ADDIS ABABA UNIVERSITY
FACULTY OF MEDICINE
DEPARTEMENT OF COMMUNITY HEALTH

ASSESSEMENT OF INTENTION AND PRACTICE OF VCT AND INFANT FEEDING IN THE CONTEXT OF HIV/AIDS AMONG LACTATING MOTHERS IN HARAR TOWN

BY MESELECH ASSEGID (B.Sc)

A THESIS SUBMITED TO THE SCHOOL OF GRADUATE STUDIES
ADDIS ABABA UNIVERSITY IN PARTIAL FULLFILLEMENT
OF THE REQUIREMENT FOR MASTER OF PUBLIC HEALTH

MARCH 2006

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Advisor

Fikru Tesfaye (MD, MPH)

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Table of contents

1.ACKNOWLDGEMENT ..... **I**
2. TABLE OF CONTENTS ..... **II**
3. LIST OF TABLES ..... **III**
4. LIST OF FIGURES ..... **IV**
5. ACRONYMS ..... **V**
6. ABSTRACT ..... **VI**
7. INTRODUCTION **1**
8. LITERATURE REVIEW **4**
9. OBJECTIVES **13**
GENERAL OBJECTIVE 13
SPECIFIC OBJECTIVES 13
10. METHODS AND MATERIALS **14**
STUDY AREA **14**
STUDY DESIGN 14
STUDY POPULATION 14
SAMPLE SIZE DETERMINATION 15
SAMPLING PROCEDURE 15
DATA COLLECTION INSTRUMENT: 17
FIELD TESTING 17
DATA QUALITY CONTROL 18
OPERATIONAL DEFINITIONS 18
DATA ANALYSIS 20
11. ETHICAL CONSIDERATION **21**
12. RESULTS **22**
13. DISCUSSION **49**
14. CONCLUSIONS **55**
15. RECOMMENDATIONS **56**
16. REFERENCES **58**
17. ANNEXES **63**

List of tables

TABLE-1. SOCIO DEMOGRAPHIC CHARACTERISTICS OF THE STUDY PARTICIPANTS AND THEIRPOUSES HARAR TOWN. JANUARY, 2006 22

TABLE 2 OBSTETRIC HISTORY OF MOTHERS . HARAR TOWN, JANUARY, 2006 24

TABLE 3- RESPONDENTS SOURCES OF INFORMATION ON HIV/ AIDS AND VCT, HARAR TOWN. JANUARY, 2006 25

TABLE-4 PREDICTORS OF GOOD KNOWLEDGE OF HIV/AIDS, HARAR TOWN, JANUARY 2006 33

TABLE 5. PREDICTORS OF KNOWLEDGE OF TRANSMISSION OF HIV FROM MOTHER-TO-..... 35
CHILD (MTCT) HARAR TOWN, JANUARY 2006 35

TABLE- 6 PREDICTORS OF GOOD KNOWLEDGE OF PREVENTION MOTHER-TO-CHILD TRANSMISSION PMTCT AMONG STUDY SUBJECTS, HARAR TOWN, JANUARY 2006..... 37

TABLE- 7 PREDICTORS OF GOOD ATTITUDE TOWARDS VCT AMONG STUDY SUBJECTS,HARAR TOWN, JANUARY 2006..... 39

TABLE -8 PREDICTORS OF MOTHERS' INTENTION TO HAVE VCT, HARAR TOWN ,JANUARY, 2006 ... 40

TABLE -9 PREDICTORS OF MOTHERS' PRACTICE OF VCT, HARAR TOWN. JANUARY, 2006 42

List of figures

FIG 1 REPORTED RISK PERCEPTION BY RESPONDENTS HARAR TOWN, JANUARY 2006..... 27

FIG 2. INTENTION OF MOTHERS ON DURATION OF BREAST FEEDING, HARAR TOWN, JANUARY 2006..... 30

FIG.3 RESPONDENTS SOURCE OF INFORMATION ON OPTIONS OF BREAST FEEDING, HARAR TOWN, JANUARY 2006…….39

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARV	Anti Retro Viral
AZT	Zidovidne
BCC	Behavioural Change Communication
BMS	Breast Milk Substitution
HIV	Human Immunodeficiency Virus
IEC	Information Education Communication
MCH	Maternal and Child Health
MTCT	Mother-to-child Transmission
PCR	Polymerase Chain Reaction
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother-to-child Transmission
PNC	Post Natal Care
STI	Sexually Transmitted Infections
UNAIDS	Joint United Nations' Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

ABSTRACT

Introduction: - *Mother-to-child transmission of HIV is the most significant route of HIV infection in children and by far the largest source of HIV infection in children below the age of 15 years*

Objectives*: - the aim of this study was to assess current practices and future intention of lactating mothers on VCT and infant feeding in relation to prevention of MTCT of HIV in Harar town.*

Methods: - *A community based cross sectional quantitative survey supplemented with a qualitative method was conducted from January to February 2006 using standardized questionnaire, among lactating mothers in Harar town selected using probability proportional to size.*

Results: - *Lactating mothers had good knowledge of HIV/AIDS but fair knowledge on MTCT and PMTCT of HIV. Intention to undergo VCT had significant association with knowledge about PMTCT. Practices of VCT had significant association with age of mothers, parity, frequency of ANC check-up, HIV knowledge, PMTCT knowledge and attitude towards PLWHA.*

Conclusion*: -* *There is a high intention to undergo VCT whereas only few mothers have undergone the test, indicating a wide gap between intention and practice. The mothers' breast feeding practice in the context of HIV and nutrition is risky as suboptimal breast feeding practices are widespread.*

Recommendation: - Increasing utilization of MTCT, PMTCT, and VCT including optimal infant feeding requires IEC and BCC. Information, Education Communication (IEC) and Behavioural Change Communication (BCC) on VCT, MTCT, PMTCT and infant feeding shall be strengthened. Establish communication/ referral network between health facilities and organizations working on HIV/AIDS,

working towards alleviating the problem that social stigma poses on mothers' adoption of safer infant feeding options to prevent MTCT of HIV and full day VCT services shall be made available for mothers seeking delivery services in hospitals to minimize missed opportunities.

1. Introduction

As per 2004 global UNAIDS report, the epidemics burden of HIV on women accounted for 50% of all PLWHA worldwide, 57% for sub-Saharan Africa. In Ethiopia out of PLWHA women accounts about 51%. According to sentinel surveillance on pregnant women the prevalence of HIV varied across sites from 0.5% to 30%; 2.2% to 30.2% in urban and 0.5% to 1.9%rural as reported in June 2004. (1, 2).

Mother to child transmission (MTCT) of HIV is the most significant route and by far the largest source of HIV infection in children below the age of 15 years. Worldwide 2000 infants are infected each day or almost 720,000 per year. In Ethiopia out of PLWHA 96,000 are children less than 15 years (1, 2, 3).

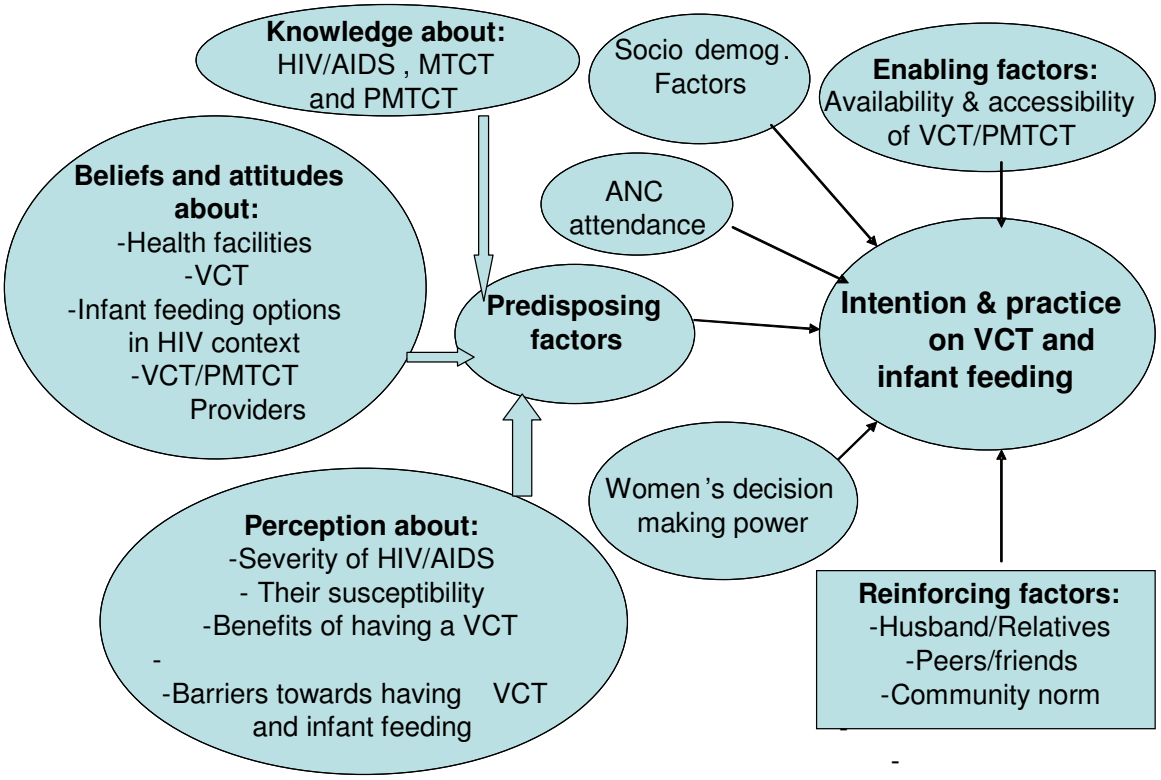
In the absence of any intervention, the risk of a baby acquiring the virus from an infected mother ranges from 15% to 25% in industrialized countries, and 25% to 35% in developing countries. HIV transmission rate and time of transmission is estimated to be 5% to 10% during pregnancy, 10% to 15% during delivery, and 5% to 20% during breast feeding. Overall, without breastfeeding 15% to 25%, with breast feeding to six months 20 % to 35% and with breast feeding to 18 to 24 months 30 % to 45 % of transmission rate is estimated (3, 4, 5, 6, 7).

Considering the problem of MTCT of HIV, studies in some African countries showed that the risk to all infants in the community approaches 25% to 40% while studies addressing this issue in Ethiopia are few (8). Access to VCT and improved breast

feeding by counselling on infant feeding options are among the core intervention of MTCT of HIV (3).

The proposed study intends to assess the intention and practice of VCT and infant feeding in the context of HIV using behavioural models. The result of the study will produce information that can be used by program managers and stakeholders in the planning and implementation of interventions for improving activities in the context of prevention of HIV transmission from mother to child (PMTCT) scale-up.

Conceptual Model Used In The Assessment Of Intention And Practices Of VCT And Infant Feeding Related To The Risk Of MTCT.



2. Literature review

Based on theoretical assumptions from behavioural modelling which enables individuals to make informed choices and decisions towards behavioural change in MTCT, several factors affect women to seek services like VCT and appropriate infant feeding options during pregnancy, child birth and after child birth (3). This can be summarized as socio demographic and personal environmental social interactions, predisposing, reinforcing, and enabling factors (Annex 1).

Predisposing factors:

Knowledge of HIV AIDS, MTCT and PMTCT

In assessment of PMTCT awareness and knowledge covering PMCTC sites in 6 regions of Ethiopia on lactating mothers, 98% of them had heard of HIV /AIDS, about 44% of the women were able to name at least 2 modes of HIV transmission with 26% of MTCT. Only 13 % of women correctly identify the three ways of that HIV can be transmitted from mother to child: during pregnancy, delivery and through breastfeeding and 23% did not mention any means of PMTCT during pregnancy .The methods of HIV prevention mentioned were being faithful to partner (68%), followed by abstinence (52%) and use of condom (49%). In case of PMTCT during pregnancy, 18% said nothing could be done (7).

As **s**tudies in Hong Kong, China on pregnant women attending antenatal care clinic at different time indicate that, they have good knowledge of HIV/AIDS (91.6%) with mean score of 4.8 of the possible six, and 62% to 89% knew that using condoms reduce the chance of getting HIV/AIDS. However women were less knowledgeable on MTCT (57%) with mean score of 3.6 of the possible six. Knowledge of means of reducing of HIV transmission to her baby and transmission through breastfeeding

were very less (15.7%).Their knowledge was significantly associated with their educational level (14,15).

Similarly a study conducted in Ghana on voluntary counselling and HIV testing of pregnant women has shown 74.4% spontaneously mentioned sex and blood transfusion and 25% MTCT. On specific inquiry in this study 51.1% mentioned that MTCT could occur during pregnancy and delivery and 31.5% during breastfeeding (16).

For prevention during breast feeding period 35% of lactating women identify at least one method. From prevention, provision of cow's milk was (34%) followed by stop or don't breast feed (29%), and give formula milk (25%) (7).

In community based study in Lusaka, Zambia , 31.8 % of respondent believed that nothing could be done to prevent MTCT during breast feeding and the PMTCT given were condom (8%) and abstinence (11%) and no mother mention exclusive breast feeding as a method to avoid MTCT during breast feeding .In this study, feeding practices among community mothers of infant less than 6 months old were exclusive breast feeding (56.7%), mixed feeding (42.8%), and exclusive replacement feeding was 0.5% (17).

As study done in Jimma town, Ethiopia on pregnant and lactating mothers 38.8% of pregnant mothers and 41.8 % of lactating mothers had sufficient knowledge about MTCT and PMTCT. Moreover 62.4% of study participants had good attitude towards VCT. Among these mothers 84.5 % of them visited health institution during the

current and last pregnancy out of which 35.7% of them used VCT. The proportion of grandmultipara was 6.4% (36).

Perception of risk and risk behaviours

In highly stigmatized societies, women who believe themselves to be at high risk of infection are less likely to choose to be tested for HIV or to come back for their test results. Of the 445 pregnant women tested and diagnosed as HIV positive, 177 did not return back for their test results. Similarly in Ethiopia out of tested lactating mothers21% not believe they were at risk related with partner faithfulness and having one partner. Out of women who did feel at risk for getting infected with HIV, they were not trust the sexual behaviour of their partner /s. According to study in cape town South Africa, on risk behaviour history, over 40% had two or more sex partners, more than 10% had traded sex to meet survival needs, 35% had had an STI, and 13% had a history of genital ulcers (7,9,11, 17).

As study in Hong Kong, China, nearly half (42.9%) would verbalize their concern to their husband, however about 2.1% may remain silent to avoid conflict. Perception that HIV /AIDS is such a "bad" disease that the period of pregnancy was not an appropriate time for a woman to be told about it (15.2%) and possible suicidal tendency after a positive HIV test (6.8%) is reported in study in Ghana. (14, 15, 17).

Attitudes towards VCT

In a study 19% of women responded that it was possible to get a voluntary and confidential HIV testing and only 18% of the participant women reported to have been ever tested for HIV during pregnancy of which 69% took the test during last pregnancy (7). The majority (96.6%) were willing to undergo HIV testing if it were freely available at the hospital. About 51.5% considered that VCT is useful for a pregnant women by giving the main reasons like to know her HIV status, the need to protect oneself from infection in case the test was negative , the need to seek care if the test turned out positive (36%), the urge to ally anxiety (32%), the need to protect others from getting infected , to protect the unborn child if the test turned out positive (11%), and disturb her if the test is positive (48%).

Attitudes and stigma associated with breast feeding and HIV, very few women (15%) specifically mentioned that a mother suspected to be HIV positive if she does not breast feed (10).

In China attitude to testing, the majority (77%) claimed to be willing to undergo testing for HIV. Three fourth would tell their partner if they were positive and a lot less (7%) would tell any body. Eighty four percent regard termination as the best option if tested positive but many would accept medication to reduce MTCT in preference to termination. According to a study in Lusaka, Zambia , almost all women were aware of VCT services; they consider it as a source of stress and choose not to use the service (7, 15, 16, 17).

Reinforcing factors:

Despite its benefits breastfeeding is undoubtedly one of the routes of HIV transmission. In breast feeding infants, the risk of transmission could be related to the duration of breast feeding, the time of exposure, the infectiousness of the milk, and the presence of HIV antibodies in the milk. A study conducted in Malawi showed that in breast fed infant who were found to be HIV negative by PCR at 1 month of age (and whose only remaining risk factor was thus breast feeding), the rate of infection was 5.2% at 6 months, 9% at 1 year, and 13.8% at 2 years of age (4,9,13).

Determinants of willingness to get tested for HIV, and who were significantly more likely to want to get tested were: knowledge of at least one mode of HIV transmission, those knew that drugs that reduce the chance of HIV vertical transmission exist, affordability of the cost of an HIV test, those who consider it useful for a pregnant mother to know her HIV status, confident that they would disclose the result of test to their husbands, the result would be kept confidential (51.9%),acceptance by their partners i. e either feared divorce or physical abuse . (7, 12, 15, 16).

A study in Lusaka, Zambia showed that more than 70 percent of respondents shared their HIV test results with their partners. After being counselled and tested as part of the PMTCT programme more than half of women in Karatina and in Homa Bay shared their HIV test results with someone (partner, family member, friend, etc…)(31).

Most of the mothers had originally chosen breast feeding because of a fear of being identified as HIV positive or because of social pressure from their families or from

midwives in the maternity room .According to study on HIV infected and uninfected mothers with median infants' age of 6 months, one quarter of the HIV infected mothers reported having been advised to stop breastfeeding because of their HIV status. Exclusive breastfeeding was practiced by 35% of the mothers with infants aged 4 months or younger (18, 21).As the study in Durban, South Africa, on 13 women, any of these women were not informed during their pregnancy, or even immediately after birth the risk of HIV transmission through breast feeding. (23).

Intention of mothers on duration of breast feeding

.Most mothers planned to breast feed for 2 years, with an intended median duration of 20 months. A large proportion of HIV infected mothers intended to breastfeed for less than 12 months and to stop by 18 months. More HIV infected mothers reported commencing alternative liquids below the age of 2 months. Out of 106 infants aged 4 months or older, 52% had been started on alternative fluids to breast milk by 4 months of age. The median age of introduction of complementary foods was 4 months (15% by 2 months, and 60% by 4 months). The median age at which breast milk substitution (BMS) were commenced was 2.5 months. Similarly in a study done in Adigrat, Tigray the mean age at commencement of supplementary diet was 3.3(SD $\pm$ 0.79) months and the median age was 3.0 months. The age range was 1 to 6 months. Comparative study between well nourished and malnourished children done in Addis Ababa shows that the mean age at which supplementary food was started in malnourished households was 4.9 ($\pm$ 2.9) months. The BMS used by mothers were commercial formula feeds, fresh cow's milk, and modified cow's milk. The main reasons stated for early introduction of complimentary foods were: the baby crying, and the mother's perception of having insufficient breast milk. In case of water

quality, 52% always boiled water given to the baby, 38% added chlorine and boiled, and 27% did neither boiling nor add chlorine (5, 23, 32, 33, 34, 35).

Attitudes of mother of women opt not to breast fed; the majority expressed negative views not breastfeeding by stating reasons like feeling deprivation of child's nutrition, a bad feeling, feeling of very painful even crying , have no choice as they have no money, and stigma of HIV infection which had become associated with formula feeding . Their relatives and friends have also negative responses by saying like not be happy, want to know why not breastfeeding and think the mother has an illness which is transmitted in breast milk that may lead to recrimination and punishment (9, 21, 23).

Enabling factors:

On PMTCT of HIV in developing countries, levels of maternal and child morbidity and mortality, as well as the availability of MCH services vary from place to place. Even thought over all median acceptability rate of VCT was 65%in Africa while in Thailand reached 95%, the current strategy to reduce MTCT was that all effort should be made to proper voluntary HIV counselling and testing to all pregnant during the antenatal period and to recommended that they avoid breast feeding when possible since VCT is now seen as entry point for these preventive services. However, it should be clear to a woman that the most effective interventions can not be made available to women whose HIV status is not known (8,9,25,26,27).

A study done in Brazil on Voluntary HIV counselling and testing during prenatal care mother's opinions about the counselling session showed that it was highly effective in clarifying the benefits of HIV testing. In this study counselling was given for 39

mothers only 3 of them refused the HIV test. Low income, late beginning of prenatal care, use of rapid test, and absence of prenatal care were associated with not being counselled during the current pregnancy. (30).

The latest United Nation policy statement on HIV and infant feeding was issued in 2001, says “when replacement feeding is acceptable, feasible, affordable, sustainable, and safe, avoidance of all breast feeding by HIV infected mother is recommended (9,13,28,29).

For women who are HIV negative or of unknown HIV status, exclusive breastfeeding for the first six months is a single infant feeding recommendation that may protect their infant becoming infected with HIV (28).

In studies in Abidjan, Cote d’ivoire targeted on breastfeeding at 6 weeks; 36(45.6%) were being breastfed, 2 (2.5%) were receiving mixed feeding, and 41 (52.5%) were receiving artificial feeding. A total of16 mothers switched from breastfeeding to artificial feeding during the first 6 weeks of their babies lives without a period of mixed feeding (11).

Women who initiated breast feeding, 21%of initiators quit in the first two weeks, 30% between 2 weeks and 2 months, 28% between 2 months and 4 months, and 21% breastfed 4 months or more. In the hospital, the reasons for initiation of mixed feeding was mother's inability to produce sufficient milk for the child, caesarean section discomfort and problems of feeding diluted cow milk during the night (19).

In women who never breastfed, reason reported were: 'I did not want '(48%), 'I did not want to pass dangerous things '(25%), and 'other reason' (11%) . Less common were 'Nipple and breast problems' (9%), 'I was ill/ weak '(4%),'baby refused' (3%),'I produce insufficient milk' (3%), 'baby was ill or sick' (1%),and ' I was never thought' (1%) (20).

The most commonly reported reasons given for discontinuation were: Baby refused (24%), I produced insufficient milk (23%), nipple or breast problem (17%), schedule difficulty (10%), I do problem was the most common reason cited while among women who breastfed 4 months or more schedule problem was most common (20).Women's individual, social and financial circumstances must be taken in to account by health workers when helping a woman to decision about feeding her baby (23, 24).

A study done in Jimma revealed that mixed infant feeding was practiced by the majority (81.0%), and exclusive breast feeding by 18. 4% for a child before 6 months age. Concerning decision making on how to feed their infant 35.7% was made by mothers, 55.8% by husband and 8.3% by mother in law (36).in the same way as study in baseline survey of PMTCT in Ethiopia decision on what to feed the child , 65% of the women mentioned only by themselves and 22% mentioned both themselves and the father (7).

3. Objectives

General objective

- To assess intentions and practices of lactating mothers on VCT and infant feeding, in relation to PMTCT of HIV in Harar town

Specific Objectives

- To assess the knowledge and attitude of lactating mothers on MTCT of HIV
- To assess knowledge, attitude, practice and future intention of lactating mothers on VCT
- To assess current practice and future intention of infant feeding in relation to PMTCT
- To assess determinants of intention and practices of lactating mothers on VCT in relation to PMTCT
- To explore perceptions and experiences of health workers on VCT and infant feeding options counselling of mothers

4. Methods and materials

Study area:

The study was conducted in Harar town which is located 525 KM East of Addis Ababa .The town is divided into 19 Kebeles. According to 1994 census, the projected population of the town by 2005 is estimated to 118,000. The major ethnic groups based on population size of the town are Amhara, Oromo, Harari, Gurage, Tigrae and Somalie. There are 5 hospitals and 12 clinics (3 factory clinic, 8 private clinics and 1 NGO clinic) in the town. Out of these 3 of the hospitals provide PMTCT service and the NGO clinic provides VCT service. By considering 2% of expected pregnancy per year in urban, the expected number of pregnancy per year is about 2360. Antenatal check up coverage of the region was 57.4%, attended delivery was 23.8% and family planning coverage was 34.7% (Health and health related indictor2004/2005).

Study design: a community based cross sectional study was conducted to assess intention and practices of VCT and breast feeding.

Study period: The study was conducted in January 2006.

Source population: the source population was all women in the reproductive age (15-49 years) in Harar town.

Study population: the study population was all lactating mothers having a child/ children younger(less) than one year without considering their HIV status and health workers in MCH unit. The age of infants was estimated /stated by the women

themselves and those lactating mothers having child/children less than one year were identified as eligible for the study.

Sample size determination*:*

Sample size was estimated as 18% practice rate of VCT among lactating mothers (7). Three percent marginal error with 95 % confidence of certainty of any outcome was used. Based on this the actual sample size calculated using the formula for single population proportion,

$$n = (Z\alpha/2)2\ P\ (1-P)/\ d2$$

Where P= the prevalence of practice of HIV testing among lactating mothers (0.18)

d= marginal error between the sample and the population (0.03)

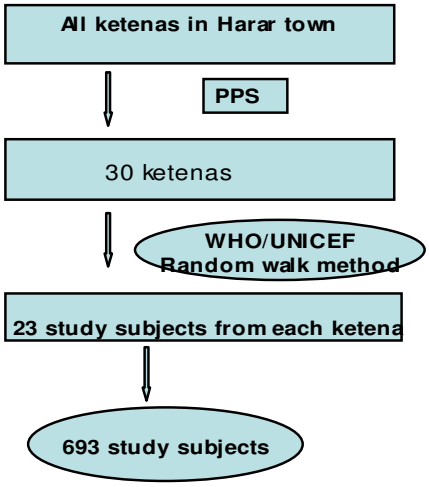
Z =Critical value at 95% certainty (1.96)

The calculated sample size was 630 .Considering 10% non response rate, the overall sample size was 693.

Sampling procedure*:*

For quantitative data**:** Selection of the study subjects was done using probability proportion to size (PPS) sampling technique. There are 19 kebeles and these are divided in to 70 ketenas. Out of these 30 ketenas were selected for the survey by calculating the cumulative frequency of the population of each kebeles with their respective ketenas. After selection of ketena, the data collector stood at the centre of the Ketena assisted by local guide and assigned numbers for whole possible directions and used random method to select walking direction. The data collectors took a maximum number of 23 eligible study subjects from each ketena. Individuals were selected irrespective of their HIV status. In case if the direction selected didn't

complete the sample size, the method was repeated. If more than one eligible was found in any households, all were taken as study subjects. Population of female in the reproductive age group in the town was obtained from planning and economic development of the region (37).



Sampling procedure for qualitative data

In depth interview was conducted by selection of key informants who were directly involved in the PMTCT /VCT service provision from hospital/s .The selection of key informants was carried out by consultation of administrators of the institution. A total of six professionals from Hiwot Fana Hospital participated in the study. These were two midwives from Antenatal Care Unit, one midwife and one gynaecologist from delivery room, one nurse counsellor from VCT unit and one nurse from ART unit. In addition the records in MCH was revised to know proportion of women tested during pregnancy and delivery.

Inclusion criteria: Mothers, who gave birth in the past 12 months of study period, as reported by the respondents without considering their HIV status, were included in the study from the selected households.

Exclusion criteria: mothers who did not satisfy the inclusion criteria and who were not willing to give an informed consent were excluded from the study.

Data collection instrument:

The questionnaires were developed according to theoretical behavioural models; Health belief model (HBM), theory of planned reasoned action (PRA) and PRECEDE-PROCEED model(38).Quantitative data was collected using adopted standardized structured questionnaires (39), and the qualitative data was collected using guiding questions which were designed to include VCT and PMTCT service provision (40). The questionnaires were translated from English to Amharic for better understanding for data collectors and the respondents.

Selection and training of data collectors

Ten data collectors were recruited from Harar town; those who have completed grade 12 and have previous experience in data collection were selected. The principal investigator gave training for 2 days for data collectors and two supervisors (BSc holders) prior to data collection on objectives of the study and techniques of presenting the questions in understandable manner for the respondents. The qualitative interview was conducted by the principal investigator.

Field testing

The questionnaires were pre-tested for clarity, flow, repetition and time requirement on the same eligible residing in ketenas which were not included in the study.

The research methods and data collection tools (questionnaires) were pre-tested on 20 lactating mothers before the initiation of the main research (study).

Findings and experiences from the pre-test was utilized in modifying the data collection tools.

Data quality control

Supervision was conducted by two supervisors from Alemaya University and the principal investigator, by observing administration of the questions to the respondents and its completeness. To ensure data quality, each data collector and supervisors checked the questionnaires for completeness before winding up the visit to each study participant. Some sub-samples of the questionnaires (5%) were rechecked by the principal investigator.

Operational definitions

Behavioural Intention- Readiness or willingness of an individual to perform a certain behaviour.

Behavioural modelling-An attempt to identify and propose a working set of determinant factors which are thought to be the most important ones in affecting or influencing behaviours.

Exclusive breast feeding - Giving the infant no other food or drink rather than breast milk, not even water, apart from breast milk (Including expressed breast milk), with the exception of drops or syrups consisting of vitamins, mineral supplements or prescribed medicines.

Predominantly breast feeding – Infants who feed on breast milk and other fluids like tea, water and juice but not other milk products.

Mixed feeding- Giving a baby breast milk and milk products such as formula milk and cow milk including solid and semi sold foods.

Replacement feeding- The process of feeding a child who is not receiving breast milk with a diet that provides all the nutrients to the child needs until the child is fully fed on family foods.

Complementary feeding- Giving other foods (called complementary foods) in addition to breast milk.

Good knowledge of HIV/AIDS- those respondents with mean score and above related to questions of mode of transmission of HIV are considered as having good knowledge and scores less than mean are considered as having poor knowledge.

Good knowledge of MTCT of HIV - those respondents with mean score and above to questions on time of transmission of HIV from mother to child are considered as having good knowledge and scores less than mean are considered as having poor knowledge.

Good knowledge of PMTCT of HIV- those respondents with mean score and above to the questions pertaining to prevention of HIV transmission from mother to child are considered as having good knowledge and scores less than mean are considered as having poor knowledge.

Good attitude towards HIV/AIDS - those respondents with mean score and above to the questions pertaining to attitudes towards HIV/AIDS are considered as having good attitude and scores less than mean are considered as having bad attitude.

Good attitude towards VCT - those respondents with mean score and above to the questions pertaining to attitudes towards VCT are considered as having good attitude and scores less than mean are considered as having bad attitude.

Data analysis

Pre coded data was entered, and cleaned in EPI 6 software version. The data was exported in to SPSS software version 11 and analysed. Frequencies, proportion and summary statistics were used to describe the study population in relation to relevant variables. Odds ratio was computed to assess the presence and degree of association between dependent and independent variables. Moreover, multiple logistic regression analysis was employed to control the possible confounding effects and to assess the separate effects of the variables.

Each variable for the theoretical models was measured with the help of a five point liker scale and closed ended questions. The response options were in the five point liker scale ranging from strongly agree to strongly disagree. For each construct where more than one item was measured a sum score was calculated to obtain an average of the whole set of items. Mean, median and range were calculated for Knowledge and attitude sum scores. The measure of perceived severity consisted of one items which suggested that "do know any who has or died of HIV/AIDS". The measure of perceived susceptibility was assessed using one items which suggests the likelihood that makes her at risk of getting HIV. The response options were in the five point likert scale ranging from strongly agree to strongly disagree.

In order to determine their prediction as well as their determinations for other dependent (out comes) dichotomization was done using their mean after checking their distribution. Those who scores mean and above were considered as having good knowledge or attitude. Finally socio-demographic variables were included to appreciate how each component improved the performance of the model.

The qualitative data was recorded using cassette recorder tape, and then the conversation was transcribed and analyzed. The information obtained was triangulated with the quantitative information to answer the research questions.

Variables

Dependent- intention and practices of VCT, current infant feeding practice and future intentions of lactating mothers on time of initiation of complementary food and duration of breast feeding

Independent:- **Socio demographic variables** (Age, Marital status, Parity, Ethnicity, Religion, Level of education, occupation, income),**Knowledge and attitude variable** (Knowledge about HIV, VCT, and MTCT/PMTCT, Knowledge of breast feeding options in HIV context, Attitudes towards people living with HIV/AIDS, Attitudes towards VCT, and Counselling on infant feeding.

5. Ethical consideration

The study was approved by the ethical review committee of the AAU, DCH and FOM. Written consent of the administrative officials in the respective study area and verbal consents of the study participants was obtained. All the interviews with subjects was made with strict privacy. The right of the respondents to refuse answer for few or all of the questions was respected. During data collection necessary advice was given for mothers practicing suboptimal breast feeding.

6. RESULTS

A total of 682 (98.4%) mothers participated in the study. The majority of the study participants were in the age group of 25 to 34 years with mean age of 25.8(+ SD 5.04). The majority were married 604 (88.6%), house wives in occupation, 431(63.3%), and had good schooling that 285(41.8%) attended high school education. In case of religion of mothers, orthodox Christian accounts about 338 (49.4%). Oromo, Amahara, Gurage and Harari ethnic groups constituted 272 (39.9%), 231(33.9%), 80 (11.7%) and 69 (10.1%) respectively. Majority of the study participants 441(60.7%) earn more than 300 ETB per month. Similarly Husbands of most participants 365(55.1) had attended secondary and 203 (30.7%) were government employee.

Table-1. Socio demographic characteristics of the study participants and their spouses Harar town. January, 2006

Variable	Frequency	Percent
Age (years)		
15-24	280	41.1
25-34	348	51.0
35-49	54	7.9
Marital status		
Married	604	88.6
Single	37	5.4
Divorced	20	2.9
Widowed	12	1.8
Separated	9	1.3
Educational status of mothers		
Cannot read and write	122	17.9
Informal education	64	9.4
Primary	179	26.2
Secondary	285	41.8

Teritiery	32	4.7
Religion		
Moslem	338	49.5
Orthodox	288	42.2
Protestant	56	8.3
Ethnicity		
Oromo	272	39.9
Amhara	231	33.9
Gurage	80	11.7
Harari	69	10.1
Tigre	19	2.8
Others	11	1.6
Occupation of mothers		
Housewife	431	63.3
Government employed	72	10.6
Merchant	52	7.6
Daily labourer	48	7.0
Private employed	39	5.7
Housemaid	24	3.5
Others	15	2.2
Educational status of spouse (husbands)		
Cannot read and write	25	3.8
Informal education	45	6.8
Primary	123	18.6
Secondary	365	55.1
Tertiary	104	15.7
Occupation of spouse (husbands)		
Government employed	203	30.7
Merchant	133	20.1
Private employed	120	18.2
Daily labourer	117	17.7
Driver	64	9.7
Others	24	3.6
Income of the household		
Less than 100	22	3.2
101-300	159	23.3
301-500	160	23.5
> 500	281	41.2

Most of the mothers (96.7 %) are mulitpara with mean of 2.0 and had ANC follow up (87.7%) during the last pregnancy. Similarly, majority of the mothers in the study

(84.9) had antenatal visits either in the first or second trimester with mean of 14.85 weeks. The majority (85.7%) had antenatal follow up more than four times with mean frequency of 6.79 times. Table 2 depicts the obstetric history of the study participants.

Table 2 Obstetric history of mothers (n= 682). Harar town, January, 2006

Variable	Frequency	Percent
Parity of mothers		
Grandmultipara (>5)	276	40.5
Multipara (2-5)	383	56.2
Primipara	23	3.4
ANC follow up		
Yes	598	87.7
No	84	12.3
Time of first Antenatal visit		
First trimester	305	44.5
Second trimester	274	40.2
Third trimester	19	2.8
Place of antenatal check up		
Hospital	385	64.4
Clinic(Private)	117	19.6
FGAE	61	10.2
Clinic(Govn't)	35	5.9
No of ANC follow up		
Less than four	85	14.3
Four or more	510	85.7
Place of delivery		
Hospital	525	77.1
Home	138	20.3
Clinic (Private)	13	1.9
Clinic (Govn't)	5	0.7
Delivery assistance		
Health professional	572	83.9
TTBA	46	6.7
Untrained TBA	46	6.7
Relative	18	2.6

Source of information on HIV/AIDS for majority were mass media (91.6%) and health professional (36.4%). Community meeting also contributed markedly as a source of information (24.3%) and other sources like institutions contribute as a source. Similarly, the main sources of information about VCT were mass media (62.2%) and health professionals 33.4%.

Table 3- Respondents sources of information on HIV/ AIDS and VCT, Harar town. January, 2006

Variables	Frequency	Percent
Respondents' source of information on HIV/AIDS		
Mass media	625	91.6
Health professional	248	36.4
Community meeting	166	24.3
Friends	84	12.3
Relatives	34	5.0
Others	20	2.9
Respondents Sources of information on VCT		
Mass media	424	62.2
Health professional	228	33.4
Community meeting	106	15.5
Friend/Relatives	51	7.5

- Total exceeds 100% as more than one response was possible

KNOWELEDGE ABOUT HIV/AIDS, MTCT and PMTCT

A total of eleven closed ended questions were included to assess the knowledge status of the study population about HIV transmission including MTCT and its prevention.

Out of the total 651 respondents for mode of HIV transmission, only 33 (5.1%) gave correct answer to all four questions, 92(14.1%) to one, 364(55.9%) to two and 162(24.9%) to three. Generally 559(85.9%) of the respondents had good knowledge on HIV/AIDS.

Another set of three questions was asked to assess the knowledge of respondents about transmission of HIV from mother to child (MTCT). Out of 587 respondents 64 (10.9%) gave correct answer to all, 284(48.4%) to one and 239(40.7%) to two out of three questions. From the respondents 303 (51.6%) of them had good knowledge of MTCT. Concerning time of MTCT, time of delivery and breastfeeding were well known but only 32.6% of the respondents knew transmission of HIV during pregnancy.

Four questions were asked to assess the knowledge of respondents about prevention of HIV transmission from mother to child. Out of 542 respondents 1(0.2%) gave correct answer to all, 249 (45.9%) to one, 194(35.8%) to two and 98(18.1%) to three out of four questions. Those who had good knowledge of PMTCT were 293 (54.1%). From methods of PMTCT by taking drugs (55%) and by avoiding breastfeeding (52.8%) were responded while having save delivery was reported only by 28% of the respondents.

Perception of risk of acquiring HIV, and severity of HIV

Among 674 respondents 151 (22.1%) reported they are susceptible to or at risk of acquiring HIV (Figure1). The reasons for their perceived susceptibility were multiple sexual partner 45(6.6%), sexual practices without condom 91(13.3%), and other

reasons 26(3.7%) including history of receiving blood transfusion, history of STDs like genital ulcer. Those who reported they don't feel susceptible mentioned reasons such as trusting ones own sexual partner 326 (47.8%), having single sexual partner 214(31.4%), having no history of unsafe injection 42(6.2%) and using condom during sexual contacts 8(1.2%) .

Out of 677 responded for this question, 460(67.4%) perceived severity of HIV /AIDS from their experiences of illness and suffering of AIDS patients.

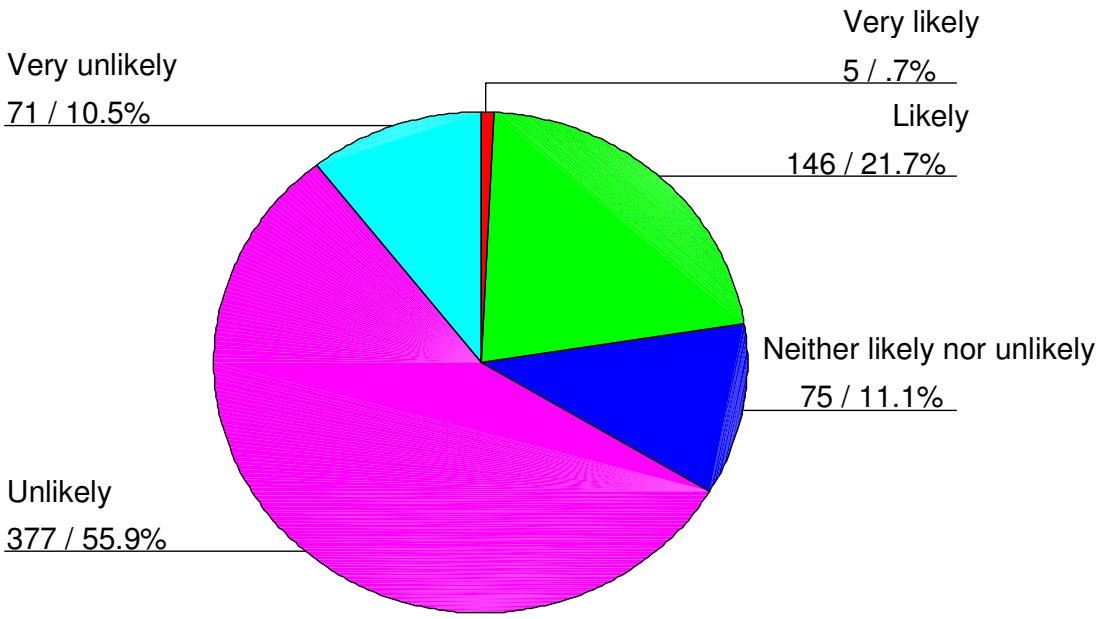


Fig 1 Reported risk perception by respondents, Harar town, January 2006 .

Attitudes towards PLWHA

A total of five questions about disease of HIV/AIDS and people living with HIV/ AIDS were asked to assess the attitude of respondents using Likert's scale. Out of 629 respondents 302 (48.1%) had good attitude and 327 (51.9%) had bad attitude towards

people living with HIV/AIDS. The responses of all (629) were scored and summed up together.

Attitude of Voluntary Counselling and Testing

A total of three questions were included to assess about attitude of VCT pertaining to discussion about VCT with partner, importance of VCT for pregnant mothers and advantage of having VCT for pregnant mother by Likert's scale. Out of 614 respondents 316(51.54%) had good attitude and 298(48.5%) of them had poor attitude towards VCT. The responses of participants were scored and summed up.

Intention and practice of voluntary counselling and testing (VCT)

Out of 665 study participants, 469 (70.5%) did not undergo HIV test, while the remaining 196(29.5%) were tested. Among study subjects who were not tested for HIV, 328(69.94%) had future intention of having VCT and 369 (77.8%) of them reported that they can decide by themselves to undertake VCT.

Among study participants who were tested, 82(41.8%) were tested before marriage, 97(49.5%) during pregnancy and 17(8.7%) were tested during delivery. Four hundred fifty two (66.3%) of the study participants knew the availability of VCT in the nearby health facilities.

With regard to HIV test result receiving preference , the respondents agreement were face to face 611(89.9%), by telephone 137 (20.1%), enclosed in envelop 238(34.9%), by relatives 130(19%) and by parents 311(45.6%). Regarding communication of positive HIV test result, the majority agreed on reporting to husband 625(91.7%), to

children/ brothers/sisters 410 (59.9%), and only 24 (3.5%) of them agreed on no need of communication.

INTENTION AND PRACTICES OF BREAST FEEDING

Almost all of the mothers in the study area (98.1%) ever breastfed, of which three quarters initiated breast feeding in the first hour of delivery. In addition, around 42% of the mothers gave either sugar or water to their new born before initiation of breast feeding. Out of 269 children less than six months old only 1(0.4%) was exclusively breastfed, while 101(37.5%) were predominantly breastfed. The majority of mothers who gave mixed food such as porridge, cow milk, formula milk and adult food for their children started before four months, whereas, adult food was started after four months.

Almost all 669(99.1%) of respondents reported self decision making ability on infant feeding options while 130 (19.3%) reported both mother and husband based decision. Mothers already provide some types of food and fluid like water while not considering them as food. They were asked when they intend to start additional (supplementary) food, and 59(20.4%) want to start before six months, 163(56.4%) six to twelve months, and 67(23.2%) after one year. Among the participants 380 (55.7%) knew the availability of infant feeding counselling including breast feeding counselling in the nearby health facilities. The study also revealed that majority of the mothers (87%) had intention of feeding breast milk for an overall duration of 1-2

years.

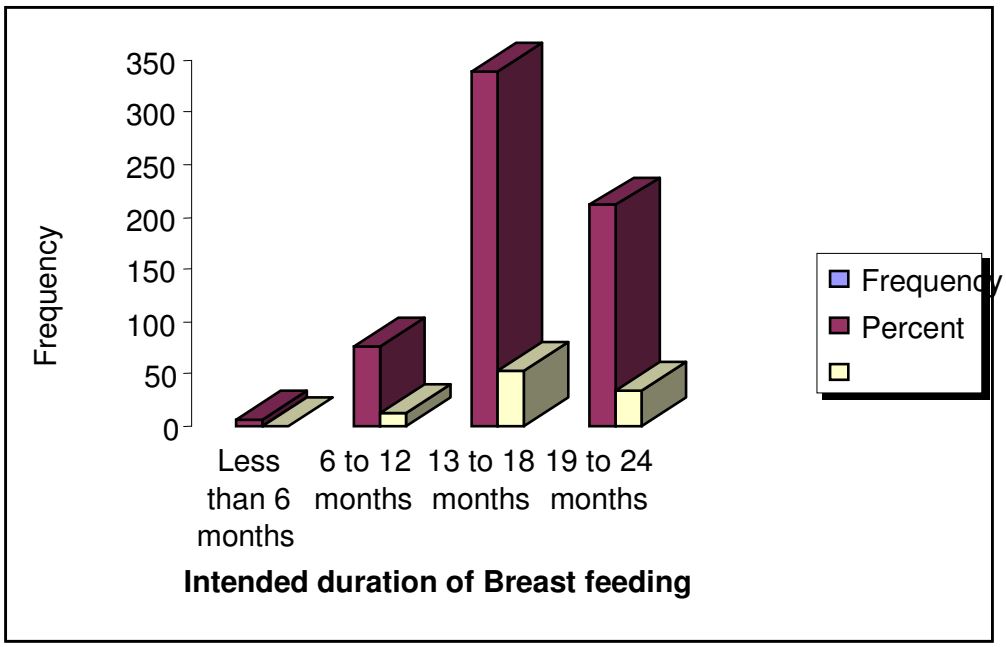


Fig 2. Intention of mothers on duration of breast feeding, Harar town, January 2006

Source of information to mothers on infant feeding options were mainly health professionals 229 (43.8%), mass media 161 (23.6%), while the least frequent source of information was reported to be the husband 37(5.4%) and mother-in-low 32(4.7%).

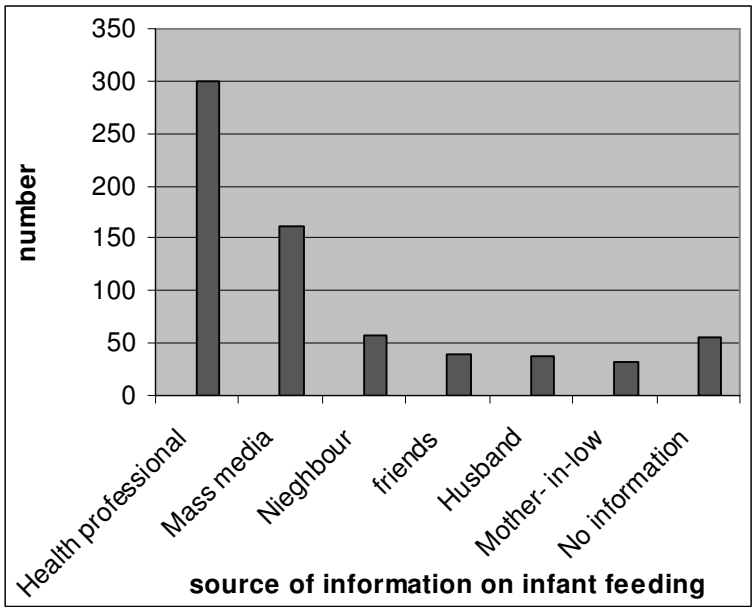


Fig.3 Respondents source of information on options of breast feeding, Harar town, January 2006

Mother reported faced problems in relation to breast feeding were breast engorgement 12(1.8%) and infants' inability to suck 35(5.1%), and mothers' sickness since delivery 55(8.1%).The commonly taken action when they encounter problems during breast feeding or stopped breast feeding were provide food for their child other than breast milk 10(1.5%), consult health professional and took drugs 9(1.3%).

The other practice that the study revealed was wet nursing 15(2.2%). The reason of the respondents for wet nursing were separation of the mother from the child 10(1.5%), breast of the mother had no enough milk 2(0.3%) and due to sickness of the mother 2(0.3%). As reported by respondents those who breast fed their child were their sisters 6(0.9%), by their mother 3(0.4%) and others 2(0.3%).

In case of the assessment of respondents' knowledge on infant feeding options for HIV positive mother, common responses were feeding only breast milk 20 (2.9%),

not feeding breast 512(75.1%),give formula feeding 262 (38.4%), cow milk 311 (45.6 %), mixed food 21 (3.1%) , and 54 (7.9%) of them did not know any feeding options. In case of accessibility and availability of counselling of infant feeding options in nearby health facilities 380 (55.7%) knew the availability of infant feeding counselling including breast feeding.

Assessment of association between reported knowledge status on HIV/AIDS, MTCT of HIV/AIDS, PMTCT of HIV/AIDS, intention of having VCT and practices of HIV test (VCT) was made by employing logistic regression statistical model. This model was employed with the assumption that it helps to predict the extent by which HIV testing and breast feeding practices in relation to PMTCT of HIV/AIDS and intention on VCT for HIV could be explained by the socio demographic characteristics, predisposing, and enabling factors.

HIV/AIDS knowledge of the study participants had significant association with spouses occupation.Those mothers whose spouses are merchant and driver had less knowledge than those whose spouses are government employee [OR (95%CI); 0.43(0.19, 0.95)] and [OR (95%CI); 0.32(0.12, 0.86)] respectively.

In this study educational status of mothers and their spouses, parity, marital status, age of mother, occupation of mother, income of the household, having ANC check up and availability of VCT in nearby health facility had no significant association with knowledge of HIV/AIDS.

****Table-4 Predictors of good knowledge of HIV/AIDS, Harar town, January 2006**

Variables	knowledge of HIV/AIDS]		Crude OR (95%CI)	Adjusted OR (95% CI)
	Good	Poor		
Place of antenatal check up				
	405	**74**		
Hospital	332	42	+1	
Private clinic	106	6	2.23(0.92, 5.40)	2.48(0.91, 6.8)
Government clinic	27	5	0.68(0.25, 1.87)	0.91(0.19, 4.32)
FGAE	39	2	0.24(0.13, 0.44)	0.23(0.11, 0.50)*
Frequency of ANC follow up				
	501	**74**		
Less than four	70	10	+1	
Four and above	431	64	0.96(0.47, 1.96)	0.93(0.28, 3.33)
Place of delivery				
	558	**92**		
Hospital	445	63	+1	
Clinic (private)	10	2	0.71(0.15, 3.31)	0.45(0.03, 6.84)
Clinic (Gov't)	4	1	0.57(0.06, 5.15)	13.0(8.03, 52E+)
Home	99	26	0.54(0.33, 0.89)	0.78(0.21, 2.89)
Occupation of spouse				
	544	**89**		
Gov't employee	180	18	+1	
Private employee	104(19.9)	13	0.80(0.38, 1.70)	1.33(0.41, 4.37)
Daily labourer	86(16.4)	20	0.43(0.22, 0.85)	0.45(0.18, 1.17)
Merchant	105(20.1)	23	0.46(0.24, 0.89)	0.43(0.19, 0.95)*
Driver	48 (9.2)	14	0.34(0.16, 0.74)	0.32(0.12, 0.86)*

* $p<0.005$

** Adjusted for socio-demographic factors

Knowledge of respondents on HIV transmission from mother to child had significant association with frequency of ANC and their spouses' occupation as shown below. Mothers who attended ANC follow up four or more times had better knowledge of MTCT of HIV than those who attended less than four times [OR(95%CI);2.53(1.22,5.27)].Those women whose spouses are non government employee had less knowledge of MTCT of HIV than those whose spouses are government employee (Table 5 below).

There is no significant association between educational status and occupation of mothers, educational status of their spouse, parity, marital status, age of mother, income of the household, having ANC check up and availability of VCT in nearby health facility, place of ANC and delivery with knowledge of MTCT of HIV in this study.

****Table 5. Predictors of Knowledge of transmission of HIV from mother-to-child (MTCT) Harar town, January 2006**

Variables	Knowledge of MTCT of HIV		Crude OR (95%CI)	Adjusted OR (95% CI)
	Good	Poor		
Occupation of spouse	**293**	**277**		
Govern't employee	122	70	+1	
Private employee	43	60	0.41(0.25, 0.67)	0.44(0.24, 0.81)*
Daily labourer	33	52	0.36(0.22, 0.62)	0.40(0.20, 0.81)*
Merchant	61	53	0.66(0.41, 1.06)	0.59(0.34, 1.05)
Driver	21	37	0.33(0.18, 0.60)	0.29(0.14, 0.59)*
Frequency of ANC follow up	**284**	**254**		
Less than four	20	51	+1	
Four and above	264	203	3.31(1.92, 5.73)	2.53(1.22, 5.27)*
Parity	**303**	**284**		
Multipara	172	290	1.04(0.75, 1.45)	1.06(0.71, 1.59)
Primipara	131	120	+1	
Income of household	**280**	**264**		
≤ 100 ETB	8	7	0.78(0.27, 2.1)	2.73(0.47, 15.93)
101-300 ETB	44	77	0.39(0.25, 0.61)	1.14(0.57, 2.31)
301-500 ETB	72	74	0.66(0.44, 0.99)	1.13(0.68, 1.91)
>500ETB	156	106	+1	

* $p<0.005$

**Adjusted for socio-demographic factors

Knowledge of respondents on prevention of HIV transmission from mother to child had significant association with occupation, educational status of their spouses, parity and place of delivery as shown below. Women who have less knowledge on PMTCT of HIV were those whose occupation is housemaid compared to government

employee [OR(95%CI);0.07(0.01,0.89)], who attended primary school compared to tertiary level [OR(95%CI);0.39(0.18,0.86)] and those who delivered at home[OR(95%CI); 0.24(0.10,0.59)]. Multipara mothers had better knowledge of PMTCT of HIV than primpara [OR (95%CI); 2.05(1.21, 3.48)].

There is no significant association between educational status of mothers, parity, marital status and age of mother, income of the household, having ANC check up and availability of VCT in nearby health facility, and place of ANC with knowledge of PMTCT of HIV in this study.

****Table- 6 Predictors of good knowledge of prevention mother-to-child transmission of HIV (PMTCT) among study subjects, Harar town, January 2006**

Variables	Knowledge of PMTCT of HIV		Crude OR (95%CI)	Adjusted OR (95% CI)
	Good	Poor		
Occupation of mother	**292**	**249**		
Govern't employee	46	22	+1	
Private employee	21	11	0.54(0.23, 1.28)	0.48(0.17, 1.36)
Housewife	170	170	0.48(0, 28, 0.83)	0.64(0.32, 1.28)
Housemaid	28	8	0.17(0.05, 0.61)	0.07(0.01, 0.89)*
Merchant	21	18	0.56 (0.25, 1.25)	0.75(0.27, 2.09)
Educational status of spouses	**284**	**243**		
Informal education	13	15	0.77(0.29, 2.03)	4.87(0.89, 26.69)
1-6 grade	37	49	0.44(0.24, 0.80)	0.39(0.18,0.86)*
7-12 grade	177	146	0.70(0.43, 1.14)	0.79(0.42, 1.46)
Grade 12+	57	33	+1	
Educational status of mothers	**293**	**249**		
Cannot read and write	13	39	0.11(0.04, 0.31)	0.36(0.08, 1.68)
Informal education	17	26	0.21(0.07, 0.59)	0.55(0.12,2.54)
1-6 grade	87	65	0.43(0.17, 1.06)	0.79(0.23, 2.78)
7-12 grade	154	112	0.44(0.18, 1.06)	0.71(0.23, 2.23)
Grade 12+	22	7	+1	
Parity				
	293	**249**		
Multipara	164	141	1.05(0.74, 1.48)	2.05(1.21, 3.48)*
Primipara	129	108	+1	

Place of delivery				
	293	**248**		
Hospital	260	196	+1	
Clinic	9	5	2.01(0.53, 7.67)	1.06 (0.06, 26.78)
Home	24	47	0.39(0.23, 0.65)	0.24(0.10, 0.59)*

* $p<0.05$

** Adjusted for socio-demographic factors

Good attitude of respondents to VCT had significant association with marital status of the study participants and place of antenatal care follow up and frequency of ANC follow up as shown below. Married study participants (mothers) had poor attitude towards VCT than those who were not married [OR (95%CI); 0.06(0.01, 0.28)]. The same is true for mothers who had four or more ANC follow up compared to those who had less than four [OR(95%CI);0.26(0.13, 0.53)]. Mothers who were having ANC follow up at institutions other than hospital had better attitude towards VCT.

****Table- 7. Predictors of good attitude towards VCT among study subjects, Harar town, January 2006**

Variables	Attitude towards VCT		Crude OR (95%CI)	Adjusted OR (95% CI)
	Good	Poor		
Marital status				
	316	**298**		
Single	26	9	+1	
Married	266	275	0.34(0.15, 0.73)	0.06(0.01, 0.28)*
Others	24	14	0.73(0.24, 3.76)	0.52(0.02, 8.01)
Place of antenatal check up				
	250	**285**		
Hospital	139	210	+1	
Clinic (private)	57	44	1.96(1.25, 3.06)	2.82(1.61, 4.94)*
FGAE	31	24	1.95(1.10, 3.47)	3.13(1.55, 6.30)*
Frequency of ANC follow up				
	248	**284**		
< 4	60	24	+1	
≥ 4	188	260	0.29(0.17, 0.48)	0.26(0.13, 0.53)*

*p <0.05

** Adjusted for socio demographic factors

Future intention of the respondents to have HIV test (VCT) had significant association with good knowledge of PMTCT. Mothers who had good knowledge of PMTCT of HIV had more intention to have VCT than who had poor knowledge of PMTCTC of HIV [OR (95%CI); 2.60(1.05, 6.46)].

****Table -9 Predictors of mothers' intention to have VCT, Harar town.**

January, 2006

Variable	Intention to have VCT		Crude OR (95% CI)	Adjusted OR (95% CI)
	Yes	No		
Parity	**328**	**146**		
Grandmultipara	8	9	0.29(0.10, 0.79)	0.22(0.01, 6.84)
Multipara	186	94	0.64(0.42, 0.97)	0.57(0.18, 1.79)
Primipara	134	43	+1	
Time of 1st ANC visit	**289**	**109**		
First trimester	152	40	+1	
Second trimester	126	63	0.53(0.33, 0.84)	1.16(0.05, 26.47)
Third trimester	11	6	0.48(0.17, 1.38)	0.60(0.03, 10.75)
Place of ANC follow up	**289**	**109**		
Hospital	189	69	+1	
Private clinic	50	16	1.14(0.61, 2.14)	1.29(0.30, 5.63)
Gov't clinic	14	16	0.32(0.15, 0.69)	0.16(0.01, 1.78)
FGAE	36	8	1.64(0.73, 3.71)	1.52 (0.24, 9.50)
Knowledge of PMTCT	**281**	**81**		
Good	148	36	1. 39(0.85, 2.29)	2.60(1.05, 6.46)*
Poor	133	45	+1	
Knowledge of availability of VCT service				
	328	**92**		
Yes	233	64	1.07(0.62, 1.82)	0.93(0.55, 1.61)
No	95	28	+1	

* $p<0.005$

** Adjusted for socio-demographic, predisposing and enabling factors

Practice of HIV test had a significant association with some of socio demographic factors and predisposing factors. Mothers who are 25 to 34 years old had less practice of VCT than 35 to 49 years old [OR (95%CI) 0, 24 (0.06, 0.98)]. Similarly, multipara mothers had less practices of VCT than primpara mothers[OR (95%CI) 0.49(0.29,0.83) and mothers who attend ANC less than four times had less practice of VCT[OR(95%CI)0.22(0.08,0.59)] .In addition there was a significant association between knowledge of HIV ,MTCT and PMTCT and attitudes towards HIV/AIDS and practice of HIV test as indicated in table below. Mothers who have good knowledge of HIV, MTCT and PMTCT had more practice of VCT than those who have poor knowledge. Women who had good attitude towards PLWHA had less practice than those with bad attitude.

****Table -10 Predictors of Mothers' practice of VCT, Harar town. January, 2006**

Variable	VCT Practice		Crude OR (95% CI)	Adjusted OR (95% CI)
	Yes	No		
Age of mother	**196**	**469**		
15-24	90	182	0.03(0.97, 4.23)	0.95(0.56, 1.62)
25-34	96	246	1.60(0.77, 3.32)	0.24(0.06, 0.98)*
35-49	10	41	+1	
Educational status of mothers				
	196	**469**		
Cannot read and write	19	96	+1	
Informal education	13	48	1.37(0.62, 3.00)	1.17(0.23, 6.05)
1-6 grade	45	134	1.70(0.93, 3.08)	1.38(0.40, 4.82)
7-12 grade	104	175	3.00(1.73, 5.12)	1.80(0.51, 6.31)
Grade 12+	15	16	4.74(2.01, 11.18)	1.85(0.35, 9.87)
Parity	**196**	**469**		
Multipara	99	297	0.60(0.43, 0.85)	0.49(0.29, 0.83)*
Primipara	97	172	+1	
Frequency of ANC follow up				
	193	**390**		
< 4	15	65	+1	
≥ 4	178	325	2.37(1.32, 4.28)	0.22(0.08, 0.59)*
HIV Knowledge	**193**	**451**		
Good	180	373	2.89(1.57, 5.34)	3.72(1.20, 11.52)*
Poor	13	78	+1	
PMTCT Knowledge	**178**	**357**		
Good	109	181	1. 54(1.07, 2.22)	1.99(1.17, 3.40)*
Poor	69	176	+1	
MTCT Knowledge	**179**	**402**		
Good	108	192	1. 66(1.16, 2.38)	1.16(0.68, 1.99)
Poor	71		+1	

Attitude towards people living with HIV/AIDS				
	174	**438**		
Good	61	237	0.46(0.31, 0.67)	0.50(0.29, 0.85)*
Bad	113	201	+1	
Attitude towards VCT	**178**	**420**		
Good	75	241	0.54 (0.37, 0.78)	0.99(0.55, 1.76)
Bad	103	179	+1	

* $p < 0.05$

** Adjusted for socio-demographic, predisposing and enabling factors

Result of qualitative study (In-depth Interview of Health workers

Health workers source of information, and knowledge about MTCT and PMTCT

Most of the counsellors had training on VCT and PMTCT especially professionals in Antenatal Care unit and counselling unit of the hospital. The others use their basic knowledge of HIV from their basic training, by read books, magazines and mass media to advice or counsel mothers on VCT particularly on infant feeding.

Participants experience on counselling mothers on PMTCT

One of the study participants said among the pregnant women expected to attend ANC with in this hospital catchment's area half of them come for the service. The service is provided starting with provision of mass education for all clients including mothers who come for sick baby clinic including using audiovisual teaching aids. In addition leaflet called "Efoye" is provided for new pregnant mother who comes for the first time and get counselling on PMTCT.

"As to my knowledge great problem related to PMTCT is not the refusal of the service by mothers but the major problem is pregnant women particularly who live in this town do not come for ANC to this hospital rather prefer to attend in other facilities like private clinics. When every pregnant woman comes to MCH for ANC visit for the first time she is counselled about PMTCT and if she is volunteer to be tested, she is tested. Till now the majority of pregnant mothers those who came to MCH were volunteer t o be counselled and tested. From mothers who came for ANC for the first time, 70% of them were tested." One of the participant.

As reported by key informant interview the reason for their refusal of HIV testing were commonly fear; i.e fear of discussing about HIV test with their partner and fear of community that what they say when they heard that she is tested. When they come with their family members, they tell us “Don’t talk about this issue in front of them”. Most of the time their partners were not volunteer to come and tested specially those women whose test results turned positive. .

Concerning confidentiality discussion about PMTCT is made when she comes to a room for assessments like abdominal examination rather than other rooms where other services are provided like family planning and immunization in addition to ANC. For a mother the pre test counselling, drawing blood, coding and taking to the laboratory, post test counselling and follow up are all taken care of by one health care provider.

As four months’ (September to December 2005) record review of ANC and Delivery rooms of Hiwot Fana hospital showed, out of 450 mothers gave birth at this hospital only 12 got counselling service on test for HIV and 11 of them got tested out of whom 3 were seropositive for HIV. During this period there were 84 new pregnant mothers who came for ANC service. Out of these 65 of them got counselled, 40 were tested, 5 of them were seropositive for HIV.

Participants Experience on Infant Feeding For HIV Positive Mothers and Their Choices With Factors Affecting Them

Infant breast feeding counselling is given for all mothers during pregnancy, on discharged from the hospital after delivery and when they come to well baby clinic for

immunization. In case of PMTCT mothers are counselled on infant feeding whatever the result of the test may be. "From my experience most of them choose breast feeding. Now days from our counselling they give more attention to cow milk and they started to choose it (one of the participant said). Their reasons for not stopping breast feeding are related to economical problem and fear of stigma and discrimination by their families and community.

A Case report from Key informant interview

we had different mothers' experience from two HIV positive mothers. One gave birth to single baby and the other mother delivered twin. A mother of a single baby at the beginning said "I had no choice to feed my child rather than breast milk". Then we accepted her reason and she started to breastfeed. After some time she came to me and said "I have convinced my self to stop breast feeding and start cow milk for my child". When I asked her she said that why didn't do this at the beginning, she told me that "I can afford the expense of other infant foods but at the beginning I feared the community and my families to tell them that I am not breastfeeding my child as they suspect me for HIV infection but now I can give other reasons to stop breastfeeding.

A mother of twins, is famous in the town, has no economical problem, and her families and families of her husbands are also living in the town. She was counselled starting from pregnancy .But she was not convinced not to breast feed. Finally, she decided to breastfed one of her child and to feed formula food for the other.

Follow up, care and support for HIV positive mothers and their infants

HIV positive mothers are referred to ART unit after delivery for follow up. In the ART unit she is registered and put on care (treatment and prevention) and they are counselled on issues like infant feeding and prevention of infecting others such as condom usage during sexual intercourse and family planning. Subsequently they are followed up on regular basis with appointments. Whenever the mother or her child acquires an opportunistic infection, they get treatment.

Communication between health facilities and organizations working on HIV/AIDS

There is no communication between different health facilities and units of the hospital like delivery room and ANC unit. In this case means of communication used on PMTCT, Nevirapin is given for the mothers and advised to take by themselves during labour at least two hours before delivery and bring the child for Neviraoin syrup to Hiwot Fana hospital in case she delivered in Misrak Arbegnoch hospital. In the same way there is no communication between any of the organizations working on HIV/AIDS which might be useful especially for mothers who needs assistance on infant feeding. The other area where mothers miss the chance of getting PMTCT is in the case of those mothers who have no ANC follow up or those their ANC follow up is not in Hiwot Fana hospital but come for delivery at night. Because counselling and testing in delivery room is only at day time and not given at night totally despite of the majority of mothers gave birth during night.

Problems proposed by the participants

1. High work load on health professional and shortage of trained professionals on PMTCT.
2. Lack of testing kit in counselling rooms (ANC and delivery rooms). Thus testing is done in the general laboratory.
3. Lack of communication between units in the hospital, health facilities and organizations working on HIV/AIDS.

Proposed solutions by participants to improve PMTCT service

1. Training of health professionals on PMTCT and motivating the staff working on PMTCT like additional payments.
2. Increasing human power to decrease work load and improve quality of service
3. Fulfilling the materials for HIV testing
4. Any health professional in any unit and facility should advocate the presence and advantage of PMTCT to save the generation.
5. Developing network of communication at different levels including kebeles, health posts, clinics and hospitals.

7. Discussion

The study has tried to asses the intention and practices of mothers on VCT and breast feeding practices in the context of HIV/AIDS. In this study it was found that majority of study participants had ANC follow up during the last pregnancy. This finding is in line with study done in Jimma town on pregnant and lactating mothers that the study participants had ANC check up during their last pregnancy (36). In this study it was found that majority of the study subjects had considerably high knowledge score of HIV/AIDS and less knowledge of MTCT and PMTCT. This might be due to that PMTCT service is started in the last few years in the area as well as in the country that may not be compared with that of HIV/AIDS knowledge. Moreover, this finding is in harmony with other similar studies done in Hong Kong and China on women attending ANC clinic, base line survey of PMTCT in Ethiopia on 6 regions other than Harar town on lactating mothers and the study done in Jimma on pregnant and lactating mothers (7, 14, 36). The proportion of grand multiparty was high among the study participants when compared with similar study done in Jimma which may contribute to less knowledge of MTCT/PMTCT and a high risk factor for overall maternal health (36).

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Those participants whose spouses are merchants and driver had less knowledge of HIV/AIDS than those whose spouses are government employee. This might be attributed to the fact that the highest percentage of the respondents' occupation was found to be government employee who might influence both income level of the household and HIV/AIDS related information. Similarly those mothers whose spouses

are non governmental employee (private employee, daily labourer, and driver) had less knowledge of MTCT than those of government employee. This might be explained by the difference to access of information related to MTCT of HIV. Mothers who had ANC check up for four or more times during the last pregnancy had more knowledge of MTCT than those mothers who attended ANC check up less than four times. This could be due to the access to more information with more ANC visits. Those respondents whose occupation is housemaid, spouses' educational level of primary school and who delivered the last child at home had less knowledge of PMTCT which can also be explained by less access to information as most of source of information for the respondents were health professionals and mass media.

In this study about half of the respondents had good attitude towards VCT. This finding is in line with a study in Jimma town on pregnant and lactating mothers, where the majority of the respondents had good attitude towards VCT (36). Out of tested study participants half of them were tested during the last pregnancy which is some what similar with that of study done in Jimma (36). As it revealed in record review of the hospital in which PMTCT service is provided almost two-third of the mothers who have been counselled were under go HIV test that results in high proportion of testing in Harar town.

Married participants when compared with single participants had less attitude towards VCT. This might be due to the fact that most of the respondents perceived that they are not at risk of acquiring HIV as they reported of having single sexual partner and trusting ones own sexual partner which might have influenced their attitude. Mothers who attended their ANC checkups at institutions other than hospital had higher

attitude towards VCT than those who attended at hospital. This could be because of less time spent by a health worker with clients due to work load as revealed in key informant interview.

Mothers who attended antenatal check up for four or more times had less attitude towards to VCT which it may not indicate as it expected. This might be related with the information on VCT provided at each visit is strong enough to change their attitude and information and counselling is also only provided in the first visit for antenatal check up.

It is also revealed that the study participants risk perception is relatively low as compared to the perceived severity. This is also in line with study done in Hong Kong Chinese pregnant mothers on HIV/AIDS knowledge and risk perception and study done in Ethiopia on base line assessment of PMTCT showing the low prevalence of risk perception in lactating mothers who believe that they are not at risk due to partner faithfulness and having one partner (7, 14).

In case of preference of hearing HIV test result; participants agreed on face to face, parents, enclosed in envelop, and the least agreement being by relatives in that order. In case of communication of positive HIV test result communication, majority of study participants agreed to communicate with their partners; and the rest agreed to communicate with their family members (children, brother, sister) that similar with a study done in Lusaka, Karatina, and Homa Bay in Kassena Nankana district of North Ghana and China showed that pregnant mothers shared their HIV test result with someone (partner, family member, friend) particularly in Kenya and Karatina, Lusaka more than half of women shared their HIV test result with their partner (15, 16, 17,

21, 31). As reported in qualitative responses mothers who get tested for PMTCT usually bring their partners for VCT.

The study revealed that participants who have good knowledge of PMTCT reported that they have more intention of VCT than those with poor knowledge. This finding is harmony with study done in North Ghana those pregnant women who know at least one mode of prevention of MTCT of HIV transmission and study done in China (15,16). This study also showed that knowledge of availability of VCT in nearby health facilities had no association with intention of VCT.

In this Study participants who are 25 to 34 years old had less practices of VCT than mothers whose age is 35 to 49 years old. Similarly multipara mothers had less practices of VCT than primipara. In this case the reason might be due less risk perception by multipara mothers. Mothers who attended ANC follow up four or more times had less practices of VCT. Having good knowledge of HIV/AIDS, PMTCT of HIV/AIDS and good attitude towards HIV/AIDS were associated with more practices of VCT. This finding is harmony with study done in North Ghana that pregnant women who know at least one mode of MTCT of HIV transmission and one means of prevention of MTCT of HIV transmission , study done in China and different studies of USAID reports were more likely to receive HIV testing (12,15,16).

Regarding breast feeding practices and initiation of mothers on duration of breastfeeding and starting additional/ supplementary foods; this study revealed that almost all mothers of the study participants initiate breast feeding with in the first hour of delivery. This could be related to place of delivery that the majority of

mothers delivered in health institutions particularly in hospital that might gave an opportunity for early initiation of breast feeding. In addition; as reported in qualitative responses health workers always advice a mother delivered in hospital on initiation of early breast feeding and excusive breast feeding. In this study decision makers on infant feeding options are mothers in majority of the cases followed by husbands and mother in law. As such a study in Jimma showed that major decision makers on infant feeding options are husbands followed by mother and mother in law while in the study of baseline survey of PMTCT in six regions of Ethiopia revealed that the major decision makers are mothers followed by both mother partners (7, 36).

In this study exclusive breastfeeding practice is very rare but the majority of mothers who gave mixed food such as porridge, cow milk, formula milk and adult food for their children started before four months except adult food which was started after four months. This finding is similar with the study done in Lusaka that mixed feeding were given at three months of age, study done in Ethiopia, Butajira that weaning was started before the age of four months and a study done in Jimma town where mixed feeding is a common practice before six months of age (21,33,36).

The reported time of mothers intention on initiation of supplementary or additional foods for their child was assessed and one third of them planed to start before six months .This might be due to the occupation of mothers which like government employees make them to be separated from their child as they gave reason for breastfeeding their child by any one else than the mother and as common practices in the community.

Further more this study assessed the intention of mothers on duration of breast feeding. As such the majority of them want to breastfeed for 13 to 18 months and for 19 to 24 months. This finding was similar with studies done in Butajira, Ethiopia and Durban, South Africa and (23, 33).

As it was revealed by in depth interview of health workers, HIV positive mothers in the study area usually don't want to stop breast feeding because of fear of stigma and discrimination in the community and lack of money to afford for replacement feeds. In the same way in different African countries a study showed that mothers choose not to enrol into replacement feeding because of the stigma of HIV infection in the community and relatives, and also associated with lack of money to provide replacement foods like formula feeding (9,8,21,23) .

STRENGTH OF THE STUDY

- The use of theoretical behavioural model of assessment method to answer the research problem
- Methodological triangulation used in the study
- Probability sampling method was used to include all kebeles in the town to be representative of the whole population in the town

LIMITATION OF THE STUDY

- The design of the study do not allow to validate the intentions forwarded for VCT and initiation of weaning foods
- There were few researches/studies done in this area which makes it difficult to get literatures for comparison and discussion.

Conclusions

The findings from this study in relation to prevention of HIV transmission revealed that mothers had good knowledge of HIV/AIDS but fair knowledge of MTCT and PMTCT. The study participants also have good attitude towards PLWHA and VCT which may have a contribution to intention of the mothers to have HIV test. Majority of the study participants who didn't undergo HIV test reported an intention to have HIV test. However in actual practice only one fourth of the study participants reported to had had HIV test. This implies that the intention to have HIV test and the practice of undergoing HIV test were not going parallel. Most of the study participants perceived the severity of HIV/AIDS but their perceived susceptibility is low which hindered them to take action to be tested and prevent the transmission of HIV from mother to child.

The mothers' ANC coverage and decision making power is high but the practice of having HIV test is low. This may be related to the influence of socio-demographic and obstetric factors like age, educational status, and parity of mothers and attitude and knowledge on HIV with fear of stigma and discrimination.

Majority of the mothers in this study know the availability of VCT service but the majority don't know the availability of infant feeding counselling in a nearby health facility. Majority of the mothers also responded that they have the accessibility to these services.

The mothers' infant feeding intention and practice in the context of HIV and nutrition might be risky as suboptimal breast feeding practice is common. Exclusive breast feeding is rare and early weaning with mixed type of feeding practice is common. This predisposes the infants to malnutrition and risky for MTCT of HIV as exclusive breast feeding is considered to be protective in communities who don't know their HIV status. Wet nursing is another breast feeding practice that was revealed in this study which may put an infant to get HIV.

Out of mothers who attended the facility where PMTCT service is available majority got the service. However mothers who attended ANC other than the facility where PMTCT service is not available were not referred or didn't seek the service. Counselling and Testing for HIV was not regularly provided in delivery rooms of facility where PMTCT service is provided in spite of its advantage to test mothers who are missed during other times. There is poor communication on PMTCT services between facilities and organizations which makes initiation and follow up of the clients as well as supporting of HIV positive mothers especially in infant feeding options difficult.

Recommendations

Increasing utilization of PMTCT requires addressing both obstacles to service delivery and attention to the demand for service. Based on the findings from this study the following recommendations are made:

1. Information, Education and Communication (IEC) and Behavioural Change Communication (BCC) on VCT, MTCT, PMTCT and infant feeding shall be Strengthen

2. Create an enabling environment for mothers through increasing the frequency of antenatal care (ANC) services to help them get IEC services on MTCT
3. Promotion of VCT during pregnancy and pre marriage times to augment the effort to prevent MTCT of HIV
4. Reinforce the importance of exclusive breast feeding during antenatal and post natal follow up, as well as in out reach services
5. Advocate optimal infant feeding counselling beyond antenatal care visit and postpartum period
6. Prevention of mother to child transmission of HIV (PMTCT) service shall be accessed to some groups of the community such as housemaid and housewives as much as possible to get information utilize the services.
7. Carry out rapid testing in MCH unit rather than testing in major laboratory where all laboratory activities done and give women their results the same day to avoid another visit to receive the results(by MCH staff)
8. Establish communication/ referral network between health facilities and organizations working on HIV/AIDS
9. working towards alleviating the problem that social stigma poses on mothers' adoption of safer infant feeding options to prevent MTCT of HIV
10. Full day VCT services shall be made available for mothers seeking delivery services in hospitals to minimize missed opportunities.
11. Special attention should be given to maternal reproductive health services like family planning to address the high multiparity rate found in the study area
12. Further study is recommended on status of VCT and infant feeding practice including rural setup

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ANNEXES

Annex-1 points about behavioural models the health belief model

In this model ,it is believed that people will take action to prevent , to screen for, or to control ill health conditions if they regarded themselves as susceptible to the condition, if they believe it would have potentially serious consequences, if they believe that a course of action available to them would be beneficial in reducing either their susceptibility to or the severity of the condition, and if they believe that the anticipated barriers to (or costs of) taking the action are outweighed by its benefits. Its components are perceived susceptibility, perceived severity, perceived benefits, perceived barriers and cues to action.

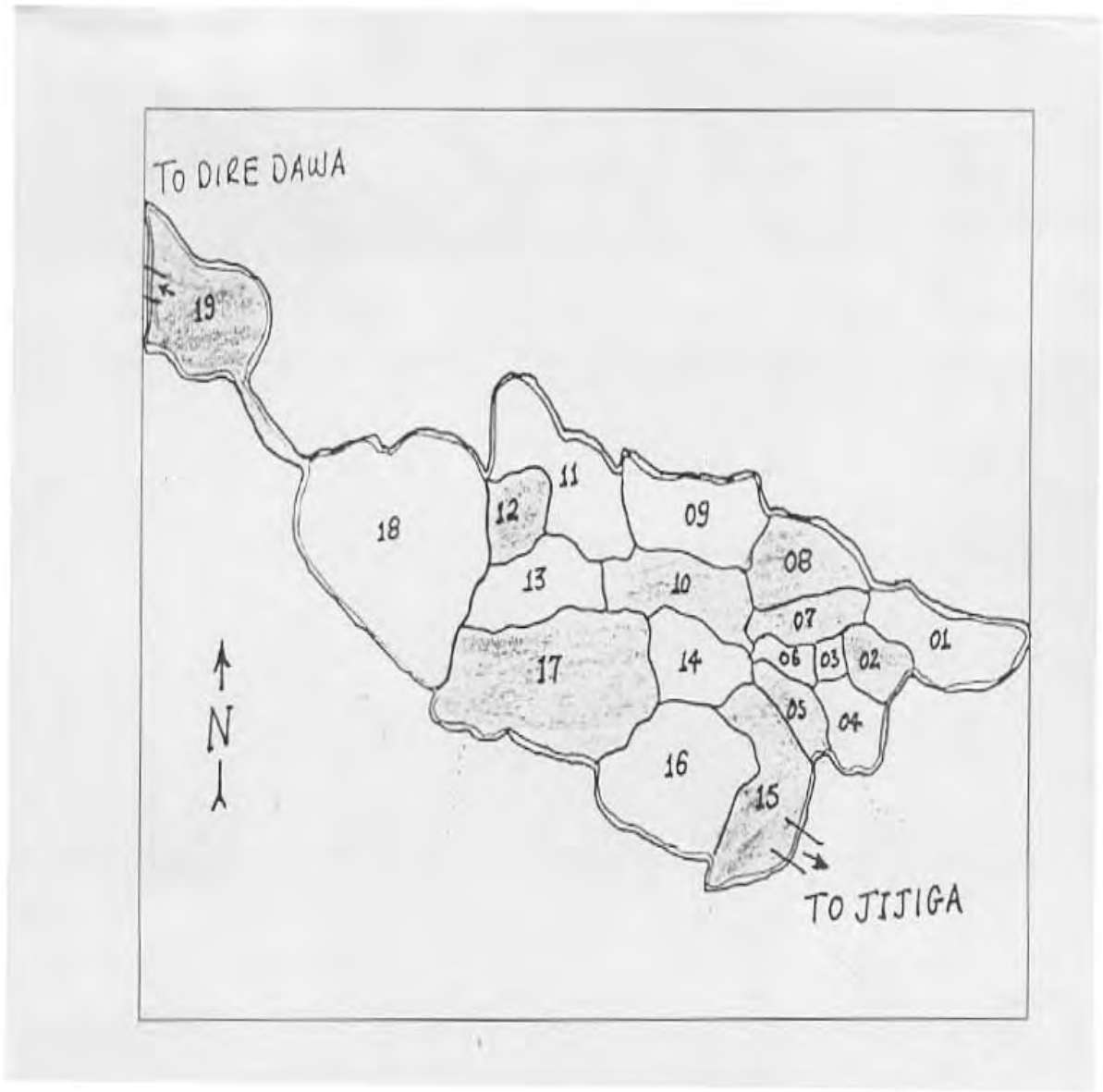
THE THEORY OF PLANNED (REASENED ACTION) BEHAVIOR

The theory of planned or reasoned action asserts that the most important determinant of behaviour is a person's behavioural intention. The direct determinants of an individuals behavioural intention are their attitude toward performing the behaviour and their subjective norm associated with the behaviour. Thus, a person who holds strong beliefs that positively valued outcomes will results from performing the behaviour will have a positive attitude toward the behaviour.

THE PRECEDE-PROCEED MODEL

This model has nine phases, which range from identifying health problems to conducting intervention activities and evaluating their effectiveness. And one of the phases is making educational diagnosis-identifying factors which promote or prevent from forming a health-conducive behaviour. The model suggests that are three groups of factors influence health behaviours and they are predisposing factors, enabling factors, and reinforcing factors.

Annex 2. SKETCH MAP OF HARAR TOWN



Annex 3 - GENERAL INFORMATION FOR THE STUDY PARTICIPANTS

My name is Meselech Assegid I am a Master of Public Health (MPH) student of Addis Ababa University faculty of medicine department of community health. I am here to study the intention and practices of lactating mothers on VCT and breast feeding in relation of the risk of maternal to child transmission of HIV. The result of the study will be helpful to the study population by identifying in proper breast feeding practices and thereby provision of the right information accordingly. It may also be used as a base line data for intervention project in the same population. It will also be used for the planning and intervention on prevention of HIV transmission from mother to child in the local area as well as nationally. I am going to ask you questions to be responded by you. Some of the questions are very personal questions that some people find them difficult to answer. Your answers are completely confidential. Your name will not be written on this form, and will never be used in connection with any of the information you tell me. Participation by answering the questions that I am going to provide you is strictly on voluntary base. However, your honest answer to the question will help me for better understanding of what people think, say and do about certain kinds of behaviours. I would greatly appreciate your cooperation and help in response to this study. The interview will take about 30 minutes.

There fore your honest and genuine participation by responding to the questions is highly appreciated.

CONSENT FORM

I the undersigned have been informed about the purpose of this particular research project and I have also been informed that I am going to respond only to questions I know and I can refuse to any question which I don't want to respond. I have been informed that the information I give will be used only to the purpose of the study. I addition I am also informed that my identity as well as the information I will be providing will be kept confidentially .Furthermore I am aware that I can stop responding to the questions at any time in the process. Based on the above information I agree to participate in the research voluntarily.

Signature

Date

ANNEX 4 - assessment of intention and practices of VCT and breast feeding related to the risk of maternal to child transmission of HIV

Part 0 Questionnaire identification data

001 Questionnaire identification number _____

002 Region_____

003 City _____

004 Kebele _____

005. Ketena_____

006 House hold number _____

Interviewer visit

	Visit		
	Visit 1	Visit 2	Visit 3
Date			
Interviewer			
Result			

Result Codes: Completed 1
Not at home 2
Refused 3
Partially completed 4
Other (specify)

Checked by: Supervisor: Name _____ Signature _____

Date_____

007. Interviewer's code _____ Name _____

008. Supervisor's code _____ Name _____

09. Date of interview _____/ _____/ _____

day month year

Time of start of the interview: _____

Time of end of the interview: _____

PART I. SOCIODEMOGRAPHIC CHARACTERSTICS

No	Questions	Coding categories	Skip to
101	How old are you?	_____ completed years	
102	What is your current marital status? (circle the response)	Single 1 Married 2 Divorced 3 Widowed 4 Separated 5	
103	What is the highest educational level you completed?	Unable to read and write 1 Able to read and write 2 Grade 1-6 3 Grade 7-12 4 Grade 12+ 5	
104	What is your religion?	Orthodox Christian 1 Catholic Christian 2 Protestant Christian 3 Muslim 4 Others (specify) _____ _ 5	
105	What ethnic group do you belongs to?	Oromo 1 Harari 2 Amhara 3 Guragae 4 Tigre 5 Others (specify)_____ 6	
106	What is your current occupation?	Government employee 1 Private employee 2 House wife 3 Daily labourer 4 Housemaid/ servant 5 Merchant 6 Others (specify)_____ 7	
107	What is your husband's educational status?	Unable to read and write 1 Able to read and write 2 Grade 1-6 3 Grade 7-12 4 Grade 12+ 5	
108	What is your husband's current occupation?	Government employee 1 Private employee 2 Daily labourer 3 Driver 4 Merchant 5	

		Others (specify)_____ 6	
109	What is your total monthly income?(approximately)	_____ Eth. Birr	
110	What is the main source of drinking water for the member of your household? (more than one answer is possible)	Well 1 Spring 2 River 3 Pipe 4 Others(specify)_____ 5	
111	How many pregnancies did you have?	_____(in number)	
112	What is your relation to the head of the household?	Wife (only one) 1 Wife (one among several) 2 Daughter 3 Housemaid 4 Others (specify)_____ 5	
113	How many live birth have you had in your life?	_____ (in number)	
114	Did you attend antenatal care during your last pregnancy?	Yes 1 No 2	If 'no' ,skip to Q.118
115	At what gestational age?	_____weeks _____ months	
116	At which health institution did you attend?	Hospital 1 Private clinic 2 Government clinic 3 FGAE 4	
117	How many times did you attend antenatal care follow-ups?	_____ (in number)	
118	Where did you deliver your last child?	At hospital 1 At private clinic 2 At government clinic 3 At home 4 Other(specify)_____ 5	
119	Who assisted you during your last delivery?	Health professional 1 Trained traditional birth attendant 2 Untrained traditional birth attendant 3 Relatives 4 Others (specify)_____	

PART II KNOWELEDGE AND ATTITUDES TOWARDS HIV, MTCT AND PMTCT

No	Questions	Coding categories	Skip to
201	Have you ever heard of HIV or disease called AIDS?	1 Yes 2 No	
202	From where did you hear? (more than one answer is possible)	From health professionals 1 From mass media 2 From friends 3	

		From relatives 4 from community meeting 5 Others (specify)_____6	
203	What are the routes of transmission of HIV from one person to another?	1. By having unsafe sexual intercourse 2. From mother to child 3. By using unsafe blood transfusion 4. Using Contaminated sharps objects 5. Others (specify)_____	
204	Do you know anyone who has or died of HIV/AIDS?	1 Yes 2 No 3 Do not know	
205	When do you think an HIV/AIDS positive pregnant woman transmit the virus to her baby? (more than one answer is possible)(probe for more)	During pregnancy 1 Yes 2 No 3 DK During delivery 1 Yes 2 No 3 DK During breast feeding 1 Yes 2 No 3 DK Others (specify)_____	
206	If a mother is infected with HIV, is there any way to avoid transmission to the baby?	1. Yes 2. No	
207	Do you know any preventive methods to prevent transmission of HIV/AIDS from mother to child?	By taking medicine 1 Yes 2 No 3 DK By safe delivery 1 Yes 2 No 3 DK By Not breast feeding 1 Yes 2 No 3 DK By exclusive breast feeding 1 Yes 2 No 3 DK Others (specify)_____	
I will read the following statements for you then tell me you response by saying 1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly disagree			
208	HIV /AIDS can be cured	1 2 3 4 5	
209	HIV/AIDS a disease of low class or foolish peoples.	1 2 3 4 5	
210	It is possible to determine HIV infected individuals by their appearance.	1 2 3 4 5	
211	People leaving with HIV get the right of marriage.	1 2 3 4 5	
212	People leaving with HIV have the right to bear children.	1 2 3 4 5	

PART III. PERCEPTION (PERCEIVED SUSCEPTIBILITY) QUESTIONS

No	Questions	Coding categories	Skip to
301	What is the likelihood that you are at risk of getting HIV/AIDS? (Read the choices)	Very likely 1 Likely 2 Neither likely nor unlikely 3 Unlikely 4 Very unlikely 5	If 4 &5 skip to Q.303
302	What is/are your reason(s) of risk of being infected with HIV? (don't read the choices probe for more)	Had multiple sexual partners 1 Yes 2 No Had an STI1 Yes 2 No Never used condoms 1 Yes 2 No Received blood transfusion 1 Yes 2 No Used contaminated sharp objects 1 Yes 2 No Had history of genital ulcer 1 Yes 2 No Others (specify)_____	
303	What is/are your reason(s) of not at risk of being infected with HIV? (don't read the choices probe for more)	I trust my partner 1 Yes 2 No I always use condom 1 Yes 2 No I have only one partner 1 Yes 2 No I have no unsafe injection 1 Yes 2 No Others (specify)----------	

PART IV. PERCEPTION (ATTITUDE/INTENTION, PRACTICES) TOWARDS VCT

No	Questions	Coding categories	Skip to
401	Have you ever heard of VCT?	1 Yes 2 No	If 'no' skip to Q.404
402	When did you hear about VCT? (don't read the choices probe for more)	During follow up of antenatal visit 1 Yes 2 No During delivery 1 Yes 2 No During child care visits 1 Yes 2 No Any time else 1 Yes 2 No	
403	From where did you hear first about VCT? (don't read the choices probe for more)	From mass media 1 From friends/relatives 2 From health professional 3 From community meeting 4 Others (specify)_____	
404	I don't wont know the result, have you ever had an HIV test?	Yes 1 No 2	If 'No' skip to

			Q.410
405	When did you have your most recent HIV test?	Before marriage 1 Yes 2 No During this pregnancy 1 Yes 2 No During delivery 1 Yes 2 No Other specify_____	
406	How much did you pay for your most recent test?	_____ Birr(Eth.)	
407	Did you get counseling before or after the HIV test?	1. Yes before 2.Yes after 3.Yes before and after 4. No	
408	Were you satisfied with pre and post-test counseling?	1 Yes 2 No	If 'yes' skip to Q.410
409	Why were you not satisfied with the pre and post-test counseling? (don't read the choices probe for more)	1. Shortage of time 1. Yes 2. No 2. Unpleasant approach of health worker 1. Yes 2. No 3. Lack of privacy 1. Yes 2. No 4. Others(specify)_____	
410	Do you want/plan to be tested?	Yes 1 No 2 Don't know 99	
411	If you want to get HIV testing, can you decide by your own?	1 Yes 2 No	
I will read the following statements for you then tall me your response by saying 1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly disagree			
412	Discussing about HIV testing with husband/partner/boy friend is important.	1 2 3 4 5	
413	HIV testing is important for pregnant mother.	1 2 3 4 5	
414	HIV testing / VCT helps for pregnant mother to receive medicine to prevent her baby from HIV infection in case the test is positive	1 2 3 4 5	
415	Which way is preferred to provide the HIV test result? (read the choices and ask for comments for more)	Face to face 1 Yes 2 No Telephone 1 Yes 2 No Enclose in an envelope 1 Yes 2 No Relatives 1 Yes 2 No Partner1 Yes 2 No	

		Others(specify)_____	
416	If you test positive for HIV, whom would you tell about you result? (read the choices and ask for comments for more)	Your husband 1 Yes 2 No Your children 1 Yes 2 No Your brother/s 1 Yes 2 No Your sister/s 1 Yes 2 No Your relatives 1 Yes 2 No Your friend/s 1 Yes 2 No Your neighbour 1 Yes 2 No Religious leader1 Yes 2 No Your employer 1 Yes 2 No No other person1 Yes 2 No	

PART V. BREAST FEEDING INTENTION AND PRACTICES

No	Questions	Codes Categories	Skip to
501	What is the age of your child?	_____ days _____ weeks _____ months	
502	Did you ever breastfed your child?	1 Yes 2 No	If 'no' skip to Q. 521
503	How long after birth did you first put to the breast?	Within first hour 1 With in first 8 hours 2 After first 8 hours 3	
504	Did your infant receive any thing to drink or eat before first put to the breast?	Yes 1 No 2	If 'no' skip to Q. 508
505	What food or fluid provided? (more than one answer is possible, don't read the choices probe for more)	Butter 1 Yes 2 No Water 1 Yes 2 No Tea 1 Yes 2 No Water and Sugar 1 Yes 2 No Others (specify)_____	
506	Now I would like to ask you about the types of liquids drank over the last seven days, including yesterday. How many days during last seven days did drink each of the following? (probe for more, don't read the choices probe for more)	Plain water 1 Yes 2 No Commercially produced infant formula. 1 Yes 2 No Powdered milk 1 Yes 2 No Fresh animal milk 1 Yes 2 No Fruit juice 1 Yes 2 No Any other liquid 1 Yes 2 No	
507	Are you currently breastfeeding your child?	Yes 1 No 2	If 'no' skip to Q. 512

508	At what age of your child do you intend to stop breast feeding?	Less than 6 months1 Yes 2 No Six to 12 months 1 Yes 2 No 13 to 18 months 1 Yes 2 No 19 to 24 months 1 Yes 2 No	
509	Since birth, have you given your child any foods/fluids other than breast milk?	1. Yes 2. No	
510	Why did you provide these foods or fluids? (probe for more)	Infant perceived unwell 1 Yes 2 No Mother unwell 1 Yes 2 No Infant and mother unwell 1 Yes 2 No Advised by husband 1 Yes 2 No Advised by other person1 Yes 2 No It is a norm of the society or ethnic group 1 Yes 2 No Others(specify)_____	
511	What foods or fluids other than breast milk did the child receive? (more than one answer is possible)	Water or tea 1 Yes 2 No (Age of child _____) Water with sugar 1 Yes 2 No (Age of child _____) Formula /powder milk 1 Yes 2 No (Age of child _____) Cow milk 1 Yes 2 No (Age of child _____) Porridge/ cereal based fluid 1 Yes 2 No (Age of child _____) Adult food 1 Yes 2 No (Age of child _____) Others (specify)_____	
512	What was your child's age at the time you stopped breast feeding?	_____ days -_____Weeks _____-months	
513	Why did you stop breast feeding your child?	Infant no longer wanted to breast fed 1 Yes 2 No To encourage infant to eat solid food 1 Yes 2 No Pregnancy 1 Yes 2 No Fear of transmitting HIV 1 Yes 2 No Mother can afford replacement feeding 1 Yes 2 No Advised by health provider 1 Yes 2 No Infant too sick to breastfeed 1 Yes 2 No 1 Yes 2 No Mother too sick to breastfeed 1 Yes 2 No Advised by husband 1 Yes 2 No	

		Advised by other person 1 Yes 2 No Others (specify)_____	
514	At what age of your child do you intend to start additional food to breast milk?	_____days _____weeks _____months _____ years	
515	Did you encounter any problem when you stopped breastfeeding?	1 Yes 2 No	If 'no' skip to Q. 518
516	What problems did you encounter when you stopped breastfeeding your infant?	Infant cries or unhappy 1 Yes 2 No Breast engorgement 1 Yes 2 No Disapproved by partner/family /neighbors1 Yes 2 No Disapproved by health workers 1 Yes 2 No No food or milk to feed the infant 1 Yes 2 No Other problems (specify)_____	
517	Have you experienced any breast feeding difficulties during breastfeeding your infant?	1 Yes 2 No	If 'no' skip to Q. 521
518	Can you describe what type of difficulties?	Mother was sick 1 Yes 2 No Infant was not able to suck 1Yes 2 No Infant had lesions/thrush in the mouth 1 Yes 2 No Infant had difficulty breathing 1 Yes 2 No Mother thought she did not have enough milk 1 Yes 2 No Others (specify) _____	
519	What did you do at that time?	Nothing, I continued breast feeding 1 Yes 2 No I Gave infant other milk/food/liquid 1 Yes 2 No I consulted a health care provider 1 Yes 2 No I took medicine 1 Yes 2 No Others (specify) _____	
520	Has anyone else (beside your self) ever breastfed your infant?	1 Yes 2 No	If 'no' skip to Q.524
521	Why did the other person breastfeed your infant?	Mother ill/sick 1 Yes 2 No Breast or nipple difficulty 1Yes 2 No No enough milk 1 Yes 2 No Had to go out /separated from the infant 1 Yes 2 No Advised by husband/other family	

		member 1 Yes 2 No Work 1 Yes 2 No Did not want to infect with HIV 1 Yes 2 No Others (specify)_____	
522	Who besides you (the mother) has breast fed your infant?	Your sister 1 Yes 2 No Your mother 1 Yes 2 No Other family member 1 Yes 2 No Neighbors 1 Yes 2 No Other (specify)_____	
523	Have you ever expressed your breast milk since birth?	1 Yes 2 No	If 'no' skip to Q.526
524	Why did you express the milk?	To relieve breast pain/engorgement 1 Yes 2 No To relived pain due to cracked nipples 1 Yes 2 No To heat treat before feeding 1 Yes 2 No Has to be separated from the infant 1 Yes 2 No To wean or stop breast feeding 1 Yes 2 No Infant unable to suckle on breast feeding 1 Yes 2 No Others (specify) _____	
525	Have you ever been sick since your last delivery?	1 Yes 2 No	.
526	What did you feed your child during that time?	Continue breastfeeding 1 Yes 2 No I fed expressed milk from breast 1 Yes 2 No Stopped breast feeding 1 Yes 2 No Began giving non human milks 1 Yes 2 No Began giving other liquids 1 Yes 2 No Began other solid food 1 Yes 2 No Others (specify) _____	

PART VI KNOWLEDGE ON INFANT FEEDING OPTIONS

No	Questions	Coding categories	Skip to
601	Who is the most important when making a decision on how or what you should feed your infant?	Yourself 1 Yes 2 No Husband 1 Yes 2 No Mother in law 1 Yes 2 No Relative 1 Yes 2 No Others(Specify)_____	
602	If a lactating mother tells you that she became HIV positive,	Only to breast feed 1 Yes 2 No	

	what would you advice her on infant feeding?	Not to breast feed at all 1 Yes 2 No Formula milk 1 Yes 2 No Cow milk 1 Yes 2 No Mixed feeding 1 Yes 2 No	
603	Were you counselled about infant feeding?	1 Yes 2 No	
604	What information did you get during counselling? (Circle 1 if she was informed Circle 2 if she was not informed)	Breast feeding 1 Yes 2 No Bottle feeding 1 Yes 2 No Supplementary feeding 1 Yes 2 No Replacement feeding 1 Yes 2 No Mixed feeding 1 Yes 2 No Others(specify)_____	
605	From whom did you hear about infant feeding? (more than one answer is possible)	Health professional 1 Yes 2 No Husband 1 Yes 2 No Mother in law 1 Yes 2 No Friend 1 Yes 2 No Neighbour 1 Yes 2 No Mass media 1 Yes 2 No Others(specify) _____	

PART VII. ENABLING FACTORS (AVAILABILITY AND ACCESSIBILITY OF SERVICES)

No	Questions	Coding categories	Skip to
701	Is there nearby health facility with VCT counselling services?	1 Yes 2 No	
702	Is there nearby health facility with infant feeding counseling services?	1 Yes 2 No	
703	In which health facility the VCT counselors are found ?	Misirak Arbegnoch hospital 1 Yes 2 No Hiwot Fana hospital 1 Yes 2 No Police hospital 1 Yes 2 No Army hospital 1 Yes 2 No Family guidance association clinic 1 Yes 2 No Others(specify)_____	
704	In which health facility the infant feeding including breast feeding counselors are found?	Misirak Arbegnoch hospital 1 Yes 2 No Hiwot Fana hospital 1 Yes 2 No Police hospital 1 Yes 2 No Army hospital 1 Yes 2 No	

		Family guidance association clinic 1 Yes 2 No Others(specify)_____	
705	Can you afford to pay for services to visit health facility with skilled counselor?	1 Yes 2 No 99 Do not know	
706	Can you get transport services to visit health facility with skilled counselor?	1 Yes 2 No 99 Do not know	

Annex 5. CONSENT FORM

I undersigned have been informed that the discussion is conducted to gathers information on the perception and experiences of health workers counselling on VCT and infant feeding options in the community irrespective of their HIV status. The result of this study will help in better understanding on the issue mean while helping the policy and decision makers planning and evaluating programs aiming at combating MCTC of HIV/AIDS.

I am also asked to participate in the discussion voluntarily and because it is thought I have good information on the subject matter. I am also agreed that experiences of mothers attending my service can be raised in the discussion and the confidentiality of the responses is kept at maximum level. I am also agreed to keep the confidentiality on the opinions raised in the discussion. I am also told and agreed that I am also going to be recorded with audiotape and the recorded or other data will be kept confidential.

Signature _____ Name (Optional) _____

Date _____

ANNEX 6 - GUIDING QUESTIONS (DISCUSSION POINTS) IN KEY INFORMANT INTERVIEW FOR QUALITATIVE DATA

Part I. Health Provider back ground

Current job in the facility----------

Type of basic training ----------

Unit of work----------

Training in the area of VCT/PMTCT----------

Duration of stay in the unit ----------

Part II. For antenatal care providers

1. Approximately what proportion of women visit the ANC at least once during a new pregnancy?
2. How many midwifes/nurses are usually assigned to the ANC on any given day?
3. What services are provided for pregnant women during ANC?
4. Are women charged for ANC related services? If yes, for which service?
5. Is their any pregnant women exempted form paying any of these fees, if any?
6. If yes, for whom?
7. Which of the PMTCT related services are offered at your site?
8. How are patients records kept?

Part III. For delivery service providers

1. Approximately what proportions of women give birth with in a week?
2. How many midwifes/nurses are usually assigned to delivery service on any given day?
3. What services are provided to a woman during labor and after delivery?
4. Which of the PMTCT related services are offered at your site?

Part IV. For VCT/PMTCT service providers

1. How many of your VCT/PMTCT providers have been trained for PMTCT service provision?
2. For whom testing and counselling and testing (VCT) being offered?
3. Approximately what proportion of women visit your unit for VCT/PMTCT

service?

4. Where is pre and post-test counselling or HIV testing provided (at MCH, at designated VCT unit,…etc)
5. Where HIV testing of pregnant women for PMTCT does takes place?
6. Approximately what percent of couples are tested for HIV together with in a month?
7. Do you provide infant feeding counselling?
8. Who provides infant feeding counselling?
9. Which group of women receives infant feeding counselling?
10. What is the most common method of choice?
11. Do you carry out any out reach services for PMTCT?
12. What is the perception of clients towards the PMTCT (VCT, infant feeding options) services from your experience?
13. What are the strengths and weaknesses related with these services?
14. Do you have any partnerships with other programs or community organizations providing HIV/AIDS related services in your catchment's area?
15. What impressive works do you know that was done by this strategy in your institution and in the community?
16. What Challenges did you face in counselling mothers about feeding options and VCT?

ANNEX 4በሐረር ከሪማ ውስጥ ወደ ልጅ በሚተላላፈው ኤች ቪ ጋር በተያያዘ ከአንድ ዓመት በታች ልጅ ላላቸው እናቶች በፈቃደኝነት ላይ ተመሰረተ የኤች አይ ቪ ምክርና ምርማራ በጡት ወሪት አመጋብ በተመለከተ የተዘጋጀ መጠይቅ

ክፍል 0 የመጠይቅ መላየ መረጃ

001 የመጠይቁ መለያ ቁጥር

002 ክልል ሐረሪ

003. ከተማ ሐረር

004. ቀበሌ /ቀጠና ----------/----------

05. የቤት ቁጥር

መግቢያ

ስሜ ----------ይባላል፡፡ በአዲስ አበባ ዩኒቨርሲቲ ህክምና ፋኩሊቲ የሚገኘው የህብረተሰብ ጤና ክፍል እየተካሄደ ላው ጥንታዊ ዳሰሳ መረጃ ስብሰቢ ነኝ፡፡ የእናቶች በፍቃደኝት ላይ በሪመሠረት የኤች ኤይ ቪ ምርመራ እና የጡት ወተት አመጋገብን ከእናት ወደ ልጅ ከሚራላለፈው ኤች አይ ቪ ኤድስ ጋር በማያያዝ ያለቸውን ዕቅድና ተግባርን በሪመለከተ ቃለ መጠይቅ እያደረግን ሲሆን ዓለማውም ትክክለኛውን የማጠናከር ኤች አይ ቪ ከእናት ወደ ልጅ እዳይራላለፍ ለመካላል የሚያስችል ስልቶችንና አሠራሮችን ለመቀየስ የሚጠቅም መረጃ ለማግኘት ነው፡፡ ይህንን አላማ ለማሳከት ለሪዘጋጁ ጥያቄች የሚሰጡን እውነተኛና በጣም ጠቃ ስለሆኑት መልስ በቅዲሚያ ልናመሰግን እንወዳለን፡፡

በቅድሚያ አንዳንድ ሰች ለመመለስ ሊያስቸግራቸው የሚችሉ በጣም የግል የሆኑ ጥያቄችን መጠይቁ ማከተቱንና የምንጠይቅዎት መሆኑን እንገልፃለን፡፡ ሆኖም የሚሰጡን ማንኛውም አይነት መልሶች በሚስጢር እንደሚያዙና ስምን ወይም የእርሶን ማንነት የሚገልፅ ማናቸውም አይነት ነገር እንደማይፃፍ እና ከሰጡት መልሶች ጋር ፈፅሞ እደማይያያዝና ለማንም ሊገልፅም ሊታወቅም በጣም እንዲረዱልን እፈልጋለን፡፡ በመጠይቁ ወቅት መመለስ የማይፈልጉሪን ማንኛውንም አይነት ጥያቄ መተው ወየም በማንኛውም ሰዓት ማቋረጥ ይችላሉ፡፡ ነገር ግን ለጥያቄቹ የሚሰጡን መልሶች እናቶች በዚህ ወቅት ያላቸውን የጡት አመጋገብና በፈቃደኝነት ላይ በሪመሰረተ የኤች አይ ቪ ምርመራ ያላቸውን ልምዶችና እቅድ ይበልጥ መረዳት እንድንችል ይጠቀመናል፡፡ ስለዚህም በቅድሚያ ለሚያደርጉልን ትብብር ምስጋናች ከልቭ የመነጨ ነው ፡፡ መጠይቁ 30 ደቂቃ ያህል ሊወስድ ይችላል፡፡

በዚህ ጥናት ላይ መሳተፍ ይችላሉ?

መልሱ አዎ ከሆነ ወደሚቀጥለው እለፉ/ፊ

አልችልም ከሆነ አመስግህ/ህ መጠይቁን አቋርጥ/ጪ

----------ለመስማማታቸው የመረጃ ስብሳቢው/ዋ ፊረማ

የመረጃ ሰብባቢው/ዋ ጉብኝት

	ጉብኝት 1	ጉብንት 2	ጉብኝት 3
ቀን			
መረጃ ሰብሳቢ			
ውጤት			

ውጤት ከ፡- 1. የተጠናቀቀ 2. ተጠያቂዋ አልተገኙም 3. የተቃወሙ 4. በከፊል ተማልቷል 5. ሌላ (ይገልፅ)

ረጋገጣ ሪቆጣጣሪ ስም ---------- ፊርማ----------ቀን ----------

008. የመረጃ ሰብሳቢው መለያ ቁጥር----------ስም----------

009.የተቆጣጣሪው መለያ ቁጥር ---------- ስም

መጠይቁ የተጀመረበት ሰዓት ----------ደቂቃ --------

መጠየቀቁ ያቀበት ሰዓት ----------ደቂቃ----------

ክፍ 1 የግለባ ማህበራዊና ኢኮኖሚያዊ ሁኔታ

101	እድምዎ ስንት ነው? -------ዓመት (በዓመት ይፃፉ	
102	አሁን ያዎት የጋብቻ ሁኔታ ምን ይመስላል?	1. ያላገባች 2. ያገባች 3. በሞት የተለየ 4. የተለያዩ
103	ያጠናቀቁት ከፍተና የትምህርት ደረጃ ስንት ነው?	1. ማንበብና መፃፍ የማትችል 2. ማንበብና መጻፍ ምትችል 3. 1-6 ክፈል ያጠናቀቀች 4. 7-12 ክፍል ያጠናቀቀች 5. ከ12ኛ በላይ
104	ሐይማኖትዎ ምንድ ነው?	1. ኦርቶዶክስ 2. ከቶሊክ 3. ፕሮተስታንት 4. ሙስሊም 5. ሌላ (ይልለፅ) -----
105	ብሔርዎ ምንድን ነው?	1. ኦሮሞ 2. ሐረር 3. አማራ 4. ጉራጌ 5. ትግሬ 6. ሌላ (ይጥቀሱ)
106	ምአሁኑ ጊዜ ሥራዎ ምንድን ነው?	1. የመንግስት ሠራተና 2. የግል ሠራተኛ 3. የቤት እመቤት 4. የቀን ሠራተኛ 5. የቤት ሠራተኛ 6. ነጋዴ 7. ሌለ(ይጥቀሱ)
107	የባለቤትዎ ያጠናቀቁት ከፍተኛ የትምህርት ደረጃ ስንት ነው?	1. ማንበብና መፃፍ የማትችል 2. ምንበብና መጻፍ የምትችል 3. 1-6 ክፍል ያጠናቀቀች 4. 7-12 ክፍል የጠናቀቀች 5. ከ12 ኛ በላይ
108	በአሁኑ ጊዜ የባለቤትዎ ሥራ ምንድን ነው?	1. የመንግስት ሠራተኛ 2. የግል ሠራተኛ 3. የቀን ሰራተኛ 4. ሾፌር 5. ነጋዴ 6. ሌላ (ይጥቀሱ)
109	የቤተሰቡ የወር ገቢ ምን ያህል ነው?	-------(የኢ.ብር)
110	የቤተሰቡ አባላት የሚጠቀሙበት ዋነናው የመጠጥ ውሃ	1. የጉደንድ 2. የምንጭ

	አይነት ምንድን ነው? ከአንድ በላይ መልስ ይቻላል (ሌላስ በማት ይጠይቁ)	2. ወንዝ 3. ቧንቧ 4. ሌላ (ይጥቀስ)
111	ከቤተሰቡ ጎላፊ ጋር ያለዎት ግንኙነት ምንድን ነው?	1.ሚስት (አንድ ስንት ብ ለከው) 2. ሚስት (ከሌሎች አንዷ) 3. ልጅ 4. የቤት ሠራተኛ 5.ሌላ (ይጥቀሱ)
112	በሕይወት ዘምንዎ ስንት ጊዜ አርግዘዋል (በቁጥር ይፃፉ	-------
113	በሕይወት ዘመንዎ ስንት ልጀረ በሕይወት ወልደዋል? (በቁጥር ይፃፉ	
114	በመጨረሳ የእርግዝና ጊዜዎ የነፍስጡር ምርመራ ክትትል አድርገው ነበር?	1. አዎን 2. አላደረኩም (ወደ 188 እለፉ/ፊ
115	የነፍስጡር ምርመራ አድረገው ከነበረ በስንሪኛው የእርግዝና ወር ላይ ሄዱ»	1. የእርግዝና ወር----99 አላውቅም

116	የነፍስጡር ምርመራ ያደረጉት በየትኛው የጤና ድርጅት ነው?	1. የመንግስት ሆስፒታል 2. የግል ክሊኒክ 3. የመንግስት ክሊኒክ
117	የነፍስጡር ምርመራ ባደረጉበት የጤና ድርጅት ውስጥ ለስንት ጊዜያት ክትትል አድርገው ነበር? (በቁጥር ይግለፁ)	----------
118	የመጨረሻ ልጅዎን የወለዱት የት ነበር?	1. በሆስፒታል 2. በግል ክሊኒክ 3. መንግስት ክሊኒክ 4. በቤት ውስጥ 5. ሌላ ይጥቀሱ)
119	በመጨረሻ የወሊድ ጊዜዎ (የመጨረሻ ልጅዎን) ያዋለዶት ማን ነው?	1. የጤና ባለሙያ 2. የሰለጠነች የልምድ አዋላጅ 3. ያልሰለጠነች የልምድ አዋላጅ 4. ቤተ ዘመድ 5. ሌላ (ይጥቀሱ)

ክፍል 2. ስለ ኤች አይ ቪ ከእናት ወደ ልጅ መተላለፊያ መንገድ፣ እውቀትና አመለካከት መረጃ

201	ኤች አይ ቪ ኤድስ ስለሚባል በሽታ ሰምተዉ ያውቃሉ?	1. አዎን 2. አለውቅም
202	ስለ ኤች አይ ቪ ኤድስ ከየት ሰሙ (ከአንድ መልስ በላይ ይቻላል) (ሌላስ በማለት ይጠይቁ)	1. ከጤና ባለሙያ 2. ከቡዚሃን መገናኛ 3. ከጓደኛ 4. ከዘመድ 5. በቀበሌ ስብሰባ 6. ሌላ ይጥቀሱ
203	ኤች አይ ቪ ኤድስ ከአንድ ሰው ወደ ሌላ የሚተላለፍባቸው መንገዶችየትኞቹ ናቸዉ? (ሌላስ በማለትይጠይቁ መልሶቹ አይነበቡ)	1. ልቅ በሆነ ግብረሥጋ ግንኙነት 2. ከእናት ወደ ልጅ 3. ጠንቃቂ የጎደለው ደም በመውሰድ 4. በተበከሉ ስለታም መሣሪዎች በመጠቀም 5. ሌላ (ይጥቀሱ)
204	በኤች አይ ቪ ኤድስ በሽታ የተያዘ ወይ የሞተ ሰው ያውቃሉ?	1. አዎን 2. አላውቅም
205	ኤች አይ ቪ ኤድስ በሽታ ያለባት እርጉዝ ሴት ወደ ልጇ ልታስተላለልፍ የሚችችለው መቼ ነው? (ሌላስ በማለትይጠይቁ ከአንድ መልስ በላይ ይቻላል ምርጫዎቹን	1. በእርግዝና ጊዜ 2. በወሊድ ጊዜ 3. በጡት ወተት (ጡት በማጥባት)

	አታንብቡ)	4. ሌላ (ይጥቀሱ)
206	አንዲት እናት በኤች አይ ቪ ብትያዝ ወደ ልጇ እንዳይተላለፍ የሚረዱ መንገዶች አሉ?	1. አዎን 2 አይ
207	ኤች አይ ቪ ኤድስ በሽታ ከእናት ወደ ልጅ እንዳይተላለፍ የሚረዳ/ዱ መንገዶችን ምንድን ናቸው? (ሌላስ በማለትይጠይቁ ምርጫዎቹን አያንብቡ)	1. መድኃኒት በመውሰድ 2. በወሊድ ጊዜ በመጠንቀቅ 3. ጡት ባለማጥባት 4. እስከ ስድስት ወር ጡት ብቻ በማጥባት 5. ሌላ ይጥቀሱ

ቀጥሎ ጥቂት አባባሎችን አነብሎታለሁ ያሎትን አስተያየት 1.በጣም እስማማለሁ፣ 2.እስማማለሁ፣ 3.ምንም አስተያየት የለኝም፣ 4.አልስማማም፣ 5.በጣም አልስማማም በማለት ይግለፁልኝ

208	ኤች ኤይ ቪ ኤድስ የሚድን በሽታ ነው	1	2	3	4	5
209	ኤች አይ ቪ ኤድስ የደሀ ወይም የሞኞች በሽታ ነው	1	2	3	4	5
210	ኤች አይ ቪ ቫይረስ ያለበት ሰው በማየት መለየት ይቻላል	1	2	3	4	5
211	ኤች አየ ቪ ቫይረስ ያለባቸው ሰዎች የማግባት መብት አላቸው	1	2	3	4	5
212	ከኤች አይ ቪ ቫይረስ ጋር የሚኖሩ ሰዎች ልጅ የመውለድ መብት አላቸው	1	2	3	4	5

ክፍል 3. በኤች አይ ቪ የመጋለጥሁኔታ መረጃ

301	በኤች አይ ቪ የመያዝ እድሌ ምን ያህል ነው ብለው ያስባሉ? (መልሶቹ ይነበቡ)	1. በጣም ልያዝ እችላለሁ 2. ልያዝ እችላለሁ 3. ከሁለቱም የለኝም 4. ልያዝ አልችልም 5. በጣም ሊያዝ አልችልም
302	በኤች አይ ቪ ለመያዝ ምክንያቶ ምንድን ነው ብለው ያስባሉ?(ምርጫዎቹን አያንብቡ ሌላስ በማለትይጠይቁ)	1. የተለያዩየፍቅር ጓደኞቹ ስላሉኝ 2. ያባለዘር በሽታ ስለነበረብኝ 3. ኮንዶም ተጠቅሜ ስለማላውቅ 4. ደም ተሰጥቶን ስለነበር 5. በብልቴ ላይ ቁስል ስለነበረ ሌላ ይጥቀስ
303	በኤች አይ ቪ ላለመያዝም ምክንያቱ ምንድነው ብለው የስባሉ? (ምርጫዎቹን አያንብቡ ሌላስ በማለትይጠይቁ)	1.ባለቤቴን /ጓደኛዬን ስለማምነው 2. ሁል ጊዜ ከንደም ስለምጠቀም 3. አንድ ጓደኛ ወይም ባለቤት ብቻ ስላለኝ 4.ጥንቃቄ የሌለውን መረፈ ተወግቼ ስለነበር 5. ሌላ ይጥቀሱ

ክፍል 4. በፈቃደኝነት ላይ የተመሠረተ የኤች አይ ቪ ኤድስ ምርመራና ምክር አገልግሎት እዉቀት ፣አስተሳሰብ፣ ልምድ እቅድ መረጃ

401	በፍቃደኝነት ላይ የተመሠረተ የኤች አይ ቪ ምክርና ምርመራን በተመለከተ ሰምተው ያውቃሉ?	1. አዎን 2. ሰምቼ አላውቅም (ወደ 404 እለፍ/ፊ)
402	ሰምተው የማያውቁ ከሆነ መቼ ሰሙ?(ከአንድ መልስ በላይ ይቻላል ሌላስ በማለት ይጠይቁ)	1.በእርግዝና ምርመራ ጊዜ 2. በወሊድ ጊዜ 3. ልጅን ወደ ሐኪም ቤት ስወስድ 4. በሌላ ጊዜ
403	ሰምተው የሚያውቁ ከሆነ መጀመሪያ ከየት ሰሙ? (ምጫዎቹ አይነበቡ ሌላስ በማለት ይጠይቁ)	1. ከብዙሐን መገናኛ 2 .ከጓደኛ/ከዘመድ 3. ከጤና ባለሙያ 4. በቀበሌ ስብሰባ 5. ሌላ (ይግለጹ) ----------
404	ዉጤቱን ማወቅ አልፈልግም ለኤች አይ ቪ ምርመራ አድርገው ያውቃሉ?	1. አም 2. አድርጌ አላውቅም (ወደ 407 እለፍ/ፊ)
405	በቅርቡ ያደረጉት የኤች አይ ቪ ምርመራ	1. ከ3ብቻ በፊት 2. በአሁኑ እርግዝና 3. በወሊድ ጊዜ 5. ሌላ

	መቼ ነበር?	(ይግለጹ) ----------
406	በቅርቡ ላስሩት የኤች አይ ቪ መርመራ ምን ያህል ከፈሉ ?	---------- ኢ.ብር
407	ከኤች አይ ቪ ምርመራ በፊትና በኃላ ምክር ተሰጥቶታል	1. አዎ ከምርመራ በፊት 2. አዎን ከምርመራ በኃላ 3. አዎ ከምርመራ በፊትና በኃላ 4. አይ አልተሰጠኝም
408	በምክር አገልግሎቱ ተደስተዋል?	1. አዎን (ወደ 410 እለፍ/ፊ) 2. አይ
409	ከምርመራ በፊትና ከምርመራ በኃላ በተሰጥዎት ምክር ደስተኛ ያልሆኑት ለምንድን ነው?(ምርጫዎቹ አይነበቡ ሌለሳስ በማለት ይጠይቁ ከአንድ መልስ በላይ ይቻላል)	1.ጊዜው አጭር ስለነበረ 2. የጤና ባሙያዎቹ አቀራረብ አይመችም 3. ገለልተኛ የሆነ ቦታ ስለሌለ 4. ሌላ (ይግለጹ) ----------
410	የኤች አይ ቪ ምርመራ ለማስደረግ ይፈልጋሉ?	1. አዎን 2. ለማስደረግ አልፈልግም 3. አላውቅም
411	የኤች አይ ቪ ምርመራ ማድረግ ቢፈልጉ ለራስዎ መወሰን ይቻላሉ?	1. አዎን 2.አይ
ቀጥሎ ጥቂት አባባሎችን አነብሎታለሁ ያሎትን አስተያየት 1.በጣም እስማማለሁ፣ 2.እስማማለሁ፣ 3.ምንም አስተያየት የለኝም፣ 4.አልስማማም፣ 5.በጣም አልስማማም በማለት ይግለፁልኝ		
412	ስለኤች አይ ቪ ምርመራ ከባለቤት/ከፍቅር ጓደኛ ጋር መወያየት ጠቃሚ ነው::	1 2 3 4 5
413	የኤች አይ ቪ የደም ምርመራ ለእርጉዝ እናት አስፈላጊ ነዉ	1 2 3 4 5
414	የኤች አይ ቪ ምርመራ ለእርጉዝ እናት የሚረዳው ቫይረሱ ከሪገኘላት ወደ ልጇ እንዳይተላለፉ መድሃኒት ለመውሰድ	1 2 3 4 5
415	የኤች አይ ቪ የምርመራ ውጤት እንዴት ቢሰጥ/ቢነገርይሻላል? (ምርጫዎቹን አንብበህ/ሽ አስተያየታቸዉን ጠየቅ/ቂ) 1. ፊት ለፊት 2. በስልክ 3. በፖስታ ታሽጎ 4. በቤተ ዘመድ 5. በትዳር/በፍቅር ጓደኛ	 1. አዎን 2 አይ 1. አዎን 2 አይ 1. አዎን 2 አይ 1. አዎን 2 አይ 1. አዎን 2 አይ
416	ምክንያቱን አልፈልግም አንዲት እናት ኤች አይ ቪ ተመርምራ ቫይረሱ ቢገኝባት ውጤቱ ለማን መንገር አለባት? (ምርጫዎቹን አንብበህ/ሽ አስተያየታቸዉን ጠየቅ/ቂ) 1. ለባለቤቷ 2. ለልጆችዋ 3. ለወንድሞችዋ 4 .ለእህቶቿ 5. ለቤተ ዘመድ 6. ለጓደኛ 7. ለጎረቤት 8. ለሀይማኖት መሪ 9. ለመሥሪያ ቤት 10. ለማንም መናገር የለባትም	1.በጣም እስማማለሁ 2. እስማማለሁ 3. ምንም አስተያየት የለኝም 4. አልስማማም 5.በጣም አልስማማም 1. አዎን 2 አይ 1. አዎን 2 አይ 1. አዎን 2 አይ 1. አዎን 2 አይ 1. አዎን 2 አይ 1. አዎን 2 አይ 1. አዎን 2 አይ 1. አዎን 2 አይ 1. አዎን 2 አይ 1. አዎን 2 አይ

ክፍል 5 በጡት ማጥባት ፍላጎትና ልምድ መረጃ

501	የመጨረሻ የልጅዎ እድሜ ስንት ነወ?	---------- ቀናት ---------- ሳምንታት----------ወር
502	የመጨረሻ ልጅዎን ጡት አጥብተዋል?	1. አዎን 2. አይ(ወደ 521 እለፍ/ፊ
503	ሕፃኑ ከተወለደ/ች ከስንት ጊዜ በሆላ ነዉ	1. በመጀመሪያው አንድ ሰዓት

	ጡት ያጠቡት ?	2. በመጀመሪያው ስምነት ሰዓት 3. ከስምንት ሰዓት በኃላ
504	ለሕፃኑ ጡት ከማጥባትዎ በፊት የሚበላ ወይም የሚጠጣተሰጥቶታል?	1. አዎ 2. አይ
505	ለሕፃኑ ጡት ከማጥባትዎ በፊት የተሰጠው ምግብ ወይም መጠጥ ምንድን ነው/ ናቸው? (ከአንድ መልስ በላይ ይቻላል ምርጫዎቹን አያንብቡ)	1. ቅቤ 2. ውሃ 3. ሻታ 4. ውሃና ስኳር 5. ሌላ (ይግለፅ)
አሁን ባለፉት ሰባት ቀናት ትናንትናን ጨምሮ ለልጅዎ የሰጡትን የፈሳሽ አይነት ነው የሚጠይቁት (ከ6 ወር በታች ልጅ ለላት እናት)		
506	ባለፉት ሰባት ቀናት ውስጥ ልጅዎ ከሚከተሉትን ፈሳሾች የትኞቹን ወስዷል? (ከአንድ መልስ በላይ ይቻላል ምርጫዎቹን አያንብቡ)	1. ውሃ 2. በፋብሪካ የተመረቱ የሕፃናት ምግቦች 3. የዱቄት ወተት 4. ትኩስ የከብት ወተት 5. የአትክልት ጭማቂ 6. ከተጠቀሱት ፈሳሾች ውጪ
507	እነዚህን ምግቦች ወይም ፈሳሾች ለምን ሰጡ/ (ከአንድ መልስ በላይ ይቻላል ምርጫዎቹ አይነበቡ)	1. ሕፃኑ ጤነኛ ስላልነበረ 2. እናቱ ጤነኛ ስላልነበረች 3. እናትም ሕፃኑምጤነኛ ስላልነበሩ 4. በባለቤቴ ተመክሬ ነው 5. በሌሎች ሰዎች ተመክሮ ነው 6. የሐዝቡ/የብሔረሰቡ ባህል (ወግ ስለሆነ ነው) 7. ሌለ (ይግለጹ
508	በአሁኑ ጊዜ ልጅዎን እያጠቡ ነው?	1. አዎን 2. አይ (ወደ513እለፍ/ፊ)
509	የልጅዎ ዕድሜ ምን ያህል ሲሆነ ጡት ማጥባት ማቆም ይፈልጋለ?	1. ከ6 ወር በታች /እስከ 6 ወር 2. ከ6ወር እስከ አንድ አመት 3. ከ 13 እስከ 24 ወራቶች 4. ከ19 እስከ 24 ወራቶች
510	የመጨረሻ ልጅዎ ከተወለደ ጀምሮ እስከ አሁን ከጡት ወተት ውጪ ምግብ ወይም ፈሳሽ ሰጥተዉት ያውቃሉ?	1. አዎን 2. አይ (ወደ 512 እለፍ/ፊ)
511	ከጡት ወተት ውጪ ለልጅዎ የተሰጡት ምግቦች ወይም ሌሎችፈሳሾች ምንድን ናቸው? (የልጅዎ ዕድሜ ይጠቀስ)	1. ውሃ ወይም ሻታ (የልጅዎ ዕድሜ-----) 2. ውሃ ስኳር (የልጅዎ ዕድሜ --------) 3. የዱቄት ወተት (የልጅዎ ዕድሜ -----) 4. ሙቅ (የልጅዎ ዕድሜ -----) 5. የከብት ወተት (የልጅዎ ዕድሜ -----) 6. የአዋቂ ምግብ (የልጅዎ ዕድሜ -----) 7. ሌላ (ይግለፅ)
512	ለልጅዎ ከጡት ወተት በተጨማሪ ምግብ ለመጀመር የሚያስቡት መቼ ነው? (ተጫማሪ ምግብ ላልጀመረች እናት)	------- ቀን በኃላ ----------ሳምንታት በኃላ---------- ወራት በኃላ --------- አመት በኃላ
513	ጡት ማትበት ሲያቆሙ የልጆዎ ዕድሜ ስንት ነበር?	---------- ቀናት ---------- ሳምነታት ----------ወሮች
514	ልጅዎን ጡት ማጥባት ለምን አቆሙ? (ምርጫዎቹ አይነበቡ ሌላስ በማለት ይጠይቁ ከአንድ መልስ በላይ ይቻላል)	1. ልጅ ማጥባት ስላልፈለገ 2. ልጅ ሌላ ምግብ እንዲመገብ ለማድረግ 3. በእርግዝና ምክንያት 4. ኤች አይ ቪ እዲያይተላለፍበት 5. የጡት ወተትን የሚተካ ምግብ መግዛት ስለሚችል 6. በጤና ባለሙያ ተመክሬ ፡ 7. ሕፃኑ ልጅ በጣም ታሞ መጥባት ስላልቻለ 8. በጣም ታምሜ ማጥባት ስላልቻልኩ 9. ባለቤቴ ስለመከረኝ 10. በሌሎች ሰዎች ስለተመከርኩኝ 11. ሌላ ይግለፁ
515	ጡት ማጥባት ሲያቆሙ ችግር አጋጥሞት ነበር?	1. አዎን 2. አይ
516	ጡት ማጥባት ሲያቆሙ ምን አይነት ችግር ነዉ ያጋጠሞት?	1. ልጅ በጣም አልበ ነበር 2. የጡት ሕመም

	(ምርጫዎቹ አይነበቡ ሌላስ በማለት ይጠይቁ ከአንድ መልስ በላይ ይቻላል)	3. ባለቤት /ቤተሰብም / ጎረበተ አልተቀበሉም 4. የጤና ባለጨ አልተቀበሉትም 5. በጀን የሚመገበዉ ወተት ወይም ምግብ ማጣት 6 ሌላ (ይገለፅ)
517	ልጅዎት ጡት በሚያጠቡበት ጊዜ ጡት የማጥባት ችግር አጋጥሞታል ያዉቃል?	1.አዎን 2. አይ(እለፍ ወደ 521)
518	ጡትሲያጠቡ ያጋጠመዎት ችግር ምን ነበር ?(ሌላስ በማለት ይጠይቁ	1. ታመምኩ 2. ልጂ ጡት መሳብ አቃተዉ 3. ልጂ አፉ ቆሰለ 4. ልጂ መተንፈስ አቃተዉ 5. ጡቴ ወተት አልነበረውም 6. ሌላ (ይገለፅ)
519	ጡትዎን ሲያጠቡ ችግር ባጋጠመዎት ጊዜ ምን አደረጉ? (ምርጫዎቹ አይነበቡ ሌላስ በማለት ይጠይቁ ከአንድ መልስ በላይ ይቻላል)	1. ምንም አልደረኩም ማጥባቱን ቀጠልኩኝ 2. ለልጂ ሌላ ምግብ (ወተት፣ፈሳሽ፣ምግብ) ሰጠሁት 3. የጤና ባለሙያ አማከርኩ 4. መድሀኒት ወስደሽ 5. ሌላ (ይገለፁ)
520	ከእርስዎ ሌላ ሰዉ ልጅዎን አጥብቶ ያዉቃል?	1.አዎን 2. አይ(ወደ523 እለፉ/ፊ)
521	ከእርስዎ ሌላ ሰዉ ለምንድነዉ ልጅዎን ያጠባው? (ምርጫዎቹ አይነበቡ ሌላስ በማለት ይጠይቁ ከአንድ መልስ በላይ ይቻላል)	1. ታምሜ 2. የጡት ጫፍ ችግር 3. በቂ ወተት ስለልነበረን 4. ሌላ ቦታ ሄጂ/ከልጅ ተለይቼ 5. በባለበት /በቤተሰብ በመመከር 6. በስራ ምክንያት 7. በኤች አይ ቪ አንዳይያዝ 8. ሌላ (ይገለፅ)
522	ከእርስዎ ዉጪ ልጅዎን ያጡባ ማነዉ? (ምርጫዎቹ አይነበቡ ሌላስ በማለት ይጠይቁ ከአንድ መልስ በላይ ይቻላል)	1. እህት 2. እናት 3. ሌሎች የቤተሰብ አባላት 4. ጎረበት 5. ሌላ ይገለፅ
523	ከወለዱ ወዲህ ከጠትዎ ወተት አልበዉ ያዉቃሉ?	1.አዎን 2. አይ
524	ለምንድን ነዉ ጡትዎን ያለቡት /የጨመቁት? (ምርጫዎቹ አይነበቡ ሌላስ በማለት ይጠይቁ ከአንድ መልስ በላይ ይቻላል)	1. የጡት ሕመም ለማስታገስ 2. የጡት ጫፍ ቁስል ለማስታገስ 3. ከማጥባት በፍት የጡት ወተት ለማሞቅ 4. ከልጂ ስለምለይ 5. ጡት ለማስጣል (ለማስቆም) 6. ልጂ ጡት ስቦ መጥባት ስላልቻለ 7. ሌላ (ይገለፅ)
525	ከወለደ በሆላ ታመዉ ያዉቃሉ?	1.አዎን 2. አይ
526	በታመሙ ጊዜ ልጅዎን ምን መገቡ?	1. ጡት ማጥባት ቀጠልኩ 2. ጡቴን አልቤ ሰጠሁት 3. ጡት ማጥባት አቆምኩኝ 4. የከብት ወተት ሰጠሁት 5. ሌሎች ፈሳሽችን ሰጠሁት 6. ሌሎች ምግቦችን ሰጠሁት

ክፍል 6. በልጅ አመጋገብ ምርጫዎችና እዉቀቱን በተመለከተ መረጃ

601	ልጅዎ እንዲትና ምን መመገብ አንዳለበት የሚወስነዉ ማነዉ ? (ምርጫዎቹ ይነበቡ ከአንድ መልስ በላይ ይቻላል)	1. ራሴ 2. ባለቤቱ 3.የባለቤቱ እናት 4. ቤተዘመድ 5. ሌላ (ይገለፅ) ----------
602	አንዲት የምታጠባ እናት ኤች አይ ቪ ይዞኛል ብላ ብትነግርዎት ልጇን ምን እንድትመግብ ይመክሯታል? (ምርጫዎቹ ይነበቡ ከአንድ መልስ በላይ ይቻላል)	1. ጡት ብቻ እንድታጠባ 2. ጡት እንዳታጠባ 3. የዱቄት ወተት 4. የከብት ወተት 5. የጡት ወተት እና ሌሎች ምግቦች
603	የልጅ አመጋገብን በተመለከተ ምግብ ወይም ትምህርት አግኝተዉ ያወቃሉ ?	1.አዎን 2. አይ
604	ስለ ልጅ አመጋገብ ከማን ነዉ የሰሙት? (ምርጫዎቹ አይነበቡ ከአንድ መልስ በላይ ይቻላል)	1. ከጤና ባለሙያ 2. ከባለቤቱ 3. ከባለቤቱ እናት 4. ከጎደኛ 5. ከጎረቤት 6. ከብዝሀን መገናኛ 7 ሌላ (ይገለፅ) --------

ክፍል 7 የአገልግሎት መኖርና ቅርበት መረጃ

701	በአቅራቢያዉ በሚገኘዉ ጤና ድርጅት ዉስጥ የኤች አይ ቪ ምክርና ምርመራ የሚሰጡ ባለሙያዎች አሉ?	1.አዎን 2. አይ 99. አላዉቅም
702	በአቅራቢያዉ በሚገኘዉ ጤና ድርጅት ዉስጥ ስለ ልጅ አመጋገብ የጡት ወተትን ጨምሮ ምክር የሚሰጡ ባለሙያዎች አሉ?	1.አዎን 2. አይ 99. አላዉቅም
703	ስለ ኤች አይ ቪ ምክርና ምርመራ አገልግሎት ሰጪዎች በየትኛዉ የጤና ድርጅት ይገኛሉ ?	1. ምስራቅ አርበኞች ሆስፒታል 2. ሕይወት ፋና ሆስፒታል 3. ፖሊስ ሆስፒታል 4. ጦርሀይል ሆስፒታል 5. ቤተሰብ መምሪያ 6. ሌላ(ይገለፅ) ------
704	ስለ ልጅ አመጋገብ የጡት ወተትን ጨምሮ የምክር አገልግሎት ሰጪዎች በየትኛዉ የጤና ድርጅት ይገኛሉ ?	1. ምስራቅ አርበኞች ሆስፒታል 2. ሕይወት ፋና ሆስፒታል 3. ፖሊስ ሆስፒታል 4. ጦርሀይል ሆስፒታል 5. ቤተሰብ መምሪያ 6. ሌላ(ይገለፅ) ------
705	በጤና ድርጅት ዉስጥ ካሉት አማካሪዎች አገልግሎት ለማግኘት የሚጠይቀዉን ክፍያ መክፈል ይችላሉ?	1.አዎን 2. አይ 99. አላዉቅም
706	አማካሪዎች ያሉበት ጤና ደርጅት ለመሄድ ትራንስፖርት(መጓጓዣ) ማግኘት ይቻላል?	1.አዎን 2. አይ 99. አላዉቅም

በአዲስ አበባ ዩኒቨርስቲ ከእናት ወደ ልጅ በሚተላለፈው ኤች አይ ቪ ጥናታዊ ዳሰሳ ለጤና ባለሙያዎች የሚደረግ መጠይቅ

ክፍል <u>1 በእናቶች ቅድመ ወሊድ ምርመራ ክፍል ለሚሠራ/ለምትሠራ ባለሙያ የሚቀርብ መጠይቅ</u>

የባለሙያ ሁኔታ

- ዕድ
- በአሁኑ ጊዜ በጤና ድርጅት ውስጥ ያለው/ያላት ሥራ ድርሻ
- የወሰደው/ችው ሥልጠና
- የምትሠራበት /የሚሠራበት ክፍል
- በቪሲቲ ወይም ቢጽ.ኤም.ቲ.ሲ.ቲ ላይ ያለው ሥልጠና
- በክፍሉ የቀየበት ጊዜ

1. በአካባቢው ባሉት እርጉዝ እናቶች ለቅድመ ወሊድ የእርግዝና ምርመራ ቢያንስ አንድ ጊዜ ወደ እዚህ የሚመጡ ምን ያህሎች ናቸው። ለምን?
2. በቀን ምን ያህል ነርሶች/አዋላጅ ነርሶች አገልግሎ ለመስጠት እዚህ ክፍል ይመደባሉ?
3. ለቅድመ ወሊድ ምርመራ ለመጣች እርጉዝ እናት ምን ምን አገልግሎቶች ይሠጣሉ?
4. ለሚሠጣቸው አገልገሎት ክፍያ የሚየቁበት አገልግሎቶች አሉ/ምን ያህል ለምን አይነት አገልግሎት?
5. ይህንን ክፍያ የማይከፍሉ እርጉዝ እናቶች ይኖራሉ?
6. በዚህ ክፍ አገልገሎት የሚሠጡት የጤና ባለሙያዎች መካከል ከእናት ወደ ልጅ በሚተላለፈው ኤች አይ ቪ በመከላከል ላይ ስልጠና የወሰዱ አሉ? ምን ያህል ናቸው?
7. ከእናት ወደ ልጅ በሚተላለፈው ኤች አይ ቪን በመከላከል በተመለከተ ምን ምን አገልገሎቶች ይሠጣሉ?
8. የተገልጋዮችን ሚስጢር የያዙት መዝገቦች ወይም ካርዶች የሚቀመጡት እንዴት ነው እና የትነው?
9. የኤች አይ ቪ ቫይረስ በእናት ወደ ልጅ መተ ላለፍን ለመከላከል እንዲችሉና ያገልግሎቱ ተጠቃሚ እንዲሆኑ ምን መደረግ አለበት ብለህ/ብለሽ ታስቢያለሽ/ታስባለህ?

<u>ክፍል 2 ማዋለኛ ክፍል ለሚሰሩ ባለሙያዎች የሚቀርብ መጠይቅ</u>

<u>የባሙያ ሁኔታ</u>

- ዕድ
- በአሁኑ ጊዜ በጤና ድርጅት ውስጥ ያለው/ያላት የሥራ ድርሻ
- የወሰደው/ችው ስልጠና
- የሚሰራበት/የምትሠራበት ክፍል
- በቪሲቲ ወይም ቢጽ.ኤም.ቲ.ሲ.ቲ ላይ ያለው ሥልጠና
- በክፍሉ የቀየበት ጊዜ

1. በአካባቢው ካሉት እርጉዝ እናቶች ለወሊድ ወደዚህ የሚመጡት ምን ያህሎች ናቸው::
2. በቀን ምን ያህል ነርሶች/አዋላጅ ነርሶች አገልግሎት ለመስጠት ክፍል የመደባሉ?
3. ለሚሠጣቸው አገልግሎት ክፍያ የሚጠየቁበት አገልግሎቶች ይሠጣሉ?
4. ለሚሠጣቸው አገልግሎት ክፍያ የሚጠየቁበት አገልግሎቶች አሉ/ምን ያህል?
5. ይህንን ክፍያ የማይፍሉ እናቶች ይኖራ?
6. በዚህ ክፍያ አገልግሎት የሚሠጡት የጤና ባለሙያዎች መካከል ከእናት ወደ ልጅ በሚተላለፍው ኤች አይ ቪን በመከላከል ላይ ስልጠና የወሰዱ አሉ? ምን ያህል ናቸው?
7. ከእናት ወደ ልጅ በሚተላለፈው ኤች አይ ቪን በመከላከል በተመለከተ ምን ምን አገልግሎቶች ይሠጣሉ?
8. የተገልጋዮችን ሚስጥር የያዙት መዝገቦች ወይም ካርዶች የሚቀመጡት እንዴት እና የት ነው?
9. የኤች አይ ቪ ቫይረስ ከእናት ወደ ልጅ መተላለፍን ለመከላከል እንዲችና ያገልግሎቱ ተጠቃሚ እንዲሆኑ ም መደረግ አለበት ብለህ/ብለሽ ታስቢያለሽ/ታስባለህ?

ክፍል 3 በቪ.ሲ.ተ/ኤም ቲ.ሲ.ቲ ክፍል ባሉበት ባለሙያ የሚቀርብ መጠይቅ

የባሙያ ሁኔታ

- ፆታ
- በአሁኑ ጊዜ በጤና ድርጅት ውስጥ ያለው/ያላት የሥራ ድርሻ
- የሚሠራ/የምትሰራበት ክፍል
- በቪሲቲ ወይም ቢ.ፒ.ኤም .ቲ .ሲ.ቲ ላይ ያለው ስልጠና በክፍሉ የቆየበት ጊዜ

1. በቀን ምን ያህል ነርሶች /ባሙያዎች አገልግሎት ለመስጠት እዚህ ክፍል ይመደባሉ?
2. ለምርመራ ለመጣች እርጉዝ/ሌሎች እናቶች ምን ምን አገልግሎት ይሠጣሉ?
3. ለሚሠጣቸው አገልገሎት ክፍናየ የሚጠየቁበት አገልግሎቶች አሉ? ምን ያህል? ለምን አይነት አገልግሎት?
4. ይህንን ክፍያ የሚከፍሉ እናቶች ይኖራሉ?
5. በዚህ ክፍል አገልግሎ ይሚሠጡት የጤና ባለሙያዎች መካከል ከእናት ወደ ልጅ በሚተላለፈው ኤች አይ ቪን በመከላከል ላይ ስልጠና የወሰዱ አሉ? ምን ያህሎቹ ናቸው?
6. ከእናት ወደ ልጅ በሚተላለፈው ኤች አይ ቪን በመከላል በተመለከተ ምን ምን አገልግሎቶች ይሠጣሉ?
7. የተገልጋዮችን ሚስጥር ያየዙት መዝገቦች ወይም ካርዶች የሚቀመጡት ለነማን ነው?

8. በፈቃደኝነት ላይ የተመሠረተ የኤች አይ ቪ ምክርና ምርመራ የምትሠጡት ለነማን ነው?
9. በግምት ምን ያህል እናቶች ለቪ.ሲ.ቲ/ፕ.ቼም.ቲ.ሲ.ቲ አገልግሎ በወር ወስጥ ወደዚህ/እናንተ ጋር ይመሉ
10. እናቶች በፍቃደኛነት ላይ የተመሠረተ ኤች አይ ቪ ምርመራ ምክር የምትሠጡት ይ ነው? ቅድ ምርመራ ምክር ከምርመራ በኋላ?
11. በህፃናት ወይም በልጆች አመጋገብ ላይ በምክር አገልግሎት የሠጣል? ለምን? መቼ?
12. በማሠጠው የአመጋብ የምክር አገልግሎት ካሉት አማራጮች በብዛት የሚመረጡት የትኛቹ ናቸው?
13. የፒ.ኤም.ሲ.ቲ አገልግሎትን በተመለከተ የመስክ አገልግሎት አላችሁ? የሚሠጡት አገልግሎቶች ምንድን ናቸው?
14. የተገልጋዮችን ሚስጢር የያዙት መዝገቦች ወይም ከርዶች እንዴት እና የት ነው?
15. የኤች አይ ቪ ቫይረስ ከእናት ወደ ልጅ መሪላለፍን ለመከላከል እንዲችና ያገልግሎቱ ተጠቃሚ እንዲሆኑ ምን መደረግ ለበት ብለህ/ብለሽ ታስቢያለች?