree
4.	Workplace □ Regional Hospital □ Township Hospital □ Station Hospital
5.	Job Position □ Senior Medical Officer □ Head Nurse □ Medical Officer □ Senior Nurse

	□ House Officer □ Junior Nurse
6.	Working Experience (total period since graduation) _____Years
7.	Have you ever been attended a training on gender-based violence response? □ Yes □ No
8.	Have you ever been attended a training on management of STIs? □ Yes □ No
9.	Have you ever been attended a training on the multidisciplinary team work? □ Yes □ No
10.	Have you ever been attended a training related to communication skill? □ Yes □ No
Section (2) **Knowledge on Health Care for Gender-Based Violence Cases** **Please tick the answers those are correct according to your knowledge.**	
11.	Forms of gender-based violence include, □ Constant humiliation □ Yes □ No □ Economic dependency □ Yes □ No □ Unwanted sexual comments □ Yes □ No

	□ Argument	□ Yes	□ No
	□ Controlling behaviors by the spouse	□ Yes	□ No
12.	The violence can cause these adverse effects on health.		
	□ Acute kidney failure	□ Yes	□ No
	□ Depression	□ Yes	□ No
	□ Unwanted pregnancy	□ Yes	□ No
	□ Varicose vein	□ Yes	□ No
	□ Suicide	□ Yes	□ No
13.	In providing clinical management to a sexual assault survivor, these are the procedures to be included.		
	□ Obtaining informed consent	□ Yes	□ No
	□ Oral care	□ Yes	□ No
	□ Prevention of STIs	□ Yes	□ No
	□ Cervical cancer screening	□ Yes	□ No
	□ Psychological support	□ Yes	□ No
14.	In providing treatment and care to a sexual assault survivor, prevention of these diseases are mandatory.		
	□ Tetanus	□ Yes	□ No

	□ Skin fungal infections	□ Yes	□ No
	□ Measles	□ Yes	□ No
	□ Hepatitis B	□ Yes	□ No
	□ Gonorrhea	□ Yes	□ No
15.	During history taking and physical assessment, these data should be collected.		
	□ Vaccination history	□ Yes	□ No
	□ Current contraceptive use	□ Yes	□ No
	□ Assessment for virginity	□ Yes	□ No
	□ Assessment on pelvic and anal region	□ Yes	□ No
	□ Causes of being violated	□ Yes	□ No
16.	These are the specimen that can be collected for the forensic purpose.		
	□ Clothing	□ Yes	□ No
	□ Hair	□ Yes	□ No
	□ Skin	□ Yes	□ No
	□ Urine	□ Yes	□ No
	□ Sanitary pads/ tampons	□ Yes	□ No
17.	In order to provide psychological support to the survivor,		
	□ A private environment is required to support open communication		

		□ Yes	□ No
	□ Force the survivor not to cry	□ Yes	□ No
	□ Explain the survivor that the information will be kept confidential	□ Yes	□ No
	□ Explain the survivor that it is the perpetrator's fault and she does not need to feel guilty	□ Yes	□ No
	□ Explain that if orgasm occurred during the assault, it is the survivor's fault	□ Yes	□ No
18.	Follow-up visits are appointed for,		
	□ Checking the adherence of medications	□ Yes	□ No
	□ Providing contraceptives	□ Yes	□ No
	□ Evaluating the mental health status	□ Yes	□ No
	□ Evaluating the status of STIs	□ Yes	□ No
	□ Evaluating the status of thyroid hormones	□ Yes	□ No
19.	These organizations can be contacted for the legal or social support.		
	□ Ministry of Foreign Affairs	□ Yes	□ No
	□ Myanmar Women's Affairs Federation	□ Yes	□ No
	□ Myanmar Maternal and Child Welfare Association	□ Yes	□ No

	□ INGOs	□ Yes	□ No
	□ Community-based organizations	□ Yes	□ No
Section (3) **Attitude towards Gender-Based Violence Cases** **Tick one answer only that is true for you in the box for each question.**			
20.	Health providers have the responsibility to interview the clients with musculoskeletal injuries about the violence. □ Agree □Not sure □Disagree		
21.	Domestic violence is a private matter. No third party should not interfere. □ Agree □Not sure □Disagree		
22.	The client might feel offended if you ask them directly about the domestic violence. □ Agree □Not sure □Disagree		
23.	A sex-worker cannot be a victim of sexual violence. □ Agree □Not sure □Disagree		
24.	A client complaining insomnia can be a GBV victim. □ Agree □Not sure □Disagree		
25.	A rape case is a serious case and need urgent care. □ Agree □Not sure □Disagree		

26.	The gender-based violence can be experienced by all males, females and LGBTs. (lesbians, gays, bisexuals, trans-genders) □ Agree □Not sure □Disagree
27.	The survivor has to follow all treatment procedures as the service provider is doing for his/her own benefit. □ Agree □Not sure □Disagree
Section (4) **Supportive Environmental Factors** **Tick one answer only that is true for you in the box for each question.**	
28.	Protocol or guideline regarding the management of GBV survivor is available in your workplace. □ Yes □ No □ Not Sure
29.	Do you have a private room (i.e. the patient cannot be heard or seen from outside) for history taking and physical assessment in your department? □ Yes □ No □ Not Sure
30.	Record form for history taking and physical examination for sexual violence survivor is available in your workplace. □ Yes □ No □ Not Sure
31.	Do you have rapid diagnostic test kit for HIV in your workplace?

	□ Yes □ No □ Not Sure
32.	Can you provide health care to a rape victim free of charge and then claim back from the relevant health administrators? □ Yes □ No □ Not Sure
33.	Do you have emergency pills (which is not expired) in handy? □ Yes □ No □ Not Sure
34.	Do you know any contact to refer a survivor for psychosocial support? □ Yes □ No □ Not Sure
Section (5) **Health Care Practices** **Tick one answer only that is true for you in the box for each question.**	
35.	Have you ever experienced managing a GBV case within last two years? □ Yes □ No
	If 'No', please go to question 37.
36.	Please describe the details of the cases as remember as you can. How many cases? _____ Case (1) Type of violence □ Psychological □ Physical □Sexual

	(You can choose more than one answer.) Gender of the survivor □ Male □ Female □Others Perpetrator □ Unknown □ Spouse □ Family Member (e.g. mother-in-law) □ Stranger Case (2) Type of violence □ Psychological □ Physical □Sexual (You can choose more than one answer.) Gender of the survivor □ Male □ Female □Others Perpetrator □Unknown □Spouse □Family Member (e.g. mother-in-law) □Stranger Case (3) Type of violence □ Psychological □ Physical □Sexual (You can choose more than one answer.) Gender of the survivor □ Male □ Female □Others Perpetrator □Unknown □Spouse □Family Member

	□Stranger (e.g. mother-in-law)
37.	Have you ever asked an injured patient for suspected GBV? □ Never □ Yes ⟶ □ Always (_____/_____cases) □ Often (_____/_____cases) □ Sometimes (_____/_____cases) □ Rare (_____/_____cases)
	-If you have NO EXPERIENCE on managing GBV cases but have asked for suspected GBV 1-3 TIMES OR >3 TIMES, please go to question 38. **-If you have NO EXPERIENCE on managing GBV cases and NEVER ASKED for suspected GBV cases, please stop here.**
38.	Have you ever used a GBV protocol? □ Never □ Yes ⟶ □ Always (_____/_____cases) □ Often (_____/_____cases) □ Sometimes (_____/_____cases) □ Rare (_____/_____cases)
	If you have no experience on managing GBV cases but have asked for suspected GBV 1-3 Times or >3 Times and used/never used GBV protocol, please stop here.

39.	Have you ever spent time to console or calm a GBV survivor who is hysterical or crying? □ Never □ Yes ⟶ □ Always (_____/_____cases) □ Often (_____/_____cases) □ Sometimes (_____/_____cases) □ Rare (_____/_____cases)
40.	Have you ever taken history of a GBV client at the presence of his/her family member? □ Never □ Yes ⟶ □ Always (_____/_____cases) □ Often (_____/_____cases) □ Sometimes (_____/_____cases) □ Rare (_____/_____cases)
41.	Have you ever given enough time listening to a GBV client and pay attention about the details of the violence? □ Never □ Yes ⟶ □ Always (_____/_____cases) □ Often (_____/_____cases) □ Sometimes (_____/_____cases) □ Rare (_____/_____cases)
42.	Have you ever briefed the GBV cases regarding the health care procedures?

	□ Never □ Yes ⟶ □ Always (_____/_____cases) □ Often (_____/_____cases) □ Sometimes (_____/_____cases) □ Rare (_____/_____cases)
43.	Have you ever counsel a GBV client for HIV testing and post-exposure prophylaxis? □ Never □ Yes ⟶ □ Always (_____/_____cases) □ Often (_____/_____cases) □ Sometimes (_____/_____cases) □ Rare (_____/_____cases)
44.	Have you ever made an appointment for follow-up with a GBV survivor? □ Never □ Yes ⟶ □ Always (_____/_____cases) □ Often (_____/_____cases) □ Sometimes (_____/_____cases) □ Rare (_____/_____cases)
45.	Have you ever involved in referring a GBV survivor for legal support? E.g. informing the police. □ Never □ Yes ⟶ □ Always (_____/_____cases) □ Often (_____/_____cases)

	□ Sometimes (_____/_____cases) □ Rare (_____/_____cases)
46.	Have you ever involved in referring a GBV survivor for social support? e.g. contacting with women's support organizations. □ Never □ Yes ⟶ □ Always (_____/_____cases) □ Often (_____/_____cases) □ Sometimes (_____/_____cases) □ Rare (_____/_____cases)
47.	Have you ever made sure that the survivor was in a safe place (e.g. in a shelter)? □ Never □ Yes ⟶ □ Always (_____/_____cases) □ Often (_____/_____cases) □ Sometimes (_____/_____cases) □ Rare (_____/_____cases)

Thank You Very Much for Your Participation

Appendix F: Information Sheet in Myanmar Language

သုတေသနတွင် ပါဝင်မည့်သူများအတွက် သတင်း အချက်အလက်

သုတေသနခေါင်းစဉ်- -မြန်မာနိုင်ငံ၊ရန်ကုန်မြို့ရှိ ကျန်းမာရေးစောင့်ရှောက်ကုသသူများ၏

ကျား/မ အခြေပြု အကြမ်းဖက်မှုခံစားရသူတို့အတွက် ကျန်းမာရေးစောင့်ရှောက်မှုနှင့်

ပါတ်သက်သော ဗဟုသုတ, သဘောထား နှင့် အလေ့အကျင့်တို့အားလေ့လာခြင်း

သုတေသီ၏ အမည် : မအေးငြိမ်းအိ

နေရပ်လိပ်စာ : နံပါတ် ၅၈ ၊ ၁၃ လမ်း ၊ လမ်းမတော်မြို့နယ် ၊ ရန်ကုန်။

ဖုန်း : ၀၉၅၄၁၄၀၀၉

E-mail: nyeinnyein.feb.nn93@gmail.com

၁။ မိတ်ဆက်

ကျွန်ုပ်၏အမည်မှာ မအေးငြိမ်းအိဖြစ်ပြီး ထိုင်းနိုင်ငံ၊ ချူလာလောင်ကွန်းတက္ကသိုလ်တွင် ပြည်သူ့ကျန်းမာရေးမဟာဘွဲ့ အတန်းကို တက်ရောက်နေပါသည်။ ကျွန်ုပ်သည် အထက်ဖော်ပြပါ သုတေသနအားပြုလုပ်နေပြီး သင့်အား ဤသုတေသနတွင်ပါဝင်ရန် ဖိတ်ခေါ်ပါသည်။ အောက်ပါအချက်အလက်များကို သေချာစွာဖတ်ပြီး မရှင်းလင်းသည်ဖြစ်စေ၊ တစ်ခုခုသိလိုၗဖြစ်စေ မေးမြန်းနိုင်ပါသည်။

၂။ ရည်ရွယ်ချက်

ဤသုတေသန၏ ရည်ရွယ်ချက်မှာ မြန်မာနိုင်ငံ၊ ရန်ကုန်မြို့ရှိ ကျား/မ အခြေပြု အကြမ်းဖက်မှုခံစားရသူများအတွက် ကျန်းမာရေးစောင့်ရှောက်မှု ပေးဘူးသော ကျန်းမာရေးစောင့်ရှောက်သူ အရေအတွက်ကို ဖော်ပြရန်၊ ကျန်းမာရေး စောင့်ရှောက်သူများ၏ ကျား/မ အခြေပြု အကြမ်းဖက်မှုခံစားရသူများအတွက် ကျန်းမာရေးစောင့်ရှောက်မှု နှင့် ပါတ်သက်သော ဗဟုသုတ၊ သဘောထား၊ ဆေးဝါးနှင့် အခြားပစ္စည်းများ ပြည့်စုံမှု နှင့် အလေ့အကျင့်တို့ အားလေ့လာရန်၊ ထိုအချက်အလက်များ ဆက်စပ်မှု ရှိ/ မရှိ ဖော်ပြရန် တို့ဖြစ်သည်။

၃။ သုတေသနတွင် ပါဝင်မည့်သူအားရွေးချယ်ခြင်း

လက်ရှိ ပြည်သူ့ဆေးရုံများတွင် ခြောက်လထက် မနည်း တာဝန်ထမ်းဆောင်နေသော ဆရာဝန်နှင့် သူနာပြုများကို ဤသုတေသနတွင်ပါဝင်ရန် ဖိတ်ခေါ်ပါသည်။

၄။ သုတေသနမေးခွန်းလွှာ

ဤ သုတေသနမေးခွန်းလွှာတွင် အပိုင်းငါးပိုင်းပါဝင်ပါသည်။ ဖြေဆိုချိန်မှာ ၁၅မိနစ်ခန့် ကြာမြင့်မည်ဖြစ်ပါသည်။

အပိုင်း (၁) ဖြေဆိုသူ၏ အထွေထွေ အချက်အလက်

အပိုင်း (၂) ကျား/မ အခြေပြု အကြမ်းဖက်မှုခံစားရသူများအတွက် ကျန်းမာရေးစောင့်ရှောက်မှုနှင့် ပါတ်သက်သော ဗဟုသုတပိုင်းဆိုင်ရာမေးခွန်း

အပိုင်း (၃) ကျား/မ အခြေပြု အကြမ်းဖက်မှုခံစားရသူများ အပေါ် သဘောထားခံယူချက်ဆိုင်ရာမေးခွန်း

အပိုင်း (၄) လိုအပ်သည့်ဆေးဝါးနှင့် အခြား ပစ္စည်းများ ပြည့်စုံမှုဆိုင်ရာမေးခွန်း

အပိုင်း (၅) ကျား/မ အခြေပြု အကြမ်းဖက်မှုခံစားရသူများအတွက် ကျန်းမာရေးစောင့်ရှောက်မှုနှင့် ပါတ်သက်သော အလေ့အကျင့်ပိုင်းဆိုင်ရာမေးခွန်း

၅။ မိမိဆန္ဒအလျောက် ပါဝင်ခြင်း

သုတေသီမှ ဤသတင်းအချက်အလက်များကိုရှင်းပြပြီးနောက် သင်ပါဝင်ရန်သဘောတူပါက သဘောတူညီချက်တွင် လက်မှတ်ရေးထိုးပေးရပါမည်။ ဤသုတေသနတွင် ပါဝင်ခြင်းမှာ မိမိသဘောဆန္ဒ အတိုင်းသာ ဖြစ်ပါသည်။

မပါဝင်လိုပါကလည်း အကြောင်းပြချက်ပေးရန် မလိုပါ။ ဖြေဆိုနေစဉ်တွင် ဆက်လက် မဖြေဆိုလိုပါကလည်း အချိန်မရွေးနှုတ်ထွက်ခွင့် ရှိပါသည်။

၆။ အကျိုးခံစားခွင့်

ဤသုတေသနတွင်ပါဝင်ခြင်းအားဖြင့် သင့်အားတိုက်ရိုက်အကျိုးပြုမည်မဟုတ်သော်လည်း ကျား/မ အခြေပြု အကြမ်းဖက်မှုခံစားရသူများကို ကျန်းမာရေးစောင့်ရှောက်မှုပေးနိုင်ရေးအတွက် လိုအပ်သော သင်တန်းများ၊ လုပ်ငန်းစဉ်များ ရေးဆွဲရာတွင် အဖိုးတန်သောအချက်အလက်များ ပေးနိုင်မည်ဖြစ်ပါသည်။

၇။ လျှို့ဝှက်ထားရှိခြင်း

သင်နှင့်သက်ဆိုင်သော အချက်အလက်များကို လျှို့ဝှက်ထားရှိမည်ဖြစ်ပါသည်။ သုတေသနစာတမ်းကို ထုတ်ဝေရာတွင်လည်း သင်၏အမည်နှင့် အချက်အလက်များကို ဖော်ပြမည် မဟုတ်ပါ။ သုတေသန စာတမ်းကို သုတေသီထံတွင် ရနိုင်ပြီး သုတေသနလုပ်ငန်းမှလွဲ၍ အခြား မည်သည့် အကြောင်း အတွက်မျှ အသုံးပြုမည် မဟုတ်ပါ။ ရရှိသော အချက်အလက်များကို သုတေသနပြုနေချိန် တစ်လျှောက်လုံးတွင်

သေချာစွာ လျှို့ဝှက်ထားရှိမည်ဖြစ်ပြီး နောက်ဆုံးသုတေသနစာတမ်း ထွက်ရှိပြီးပါက ထိုအချက် အလက်များကို ဖျက်စီးသွားမည် ဖြစ်ပါသည်။

၈။ ပါဝင်သူ၏ အခွင့်အရေး

ဤသုတေသနတွင် ပါဝင်ခြင်းမှာ မိမိသဘောဆန္ဒ အတိုင်းသာ ဖြစ်ပါသည်။ သဘောတူညီချက် ပေးပြီးသော်လည်း ဆက်လက် မဖြေဆိုလိုပါက အချိန်မရွေးနှုတ်ထွက်ခွင့် ရှိပါသည်။ သင့်အား တစ်စုံတစ်ရာ ဆိုးကျိုးဖြစ်စေမည် မဟုတ်ပါ။ မေးမြန်းလိုသော အကြောင်းအရာများ ရှိပါက အထက်ပါသုတေသီကို ဆက်သွယ်မေးမြန်းနိုင်ပါသည်။ သုတေသနနှင့် ပါတ်သက်၍ မကျေနပ်မှု တစ်စုံတစ်ရာ ရှိပါက အောက်ပါအဖွဲ့အစည်းကိုတိုင်ကြားနိုင်ပါသည်။

သုတေသနလူ့ကျင့်ဝတ်ဆိုင်ရာကော်မတီ၊ ချုပ်လာလောင်ကွန်းတက္ကသိုလ်၊ ချန်ချူရီ အဆောက်အဦ ၁၊ ဒုတိယထပ်၊ ဖရားထိုင်းလမ်း၊ အမှတ် ၂၅၄၊ ဘန်ကောက်မြို့။ ဖုန်း ၆၆၂၁၈၃၂၀၅၊ E-mail- eccu@chula.ac.th

Appendix G: Informed Consent in Myanmar Language

သဘောတူညီချက်

သုတေသနခေါင်းစဉ် - မြန်မာနိုင်ငံ၊ ရန်ကုန်မြို့ရှိ ကျန်းမာရေးစောင့်ရှောက်သူများ၏ ကျား/မ အခြေပြု အကြမ်းဖက်မှုခံစားရသူများအတွက် ကျန်းမာရေးစောင့်ရှောက်မှု နှင့် ပါတ်သက်သော ဗဟုသုတ, သဘောထား နှင့် အလေ့အကျင့်တို့အားလေ့လာခြင်း

သုတေသီအမည် -မအေးငြိမ်းအိ

နေရပ်လိပ်စာ : နံပါတ် ၅၈ ၊ ၁၃ လမ်း ၊ လမ်းမတော်မြို့နယ် ၊ ရန်ကုန်။

ဖုန်း : ၀၉၅၄၁၄၀၀၉

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ကျွန်ုပ်သည် အထက်ပါသုတေသန၏ ရည်ရွယ်ချက်၊ လုပ်ထုံးလုပ်နည်း၊ ပါဝင်သူများ၏ အခွင့်အရေးစသည်တို့ကို ဖတ်ရှုနားလည်ပြီးဖြစ်ပါသည်။ ကျွန်ုပ်သည် ပါဝင်ဖြေဆိုသူ ၄၀၀တွင် တစ်ဦးအပါအဝင်ဖြစ်ပြီး ကျွန်ုပ်၏ အထွေထွေ အချက်အလက် အပါအဝင် အခြားအချက်အလက်များကို မေးမြန်းမည်ဖြစ်ကြောင်း သိရှိပြီးဖြစ်ပါသည်။ ဖြေဆိုချိန်မှာ ၁၀-၂၀ မိနစ်ခန့်ကြာမြင့်မည် ဖြစ်ပါသည်။

ကျွန်ုပ်သည် မိမိ၏သဘောဆန္ဒအလျောက် ဤသုတေသနတွင် ပါဝင်ခြင်း ဖြစ်ပါသည်။

ဤသုတေသနမှ အချိန်မရွေးနုတ်ထွက်နိုင်ကြောင်း၊ ဤသို့နှုတ်ထွက်ခြင်းကြောင့်

မည်သည့်ဆိုးကျိုးတစ်စုံတစ်ရာမှ မရှိကြောင်း သိရှိပြီး ဖြစ်ပါသည်။ သုတေသနမှ ရရှိသော

အဖြေများကို ခြုံငုံ၍ဖော်ပြမည် ဖြစ်ပီး တစ်ဦးချင်းဆိုင်ရာ အချက်အလက်များကို

လျှို့ဝှက်ထားရှိမည်ဖြစ်ကြောင်း သိရှိပြီး ဖြစ်ပါသည်။

သိရှိလိုသည်များရှိပါကဆက်သွယ်နိုင်သော၊ သုတေသနနှင့်ပါတ်သက်၍

တိုင်တန်းနိုင်သော လိပ်စာများကိုလည်း သိရှိပြီး ဖြစ်ပါသည်။

လက်မှတ်: ……..…… လ က် မ တ် :

……..……

အမည်: ……..…….. အ မ ည် :

……..……..

သုတေသီ ပါဝင်သူ

လက်မှတ်.....

အသိသက်သေ

Appendix H: Questionnaire in Myanmar Language

ကျား/မ အခြေပြု အကြမ်းဖက်မှုခံစားရသူများအတွက် ကျန်းမာရေးစောင့်ရှောက်မှု နှင့် ပါတ်သက်သော ဗဟုသုတ, သဘောထား နှင့် အလေ့အကျင့် ဆိုင်ရာ သုတေသနမေးခွန်းလွှာ ကုတ်နံပါတ်-	
အပိုင်း (၁) ဖြေဆိုသူ၏ အထွေထွေ အချက်အလက်	
1.	ပြည့်ပြီးသော အသက် _____နှစ်
2.	ကျား/မ □ အမျိုးသား □ အမျိုးသမီး
3.	ပညာအရည်အချင်း □ ဒီပလိုမာ □ ဘွဲ့ရ □ ဘွဲ့လွန် □ Ph.D
4.	လုပ်ငန်းတည်နေရာ

	□ ခရိုင်အဆင့်ဆေးရုံ □ မြို့နယ်ဆေးရုံ □ တိုက်နယ်ဆေးရုံ
5.	ရာထူး □ PG or Above □ သူနာပြုဆရာမကြီး □ လက်ထောက်ဆရာဝန် □ အထက်တန်းသူနာပြု □ အလုပ်သင်ဆရာဝန် □ သူနာပြု
6.	လုပ်သက် (အလုပ်စတင်ဝင်ရောက်ချိန်မှ ယခုအထိ စုစုပေါင်း) _____နှစ်
7.	ကျား/မ အခြေပြု အကြမ်းဖက်မှုခံစားရသူများအတွက် ကျန်းမာရေးစောင့်ရှောက်မှုပေးနိုင်ရန် သင်တန်း တက်ရောက်ဖူးပါသလား။ □ တက်ရောက်ဖူးပါသည် □ မတက်ရောက်ဖူးပါ
8.	လိင်မှတဆင့် ကူးစက်တတ်သောရောဂါများကို ကုသနိုင်ရန်အတွက် သင်တန်း တက်ရောက် ဖူးပါသလား။ □ တက်ရောက်ဖူးပါသည် □ မတက်ရောက်ဖူးပါ
9.	အခြားသော အဖွဲ့အစည်းများဖြင့် (လူမှုရေးရာ၊ ဥပဒေရေးရာ)

	ချိတ်ဆက်ဆောင်ရွက် ကျန်းမာရေး စောင့်ရှောက်မှုပေးနိုင်ရန် သင်တန်း တက်ရောက်ဖူးပါသလား။ □ တက်ရောက်ဖူးပါသည် □ မတက်ရောက်ဖူးပါ
10.	လူမှုပေါင်းသင်းဆက်ဆံခြင်းစွမ်းရည် (communication skill) ဆိုင်ရာ သင်တန်း တက်ရောက်ဖူးပါသလား။ □ တက်ရောက်ဖူးပါသည် □ မတက်ရောက်ဖူးပါ
အပိုင်း (၂) **ကျား/မ အခြေပြု အကြမ်းဖက်မှုခံစားရသူများအတွက် ကျန်းမာရေးစောင့်ရှောက်မှုနှင့် ပါတ်သက်သော ဗဟုသုတပိုင်းဆိုင်ရာမေးခွန်း** **အဖြေကို □ တွင် အမှန်ခြစ်ပါ။**	
11.	ကျား/မ အခြေပြု အကြမ်းဖက်မှုတွင် အောက်ပါပုံစံများ ပါဝင်ပါသည်။ • နှိမ့်ချစော်ကားသောအသုံးအနှုံးများဖြင့် ခေါ်ဆို/ဆက်ဆံခြင်း □ မှန် □ မှား • လက်တွဲဖော်၏ ဝင်ငွေအပေါ် မှီခိုနေရခြင်း □ မှန် □ မှား

	• နှုတ်အားဖြင့် လိင်ပိုင်းဆိုင်ရာ ထိပါးနှောင့်ယှက်ခြင်း □ မှန် □ မှား • ငြင်းခုံစကားများခြင်း □ မှန် □ မှား • အိမ်ထောင်ဖက်မှ ထိန်းချုပ်သည့် အပြုအမူများ □ မှန် □ မှား
12.	ကျား/မ အခြေပြု အကြမ်းဖက်မှုခံစားရသူများကြုံတွေ့ရနိုင်သော ကျန်းမာရေးဆိုးကျိုးများမှာ • ကျောက်ကပ်ရောဂါ □ မှန် □ မှား • စိတ်ကျရောဂါ □ မှန် □ မှား • မလိုလားသော ကိုယ်ဝန်ဆောင်ရခြင်း/ မလိုချင်ဘဲ ကိုယ်ဝန်ရခြင်း □ မှန် □ မှား • သွေးကြောထုံးရောဂါ □ မှန် □ မှား • မိမိကိုယ်ကို သတ်သေခြင်း □ မှန် □ မှား
13.	လိင်ပိုင်းဆိုင်ရာ အကြမ်းဖက်ခံရသူအတွက် ဆောင်ရွက်ပေးရမည့် ကျန်းမာရေး စောင့်ရှောက်မှု လုပ်ငန်းများမှာ

	• အသိပေးရှင်းပြ၍ သဘောတူခွင့်ပြုချက်ရယူခြင်း □ မှန် □ မှား • ခံတွင်းကျန်းမာရေးစောင့်ရှောက်မှုပေးခြင်း □ မှန် □ မှား • လိင်မှတဆင့် ကူးစက်တတ်သောရောဂါ ကာကွယ်ခြင်း □ မှန် □ မှား • သားအိမ်ခေါင်းကင်ဆာ စစ်ဆေးခြင်း □ မှန် □ မှား • စိတ်ကျန်းမာရေးစောင့်ရှောက်မှုပေးခြင်း □ မှန် □ မှား
14.	လိင်ပိုင်းဆိုင်ရာ အကြမ်းဖက်ခံရသူအတွက် ကျန်းမာရေးစောင့်ရှောက်မှုပေးရာတွင် အောက်ပါ ရောဂါများကို ကာကွယ်ရန် လိုအပ်ပါသည်။ • မေးခိုင်ရောဂါ □ မှန် □ မှား • အရေပြားမို့ရောဂါ □ မှန် □ မှား • ဝက်သက်ရောဂါ □ မှန် □ မှား • အသည်းရောင် အသားဝါ ဘီ ရောဂါ □ မှန် □ မှား • ဂနိုရောဂါ □ မှန် □ မှား

15.	ကျန်းမာရေးရာဇဝင်မေးမြန်းစဉ်နှင့် ရုပ်ပိုင်းဆိုင်ရာစစ်ဆေးစဉ်တွင် အောက်ပါ အချက်အလက် များကို မေးမြန်းသင့်ပါသည်။ • ကာကွယ်ဆေးထိုးမှတ်တမ်း □ မှန် □ မှား • သားဆက်ခြားနည်းလမ်း အသုံးပြုခြင်းမှတ်တမ်း □ မှန် □ မှား • အပျိုစစ်/ မစစ် စစ်ဆေးခြင်း □ မှန် □ မှား • လိင်အင်္ဂါနှင့်စအိုတို့ကို စစ်ဆေးခြင်း □ မှန် □ မှား • အကြမ်းဖက်ခံရခြင်းအကြောင်းရင်းကိုမေးမြန်းခြင်း □ မှန် □ မှား
16.	ဥပဒေရေးရာအထောက်အထား အဖြစ်ရယူနိုင်သော အရာများမှာ • အဝတ်အစား □ မှန် □ မှား • ဆံပင် □ မှန် □ မှား • အရေပြား □ မှန် □ မှား • ဆီး □ မှန် □ မှား • အမျိုးသမီး လစဉ်သုံးပစ္စည်း □ မှန် □ မှား

17.	စိတ်ကျန်းမာရေးစောင့်ရှောက်မှုပေးရာတွင် • ပွင့်ပွင့်လင်းလင်းပြောဆိုနိုင်ရန် အခြားသူများမကြားနိုင်သော နေရာလိုအပ်ပါသည်။ □ မှန် □ မှား • အကြမ်းဖက်ခံရသူ ငိုကြွေးနေပါက မငိုအော်ပါ ။ □ မှန် □ မှား • အကြမ်းဖက်ခံရသူ၏ ကျန်းမာရေးမှတ်တမ်းများကို လျှို့ဝှက်ထားမည် ဖြစ်ကြောင်း ရှင်းပြပါ။ □ မှန် □ မှား • အကြမ်းဖက်ခံရသူသည် မိမိကိုယ်ကို အပြစ်တင်ရန် မလိုကြောင်း၊ ကျူးလွန်သူ၏ အမှားဖြစ်ကြောင်း ရှင်းပြပါ။ □ မှန် □ မှား • မုဒိမ်းကျင့်ခံရစဉ်တွင် ကျူးလွန်ခံရသူတွင် ပြီးမြောက်ခြင်း (orgasm) ဖြစ်ခဲ့ပါက ကျူးလွန်ခံရသူ၏ အပြစ်ဖြစ်ကြောင်း ရှင်းပြပါ။ □ မှန် □ မှား
18.	ဆက်လက်ချိန်းဆိုမှုများမှာ အောက်ပါတို့ကို စောင့်ရှောက်ကုသမှုပေးနိုင်ရန်ဖြစ်သည်။

	• ဆေးများကို ဆေးပတ်လည်အောင် သောက်/ မသောက်စစ်ဆေးရန် □ မှန် □ မှား • သန္ဓေတားဆေးပေးရန် □ မှန် □ မှား • စိတ်ကျန်းမာရေး အခြေအနေကို ဆန်းစစ်ရန် □ မှန် □ မှား • STI လက္ခဏာများ စစ်ဆေးရန် □ မှန် □ မှား • သိုင်းရွိုက်ဟော်မုန်းစစ်ဆေးရန် □ မှန် □ မှား
19.	မြန်မာနိုင်ငံ၌ အကြမ်းဖက်ခံရသူများအတွက် ပံ့ပိုးကူညီမှု ရနိုင်မည့်နေရာများမှာ • နိုင်ငံခြားရေးဝန်ကြီးဌာန □ မှန် □ မှား • အမျိုးသမီးရေးရာ အဖွဲ့ □ မှန် □ မှား • မြန်မာနိုင်ငံ မိခင်နှင့်ကလေးစောင့်ရှောက်ရေးအသင်း □ မှန် □ မှား • အစိုးရမဟုတ်သော အဖွဲ့အစည်းများ (NGOs) □ မှန် □ မှား • လူထုအခြေပြု အဖွဲ့အစည်းများ □ မှန် □ မှား
အပိုင်း (၃)	

ကျား/မ အခြေပြု အကြမ်းဖက်မှုခံစားရသူများ အပေါ် **သဘောထားခံယူချက်ဆိုင်ရာမေးခွန်း** ***အဖြေကို □ တွင် အမှန်ခြစ်ပါ။***	
20.	ကြွက်သား/ အရိုးထိခိုက်ဒဏ်ရာဖြင့် လာရောက်ပြသသော လူနာကို အကြမ်းဖက်ခံရမှု ရှိ/ မရှိ မေးမြန်းရန် ကျန်းမာရေးဝန်ထမ်းတွင် တာဝန်ရှိပါသည်။ □ သဘောတူပါသည် □ မသေချာပါ □သဘောမတူပါ
21.	အိမ်တွင်းအကြမ်းဖက်မှုသည် ကိုယ်ရေးကိုယ်တာကိစ္စဖြစ်သောကြောင့် အပြင်လူများက ဝင်ရောက် စွက်ဖက်ခြင်းမပြုသင့်ပါ။ □ သဘောတူပါသည် □ မသေချာပါ □သဘောမတူပါ
22.	လူနာကို အိမ်တွင်းအကြမ်းဖက်မှုအကြောင်း တိုက်ရိုက်မေးမြန်းပါက လူနာမှ စိတ်ဆိုးသွားနိုင် သည်။ □ သဘောတူပါသည် □ မသေချာပါ □သဘောမတူပါ
23.	လိင်ပိုင်းဆိုင်ရာ အသက်မွေးဝမ်းကြောင်းပြုသူသည် လိင်ပိုင်းဆိုင်ရာအကြမ်းဖက်မှု မကြုံတွေ့ရနိုင်ပါ။

	□ သဘောတူပါသည် □ မသေချာပါ □သဘောမတူပါ
24.	ည အိပ်မပျော်သောကြောင့် လာရောက်ကုသသူ လူနာသည် ကျား/မ အခြေပြု အကြမ်းဖက်မှုခံစားရသူ ဖြစ်နိုင်ပါသည်။ □ သဘောတူပါသည် □ မသေချာပါ □သဘောမတူပါ
25.	မုဒိမ်းမှုသည် အရေးပေါ် အခြေအနေတစ်ခုဖြစ်ပါသည်။ □ သဘောတူပါသည် □ မသေချာပါ □သဘောမတူပါ
26.	ကျား/မ အခြေပြု အကြမ်းဖက်မှုကို ယောကျ်ား၊ မိန်းမ၊ လိင်စိတ်ခံယူမှုကွဲပြားသူ အားလုံး တွေ့ကြုံရနိုင်ပါသည်။ □ သဘောတူပါသည် □ မသေချာပါ □သဘောမတူပါ
27.	ကျန်းမာရေးစောင့်ရှောက်မှုပေးသူသည် အကြမ်းဖက်ခံရသူ၏ကောင်းကျိုးအတွက် ဆောင်ရွက်ပေးခြင်း ဖြစ်သောကြောင့် အကြမ်းဖက်ခံရသူက ကုသမှုအားလုံးကို လက်ခံရပါမည်။ □ သဘောတူပါသည် □ မသေချာပါ □သဘောမတူပါ
အပိုင်း (၄)	

လိုအပ်သည့်ဆေးဝါးနှင့် အခြား ပစ္စည်းများ ပြည့်စုံမှုဆိုင်ရာမေးခွန်း ***အဖြေကို □ တွင် အမှန်ခြစ်ပါ။***	
သင်၏ လုပ်ငန်းခွင်တွင်	
28.	ကျား/မ အခြေပြု အကြမ်းဖက်မှုခံစားရသူများအတွက် ကျန်းမာရေးစောင့်ရှောက်မှုပေးနိုင်ရန် လုပ်ငန်းလမ်းညွှန် □ ရှိပါသည် □ မရှိပါ □ မသေချာပါ
29.	လုံခြုံမှု ရှိသော လူနာစမ်းသပ်ခန်း □ ရှိပါသည် □ မရှိပါ □ မသေချာပါ
30.	လိင်ပိုင်းဆိုင်ရာအကြမ်းဖက်ခံရပြီးနောက် စောင့်ရှောက်ကုသမှုကိုမှတ်တမ်းတင်ရန် ပုံစံ □ ရှိပါသည် □ မရှိပါ □ မသေချာပါ
31.	HIVရောဂါပိုး ရှိ/ မရှိ အမြန်စစ်နိုင်သော သွေးစစ်ကိရိယာ (HIV test kit) □ ရှိပါသည် □ မရှိပါ □ မသေချာပါ
32.	မုဒိမ်းမှုကျူးလွန်ခံရသူအား အခမဲ့ ကုသပေးခြင်း/ ကုသမှုပေးသည့်

	ဆေးဝါးကုန်ကျစားရိတ်ကို သက်ဆိုင်ရာ ကျန်းမာရေးဦးစီးဌာနသို့ တောင်းခံနိုင်ခြင်း □ ရှိပါသည် □ မရှိပါ □ မသေချာပါ
33.	(အသုံးပြုရန် ရက်စွဲမလွန်သော) အရေးပေါ်ကိုယ်ဝန်တားဆေး □ ရှိပါသည် □ မရှိပါ □ မသေချာပါ
34.	အကြမ်းဖက်ခံရသူများအတွက် လူမှုရေးနှင့် စိတ်ပိုင်းဆိုင်ရာ ပံ့ပိုးကူညီမှု ရနိုင်မည့်နေရာများကို သင်သိပါသလား။ □ သိပါသည် □ မသိပါ □ မသေချာပါ
အပိုင်း (၅) **ကျား/မ အခြေပြု အကြမ်းဖက်မှုခံစားရသူများအတွက် ကျန်းမာရေးစောင့်ရှောက်မှုနှင့် ပါတ်သက်သော အလေ့အကျင့်ပိုင်းဆိုင်ရာမေးခွန်း** **အဖြေကို □ တွင် အမှန်ခြစ်ပါ။**	
35.	လွန်ခဲ့သော နှစ်နှစ်အတွင်း ကျား/မ အခြေပြု အကြမ်းဖက်မှုခံစားရသူများကို ကျန်းမာရေး စောင့်ရှောက်မှု ပေးဘူးပါသလား။ □ ပေးဘူးပါသည် □ မပေးဘူးပါ

	မပေးဖူးပါက မေးခွန်းနံပါတ် ၃၇ သို့သွားပါ။
36.	ပေးဖူးပါက ထိုလူနာများ၏ အကြောင်းကို မှတ်မိသမျှ ဖြေဆိုပါ။ လူနာအရေအတွက်_____ **လူနာ (၁)** အကြမ်းဖက်မှုပုံစံ (တစ်ခုမက ဖြေဆိုနိုင်ပါသည်။) □ စိတ်ပိုင်းဆိုင်ရာ □ ရုပ်ပိုင်းဆိုင်ရာ □လိင်ပိုင်းဆိုင်ရာ အကြမ်းဖက်ခံရသူ၏ လိင်ပိုင်းဆိုင်ရာ ခံယူချက် □ ကျား □ မ □အခြား (မိန်းမလျာ၊ ယောကျ်ားလျာ စသည်) အကြမ်းဖက်မှု ကျူးလွန်သူ □ မသိပါ □ လက်တွဲဖော် □ မိသားစုဝင် □ သူစိမ်း (ဥပမာ-ယောကျ္ခမ) **လူနာ (၂)** အကြမ်းဖက်မှုပုံစံ (တစ်ခုမက ဖြေဆိုနိုင်ပါသည်။)

□ စိတ်ပိုင်းဆိုင်ရာ □ ရုပ်ပိုင်းဆိုင်ရာ □လိင်ပိုင်းဆိုင်ရာ

အကြမ်းဖက်ခံရသူ၏ လိင်ပိုင်းဆိုင်ရာ ခံယူချက်

□ ကျား □ မ □အခြား (မိန်းမလျာ၊ ယောကျ်ားလျာ စသည်)

အကြမ်းဖက်မှု ကျူးလွန်သူ

□ မသိပါ □ လက်တွဲဖော် □ မိသားစုဝင် □ သူစိမ်း

(ဥပမာ-ယောကျ္ခမ)

လူနာ (၃)

အကြမ်းဖက်မှုပုံစံ (တစ်ခုမက ဖြေဆိုနိုင်ပါသည်။)

□ စိတ်ပိုင်းဆိုင်ရာ □ ရုပ်ပိုင်းဆိုင်ရာ □လိင်ပိုင်းဆိုင်ရာ

အကြမ်းဖက်ခံရသူ၏ လိင်ပိုင်းဆိုင်ရာ ခံယူချက်

□ ကျား □ မ □အခြား (မိန်းမလျာ၊ ယောကျ်ားလျာ စသည်)

အကြမ်းဖက်မှု ကျူးလွန်သူ

□ မသိပါ □ လက်တွဲဖော် □ မိသားစုဝင် □ သူစိမ်း

	(ဥပမာ-ယောကျ်ားမ)
37.	ထိခိုက်ဒဏ်ရာ ရရှိသော လူနာများကို ကျား/မ အခြေပြု အကြမ်းဖက်ခံရခြင်း ဟုတ်/မဟုတ် သတိပြုမေးမြန်းရာတွင် ပါဝင်ဘူးပါသလား။ □ မပါဝင်ဘူးပါ □ ပါဝင်ဘူးပါသည်⟶ □ အမြဲတမ်း (_____/_____cases) □ မကြာခဏ (_____/_____cases) □ တစ်ခါတစ်ရံ (_____/_____cases) □ အလွန်နည်း (_____/_____cases)
	ကျား/မ အခြေပြု အကြမ်းဖက်မှုခံစားရသူများကို ကျန်းမာရေးစောင့်ရှောက်မှု မပေးဘူးသော် လည်း အကြမ်းဖက်ခံရခြင်း ဟုတ်/မဟုတ် သတိပြုမေးမြန်းဘူးပါက မေးခွန်း ၃၈ သို့ သွားပါ။ ***ကျား/မ အခြေပြု အကြမ်းဖက်မှုခံစားရသူများကို ကျန်းမာရေးစောင့်ရှောက်မှု မပေးဘူး၊ အကြမ်းဖက်ခံရခြင်း ဟုတ်/မဟုတ်***

	သတိပြုမေးမြန်းခြင်းမလုပ်ဘူးပါက ဤနေရာတွင် ရုပ်ပါ။
38.	ကျား/မ အခြေပြု အကြမ်းဖက်မှုခံစားရသူများအတွက် ကျန်းမာရေးစောင့်ရှောက်မှုပေးနိုင်ရန် လုပ်ငန်းလမ်းညွှန်ကို အသုံးပြုဖူးပါသလား။ □ အသုံးမပြုဘူးပါ □ အသုံးပြုဘူးပါသည်→ □ အမြဲတမ်း (_____/_____cases) □ မကြာခဏ (_____/_____cases) □ တစ်ခါတစ်ရံ (_____/_____cases) □ အလွန်နည်း (_____/_____cases)
	ကျား/မ အခြေပြု အကြမ်းဖက်မှုခံစားရသူများကို ကျန်းမာရေးစောင့်ရှောက်မှု မပေးဘူး၊ အကြမ်းဖက်ခံရခြင်း ဟုတ်/မဟုတ် သတိပြုမေးမြန်းခြင်းမလုပ်ဘူး၊ လုပ်ငန်းလမ်းညွှန် အသုံးမပြုဘူးပါက ဤနေရာတွင် ရုပ်ပါ။
39.	ငိုကြွေးနေသော ကျား/မ အခြေပြု အကြမ်းဖက်မှုခံစားရသူကို နှစ်သိမ့်ပေးရာတွင် ပါဝင်ဘူးပါသလား။

	□ မပါဝင်ဘူးပါ □ ပါဝင်ဘူးပါသည် ⟶ □ အမြဲတမ်း (_____/_____cases) □ မကြာခဏ (_____/_____cases) □ တစ်ခါတစ်ရံ (_____/_____cases) □ အလွန်နည်း (_____/_____cases)
40.	ကျား/မ အခြေပြု အကြမ်းဖက်မှုခံစားရသူကို ရောဂါ ရာဇဝင်ယူရာတွင် သူ၏ မိသားစုဝင်ကို ကျူးလွန်ခံရသူအနား/ အတူတကွ ခေါ်ထားဘူးပါသလား။ □ မခေါ်ထားဘူးပါ □ ခေါ်ထားဘူးပါသည် ⟶ □ အမြဲတမ်း (_____/_____cases) □ မကြာခဏ (_____/_____cases) □ တစ်ခါတစ်ရံ (_____/_____cases)

	□ အလွန်နည်း (_____/_____cases)
41.	ကျား/မ အခြေပြု အကြမ်းဖက်မှုခံစားရသူပြောဆိုလိုသော အကြောင်းအရာများကို အချိန်ပေး၍ နားထောင်ဘူးပါသလား။ □ မနားထောင်ဘူးပါ □ နားထောင်ဘူးပါသည် ⟶ □ အမြဲတမ်း (_____/_____cases) □ မကြာခဏ (_____/_____cases) □ တစ်ခါတစ်ရံ (_____/_____cases) □ အလွန်နည်း (_____/_____cases)
42.	ကျား/မ အခြေပြု အကြမ်းဖက်မှုခံစားရသူများကို ကျန်းမာရေးစောင့်ရှောက်မှု အဆင့်များကို ရှင်းပြရာတွင် ပါဝင်ဘူးပါသလား။ □ မပါဝင်ဘူးပါ □ ပါဝင်ဘူးပါသည် ⟶ □ အမြဲတမ်း (_____/_____cases)

	□ မကြာခဏ (_____/_____cases) □ တစ်ခါတစ်ရံ (_____/_____cases) □ အလွန်နည်း (_____/_____cases)
43.	ကျား/မ အခြေပြု အကြမ်းဖက်မှုခံစားရသူများကို HIVစစ်ဆေးခြင်း၊ ကာကွယ်ရန် ဆေးပေးခြင်း (PEP) နှင့်ပါတ်သက်ပြီး ရှင်းပြရာတွင် ပါဝင်ဘူးပါသလား။ □ မပါဝင်ဘူးပါ □ ပါဝင်ဘူးပါသည် ⟶ □ အမြဲတမ်း (_____/_____cases) □ မကြာခဏ (_____/_____cases) □ တစ်ခါတစ်ရံ (_____/_____cases) □ အလွန်နည်း (_____/_____cases)
44.	အကြမ်းဖက်ခံရသူကို ဆက်လက်စောင့်ရှောက်ကုသမှုပေးနိုင်ရန်

	ချိန်းဆိုဘူးပါသလား။ □ မပါဝင်ဘူးပါ □ ပါဝင်ဘူးပါသည် → □ အမြဲတမ်း (_____/_____cases) □ မကြာခဏ (_____/_____cases) □ တစ်ခါတစ်ရံ (_____/_____cases) □ အလွန်နည်း (_____/_____cases)
45.	အကြမ်းဖက်ခံရသူကို ဥပဒေဆိုင်ရာ အကူအညီပေးနိုင်သည့် အဖွဲ့အစည်းများထံ ညွှန်းပို့ရန်စီစဉ်ရာတွင် ပါဝင်ဘူးပါသလား။ □ မပါဝင်ဘူးပါ □ ပါဝင်ဘူးပါသည် → □ အမြဲတမ်း (_____/_____cases) □ မကြာခဏ (_____/_____cases) □ တစ်ခါတစ်ရံ (_____/_____cases)

	□ အလွန်နည်း (_____/_____cases)
46.	အကြမ်းဖက်ခံရသူကို လူမှုရေးအကူအညီပေးနိုင်သည့် အဖွဲ့အစည်းများထံ ညွှန်းပို့ရန်စီစဉ်ရာတွင် ပါဝင်ဘူးပါသလား။ □ မပါဝင်ဘူးပါ □ ပါဝင်ဘူးပါသည်⟶ □ အမြဲတမ်း (_____/_____cases) □ မကြာခဏ (_____/_____cases) □ တစ်ခါတစ်ရံ (_____/_____cases) □ အလွန်နည်း (_____/_____cases)
47.	အကြမ်းဖက်ခံရသူသည် ဘေးကင်းလုံခြုံသောနေရာသို့ ရောက်ရှိစေရန် စီစဉ်ရာတွင် ပါဝင်ဘူးပါသလား။ □ မပါဝင်ဘူးပါ □ ပါဝင်ဘူးပါသည်⟶ □ အမြဲတမ်း (_____/_____cases) □ မကြာခဏ

	(_____/_____cases) □ တစ်ခါတစ်ရံ (_____/_____cases) □ အလွန်နည်း (_____/_____cases)

ပါဝင်ဖြေဆိုပေးခြင်းအတွက် ကျေးဇူးတင်ပါသည်။

Appendix I: IOC Score of the Measurement Tool

Item No.	Expert 1	Expert 2	Expert 3	Total Score	IOC Index
1	1	1	1	3	3/3=1
2	1	1	1	3	3/3=1
3	1	1	1	3	3/3=1
4	1	1	1	3	3/3=1
5	1	1	1	3	3/3=1
6	0	1	1	2	2/3=0.67
7	1	1	1	3	3/3=1
8	1	1	1	3	3/3=1
9	1	1	1	3	3/3=1
10	1	1	1	3	3/3=1
11	1	1	1	3	3/3=1
12	1	1	1	3	3/3=1
13	1	1	1	3	3/3=1
14	1	1	1	3	3/3=1
15	1	1	1	3	3/3=1

16	1	1	1	3	3/3=1
17	1	1	1	3	3/3=1
18	1	1	1	3	3/3=1
19	1	1	1	3	3/3=1
20	-1	1	1	1	1/3=-0.33
21	1	1	1	3	3/3=1
22	1	1	1	3	3/3=1
23	1	1	1	3	3/3=1
24	1	1	1	3	3/3=1
25	1	1	1	3	3/3=1
26	1	0	1	2	2/3=0.67
27	1	1	1	3	3/3=1
28	1	1	1	3	3/3=1
29	1	1	1	3	3/3=1
30	1	1	1	3	3/3=1
31	1	1	1	3	3/3=1
32	1	1	-1	1	1/3=0.33
33	1	1	1	3	3/3=1

34	1	0	1	2	2/3=0.67
35	1	1	1	3	3/3=1
36	0	1	1	2	2/3=0.67
37	1	1	1	3	3/3=1
38	1	1	0	2	2/3=0.67
39	1	1	1	3	3/3=1
40	1	1	1	3	3/3=1
41	1	1	1	3	3/3=1
42	1	1	1	3	3/3=1
43	1	1	1	3	3/3=1
44	1	1	1	3	3/3=1
45	1	1	1	3	3/3=1
46	1	1	1	3	3/3=1
47	1	1	1	3	3/3=1

Score for the whole questionnaire = 44.01/47 = 0.94

Question number 20 was revised according to the comments and checked. Question number 32 is deleted and substituted with a new question advised by the experts.

Appendix J: Budget Estimation

No.	Description	Estimated Expenses (Baht)	Remark
1	A4 Paper	2000	
2	Buying Stationary	1000	
3	Printing Materials	2000	
4	Treats and Presents for Respondents	13000	for 422 participants
5	Transportation to Study Sites	6000	
7	Accomodation when data collection	6000	
	Total	30000	
	As my sample size is quite large (422) the budget on souvenir for respondents is high.		

Appendix K: Time Schedule

Research Activities	**Time Frame**										
	Sep	Oct	Nov	Dec	Jan	Feb	March	April	May	June	July
Literature Review											
Thesis Proposal Writing and Preparation											
Tool Development for Data Collection											
Thesis Proposal Defense/ Ethical Approval											
Field Preparation and Data											

Collection											
Data Analysis											
Thesis Writing											
Thesis Defense Exam											
Submitting Final Thesis											
Total	**11months**										

Appendix L: Respondents by Knowledge on GBV Cases

Statement (n=398)	**Scores n (%)**					
	0	**1**	**2**	**3**	**4**	**5**
1. Forms of gender-based violence include, □ Constant humiliation □ Economic dependency □ Unwanted sexual comments □ Argument □ Controlling behaviors by the spouse	7 (1.8)	11 (2.8)	53 (13.3)	116 (29.1)	121 (30.4)	90 (22.6)
2. The violence can cause these adverse effects on health. □ Acute kidney failure □ Depression □ Unwanted pregnancy □ Varicose vein □ Suicide	0 (0.0)	13 (3.3)	8 (2)	30 (7.5)	62 (15.6)	285 (71.6)
3. In providing clinical management to a sexual assault survivor, these are the procedures to be included.	0 (0.0)	1 (0.3)	26 (6.5)	77 (19.3)	216 (54.3)	78 (19.6)

□ Obtaining informed consent □ Oral care □ Prevention of STIs □ Cervical cancer screening □ Psychological support						
4. In providing treatment and care to a sexual assault survivor, prevention of these diseases are mandatory. □ Tetanus □ Skin fungal infections □ Measles □ Hepatitis B □ Gonorrhea	0 (0.0)	8 (2)	54 (13.6)	157 (39.4)	141 (35.4)	38 (9.5)
5. During history taking and physical assessment, these data should be collected. □ Vaccination history □ Current contraceptive use □ Assessment for virginity □ Assessment on pelvic and anal region □ Causes of being violated	0 (0.0)	8 (2)	73 (18.3)	177 (44.5)	121 (30.4)	19 (4.8)

6. These are the specimen that can be collected for the forensic purpose. □ Clothing □ Hair □ Skin □ Urine □ Sanitary pads/ tampons	0 (0.0)	17 (4.3)	96 (24.1)	144 (36.2)	104 (26.1)	37 (9.3)
7. In order to provide psychological support to the survivor, □ A private environment is required to support open communication □ Force the survivor not to cry □ Explain the survivor that the information will be kept confidential □ Explain the survivor that it is the perpetrator's fault and she does not need to feel guilty □ Explain that if orgasm occurred during the assault, it is the survivor's fault	0 (0.0)	0 (0.0)	4 (1)	78 (19.6)	126 (31.7)	190 (41.7)
8. Follow-up visits are appointed for,	0 (0.0)	2 (0.5)	16 (4.0)	78 (19.6)	245 (61.6)	57 (14.3)

□ Checking the adherence of medications □ Providing contraceptives □ Evaluating the mental health status □ Evaluating the status of STIs □ Evaluating the status of thyroid hormones						
9. These organizations can be contacted for the legal or social support. □ Ministry of Foreign Affairs □ Myanmar Women's Affairs Federation □ Myanmar Maternal and Child Welfare Association □ INGOs □ Community-based organizations	0 (0.0)	0 (0.0)	17 (4.3)	21 (5.3)	142 (35.7)	218 (54.8)

VITA

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