ADDIS ABABA UNIVERSITY
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A RESARCH PAPER ON* ASSESSEMENT OF KAP OF HIV POSITIVE *MOTHERS ON VCT AND INFANT FEEDING IN AKAKI KALITI, ADDIS ABEBA, ETHIIOPIA.

BY:

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ACRONYMS

AA: – Addis Ababa

VCT: - Voluntary Counseling and Testing

HIV: - Human Immunodeficiency Virus

AIDS: - Acquired Immunodeficiency Syndrome

EDHS-Ethiopian demographic health survey

MTCT: - Maternal to Child Transmission

PMTCT: - Prevention of Maternal To Child Transmission

UNAIDS: - Joint United Nations Program on HIV

UNDP: - United Nations Development Program

UNFPA: - United Nations Population Fund

UNICEF: - United Nations Children's Fund

WHO: - World Health Organization

MOH: - Ministry of Health

ANC: - Antenatal Care

AFASS: - Acceptable, Feasible, Affordable, Sustainable and Safe

ART: - Antiretroviral Therapy

MCH: -Maternal and Child Health

EPI: - Expanded Program on Immunization

BCC: - Behavioral Change Communication

IMNCI: - Integrated Management of Neonatal Childhood Illness

TB: - Tuberculosis

ABSTRACT

Background: *Strategies to respond to the global HIV epidemic include preventing new infections and providing care and support to infected individuals. Prevention of Mother to Child Transmission of HIV (PMTCT) is one of the strategies given high priority. In Ethiopia, 96 000 children under fifteen live with HIV, which is related to the prevalence rate of HIV/AIDS and mother to child transmission (MTCT) of the virus. Without intervention, the risk of MTCT of HIV is 15-30% in non breastfeeding populations; breastfeeding by an infected mother increases the risk by 5-20% to a total of 20-45%. Studies have also shown the variation in MTCT rates by duration of breastfeeding, exclusivity of breastfeeding, and the danger of mixed feeding.*

Objective *This study was at determining the levels and identifying determinants of KAP of mothers about VCT and feeding of infants born to HIV positive women.*

Methods: *A cross-sectional descriptive study was conducted by using quantitative data collection method with pre tested structured questioner on 300 mothers (79 pregnant and 221 lactating) residing in akaki kality sub city from April to may 2014. Study subjects were selected using simple random sampling. Data was analyzed using SPSS version 16. Descriptive statistics were used to describe characteristics of the study subjects and logistic regression model were used to predict the association of the independent and outcome variable.*

Results: *Among the mothers (n=300), 38.8% had sufficient knowledge about MTCT (during pregnancy, labor, breastfeeding), 4 1.8% had sufficient knowledge about PMTCT, 30.5% had sufficient knowledge about infant feeding options recommended to HIV positive women, 62.4% had favorable attitude towards VCT, 4.7% had favorable attitude towards the feeding options, 84.5% visited health institutions for antenatal care and 35.7% used VCT service during their last pregnancy. Beside these lactating mothers (n=221) practiced mixed feeding 81.5%, exclusive breastfeeding 13.4% and most (91.1%) of the pregnant mothers intended to mixed feed their infants of age 0-6 months. Based on logistic regression analysis, knowledge of the mothers about the infant feeding options was significantly associated with their, age, husbands being important persons for mothers to decide on how to feed their infants, and counseling mothers on infant feeding during ANC. Infant feeding practices of lactating mothers was also having a statistically significant association with their ANC use, and place of delivery.*

Conclusion/ recommendation: *Mixed feeding increases the risk of non HIV diseases like diarrhea and malnutrition for infants of age 0-6 months, and for most of mothers didn't know their HIV status potentially increases risk of MTCT of HIV. Therefore, strengthening counseling mothers on safe infant feeding practices, and introducing an appropriately designed BCC program to the community on safe infant feeding Practices and importance of partners Involvement in HIV testing and counseling are mandatory*

Key words: *- Infant feeding, VCT, PMTCT, MTCT.*

1. INTRODUCTION

1.1 BACKGROUND

Of the 37.8 million people living with HIV/AIDS worldwide at the end of 2003, 2.1 million were children under 15. 630,000 children were newly infected with the AIDS virus, with 90% of these infections occurring in sub-Saharan Africa. The most significant source of HIV infection in children and infants is transmission of HIV from mother to child during pregnancy, childbirth, or breastfeeding(1).

HIV/AIDS is causing a devastating impact on the world's children (1-2). Globally, over 1,500 unborn or newborn babies are infected every day and over 90% of newly infected children are babies born to HIV-positive women, who acquire the virus at birth or through their mother's breast milk. Mother-to-child transmission (MTCT) is by far the largest source of HIV infection in children under the age of 15, with 90% of the cases infected during pregnancy, birth, or breast-feeding. In countries where blood products are regularly screened and clean syringes and needles are widely available, it is virtually the only source infection in young children (2).

Under-5 mortality rates showed an increase in most countries with high adult HIV prevalence (3). Though Africa accounts for only 10 percent of the world's population, one in four infants are delivered to an HIV infected mother and, in the absence of intervention, one in ten per year will become infected themselves largely as a consequence of high fertility rates combined with very high infection rates. In Ethiopia, it is estimated that there were some 128,000 HIV positive pregnancies and 35,000 HIV positive births in 2003(3).

Ethiopia is the second most populous country in Africa, with a 2003 population estimated at 70 million people. As reported in the 5th edition of –AIDS in Ethiopia" published in June

2004, the national adult prevalence of HIV for 2003 is estimated at 4.4%, with a 12.6% urban rate and a 2.6% rural rate. The corresponding figures in the earlier report for 2001 were 6.6% (national), 13.7% (urban), and 3.7% (rural)(1).

Based on current estimates and projections, the urban epidemic has peaked and it is expected that prevalence in urban areas is going to remain steady up to 2008, whereas in rural areas it will increase steadily and may reach 3.4% from current level of 2.6%. Several efforts will be required in all areas if the tide of HIV/AIDS is to be controlled in Ethiopia(4).

1.2 STATEMENT OF THE PROBLEM

Developing and implementing a PMTCT program-complete with strategies for ARV prophylaxis, safer childbirth, and safer infant feeding practices-is a complex process. The healthcare managers must determine which elements of a comprehensive program should be given special attention, and they must ensure that appropriate policy and legislation support chosen interventions. They should mobilize resources and establish a systematic approach to implementing interventions. Finally, all healthcare providers working in the program must be trained. To compound the complexity of PMTCT efforts, the existing maternal and child health infrastructure might require strengthening before the PMTCT program can operate(5).

The interventions recommended is supported by evidence from pilot projects in several countries that demonstrated the feasibility of implementing various PMTCT interventions-including short-course ARV prophylaxis-in resource-constrained setting like Ethiopia(6). Many of those nations are now shifting from pilot projects to national programming, integrating PMTCT interventions into antenatal care (ANC) and reproductive healthcare settings(6).

The rapidly growing HIV/AIDS epidemic in Ethiopia requires an effective and coordinated approach to

training and collaboration to maximize the resources available for capacity building. Growing support for PMTCT is evident in various new funding initiatives.

The World Health Organization (WHO) 3 by 5 initiative aims to distribute treatment for 3 million people in developing countries by 2005. Training healthcare workers is essential to effective PMTCT programs, which serve as a critical entry point to ARV therapy and supportive care(6).

The U.S. government also has offered further support to Ethiopia and several other countries in Africa in the fight against HIV/AIDS with the President's Emergency Plan for AIDS Relief (PEPFAR), a program for providing treatment and care in developing countries(7). PEPFAR funding will support the rapid scale up of HIV treatment programs through 2005 in an effort to treat 2 million people, prevent 7 million infections, and provide care for 10 million people. PEPFAR also will provide for the development of prevention initiatives, including PMTCT, palliative care, and service for orphans and vulnerable children(6). In the collaborative effort against the HIV/AIDS epidemic, PMTCT plays a central role by preventing new infections and by providing the services needed to ease the burden on HIV-infected women(8).

1.3 SIGNIFICANT OF STUDY

To date no community based studies have been conducted to assess the level of knowledge, attitude and practice of target population of PMTCT programs (pregnant or lactating mothers), and counseling/ care providers about feeding of infants born to HIV positive women in Ethiopia. Thus, this study will contribute to fill the information gap, and in design of the strategies to prevent mother to child transmission of HIV and to promote appropriate infant feeding practice in the study setting.

2. LITRATURE REVIEW

2.1 PREVALENCE OF HIV/AIDS IN PREGNANCY AND LACTATING MOTHERS IN ETHIOPIA

Ethiopia's burden of HIV/AIDS is great. The number of adults and children living with HIV/AIDS in 2003 is estimated at 1.4 million and 95,000 respectively. It is estimated that there were 128,000 HIV positive pregnant mothers and 35,000 HIV positive births in 2003. There were some 245,000 new PLWHA in need of antiretroviral (ART) therapy in 2003. In 2004 an additional 265,000 persons will need ART. The number of new AIDS cases in 2003 is estimated at 98,000 and 25,000 for adults and children respectively. In the same year there were approximately 90,000 adult and 24,000 pediatric AIDS deaths (9).

In other hand the majority (63%) of children born to HIV-infected mothers are uninfected. About 10-20% of the babies acquire the virus from their mothers during breast-feeding for the first 24 months (11-12). However, the risk may increase depending on certain situations related to themother, the baby and the virus (11,13). The rate of MTCT prior to the advent of interventions in Europeand USA was around 15–20%, compared with about 30% inAfrica (14). Most of this difference is a result of breast-feeding,which approximately doubles the transmission rate. In non-breast feeding populations, around two thirds of MTCT occurs aroundthe time of delivery. The increased uptake of interventionsin pregnancy has led to vertical transmissionrates falling below 2% in women diagnosed prior to delivery (13). Although there are many possible explanations for this disparity, the distinct difference in the prevalence of breast-feeding among HIV-infected mothers in resource-rich versus resource-poor settings is likely implicated (14).

Orphan numbers are staggering. It is estimated that there are 4.6 million orphans in 2003, of which 536,720 were AIDS orphans (15).

The unadjusted HIV prevalence among urban antenatal attendees was 12.0% and rural 4.1%. Though not significant, the majority of the urban sites show a lower prevalence in 2003 compared to previous years (16).

Of the urban sites reporting, Dubti Hospital in Afar (24%), Bahir Dar Health Center in Amhara (20.2%) and Gambella Hospital in Gambella (18.7%) reported the highest prevalence of HIV among antenatal mothers(1). Federal Police Hospital, which caters to their own staff only, reported 30.2% prevalence among antenatal mothersand the Armed Forces General Hospital 15.3%. Among the rural sites the highest prevalence was reported by Haik Health Center (11.9%), Tenta Health Center (11.5%) in Amhara, and Dello Health Center in Oromia (8.5%)(9)

From the analysis of the site data, as described in AIDS in Ethiopia (5th edition) it was found that 7.8 % ANC attendees in the age group 15-19 years were HIV positive. This age group, most likely being the sexual debut period, can be a proxy for new infections and thus indicate incidence of HIV. However, HIV prevalence is highest (12.9%) among urban ANC attendees in age group of 20-24 with the same age group in rural area having 4.2%. Whereas national prevalence among the same age group is 9.0%(9).

2.2 KNOWLEDGE OF PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV/AIDS

Increasing knowledge of ways in which HIV can be transmitted from mother to child and of the fact that the risk of transmission can be reduced by using antiretroviral drugs is critical to reducing

mother-to-child transmission (MTCT) of HIV (17). To obtain information on these issues, the 2011 EDHS asked respondents if the virus that causes AIDS canbe transmitted from a mother to a child during breastfeeding and whether a mother with HIV can reduce the risk of transmission to the baby by taking certain drugs (antiretroviral) during pregnancy (18).

77 percent of women and 76 percent of men—know that HIV can be transmitted to a baby through breastfeeding. More than four in every ten women (44 percent) and more than half of men (53 percent) know that the risk of MTCT can be reduced through the use of ARTs during pregnancy (19). Overall, 42 percent of women and 47 percent of men know both that HIV can be transmitted through breastfeeding and that HIV positive women can reduce the risk of MTCT by taking special drugs during pregnancy.

This knowledge has increased dramatically since the 2005 EDHS, from 20 percent to 42 percent for women and from 26 percent to 47 percent for men (20).

There are notable differences in knowledge of prevention of MTCT by background characteristic. The oldest respondents, age 40-49, are the least likely to know both facts about MTCT (34 percent of women and 42 percent of men), compared with younger respondents. Knowledge of both facts about MTCT is the highest among never-married respondents who have ever had sex (75 percent of women and 62 percent of men), compared with other marital status sub-groups. Urban women are more than twice as likely as rural women (71 and 32 percent, respectively) to report knowledge about mother-to-child transmission (21).

Among men 67 percent of urban residents, comparedwith 41 percent of rural residents, have correct knowledge about both aspects of MTCT. Women and men in the Somali region are the least

knowledgeable about the two aspects of MTCT (17 percent of women and 26 percent of men), while those in Addis Ababa are the most knowledgeable (81 percent of women and 71 percent of men) (22).

Knowledge of MTCT is lowest among respondents with no education (28 percent of women and 31 percent of men) and highest among those with more than secondary education (84 percent of women and 74 percent of men). This knowledge increases from 24 percent of women and 31 percent of men in the lowest wealth quintile to 71 percent of women and 68 percent of men in the highest wealth quintile (23).

2.3 ATTITUDES TOWARDS PEOPLE LIVING WITH HIV/AIDS

Widespread stigma and discrimination towards people infected with HIV or living with AIDS can adversely affect both people's willingness to be tested for HIV and their adherence to antiretroviral therapy. Thus, reduction of stigma and discrimination is an important indicator of the success of programmes to prevent and control HIV/AIDS (24).

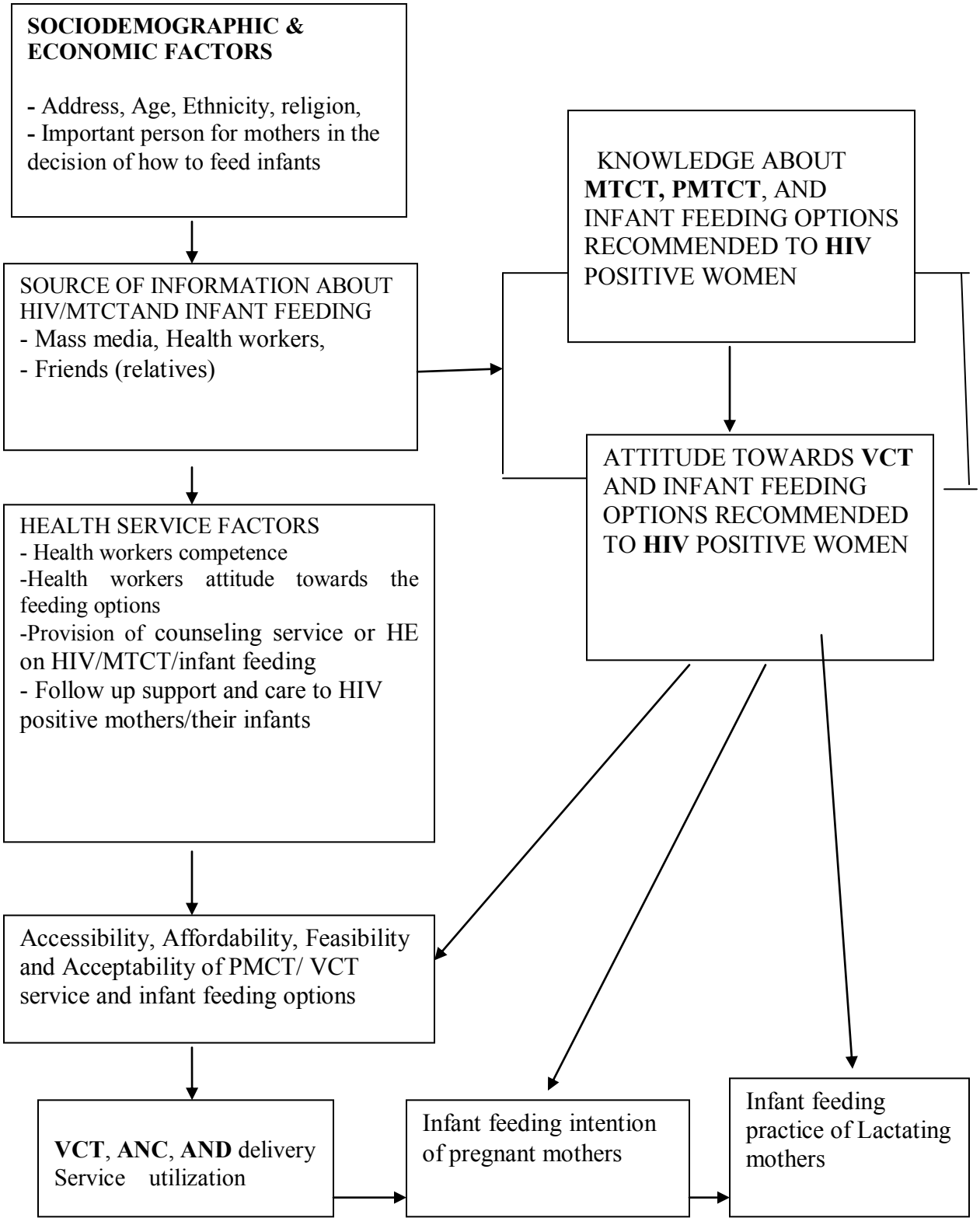
To assess survey respondents' attitudes towards people living with HIV/AIDS, respondents who had heard of AIDS were asked if they would bewilling to care for a relative sick with AIDS in their own households, if they would be willing tobuy fresh vegetables from a market vendor who had the AIDS virus, if they thought a female teacher who has the AIDS virus but is not sick should be allowed to continue teaching, and if they would want to keep a family member's HIV positive status secret (25). Most women and men age 15-49 (82 percent of women and 93 percent of men) would be willing to care at home for a relative with AIDS (27). Three women 15-49 of every ten (32 percent) and about

five men 15-49 in every ten (47 percent) would buy fresh vegetables from a market vendor with the AIDS virus, and six women of every ten (59 percent) and seven men of every ten (70 percent) believe that an HIV positive female teacher who is not sick should be allowed to continue teaching (28).

More than half of respondents (59 percent of women and 66 percent of men) would not want to keep secret the fact that a family member is infected with HIV. Overall, men are more likely than women to express accepting attitudes regarding all four situations (28 percent compared with 17 percent) (29).

Accepting attitudes are generally more common among respondents in urban areas than among those in rural areas and increase with education and wealth. Women and men residing in Addis Ababa, Dire Dawa, and Harari are the most likely to express accepting attitudes on all four indicators, while those living in SNNP region are the least likely (30).

Conceptual frame work of factors related to mothers KAP of VCT & feeding of infants



3. OBJECTIVES

3.1 General objectives

The aim of this study is to determine the levels and identify determinants of knowledge, attitude and practice (KAP) of mothers about VCT and feeding of infants born to HIV positive women in Akaki Keliti Kefila Ketama, Addis Ababa

3.2 Specific objectives

1. To determine the levels of knowledge, attitude and practice (KAP) of mothers about VCT and feeding of infants born to HIV positive women
2. To identify determinants of knowledge, attitude and practice (KAP) of mothers feeding of infants born to HIV positive women.

METHODS AND MATERIALS

4.1. Study area and period

Addis Ababa is the capital city of Ethiopia and head quarter of African Union covering an area of 540 sq. km. The total population of the city is about 3.3 million with 5046 peoples per square kilo meter, more of slum and overcrowded. The Administrative region has 10 sub cities and 106 woreda (districts). According to Addis Ababa health bureau report of 2010, there were 49 hospitals of which 13 were government owned, 5 NGOs and 31 are private, 27 public health centers, and 130 public health stations, 700 different levels private clinics are found in Addis Ababa city Administrative region. The study was conducted from April 11 to may 11, 2014

4.2. Study design

A cross-sectional study were conducted determine the levels and identifying determinants of knowledge, attitude and practice (KAP) of mothers about VCT and feeding of infants born to HIV positive women in Akaki Keliti Kefila Ketama, Addis Ababa, from April 11 to may 11, 2014.

4.3. Population

4.3.1. Source population

All HIV positive mothers residing in Addis Ababa

4.3.2. Study population

The study population was all pregnant mothers residing in Akaki Keliti Kefila Ketama and Have ANC follow up visit in the study area. And mothers of under one year old children sampled (selected) from this study population will be the study subjects.

Inclusion criteria

Pregnant women and all mothers who gave birth in the past 12 months of the study period regardless of its outcome (live birth, still birth, infant or neonatal death)as reported by respondents will be included in the study from the selected health centers.

Exclusion criteria

Mother of above one year old child and women who are not volunteer to participate

4.4. Sample size determinations and sampling technique

4.4.1. Sample size determination

The actual sample size for the study were determined using the formula for single population proportion by assuming 5% marginal error and 95% confidence interval (∂ (alpha)=0.05) and the prevalence for KAP on VCT and infant feeding practices was 89.1%, or P=89.1 , taken from Ethiopian Demographic Health Survey 2011. by using the following formula

$$n=\frac{\left(Z\frac{\alpha}{2}\right)^2 p(1-p)}{d^2}=\frac{Z^2 p(1-p)}{d^2}=\frac{(1.96)^2 X 0.05(1-0.05)}{(0.05)^2}=149$$

The required sample size is calculated by the following formula and p-value, prevalence of P= 89.1%, q= 10.9%, d= 0.05, z = 1.96

$n_o = (Z\alpha/2)^2 P (1 – P)/d^2$

$= 1.96^2 x\ 0.891x0.109/\ 0.05^2$

= 149

By assuming non-respondent rate and incomplete questionnaire taking 5% the total sample size and taking the design effect 2 the required sample size will be:-

N= 149 x 5% =149+ 7.5=156.5 then156.5 x 2 = 313

n = the required sample size

z = the value of the standard normal curve score corresponding to the given confidence interval=1.96

p = Assumed proportion of fertility desire= 50%

d = the permissible margin of error (the required precision) =5%

4.4.2. Sampling technique

A simple random sampling technique with population proportionate to size allocation (PPS) and lottery method were used. The Pregnant women and all mothers who gave birth in the past 12 months of the study period regardless of its outcome (live birth, still birth, infant or neonatal death) as reported by respondents was included in the study by lottery method.

4.5 Operational definitions

Lactating mother: a woman who gave birth in the past 12 months of thestudy period regardless of its outcome (live birth, still birth, infant or neonatal death).

Lactating mother Practiced Exclusive Breastfeeding: If the mother has given or fed her infant only the milk of her breast or a wet nurse, or expressed breast milk and no other liquids, or solids with the exception of vitamins, mineral supplements, or medicines

Lactating mother Practiced Mixed feeding: If the mother has given or fed her infant some breast milk and artificial feeds, either milk or cereal, or other food or liquids.

Lactating mother Practiced Exclusive Replacement feeding: If the mother has given or fed her infant only breast milk substitute, not breast-fed at all

Intention to Exclusive Breastfeed: When the respondent woman reported that her prenatal intention is (was) to feed her infant only the milk of her breast or a wet nurse, or expressed breast

milk and no other liquids, or solids with the exception of vitamins, mineral supplements, or medicines in the first six months of infancy.

Intention for Mixed Feeding: When the respondent woman reported that her prenatal intention is (was) to feed her infant some breast milk and artificial feeds, either milk or cereal, or other food or liquids in the first six months of infancy.

Intention to Exclusive Replacement Feeding: When the respondent woman reported that her prenatal intention is (was) to feed her infant only breast milk substitutes (not breast-milk at all), in the first six months of infancy.

Used VCT: If a respondent woman reported that she was counseled and offered voluntary HIV testing and received the test result during hermost recent pregnancy or before her most recent birth.

Knowledgeable about MTCT during pregnancy, delivery, and breastfeeding: A respondent who reported that HIV can be transmitted from mother to child during pregnancy, delivery, and through breast feeding.

Sufficient Knowledge about PMTCT: When the respondent woman identified correctly at least five correct or true statements out of six statements prepared about PMTCT of HIV.

Good Attitude towards VCT: When the respondent woman reported accepting attitude to all of three prepared statements of favorable attitude towards VCT.

Good Attitude towards Infant feeding options recommended to HIV positive women:

When the respondent woman reported accepting attitude to all of three prepared statements of favorable attitude towards the infant feeding options (exclusive replacement and exclusive breast feeding) recommended to HIV positive women.

Sufficient Knowledge about infant feeding options recommended to HIV positive women: When the respondent woman identified correctly at least seven true or false statements out of eight statements prepared about infant feeding options recommended to HIV positive women.

4.6 Variables

i. Dependent variable

☞ Knowledge

☞ Attitude

☞ Practice

ii. Independent variables

☞ Age

☞ Sex

☞ Religion

☞ Occupational status

☞ Educational status

☞ Marital status

☞ Economic status

4.7. Data collection and procedure

4.7.1 Data collection tool

Structured questionnaires were used for to collect the data It was prepared in English, translated into Amharic and then translated back in to English to check for consistency. Main points included in the questionnaire were Variables related to socio demographic characteristics, knowledge, attitude, and practice of mothers on VCT/PMTCT and Infant feeding

4.7.2 Pre test /pilot of study

Pilot study was conducted by considering 10% of the total sample size to test the questionnaires variability and subjects who were involved in the pre-test were excluded from the study, then the questionnaire assessed for its clarity, time it takes and completeness and the necessary correction was done accordingly

4.7.3 Data collection and quality control

The structured questionnaire is translated to Amharic languages and discussions will be made if there are culturally unacceptable questions, ambiguous words etc with small group of respective ethnic groups. Then the questionnaire were pretested on local people. Training will be given for one supervisor and data collectors (3 BSc nurse) and included provision of handouts on a review of general study objectives and procedures, detailed discussion of every data item to be collected and discussion of how to resolve potential problems, practical session on measurement and observations based on standard way.

The data collection format of each data collectors was checked daily for completeness, missed or other relevant information on meeting and supportive supervision during data collection. Data editing was done by the data collectors, supervisors and the principal investigator in the field and further cleaning of data, coding

and entry to computer.

4.8 Data entry, analysis and processing

Data was entered to Epi-Info 3.4.3 for windows and analyzed using SPSS version 16.0 for windows The data was cleaned and edited before analysis. Data exploration was undertaken to see if there were odd codes or items that were not logical and then subsequent editing were made. Frequency distributions, pie chart, figures and tables were used to provide an overall and coherent presentation and description of data. Multivariate logistic regression model were used to express the magnitude and association between the independent and outcome variable .Adjusted OR with 95% CI and P – value <0.05 were calculated to control confounding variable, variables included in the model were restricted to those significantly related at least to one of the two outcome variable at the bivariate level

4.9 Ethical consideration

The proposal was submitted to Addis Ababa University, college of health science, School of Allied Health Science, Department of Nursing and Midwifery, Nursing Research Review Committee for approval. Following the approval by Nursing Research Review Committee, Official letter of co-operation was written to the concerned bodies by School of Allied Health science, Department of Nursing and Midwifery. Because the study was conducted through review of medical records and non-invasive data collection methods, the individual patients was not subjected to any harm as far as the confidentiality is kept. No personal identifiers were used on data collection form. The recorded data was not accessed by a third person except the principal investigator, and was kept confidentially.

4.10 Dissemination of results

The result of the study will be communicated to relevant bodies including Addis Ababa University, college of health science, department of nursing and midwifery and furthermore, all attempts will be made to present the findings to scientific conference and attempt will be made to publish the finding in reputable journal

5. Results

Out Of 313 mothers who were eligible for the study 13 (4.2%) refused to participate. Of the remaining 300 mothers, 79 were pregnant (gestation age beyond 6 month as reported by the respondents) and 221 lactating mothers (mothers within 12 months postpartum)

5.1 Socio-demographic Characteristics

The mean age of the mothers was 26 years (SD=4.2) and ranges from 17 to 42 years. Regarding the marital status, 261 (87%) were married, 29 (9.7%) were single, 10 (3.3 %) were divorced (separated). Most 247(82.3%) of the mothers gave birth to 1-4 live children in their life time, while 33(11. %) were nullipara and 20(6.7%) grand-multipara mothers (Table 1).

Similar proportion of mothers 131 (43.7%) and 127 (43%) respectively, were followers of the Orthodox Christian and Islam. Nearly half of the study subjects were Oromo 144 (48%), followed by Amhara 56(18.7%) by ethnicity (Table 1).

During the study period, most of the mothers were housewives, 241 (80.3%), or jobless (students), 24 (8%), by occupation. The median household monthly income was 130 ETB, and ranges from nil to 5000 ETB (Table 1).

Fifty two percent of the study subjects (n=300) completed grade 7 and above, while another 25.7% completed grades 1 to 6. The remaining, 19.3% were unable to read or write (Table 1).

Regarding drinking water source, the majority 280 (93.3%) of the households included in the study got drinking water from a pipe water supply (Table 1).

Table 1 socio-demographic characteristic of mothers in Akaki-kality sub-city, AA, Ethiopia, June 2014

	mothers		
VARIABLES	**Pregnant (n=79)**	**Lactating (n=221)**	**Total**
	No. (%)	**No. (%)**	**No. (%)**
Age Group(years)			
< 20	22 (27.8)	63 (28.5)	85 (28.3)
21-25	31(39.2)	82(37.1)	113 (37.7)
26-30	18 (22.8)	54(24.4)	72 (24)
>31	8(10.1)	22(10)	30 (10)
Martial Status Single	7(8.9)	22 (10)	29 (9.7)
Married	70 (88.6)	191 (86.2)	261 (87)
Divorced/separated	2(2.5)	8 (3.7)	10 (3.3)
Parity 0	32 (40.5)	1 (0.5)	33 (11)
1 - 4	44 (55.7)	203 (91.9)	247(82.3)
> 5	3 (3.8)	17(7.7)	20 (6.7)
Religion Orthodox	35 (44.3)	96(43.4)	131(43.7)
Protestant	10 (12.7)	30(13.6)	40(13.3)
Muslim	34 (43)	95(42.9)	129(43)
Ethnicity Oromo	39 (49.4)	105(47.5)	144 (48)
Amhara	14(17.7)	42(19)	56 (18.7)
Tigrea	8 (10.1)	21(9.5)	29 (9.7)
Guragie	6 (7.6)	19 (8.6)	25(8.3)
Others	12(15.2)	34 (15.4)	46 (15.3)
Educational status Unable to read and write	19(24.)	39(17.6)	58(19.3)
Able to Read and write	2(2.5)	7(3.2)	9 (3)
Grades 1 - 6	19 (24)	58(26.2)	77(25.7)
Grades 7 and above	39(49.4)	117(53)	156(52)
Occupation Jobless/student	6(7.6)	18 (81)	24 (8)
Housewife	65 (82.3)	176 (79)	241
Gov't/private org. employee	4 (5.1)	14(6.6)	18 (6)
Merchant	1 (1.3)	5 (2.3)	6(2)
House maid	1 (1.3)	5(2.3)	6 (2)
Daily laborer	2 (2.5)	3 (1.4)	5 (1.7)
Household monthly Income < 100 ETB	22 (27.8)	55 (24.7)	77(25.7)
101 - 300 ETB	20 (25.3)	54 (24.4)	74
301 - 500 ETB	9 (1011.4)	24(10.9)	33 (11)
Above 500 ETB	10(12.7)	39 (17.7)	49
Didn't want to mention it	18 (22.8)	49 (22.2)	67
Household's drinking water source: Pipe water	74 (93.7)	206 ()93.2	280(93.3)
Unprotected well and spring (some times pipe) water	5 (6.3)	15(6.8)	20 (6.7)

5.2 Mother's Utilization of Maternal Health and VCT Services and Important Persons on Infant Feeding decisions:

Among the study subjects (n=300), 84.5% visited health institutions for antenatal care and 36% used VCT service during their current pregnancy or last pregnancy (lactating mothers). 254(81.2%) of the VCT users underwent test for HIV in government hospital (Table 2).

The distribution of mothers by place of delivery shows that half (50.7%) of the lactating mothers (n=221) delivered their infants in government hospital, while 31.5%, and 16 % of them delivered at their own home and government health center respectively. (Table 2)

Regarding the important person in making decision on how to feed infants; 108 (36%) mothers themselves, husbands (partners) 167 (55.6%) and the grandfather of the infants 25 (8.3%) were reported to be important in deciding on how to feed their infants (Table 2).

Table.2: Distribution of mothers by utilization of maternal health and VCT services in Akaki-kality sub-city, AA, Ethiopia, June 2014

VARIABLES	MOTHERS :(n=300)		TOTAL
	Pregnant No. (%)	Lactating No. (%)	No. (%)
Antenatal care use during the recent pregnancy			
Yes	62 (78)	191 (86.4)	253
No	17 (21.5)	30 (13.6)	47 (15.5)
Institutions used for ANC: :			101
Government Hospital	22 (27.8)	79 (35.7)	(39.7)
Government health center	30 (37.9)	96 43.3)	126
Others	27 (34.2)	46 (21)	73(10.7)
Counseled about infant feeding during ANC visits:			
Yes	26 (33)	88 (39.8)	114 (38)
No	53 (67)	133 (60.2)	186(62)
Place of the recent delivery:			112
Government Hospital	NA	112 (50.7)	(50.7)
Own home	NA	70 (31.5)	70 (31.5
Government health center	NA	35(16.0)	35 (16.0)
Government/private clinic	NA	4 (1.9)	4 (1.9)
The most important person in making decision on how to feed their infant: n=			
The mother herself	30 (38)	78 (35.2)	108 (356)
Husband/partner	42 (53)	125 (56.7)	167
The mother's father	7(9)	18(8.1)	25 (8.3)
VCT use			108
Used	28 (35.4)	80(36.0)	(35.7)
Not used	51(64.5)	141(64.0)	192(64.3)
Place of HIV test			
Government Hospital	62 (78.5)	180(81.9)	242(81.2)
Others	17 (21.5)	41 (18.1)	58 (18.8)

5.3 Source of Information of Mothers about MTCT of HIV and Infant Feeding:

Among the 300 mothers, 11 mothers did not know or were not responding about their source of information of MTCT of HIV. For the remaining (290) mothers, the sources of information about MTCT of HIV were found to be mass media 211(39.5%), health workers or health facilities 187 (35%), and friends or relatives 370 (43.9%) (Table 3).

Similarly, among the 300 mothers 5 mothers did not know or were not responding about their sources of information of infant feeding. For the remaining (295) mothers, friends or relatives 37.2%, health workers or health facilities 31.5%, and mass media 28.6% were mentioned as their sources of information about infant feeding(Table 3).

Table 3: Distribution of mothers by their source of information about MTCT and infant feeding in Akaki-kality sub-city, AA, Ethiopia, June 2014.

VARIABLES	MOTHERS		TOTAL
	Pregnant	Lactating	
	No. (%)	No. (%)	No. (%)
Source of Information about mother to child transmission of HIV (n=290)			
Health workers(health facilities	46 (33)	141 (35.7)	187 (35)
Mass media	55 (39.3)	156 (39.6)	211(39.5)
Friends (relatives)	36 25.7)	91 (23)	127(23.8)
Others	3 (2.1)	6 (1.5)	9 (1.7)
No response/Didn't know the source(n=11)	3 (100.0)	8(100.0)	11 (100.0)
Source of Information about infant feeding: (n=295)			172
Health workers(health facilities	36(25.7)	136(33.5)	(31.5)
Mass media	43(30.7)	113 (27.8)	156(28.6)
Friends (relatives)	55 (39.3)	148(36.4)	203(37.2)
Others	6 (4.3)	9(2.2)	15 (2.7)
No response/ Didn't know the source(n=5)	2 (100.0)	3 (100.0)	5 (100.0)

5.4 Knowledge and Attitude of Mothers towards VCT and Infant Feeding Options Recommended to HIV Positive Women:

Based on this assessment, 38.8%, 41.8%, & 30.5% of the mothers were having sufficient knowledge about MTCT, PMTCT, and infant feeding options recommended to HIV positive women respectively. Moreover, 62.4% of the mothers were having favorable (good) attitude towards VCT. In the contrary, only 4.7 % of the mothers were having favorable (good) attitude towards the feeding options (Table 4).

Table 4: Distribution of mothers by their knowledge about and attitude towards P/MTCT or VCT, and infant feeding options recommended to HIV positive women. Inakaki-kality subcity AA,Ethiopia, June 2014

VARIABLES	MOTHERS		
	Pregnant (n=79) No. (%)	Lactating (n=221) No. (%)	TOT (n=300)
Knowledge about MTCT during pregnancy, labor, and breastfeeding			
Sufficient	31(39.4)	85(38.6)	116(38
Not sufficient	48(60.6)	136(61.4)	184(61
Knowledge about PMTCT			
Sufficient	35(44.2)	90(40.9)	127(41
Not sufficient	44(55.8)	131(59.1)	175(58
Attitude to VCT			.2)
Good	49(61.9)	138(62.6)	187
Bad	30 (38.1)	83 (37.4)	113
Knowledge about the infant feeding options			(37.6)
Sufficient	23 (27.3)	70 (31.6)	93
Not sufficient	56 (72.7)	151 (68.4)	207
Attitude towards the feeding options			(69.5)
Good	4(5.2)	10 (4.5)	14
Bad	75 (94.8)	211(95.5)	286

5.5 associations of mother's knowledge and attitude towards the infant feeding options, MTCT, VCT and utilization of maternal health care with selected independent variables

Regarding the relationship of the mother's knowledge and attitude towards the infant feeding options with the independent variables; the knowledge of the mothers about the feeding options was also associated significantly with age. Mothers aged 26-30 years were significantly more knowledgeable than young (< 20 years old) mothers with OR of 1.50 and 95% CI (1.003, 2.23) (Table 5).

Beside these, In this study mothers marital status, parity, religion, ethnicity, educational status, occupation, and household monthly income were not having a statistically significant association with knowledge and attitude of mothers towards the infant feeding options.

Table 5: Socio-demographic determinants of knowledge and attitude of mothers towards infant feeding options. In akaki kality subcity

Variables	Popln. Total	Knowledge about infant feeding options recommended to HIV positive women			Attitude towards infant feeding options recommended to HIV positive women		
		No. (%)	Sufficient Adjusted OR** (95% C.I.)		No. (%)	Good Adjusted OR** (95% C.I.)	
Age (years)							
< 20	85	74 (8.4)	1.00		14 (1.6)	1.00	
21-25	113	93 (10.6)	0.94	(0.65, 1.36)	20 (2.3)	1.11	(0.55, 2.32)
26-30	72	79 (9.0)	1.51	(1.003, 2.23)*	6 (0.7)	0.51	(0.19, 1.40)
>31	30	21 (2.4)	0.74	(0.42, 1.31)	1 (0.1)	0.16	(0.02, 1.35)
Ethnicity							
- Oromo	144	128 (14.6)	1.00		21 (2.4)	1.00	
- Amhara	56	47 (5.4)	0.98	(0.64, 1.50)	6 (0.7)	0.64	(0.24, 1.71)
- tigire	29	55 (6.3)	1.30	(0.87, 1.92)	7 (0.8)	0.96	(0.40, 2.37)
-guirage	6	37 (4.2)	0.81	(0.52, 1.25)	7 (0.8)	0.96	(0.39, 2.38)
Educational status							
- Unable to Read & write	58	52 (5.9)	1.00		9 (1.0)	1.00	
- Able to Read & write	9	13 (1.5)	2.01	(0.87, 4.66)	1 (0.1)	0.70	(0.08, 6.07)
- Grades 1 - 6	77	70 (8.0)	1.02	(0.66, 1.58)	10 (1.1)	0.70	(0.31, 2.04)
- Grades 7 and above	156	132 (15.1)	0.94	(0.63, 1.42)	21 (2.4)	0.73	(0.31, 1.70)

* Significant at p. value < 0.05

The knowledge of mothers, about infant feeding options helpful to prevent MTCT of HIV, was having a statistically significant association with counseling mothers about infant feeding during ANC. The knowledge was significantly low in mothers who were not counseled about infant feeding during antenatal care visits [with OR of 0.55 and 95% CI (0.38, 0.80)] than the mothers who were counseled about it. It was also significantly low in those mothers whose most important person in making decision on how to feed their infants were husbands/partners than the mothers themselves with OR of 0.43 and 95% CI between 0.29 and 0.63. But, both explanatory variables were not found to have statistically significant association with attitude of the mothers to wards the feeding options. Similarly, place of recent delivery and VCT use also did not show a statistically significant relationship with mothers' knowledge about and attitude towards the feeding options (Table 6).

Table 6: Knowledge and attitude of mothers towards infant feeding options recommended to HIV positive women versus utilization of maternal health and VCT services inakaki-kality subcity AA,Ethiopia, June 2014

Variables	Popln. Total	Knowledge about infant feeding options recommended to HIV positive women		Attitude towards infant feeding options recommended to HIV positive women	
		No. (%)	Sufficient Adjusted OR** (95% C.I.)	No. (%)	Good Adjusted OR** (95% C.I.)
Being counseled about infant feeding during ANC visits:					
Yes	114	100	1.00	15	1.00
No	186	132	0.55 (0.38, 0.80)*	17	0.56 (0.24, 1.29)
Place of the recent delivery:		107			
Gov't Hospital	112	(16.6)	1.00	13	1.00
Gov't health center	35	36 (5.6)	1.10 (0.66, 1.84)	8 (1.2)	1.82 (0.67, 4.96)
Gov't/private clinic	4	3 (0.5)	1.07 (0.27, 4.21)	-	0.01 (0.00,
Own home	70	58 (9.0)	0.73 (0.46, 1.17)	8 (1.2)	0.81 (0.27, 2.42)
Most important person					
how to feed their		126		20	
infant:	108	(14.4)	1.00	(2.3)	1.00
Husband/partner	167	122	0.43 (0.29, 0.63)*	17	0.53 (0.22, 1.26)
The mother's father	25	19 (2.2)	0.59 (0.29, 1.23)	4 (0.5)	0.85 (0.18, 4.03)
VCT use		108		15	
Used	108	(12.3)	1.00	(1.7)	1.00
Not used	192	159	0.79 (0.54, 1.17)	26	1.19 (0.49, 2.90)

* Significant at p. value 0.05

5.6 Infant Feeding Practices of Lactating Mothers, and Intention of Pregnant Women:

221 lactating mothers were asked about what they have been feeding their infants since birth. And, it was found that mixed feeding was practiced by the majority, 180(81.5%), of the lactating mothers, exclusive breast feeding only by 40(18%) and exclusive replacement feeding by 1(0.5%) of the mothers from birth up to the 6th months of age of their infants (table 7).

Largest proportion (91.1%) of the pregnant mothers participating in this study (n=79) were also intending to mixed-feed to their infants in the first 6 months of infancy. (Table 7)

Table 7: Infant feeding practice of lactating mothers (n =221), and intention to infant feeding among pregnant women (n=79) from birth up to the 6th month after delivery services inakaki-kality sub city AA, Ethiopia, June 2014

	Frequency	Percent
Infant feeding practice of lactating mothers		
Exclusive breast feeding	40	18
Exclusive replacement feeding	1	0.5
Mixed feeding	180	81.5
Prenatal intention to infant feeding among pregnant mothers		
Exclusive breast feeding	6	7.6
Exclusive replacement feeding	1	1.3
Mixed feeding	72	91.1

Among the variables of infant feeding practice of the lactating mothers, exclusive breast feeding practiced by very few mothers. As a result, the numbers/proportions related to it were found to be too little for any cross tabulation or statistical test, hence excluded from such further statistical analysis.

Regarding the relationship of the remaining infant feeding practices of lactating mothers with the independent

variables; Lactating mothers who didn't visit health institutions for antenatal care during their last pregnancy practiced exclusive breast feeding significantly less than lactating mothers who attended it at least once with OR of 0.53 and 95% CI between 0.29 and 0.96. The lactating mothers who reported that the place of delivery of their last infants was at Government Health Center were found to practice mixed feeding more than those delivered at government hospital with OR of 2.10 and 95% CI between 1.05 and 4.21(Table 8). In the contrary, lactating mothers whose fathers (grandfathers of the infants) were most important person in making decision on how to feed the infants, with OR of 0.44 and 95% CI (0.21, 0.90), had significantly practiced mixed feeding less than those mothers who were making decision about feeding of their infants by themselves. In addition to these there no statistically significant association was not revealed between infant feeding practices of the lactating mothers, and VCT use (Table 8).

In this study, statistically significant association was not revealed between infant feeding practices of the lactating mothers, and the other socio-demographic variables.

Table 8: Infant feeding practices of lactating mothers (to infants under 6 months of age) versus utilization of maternal health and VCT services inakaki-kality sub city AA, Ethiopia, June 2014

VARIABLES		Exclusive breast feeding		mixed feeding	
	total Popl.	No. (%)	Adjusted OR** (95% C.I.)	No. (%)	Adjusted OR** (95% C.I.)
Antenatal care use					
Yes	253	96 (14.9)	1.00	253(70.9	1.00
No	47	22 (3.4)	0.53 (0.29,	47(10.1)	0.57 (0.32, 1.04)
Place of the recent delivery					
Gov't Hospital	112	67 (10.4)	1.00	112(40.1	1.00
Gov't health center	35	11 (1.7)	1.98 (0.99,	35(14.3)	2.10 (1.05,
Gov't/private clinic	4	1 (0.2)	3.10 (0.38,	4 (1.6)	1.51 (0.31, 7.30)
Own home	70	39 (6.1)	1.11 (0.68,	70(25.0)	1.11 (0.68, 1.80)
Most important in deciding how to feed infant					
Mother herself	108	33 (5.1)	1.00	108(30.0	1.00
Husband/partner	167	72 (11.2)	0.66 (0.42,	167(45.4	0.69 (0.44, 1.08)
Mother's father	25	13 (2.0)	0.51 (0.24,	25(5.8)	0.44 (0.21,
VCT use				108(28.0	
Used	108	51 (7.9)	1.00	)	1.00
Not used	192	67 (10.4)	1.53 (0.98,	192(53.0	1.44 (0.93, 2.25)

* Significant at p. value < 0.05

6. DISCUSSION

This study revealed that a small proportion of mothers in the study area had sufficient knowledge about MTCT (38.8%), PMTCT of HIV (41.8%), and infant feeding options recommended to HIV positive women (30.5%). However, the knowledge of mothers about MTCT of HIV during pregnancy, delivery, and breastfeeding is more than the 6% reported in the 2011 Demographic Health Survey of Ethiopia . It could be due to the situation that the current study was conducted many years after initiation of PMTCT program in the sub city.

Mothers in the age group of 26 to 30 years were also significantly more knowledgeable about the infant feeding options valuable in PMTCT of HIV, than the younger (< 20 years old) mothers included in this study. Likewise, in an institutional based cross-sectional study done in Addis Ababa in 2004, post-natal mothers of age 21- 25 years and above 30 years and mothers completed above secondary grade were more knowledgeable about MTCT of HIV during pregnancy, delivery and breastfeeding than the younger and less educated mothers. The fifth report of AIDS in Ethiopia also revealed that the highest HIV prevalence still occurs in the age group 15 – 24 years, among females than males and in urban than rural areas . Thus, the findings of these studies indicate the importance of empowering mothers using education and the need of targeting the young mothers for interventions promoting appropriate or safe infant feeding practices and prevention of MTCT of HIV.

In this study, 84.6 % of mothers visited health institutions for antenatal care and 36% used VCT service during their last pregnancy. A relatively high (38%) number of mothers were counseled (got advice) on infant feeding as compared to the study done in Addis Ababa in 2006 (18%). A statistically significant relationship was found between counseling mothers on infant feeding during their antenatal follow-ups and the knowledge of mothers towards the infant feeding options. That is, mothers who were not counseled about infant feeding during

antenatal care visits were having a statistically significant low knowledge about infant feeding options useful to prevent MTCT of HIV. Though, it was not done in the Context of HIV (it didn't assess mothers' knowledge about the recommended feeding options for HIV positive women)

The study from India also supports the important role of hospital counselors in assisting HIV positive women in their intended feeding choice as well as actual practice. And it also documented that the time immediately after delivery is critical for re-counseling about infant feeding and further support of the woman's decision, thus lowering mixed feeding. Therefore, strengthening the counseling being provided during antenatal clinic visits of mothers in the health institutions of the current study area and the started follow up health assessment of their babies and reinforcing counseling of the HIV positive mothers should be delivered in the maternity ward as part of the PMTCT program .

Majority (62.4%) of the mothers participated in this study were having favorable (good) attitude towards VCT. However, most (95.3%) of the mothers were found to have unfavorable attitude to wards the infant feeding options recommended to HIV positive mothers. This may be related to low awareness of the community about the importance of the feeding options recommended to HIV positive women in the prevention of MTCT of HIV, which is supported by the observed insufficient knowledge of most of the mothers included in this study about MTCT and PMTCT of HIV in general and the feeding options in particular.

In this study the knowledge of mothers significantly decrease in those mothers whose most important person in making decision on how to feed their infants were husbands (partners than the mothers themselves).

Regarding prevalence of infant feeding practices; in the current study, the lactating mothers

Practicing mixed feeding were 81.5%, exclusive breastfeeding 18%, and exclusive replacement feeding 0.5%, for the infants of 0 to 6th month of age. The rate for exclusive breast feeding (18%) is greater than the rate (6.91%) found in the other study done in Jimma town. Even though, this finding seems encouraging, still it is much lower than the rate of exclusive breast feeding documented in the 2011 Demographic Health Survey of Ethiopia (38%) and the Addis Ababa's Study (32%); and, the rate for mixed feeding is consistently high in the study area.

In the current study, lactating mothers who didn't visit health institutions for antenatal care during their last pregnancy practiced exclusive breast feeding significantly less than lactating mothers who attended it at least once. The mothers delivered their last infants at government health center were practicing mixed feeding significantly more than the mothers who delivered at government hospital. The associations of antenatal care use and place of delivery to the infant feeding practices as well as the relation of exclusive breast feeding practice to attending post natal care found in the other study reinforces the importance of expanding and integrating well the interventions promoting exclusive breast feeding and PMTCT of HIV with the MCH services of all health institutions of the town.

Besides this, lactating mothers whose father (grandfather of the infants) were most important person in making decision on how to feed their infants significantly practiced mixed feeding less than those mothers who were making decision about feeding to their infants by themselves. It could be due to the insufficient knowledge of mothers about PMTCT and the paramount importance of exclusive breast feeding regardless of their HIV status.

Inline to this idea, the study done in Nairobi, Kenya, showed that mothers who were having knowledge of exclusive breast feeding were the list likely to end exclusive breast feeding early .otherwise, the mothers may tend to mixed feed their infants. But, half of mothers, in the current study, were living in a household of having almost none or very low monthly income and the grand fathers might have forced the mothers (members of their households) to feed their infants only breast milk mainly for economical reason. On the other hand, since it is commonly known that mothers decide motherhood experiences by learning from grandmothers rather than grandfathers of their infants, this particular finding seems not plausible and inconsistent with other studies.

The failure of HIV positive mothers to adhere to safe infant feeding practices and the high prevalence of mixed feeding practice of the mothers of the study area are very clear signs of the potential high transmission of HIV to children of the study area. In addition to increased risk of MTCT, regardless of the HIV status of the mothers, the infants are at risk of death from non HIV diseases. Literatures also agree with the fact that mixed feeding increases not only MTCT of HIV but also the risk of non HIV diseases like diarrhea and malnutrition in the 1st 6 months of age of infancy Thus, the aforementioned situations may indicate the need of integrated and comprehensive efforts to reduce urgently the risk of MTCT in the study area and other similar parts of the country.

Moreover, according to WHO, interventions focusing on the PMTCT of HIV need to be complemented by interventions that address primary prevention of HIV infection, especially among women of childbearing age and their partners, prevention of unintended pregnancies among HIV-infected women, and the provision of care, treatment and support for HIV-infected women, their children and families .

7. STRENGTH AND LIMITATIONS OF THE STUDY

STRENGTH

At the design stage and before the implementation of the study well defined inclusion and exclusion criteria were made, data collectors were trained, questionnaires were Tested and necessary

LIMITATIONS

The response given to the structured questionnaire may be prone to social desirability bias; because of the confidentiality I recruit counselor nurse working in the PMTCT unit, so respondents may provide desired answer to their counselor. (Was not telling the truth about their exact behavior)

8. CONCLUSIONS

✓ In this study, most of the mothers were housewives. The household monthly income of half of the mothers was very low (below 125 Ethiopian Birr), and majority of the households got their drinking water from pipe.

✓ Most of the mothers of the study area used antenatal care, but only small proportion of the mothers used VCT during their last pregnancy.

✓ The major source of information of the mothers about MTCT of HIV and infant feeding were friends (relatives), health workers (health facilities) and mass media.

✓ More than half of the mothers had insufficient knowledge about MTCT of HIV during pregnancy, labor and breast feeding, and its prevention. More than half of the mothers had favorable attitude towards VCT.

✓ The infant feeding practice of majority of the lactating mothers and intention of most of the pregnant mothers were found to be mixed feeding.

✓ Age of the mothers, counseling mothers on infant feeding during ANC, and husbands (partners) being important person for mothers to decide on how to feed their infants found to be determinants of knowledge of the mothers about infant feeding options recommended to HIV positive women.

✓ Attending ANC, delivering at government hospital and proximity to the main PMTCT service providing institution by address were found to be determinants of exclusive breast feeding and mixed feeding practice of the lactating mothers of the study area.

9. RECOMMENDATIONS

By taking in to account the results of this study the following recommendations are forwarded:

☞ Strengthen and integrate counseling of mothers on appropriate infant feeding practices with health services by providing training on infant feeding counseling including the feeding options recommended to HIV positive women to all health workers working in VCT, antenatal care, maternity, postnatal/family planning, well and sick child care/IMCI, and TB follow-up rooms/units of the health institutions in order to reduce the highly prevalent and risk full infant feeding practice(mixed feeding) and mount the exclusive breast feeding practice of the study area. Integrating the infant feeding counseling to the mentioned areas may help to avoid missed opportunities.

☞ Introducing an appropriately designed BCC program to the community on appropriate (safe) infant feeding practices, importance of partners involvement in HIV testing and empowering women in order to promote exclusive breast feeding as well as for better success in PMTCT of HIV, by targeting all women in the reproductive age group and males (husbands).

☞ Scaling up of Antiretroviral (ARV) treatment for mothers' own health and prophylaxis for mothers and infants in order to reduce markedly the risk of MTCT of HIV.

☞ Periodic reassessment of the KAP of mothers about safe infant feeding practices and PMTCT/VCT in the study area and other parts of the country.

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Annexes

Annex1 QUESTIONNAIRE

QUESTIONNAIRE FOR LACTATING MOTHERS

(Within 12 months after delivery)

SECTION 0: QUESTIONNAIRE IDENTIFICATION DATA

001 QUESTIONNAIRE IDENTIFICATION NUMBER _____

002 ADMINITRATIVE: ADDI ABABA

003 SUB-CITIES: AKAKI KALITI

004 HIGHER _____KEBELE _____

005 KETENA NUMBER _____

006 LINE NUMBER _____

007 HOUSEHOLD NUMBER _____

INTRODUCTION:

My name is ----------. I am working as data collector in a survey conducted by the Community Health Department of Nursing and Midwifery, Addis Ababa University. We are interviewing women here about VCT and infant feeding related knowledge, attitude, and practice in order to generate information necessary for the planning of appropriate strategies (interventions) to prevent mother to child transmission of HIV and promote appropriate infant feeding practice in the town and the country. To attain this purpose, you‟re honest and genuine participation by responding to the question prepared is very important & highly appreciated.

CONFIDENTIALITY AND CONSENT

We would like you to answer some personal questions that some people may find it difficult to answer. Your answers are completely confidential. Your name will not be written on this form. The nurses, doctors, and other people will not be told what you said in connection to your name. You do not have to answer any question if you don't want to and you can stop the interview at any time. However your honest answer to these questions will help us to better understand the experience of mothers related to VCT and infant feeding practices. We would greatly appreciate

your help in responding to this study. The interview will take about 20 - 30 minutes. Would you be willing to participate?

If yes, proceed

If no, thanks and stay with us until the others finish the questions. _

(Signature of interviewer certifying that respondent has given informed consent verbally)

Result Codes:

- ☞ Completed 1
- ☞ Not at home2
- ☞ Refused 3
- ☞ Partially completed 4
- ☞ Other (specify)_____ 5

CHECKED BY SUPERVISOR– Name _____ Signature _____

Date _____

008. INTERVIEWER'S: CODE _____ NAME_____

009. SUPERVISOR'S: CODE _____ NAME_____

010. DATE OF INTERVIEW: _______________

Daymonth year

Time of start of the interview: _____:_____

Hour Minute

SECTION I: SOCIO-DEMOGRAPHIC AND ECONOMIC INFORMATION

Please circle your answers

101. How old are you? _____ Years

102. What is the highest education level you completed?

1. Illiterate
2. Read and write
3. Elementary school
4. Secondary school
5. College/University

103. What is your current marital status?

1. Single
2. Married
3. Divorced
4. Widowed
5. Separated

104. What is your religion?

1. Orthodox
2. Protestant
3. Catholic
4. Muslim
5. Other (describe)_____

105. What ethnic or linguistic group do you belong to?

1. Oromo
2. Amhara
3. Gurrage
4. Tigre
5. Other (specify)_____

106 What is your current occupation?

1. Unemployed
2. Student
3. Housewife
4. House servant
5. Daily laborer
6. Merchant
7. Government Employee
8. Private employee
9. Other (specify) _____

107. What is your total monthly family income (approximately)? _____Eth. Birr

1. No income
2. Don't know
3. No response

108. How many children do you have now? No of children_____

109.What is the total number of the members of the household? Noof member of house hold _____

110. Are you the head of the house hold?

1. Yes
2. No

SECTION II: PRACTICE / INTENTION TO VCT AND INFANTFEEDING

201. During your last pregnancy, did you attend antenatal care in any health institution?

1. Yes
2. No
3. Don't know

202. If you went for antenatal checkup for the last pregnancy at what gestation age? Gestation age in month:_____

Don't know

203. If you went for antenatal checkups for your last pregnancy to which health institution did you go?

1. Governmental Hospital
2. Governmental Health Center
3. Governmental Clinic
4. Private Clinic
5. Other (specify)_____

204. How many times have you attended the antenatal care in that specific health facility?

No of antenatal visits (follow-ups)_____ Don't know

205 During antenatal care visits, were you counseled about infant feeding?

1. Yes
2. No

206 What information (advice) on infant feeding was given to you during the antenatal visits? (Read Choices Circle 1 if she was informed 2 if she was not informed)

1. About Breast feeding only 1 2
1. 2.About bottle feeding 1 2
2. 3.About supplementary feeding 1 2
3. About replacement feeding 1 2
4. 5.Other (specify)_____ 1 2

207. Where was the place of your last child's delivery?

1. Governmental Hospital
2. Governmental Health Center
3. Governmental Clinic
4. Private Clinic
5. Own home
6. Other (specify)_____

208. Who assisted you during your last child's delivery?

1. Health professional
2. Trained traditional birth attendant
3. Untrained traditional birth attendant
4. Relative (friends, neighbor)
5. Other (specify)_____

209. What was the outcome of your recent delivery?

1. Live Birth At _____ month of pregnancy
2. Still Birth At _____ month of pregnancy

210. Is the child alive now?

1. Yes
2. No

211. What is the age of the child in month? Child‟s Age (in months)_____ (_____days)

212. What was the age of the child at death? Child's age at death (in months)_____ (_____days)

213 What did you give (feed) your baby with in the first three days after delivery, before your white milk began flowing regularly?

More than one answer is possible Circle 1 if mentioned 2 if not mentioned)

1. The fluid that came from the breasts12
2. Butter 1 2
3. Water & Sugar 12
4. Nothing fed 1 2
5. Other (specify) _____ 1 2

214 Since birth, what did the child receive?

(• •• •Read choices • •• •Circle 1 if the child received it 2 if not received it)

1. Water/tea 1 2
2. Water and sugar/salt 1 2
3. Breast milk 1 2
4. Powdered milk 1 2
5. Cow"s milk 1 2
6. Porridge 1 2
7. Cereal based fluid 1 2
8. Adult food 1 2
9. Other(specify) _____1 2

215. For the above foods, the foods you gave to your child, at what age were the different foods given (started)?

1. Water/tea at ____ day/s_____month/s
2. Water and sugar/salt tea at ___day/s ___ month/s
3. Breast milk at ___day/s ___ month/s
4. Powdered milk at___day/s ___ month/s
5. Cow"s milk at___day/s ___ month/s
6. Porridge at___day/s ___ month/s
7. Cereal based fluid at ___day/s___ month/s
8. Adult food at ___day/s ___ month/s
9. Other (specify at___day/s ___ month/s

216 Up to what age did you feed (give) your child the above foods? (If less than one month record days, otherwise months)

1. Water/tea up to ____ day/s___month/s
2. Water and sugar/salt up to ____ day/s___month/s
3. Breast milk up to___ day/s___month/s
4. Powdered milk up to___ day/s____month/s
5. Cow"s milk up to __ day/s___month/s
6. Porridge up to____ day/s____month/s

7. Cereal based fluid up to____ day/s____month/s 88

8. Adult food up to ____ day/s____month/s 88

9. Other(specify) _____ up to ____ day/s____month/s 88

217 If the child was ever breast fed, how soon after birth did you first put the child to the breast? (If less than one hour circle "0" if 1 hour up to 24 hours record hours, otherwise days)

Hours_____ Days _____

1. Immediately
2. Don't Know
3. Not applicable

218. If the child hasn't fed an thing except breast milk till now, when do you intend (plan) to start additional diet? See the response to 214

When the child completes age (in month)_____

219. Are you still breastfeeding the child?

1. Yes 2. No

220.How many times did you breast-feed last night between sunset and sunrise?

(If answer is not numeric, probe for Number of night time breast feedings_____ approximate number) Don't know

221 How many times did you breast-feed yesterday during the day light hours?

(If answer is not numeric, probe for approximate number)

Number of day light breast feedings_____. Don't know

222. When do you usually breast-feed the child?

(Read choice Circle 1 if applied 2 if not applied)

1. When the child wants 1 2
2. When the child cries 1 2
3. On schedule 1 2
4. On convenience 1 2
5. When breast engorged 1 2
6. Other (specify)_____ 1 2

223. Have you experienced any breast feeding problems while you were breast feeding the last child?

Yes No

224. What was the breast feeding problem?

(PROBE any more?More than one answer is possible. Circle 1 if mentioned 2 if not mentioned)

1. Not enough milk 1 2
2. Nipple / breast problem 1 2
3. Sourness of the baby's mouth 1 2
4. Other (specify)_____

225. (This question is only for mothers whose child is not on breast-feeding or ceased breast-feeding) See the response to 219

When did you totally stop breastfeeding the last child?

When child's completed age (in month) _____

At the time of his death

226 (This question is only for mothers whose child is not on breast-feeding, never breastfed or ceased breast feeding) See the response to 214 and 219

227. Why did you stop breast-feeding (never breastfed) the last child?

(PROBE any more?More than one answer is possible Circle 1 if mentioned 2 if not mentioned)

1. Not enough milk 1 2
2. Nipple / breast problem 1 2
3. Sourness of the baby's mouth 1 2
4. Mother ill / weak 1 2
5. Child ill / weak 1 2
6. Mother working 1 2
7. Child refused 1 2
8. Weaning age 1 2
9. Become pregnant 1 2
10. Started using contraception 1 2
11. Other (specify)_____ 1 2
12. Not applicable 1 2

228. (This question is only for a child older than 6 months of age, never breast fed at all or ceased breast feeding) See the response to 214

How many times was the child fed mashed or pureed food or solid or semi-solid food yesterday during or at night?

Number of time_____

Don't know

Not applicable

229. If you offered the child mashed or fluid food, what did you use to give the fluid foods with?

1. Bottle nipple
2. Spoon (cup)
3. By hand
4. Other (specify) _____

229. Before delivery, what was your intention (plan) to give (feed) your baby with in the first three days after delivery (before your white milk begins flowing regularly)?
(PROBE any more? More than one answer is possible Circle 1 if mentioned 2 if not mentioned)

1. The fluid that came from the breasts 1 2
2. Butter 1 2
3. Water & Sugar 1 2
4. Nothing fed 1 2
5. Other (specify) _____ 1 2

230 Before delivery, what was your intention (plan) to give (feed) your baby from birth up to 12 months after delivery? (• •• •Read choices • •• •Circle 1 if it was planned 2 if it was not planned)

1. Water/tea 1 2
2. Water and sugar/salt 1 2
3. Breast milk 1 2
4. Powdered milk 1 2
5. Cow‟s milk 1 2
6. Porridge 1 2
7. Cereal based fluid 1 2
8. Adult food 1 2
9. Other(specify) _____1 2

231 For the above foods, the foods you intended to feed your child, at what age was your plan to give (start) the intended foods?

1. Water/tea at ____ day/s_____month/s
2. Water and sugar/salt tea at ___day/s ___ month/s
3. Breast milk at ___day/s ___ month/s
4. Powdered milk at___day/s ___ month/s
5. Cow‟s milk at___day/s ___ month/s
6. Porridge at___day/s ___ month/s
7. Cereal based fluid at ___day/s___ month/s
8. Adult food at ___day/s ___ month/s
9. Other (specify at___day/s ___ month/s

232. Up to what age was your intention (plan) to feed (give) your child the above foods (the intended foods)? (If less than one month record days, other wise months)

1. Water/tea up to ____ day/s___month/s 88
2. Water and sugar/salt up to ____ day/s___month/s 88
3. Breast milk up to___ day/s___month/s 88

4. Powdered milk up to___ day/s____month/s 88

5. Cow‟s milk up to __ day/s___month/s 88

6. Porridge up to____ day/s____month/s 88

7. Cereal based fluid up to____ day/s____month/s

8. Adult food up to ____ day/s____ month/s

9. Other(specify) _____ up to ____ day/s____ month/s

233. Were you able to execute your intention as you intended (planned) to feed your child?

1. Yes 2. No 3. Not applicable

234. If „No‟ Why not? (Mention only one main reason)

……

235 Do you have any suggestion to any program (organization) how it could have supported you dealing with the challenges you faced in executing your infant feeding plan or choice? (Mention only one main important suggestion)

……

236 What support from health workers would assist you to better feed your infant? (Mention only one main important suggestion)

……

237 (This question is only for mothers intended to breastfeed their baby)

See the response to 230 If it was your intention to breast feed your baby, how soon after birth was your intention (plan) to put the child to the breast for the first time? (If less than one hour circle " 0 "if 1 hour up to 24 hours record hours, otherwise days)

Hours _____

Days _____

1. Immediately 2. Don't Know 3. Not applicable

238. Who is the most important when making a decision on how you should feed your infant?

1. My father
2. My Husband/ Partner
3. My mother
4. My sister
5. My aunt
6. Myself
7. HealthWorker
8. Other (Specify) ----------

239. Have you heard of voluntary HIV counseling and testing?

1. Yes
2. No

240. If yes, where did you get this information?

(PROBE anymore? More than one answer is possible Circle 1 if mentioned 2 if not mentioned)

1 Health worker/Facility 1 2
2. Mass media(radio, TV) 1 2
3. Friends (relatives) 1 2
4. Neighbors 12
5. Others(Specify) 1 2

241. Have you discussed about HIV testing with your partner/boyfriend/husband?

1. Yes
2. No
3. No response

242. I don't want to know the result, but have you ever had an HIV test?

Yes No No response

243. If you ever had an HIV test, please do not tell me the result, but did you collect the result of your test?

1. Yes
2. No
3. No response

243. When did you have your most recent HIV Test? (Read choices Circle that applied)

1. During the last pregnancy
2. Before the last pregnancy
3. Other(specify)_____
4. No response

244. Where did you undergo your recent HIV test? Government Hospital

1. Government Health center
2. Private clinic
3. Government VCT center
4. Private VCT center
5. NGO VCT center
6. Others (specify)
7. No response

245. How much did you pay for your most recent HIV test? _____Ethiopian Birr

1. None
2. Don't know

246. Did you receive any pretest counseling before you undertook your HIV test?

1. Yes
2. No
3. Don't know

247. Did you receive any post- test counseling when you got your HIV test result?

1. Yes 2. No 3. Don't know

248. Were you satisfied with the pre- test counseling you received?

1. Yes
2. No
3. Could have been better
4. No response

249. Were you satisfied with the posttest counseling you received?

1. Yes
2. No
3. Could have been better
4. No response

250. By whom do you prefer to get VCT?

1. Physician (Doctor)
2. Nurse
3. Trained counselor
4. Religious leader
5. No need of counselor
6. Other (specify)

251. Which way do you prefer to obtain the HIV test result?

1. Face to face
2. Telephone
3. Secretive letter
4. Relative
5. Partner
6. Others (specify)_____
7. Don't known
8. No response

252. If you test positive for HIV, would you tell any of the following individuals about your HIV test result? (Read out options Circle all that apply)

1) Your husband (spouse)
2) Your children
3) Your brother/s
4) Your sister/s
5) Your other relative/s
6) Your friend/s
7) Your landlord
8) Your neighbor/s
9) Your religious leader/s
10) Your community lender/s
11) Your employer/s
12) Other (specify)_____

SECTION III: KNOWLEDGE AND ATTITUDE TOWARDS VCT (PMTCT) AND INFANT FEEDING OPTIONS

301. Have you heard of a disease called HIV/AIDS?

1. Yes
2. No

302. From where did you hear about HIV/AIDS? (PROBE anymore? More than one answer is possible Circle 1 if mentioned 2 if not mentioned)

1. Health worker/Facility 1 2
2. Mass media(radio, TV) 1 2
3. Friends (relatives) 1 2
4. Neighbors 1 2
5. Others(Specify) 1 2

303. Attitude to VCT:

1. If you never had an HIV test, do you have any intention (plan) to be tested?

1. Yes
2. No
3. No response
4. Not applicable

2. If your sister, relative or friend was pregnant, would you advise her that it is good to be tested for HIV?

1. Yes
2. No
3. No response

3. Would you recommend HIV testing to anyone else?

1. Yes
2. No
3. No response

304. If you don"t have any intention (plan) to be tested, Why not?

See the response to 303 NO.1

1. I don't know where to get
2. I don't believe it will help
3. I trust myself and my partner
4. Afraid to ask my partner
5. Other_____
6. Don't know about it
7. Not applicable
8. No response
9.

305 (**Attitude to the feeding options**): If your sister or relative has told you that she became HIV positive:

1. Would you encourage her only to breast feed her baby?

1. Yes
2. No
3. No response

2. Would you encourage her not to breast feed at all?

3. Would you try to support her to feed only formula or cow's milk to her baby?

4. If you don't want to support her to feed her baby only formula or cow's milk, why not?

(PROBE anymore?More than one answer is possible Circle 1 if mentioned 2 if not mentioned)

1. Not breastfeeding at all is culturally unacceptable 1 2
2. Expensive to purchase it for long time 1 2
3. Getting fuel or cooking material is difficult 1 2
4. Frequent feeding with cup is difficult 1 2
5. Not breastfeeding leads to be suspected for HIV, stigma and discrimination 1 2
6. Other (specify)_____ 1 2
7. No response 1 2

(**Knowledge on MTCT, AND PMTCT**):

I am going to read out some statements about HIV/AIDS. For each statement, please tell me whether you think it is true or not

1. Condom use during sex with an HIV infected partner can prevent HIV transmission.

1. True 2. Not true 3. Don't know

2. Women with HIV infection can infect their babies with HIV during pregnancy.

1. True 2. Not true 3. Don't know

3. Women with HIV infection can infect their babies with HIV during labor.

1. True 2. Not true 3. Don't know

4. Women with HIV infection cannot infect their babies with HIV through breastfeeding.

1. True 2. Not true 3. Don't know

5. There are medicines which HIV infected mothers can take during pregnancy to prevent transmission of HIV infection to their babies.

1. True 2. Not true 3. Don't know

307. I am going to read out some statements about the importance of undergoing a voluntary HIV test for pregnant woman. Please tell me whether you think itis "Correct" or "Incorrect"

1. To find out her HIV status?

1. Correct 2. Incorrect 3. Don't know

2. To receive medicines to prevent her baby from being HIV positive.

1. Correct 2. Incorrect 3. Don't know

3. To decide on what to feed her baby to prevent the baby from being HIV positive.

1. Correct 2. Incorrect 3. Don't know

4. To discontinue pregnancy when she is HIV positive.

1. Correct 2. Incorrect 3. Don't know

308. From where did you get information about MTCT of HIV? (• •• •PROBE Any more? • •• •More than one answer is possible • •• •Circle 1 if mentioned, 2 if not mentioned)

1. During HIV testing 1 2
2. During follow up antenatal visits 1 2
3. Postpartum check 12
4. During child care visits 1 2
5. From mass media (radio, TV) 1 2
6. From friends (relatives) 1 2
7. Other specify _____ 1 2
8. Don't know 1 2
9. No response 1 2

309 (Knowledge on infant feeding options):I am going to read out some statements about infant feeding. For each statement, please tell me whether you think it is true or not.

1. Feeding only breast milk is adequate to babies in the 1st6months for all women.

1. True 2. Not True 3. Don't know

2. Breast milk prevents childhood illnesses.

1. True 2. Not True 3. Don't know

3. HIV infection can be transmitted form HIV infected mother to her baby through breast feeding.

1. True 2. Not True 3. Don't know

4. Feeding only formula or other food to babies is expensive than breast milk.

1. True 2. Not True 3. Don't know

5. Feeding only formula or other food to baby prevents transmission of HIV from an infected woman to her baby.

1. True 2. Not True 3. Don't know

6. Feeding infants breast milk and formula or other fluids is good for all babies in the 1st6 months.

1. True 2. Not True 3. Don't know

7. Giving both breast milk of the mother and complimentary food (other foods) starting the 6th month is important for the healthy growth of all babies of HIV negative mothers.

1. True 2. Not True 3. Don"t know

8. Giving both breast milk of the mother and complimentary food (other foods) starting the 6th month will increase transmission of HIV from infected mother to her baby.

1. True 2. Not True 3. Don"t know

310. Where did you get the information about infant feedings?

(• •• •PROBE Anymore? • •• •More than one answer is possible • •• •Circle 1 if mentioned, 2 if not mentioned)

1. During HIV testing 1 2
2. During follow up antenatal visits 12
3. Postpartum check 1 2
4. During well baby clinic visits 1 2
5. From mass media (radio,TV) 1 2
6. From friends (relatives) 1 2

Other specify _____ 1 2

8. Don"t know 1 2
9. No response 1 2

This is the end of the questionnaire!

THANKYOU!!!

Annex 3 በአዲስ አበባ ከተማ ውስጥ ለሚኖሩ ከወሊድ በኋላ አንድ ዓመት ባልሞላ ጊዜ ውስጥ ላሉ አናቶች የልጅ አመጋገብና በፍቃደኝነት ላይ የተመሰረ የኤች አይ ቪ ኤድስን ምርመራን በተመለከተ የተዘጋጀ መጠይቅ

ክፍል 0፡ የመጠይቁ መለያ መረጃ

001 የመጠይቅ መለያ ቁጥር _____

002 ክልል አ.አ. ክልል 14 _____

003 ከፍተኛ አ.አ.

004 ክፍተኛ _____

005 የቀጠና ቁጥር _____

006 የመስመር ቁጥር _____

007 የቤት ቁጥር _____

መግቢያ ስሜ ታደለች መብራቱ ይባላል፡፡ አዲስ አበባ ዩኒቨርስቲ ህክምና ፋኪሊቲ በሚገኘው ነርስና አዋላጅ ት/ቤት ክፍል እየተካሄደ ላለው ጥናታዊ ዳሰሳ መረጃ ሰብሳቢ ነኝ፡፡ እናቶችን በፍቃደኝነት ላይ የተመሰረተ የኤች .አይ.ቪ ምርመራና የህፃን አመጋገብን ለማጠናከር የኤች.አይ.ቪ ኤድስን ከእናት ወደ ልጅ እንዳይተላለፍ ለመከላከል የሚያስችሉ ስልቶችን/አሰራሮችን/ ለመቀነስ የሚጠይቅ መረጃ ለማግኘት ነው፡፡ ይህን አላማ ለማሳካት ለተዘጋጁት ጥያቄዎች የሚሰጡት እውነተኛና ባጣ ስለሆኑት መልስዎት በቅድሚያ ልናመሰግናት እንወዳለን፡፡

ሚስጥርን የመጠበቅና የፍቃደኝነት መግለጫ

በቅድሚያ አንዳንድ ሰዎች ለመመለስ ሊስቸግራቸው የሚችሉ በጣም የግል የሆኑ ጥያቄዎችን መጠየቁ ማካተቱንና የምንጠይቅዎ መሆኑን እንገልፃለን፡፡ ሆኖም የሚሰጡት ማናቸውም ዓይነት መልሶቾዎ በሚስጥር እንደሚያዙና ስምዎን ወይም የእርሶን ማንነት የሚገልፁ ማናቸውም ዓይነት ነገር እንደማይፃፍ በጣም እንዲረዱልን እንፈልጋለን፡፡ ስለዚህ ሰውም ከሰጡን መልሶች ጋር ፈፅሞ እንደማይያያዝና ለሐኪሞች ለነርሶችም ሆነ ለማንም ሰው ስምዎ ፈጽሞ ሊገለጽም ሆነ ሊታወቅ አይችልም፡፡ በመጠይቁ ወቅት መመለስ የማይፈልጉትን ማንኛውንም ዓይነት ጥያቄ መተው ወይም በማንኛውም ሰዓት መቋረጥ ይችላሉ፡፡ ነገር ግን ለጥያቄዎቹ የሚሰጡን የእርስዎ መልሶች እናቶች በዚህ ወቅት ያላቸውን የህንፃ አመጋገብና በፍቃደኝነት ላይ የተመሰረተ የኤች.አይ.ቪ ምርመራን በተመለተ ያላቸውን አመለካከትና ለምዶች ይበልጥ መረዳት ከ20 እስከ 30 ደቂቃ ሊስድ ይችላል፡፡ በዚህ ጥናት ላይ መሳተፍ ይችላሉ?

- መልስዎ አዎ ከሆነ ወደ ሚቀጥለው እለፍ/ፊ

አልችልም ከሆነ አመሰነህ/ሽ መጠየቁን አቋርጨ/ጥ፡፡

የጠያቂውን እናት ፍቃደኝነት

ለማረጋገጥዋ/ጡ የመረጃ

ሰብሳቢዋ/ው ፊርማ

የመረጃ ሰብሳቢዋ/ው ጉብኝት

	ጉብኝት 1	ጉብኝት 2	ጉብኝት 3
ቀን			
መረጃ ሰብሳቢ			
ውጤት			

ውጤት፡- የተጠናቀቀ 1

ተጠያቂው አልተገኘም 2

የተቃወሙ 3

በከፊል ተመልሷል 4

ሌላ/ይገለጽ/_____5

ያረጋገጠው ተቆጣጣሪ፡- ስም_____ፊርማ_____ቀን_____

008 የመረጃው ሰብሳቢው መለያ ቁጥር _____ስም_____

009 የተቆጣጣሪው መለያ ቁጥር _____ስም_____

010 መጠይቁ የተካሄደበት _____/_____/_____

ቀን ወር ዓ.ም.

መጠይቁ የተጀመረበት ሰዓት _____/_____

ሰዓት ደቂቃ

ክፍል 1 የግለሰቧ ማህበራዊና ኢኮኖሚያዊ ሁኔታ

ተ.ቁ	ጥያቄዎች	መልስና ኮድ	አለፍ ወደ
101	እድሜዋ ስንት ነው? /በጣም የተሻለ ግምት ላይ ለመድረስ ጥረት ይደረግ፡፡/	---------- ዓመት	
101	ያጠናቀቁት ከፍተኛ የትምህርት ደረጃ ስንት ነው?	ማንበብና መፃፍ የማትችል 1 ማንበብና መፃፍ የምትችል 2 ያጠናቀቀችው የትምህርት ደረጃ ----	
103		ያገባች 1 ያገባች 2 አግብታ የፈታች 3 በሞት የተለየ 4 የተለያዩ 5	
104	ሐይማኖትዎ ምንድን ነው?	ኦርቶዶክስ 1 ፕሮቴስታንት 2 ካቶሊክ 3 ሙስሊም 4 ሌላ/ይግለጹ/ -------- 5	
105	የየትኛው ብሔረሰብ አባል ኖዎት?	ኦሮሞ 1 አማራ 2 ጉራጌ 3	

		ዳውሮ 4 ጃንጆሮ/የም/ 5 ከፍቾ 6 ሌላ/ይግለጹ/ ---------- 7	
106	በአሁኑ ጊዜ ስራዎ ምንድን ነው?	ስራ አጥ 1 ተማሪ 2 የቤት እመቤት 3 የቤት ሠራተኛ 4 የቀን ተቀጣሪ 5 ነጋዴ 6 የመንግት ሠራተኛ 7 የግል ድርድት ሠራተኛ 8 ሌላ ይግለጹ ---------- 9	
107	አጠቃላይ የቤተሰብዎ የወር ገቢ ስንት ነው? /በግምት/	---------- ኢት.ብር ምንም ገቢ የለንም 1 አላውቅም 88 መልስ የለም 99	
108	በህይወትዎ ዘመን ስንት ልጆች በህይወት ወልደዋል?	በህወት የተወለዱ ህፃናት ብዛት /በቁጥር/ ምንም አልወለድኩም	
109	በአሁኑ ጊዜ ምን ያህል ልጆች በህይወት አልዎ?	አሁን በህይወት ያሉ ልጆች ብዛት /በቁጥር/	
110	የቤተሰቡ አባል ብዛት ምን ያህል ነው?	የቤተሰብ አባላት ብዛተ /በቁጥር/	
111	እርስዎ የቤተሰቡ ኃላፊ ነዎትን?	አዎ 1 አይደለሁም 2	
	ከቤተሰቡ ኃላፊ ጋር ያለዎት ግንኙነት ምንድን ነው?	ሚስት /አንድ ብቻ/ 1 ሚስት /አንድ ከብዙዎች መካከል 2 የቤት ልጅ 3	

		የቤት ሠራተኛ 4 ሌላ/ይገለጽ/ ---------- 5	
	የቤተሰቡ አባላት የሚጠቀሙበት ዋነኛው የመጠጥ ውሃ አይነት/ምንጭ/ ምንድነው?	የቧንቧ ውሃ 1 ክዳን የሌለው ጉድጓድ /ምንጭ/ ውሃ 2 የወንዝ /የኩሬ/ ውሃ 3 የዝናቡ ውሃ 4 ሌላ/ይገለጽ/ ---------- 5	

ክፍል 2፡- በፍቃደኝነት ላይ የተመሰረተ የኤች.አይ.ቪ ምርመራ ተጠቃሚነትና የህንፃ አመጋገብ ልምድ መረጃ

ተ.ቁ	ጥያቄዎች	መልስና ኮድ	አለፍ ወደ
201	በመጨረሻ የእርግዝና ጊዜዎ በጠና ድርጅቶች ውስጥ የነፍስጡር ምርመራ ክትትል አድርገው ነበር?		
202	የመጨረሻውን ልጅ አርግዘው እያሉ የነፍስጡር ምርመራ ተከታትለው ከነበር በስንተኛው የእርግዝና ወር ላይ ሄዱ?	የእርግዝና ወር -------- አላስታወስም 88	
203	የመጨረሻውን ልጅ አርግዘው እያሉ ለነፍስ ጡር ምርመራ ሄደው ከነበር በየትኛው የጤና ድርጅት ክትትል አደርጌ?	በመንግስት ሆስፒታል 1 በመንግስት ጤና ጣቢያ 2 በመንግስት ክሊኒክ 3 በግል ክሊኒክ 4 ሌላ /ይገለፃል/ ---------- 5	
204	የነፍስ ጡር ምርመራ ባደረጉት የጤና ድርጅት ውስጥ ስንት ጊዜያት ክትትል አድርገው ነበር?	የተከታተሉበት ጊዜያት ብዛት /በቁጥር /----አላስታውስም 88	
205	በነፍስ ጡር ምርመራ ክትትል ወቅት ስለህፃን አመጋገብ ምክር ተሰጥዎት ነበር?	አዎ 1 አልተሰጥኝም 88	
206	ልጅ አመጋገብን በተመለተ በየትኛው /በምን/ርእስ ላይ የጤና ትምህርት /ምክር/ ተሰጥቶት ነበር? /ምርጫዎቹ ይነበቡላቸው፡፡ በተመከሩት ትክክል 1	አዎ አልተሰጠኝም 1. ስለ ጡት ማጥባት ብቻ 1 2 2. ስለ ጡጦ 3. ጡትን አያጠቡ በተጨማሪ ሌላ ስለመመገብ 1 2 4. ጡትን ሳይሰጡ ሌላ ስለመመገብ	

	ባለተመከሩት ትክክል 2 ክብ ይደረጋል።/	1 2 5. ሌላ /ይግለጹ/ ---------- 1 2	
207	የመጨረሻ ልጅዎን የወለዱት የት ነበር?	በመንግስት ሆስፒታል 1 በመንግስት ጤና ጣቢያ 2 በመንግስት ክሊኒክ 3 የግል ክሊኒክ 4 በቤቱ ውስጥ 5 ሌላ /ይገለጽ/ 6	
208	የመጨረሻ የምጥ/የወሊድ/ ጊዜዎ ውጤት ምን ነበር?	የጤና ባለሙያ የሰለጠነ የልምድ አዋላጅ 1 የሰለጠነ የልምድ አዋላጅ 2 የልሰለጠነ የልምድ አዋላጅ 3 ቤተ ዘመድ/ጓደኛ፣ ጎረቤት/ 4 ሌላ/ይገለጽ/ ---------- 5	
209	የመጨረሻ ልጅዎ አሁን በሕይወት አለን?	በ---------- ወሩ በሂወት የተወለደ ህፃን 1 በ---------- ወሩ ምቶ የተወለደ ህፃን 2	
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253	በደም ውስጥ የኤተ አይቪ ቢገኝ ከሚከተሉት ለየትኞቹ ውጤቱን ይናገራሉ? /ምርጫዎቹ ይነበቡላቸው። የመለሱት ሁሉ ክብ ይደረግ/ 1. የትዳር ጓደኛ /በፍቅር ጓደኛ/ 2. ለልጅ 3. ለወንድም 4. ለእህት 5. ለሌላ ዘመድ 6. ለጓደኛ 7. ለቤት አከራይ 8. ለጎረቤት 9. ለኃይማኖት መሪ 10. ለአካባቢ /ሰፈር/ ኃላፊዎች 11. ለሰራ ቀጣሪ 12. ሌላ /ይገለጽ/.....	አዎ አይ አይመለከትም መ.የለም 1 2 3 99 1 2 3 99 1 2 3 99 1 2 3 99 1 2 3 99 1 2 3 99 1 2 3	

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	3. ህፃኗ በኤች አይ ቪ እንዳይያዝ ምን መመገብ እንዳለባት ለመወሰን እንድትችል።	ትክክል ነው 1 ትክክል አይደለም 2 አላውቅም 88	
	4. በኤች አይ ቪ ከተያዘች ጽንስን ማቋረት /ማስወጣት/ እንድችል።	ትክክል ነው 1 ትክክል አይደለም 2 አላውቅም 88	
261	ስለ ኤች አይ ቪ ከእናት ወደ ልጅ መተላለፍ በተመለተ ከየት ሰሙ? /ከዚህ ሌላስ? በማየት ደግሞ ይጠየቅ። ከአንዱ በላይ መልስ ሊኖር ይችላል። የሰሙበትን በገለፁት ትክክል 1 ላልተገለፀው 2 ክብ ይደረግ/	አዎ አይደለም 1. በኤች አይ ቪ ምርመራ ወቅት 1 2 2. በነፍሰጡር ምርመራ ጊዜ 1 2 3. በድህረ ወሊድ ምርመራ ጊዜ 1 2 4. በህፃን ምርመራ ጊዜ 1 2 5. ከብዙሀን መገናኛ 1 2 6. ከጓደኞቹ /ዘመድ/ 1 2 7. ሌላ/ይገለጽ/……1 2 8. አላውቅም 1 2 9. መልስ የለም 1 2	
262	/የህፃን አመጋገብ እውቀትን በተመለተ ከዚህ በመቀጠል ደግሞ የህፃን አመጋገብን በተመለተ ስለማነብልዎ አረፍተ ነገሮች ትክክል ነው ብለው ካሰቡ "እውነት" ትክክል ካልሆኑ "ሐሰት" በማለት ይመልሱ።		
	1. ማንኛውም እናት ልጇን በመጀመሪያዎቹ 6 ወራት ውስጥ ጡቷን ብቻ ብትመግብ በቂ ነው።	እውነት 1 ሐሰት 2 አላውቅም 88	
	2. የእናት ጡት ወተት የህፃናት በሽታዎችን ይከላከላል።	እውነት 1 ሐሰት 2 አላውቅም 88	
	3. ኤች አይ ቪ ጡት በማጥባት በበሽታው ከተያዘች እናት ወደ ህፃኗ ሊተላለፍ ይችላል።	እውነት 1 ሐሰት 2 አላውቅም 88	
	4. ህፃናት የዱቄት ወተት ወይም ሌሎች ምግቦች መመገብ ከእናት ጡት ወተት ይልቅ ዋጋቸው ውድ ነው።	እውነት 1 ሐሰት 2 አላውቅም 88	

	5. ህፃንን የዱቄት ወተት ወይም ከእናት ጡት ወተት በቀር ሌሎች ምግቦችን ብቻ መመገብ ኤች አይ ቪ በበሽታው ከተያዘ ሴት ወደ ህፃኗ እንዳይተላለፍ ለመከላከል ያስችላል።	እውነት 1 ሐሰት 2 አላውቅም 88	
	6. ለማንኛውም ህፃን ከእናቱ ጡት ወተት በተጨማሪ የዱቄት ወተት ወይም ሌሎች ምግቦችን /ፈሳሾችን/ በመጀመሪያው ስድስት ወራት ውስጥ መመገብ ጥሩ ነው።	እውነት 1 ሐሰት 2 አላውቅም 88	
	7. በኤች አይ ቪ ላልተያዘች እናት ህፃን ከ6 ወሩ ጀምሮ ጡት ወተት እና ሌሎች ተጨማሪ ምግቦችን መመገብ ጤናማ እድገት እንዲኖረው ይጠቅማል።	እውነት 1 ሐሰት 2 አላውቅም 88	
	8. ኤች አይ ቪ ለተያዘች እናት ህፃን ከ6 ወር ጀምሮ የእናቱን ጡት ወተት እና ሌሎች ተጨማሪ ምግቦችን ኤች አይ ቪን ከእናትየዋ ወደ ህፃኑ የመተላለፍን መጠን ይጨምረዋል።	እውነት 1 ሐሰት 2 አላውቅም 88	
263	ስለ ህፃን አመጋገብ መስማት /መረዳት/ የቻሉ ከየት ነው? /ከዚህ ሌላስ? በማለት ደግሞ ይጠየቅ። ከአንድ በላይ መልስ ሊኖር ይችላል። የሰሙበትን በተገለጸው ትክክል 1 ላልተገለጸው 2 /ክብ ይደረግ/	አዎ አይደለም 1. በኤች አይ ቪ ምርመራ ወቅት 1 2 2. በነፍሰጡር ምርመራ ጊዜ 1 2 3. በድህረ ወሊድ ምርመራ ጊዜ 1 2 4. በህፃን ምርመራ ጊዜ 1 2 5. ከብዙሃን መገናኛ 1 2 6. ከጓደኞች/ዘመድ/ 1 2 7. ሌላ/ይገለጽ/ 1 2	

Annexes 2 Declaration

I the undersigned declare that this is my original work and has not been presented in this or any other University and all sources of materials used for this proposal have been fully acknowledged.

Name of student : Tadelech Mebratu (BSc)

Signature: _____

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Name of Advisor: Tefari Fite (RN, BSc N, MSC)

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