

**Mother Support Group in Prevention of Mother to Child Transmission of
HIV/AIDS (PMTCT) Services at Ambo Hospital**

Abera Rundasa

Advisor: Dr. Ashenafi Hagos

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Abera Rundasa

School of Social Work

Approved by Examining Board

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External Examiner	Signature	Date
_____	_____	_____
Internal Examiner	Signature	Date
_____	_____	_____
Advisor	Signature	Date

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Acronyms and Abbreviations

AIDS	Acquired Immuno Deficiency Syndrome
ANC	Ante-natal Care
ART	Antiretroviral Therapy
ARV	Anti Retro Viral
BCC	Behavioral Change Communication
HAPCO	HIV/AIDS Prevention and Control Office
HIV	Human Immune Deficiency Virus
IEC	Information Education Communication
ICAP	Center for AIDS Care and Treatment Programs
FDRE	Federal Democratic Republic of Ethiopia
FMOH	Federal Ministry of Health
MSG	Mother Support Group
MTCT	Mother to Child Transmission of HIV
PMTCT	Prevention from Mother to Child Transmission
PNC	Post-natal Care
USAID	United States of America for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
UNAIDS	United Nations Joint Program on HIV/AIDS
UNICEF	United Nations Children's Fund

Abstract

This study entitled with mother support group in PMTCT services was conducted at Ambo Hospital. The main objective of the study was to explore and describe the role and related activities of mother support group in PMTCT services. Descriptive case study method was used to conduct such type of qualitative study. Participants of the study included were members of MSG, HIV positive pregnant and post partum women, and health professionals. The participants were selected through non probability sampling method, using purposive sampling technique accompanied by setting criteria. In-depth interviews and key informant interviews were used to collect data from the participants. In addition, observations were conducted to substantiate the data. The analysis started with transcription and translation of the data. Codes had been given based on participant answers, ideas, and meanings in relation to in-depth interview guide and key informant interview questions. The identified themes were examined against the stated research questions and research objectives. The final themes were developed through comparing initially stated propositions against the research findings. To enhance the rigor of the data mechanisms like familiarity with the culture, rapport building, and triangulation were applied. The study conducted according to social work ethical guide-line using consent form.

The findings revealed that MSG primarily established to share their experiences to similar peers. Provision of PMTCT education, and psycho social support during ante-natal care, delivery and post partum care were the main services provided by MSG. Improvement of knowledge and skill on PMTCT, and infant and young child feeding practice, decrease of stigma and discrimination, increment of partner disclosure, increase of uptake of ARV, ante and post-natal care, decrease of work burden of clinicians, and low level of mother to child transmission were the main benefits of the services, and made the services is contributing to PMTCT services. Lack of continues training for MSG, absence of income generating activities, and low professional support were major challenges of services. The study has implication for social workers, maternal and child health programs and policies as to inculcate engagement of community members in different steps of their activities.

Key words MTCT, PMTCT, mother support group, and roles and related activities of MSG

Chapter One

1. Introduction

1.1. Background of the Study

Mother to child transmission or vertical transmission is the transmission of HIV infection from an HIV infected mother to her child during pregnancy, delivery, and breast feeding. FMOH (2007) reported that the estimated risk of mother to child transmission ranges from 5-10% during pregnancy, 10-15% during delivery, and 5-20% during breast feeding. Krebs (2012) said that the period of vulnerability for MTCT ranges from early pregnancy of less than 28 weeks to 24 months of post partum.

Mother to child transmission of HIV (MTCT) is one of the global public health problems affecting the well being of mothers and their children. Kendall and Fellow (2014) asserted that internationally HIV and complication of child bearing were the top causes of deaths among women of reproductive age and their infants. Women encountered opportunistic infections, mental stress, social isolation, stigma and discrimination. Children who were exposed to HIV infection suffered from early morbidity and mortality. Without intervention, the risk of HIV infected mothers passing the infection to children ranges from 20-45%. However, with evidence based intervention the risk of MTCT can be reduced to 2-5%. Hence, measures have to be taken to reverse the problem.

Prevention of mother to child transmission (PMTCT) implies the prevention process of MTCT thereby improve maternal and child health. According to WHO (2010), PMTCT has four strategic frame works. This includes prevention of HIV among parents, prevention of unwanted pregnancies among HIV positive women, care and treatment of HIV positive pregnant women,

and prevention of mother to child transmission of HIV. This study considered the last two PMTCT frame works.

PMTCT activities ranges from pre-natal care to post deliver regime. Kalembo, Yukai, Zgambo, & Jun (2012) discussed that PMTCT program consists of a range of interventions. It embraces improved ANC service, pre and post test HIV counseling, and provision of ARV drug for HIV positive pregnant women and infants. In addition, referral to support groups, and counseling on option of safer feeding practice, and follow up of HIV positive mothers are the other components of the intervention.

In Ethiopia, various research reports show that the coverage of PMTCT service remains low. For instance, UNAIDS (2013) outlined that Ethiopia reached less than 50% of pregnant women living with HIV with ARV drug to prevent the vertical transmission of HIV to children. This low achievement was the product of various challenges and interrelated factors. Krebs (2012) asserted that high missed to follow up along the PMTCT cascade particularly at the initiation of ante-natal care, adherence problem, and Poor facility based deliver were major contributing factors to lower PMTCT effectiveness in Ethiopia. Yonas (2007) also argued that quality of health care during PMTCT counseling, follow up, and delivery, stigma, discrimination, distance from health facilities, and religious factors were identified as reasons for low uptake of PMTCT service. Hailemichael (2006) argued that the problem of low uptake of PMTCT service attributed to the structural and health facility barriers.

One of intervention strategies designed by FMOH and concerned stake holders to enhance the performance of PMTCT service in the country was ensuring the engagement of community groups such as people with HIV/AIDS in HIV/AIDS related services. According to

UNAIDS (2012), community engagement inculcate the concept of empowerment where the member can make an influence on the program.

There are different mechanisms to develop the participation of community members. One of these mechanisms is establishing mothers support group (MSG). In Ethiopia, it was first introduced in 2005. According to USAID (2008), Mother Support Group is a group of people organized by HIV positive women who were interested to serve and share their experiences for HIV positive women across PMTCT cascade at health setting and getting less monthly salary. Viadro, Stratton, Yetnaye, and Abebe (2008) contended that MSG is a type of program based at health center and closely integrated with clinic based PMTCT program. It is a peer support program that aims to provide education and psycho-social support to HIV positive pregnant and post partum women.

The primary target group of MSG is HIV positive women. HIV positive women include two different groups. The first one is pregnant women who identified their HIV status as being positive and follows ante-natal care services. The second one is women who identified their HIV status as being positive but already delivered their children under post-natal care services.

This study was designed to explore and describe the roles and related activities of MSG in PMTCT services. These can be reflected in terms of activities done by MSG across PMTCT regimes. The study was conducted at Ambo Hospital which is located at West of Addis Ababa away 110km in the Oromia Regional State. According to USAID (2009) report, different factors contribute to HIV/AIDS exposure in the area. These include but not limited to existence of large number of college and university students, anti social behaviors, diverse workers, and transition of a number of people crossing the town. Hence, the study discusses about the most affected part of the population who are HIV positive women under PMTCT utilization.

1.2. Statement of the Problem

There are various researches conducted in the area of prevention from mother to child transmission of HIV by different researchers at different times and places in Ethiopia. Anteneh & Habtamu (2013), and Solome & Telahun (2005), conducted researches in the area of awareness and knowledge related to PMTCT. Anteneh & Habtamu (2013) concerned on knowledge on timing of MTCT with the objective of assessing knowledge on timing of HIV among pregnant women's Antenatal care (ANC) attendants in Southern Ethiopia. This research come up with, in spite of high level of awareness on mode of transmission of HIV/AIDS, women had low level of awareness and knowledge on timing of MTCT of HIV. Solome & Telahun (2005) did a research on the knowledge and attitude towards MTCT of HIV and its prevention, but they focused on the Post-natal care among post-natal mothers in Tikur Anbessa and Zewditu Hospitals. The researchers identified that majority of mothers had positive attitude towards VCT and knowledgeable on MTCT and its protective means but less likely on infant feeding practices.

The other group of researchers namely Haile michael (2006), Temsigen (2008), and Zenebe (2011), emphasized on determinant factors affecting PMTCT .Haile michael (2006) said that PMTCT utilizations was affected by the health care system and community based organizations and structures at Adama Town. He tried to identify formal institutional factors and socio cultural dimensions affecting PMTCT. Likewise, Temesgen (2008) outlined that acceptance of HIV counseling and testing affected by prior HIV test, frequent ANC visit and education of mothers. Zenebe (2011) examined that residence; women's occupation, marital status, and house hold size were the main socio demographic factors that affect ANC service utilization at Ofa woreda of Wolaita Zone.

Uptake of ARV prophylaxis is still the other dimension in PMTCT service utilization. Alemnesh, Gudmund, Mitike, Marie & Morkve (2011), and Ali (2011), were interested on uptake of ARV drug and its determining factors. Alemnesh et al. (2011) worked on medication adherence and infant follow up in the PMTCT program in Addis Ababa. The researcher asserted that medication adherence was found to be at progressive decline across the prenatal period. And, also follow up for HIV exposed infants seem not to be organized and is inconsistent. Similarly, Ali (2011) found out that the uptake of ARV prophylaxis was very low and only small proportion of women started ART at South Wollo.

The researchers who focused on the level of male involvement in the PMTCT service were Abenet (2007), and Fisaha & Yemane (2014). Abenet (2007) focused on assessment of male partners influence on pregnant women towards voluntary HIV testing and support on PMTCT in hospitals of Addis Ababa through cross sectional survey. He discussed that the number of male partners who were present to PMTCT centers along with women were very minimal. The decision of the pregnant on HIV testing was influenced by male partners, being married, and need of social and financial support. Fisaha & Yemane (2014) who examined the level of male involvement through cross sectional study among 473 pregnant women in Mekelle Town said that only 20% of the pregnant women were accompanied by their male partners.

Infant feeding practice is another concern for scholars engaged in PMTCT area. Yetayesh & Jemal (2009) and Digsu & Berihun (2013) have dealt with this issue. Yetayesh & Jemal (2009) in their work of infant feeding practice of HIV positive mothers and its determinants in selected health institutions in Addis Ababa, showed that only less than half of positive mothers practiced exclusive breast feeding up to six months that decreases the rate of infection. Digsu & Berihun (2013) did a research on MTCT of HIV and its predictors among

HIV-exposed infants at a PMTCT clinic in Gondar Referral Hospital. The study reveals that there was high risk of MTCT of HIV among exposed infants on follow up with PMTCT clinic. Late enrollment to the exposed infants follow up, rural residence, home delivery, absence of intervention and mixed infant feeding were significantly associated with MTCT.

Except few, most of these researches in the area of PMTCT were targeted at women attendants of antenatal care. Hence, additional explanation is required that focus on the women/mothers attendants of post-natal care. These researches also gave little attention for community engagement in PMTCT services. They mainly base their analysis on institutional PMTCT service delivery and its related factors. However, there are few researches that examined the role of community based organizations in mitigating the impact of HIV/AIDS.

Mohammed (2007) proved that Iddirs in home and community based care program have been contributing to improve the life of bed ridden patients at Adama Town. Bogale (2011) also conducted a research on willingness to home based HIV counseling and testing against the impact of HIV/AIDS in Amhara Region. He argued that people were very much interested to get VCT services at community and household level. The aforementioned community related researches tried to uncover ways of combating HIV/AIDS issues through the involvement of different parts of the community. However, they did not examine the service in the context of mother to child transmission of HIV/AIDS.

Hence, this research explored and described the roles and related activities of community engagement with particular reference to Mother Support Group in PMTCT services at Ambo Hospital.

1.3. Research Question

This study was intended to address the following research questions.

1. What are the roles and related activities of Mother Support Group in PMTCT services at Ambo Hospital?
2. What are the types of PMTCT services provided by Mother Support Group at Ambo Hospital?
3. What are the benefits of PMTCT services provided by Mother Support Group at Ambo Hospital?
4. What is the contribution of Mother Support Group in PMTCT services at Ambo Hospital?
5. What are the challenges of MSG in providing PMTCT services at Ambo Hospital?

1.4. Objective of the Study

1.4.1. General Objective

The general objective of the study is to explore and describe the role and related activities of Mother Support Group in PMTCT services at Ambo Hospital.

1.4.2. Specific Objectives

The specific objectives of the study stated as follows.

1. To illuminate major types of PMTCT services provided by Mother Support Group at Ambo Hospital
2. To identify benefits of PMTCT services rendered by Mother Support Group at Ambo Hospital as perceived by service users
3. To examine the contribution of Mother Support Group in PMTCT services at Ambo Hospital
4. To find out challenges of Mother Support Group in providing PMTCT services at Ambo Hospital

1.5. Rationale of the Study

HIV/AIDS is the main hindering factor affecting the well being of mothers and children. According to Federal MOH (2012) report, in Ethiopia MTCT of HIV was the main way that transmits HIV to children that accounts for 90% children related morbidity and mortality. Without necessary actions, the problem goes to complicating the health status, and affects the psycho- social well being of mothers and children. Thus, enhancing the prevention mechanisms with evidence based intervention is the pre-requisite to save the lives of mothers and their children.

Various reasons necessitate conducting the research in this area. Primarily, conducting study on the role of Mother Support Group in PMTCT service in the modern health care system is beneficial to evaluate community's' role parallel to health professionals. The role of clinicians has been predominantly discussed in preventing MTCT of HIV. Additional investigation is needed to identify the role of MSG that substantiates the work of health professionals. The study will provide understanding on how experience exchange and psycho- social support among HIV positive women would impact PMTCT utilization.

Exploring the role of HIV positive peer group is useful to address the challenges encountered in the process of implementing PMTCT services. According to Taye, Lecerof & Jeppsson (2011) the strategic challenges of PMTCT program in Ethiopia with particular focus on the Oromia region proved that, 47% pregnant women who attended ANC were tested for HIV. Although 65% HIV positive women left out without intervention, 71% babies born to HIV positive mothers did not access prophylactic medicine. The problem is aggravated by less ART adherence, missed from follow up of PMTCT services, and male partner influence. These challenges were the product of multiple acts of environmental, social, economic, cultural and

structural barriers. This problem will create complicated and intergenerational health crises.

Hence, assessing and discussing issues related with role of Mother Support Group in filling this gap is a paramount step to provide holistic medical and psycho- social services.

1.6. Limitation of the Study

The primary limitation is the in-ability of the researcher to translate the transcribed data using professional linguistic experts from Afan Oromo to English. Second, failure to undertake debriefing session with experts, professionals and collogues who have experiences in the area there by editing the data. Thirdly, unable to transcribe all interview responses could affect the data quality since two of the recorded data were corrupted.

Chapter Two

2. Literature Review

2.1. Introduction

The literature review part tried to assess and synthesis various researcher findings related to PMTCT services. It helped us to explore what have been done so far in the area of PMTC and what will be done to fill the knowledge gap. These reviews mainly focused on medical concern of PMTCT and few about community's activities in PMTCT. Some of the topics included were prevalence of HIV, determinant factors of PMTCT, knowledge on PMTC, uptake of ART, infant feeding practice, and community engagement on PMTCT.

2.2. Prevalence of HIV among Pregnant Women and Exposed Infants

Ante-natal care data is prerequisite to know the prevalence of MTCT. In Sub-Saharan Africa, surveillance of women attending ANC is often used to measure prevalence and monitor trends in HIV infection. In many countries across the world women are tested for HIV during pregnancy. However, ANC data do not reflect HIV prevalence levels in non pregnant women. According to (Henok, 2011), rates of HIV testing of pregnant women in Ethiopia within context of PMTCT reached 16% in 2009. In 2010 the prevalence of HIV among women between ages of 15-24 was 3.5%. Through opt out strategy in Addis Ababa the proportion of women who received HIV counseling and testing among new ANC attendees increased from 50.7% in 2007 to 84.5% in 2009.

Still Sub Saharan Africa has a number of people with HIV/AIDS as compared to other regions of the world. For example, Kalembo et al. (2012) said that UNAIDS estimated that by 2009, 33.3 million people globally were living with HIV of which; 22.5 million were in Sub Saharan Africa. Among these 60% of them were women at reproductive age. Each year

approximately 1.4 million women living with HIV become pregnant. Among ANC clients in Sub Saharan, the proportion of women living with HIV ranges from 5% to as high as 30%.

According to UNAIDS (2013) the number of women newly infected with HIV declined by 44% from 2009 to 2012 in Ghana, by 23% in Uganda, and by 21% in South Africa. Kalembo et al. (2012) said that by the end of 2009, six countries in Sub Saharan Africa provided HIV tests to less than one third of all pregnant women. These were Nigeria (13%), Democratic Republic of Congo (9%), Ethiopia (16%), Chad (6%), Angola (26%), and Sudan (3%). In these countries, considerably greater investments are needed to increase HIV testing and counseling among pregnant women in order to effectively prevent MTCT. Four countries reported to have provided HIV testing and counseling to more than 80% of pregnant women. These were South Africa (over 95%), Zambia (over 95%), Botswana (93%), and Namibia (88%).

FMOH (2012) data shows an overall prevalence of HIV among the general population was found to be 1.5%. HIV prevalence among pregnant women aged 15-24 was declined from 5.6 % in 2005 to 3.5% in 2007 and to 2.6% in 2009. Henok (2011) argued that in the last five years (2006- 2010) the prevalence of HIV among ANC attendants in the year of 2006-2010 was in declining trend in Kasanchis Health Center. The annual prevalence rates were found to be 11.15%, 7.88%, 8.66%, 6.70%, and 5.69% in 2006, 2007, 2008, 2009, and 2010, respectively. The pattern of HIV prevalence among pregnant women who visited the ANC indicates that high prevalence rates were observed in the age of 20-29, 30-39, while least prevalence observed in the age of 40-49.

UNAIDS (2013) on global report of HIV/AIDS indicates that as a result of scaled up HIV prevention services, the annual number of newly infected children in 2012 was 260, 000 in low and middle income countries, which was 35% lower than in 2009. In addition, from 2001-2012,

there was a 52% decline in new HIV infection among children. For instance, in Ghana, the risk that a women living with HIV will transmit the virus to her children has declined from 31% in 2009 to 9% in 2012. Furthermore, by 2012 children who were receiving ARV less than 15 years of age was 647,000.

According to Digsu & Berihun (2013) the risk of MTCT was high in that out of 509 infant records at Gondar Referral Hospital, a total of 51 (10%) infants were infected with HIV.

WHO (2010) asserted that the trend of PMTCT with HIV testing among pregnant women is increasing with the expansion of provider initiated testing and counseling in ANC clinics, delivery. For instance, in 2008 an estimated 21% of pregnant women giving birth in low and middle income countries were tested for HIV up from 15% in 2007. According to Tiruneh (2007) trends in HIV testes among ANC attendees in Addis Ababa were increasing mainly because of an opt-out strategy.

WHO (2010) said that despite recent progress much work remains to be done. In 2008 an estimated 430,000 children were newly infected with HIV, nearly all of them through MTCT. Moreover, globally HIV is still the leading cause of mortality among women of reproductive age. Even in countries that are rapidly scaling up PMTCT services, the major challenge is to provide more effective ARV interventions.

Kalembo et al. (2012) that UNAIDS report in 2009 2.5 children globally were living with HIV of which 1.8 million were from Sub Saharan Africa. About a third of infants in South Africa were reached with ARV prophylaxis (31% in 2008 and 35% in 2009). In Eastern and Southern Africa, 45% of infants received ARV in 2009. The coverage was 70% among children in Swaziland, Namibia, and Botswana. UNAIDS (2013) said that it is necessary to deal with the

unmet need of PMTC, family planning, early infant diagnosis, and treatment, and bringing innovative intervention strategies in the area of PMTCT.

2.3. Determinant Factors Affecting PMTCT Utilization

Multiple factors are contributing for PMTCT utilization that determines its uptake. In Sub Kalembo et al. (2012) contended that Saharan Africa in care and support for health related problems the community informally provides services at their surrounding rather than went for formal health institutions. This shows that cultural factors, social and religious norms, and the community's shared norms significantly affects health or PMTCT service utilization especially that may prohibit women in attending the services. In other way, the health care system that reflected on mistreatment of clients, lack of adequate ANC space or unit, shortage of health workers, lack of professional quality in pre post test session counseling also affects PMTCT service utilization.

In Ethiopia, there are similar and related factors of personal, community, environmental, socio economic, cultural, and policy level factors contributed for the performance PMTCT service utilization. For instance, Hailemichael (2006) argued that MTCT prevention is determined by coverage of health education, community awareness on PMTCT, counseling methodology, socio economic deprivation of women, fear of victimization from husband, family, neighbor, and community, maltreatment from few health professionals at health facility, home based delivery by untrained traditional birth attendants and lack of community involvement,

Zenebe (2011) identified socio demographic factors affecting ANC service utilization He said that residential variation in which 74% of urban women utilized the service while 72% of rural women did not attend the service significantly influences PMTCT service utilization. Other factors like lack of appropriate knowledge about benefits of PMTCT, absence of health problem

during pregnancy, household size, occupation, marital status, and intensity of pregnancy, were also important socio demographic factors affecting ANC service utilization. Basha (2008) asserted that geographical, financial inaccessibility, low access to information, health system, norms, household income, poor infrastructure, quality of health service, absence of strong health management information system, and poor organizational quality were determinants of the success or failure of PMTCT services.

2.4. Knowledge and Attitudes towards PMTCT

Awareness and knowledge of PMTCT is a pre requisite criterion for effective utilization of services and promotion of the maternal and child health. Knowledge of PMTCT is also a gateway to HIV/AIDS treatment and has documented benefits. Different studies in Ethiopia reported that there are of knowledge on PMTCT cascade which is largely minimal. Chernet (2005) said that more than 50% of mothers had insufficient knowledge about MTCT and PMTCT. They had also unfavorable attitude towards the infant feeding options. Although pregnant and lactating mothers had the intention to proper infant feeding, majority of them practiced mixed feeding that increases the morbidity and mortality of infants. The knowledge and attitude of mothers were affected by proximity, age, counseling on infant feeding, efficacy for formula milk, and fear of stigma and discrimination.

Anteneh & Habtamu (2013) argued that even though all pregnant women were aware of HIV/AIDS, they had low awareness and knowledge on timing of MTCT. Only 60.7% were aware of the risk of MTCT, and the proportion of women who were fully knowledgeable on timing of MTCT was 11.5%. This women's knowledge on timing of MTCT were associated with maternal education, employment status, and lack of discussion with male partner. In other way, Solomie and Telahun (2005) in their report on Tikur Anbessa and Zewditu Hospital revealed that

majority of post-natal mothers (89.8) knew about MTCT and 76.8% had positive attitude towards VCT. Moreover, 64.6% knew the protective effect of ARV.

2.5. Uptake of ART

World Health Organization introduced several simplifies ARV regimens. ARV takes a lion share intervention to MTCT. UNAIDS (2013) reported that ARV coverage among pregnant women living with HIV increased from 57% in 2011 to 62% in 2012. This implies that over 900,000 pregnant women living with HIV globally received ARV prophylaxis or treatment. Four priority countries Botswana, Ghana, Namibia, and Zambia have already met the goal of providing ARV medication to 90% of pregnant women living with HIV, which was supposed to be achieved by 2015.

There are also other countries whose ARV uptake remains low. UNAIDS (2013) discussed that while many countries have made significant achievement in expanding access to ARV for PMTCT, progress has been much slower in other countries. In 2012 thirteen countries with general epidemics has achieved lower performance. Among these, Angola, Chad, Democratic Republic of Congo, Ethiopia and Nigeria, reached less than 50% of pregnant women living with HIV with ARV drug to prevent the vertical transmission of HIV to children.

In Ethiopia, the proportion of HIV positive pregnant women who received ARV drug for PMTCT remains low. This was determined by limited capacity of the health care system, limited infrastructure, low ANC coverage, and lack of information on PMTCT. Yonas (2007) argued that distance from hospital, too centralized hospital based PMTCT program could contributed for the low ARV uptake. Alemnesh, etal. (2011) further argued that even though progressive improvements have been made in the coverage and quality of PMTCT services, the national coverage remains persistently low. For example in 2010 only 53% of known HIV- positive

mothers and 48% of known HIV-exposed infants have received ARV prophylaxis. This shows that only 18.7% was covered of the annual planned target. This was the result of various socio cultural, health systems, and lack of basic infrastructures, that contributed to poor PMTCT up take. However, increasing mother to mother discussion, and updating knowledge of HIV positive pregnant women about MTCT can have positive impact on increasing up take of ART.

According to UNAIDS (2013), currently a highly efficacious and safe prophylaxis regimen and lifelong ART can reduce MTCT to less than 5%. However, ensuring uptake and adherence remains a challenge specially in developing world. Experiences in many countries suggested that ARV prophylaxis for MTCT alone had limited impact unless accompanied by other holistic treatment packages. Even for facilities where ARV was available still a number of pregnant women would dropout at different steps of the health care process.

2.6. Level of Male Partner Involvement in PMTCT Service

In the ANC, PMTCT or VCT pre and post session inviting couples together will brings different advantages for the success of services including for post-natal care and safe infant feeding practices. Kalembo, etal. (2012) asserted that PMTCT effectiveness in Sub Saharan Africa partly depends on involvement of male partners considering that men are decision makers in African families. However their participation is influenced by culture, lack of information, trust and communication on PMTCT, stigma and lack of confidentiality. Economic factors such as working for a long time outside of the home and provides income for family could also prohibit male involvement in PMTCT clinic along with their wife .Fisaha & Yemane (2014) said that the involvement of male partners in PMTCT may increase adherence to PMTCT and its program outcomes. It also associated with positive outcomes regarding greater use of ART, high acceptance of post-test counseling among pregnant women, increase spousal communication

about HIV and safe sex. Moreover, male partner involvement can be utilized as an entry point for the provision of additional PMTCT services such as partner testing, condom use and infant feeding, discordant couple. Abenet (2007) also said that male can provide care, psycho social and economic support for the whole family, support the pregnant women to attend hospitals, and improves follow up and adherence both for the mothers and children.

Different literatures in Ethiopia largely reported that level of male involvement in PMTCT cascade was low. For instance, Abenet (2007) discussed that the number of male partners who presented to PMTCT centers along with women were very minimal in Addis Ababa. The decision of the pregnant on HIV testing was influenced by male partners, being married, and need of social and financial support. In addition, male could influence the choice of condom use, place of delivery, and feeding of infants.

Fisaha & Yemane (2014) argued that male partner's involvement in PMTCT services was low by asserting that, only 20% of pregnant mothers had been accompanied by their male partner to the ANC or PMTCT. Different factors like knowledge of HIV, maternal willingness to inform her husband, and previous history of couple found to be predictors of male involvement in PMTCT. Paradoxically, the study conducted by Endawoke, Gebeyaw, & Amanuel (2013) at Debre Markos Town revealed that there was better level male involvement in PMTCT service as opposed to low male involvement in Addis Ababa and Mekelle. The report underlined that occupational categories of male play significant role in which self employed and daily laborers were less likely to involve than government workers.

2.7. Infant Feeding Practice

Effective prevention of MTCT partly depends on safe and proper infant feeding practice. World Health Organization recommended that when replacement feeding is acceptable, feasible, affordable, sustainable, and safe, avoidance of all breast feeding by HIV infected mother's is necessary. For women who were HIV negative or unknown HIV status, exclusive breast feeding for the first six months is recommended that may protect their infants becoming infected with HIV. However, the knowledge, attitude, intention, and practice of mothers determine for proper infant feeding. Among the study conducted in Ethiopia

Meselech (2006) reported that mothers had good knowledge of HIV/AIDS but they had fair knowledge of MTCT and PMTCT. Even though they knew the availability of VCT service, they did not know the availability of infant feeding counseling. Exclusive breast feeding is rare and mixed feeding was common that predisposes the infants to malnutrition and risky for MTCT. Yetayesh & Jemal (2007) said that the practice of exclusive breast feeding was low (30.6%) in Addis Ababa. In addition, exclusive replacement feeding and mixed feeding accounts for 46.8% and 15.3% respectively. This variation of knowledge and practice of infant feeding influenced by household income, disclosure of HIV to spouse, mode of delivery, and infant illness.

2.8. Coverage and Quality of PMTCT Service

One of the core components of PMTCT service is its level of coverage and assurance of quality. Mohammed, Challi, & Belaineh (2011) provided that PMTCT service effective coverage is measured by the number of people received the service in the year using service statistics provided and corresponding to projected population needed the service in same year. Proposed measurement of PMTCT intervention would be by use of coverage indicator domains that includes availability, utilization, quality, and continuity of PMTCT service. Among countries in

the world, there is considerable variation in the coverage of PMTC. UNAIDS (2013) reported that the coverage was highest in Eastern and Central Europe, and Caribbean who succeed beyond 90% goal set, while much lower in Asia, Pacific, Middle East, and North Africa recording less than 20% achievement. Among the prioritized countries, in Ghana the coverage of PMTCT service for women living with HIV increased from 32% in 2009 to more than 90% in 2012. In other away, Ali (2011) said that many studies in high HIV prevalence setting such as, Sub-Saharan Africa suggested that PMTCT coverage was low, and experienced difficulties at each stage of PMTCT cascade. Majority of HIV positive pregnant women lack access to PMTCT services. Two third of HIV positive pregnant women do not have access to treatment to PMTCT.

In Ethiopia the coverage of PMTCT service found to be low as reported by different scholars in various regions of the country. Among these, Mohammed et al. (2011) said that PMTCT service coverage was found to be was low Jimma Zone. The overall PMTCT service coverage was 1.1%, the prevalence of positive HIV blood test among pre counseled women was 6.9%, and of all HIV positive pregnant women 61.13% were taking ARV.

Apart from service coverage considering the quality of the service provision is also essential for successful PMTCT service utilization. According to WHO (2010), quality PMTCT service provision implies that the provision of professional client centered counseling and testing services, in an easily an accessible, non threatening, non discriminating, where clients are treated equally with dignity, respect, and choices. The dimension of quality also might be attributed to technical competence, access to services, effectiveness, interpersonal relationship, continuum of services, and safety. Hussein (2008) outlined that in Addis Ababa counselor's communication skill, interpersonal relationship, gathering and giving information, coverage of topics in

counseling session, level of intensity in discussing core issues in pre and post counseling were significant factors affecting the quality of PMTCT service utilization.

2.9. Challenges of PMTCT Service

In the process of designing, planning, implementing, monitoring and evaluating the performance of PMTCT services, there are challenges encountered at any stage of the PMTCT cascade. Kalembo et al. (2012) outlined that there are a lot of challenges and obstacles to scale up PMTCT services in Sub Saharan Africa. Most of the programs focus only on medical intervention that leaves the social drives of MTCT. Low counseling uptake and low testing proportions, large proportion of home delivery, inadequate supply of test kits, lack of supplementary feeds for women who may opt for non breast feeding for their infants were also barriers of PMTCT services in Sub Saharan Africa .Krebs (2012) said that high attrition and loss to follow up, adherence problem, Poor facility delivery, infants born outside of the health care facilities appeared to be major contributing factors to lower PMTCT effectiveness in Africa. UNADS (2013) reported that currently half of all new episode of HIV transmission to children occur during the breast feeding period, when the majority of lactating mothers are not receiving ARV because of loss to follow up become a potential obstacle for infant prevention of HIV.

Despite significant investment on PMTCT, Ethiopia's PMTCT progress lags behind other sub Saharan Africans. FMOH (2012) suggested that in Ethiopia, low ANC uptake, severe human resource shortage, limited health facility, unknown ARV adherence, and poor performance on the social determinants of health indicators like illiteracy were barriers. Loss to follow up PMTCT service is a significant threat to the effectiveness of PMTCT. Only 10% of women initiating PMTCT care are retained throughout the PMTCT cascade. 80% of women were lost between ANC and 18 months infant follow up implies individuals who have dropped out of their

treatment regimens. Yonas (2007) proved that most of HIV positive mothers who were participated in PMTCT program were lost from follow up after their first exposure and post test counseling. He said that of 3418 tested for HIV in PMTCT service in Addis Ababa only 56% HIV positive pregnant women received ARV during delivery. And, only 57% of new born received ARV within 72 hours. This indicates that half of the mothers lost to follow up. This minimal performance on follow up were influenced by quality of health care during PMTCT counseling, follow up, and delivery, stigma, and discrimination.

2.10. National Responses towards Prevention of Mother to Child Transmission of HIV

The government of FDRE has been trying to reduce the spread of HIV/AIDS starting from the 1998 policy formulation on HIV/AIDS. The country also adopted the WHO/UNICEF/UNAIDS four pronged PMTCT strategies as a key entry point to HIV care for women, men, and families. In order to mitigate the effect of MTCT, MOH has developed different documents like training manual for PMTCT, PMTCT guideline, and national training manual for mothers support group.

The 2007 Guideline for prevention of HIV from mother to child transmission in Ethiopia was a revised guideline that replaces the 2001 guideline designed by FMOH in collaboration with Federal HACPCO. FMOH (2007) outlined that the main focus of the guideline was integrated opt out approaches as the most appropriate strategies for expanding national access and sustainability of PMTCT services in the country. Opt out strategy focused on recommending HIV test for any pregnant women attending ANC. The guideline also aimed at integration of PMTCT services with maternal and child health and reproductive health services at all levels. The main objectives of the PMTCT guideline include promoting primary prevention of HIV among women and men of reproductive age, reducing new child HIV infection, promoting

access to HIV and ART for HIV infected pregnant women, reducing HIV related morbidity and mortality, promoting accesses of HIV exposed infants to care, and addressing family planning issues.

The guideline has various implementation strategies that include primary prevention of HIV infection, prevention of unintended pregnancies among HIV infected women, prevention of HIV from infected women to their infant, treatment, care, and support of HIV infected women, their infant, and families, and intervention from the community through all levels of the health care system.

2.11. Community Engagement in PMTCT Services

The participation of different stake holders in health program is necessary step for effective implementation with a documented benefits. The engagement of community in PMTCT program has a dual benefits for formal health institutions and the community itself. The program is designed by considering the specific contexts and creates relationship with health professionals. UNAIDS (2012) outlined that specific community members at health program intervention participate in capacity building process, planning, implementing, and ensuring the sustainability of the program. Strong linkages between community and facility services are the foundation of an effective PMTCT program. Demand creation within community must also be linked to adequate client sensitive service delivery at health institution. The role of community particularly in communal society of Sub Saharan Africa in health program is very necessary at all stages. Mohammed (2007) asserted that the role of community has to be taken as an integral part of HIV/AIDS in continuum of care, and the issue is a developmental problem that requires the participation of different community members.

The role of community engagement in the process of PMTCT cascade is vital for its successful achievement. Kaai, Back, Geibel, Omondi, Ulo, Muthumbi, & Nkatha (2007) argued that the medical recommendations of PMTCT programs often difficult for women to implement as they are greatly influenced by community norms, values, and beliefs. A women's decision to participate fully in PMTCT program is influenced by the opinions of her partner, family members, and community members. In addition, the participation in PMTCT service also influenced by her perceptions and fear of possible negative reactions from societal rules, and laws. Kaai, at al. (2007) proposed three community based interventions. These are creating and moving PMTCT clinic to near community, training of traditional birth attendant to offer psycho social support to pregnant women, and training of HIV positive women as PMTCT prompters or peer counselors.

2.12. Mothers Support Groups in PMTCT Service

Various research reports proved that uptake of PMTCT remains low. Viadro et al.(2008) contended that uptake of PMTCT service is often low because of factors such as HIV related stigma, limited use of ANC and PNC services, uneven quality of care in ANC and obstetric settings, and insufficient male involvement. Hence, creative strategies are needed to ensure that HIV positive mothers receive psycho social and emotional support thereby able search the health care system to access, ANC and PMTCT services. In developing and implementing health or PMTCT program various members and groups of the community can participate through different ways. Mothers support group is one of these ways developed to participate groups of mothers in PMTCT services in Ethiopia. It is a peer type of program established by HIV positive in sharing experiences among them.

According to Long (2010) have played a key role in creating awareness, and building confidence amongst HIV positive women. There was evidence that MSGs provided safe environment in which women are able to learn more to help them take the difficult decisions. In spite of MSG women become a place in which women discuss their personal and family concerns with peer in confidence manner, the intervention brought limited impact on infant and young feeding. Besser, Falk, and Smalley (2007) elaborated that MSG had positive effect on efforts to prevent the transmission of HIV from pregnant women and post partum mothers to their babies. MSG program had significant impact on key indicators of PMTCT like increasing the number of women who received ART, level of knowledge towards PMTCT improved, and increasing of the number of women who discussed about PMTCT and family planning with partner and family members.

In Ethiopia Mothers Support Group was established by Intra Health and the program was intended to address the special needs of pregnant women and post partum women living with HIV and caring for new babies. Daniel, Senait, Bella, & Degu (2010) said that mothers support group established to address low PMTCT service uptake and loss to follow up. It is a peer mentoring program to provide educational, emotional and social support services to mothers during and after pregnancy. It helps and empowers HIV positive women or mothers and their partners to make decision about their reproductive health. It also makes women to feel safe with and respected by their peers. The peer model also lessens the distance interactive with clinicians. USAID (2009) says that the mothers support group empowers women who test positive by providing psycho social support, promoting women economic independence, reducing self stigma and discrimination, and promoting disclosure in family and community. It integrated with clinical workers and helps to reduce their work load. This program has different components

such as mothers to mothers, mothers to community, income generating activity, adherence, empowerment, and prevention. Generally, it is intended to address PMTCT gaps at health facility level and at community level.

The main objectives MSG include to enhance access and use of PMTCT services by building strong linkages between health care providers and peer support networks, to ensure adherence to ARV among pregnant and post partum women, to lessen HIV related stigma and discrimination, to increase HIV positive mothers understanding of infant feeding options, to reduce the incidence of new sexuality transmitted infections and HIV among girls and women, to increase acceptance and use of family planning among post partum women, to build linkages with other programs that strengthen women's health and decision making like nutritional support, income generating activity, and skill training. Different strategies were used to support the implementation process like peer to peer contact, and health care based peer support group. In addition, the trained mothers or mentor mothers involve in the community in order to provide prevention education, and refer pregnant women for ANC and PMTCT services.

These literatures provided us to view the issue of PMTCT from various perspectives. In one hand the existing prevalence of HIV among women and exposed infants, and in sufficient knowledge in the area guides us additional explanation and intervention is needed to safe and maintain the well being of mothers and children. In others hand, in order to increase the required outcome still community's participation has to be scaled up. This is possible through assessing the issue of HIV positive women and compiling their experiences by making the group the primary actor of PMTCT services.

Chapter Three

3. Research Methodology

3.1. Researcher's Philosophical Stance

Scholars held different theoretical orientation towards reality in discovering and explaining the natural and social world. Although there are different thoughts among scholars towards reality, there are two prominent philosophical stances towards reality. These are positivism and social constructivism. According to Krueger and Neuman positivist stance perceives social and physical reality as real and finds out there in waiting to be discovered. Reality is patterned and logically sequenced that would not been changed over time. Empirical facts exist apart from personal ideas or thought and the researcher remains neutral. Hence, scientific investigation relies on accurate and precise measurement of phenomenon outside of the individual. In addition, Abiy, Alemayehu, Daniel, Melese and Yilma (2009) said that for positivist school of thought the scientific research is restricted to observable facts and the researcher is still value free.

The social constructivist or interpretive social scientists/scholars view reality as individually constructed and differ based on specific context. For example, Kreuger and Neuman (2006) argued that for social constructivist, social reality is created with some purpose through social action and that reality is not out there to be discovered. Reality is largely what people perceive, experience, and attach meaning to it in the process of social interaction. Hence, the role of the researcher is not restricted to study external or observable behavior of people, but also to study meaningful social action. Since meanings are varied and multiple among people, it helps to see a complexity of social reality and meanings from the point of view of participants under study. As a researcher, I held the position of social constructivist views of reality. In conducting

scientific investigation about the behavior, practice and products of social interaction, it is better to explore individuals own explanations and relevant meanings. The explanation and socially constructed meanings will provide a unique insight and multiple dimensions for professional social workers. Pertaining to the topic of this study, subjective understanding is useful to address questions like how MSG is contributing to PMTCT program from the point of view of HIV positive women. Thus, it is possible to draw context specific explanations from the point view of the participants as opposed to positivism that tries to impose scholarly developed theories on individual experiences.

There is an approach of social change and community development pertaining to social constructivist perspective. According to Cox, Geisen and Green (2008) the social change and community development approach starts with the premise stated that residents continue to be involved in looking at their concerns, ideas, problems, and seeking sustainable solutions. Any lasting change will come from themselves and their community. This thought provided that we need to move from research to social change and community development by advocating on behalf of the marginalized group of people. The research activity needs to continuously influence social policy and social development. Hence, the findings of the study can be used to advocate social change and influence policies and programs on maternal and child health. Knowledge developed through listening voices of HIV positive women would be disseminated and makes influence.

3.2. Research Design

The study employed descriptive case study. This method was appropriate to address the purpose of the study which was intended to explore and describe the role and related activities of Mother Support Group in PMTCT services. According to Yin (2004), case study is a type of

design helpful to illuminate particular situations to get a close, in depth and first hand understanding. It is useful to make direct observation and collect data in natural settings. It is possible for the researcher to collect data from multiple sources of information. In addition, it provides tools for the researcher to study complex phenomenon within their contexts. Hence, in this study in depth information was gathered to understand the role and related activities of Mother Support Group from multiple sources under the existing contexts of PMTCT services. Data were gathered from Mother Support Group, HIV positive pregnant women, post partum mothers, and health professionals. This helps to triangulate the data from different participants. The units of analysis or the cases of the study was Mother Support Groups since the purpose of the study is to know the role and activities of this group in PMTCT services, and all other sources of information were used to supplement this.

Generally, this research used qualitative type of research. This type of technique is useful to assess the different aspects of social reality and focuses on socially constructed meanings from the point of view of the people understudy. The study is a cross sectional type of research since data was gathered at one point of time.

3.3. Description of Study Area

Ambo Town is found in the West Shoa Zone of Oromia Regional State. The town is located 110 km to the West of Addis Ababa. There are different public health related problems affecting the residents and the surrounding population. According to USAID (2009), malaria, intestinal parasites, maternal mortality, tuberculosis, and HIV/AIDS were the major health problem affecting the well being of the communities in the area.

HIV/AIDS is one of the epidemics affecting the population of the town. There are various reasons that adversely contribute for HIV/AIDS problem in the area. For instance,

USAID (2009) provided that factors such as large number of college and university students, anti social behavior, migration, diverse work of long truck drivers, uniformed and construction workers, and transition of a number of people crossing the town were prominent factors contributing for HIV/AIDS problem in the town. Women of reproductive age were the main group of the population exposed to HIV/AIDS related problem in the town.

A range of health services have been given to treat various disease at Ambo Hospital. Herpessa & A.D (2008) contended that Ambo Hospital is a zonal hospital serving more than 2.5 million people coming from different areas. The hospital has been providing HIV related services such as HIV counseling and testing, Tuberculosis, ART, PMTCT, sexual transmitted disease, and opportunistic infections. A PMTCT service which is the focus of this research has been given for a long time in the hospital.

In the Oromia regional state, the coverage of VCT and ANC services for pregnant women was minimal as compared to the stated goals of PMTCT. According to Oromia Health Bureau (2014) report, the trend of pregnant women, who used HIV testing and counseling in the region, remains low. For example, in the West Shoa Zone, of 85, 684 pregnant women eligible for HIV test only 31, 986 (37%) tested in 2013. In addition, of which 11883 ANC attendants, 9269 tested for HIV and 72 (0.8%) of them found HIV positive. In the same year 159 infants were exposed for HIV in which 98 (62%) of them took ART prophylaxis. This implies that additional coordinated effort is required to control HIV transmission among children thereby provides continuum of care for mothers and their children.

3.4. Selection of Study Participants

Participants included in this study were one group Mother Support Group which had 5 members, 3 HIV positive pregnant women, 4 HIV positive post partum mothers, and 2 health

professionals. The HIV positive pregnant and post partum women were beneficiaries of PMTCT services provided by Mother Support Group. The health professionals were clinicians working in the ante-natal or maternal and child health unit the hospital.

Non probability sampling method was used to select participants of the study. Among types of non probability sampling, purposive sampling technique was employed to select participants of Mother Support Group in which all members of the case was included in the study. Purposive sampling was also preferred to select the HIV positive pregnant and post partum women. Moreover, the HIV positive pregnant and post partum women were communicated through the help of Mother Support Group in getting a person who can better to provide information to others. Participants of HIV positive pregnant women and post partum mothers who fulfill the following criteria were eligible to be participants of the research.

- ✓ HIV positive pregnant women with six months or more of pregnancy period
- ✓ HIV positive pregnant women who can communicate and provide information in better way
- ✓ HIV positive post partum mothers who are found at one and half year or more of post child delivery period and proved their children HIV status as being negative
- ✓ HIV positive post partum mothers who are better to communicate and tell their experiences to others

Purposive sampling method was used to select health professionals. In addition, knowing the background of establishment of MSG, having 3 or more experiences in PMTCT services and currently working at Anti natal or maternal and child health unit were prerequisite to participate on interview.

Generally, in this case study a total of 14 participants were involved. These were five members of Mother Support Group, three HIV positive pregnant women, four HIV positive post partum mothers, and two clinicians.

3.5. Tools Development

The data collection tools were adopted from evaluation tool of USAID Ethiopia that designed to evaluate the Mother Support group strategy in PMTCT activities in Ethiopia in 2009. The characteristics of the tool had six main evaluation questions that include program management, service delivery, supportive environment for PMTCT clients and their households, capacity building and sustainability, activities of mother support group, and lesson learnt.

3.6. Tools of Data Collection

3.6.1. Semi structured in Depth Interview

Semi structured in depth interview was used to collect data from members of Mother Support Group, HIV positive pregnant women, and HIV positive post partum mothers. This tool was useful to critically explore and know about the role and related activities of Mother Support Group in PMTCT services from the point view of beneficiaries. It helped me to understand the emotional feelings of participants and their responses towards the contribution of the service. Moreover, it provides insight to analyze benefits and possible obstacles of PMTCT service utilization.

The interviews were guided by the semi structured interview guideline developed using Afan Oromo version. It had five different main questions. The main headings were rationale of establishing of Mother Support Group, major types of services, benefits of the services, organizational support, and challenges and possible recommendations of the services. The in-depth interviews were conducted at safe place in the office of MSG. This was useful in

protecting the confidentiality of HIV positive women and helps to give information without getting any stressful situation. Based on their consent tape recorder was used during interview that took a maximum of one and half hour. The recording process includes their reaction towards the question and their emotional expression. Any event that motivates or make calm during interview had been taken in to account in hand written notes. Finally, additional answers taken in to account that frame the findings of the study.

3.6.2. Key Informant Interview

Key informant interview was applied for health professionals rendering PMTCT related services in the institution. This type of interview provided a range of additional and substantive information. Health professionals were experienced in the HIV and PMTCT service delivery prior to community or Mother Support Group intervention. It was possible to understand their professional perception and role sharing with others. They were helpful to tell the type of psycho-social services of the Mother Support Groups and identify its benefits and challenges. Interview questions were prepared separately for health professionals. This had three main interview questions that include objective of establishing MSG, types of services rendered by MSG, and contribution of services provided by MSG. During interview tape recorder was used in same manner to other participants. The interview took a maximum of one hour.

3.6.3. Observation

Direct observation was conducted before and during the interview. In case study it is essential to observe and understand the contextual situations in the bounded system of the health care setting. An open observation guide was developed that has different issues. This created possibilities in observing the types of clients that used the PMTCT services, types of services

provided by Mother Support Group, and the working structure of Mother Support Group with health professionals.

3.7. Methods of Data Analysis

In the process of analyzing, primarily the data which was gathered from 14 participants through interview were transcribed in written form. After that, the researcher translated from the Afan Oromo language to English. The researcher examined the transcribed and translated data that included in-depth interview and key informant interview. Codes had been given based on participant answers, ideas, and meanings in relation to in-depth interview guide and key informant interview questions. Then, meaningful codes were organized together there by patterns were created. Answers and phrases categorized based on in-depth interview and sub thematic areas were identified based on probing questions. Finally, the identified themes were examined against the stated research questions and research objectives. The final themes were developed through comparing initially stated propositions against the research findings.

3.8. Enhancing Rigor

In conducting qualitative research considering the quality of data is a very essential step of the research. Kshenton (2004) explained that ensuring the trustworthiness of qualitative data is one of the corner issues for scholars conducting such type of researches. This study used various mechanisms to enhance the trustworthiness of the data. First, the researcher's familiarity with the culture and contexts of the study area was helpful to supplement in examining of participants' answers in their setting. Second, before the data were collected engaging and building a rapport with participants was considered. This was done parallel to the observation. This contributed to increase trustworthiness between the people under study.

Thirdly, the rigor of the data was ensured through triangulation. This was done by collecting data from different sources. The evidences collected from participants of Mother Support Group were cross checked from answers given by HIV positive pregnant women, HIV positive post partum mothers, and health professionals working in the area. Moreover, the in-depth interview guide prepared for MSG and HIV positive pregnant and post partum women were similar in different ways. This helped to triangulate interview responses from different participants. Moreover, observation was used to increase the quality of the data in the existing PMTCT service context.

3.9. Ethical Consideration

The research was conducted according to the guidelines of ethical standards of the Social Work profession. Ethical consideration was started with letter of approval from the School of Social Work. Second, informed consent was prepared that invited the willingness of the participants to participate in the interviews and to be recorded. All of the participants were signed as to show their consent in participating in interview session. However, two of them were not interested to be recorded. Thirdly, options were given for the participants not to answering questions that are not comfortable to them, and to leave the interview session whenever they need during interview. Fourthly, in keeping their confidentiality, pseudo names were used. To whom the research report would be explained for the participants. Fifthly, the potential benefits and risks of the research was stated and communicated to the participants. At the end of interview session is completed 50 birr were paid as incentive mechanism for participants of mother support group to compensate the time used for interview.

Chapter Four

4. Findings of the Study

4.1. Background of the Participants

No.	Pseudo Name	Type of Participants	Level of Education in Grade	Occupation	Marital Status	Year of Service	Family Members
1	Sifan	Mother Support Group	9	Working in the MSG	Widowed	6	3
2	Firehiwot		9		Married	5	5
3	Bontu		7		Married	6	6
4	Sara		10		Married	5	7
5	Alemitu		10		Married	6	6
6	Zahara	HIV positive pregnant women	Illiterate	Petty trade	Married		4
7	Lelise		Illiterate	Daily laborer	Married		4
8	Tsige		7	Petty trade	Married		3
9	Tarike	HIV positive post-natal mothers	9	unemployed	Married		4
10	Ayantu		Illiterate	Petty trade	Divorced		3
11	Netsanet		8	unemployed	Married		3
12	Keneni		Diploma	Petty trade	Married		4
13	Hana	Health professionals	Diploma	Clinical Nurse at ANC unit		6	
14	Soreti		Diploma	Clinical Nurse at ANC unit		6	

Table 1: Background of Participants

In this study a total of 14 participants were involved. These include five members of Mother Support Group, three HIV positive pregnant women, four HIV positive mothers (post-natal), and two health professionals. HIV positive pregnant women and post partum mothers had

been using the services provided by MSG. The highest educational level for members of Mother Support Group is found to be secondary school. Except one of the participants, who lost her husband, the rest were married and have three to six family members. Three of the participants have been serving in the Mother Support Group for the last six years. In addition, two of them have been serving for the last five years. HIV positive pregnant women participants had been found at their six months or more of pregnancy period. Moreover, all of them had no or little educational background, and engaging in petty trade and daily laborer. When we see their familial situation, they do have three to four family members.

The HIV positive post-natal mothers were found at one and half year of post partum period. They led three to four family members. Except one who had diploma the rest were at primary educational level. Except two of them who were retailers, they had no paid job. The health professionals were clinical nurses who had been working in the ante-natal care unit or maternal and child health unit for six years.

4.2. Establishment of Mother Support Group

Mother Support Group at Ambo Hospital was established by HIV positive mothers who delivered HIV free children through proper follow up of PMTCT. It was established at the end of the year of 2007. This group was primarily initiated by nurses to share their lived experiences to other similar peers. It is a type of intervention provided for HIV positive pregnant women by sharing their experiences of preventing HIV infection to the new born. Hana, described, "Health professionals may not understand the psycho social situation of HIV positive pregnant women. We need a person who feels about the pain, and share experiences of the syndrome. This decreases the burden of health professionals."

In collaboration with the organization named International Center for AIDS Care and Treatment Programs (ICAP), HIV/AIDS and PMTCT training were prepared for the selected HIV positive mothers in 2007. HIV positive women, who had HIV negative children at facility based delivery, were repeatedly contacted and communicated with nurses to attend the training. The selected mothers were trained to provide mass education. This creates an opportunity for others to save their children. Sifan explained,

I was getting treatment during pregnancy after I was referred from health center. There was one nurse who was very much committed to help me. She taught me on how to prevent HIV transmission to my child. Since then I had been following antenatal care services. Finally, I gave birth at the hospital. After one and half year, the laboratory examination result proved that my child is being HIV negative status, free of HIV status. Hence, the nurse invited me with other similar peers to share our experiences. In 2007 they linked us with the organization called ICAP that trained and employed us. The training enhanced our awareness, knowledge, and skill related to PMTCT, and how we integrate and work with health professionals. In the commencement of the program we started to give mass education pregnant on HIV/AIDS in the hospital. Through time our work focusing on HIV positive pregnant women.

In some cases, HIV positive people initially become advocators and counselors for HIV positive person at community level. The early identification of HIV status and committing to serve others enable them to provide awareness creation and care services through home based and school intervention. Through time they started to work at institutional level to help HIV positive mothers. Sara said, “After I knew my HIV status, I began to worry about others ... I started my journey through providing home based care and support services, and school HIV awareness creation. Lastly, I become member of Mother Support Group to help HIV positive women in the hospital.”

4.3. Mother Support Group Services

This section discusses about the various services delivered by MSG. The service of MSG started from early acceptance and counseling of HIV positive pregnant women at ANC unit. It

continued through provision of education on PMTCT related issues. The services also practiced through helping mothers at delivery room and providing services at home based care.

4.3.1. Treating New Comers at ANC Unit

Mother Support Group services began with treating new comers of HIV positive pregnant women at ANC unit. One of the members of MSG provided service at ANC unit in taking care of the referred women from ANC unit. But, this is not possible without confirming the willingness of the HIV positive pregnant women. The treatment started with self introduction and continued with provision of counseling on history of infection, its treatment methods, and prevention of HIV to new born. Firehiwot enlightened,

Primarily we introduced ourselves to the new comers. Then we tell them who we are and the objective of the group. This followed by explanation of our history. All these activities are done by keeping the confidentiality. Of the information provided to the new comers, counseling is given on how to properly follow up the health status of mothers before giving birth, and how to deliver a child with HIV negative status. We tell them about the benefits of testing HIV at early stage and benefits of starting ART.

The involvement of MSG creates enabling environment for HIV positive women in improving their health status. Those women who have been treated by the group become happy when they get counseling, advice, and true story in free and transparent manner. HIV positive women do have concerns of early pregnancy, partner disclosure, family influence, and fear of stigma. They hardly discuss about HIV status and pregnancy with friends and family members. The existence of similar peer made them to think and talk about the issue in stress free manner. Zahara asserted, “They approached me friendly and with affection in the first contact. I fear to talk and ask people in other unit like voluntary counseling and testing (VCT). But, this group enables me to talk freely and ask what I need.”

4.3.2. Providing Regular Education on PMTCT

In order to increase the awareness, knowledge and skill of PMTCT regular education or a form of training has been given by MSG. The education has two sessions. The first one is the education prepared for HIV positive pregnant women. This takes place once in a week. The second one is given for HIV positive mothers who already delivered their child through proper ANC and PNC. Post partum mothers attend the training twice a week. This education takes place through arranging coffee ceremony. Sifan explained,

We educate HIV positive mothers on how to prevent her child from HIV transmission, how to implement breast feeding of six months without mixing other foods, the importance of nutrition and balanced diet, how to maintain maternal and child hygiene, ... how to keep environmental sanitation. ...Advice is given on ARV, family planning, and ways of preventing sexually transmitted disease. The education is given on the regular basis through participating in the coffee ceremony program that takes place three days per week.

Based on my observation, the education session at coffee ceremony program was very much participatory and full of debate. Only one member taught about the specific topic using the training manual. Other members arranged the coffee ceremony. Then the session continued interactively by further clarifying the points that are not clear. This group interaction was attractive, friendly, and sympathetic. Sifan said, “In the coffee ceremony session people teach and learn at the same time. Participants exchange ideas and argue with providing their own experiences.”

The education program often helped group members to explore cultural and habitual issues that can affect maternal and child health. The education session touches specific topics surrounding PMTCT. It went beyond telling the general knowledge around PMTCT. The impacts of habitual actions related to birth and its solution is also discussed. Practical experiences are shared among the group in getting lesson from fault during sexual contact and

breast feeding. To enhance the well being of children and mothers technical advice is given on drug timing and supplementary foods. Zahara illuminated,

From VCT/ANC unit we prescribed medication with short counseling. However, MSG provides us with deep counseling on specific issue. They taught us about condom use, various problems of traditional birth attendants, and importance of delivering at the hospital, how to take drug for children, how to start vaccination at 45 day of post delivery, side effects of habitual infant feeding, types of foods given for young child, and how to manage other infections. The coffee ceremony is supported by experience sharing with similar peers. I am eager to attend the coffee ceremony program ... since I get something new and mental satisfaction too.

4.3.3. Helping Pregnant Women during Delivery

Helping pregnant women during delivery is the other essential service given by MSG. HIV positive pregnant women need additional help and care during delivery. However, they faced different obstacles in gaining appropriate facilities at the health setting. This comes as results of unorganized services given at different HIV/AIDS unit. This exposed them for further health related problems. Bontu said,

Prior to the establishment of Mother Support Group HIV positive pregnant women suffered during delivery. This was because of disorganized services from ANC and ART unit. During delivery she was obliged to find out her record from ANC unit. After delivery she attends at ART unit. These processes exposed for higher bleeding that reduces the level of CD4 cell. In addition, she might have no accompanying either family members or partner. We arrange all prerequisite for birth for women who follow ANC. All necessary services are given at delivery room including ART. This helps in saving maternal and child life.

The existence of MSG simplifies the work of nurses related to HIV/AIDS services thereby contributing to benefits of maternal and child health. Keneni, who follows PNC proved, “When I delivered my child here at Ambo Hospital, they provided evidences and records of my health status. It helps them to provide HIV/AIDS related medication within 24 hours for the new born and the mothers.”

The involvement of MSG during delivery was appreciated by nurses who had been working at ANC unit. They explained the role of MSG as additional human power in addressing the various dimensions of maternal and child health. The primary acceptance, counseling and recording of HIV positive pregnant women during ANC visit will influence the probability of MTCT during child birth. Hana outlined,

The work of MSG is not only reflected by accepting and counseling of HIV positive pregnant women. The group really follows whether the women are found at proper ANC follow up until the day of delivery. They have all women's records of vital sciences and the level of CD4 cell. During delivery they brought up the necessary information. It helps us to provide quality of services within short period of time at delivery room. MSG also provides care for a child and mother at delivery room that protect the transmission of HIV to other family members. They teach the mothers about infant feeding practice that decrease the likelihood of MTCT. All these things could shorten the referral process from ANC and ART unit.

4.3.4. Managing Attrition

Members of Mother Support Group were well experienced in managing lost to follow up from ante-natal and post-natal care. This problem was managed by MSG by using various methods that help to keep up relation with pregnant and post partum mothers. MSG might have gone pregnant women and explores the reason of missing ANC and PNC. They came up with possible solutions. Moreover, MSG follows ART adherence with providing essential advice. The efforts of MSG in managing missing from PMTCT services is a base in providing continuum of care and treatment for HIV positive women. Hana described, "MSG is better to register, advice and follow up of HIV positive women along PMTCT services. They gave services from pregnancy to post delivery including home visit which can't be done by health professionals."

MSG can ensure adherence of mothers who lost from the regular coffee ceremony program. Some of HIV positive mothers might miss their follow up after delivering their child at health setting. They could not have awareness and knowledge around PMTCT since they were

not found at proper follow up of PMTCT education program. This increases the probability of MTCT during breast feeding. Sara clarified,

We follow HIV positive mothers who had been attending ANC visits and delivered a child in the hospital. After some months they are expected to attend the coffee ceremony program twice a week. This enables them to get additional skills and knowledge of PMTCT after child delivery. However, we take actions if any mothers dropout from the program. We find out the reasons of missing follow up. As a result of issues related with HIV and sexual and reproductive health their might be family conflict, isolation, economic problem and partner influence. Hence, we try to manage family conflict, educate partners thereby avoid divorce.

The service given by MSG is seen as a holistic treatment. They help HIV positive women during pregnancy, assist her during delivery, and provide support after delivery. The follow up continues through re examining the progress of the person well being including approving HIV status of the child. Soreti outlined,

The approach of establishing MSG or peer group is an essential strategy to provide a full fledged ANC and PNC services for HIV positive mothers because of two reasons. First, it encourages early initiation and intervention of HIV/AIDS counseling and testing. Secondly, it is useful to provide sustainable services on PMTCT since the follow up ends up until the person brings the required changes.

4.3.5. Helping Lactating Mothers through Home Based Services

HIV positive lactating mothers have been getting households support, educational and counseling services from their peer members of MSG. Since post partum mothers stay in their home for some months they need home based PMCTC counseling. It strengthens the prevention of MTCT that comes as a result of lacking care at home setting. Tarike clarified, “When I delivered my child, Members of MSG provided me supports at my home. They taught me on infant and young feeding practice, personal hygiene, how I care for others, and how I practice safe sex.”

Mother Support Group has been contributing in fighting against stigma and discrimination. The problem of stigma and discrimination can create various problems in the life

of the person. It was worsen by low level of awareness and social services. The isolation and stigma of the people needs critical intervention at family and community level. Alemitu described,

During early times people were isolate HIV positive person and the person life become complicated that induced them to despair. Some of them become mentally ill and others attempted suicide. There were no necessary services related to awareness about HIV/AIDS. I was selected to attend PMTCT training. In that I got knowledge and skill on how to maintain maternal and child health, how to fight stigma and discrimination, and how to disclose HIV status at family and community level. After I came back to the hospital I educated the people in the hospital setting.

Cultural barriers affect the involvement of male at prevention of MTCT. This situation has been considered by MSG for further intervention. HIV positive woman face difficulty in disclosing their status to their partner. They fear the ridiculous and isolation of family members. Hana described, “The great obstacle in the process of PMTCT is difficulty of partner disclosure as a result of fear of stigma, and male influence. Mother Support Group empowers women to disclose their HIV status.’’

Visiting the houses of HIV positive mothers may lead to stigma and discrimination from the part of family members, neighborhood, and community. However, techniques used by MSG during home visits replies the reverse. Their intervention is supported by assessing the situation of family members and neighbors. It helps them to identify possible obstacles that trigger discrimination. Bontu described,

When we visit the home of HIV positive mothers after delivery, we went anonymously like her friends or relatives. Then after, we proved whether family members and neighbors were aware of the issue. Based on the environmental situations we openly discusses about HIV/AIDS and PMTCT issues with family members and neighbors. People would change their attitude thereby contribute for reduction of stigma and discrimination. There are women who disclosed their status on such events and started to get our services. Social relationship among HIV positive women have been progressing.

4.4. Benefits of the Services

This section deals with the different benefits gained after the intervention of mothers support group in PMTCT services. The services given by MSG have brought benefits for the HIV positive mothers and their families. It is revealed through increment of awareness, knowledge and skill on PMTCT. The improvement in social relationship between HIV positive women and the community is also the other benefits of the services. Moreover, the general well being among the women and their family has brought significant change.

4.4.1. Increasing Knowledge and Skill on PMTCT

Increasing knowledge and skill on PMTCT is one of the benefits of the services of PMTCT education program by MSG. Prior to the intervention of MSG in PMTCT services at Ambo Hospital, women of HIV positive had little knowledge and skill in preventing MTCT. This in turn exposed them to a more complicated problem including having HIV positive child. After they started to use the services given by MSG, they brought change in attitude and knowledge in preventing child transmission. Zahara illustrated,

Before I used the services of MSG, I did not have enough knowledge and skill on ways of preventing mother to child transmission. As a result, I have two children with HIV positive status. Now, my knowledge and skill on how to deliver HIV free child has been improved. This could be enhanced through clarifying and discussing issues at coffee ceremony with similar peers. I knew the timing and adherence of ART drugs given for the infant and young child. Hence, the primary benefits I got is delivering HIV free child. My thought towards early treatment of HIV/AIDS through VCT is also shaped. I understood the negative impact of home based delivery by traditional birth attendants.

Existence of risky and anti social behavior can lead to the infection of HIV/AIDS. It requires knowledge and awareness to avoid the consequences of the problem. MSG has taught the effect of such behavior. They talk about its individual and family effects. The awareness and outlook of the beneficiaries towards risky and anti social behavior have been improved over time. Tsige enlightened, "I understood the consequences of risky behavior on maternal and child

health. If you have addiction of alcohols and drugs ... the level of CD4 will be reduced. It accelerates the new HIV infection to children.”

Having the services of MSG brought a change in attitude of HIV positive women towards caring for others. The infection creates a great problem for people participating on work that has various links with people. MSG empowers people on how to care for others. Ayantu said, “The support given by MSG made me to have knowledge and skill of caring for my family members and domestic workers. I am participating in petty trades of selling foods. Thus, I know how to care for my employee and children.”

4.4.2. Decrease of Psycho Social Stress

Women of HIV positive have been relieving of psycho social stress .Women of HIV positive have been developing mental stress because of ARV drug side effects, possibility of having a child with HIV infection and despair of their life. Participants of HIV positive pregnant women and post-natal mothers discussed that, they think as they did some mistakes in their life that increases the level of stress and isolation from others. As a result, they faced negative social reaction in their community. This combination effects imposed to develop psycho social stress. The presence of MSG supports women of HIV positive to relief of mental stress that increases their social relationship. Lelise elucidated,

When I identified my HIV status I got shocked and felt frustrated in my life. I faced difficulty in how to lead my family in proper way. I also started to isolate myself as being heard by others. I detached myself from social relationship with others. The MSG helps me to address such problem. They gave me counseling why I developed such stress and ways to resolve it. When I exchanged ideas with similar peer I feel happiness and there is nothing wrong which is unique to me. Now, I have strong social relationship with family members, neighbors, and community.

The services of Mother Support Group increase the level of male participation and other family members. Women of HIV positive faced problem of partner disclosure as a result of

partner influence. The intervention of MSG helps them to freely disclose and discuss their HIV status. Tarike explained, “My husband faced difficulty to accept the presence of HIV in his blood. After continuous discussion with members of MSG he started to change his attitude. We freely discusses about PMTCT and family planning.”

Partner and family HIV status disclosure contributed for HIV positive mothers to increase their role in the community. The presence of MSG enables them to exert their skill and potential in the HIV/AIDS related services. Netsanet described,

The education and continues reaction with MSG made me to have self confidence and starts to think about people who did not get the services in the community. I went beyond family and neighborhood disclosure to community disclosure. I started to give voluntary services for HIV positive people through home based visits.

4.4.3. Improvement of Quality of Life

PMTCT related services given by MSG made HIV positive mothers to bring changes on individual health status and improves quality of life among their family members. The education on PMTCT and personal hygiene creates enabling environment for HIV positive mothers to improve their life situation. Ayantu expressed, “The advice on ARV adherence is useful to reduce the presence of other infectious diseases. I used various diets as appropriate to ART drug. Infant and young feeding practice helps me to have healthy child. I am leading hopeful life and healthy life.”

The improvement on the health and general well being of HIV positive mothers positively affects their level of involvement on works outside of the home setting. The support of MSG contributed for improvement of the health status and participating in socio economic activities. Keneni outlined,

Initially I had a fear to start ART drug because people talk about its side effects. I suffered from the disease and opportunistic infections. I was unable to work in the home setting and my social relations negatively affected. The peer counseling and experience

help me start ART. My health status and weight have been improving over time. I delivered a child free of HIV infection that increased my happiness and self esteem. My capacity to engage in various socio economic activities has been increased. Now, I am engaged in income generating activities through petty trading. This is essential to have income used for medication, children school, supportive foods, and covering other basic needs.

4.5. Contribution of MSG in PMTCT Service

The contribution of MSG in PMTCT services were explained in different ways. It could be considered in terms of the decrease of incidence of HIV, reduction of maternal mortality and morbidity rate, decrease of missed to follow of PMTCT, decrease of stigma and discrimination, and increase of facility based delivery.

The number of incidence or new HIV cases among children has been dramatically reduced after the intervention of Mother Support Group. Sara said, "In 2014, out of 101 HIV positive pregnant women, we have only two children who become HIV positive." Hana enlightened,

Prior to the establishment of MSG women has low level of knowledge on PMTCT. We gave services during ANC and PNC. There was no continuous follow up in all regimes. Hence, a number of children had been infected with HIV. Even, there were children who lost their parents as a result of loosely care and follow up in the hospital setting. The formation of MSG has changed the life situation of HIV positive pregnant women and their children. I can say that MSG achieved its goal of establishment. This can be explained through incidence rate of MTCT. The probability of getting new HIV infection among children has been reduced. Now days, very few children become positive. Moreover, morbidity and mortality rate of children and their parents have been declined. This was possible through provision of ART and proper counseling from the part of health professionals and MSG.

Although the service of MSG is effective in various dimensions like isolation, facility based attendants, and loss to follow up, it lacks equal recognition as other staffs from part of concerned bodies. The likelihood of stigma and discrimination both in and outside the hospital shows improvement. This is reflected both on the HIV positive women by reducing self stigma and community outlook. The Soreti described,

I want to say that MSG is effective in providing PMTCT services. Its effectiveness can be measured in multiple ways. First, the level of stigma and discrimination decreased in the health setting, at family and community level as a result of unreserved efforts by members of MSG. The attitude of health professionals and community towards HIV positive mothers has been changed as a result of disclosing and discussing the issue. People started to develop positive outlook and cooperated with this group in various socio economic activities. Second, the number HIV positive women delivered at facility based has been increasing. As HIV positive people become aware of the impacts of traditional home based delivery and get continuous education on PMTCT, almost all of them delivered their child in the hospital. Thirdly, currently we have rare number of mothers who dropout from Anti natal and post-natal care. MSG is strong in following HIV positive pregnant women and lactating mothers in adhering all medication and counseling. Hence, MSG achieved its objective since it benefits and saves the lives of many women and children. However, their effectiveness has to get equal recognition and it has to be communicated by all concerned bodies.

4.6. Kinds of Organizational Support

The work of MSG did not come to reality without the support of different bodies and organizations. Basically, Ambo Hospital and International Center for AIDS Care and Treatment Programs (ICAP) took the leading role in establishing and supporting MSG in different ways. Sifan explained, “ICAP organized and employed us. They provide us trainings, manuals of PMTCT, and working materials. However, its sustainability has to be taken in to account. Ambo Hospital also supports us by offering working and coffee ceremony office.”

There is an association that partially works with MSG particularly by encouraging them to intervene at community level. It provides some sort of support for people who lack financial support. It encourages MSG to exert their skill in the community level. Firehiwot illustrated,

An association of people with HIV/AIDS called ‘Biftu Association’ has been working with us on some aspects. The association supports us through financial provision for some people who could not able to cover medication cost. It provides some basic needs like clothes and foods. The association also creates enabling environment to provide voluntary home based HIV care and support for people with HIV. It helps us to promote community health, personal hygiene, and environmental sanitation. It supports to reduce risky behavior by promoting positive health seeking behavior in the community.

4.7. Challenges and Possible Recommendations of the Services

Mothers support group encountered different challenges in delivering their services. This included lack of continuous training, low level professional support, absence of income generating activities, low involvement in the Community, and rural inaccessibility.

4.7.1. Lack of continues training

Members of MSG claimed they have been getting training and sensitization work shop only once a year. This in turn affects their skill and knowledge in updating and serving HIV positive women. Netsanet pointed out, “The counseling and regular education given by MSG needs up to date knowledge and teaching materials. They were given training by ICAP only once a year. This affects in getting new information related to PMTCT. Hence, continuous training is needed for them.”

4.7.2. Low level of Professional Support

Low level of professional support creates gaps in giving standardized services. The work of Mother Support Group needs other professional support. It is useful for guiding and helping the group in a more effective manner. Alemitu said, “In spite of the usefulness of practical experience exchanges, the group lacks professional support. The PMTCT related services would be more effective than this.”

4.7.3. Absence of income generating activities

The work of MSG in PMTCT areas has not been strengthened by economic activities. It depends only on monthly salary. Having other economic activities can increase their role and more improve their well being. Sifan outlined, “We have no equal recognition from other unit staffs. This makes to have very low monthly payment and absence of benefit given for other staff members. Hence, additional economic support is needed either by the organizations or by

creating income generating activities. Absence of economic support could affect the overall services of PMTCT and the well being of mothers and children. Keneni demonstrated,

Members and beneficiaries of the services of PMTCT found at low economic and social status that impacts on their health status. The existence of poverty made us not to get equal HIV/AIDS related services. The disease needs income for medication, transport, and nutrition. The help of MSG saved our children's life. However, except little financial support for free medication, there is no strong economic support. This economic challenge prevents the sustainability of women and child health. Hence, income generating activities needs to be developed. It is possible to work with women and children's office and 'Biftu Associaltion'. It creates additional job opportunities for women of HIV positive. It becomes a guarantee to empower them.

4.7.4. Rural- inaccessibility

In-accessibility of MSG services to the remote and rural population is the other big challenge in addressing all HIV positive pregnant women in the area. The problem of women of HIV positive at rural areas complicated by cultural barriers, peer influence and, family pressure, lack of knowledge on PMTCT, and lack of access to health care. Sifan elaborated,

Rural in-accessibility is great obstacle to save mothers and children in remote areas. I always think and worry about these people since they have low knowledge of HIV/AIDS. They face problem of stigma and discrimination as a result of cultural barriers. They infected by co infectious, and sexually transmitted disease. Primarily women of HIV positive from rural areas faced problem of consistent ANC and PNC follow up. Coupled with cultural practices and male dominance, they obliged to interrupt their follow up to health setting. They deliver through traditional birth attendants. They exposed the child to HIV transmission and increase the mortality and morbidity rate of the mother. We have to scale up the MSG services of PMTCT in remote areas and surrounding health centers.

Generally, the findings of the study provided that Mother Support Group had been providing number of psycho social services. It starts with treating new ante natal comers and

continues to helping post partum mothers. Their great contribution is increase of knowledge and skill on PMTCT and saving the life of new generations. Hence, the finding of the study needs to discussed with existing literature in PMTCT areas and new findings from the perspectives of HIV positive women has to acknowledged.

Chapter Five

5. Discussion

Following integrated approach is important to provide maternal and child health care services. Community based strategy needs to be an integral part of health care services to substantiate the medical approach. Involvement of the different parts of the community like informal organizations, and groups of women and men will have greater impact on maternal and child health. UNAIDS (2012) outlined that specific community members at health program intervention is essential for the sustainability of the program. Strong linkages between community and facility services are the foundation of an effective PMTCT program.

5.1. Types of PMTCT services provided by Mother Support Group

MSG has been engaged in a number of activities to contribute in prevention of HIV transmission from mother to child. Their activities start at early pregnancy of HIV positive women. The intervention continues during follow up of ANC and child bearing. Providing services for post-natal mothers through psycho social support until the person bring the required change is also essential service given by Mother Support Group at Ambo Hospital.

Mother Support Group has been building the knowledge and skills of HIV positive pregnant women. During early times pregnant HIV positive mothers had low level of awareness and knowledge towards preventing mother to child transmission of HIV. For instance, Chernet (2005) argued that more than 50% of mothers had insufficient knowledge about MTCT and PMTCT. They had also unfavorable attitude towards the infant feeding options. Their intention and practice towards PMTCT especially on infant feeding was not same.

5.2. Benefits PMTCT services provided by Mother Support Group

The coming of MSG in health setting is helpful to combat challenges related to knowledge about PMTCT. The education and counseling given for women of HIV positive has been contributing to improve their knowledge. The research result reported by Besser, et al (2007) in South Africa shows that after the intervention of Mother Support Group, women's knowledge about how HIV can be transmitted from mother to infants had been increased. Identifying and counseling of new comers during ANC made pregnant women to have a vision in delivering HIV free child. The building of knowledge and skills of PMTCT did not come to reality without co interaction of the peer group.

Prevention of MTCT primarily requires knowledge and skills that are applicable during pre and post-natal care. HIV positive women and post partum mothers have been enhancing their awareness, attitude, and skills through getting education at coffee ceremony session by exchanging practical experiences among HIV positive women who brought a child of free of infection. Providing ART medication with basic counseling can't change the life of these women. HIV positive women do have their own special concerns and needs. Hence, MSG become a place where people freely talks, bring ideas, and learn more. Having PMTCT guide line coupled with group sharing of experiences greatly help the women to bring a child with no HIV positive status. Knowledge of HIV positive women towards community health, environmental sanitation, hygiene, nutrition, maternal and child health has been improved overtime.

The peer group interactive session have been creating enabling environment to assess community' habitual and cultural practices, which were either enhance or hinder mother to child transmission of HIV. Haile michael (2006) asserted that PMTCT was determined by factors such

as community awareness on PMTCT, socio economic deprivation of women, fear of victimization from family, neighbor, and community, home based delivery by untrained traditional birth attendants and lack of community involvement. MSG as part of the community raises issues of HIV positive women and their experiences on institutional based delivery. Women had no such type of experiences since they had delivered their children at home through traditional birth attendants. HIV positive women has changed their attitudes towards this and started to understand the effective of home based delivery on the life of mothers and their children.

The community's practice and norms towards infant and young feeding practice has got greater concern in the peer education. HIV positive mothers knew about such effects and started to use exclusive breast feeding for the first six months. Paradoxically, the study finding of Long (2010) proved that the service of MSG brought limited impact on infant and young feeding practice in South Africa. The activities accomplished by Mother Support Group were contributed to create a linkage with other service unit. Prior to the formation of MSG, women of HIV positive status hardly getting organized services from various units of HIV/AIDS related services. Through the help and advocacy of mother support HIV positive pregnant women able to get integrated services from Anti natal care unit and ART unit. This is beneficial for the women to reduce the referral process among various units. Integrated services is needed to decrease the burden of the mothers during prenatal and at time of delivery. This in turn, saves the life of mothers and children.

The intervention of MSG, not only accelerates service delivery, but also contributing to lessen the work load and burden of clinicians working in the area of maternal and child health, HIV/AIDS and PMTCT. The evaluation report of USAID (2009) Ethiopia reveals that the

burden of the staff in the HIV/AIDS units has decreased because of the existence of MSG. The ANC unit has numerous clients of all mothers following prenatal care regardless of their HIV status. Having HIV positive mother creates additional work of the health professionals. They provide special treatment for these mothers with snapshot of counseling. They refer HIV positive women to MSG. MSG first records demographic background, CD4 level, pregnancy period, and ART usage of HIV positive pregnant women. This makes things easy in the next related activities. MSG, who follows HIV positive pregnant women as not to dropout from ANC, enables the clinicians to easily manage their clients. Giving family planning and sexual reproductive health services to HIV positive women also reduces the work load found at different units. Providing medical records and CD4 counts to ART unit is the other dimension of MSG in supporting the role of medical professionals. This is essential for the mothers in getting necessary ART and prophylaxis for children.

In modern health care system the availability of continuum care is an essential part of treating the person. The work of Mother Support Group does not interrupt at provision of ANC services for pregnant women. But, it continues to help during delivery. It goes beyond the health setting to assist lactating mothers. It addresses the main challenges of attrition from PMTCT services. It is described through dropout from ANC, ART adherence, PNC, and coffee ceremony sessions. MSG follows up a person who missed from PMTCT service utilization. They often look for reasons to dropout. The reasons might be attributed to socio economic issues. They come up with not only the identification of the problem, but also discussion to overcome those challenges. By creating such interviewing environment among health professionals, clients and MSG, HIV positive women have been retaining at PMTCT services.

In addition to treating HIV positive pregnant women with provision of ARV drug, helping with provision of psycho social support is crucial. Mother Support Group is effective in delivering psycho social support across PMTCT services. USAID (2009) asserted that MSG was better to provide psycho social support and women feel more relaxed and happy with group and intended to remain part of the group. It starts at initial contact of ANC followers. Members of Mother Support Group shape the view of the person towards HIV/AIDS in general and PMTCT in particular. It is supported by self story telling. It makes a person to release what she feels. Pregnant women started to avoid fears and freely talk about their health status. MSG is becoming a place where similar peer creates affection and builds self confidence. According to Long (2010) women found that the support group is a place in which they can discuss concerns specific to their situation in confidence with others. It becomes an area where people discuss personal concerns by keeping their confidentiality. HIV positive women and post partum mothers have strong emotional attachment with members of MSG. They think that there is someone who is responsible for them and their child health. The group bond goes outside the health setting to help each other in their social life. Sense of worth is developed. Women decision making at family level is improved.

5.3. Contribution of Mother Support Group

The effectiveness of the services of Mother Support Group in PMTCT is reflected in various ways. Mohammed, Challi, & Belaineh (2011) proposed measurement of PMTCT intervention that would be measured by domains of availability, utilization, quality, male involvement, and continuity of PMTCT service. The uptake of PMTCT services among HIV positive women said to be increased. Increment of male involvement on PMTCT area is one of these indicators. According to Kalembo et al. (2012), PMTCT effectiveness in Sub Saharan

Africa partly depends on involvement of male partners considering that men are decision makers in African families. However their participation is influenced by culture, lack of information, trust and communication on PMTCT, stigma and lack of confidentiality. The challenge of male partner involvement in PMTCT has been improved over time. Women of HIV positive feared to disclose HIV status to her partner. MSG created an environment for discussion about the issue. Besser et al. (2007) said that the number of women disclosing their status to partner and families has increased by help of the support group. They teach women how to tell to her partner or husband. They intervened at family level in advising on benefits of VCT services. They conducted a dialogue with males and they created consensus except few males who denied in taking the advice. This involvement of both partner helped to have a joint decision and stay at PMTCT regimes like ART adherence, ANC and PNC follow up, infant and child feeding practice, use of family planning, and sexual and reproductive health issues.

The deep rooted problem of HIV/AIDS related stigma and discrimination towards HIV positive women has been reduced with the help of Mother Support Group. This problem had been reflected from health professionals in the health setting and from the part of family and community. In addition, there is self stigma in which women hide themselves by thinking that people always think about her as different person. USAID (2009) outlined that MSG made to reduce self stigma and residual stigma relation to housing and employment. The mass education given during the establishment of MSG to health setting attendants and the consecutive education eradicate the problem. MSG, educate how HIV positive pregnant women positively lives with others. During home visit, based on existing situation they discuss with family member and neighbors. People changed their attitude and become supportive environment of these women. The post partum mother who certified by having a child of negative HIV status

and graduated from the group is expected to teach in their surroundings. Members of Mother Support Group have got social status and respect from community and health professionals.

The uptake of child bearing at facility based is improved. One of the reasons creating MSG is low level of institution based delivery. Women of HIV positive rarely seek formal health services. Even, most of them knew their HIV status through seeking medication for other infections or during ANC. Formerly women gave birth through traditional birth attendants. This increases the occurrence of mother to child transmission of HIV. The intervention of MSG reverses the problem. HIV positive pregnant women starts to understand the impact of traditional birth attendants and the benefits of facility based delivery. Currently, the number of HIV positive pregnant women who are bearing a child at the hospital have increased. This in turn helps to prevent the transmission of the virus during delivery.

The low level of HIV transmission to children is one of the significant indicators of increment of PMTCT uptake at Ambo Hospital. Prior to the intervention of mother support, HIV positive women lack knowledge and skills of PMTCT. As a result, they suffered from the impact of the disease adherence problem of ART. Lacking knowledge of infant feeding practice increases the vertical transmission of the virus. The services of MSG, has been contributing in decreasing the likelihood of new infection among new born. The number of HIV positive pregnant women who take ARV drugs and keeping their follow up increased overtime. UNAIDS (2013) reported that Ethiopia reached less than 50% of pregnant women living with HIV with ARV drug to prevent the vertical transmission of HIV to children. However, Besser at al. (2007) reported that the number of women who received ART drug was increased since the coming of MSG. Very few children became infected by the virus. Proper follow up along PMTCT cascade

will have impact on decreasing the morbidity and mortality rate of the mothers and their children.

From the perspectives of HIV positive pregnant women and post partum mothers, various services given by Mother Support Group have increased the services related to PMTCT. It contributes for holistic treatment of HIV positive women and post-natal mothers. These beneficiaries are satisfied by the services of MSG and interested to scale up it. The service of MSG fills the gap existing between the medical model and social model towards health care. As proponents of bio psycho social and spiritual argue, MSG adds one more value for holistic treatment of a person in their context. Provision ARV drugs coupled with psycho social support creates positive impact on the well being of the women and her family.

5.4. Challenges of Mother Support Group's Services

Addressing existing PMTCT related challenges will be essential to bring a more effective change and creating HIV free generation. Lack of continues training to MSG is one of the challenges faced by the group. If the peer group is not empowered with continues trainings with updated materials, it will affect the wellbeing of the clients. Other challenges encountered by MSG will be discussed below.

Existence of Low Professional Support

The low involvement of professional support in peer discussion had less significance. Usually the group leads by the members, except attendants of clinical nurses when the required by the group especially at coffee ceremony program. Mother Support Group is better to be supported by professionals. It helps to exchange practical experience with scientific knowledge. It is beneficial for MSG in getting professional directives, who manage the group dynamics and creates a link with a community.

The services on PMTCT given by MSG mainly focused at health setting except the support given for post partum mothers. The clients of MSG have been getting the services after testing their HIV status during prenatal. Hence, they easily access MSG in the hospital. Their services like knowledge building on PMTCT, and provision of psycho social support needs to be expanded at community level. It benefits HIV positive women of child bearing age and address those people who did not use the services. Moreover, it is important to scale up to remote rural areas for benefits of women who lack necessary PMTCT intervention.

Absence of Income Generating Activities

Absence of income generating activities becomes the hindering factor in realizing the well being of mothers and their children. Even though Mother Support Group supposed to generate income to the benefits of HIV positive women, the practical experience does not indicate such engagement. Almost all members and beneficiaries have unmet needs, which is partially addressed through economic support. Income generating activities can create a better PMTCT services. It helps to cover medication cost, nutritional support and ensuring the sustainability of maternal and child health.

Chapter Six

6. Conclusions and Social Work Implications

6.1. Conclusions

This study explored and described the involvement of Mother Support Group in PMTCT at Ambo Hospital. Since its establishment the group has been providing various PMTCT education and psycho social supports for HIV positive pregnant and post partum women. The services are viewed as substantiating the work of clinicians working in antenatal care and HIV/AIDS unit.

Efforts have been taken to examine the contribution of MSG in increasing uptake of PMTCT among HIV positive pregnant women and their children. The findings of the study revealed that after establishment of MSG, the various components of PMTCT have shown progress.

It is possible to sum up the findings of the study in few main points. First, scholars have acknowledge the role of different parts of the community since community members can influence any policy and programs and provides practical changes. Second, health professional work burden and the institutional goal need to be supported by other intervention mechanisms. By inviting the participation of diverse experts and community skills can add values on work of clinicians. Hence, substantiating the bio medical model with psycho social model will bring the required changes.

The challenges met by Mother Support Group needs attention of all concerned bodies. Most of these challenges can be solved by existing institutional support. In addition, if we empower MSG and scale up their services we can save live of mothers and children and attain the goal of zero tolerance morbidity and mortality.

6.2. Social Work Implication

The findings of the study can be examined in relation to the profession of social work. One of the roles of social workers is ensuring the well being of infected and affected part of the population. This section thus discusses the implication of the study in terms of social work education, research, policy and practice.

6.2.1. Implication for Social Work Education

Knowledge on prevention of HIV/AIDS from mother to child transmission and the role of Mother Support Group in addressing the issue is useful to students of social work. School of Social Work can include title of PMTCT in the course of HIV/AIDS in order to work with HIV positive women. It equips students in getting information about special needs of HIV positive pregnant and post-natal women. The understanding of students towards HIV exposed infants will be enhanced. We need to equip students with counseling skills to work with Mother Support Group, HIV positive pregnant and postpartum women, and their infants.

6.2.2. Implication for Social Policy

The findings of the study also have implication for HIV/AIDS policy and maternal and child health care programs. It is better for Ministry of Health to revise National HIV/AIDS policy which was developed in 1998 as to incorporate the role of Mother Support Group to prevent HIV transmission to children. The policy discusses about community mobilization in preventing controlling HIV/AIDS. However, the policy should acknowledge the services of MSG in PMTCT. It necessitates the design of strategies to scale up the services. It contributes to reverse the pandemic in general, and mother to child transmission of HIV in particular. The findings of the study have implication for maternal and child health programs to consider the work of Mother Support Group in their projects and activities. HIV/AIDS is one of the

intervention areas of maternal and child health programs. Hence, taking in to account the role of MSG will influence the required outcomes of the programs. The overall work of Mother Support Group will add values for achieving millennium development goals regarding improvement of maternal and child health, gender disparity, and the problem of HIV/AIDS.

6.2.3. Implication for Service Provision

The findings of the study also have implication for service providers like government and Non Governmental Organizations, community based organizations and social service agencies. The study identified gaps like lack of continuous training, less professional support, and lack of equal recognition. It is better to work partner institutions to provide continuous and updated trainings thereby enhance the quality of MSG services. Professional support is crucial to increase the effectiveness of PMTCT services. Services like counseling, education, combating isolation, and home based follow up will be stronger. Service providers can help Mother Support Group through guiding the group, providing training, and empowering with various skills of working with infected person, to intensify a linkage with other service units, and to represent the voices of the group at various levels. It is possible to provide trainings for health professionals and other concerned bodies to better recognize the role of MSG in PMTCT.

Service provision will help to support the missing point of income generating activities. Lobbying and working with various agencies in realizing income generating activities and mobilizing local resources is essential. Service providers can design project plan that shows what is going to be done, who is involved, what are resources required, and how HIV positive women organized and participate on it. It influences the health status and psycho social needs of HIV positive women. Apart from these, the findings of the study are beneficial for the case management system working in HIV/AIDS issues to improve the life HIV positive individuals.

6.2.4. Implication for Social Work Research

Future researchers have to focus on the different dimensions of PMTCT and the role of MSG which has not been explored in this study. One of future research areas can be conducted by social workers and social scientists is to better understand the role of MSG through comparative analysis with other health institutions. The other area of investigation is exploring the contribution MSG in improving male partner involvement in prevention of HIV transmission to children. Assessing and compiling experiences of younger children who passed through PMTCT services rendered by MSG and become free of HIV infection is also useful to develop knowledge around PMTCT.

References

- Abenet Tekele (2007). Assessment of male partners influence on pregnant women towards voluntary HIV testing and support on PMTCT in hospitals of Addis Ababa. Master's Thesis. Addis Ababa.
- Abiy Zegeye, Alemayehu Worku, Daniel Jefera, Melese Getu & Yilma, Sileshi (2009). *Introduction to research methods*. Preparatory module for Addis Ababa University Graduate Programs. Graduate Studies and Research Office. Addis Ababa University. Addis Ababa.
- Ali Hussein (2011). Uptake of Antiretroviral prophylaxis among HIV positive pregnant women in South Wollo. Master Thesis. Addis Ababa.
- Almnes Mirkuzie, Gudmund, S., Mitike Molla, Marie, K., & Morkve, O.(2011). Current status of medication adherence and infant follow up in the PMTCT program in Addis Ababa. *Jornal of International AIDS Society*. doi: [10.1186/1758-2652-14-50](https://doi.org/10.1186/1758-2652-14-50).
- Anteneh Asefa & Habtamu Beyene (2013). Awareness and knowledge on timing of mother to child transmission of HIV among Antenatal care attending women in Southern Ethiopia. *A Cross Sectional Study*: doi 10.1186/1742-4755-10-16.
- Basha Namomsa. (2008). Factors affecting utilization of PMTCT services in East Wollega Zone. Master Thesis. Amsterdam.
- Besser, M., Falk, G., Smalley, R. (2007). Helping mothers saving babies. *Annual Report*. South Africa.
- Bogale Tessema (2011). Willingness to home based HIV counseling and testing service among Residents in Chagni Town Administration and Guangua Woreda, West Amhara Region. Master Thesis.

- Chernet Hailu (2005). Assessment of knowledge, attitude and practice .Among mothers about VCT and feeding of infants born to HIV positive women in Jimma Town. Master's Thesis. Addis Ababa.
- Cox, P., Geisen, Th, Green, R. (2008). *Qualitative research and Social Change: European Context*: Palgrave Macmillan, UK.
- Daniel Kinde, Senait G/Yesus, Bella Roman, & Degu Jenere (2010). The mothers support group program in JHU-TSEHAI supported regions in Ethiopia. *Meeting the HIV and maternal child health and social support needs of mothers and their young children*.
- Digsu Negese, & Berihun Megabiaw (2013). MTCT and its predictors among HIV exposed infants at a PMTCT clinic in Gondar University Referral Hospital. doi: [10.1186/1471-2458-13-398](https://doi.org/10.1186/1471-2458-13-398)
- Endawoke Amsalu, Gebeyaw Tiruneh & Amanuel Alemu (2013). Level of male partner involvement and associated factors in prevention of MTCT service in Debre Markos Town. *African Journal of AIDS and HIV Research*. Vol.1.(2), pp, 016-025.
- Federal Democratic Republic of Ethiopia, Ministry of Health. (2012). Country progress report on HIV/AIDS response. Addis Ababa.
- Federal Democratic Republic of Ethiopia, Ministry of Health. (2007). *Guidelines for PMTCT of HIV in Ethiopia*. Addis Ababa.
- Fisaha Haile & Yemane Brhan (2014). Male partner involvement in PMTCT in Mekelle. Doi: 10.1186/1471-2393-14-6 PMID:PMC3923985
- HaileMichael Tesfahun (2006). Determinant Factors that affect pregnant women's utilization of PMTCT services at Health Facility of Adama. Master Thesis. Addis Ababa.
- Henok Sileshi (2011). Prevalence of HIV among ANC attendants at Kasanchis Health center in

- the last Five Years (2006-2010). Master Thesis. Addis Ababa.
- Hussein Ismail (2008). Assessment of quality Antenatal linked HIV counseling and testing for intervention of PMTCT in Addis Ababa. Master Thesis. Addis Ababa.
- International. Guttmacher, S., Kelly, P., & Ruiz, Y. (2010). Community based health interventions. *Principles and application*. John Wiley and Sons, Inc
- Kaai, S., Back, C., Geibel, S., Omondi, P., Ulo, B., Muthumbi, G., & Nkatha, C.(2007). Community based approaches to PMTCT. *Findings from a low income community in Kenya*. Horizons Program International Medical Corps. Stead man Research Services.
- Kalembo, F., Yukai, D., Zgambo, M., & Jun, Q. (2012). Male partner involvement in PMTCT in Sub Saharan Africa . *Success, Challenges, and Way forward*.
- Kendal, T., Fellow, T.(2014). Research and evaluation agenda for maternal health and HIV in Sub Saharan Africa. Boston. ISBN 978-0-001380-0.
- Krebs, D.L (2012). Ethiopia's Prevention of MTCT programs: addressing attrition and loss to follow up. Master Thesis. Simon Fraser University.
- Kreuger & Neuman. *Science and Social Work Research*
- Kshenton, A.(2004). Strategies for ensuring trustworthiness in qualitative research projects. education for information. Newcastle, IOS press,
- Long, S. (2010). Community based support group for PMTCT. *Review of best practices for establishing MSG to reduce HIV vertical transmission*. Johannesburg.
- Meselech Assegid (2006). Assessment of intention and practice of VCT and infant feeding in the context of HIV/AIDS among lactating mothers in Harar Town. Master Thesis. Addis Ababa.
- Mohammed Hussein, Challi Jira, & Belaineh Girma (2011). Assessment of effective coverage of

- HIV prevention of pregnant mother to child transmission services in Jimma Zone.
Mohammed Yimer. (2007). Exploring the role of community based organizations, specially Idirs
in mitigating the spread of HIV/AIDS in Adama Town. Master Thesis. Addis Ababa.
- Solomie Jabessa & Telahun Teka (2005). Knowledge and attitude towards PMTCT and its
prevention among post natal mothers in Tikur Anbbessa and Zewditu Memorial
Hospital, Addis Ababa. Master Thesis.
- Taye Balcha, Lecerof, S., & Jeppsson, A. (2011). Strategic challenges of PMTCT program
implementation in Ethiopia. *Journal of the International Association of Physician in
AIDS Care*. DOI: 10.1177/1545109710369935. Sage.
- Temesegegn Kabeto (2008). Assessment of determining factors for acceptance of HIV testing
among pregnant women at ANC setting in Arbaminch Town. Master Thesis.
- Tilahun Worku (2007). Utilization of PMTCT Services among Pregnant Women in Western
Amhara Region. Master Thesis.
- Tiruneh Zegeye (2007). Assessment of Trends in HIV test and sero Prevalence among randomly
selected Antenatal care attendees in government health centers in Addis Ababa.
Master Thesis.
- UNAIDS. (2013). Global report on the AIDS epidemic
- UNAIDS (2012). Promising Practices in community engagement for elimination of new HIV
infections among children by 2015 and keeping their mothers alive. Geneva.
- USAID (2008). Prevention of Mother to Child Transmission (PMTCT) of HIV/AIDS in
Ethiopia. Intra Health International: Hareg Project Report. Addis Ababa
- USAID (2009). Ethiopia –Evaluation of the mothers’ support group strategy. Addis Ababa.
- Viadro, C., Stratton, S., Yetnayyet Demessie, & Abebe Shibru (2008). Mothers support group in

Ethiopia . *A peer Support Model to Address the Needs of Women Living with HIV.*

World Health Organization (2010). PMTCT Strategic Vision (2010-2015). Switzerland.

Yetayesh Maru & Jemal Haider (2009). Infant feeding practice of HIV positive mothers and its determinants in selected health institutions in Addis Ababa.

Yin, K.(2004). *Case study methods.* Complementary methods for research in education. Washington Dc.

Yonas Bekele (2007). Reasons for default from PMTCT of HIV program in Addis Ababa. Master Thesis. Addis Ababa

Zenebe Molla (2011). Socio demographic factors affecting ANC service utilization among women in OFA Woreda of Wolaita Zone. Master Thesis. Addis Ababa.

Zinabie Feleke (2008). Assessment of acceptability, potentials, and limitations of outreach VCT service in Lasta District, Amhara Region. Master Thesis. Addis Ababa

Appendixes

I. Informed Consent Form

I am Abera Rundasa, I came from Addis Ababa University, School of Social Work. I am here to conduct a thesis for partial fulfillment of a master degree in Social Work. The study aims at exploring and describing the role and related activities of mother support group in PMTCT services at Ambo Hospital. Participants who are going to participate on this research are purely based up on your willingness. Any participant can leave any question that is not comfortable with you. You can leave the interview session at any time you want. The study is useful for activities related with HIV prevention from mother to child transmission and maintaining maternal and child health. It generates insights and knowledge related to community engagement through MSG in the modern institutional health delivery services. There is no any risk that comes as a result of conducting this study and if any the researcher is responsible for it. Hence, try to give me reliable information.

The study will keep your name and address confidential since there is no mentioning of name instead pseudo name will be used. I will use tape recorder during interview that last a maximum of one and half hour. The interview will be conducted in Afan Oromo language. The summary of the report which has no any personal identification response will be given to Addis Ababa University, School of Social Work. Are you willing to participate in the interview? Thank for your devotion of time and consideration. If yes let us start the interview.

Pseudo Name _____

Signature _____

II. In-Depth Interview Guide for Mother Support Group

Age _____

Educational Level _____

Marital Status _____

Number of Family Members _____

Occupation _____

How long you have been serving in the mother support group? _____

1. Can you tell me how this group was established?
 - What were the motivating factors?
 - How the group comes in to together?
 - Who were involved during establishment?
 - At what place it was established?
2. Can you describe the major activities you have been doing?
 - In which point or unit the services begin?
 - Who are beneficiaries of the services?
 - What services given during ANC, delivery and post partum period?
3. What kind of supports you are getting from different organizations?
 - Which organizations or institutions have been working with you?
 - What kinds of support and services you are getting from the organizations or institutions?

4. What are the major challenges you have been facing in the process?
 - What are the challenges or problems encountered in providing your services during ANC, delivery, and post natal care?
5. What do you recommend for those challenges?
 - What do you think about the solutions for such problems?
6. Is there anything else?

III. In -depth Interview Guide for HIV Positive Pregnant and Post Partum Women

Age_____

Educational Level _____

Marital Status_____

Number of Family Members _____

Occupation _____

1. What kind of services you are getting from mother support group?
 - When did you start getting MSG services?
 - What type of services you are getting during ANC, delivery, and PNC?
2. Could you tell me the benefits of services you are getting from mother support group?
 - What are the changes you brought in terms of knowledge and skills on PMTCT?
 - How do you describe the benefits you gained on child feeding practice?
 - What are the benefits gained to your family members?

- Can you describe the change that comes in terms of your involvement on various social relationships?
3. Can you tell me the shortcoming of the services?
 - What are challenges you faced in the process of getting MSG services?
 4. Do you have any recommendation about the services of mother support group?
 - What do you recommend about the stated challenges?

IV. Key informant Interview Guide for Health Professionals working in the area of PMTCT

Profession _____

Working unit _____

How long you have been serving here? _____

1. What was the objective to establish mother support group?
 - What reasons induced to form MSG?
2. What are the types of services they have been providing?
 - Where is MSG start their services?
 - What are the units working with MSG?
 - What is their role during ANC, delivery, and PNC?
3. How can you describe the contribution of mother support group?
 - Is there any significant change at various PMTCT services of ANC, ART, and PNC after MSG intervention?

- How can you explain the rate of new HIV infection among children after the intervention?
 - How can you explain change in isolation and maltreatment both in the health setting and in the community?
 - What changes comes at individual, family and community level?
4. What is your attitude towards the services provided by mother support group?
- How you are viewing the services of MSG as compared to PMTCT services provided by health professionals?

V. Observation Guide

1. What types of people are getting PMTCT services?
2. What are the various types of PMTCT services given by mother support group?
3. What is the individual role of members of mother support group?
4. How the working structure of mother support group is linked with health professionals in the health care setting?

VI. Afan Oromo Version of Tools of Data Collection

Unka Waliigaltee Gaaffii fi Deebii

Maqaan kiya Abarraa Rundaasaa jedhama. Kanan dhufes Yunivarsitii Finfinnee Mumme Social Work irraayii. Kaayyoon dhufeefis qorannoo eebbaa digirii 2^{ffaa} guutachuuf kan na dandeesisu hojjachuu dhaafi. Kaayyoon qoranichaas ittisa HIV haadha irraa gara daa'imaati taasifamu keessaatti gahee fi hojiiwwan biro walgargaarsi haadholii taphachaa fi hojjachaa jiru sakkata'uun faayidaan tajaajilaa keessatti qaban adda baasuu dha. Kunis kan hojatanu Hospitaala Amboo keessaatti. Hirmaatooni qorannoo kana irratti hirmaatan guutumaa guututi fedhii keessan irratti kan hundaa'e dha. Gaaffiiwwan ka'an yoo isiniti toluu baatan irra darbuu kan dandeessanii fi addaan kutanii bahuuf mirga kan qabdan ta'uu nan ibsa.

Qorannoon kun hojiiwwan ittisa HIV haadha irraa gara daa'imaatti taasifamu keessatti akkasumas fayyaa haadholii fi daa'imaa eegsisuu keessatti galtee guddaa qabaata. Dabalataanis, beekumsaa fi odeeffannoowwan gama hirmaannaa hawaasni keessattuu garee wal gargaarsi haadholii yeroo ammayahaa tajaajili dhaabatati kennamu keessatti qabu argachuuf gumaacha guddaa qabaata. Sababa qoranichaatiin miidhaan isin irra ga'u hin jiru, akka tasaa yoo jiraatees qoratiichi itti gaafatamummaa fudhata. Kanaafuu, hamma danda'ameetti deebii barbaachisaa fi amanamaa kennuu yaalaa.

Iccitiin nama hirmaatuuf kan eegame yoo ta'u; kunis maqaa fi eenyummaa isaa kan hin ibsamne dha.. Yeroo gaaffii deebii sagalee waraabduu fi waraqaa yaadannoo kanan fayyadamu ta'ee gaaffii fi deebichi yoo baay'ate sa'atii tokkoof tura. Kunis kan taasifamu Afaan Oromootini. Gabaasni isaa qindaa'ee kan dhiyaatu Yunivarsitii Finfinnee Mumme Social Workiifi dha. Gaaffii fi Deebicha irratti hirmaachuuf fedhii qabduu? Yeroo qabdan aarsaa gochuun hirmaachuu keessaniif galatoomaa. Waliigalaan eegaluu dandeenya.

Maqaa _____

Malattoo _____

Gaaffii fi Deebiii Garee Wal Gargaarsa Haadholiif Qophaa'e

Umurii _____

Sadarkaa barnootaa _____

Haala fuudhaa _____

Baay'ina maatii _____

Gosa hojii _____

Waggaa meeqaaf garee walgargaarsa haadholii keessatti tajaajilte? _____

1. Akkaataa gareen wal gargaarsa haadholii kun itti hundeeffame naaf ibsuu

dandeessaa?

- Maaltu sin kakaase?
- Akkamiin walitti dhuftan?
- Yeroo hundeeffamu qaama kamtu hirmaate?
- Essatti hundeeffame?

2. Hojiiwwaan gurguddoon hojatamani maal fa'i?

- Bakka hojii kamiiti hojiin keessan eegala?
- Fayyadamtootni keessan eenyu fa'i?
- Tajaajili kenitan yeroo hordoffii da'umsaa, yeroo da'umsaa fi da'umsa booda kenitan maal fakkaata?

3. Deeggarsi dhaabbilee adda addaa irraa argatan maal fa'i?

- Dhaabbata kam fa'i kan isiin waliin hojatan?

- Gargaarsaa fi tajaajili dhaaboota kana irraa argatan maal fa'i?
4. Rakkoowwan adeemsa kessatti isiin quunname naaf ibsuu dandeessaa?
 - Rakkoowwan jechuunis yeroo hordoffii da'umsaa, yeroo da'umsaa fi da'umsa booda isin mudate maal fa'i?
 5. Fali rakkoowwan kanaa maali ta'a jettee yaada?
 - Rakkoowan kanaaf akka nama tokkotti fali isaa maali jettee yaada?
 6. Wanti dabalataan jetu qabdaa?

Gaaffii fi Deebii Dubartoota Ulfaa HIV positivii fi dubartoota HIV positivii dahaniif

Qophaa'e

Umurii _____

Sadarkaa barnootaa _____

Haala fuudhaa _____

Baay'ina maatii _____

Gosa hojii _____

1. Tajaajilaawwan garee walgargaarsa haadholii irraa argachaa jirtu naaf ibsuu dandeessaa?
 - Tajaajila wal gargaarsa haadholii argachuu kan jalqabde yoomi?
 - Tajaajili yeroo hordoffii da'umsaa, yeroo da'umsaa fi da'umsa booda argatu maal fa'i?
2. Faayidaawwan tajaajila kana irraa argatu maal fa'i?
 - Jijjiiramni gama beekumsaa fi daandeen fide maal fa'i?
 - Faayidaan daa'ima harma hoosisu irratti argate akkamiin ibsita?
 - Faayidaan maati keetiif argate maal fa'i?

- Jijjiirama gama walitti dhufeenya a fi hirmaanaa hawaasummaa wajjiin fide naa ibsuu dandeessaa?
3. Hanqinni tajaajili kun qabu naaf ibsuu dandeessaa?
- Haniqinni tajaajili wal gargaarsi haadholii qabu maal fa'i?
 - Rakkoowwan kanaaf maaltu fala ta'a jettee yaada?

Gaaffii fi Deebii Ogeessota Fayyaa Kutaa HIV/AIDSii tiif Qophaa'e

Ogummaa _____

Kutaa hojii _____

Waggaa meeqaaf kutaa kanatti tajaajilte? _____

1. Kaayyoon garee walgargaarsa haadholii hundeessuu maal ture?
 - Sababawwan walgargaarsi haadholii itti hundeeffaman godhan maal fa'i?
2. Gosti tajaajilaa gareen kun kennu maal fa'i?
 - Bakka kamiti tajaajili wal gargaarsa haadholii jalqaba?
 - Kutaaleen hojii wal gargaarsa haadholii wajjiin hojatan kam fa'i?
 - Gaheen isaanii yeroo hordoffii da'umsaa, yeroo da'umsaa fi da'umsa booda maal fa'i?
3. Gumachi garee kanaa akkamiin ibsitu ?
 - Jijjiiramni qabatamaan gama tajaajila ittisa HIV haadha irra gara daa'imaati dhufe maal fa'i? Gama hordoffii da'umsaa, qoricha farra HIV/AIDSii, fi hordoffii da'umsa boodaa?
 - Eega walgargaarsi haadholii hundeeffame dadarbuun HIV gama daa'imaati jiru akkamiin ibsama?

- Jijjiirama gama qolifachuu fi haalan keessumessuu dhabuu gama dhaabbata fayyaa keessa jiruu fi gama hawaasan jiru akkamiin ibsita?
 - Jijjiiramni gama nama dhuunfaan, maatii fi hawaasaan dhufe maal fa'i?
4. Tajaajila garee wal gargaarsa haadhooliin kennamu irratti ilaalcha akkamii qabda?
- Tajaajili wal gargaarsa haadhooliin kenamu yeroo tajaajila ogessota fayyaa waliin wal bira qabamu akkamiin ilaalta?

Declaration

I, the undersigned, declare that this thesis is my original work and has not been presented for a degree in any other university, that all sources of materials used for the thesis has been duly acknowledged.

Name _____

Signature _____

Place _____

Date of Submission _____

This thesis has been submitted for examination with my approval as a university advisor

Name _____

Signature _____