THE CONTRIBUTION OF MOTHER SUPPORTING GROUPS IN IMPROVING THE PREVENTION OF MOTHER TO CHILD TRANSMISSION SERVICE:A CASE OF SOUTH GONDAR AND WEST GOJAM ZONES, NORTH WEST ETHIOPIA.

MSW DISERTATION RESEARCH PROJECT

(MSWP-001)

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Social of Social Work (MSW)

November 2014

ADDIS ABABA, ETHIOPIA

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Declaration

I declare that the dissertation entitled,**The Contribution of Mother Supporting Groups in Improving the Prevention of Mother to Child Transmission Service:A Case of South Gondar and Wes Gojam Zones, North West Ethiopia.**Submittedby me for the partial fulfillment of MSW to Indira Gandhi National Open University (IGNOU).Amhara Region is my own original work and has not been submitted earlier, either to IGNOU or to any other institution for the fulfillment of the requirement for any other program of study. I also declare that no chapter of this manuscript in whole or on part is lifted an incorporated in this report from any earlier work done by me or others.

Place Addis Ababa, Ethiopiasignature……Date of Submission: November 2014 ENROLMENT NO ID1218737

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Approval Sheet

Submission of MSW Project work for Approval from Academic Counselor

This to approve that Mr. WubieZewdieEshitie student of MSW from Indra Gandhi National open University (**IGNOU)** has completed his Project Work**.** Hence Iassured that I have read and evaluated the project, entitled:The Contribution of Mother Supporting Groups in Improving the Prevention of Mother to Child Transmission Service: A Case of South Gondar and West Gojam Zones, North West Ethiopia.

I hereby certify that I have read this project prepared under my direction and recommendation that it be accepted as fulfilling the Project requirement.

Enrolment NO: ID1218737

Date of submission: November, 2014

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CERTIFICATE

As members of the examining Board of the Final MSW open defense, weThis is to certify that Mr. WUBIE ZEWDIE ESHITIE students of MSW fromIndira Gandhi National Open University,(IGNOU) , Addis Ababa was working under my supervision and guidance for his project work for the course **MSWP-001**. His project work entitled THE CONTRIBUTION OF MOTHER SUPPORTING GROUPS IN IMPROVING THE PREVENTION OF MOTHER TO CHILD TRANSMISSION SERVICE: A CASE OF SOUTH GONDAR AND WEST GOJAM ZONES, NORTH WEST ETHIOPIA, which he is submitting, is his genuine and original work.

Place Addis Ababa, Ethiopia signature……

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ANRS	Amhara National Regional State
ART	Anti Retro Viral therapy/treatment
ARV	Anti Retro Viral
CBO	Community Based Organization
EHNRI	Ethiopian Health and Nutrition Research Institute
FBO	Faith-Based Organizations
HAPCO	HIV/AIDS Prevention and Control Office
HIV	Human Immunodeficiency Virus
M2M	Mother to Mother
MSG	Mother Supporting Group
NAP+	Network of HIV Positive Associations in Amhara
NGO	Non Governmental Organization
NHAPCO	National HIV/AIDS Prevention & Control Office
OVC	Orphans and Other Vulnerable Children
PLWHIV	People Living With HIV
PMTCT	Prevention of Mother-to-Child Transmission
RHAPCO	Regional HIV/AID Prevention and Control Office
UNAIDS	United Nations Organization on AIDS
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing

Abstract

Mother support group (MSG) has the greater contribution for HIV positive mothers uptake of PMTCT services and it is used to reduce MTCT by empowering HIV positive mothers by addressing information and improving HIV positive mothers living condition. This study project was conducted South Gondar and West Gojam Zones, Data were collected by the quantitatively and qualitatively from 10 MSGs of 10 PMTCT health centers of 10 woreda health centers.The participants were 228 MSG members and 108 health and related professionals participated quantitatively. During data collection quality control and ethical consideration were taken into account and Data were analyzed by version SPSS 20.

Regarding to the data, 92.5% addressed PMTCT information, 94.3% MSG members contributed to improve HIV positive mothers' PMTCT service uptake. 92.1% of MSG members responded that there are factors to improve the uptake of PMTCT service. The relationship between, MSG after a member factors affecting HIV positive women Pearson correlation coefficient relation of MSG member is negatively correlated with r = -0.046. The relations between their neighbors and families have not been as before have problems after they become MSG members. Distance from their residence to the health centers, stigma and discriminations are expressed as an obstacles and make gaps, between MSG members and PMTCT service. There are no MSGs at health post level and health extension workers do not engagedo actively on MSG up take of PMTCT service. The results of the research,Mother support groups have an essential role in the uptake of PMTCT services especially for mothersliving with HIV and AIDS in the form of addressing information, improve uptake of PMTCT service and improve the quality of life of HIV positive mothers, and there are factors affecting MSGs contribution in improve the PMTCT service uptake of HIV positive mothers. Based on this finding, it was recommended thatHealth sectors and concerned bodies will be done on: MSG members use PMTCT service in health centers. This should be sustainable and replicated at the health post level, Contribution of MSG on the up take of PMTCT service should be scale up, Factors affecting the HIV positive mothers' uptake of PMTCT service that make gaps between MSG and PMTCT service should be resolved.

CHAPTER ONE

1. Introduction

1.1 Background of the study

Mother Support Groups began in the 1950s and have been growing rapidly since then. In 1989, there were 48 mother supporting groups in more than 40 countries. With over 70000members and 50000 qualified breastfeeding counselors. Laleche league international is the oldest and largest whereas most MSGs are based on the “experienced mothers’ helping the new mother” concept. Many groups, especially those in areas where there are few experienced mothers, have embraced the trend, but not necessarily experienced peer counseling as acceptable and appropriate development of a cadre of certified lactation consultants’ is an expansion of these concepts (Beake, 1989).

The global HIV pandemic has had a profound, multi-sectoral impact on the structure of many nations, affecting their development and economic growth, communities, households and individuals. In many countries, AIDS has been identified as a serious challenge to development with both short and long term economic effects (FHAPCO, 2007). HIV/AIDS is no longer just a medical but a socio-economic and development issue with a wide ranging and complex economic, social and cultural implications (FHAPCO, 2006).

Mother support groups (MSGs) provide individual counseling, information, support, and group discussions to enable women to practice breast-feeding and child care well. These groups have a special role, different from, but complementary to, the role of health services and health professionals. The key to the best breast-feeding practice is continued day- to- day support for the breast-feeding mother within her home and community. Mother support groups attempt to fill the void for a mother when breast feeding is not the cultural norm and when she lacks extended family and peer support. MSGs are thus a vital link between the breast-feeding woman and the health care system.

(Meaza,H. 2003),necessary to provide basic MSG training to mentor mothers who have delivered babies through PMTCT and sharing their life experience to newly HIV positive pregnant and recently delivered mothers. And they continue, as MSG program is cost-

Effective and providing valuable support to integrated mothers in to PMTCT as well as increase

Women empowerment. It is mandatory to scale MSG programIntra Health initiated mothers' support groups (MSGs) in Ethiopia in 2005 and the Capacity Project has continued them as a strategy to increase the uptake PMTCT services at government health centers (HCs). The MSG program is the product of knowledge-sharing between Intra Health and the pioneering Mothers2Mothers (M2M) program in South Africa(CET, 2009).

According to world health organization 2009 report towards universal access, scaling up priority HIV/AIDS interventions in the health sector, significant progress in the area of PMTCT has been made during the past several years. In 2008, 45% of the estimated HIV-infectedpregnant women in low- and middle-income countries receivedat least some antiretroviral (ARV) drugs to prevent HIVtransmission to their child, up from 35% in 2007 and 10% in2004. In Eastern and Southern African nations, which have the highest rates of infection, coverage with ARVs jumped to 58% in 2008 from 46% in 2007 due to increased national commitment and focused international support.

1.2. Statement of the Problem

In Ethiopia on 2011, 10% of pregnant women accessed skilled birth attendant. There were 42936mothers needing PMTCT services, from those HIV positive pregnant in need of treatment were 23029, and only 24 % of PLHA women got PMTCT service.Knowledge of MTCT of HIV & AIDS Percent of women age 15-49 is 44%: A key barrier to success in PMTCT programs is mothers lost to follow up. This indicates that still HIV positive children are born. On the other hand, the main objectives of programs focusing on mother to mother support are giving information and counseling. Moreover to prevent new HIV infection, Ethiopian government is scaling up MSG nationally. However, the uptake of the services for PMTCT of HIV services in Ethiopia is often low.

The barriers that have not been fully studied are, limited use of antenatal and postpartum services generally, and HIV-related stigma and discrimination are problem for MSG members to uptake PMTCT services. However, some research meets the information and emotional support needs of HIV-infected pregnant and postpartum women, and to improve utilization of PMTCT services.

The M2M program empowers women who test positive by providing psychosocial support, reducing stigma, and promoting disclosure in families and communities.

Even though, over half a million newborns are infected with HIV each year in sub-Saharan Africa through MTCT Clinical trials several countries have shown that MTCT of HIV can be greatly reduced through administering a short, affordable course of antiretroviral therapy to pregnant women. Institutional-level barriers to PMTCT, including stock-outs of drugs, lack of health care workers, and poor HIV counseling, have been widely addressed in the medical literature as well. Generally, the statement of the problem more focuses on:

- Whether there are problems for MSG members to use PMTCT service
- Whether MSG member address PMTCT information gap for HIV positive mothers or not
- Whether there are knowledge gap on MSG members towards PMTCT service
- Whether there are factors affecting MSGs' contribution in improving PMTCT service uptake of HIV positive mothers barriers between MSG and different supporters & services.

1.3. Research Questions

This study attempts to answer the following questions by integrating both the literature review and findings.

1. How much extent do MSGs contributed to address PMTCT service information?
2. What are the basic contributions of MSG to improve PMTCT service up take?
3. Do MSG members have knowledge barrier towards PMTCT service?
4. What are the factors affecting MSG contribution in improving uptake of PMTCT services?

1. 4. Objectives of the study

1. 4.1. General Objective

The main objective of this study is to find out the contribution of Mother Support Groups in improving PMTCT service uptake by HIV positive mothers.

1.4.2. Specific Objectives

- To assess the extent at which MSGs address PMTCT information for HIV positive mothers.
- To identify basic contributions of MSGs in improving PMTCT uptake of HIV positive mothers.
- To investigate the knowledge of MSG members towards PMTCT service uptake.
- To uncover factors affecting MSGs contribution in improve the PMTCT service uptake of HIV positive mothers

1.5. Significance of the study

The investigator of this study will strive a lot to give valuable recommendations based on how much MSG contributes to improve up take of PMTCT, how much extent MSG address PMTCT service information for HIV positive mothers, to dig out uncover factors affecting MSGs contributions, and to identify whether MSGs have PMTCT service knowledge.

The research also initiates other researchers to undertake further investigations on the area in a large scale and helps them as a reference.

1. 6. Limitation of the Study

The limitation of the study is mainly related to the samples of the population in the study it focuses on the specific area of the study and lack of resources would be among the limitations. As the study is in South Gondar and West Gojam zones, the data cannot represent the entire MSGs not only in Ethiopia but also worldwide. The samples that can be taken will not 100% represent the entire population. The reason for the restriction of my study at these zones causes lack of resources and time. So this would be the limitation of the study.

1. 7. Scope of the Study

The study had conducted in the Amhara National Regional State of two zones to find out the role of MSG on PMTCT service. The study is delimited to selected data tools and methods.

1.8. Definition of Key Terms

- **AIDS** (Acquired Immune Deficiency Syndrome): A disease of the immune system transmitted through blood products.
- **Epidemic:** is a disease that appears as new cases in a given human population during a given period, at a rate that greatly exceeds what is "expected" based on recent experience.
- **HIV** (Human Immunodeficiency Virus): The virus that weakens the immune system.
- **HIV Prevalence: A** percentage, which quantifies the proportion of individuals in a population who have HIV at a specific point in time.
- **PMTCT-FT** prevention mother to child transmission fast track

CHAPTER TWO:

2. Literature Review

2.1-Over View of MSG and PMTCT Services

According to technical overview of MSGs, there are three basic models of mother support; mother to mother, peer counseling, and certified consultants. These mothers, generally volunteers, peer counseling has emerged in area where there are few mothers with the time resources, or experience necessary to assume the role here especial training is avoided in mothering and breast-feeding skills, as well as in counseling mother-to-mother counselors or health professionals(Labok,M. & Krasovice.K,1990; Rodriguez-Gracia,R,etal 1988;Seel and etal,1991).The goal of the MSG strategy is to reduce mother-to-child transmission by empowering HIV-positive mothers and mothers-to-have informed decisions about their reproductive health (RH) and the health of their babies. Both the M2M and MSG programs are based on the concepts that peer support is an optimal model for effective education and social empowerment, and that mothers are particularly well-suited to provide support to other mothers (Labok,M. & Krasovice,1990; Rodriguez-Gracia,R,etal, 1988;Steel and etal, 1991).

Mother-to-child transmission (MTCT) of HIV represents 90% source of pediatric HIV infections **(**Seel, 1991; WHO,2010; FHAPCO,2011).In response to the MTCT threat and in line with the global declaration of commitment to universal access to HIV prevention, treatment, care, and support and global efforts to reduce pediatric HIV infections, the Nigerian National PMTCT program was launched in 2002 employing a comprehensive four-pronged approach: 1) primary prevention of HIV infection among women of reproductive age group and their partners, 2) prevention of unintended pregnancies among women infected with HIV, 3) prevention of HIV transmission from women infected with HIV to their infants and 4) provision of treatment, care, and support to women infected with HIV, their infants and their families**(**Seel,1991; Nicholas,W.2011).

2.2. KNOWLEDG on MSG AND PMTCT

The effectiveness of mother support groups depends greatly on the training of the counselors and their leaders. The program achieved substantial coverage of both pregnant and postpartum women, with almost 60 percent of women reporting that a mentor mother talked with them at least once while the women were pregnant or during their last pregnancy, (Pfizer, 2012; Intra Health International,2008).

MTCT knowledge, overall respondents knew more basic information about MTCT occurs than how to prevent it. Comparing the two groups, m2m participants had greater MTCT knowledge than non participants. Pregnant and postpartum program participants were more likely to report intending or actually giving infant formula exclusively than their counterparts who had no exposure to the program. Program participants interviewed postpartum reported significantly higher rates of having undergone CD4 testing during their last pregnancy than non-participants.

Without any intervention, 25-40% of children born to an HIV-infected mother will contract the infection, either during pregnancy, during labor, or through breastfeeding .The crucial need to prevent mother to child transmission (MTCT) in the fight against HIV/AIDS. medical intervention, the proportion of infants who contract HIV from MTCT can be reduced to 5% Sub-Saharan Africa accounts for roughly 90% of all annual cases of MTCT .

M2M aims to utilize effective interventions such as these to reduce the number of babies born with HIV and help women access medical care for themselves and their families by educating,

empowering, and providing psychosocial support to HIV-positive pregnant women and new mothers. Mentor Mothers are paid members of the health care team and work alongside doctors and nurses to support and educate women about taking medicines and caring for themselves and their babies. At all its sites, m2m seeks to improve the uptake and outcomes of established PMTCT treatment programs (Pfizer,2012)

In 2002, the Government of Nigeria (GoN) response to MTCT was in line with the global PMTCT strategy that promotes the "Four-Pronged" approach. By 2004, the actual response to MTCT was still very limited: less than 1% of pregnant women were accessing HIV testing and counseling, less than 1% of HIV-positive women were receiving ARV and virtually no HIV-exposed child received ARV prophylaxis (UNICEF, 2010; WHO,2010).

2.3. MSG members improve uptake of PMTCT services

M2m plays an important role in providing a continuum of care for HIV-positive women and infants. Compared to non-participants, m2m participants had greater psychosocial well-being, greater use of PMTCT services, and better PMTCT outcomes. Postpartum participants had more positive changes than pregnant participants, suggesting that with more contacts and time with the program, there is greater impact. Lastly, m2m keeps women linked to health facilities, which is especially important after delivery as that has been an identified weakness of many PMTCT services (Ethiopian health and nutrition research institute,2012; Debremarkos University,2010)

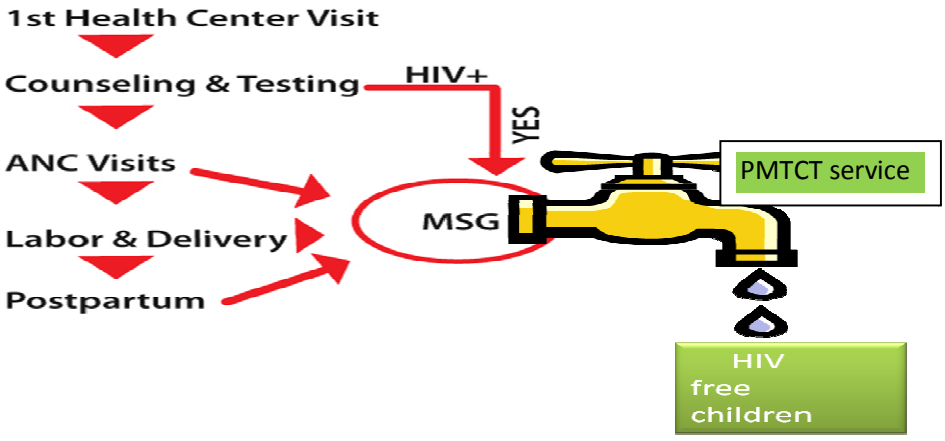

Figure 1 - Ethiopian Ministry of Health National PMTCT Strategy (2013)

The formation of a local group depends largely on the individual's personality, perseverance, and ability to adapt to the local culture. The growth of MSGs in developed countries has been held by: members that can support (financially) the group, high literacy, access to scientific research, and ability interpret and disseminate information. Unfortunately, most groups in developing countries cannot support themselves financially(UNAIDS, 2010)

Two basic things are needed for skilled MSGs to be effective: (*a*) administrative support (paid coordinators who are qualified as counselors) and office space; and (*b*) a supply of literature and up-to-date audiovisual aids. Grants enable these groups to purchase from parent organizations and others, and to adapt to local needs, including the translation and printing of materials. Some groups sell products to raise funds(Baek,1998; steel, 1991).

Ethiopia Health minister prepare strategy about elimination of PMTCT of HIV in Ethiopia (eMTCT) the impact targets are a) reduce the number of new HIV infection among children by 90% by 2015 through implementation of four prong strategy for PMTCT b) reduce by 50% maternal death by 2015 c) increase proportion of deliveries of HIV positive women that receive full course of ARV prophylaxis to 90% (FHAPCO, 2006).

International AIDS society state about mother supporting groups to reduce HIV vertical transmission in Africa seen as fallows, mothers support group play an essential role in uptake of full PMTCT services especially post delivery . More attention should supporting groups and measuring their contribution PMTCT out comes. (International AIDS society, 2012) The prevention of mother-to-child transmission (PMTCT) is a highly effective intervention and has huge potential to improve both maternal and child health. In 2001, the United Nations General Assembly set a target for 80% of pregnant women and their children to have access to essential prevention, treatment and care by 2010 to reduce the proportion of infants infected by HIV by 50% (UNAIDS, 2010).

Prevention of mother-to-child transmission (PMTCT) interventions reduces the likelihood of a HIV positive woman transmitting HIV in utero, during childbirth, or to her child through breastfeeding.(ICASA 2011)Addressing stigma in communities, rather than spending money on

mass-education campaigns, may be a more effective means of increasing PMTCT, based on HIV-positive women's cited perceptions of fear around disclosure(Karen, 2013).

Mother Mentors play an important role in increasing utilization of comprehensive PMTCT services and adhere recommended treatments including feeding options, facility level program 2.4. MSG members address PMTCT service information ownership should be strengthened (Pfizer, 2012)Ethiopia is to meet its targets for PMTCT by 2014, intensified efforts to prevent new infections among women of childbearing age and to provide family planning services to HIV-positive women. Increasing access to more efficacious PMTCT regimens, including ART for eligible women can improve the quality of maternal and child health services (Steel, 1991)Successful MSG's are providing information encouragement and support.

The goal of MSG strategy is to reduce PMTCT by empowering HIV positive mothers and mothers to be informed decisions about their reproductive health.Ministry of health national strategy for PMTCT of HIV in Ethiopia prepare a strategy to increase proportion of deliveries of HIV positive women that receive full course of ARV prophylaxis to 90%.HEW working in the community at the health post level are the back bone to service giver for the community because of this they work house to house provide education and give advice for the pregnant women those PMTCT service improving mothers access to PMTCT program.

Access to CD4 monitoring for HIV positive women is vertical component of the PMTCT guideline. The strengthening of health system is vital in addressing the challenge of limited health service that prevents large number of HIV positive pregnant women, especially in rural areas from accessing baseline and follow up laboratory investigations of at the end of 12 months the No of HIV positive pregnant women CD4 count increase from 53.8% to 90% the No of pregnant women receiving ART increased from 50% to83% and the number of client lost to follow up reduced from 58.7% to 10.7%, stigma related cases have also reduced. After the intervention, the number of exposed infants who tested negative to HIV increased from 85% to 100%.

Missing the target vertical transmission National network of positive women Ethiopians Addis Ababa Ethiopia (Ethiopian health and nutrition research institute, 2012; Ministry of Health, 2013) MSG helped to reduce the burden that health care provides face and the research

recommend MSG should be scale up for the greater source of information for the HIV positive women on PMTCT.

The main objectives of programs focusing on mother –to-mother support education and counseling. These activities can take the form of group and individual support, group meetings for group leaders/counselors and supervisors concerning publications and the media, advocacy, child survival, and other matters. Some of successful mother support groups are information, encouragement, and support. The cornerstone of the organization has been personal mother-to-mother warmth and caring(baek, 1998),

To meet the information and emotional support needs of HIV-infected pregnant and postpartum women, and to improve utilization of PMTCT services in South Africa, M2M was started in the Western Cape in 2001 and rolled out in KwaZulu-Natal. M2M employs and trains new mothers who are HIV-positive to become mentor mothers (MMs) who offer psychological, emotional, and social support to other HIV-positive women through one-on-one and support group sessions in antenatal care (ANC) and maternal and child care (MCH) clinical settings. The program serves women from pregnancy through the first year of their children's lives. The M2M program empowers women who test positive by providing psychosocial support, promoting women's economic independence, reducing stigma, and promoting(baek,1998;Amanual,Alema and et al,2010),

In addition to reducing the likelihood of mother-to-child transmission, receiving PMTCT may provide information to pregnant women about their HIV status. To receive PMTCT, a pregnant woman must test HIV positive. After receiving the result of this test, she may revise her belief about her HIV status. Although evidence on the behavioral response to learning one's HIV status is mixed, the change in her beliefs may change her subsequent reproductive decisions.

HEWs working in the community at the health-post level are the backbone of the MOH's effort to deliver services to the community. HEWs are trusted members of the communities in which they work and live. They work house-to-house, providing education and preventive care and encouraging use of the HCs for care. As part of their existing scope of work, HEWs visit households monthly and are expected to know the gestational status of all women in their catchment areas, as well as to attend all births(Msellati,P. 2009).

2.5. FACTORS affecting MSG up take of PMTCT service

PMTCT reduces the cumulative probability from between 25-45 percent in the absence of PMTCT to as little as 3 percent. Between 25 and 50 percent of HIV positive children die by age 1 and between 35 to 60 percent of HIV positive children die by age 2. PMTCT should increase life expectancy at birth for children born to HIV positive mothers, conditional on fertility seeking behavior and child human capital investment behavior remaining unchanged (Pfizer,2012)

Uptake of services for prevention of mother-to-child transmission (PMTCT) of HIV services in Ethiopia is often low, in part because many Ethiopians have little contact with the health care system. However, there are many other barriers that have not been fully studied, such as limited use of antenatal and postpartum services generally, HIV-related stigma and discrimination, the uneven quality of care in antenatal and obstetric settings, and insufficient partner and community involvement. Other barriers might be the psychosocial needs of the mother during pregnancy, delivery, and the early postnatal period, particularly where important cultural rituals and behaviors cannot be practiced; behavior changes, such as exclusive breastfeeding and taking drugs in pregnancy, that conflict with community norms, values, and beliefs; and economic barriers, such as the direct and opportunity costs of accessing PMTCT services, (Ethiopian health and nutritionInstitute, 2012).Comprehensive prevention of mother-to-child transmission (PMTCT) programs has nearly eliminated MTCT in developed countries. However, in resource-limited settings, progress implementing similar prevention programs has been slow. Only nine percent of all HIV positive pregnant women are benefiting from such services in these countries (baek,1998).

Mother-to-child transmission is the primary route of HIV infection in children under 15 years of age. Since the beginning of the HIV epidemic, an estimated 5.1 million children worldwide have been infected with HIV (UNAIDS, 2000).Clinical trials in several countries have shown that mother-to-child transmission of HIV can be greatly reduced through administering a short, affordable course of antiretroviral therapy to pregnant women. These trials culminated in a recommendation by UNAIDS and its partners in the Interagency Task Team for the PMTCT that prevention of prenatal transmission should be a part of the standard package of care for HIV-positive women and their children (Msellati, 2009).

Engaging communities in preventing mother-to-child transmission is particularly challenging because of the complexity of the HIV transmission process and the stigma associated with HIV/AIDS. Sero-status (testing, antiretroviral drugs, and breast milk substitutes) can be overshadowed by prevailing community norms, values, and beliefs regarding HIV/AIDS. Overcoming negative community perceptions about people living with HIV/AIDS and educating community members about HIV transmission are necessary to increase women's willingness to be tested for HIV, a prerequisite for participating in interventions to PMTCT.

Interpersonal-level factors are especially relevant for the study of PMTCT utilization. Researchers who used individual-level approaches were generally unsuccessful in increasing uptake of PMTCT among HIV-positive pregnant women. As mentioned previously, social stigma and discrimination are widely discussed as perceived barriers to PMTCT. In addition, fear of partner's reaction or fear of violence/conflict with the woman's partner may also prevent women from utilizing these services. Thus, theories regarding social networks and social support are useful in understanding the interpersonal influences on HIV-positive pregnant women's decision-making and health-seeking behaviors (Karen, 2013).

Social influence describes how the actions of others affect women's thoughts and actions towards PMTCT .Moth et al. found that pregnant women did not disclose their HIV status to relatives for fear of stigma and discrimination. Lastly, social undermining is the expression of negative affect or criticisms from others that may hinder pregnant women's utilization of PMTCT. For example, pregnant women are often reluctant to disclose HIV status for fear of family exclusion (Karen, 2013).Institutional-level barriers to PMTCT, including stock-outs of drugs, lack of health care workers, and poor HIV counseling, have been widely addressed in the medical literature as well. This is a separate topic beyond the scope of this paper, since the author is primarily interested in social barriers to PMTCT instead of logistical constraints (Karen, 2013). Most sub-Saharan African countries suffer from absolute poverty, but there certainly are differing social classes and varying levels of access to health care based on (Karen, 2013).

According to facility data, the uptake of at least one ANC visit among pregnant women was good in 2010 (81%), yet only 10% of pregnant women in Ethiopia accessed skilled birth

attendance in 2011, and the maternal mortality ratio in 2010 was high (350/100,000) (Labok&Krasoec,1990). In 2010, only 26% of pregnant women were tested for HIV and, in 2011 only 24% of PWLHIV received more efficacious regimens for PMTCT. Twenty-eight percent of women in Ethiopia (ages 15-49) reported unintended pregnancies in 2011, indicating high unmet need for family planning and reproductive health services(RHAPCO, 2012).

CHAPTER THREE

3. Methodology

Research Methodology presents an overview of the methods used in the study.Areas covered under this part include the study subjects, research design, research population, sample size and sampling techniques, method of data collection and plan of data analysis.

3.1. Study design:

A community based cross-sectional study design with qualitative and quantitative study approaches especially single subject design was used. The research design is description design, because it is suitable for this study**.**

3.2. Study area and study period*:*

The study was conducted in SouthGondar and West Gojam Zones Amhara National Regional State North West Ethiopia. This study was conducted from June 2013 to March 2014. The number of people living in the study area is estimated to be 266-432(489 MSG members) :60 leaders from health offices of 10 Woredasand 60 professionals, mentors and leaders from 10 health centers of the 10 Woredas and 30 MSG members in each Woreda participated in the study.

3.3. Source population & Study population

All mother supporting groups in the intervention Zones, Woreda health professionals, and mentors are sources of the population for this study. MSG members in the two Zones, Woreda health professionals and mentors are study populations. MSG members in the two Zones, Woreda health professionals, and mentors are sampling units for this study.

3.4. Inclusion criteria:

The study subjects are PLHA association leaders, HAPCO leaders and officers, women's affair office leaders, NGO mentors and other volunteers.

3.5. Sample size

The Sample size was determined using single population proportion formula with an assumption of non–response rate of 5%. Due to this calculation, the proportion of female PLHA and young females' contribution among study subjects in the two Zones was assumed to be 50% to obtain sufficiently large sample size.

3.6. Variables of the study

Dependent variables: contribution of MSG members' uptake on PMTCTservice.

Independent variables:

- Socio-economic and demographic variables:
  - ✓ Age,
  - ✓ Sex,
  - ✓ Marital status,
  - ✓ Ethnicity,
  - ✓ Religion,
  - ✓ Education level
  - ✓ Income/ monthly salary,
  - ✓ Occupation
  - ✓ Birth order
  - ✓ Residence
  - ✓ Place(distance)
  - ✓ Access to health centers

- Use of health service
- Source of information about mentors, media, health professional and leaders

3.7. Data collection tools

Questionnaire was employed for the survey part of the study. Observation and in-depth interview were employed for the qualitative parts of the study.

3.7.1 Quantitative Part

The questionnaire was adopted with little modification from standardized questionnaires used by international organizations, national studies, and published articles. The questionnaire focused on contributions of MSG in improving PMTCT uptake of mothers living with HIV and AIDS. The questionnaire was pre-tested in Bahir Dar city. The weaknesses of the questionnaire identified were corrected. Data collection was carried out by the researcher and trained data collectors. The data were checked and identified problems were corrected as soon as possible.

3.7.2.**Qualitative Part**

The qualitative part of the data was collected using interview of key informants. The qualitative data were collected by the researcher of this paper. In-depth interview guides were prepared, andpre-tested for their culture sensitiveness for in-depth interview key informants. The observation was also done and necessary information was collected.

3**.4. Data Management and Analysis**

The data were manually checked for their completeness and consistency. By taking five people from the total respondents, the necessary adjustment was made. The entered data were exported to SPSS version 20 soft ware and the analysis was done. The result has been presented using percentages in appropriate tables and figures to display the descriptive part of the result. The main concepts of in-depth interviews were also identified, examined and analyzed.

Data quality control was carried out using,

- Pre tested tool
- Supervision
- Data collection guide line

Data quality control was carried out using,

- Pre tested tool: - the questionnaire was cheeked for its completeness and errors corrected accordingly. The questionnaire was pre tested on selected PMTCT and MSG sites at Bahirdar town Hidar 11 health center ten MSG members and ten health professionals. During pretesting the questionnaire was checked for its clarity simplicity, understandability and coherency. Correction was made based on the feedback. For confusing words and phrases the local known word by the consent of respondent was used.
- Supervision:-To assure the quality of data questionnaires were designed properly to address the objectives of the study and training was given for two days to data collectors and supervisors. The principal investigators and supervisors made a day to day on site supervision during the whole period of data collection. Questionnaires were checked by immediate supervisors on necessary basis for completeness and consistency.
- Data collection: - The questionnaire was filled by the health professionals and MSG members. Training is given to supervisors and data collectors about confidentiality responders, informed consents, objective of the study, technique of the interview and how to fill the questionnaire.

3.8. Ethical considerations and Ethical clearance

Ethical clearance was obtained from St.Marry University College (Indira Gandhi National Open University/IGNOU/. Permission letters were collected from the health offices and health centers of the Woreds of the two Zones. Confidentiality and privacy of the study participants were maintained. The objectives of the study were told to the participants. The data were collected after both verbal and written consents were obtained from each study participant and the results have been presented in aggregate. The other

- Ethical clearance was obtained
- Information sheet was developed
- Confidentiality information was maintained

3.9. Dissemination and utilization of results

The findings of the research work would be communicated to St.Marry University College /Indira Gandhi national Open University, Amhara National Regional State HIV/AIDS Prevention and Control Coordination Office, agencies highly involved in the assistance of mother supporting group, & PMTCT service giving organizations and others as deemed necessary. The paper will also hopefully be communicated to other readers worldwide by sending it for publication on scientific journals.

CHAPTER FOUR

4. Result and Discussion

4.1. Result

4.1.1. Socio-demographic Characteristics on MSG Member

A total of 228 MSG members and 108 health professionals participated in the study. In relation to MSG members, 130 subjects from urban (that is 57%, of MSG who live in town) and 98subjects (43%) from rural areas took part in the study. The median age of the 69.3% of the studied MSG members was 26-35 years. Most of MSG members (greater than 84%) are followers of the Orthodox Church and they are followed by Muslims in number. All of 228 (100%) respondents were Amhara. Regarding education status, 111 (48.7%) of the members did not have formal education. The others 41.3% had greater than primary education (grades 1-8). Most of the participants, 63 MSG members (27.7%), were house wives & daily laborers and are followed by Civil Servants 30 (13.2%). It was reported that nearly 127 respondents (55.7%) have married, 47(20.6) divorced, 30 (13.2%) widowed & 24 (10.5%) unmarried.

Table1 -socio demographic characteristicsofMSG members

Characteristics	frequency	Percent (%)
Residence of the respondent		
1- Rural	98	43
2- Urban	130	57
Respondents' age group		
1- 18-25	23	10.1
2- 26-35	158	69.3
3- 36-45	47	20.3
Religion		
1- Orthodox	192	84.2

2- Muslim	28	12.3
3- Protestant	8	3.5
Ethnicity		
Amhara	228	100
. Educational Status		
1- Can't read &write	111	48.7
2- Primary school (1-8)	21	9.2
3- Secondary (9-12)	26	1.4
4- Tertiary	14	6.1
Occupation		
1- House wife/ house work	88	38.6
2- Merchant	40	17.5
3- Daily laborer	48	21.1
4- Government employee	23	10.1
5- Others -----	29	12.7
Family Monthly income		
1- -< 500birr	90	39.5
2- 500birr-1000	130	57
3- >1001	8	3.5
Material status,		
1- Married	127	55.7
2- Single	24	10.5
3- Widowed	30	13.2
4- Divorced	47	20.6
Number of children born		

1- 1st	20.2	46
3- 2nd	113	49.6
4- 3rd	54	23.7
5- 4th	15	6.6
Distance from the nearest health		
1- <5km	103	45.2
2- 5km-10km	78	34.2
3- >10km	47	20.6

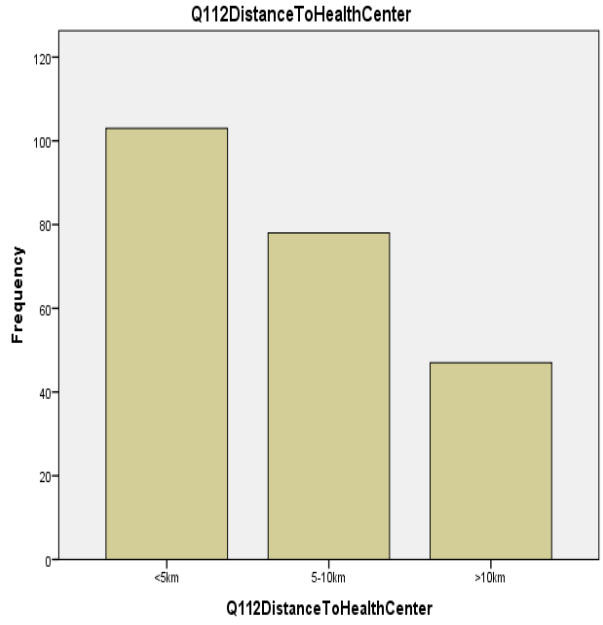

Figure 5- Distance from the nearest health by MSG respondent

4-1.2. Socio-demographic Characteristics on health and related professionals.

A total of 108 health and related professionalisms participated in the study. From these, 61 of the respondents (56.5%) were male and 43.5% females. Regarding the age category, the minimum age was 20 years, the maximum 45 and the mean was 30.94%. On the other hand, the

maximum age group was 25-35 years, 76 respondents (70.4%).Those whose education level above grade 12 was 60(55.6%). Regarding their religion, 87(80.6%) were orthodox and 13(12.5%) were Muslim. All respondents were Amhara. The monthly income of the 68(63%) health and related professionals was above 1001 birr. From their responses, 55(50.9%) of the health and related professionals were married and the least 6.5% were divorced.

Table 2- Socio demographic characteristics of respondents

Characteristics	frequency	percent (%)
Sex		
1- Male	61	56.5
2-Female	47	43.5
Age		
1- 18-25	14	13
2- 26-35	76	70.4
3- 36-45	18	16.7
Educational statuses		
1- Below grad 9^{th}	4	3.7
2- Secondary (9-12)	44	40.7
3- 12+1 and above	60	55.6
. Religion		
1- Orthodox	87	80.6
2- Muslim	13	12
3- Protestant	8	7.4
4- Other	-	-
Ethnicity		
Amhara	108	100
Family Monthly		
1- < 500	9	8.3
2- 500-1000	31	63
3- >1001	68	28.7
Marital status		

1- Married	55	50.9
2- Single	35	35.2
3- Windowed	8	6.5
4- Divorced	7	7.4

Address information and improvement of PMTCT service Questioners for (MSG members)

Among IEC respondents use 62(27.2%) community conversation 53(23.1%) radio, 42(18.4%)TV, and others are the means of MSG members address information.

The mean CD4 count form of the MSG members in ml^3 is in appropriate proportion of CD4 count greater than 501 and no risk of CD4 count has been observed. Before four months MSG members who started ART treatment were 87 (38.1%). MSG members who started ART treatment before 24 months were few (15(6.6%). This has the impact on the mothers' uptake of PMTCT service before 4 months.

Table 3-Information and improvement of PMTCT service of Respondents

Characteristics	Frequency	Percent (%)
Information education Communication use,		
1- Radio only	53	27.2
2- TV only	42	18.4
3- News paper	16	7
4- Pamphlet	23	10.1
5- Peer teaching	32	14
6- Community conversation	62	23.1
Most of you use health Service		
	---	Health post
---	228	100
Hospital	---	Health center

Duration of follow up at		
1-Pre-ART	29	1.3
2- < 6 months	15	6.6
3- 6months-11months	35	15.4
4- 12months-23months	62	27.2
5- 24months-35months	3	1.3
Current CD4 count		
1- 200ml-500	96	42.1
2- >500	132	57.9

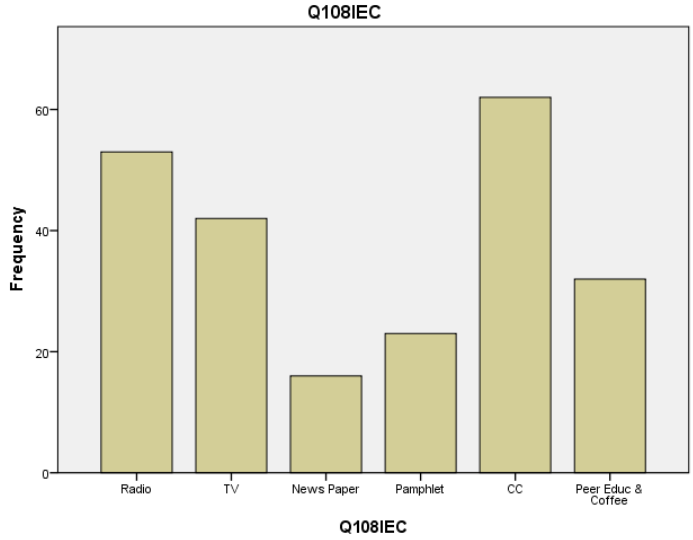

Figure 4- Information education communication use by MSGrespondent

Regarding MSG contribution to address PMTCT service information for HIV positive mothers, 198(86.8%) MSG addressed information. Most MSG members, except the 13.2%, have got good opportunities to address PMTCT information. MSG members responded that, they contributed to improve the 193(84.6%) HIV positive mothers' uptake of the PMTCT service. The 174 HIV positive mothers (76.3%) show significant improvement.

Table 4 Address information and improvement of PMTCT service

Alternative questions	Yes(%)	No(%)	I don't know

Do MSG members address PMTCT service information for HIV positive mothers?	211(92.5)	12(5.3)	5(2.2)
Do MSG members improve the HIV positive mother's uptake of the PMTCT services	215(94.3)	9(3.9)	4(1.8)
Has the MSG program significant improvement in the quality of life the HIV positive women? If so how?	210(92.1)	12(5.3)	6(2.6)
what are the reasons for the current uptake of			
1-professional counseling	86	37.6%	-
2-peer experience	70	30.6%	-
3-comfortable health service	66	28.8%	-
4-others	6	0.8%	-

Questionnaire for health and related professionals.	Yes (%)	No (%)	Idon'tknow(%)
Are the PMTCT services accessible to the target population?	102(94.4)	2(1.9)	4(3.7
Does the MSG program help HIV positive mothers to use PMTCT service?	106(98.1)	0	_
Has MSG program contributed to create suitable environment for PMTCT service? If so how	108(100)	0	0
Has the MSG program brought significant improvement in the quality of life of HIV positive women? If so how?	103(95.4)	2(1.9)	3(2.7)
Agree/dis agree questioner	Agree (%)	Disagree (%)	_

ISG program strengthened health care services bytraining health xtension workers in MSG related activities.	4(11.1)	96(88.9)	_
The current MSG structure succeeded in providing appropriate uality PMTCT services	51(47.2)	57(52.8)	_

As the responses 93(86.1%) ,MSG program helps HIV positive mothers to use PMTCT service. 96 (88.9%) respondents stated that MSG program contributes to create suitable environment for PMTCT service and brought significant improvement in the quality of life of HIV positive women. The other 92(85.2%). respondents responded that MSG program helps HIV positive mothers to use PMTCT service. MSG program strengthen health care service by training health extension workers in MSG related activates. 96(87%) health professionals agreed that the current MSG structure succeeded in providing appropriate quality of PMTCT services. 61(56.5%) health professionals agreed with the structure and others disagreed.

The respondent responses to reasons facilitating the current uptake of PMTCT service are: 86(37.6%) professional counseling, 70(30.6%) peer experience and 66(28.8%) comfortable health service.

Regarding the qualitative part of the study, open ended questions, focuses group discussion, interviews and observations were presented. Some of the questions focus on as follows**:**
Whether the MSG program has significant improvement in the quality of life the HIV positive women, the relationship with neighbors are factors affecting HIV positive mothers to uptake PMTCT service.

Qualitative results identified from the questionnaire:
When analysis was made to see whether HIV positive mothers' uptake of PMTCT service was improved, it was found that MSG program has brought significant improvement in the quality of life of the HIV positive women. MSG has created awareness for HIV positive mothers on how to live in health by taking VCT and PMTCT services. They said:

"MSG give necessary information during coffee ceremonies. MSG community conversation focuses on saving money and discussing together. MSG gives education and we get knowledge about breast feeding, nutrition and how to prevent HIV".

Most of participants said that MSG gives them unforgettable advice for their health and, as a result, this helps them to have good attitude towards HIV and PMTCT and develop good knowledge for their lives. They said that MSG assists them to live a better life and have HIV free children. The HIV positive mothers said that, due to this reason, they are very happy and healthy, use ART properly, have a good attitude towards their life and do everything like their friends. One of the respondents said that MSG contributes in improving the HIV positive mothers' uptake of PMTCT services. Here are the respondent's words:

MSG has the greater contribution for the uptake of PMTCT service, especially for women who have HIV in our blood to have our children free from HIV. We got a new hope to have HIV free generation. MSG mentors and facilitators guide us to take ART properly. And the center gives us advice properly. They show us the advantage of using the health center. By using the PMTCT service actively, I bore my HIV free child at the health center. MSG has reached for my life .I was restless and in stress but through their advice I have begun to lead a good life. Their life experience has taught and helped me to use the health center especially the ART and PMTCT service.

On the other hand, health professionals and other related workers said that:

MSG program contributed a lot to create suitable environment for PMTCT service .their special words are: "By giving care and support, MSG plays the greatest role especially for HIV positive women's uptake of PMTCT service. They create awareness for peer and group members". MSG information discussant said that MSG give and address suitable information about a new born infant and about delivery and breast feeding programs.

The MSG members teach based on their life experience about the advantage of PMTCT service as they know the reality. One respondent said

"MSG relationships to the HIV positive mothers are quick as they share their idea and help them find solutions for problems."

During the interview, MSG members expressed that they themselves resolve problems.

As the observation of the researcher at nine health centers, MSG program's contribution result is very attractive and leads to the creation of HIV free generation. The MSG contributions for HIV

positive mothers were that it enabled them to use ART properly, always visit PMTCT services, and bring significant improvement in the quality of the lives of HIV positive mothers, and as a result caused their CD4 count to become normal.

The respondents gave many similar answers. One of them said:

MSG program has brought significant improvement in the quality of life of HIV Positive mothers. They protect themselves; use the health center and PMTCT service to save their life. Many mothers have become critical thinkers and analyze the information. The others have become problem solvers and born HIV free generations .Some of HIV Positive women are participants in the MSG members and have developed the skill of coping stress and emotions. The other improvement in the quality of life of HIV positive mothers is that they use PMTCT services and partners to know themselves.

When I observed them, one third of their partners participated with MSG members. Here aresome of the respondents' words

> *"MSG program have multiple contributions. They give advice, motivate and support for HIV positive mothers". MSG members addressedinformation by the pamphlets, coffee ceremony, and others. Others can get information from MSG and can do everything.*

Regarding the improvement of HIV positive mothers' uptake of PMTCT service, MSG roles are very essential. As the information obtained from the interview, open ended questions and the field observation, the participants replied that MSGs have the greatest roles to advise HIV positive mothers to use PMTCT service. After graduations, they visit MSG members. They address information and advice their peers. During the observation, it was seen that they give advocacy for HIV positive mothers. As the respondent's response, MSGs are used as a bridge to make good relation and integrate HIV positive mothers and PMTCT service.

The respondents said that:

> *They give them advice about breast feeding and tell them the risk factors during pregnancy and how to use PMTCT service. That MSGs' roles were motivating HIV positive mothers, serving as facilitators, creating awareness and addressing new information for HIV positive mothers. MSGs have created hope for mothers who are in stress. One of the respondent said (Amharic words)"Kegoneteselfewbechinkie ken bemedersachewmedhanitenbeagbabueywesedhu HIV*

netsalejebalebetaderegewegnal"(convert to in ENGLISH). "By their greatest help, I can take my treatment properly and have got HIV free child.''

Most of the respondents gave their witness that they have got PMTCT knowledge through MSG and developed positive attitude towards PMTCT service.

To improve the uptake of PMTCT: the observation on accessibility of PMTCT service showed that most of the health centers have PMTCT service. For these services, MSGs' contribution is great when HIV positive mothers come. As the observation on the accessibility of PMTCT services, most of the health centers have fulfilled PMTCT service. There are charts, symbols and other information giving tools. Health professionals told the researcher that health and related professionals have the greatest concern for PMTCT service delivery. Equipments for delivery are fulfilled.

Many government partners, NGOs and the community have participated on this service. As the data collected from the selected health centers, research agencies management science for health put a professional mentor and two mother mentors in each health centers. It was observed that necessary materials were fulfilled. One of the respondents said,

"*To give life for them, we give high concern for the service. Even though health extension workers do not do PMTCT services, they participate by giving reference papers and integrating health center PMTCT services and MSG."*

At the PMTCT center and department, there are different models to give information and create awareness about VCT,FP,PMTCT,STI,ART,OI and their information was given during my observation. Skilled birth attendant give PMTCT and postnatal service for the women. They advise HIV positive women to take their treatment effectively and know their CD4. During the observation, it was seen that the quality of the service differs from health center to health center. For example, the counseling quality is different in different health centers. There are regular meetings to discuss about PMTCT service.

The outlook of MSG members for the uptake of PMTCT service was good. Because of this service, many of the mothers live healthily and have born HIV free children. From the observation, most of MSG members said that:

"PMTCT service has reached for their life and as a result their hope has been increasing from time to time and the number of MSG members has increased.

The observation during MSG coffee ceremony showed that the participants were very happy and used PMTCT service. One of the MSG members responded:

> *"At the beginning my wife disagreed when I told her to be a member of MSG .After I had born my child free from HIV, my wife supported me to strengthen MSG for the uptake of PMTCT service.'' The other MSG member said, "At the beginning my neighbors laughed at me when I told them I am a member of MSG but after I had born HIV free child, they admired MSG members for the uptake of PMTCT service."*

During the observation of Estie Health Center, it was seen that 28 MSG members bore HIV negative/free children .The other two did not know their status. Reports from 32 MSG members showed that 30 children have been born free from HIV. Then, the outlook of MSG on the uptake of PMTCT service has increased and become good because they used it properly.

MSG addresses information**:-** for the uptake of PMTCT service for HIV positive mothers. The data obtained from the open ended questions, observation, interview and group discussions were analyzed using data condensation. Almost all interviewees reported their contributions based on care and support for MSG and HIV positive mothers to uptake PMTCT service. It was noticed from the discussion that the MSGs' main activity was giving education for HIV positive mothers to use PMTCT service. As it was seen from what the respondents said they MSG mobilized and created awareness for them.

During the observation, an interviewee responded that they have got good knowledge and had positive attitude and skill about PMTCT. As their responses, the community care and support for HIV positive mothers has increased. Especially the government commitment has been increasing from time to time. Due to this reason, women development army and the health professionals have especial concern for PMTCT service. Due to this reason, the community care and support service has increased. They said that:

> *"This helps especially economically poor HIV positive women to be benefited. As the respondents' responses, based on communities care and support, HIV positive women got transport support by the community. Because of this, lots of follow up for HIV positive mothers' activity has been done. Some of MSG members said leaders help them to use PMTCT service at Kebele level.*

The community care and support need to be sustainable so that mothers can uptake the PMTCT service. The other respondents of the open ended questions said MSG information was used to integrate PMTCT service. The other respondent responded that health extension workers impart HIV/ADS information and participate in community conversations. Health professionals and participants responded that community care and support has risen in community conversations. The health professionals replied that different IEC (information education and communication) materials and ideas reached.

Factors affecting MSG and PMTCT service:-

Table 6- factor affecting MSG and PMTCT service for MSG member of the study subject in by MSG respondent

After you became a member of MSG, does your relationship with your neighbors continue as before?		
	Frequency	percent (%)
1. Yes	70	30.7%
2. No	147	64.5%
3. I don't know	11	4.8%

- Are there factors affecting HIV positive mothers' up take of PMTCT service? if so how?		
	Frequency	Percent (%)
1.Yes	179	78.5%
2.no	46	20.2%
3.I don't know	3	1.3%

-What are the reasons for HIV positive women not disclosing officially that they are MSG members?		
1-fear of lack of confidentiality	100	43.7%
2-fear of stigma and discrimination	89	38.9%
3-no need of service provider help	33	14.4%
4-others	-	-

-What is the reason that some of HIV positive mothers don't use PMTCT service?		
a)Lack of confidentiality	60	26.3%
b) partner disagreement	47	20.6%
c) fear of stigma and discrimination	65	23.1%
d) PMTCT service fear for HIV positive mothers	53	28.5%
e) others	3	1.3%

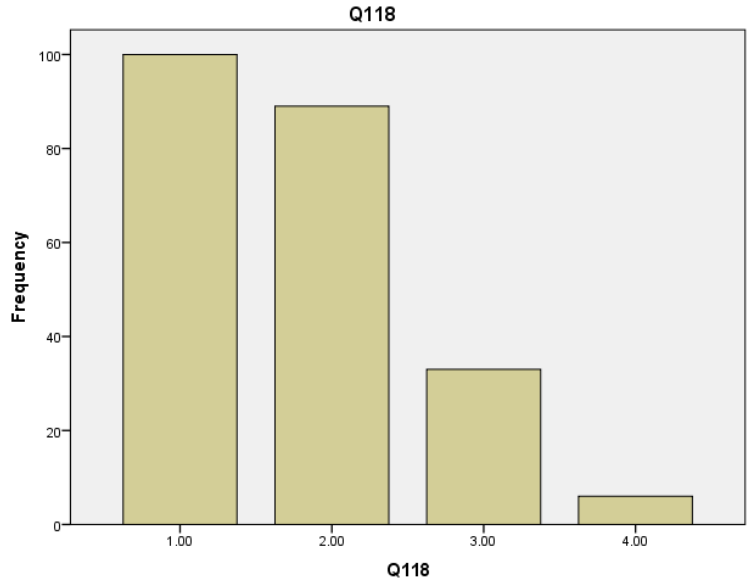

Fig 6: The reasons for not disclosing condition to be MSG member official by MSG respondent.

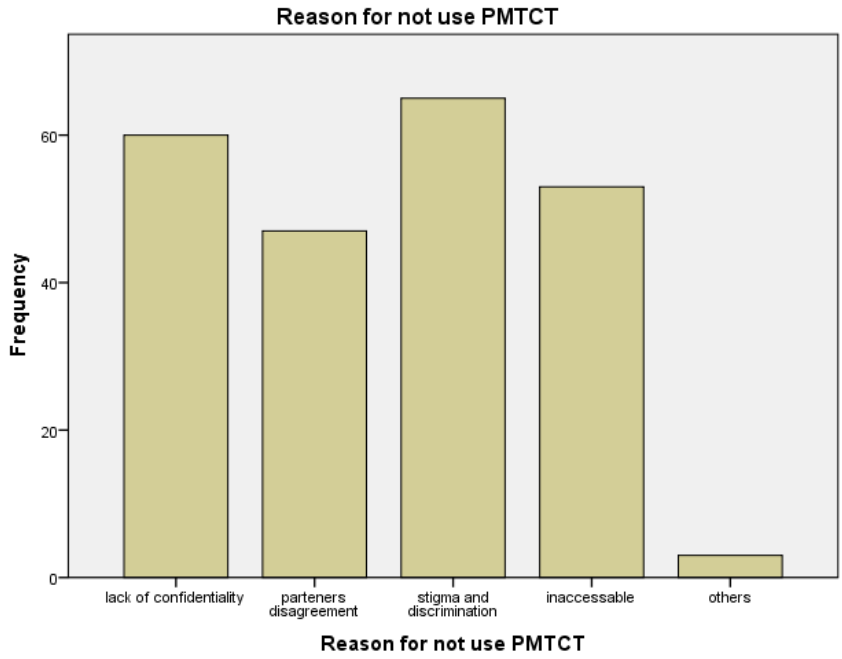

Fig 5- The reason that some of HIV positive mothers do not use PMTCT service From MSG respondent

MSG members asked HIV positive mothers about their social relationship with their neighbors and their relatives since they became the members of MSG. The respondents answered their relationship does not continue as before. The 147 (64.5%) HIV positive mothers after they became members of MSG. From the respondent 179 (78.5%)are saying there are factors affecting HIV positive mothers' up take of PMTCT service.

The numbers of respondents to the reasons for HIV positive mothers not disclosing officially that they are MSG members are: 100(43.7%) fear of lack of confidentiality, 89(38.9%) fear of stigma and discrimination and 33(14.4%) no need of service provider help. MSG members response to the reasons of HIV positive mothers of not using PMTCT service are :60(26.2%)lack of confidentiality, 47(20.5%)partners disagreement, 65(28.4%)stigma and discrimination and 53(23.1%) the distance of PMTCT service for HIV positive mothers. The basic factors which affect HIV positive mothers not to use PMTCT service, the communities based care and support for MSG to uptake PMTCT service, the gaps between MSG and PMTCT service for sustainability, information reaches MSG members, and others.

Regarding the qualitative part of the study, open ended questions, focuses group discussion, interviews and observations were presented. Some of the questions focus on as follows**:**

Whether the MSG program has significant improvement in the quality of life the HIV positive women, the relationship with neighbors are factors affecting HIV positive mothers to uptake PMTCT service. The basic factors which affect HIV positive mothers not to use PMTCT service, the communities based care and support for MSG to uptake PMTCT service, the gaps between MSG and PMTCT service for sustainability, information reaches MSG members, and others. The other respondent said:

> *There are food support and economical problems for MSG to use the PMTCT service actively. From the participants' responses, HIV positive people's dependency on syndrome developed. HIV/ADS information were tired and faded out., male partner's involvement is small, they are afraid when their partners go for peer discussion. There is no MSG in their health post and no peer education & discussion in their kebele .There is no skilled and trained PMTCT service giver in the health post and other factors influence the uptake of PMTCT service.*

Respondents gave their responses that there are factors affecting HIV positive mothers' uptake of PMTCT services. When they go to PMTCT service, they become stigmatized and stressed. Most of the respondents stated that male partners are not voluntary to use PMTCT service. As MSG respondents, during VCT and PMTCT it was difficult for partners to take the realty and some do not use actively. The community awareness shames stigma and discrimination. The respondents said:

> *There is a lack of transportation to get PMTCT service especially in rural areas. The PMTCT service was not given at health post level and MSG was not organized at kebele level. Some PMTCT clients disappeared from the service and the others are observed delivering in the health center.*

From my observation, health and related service givers need training as all of them do not have training.

During the researcher observation factors affecting HIV positive mothers' up take of PMTCT service are that most of male partners are involuntary to involve. Some participants do not uptake the PMTCT service because of lack of permission from their male partners, the others because of

long distances from the health center; many of MSG members went on foot. Stigma and discrimination are other factors that affective mothers no to participate actively in the uptake of PMTICT service .They feel shame and stop participating in the group.

There are in no MSGs in their health posts, no HIV positive mothers' peer discussions and health and mother advisors, mentors, skilled and trained PMTCT service givers in their village.

As the observation, most of the participants were in the town and the others are around the town. The other are not members of MSGS because MSGS are organized at the woreda health center level and the others cannot participate actively. As the observation shows transportation is difficult, social stigma and discrimination increase when their relatives look them. When they go long distances their relatives including their families & neighbors isolate and reject them. They rose during the discussion that HIV positive mothers go long distances for PMTCT service. It put its impact on the uptake of PMTCT service. During the observation, it was seen that there were gender inequality and male partner domination. They told the researcher:

> *The incorrect beliefs, blaming, prejudice, discounting put on MSG members. Lack of enough amounts of awareness creation, acceptance and action made gaps on the uptake of PMTCT service.*

During the observation coffee ceremony, some MSG group were supported by partners. When these partners fadeout, MSG may be sustainable. Mother mentors hold registration and minute writing. Most of the lost and absentee were women participating in rural areas far away from the health centers. During the observation, health extension, People Living with HIV Association Representatives and many referral papers were observed but the participations of women, children and Youth affair and women associations were not observed. They said that:

> *MSG members come from distant areas and when they come together, with group members, during their journey, they discuss their problems and share ideas. This resolves their tiredness and causes them to learn from each other.*

During their coffee ceremony, there was the participants' discussion. A participant came alone. As a result, she became tired and stopped coming to the MSG discussion.

Correlation Results:-

According to Mulu (2006) Pearson coefficient and phi coefficient can be used to show the correlation between independent and dichotomous dependent variables interchangeably. Therefore, the researcher applied Pearson correlation coefficient to show the correlation between age, education, occupation, marital status, number of children, IEC, on ART, CD4count, address PMTCTinformation, MSG members improvement, relationship after become a member, factor affecting PMTCT service, reason for not disclose, reason for not use PMTCT service are included. The symbol of a correlation is *r,* and its range is from -1.00 to +1.00. A correlation coefficient tells two things about the relationship between two variables; the direction of the relationship and its magnitude. The closer the measure is to 1.00, the more likely the relationship is statistically significant (Mulu, 2009). In addition, Pearson correlation coefficient indicates multi collinearly problems. The interpretation of the strength of correlation between variables is shown as follows:

Correlation betweensome socio demographic conditions the participant education and age is positive with a Pearson correlation coefficient of r = 0.067. The relation between as indicated from Pearson correlation coefficient table, and educational status is correlated to occupation with r=0.210. The p value is less than. 01. This shows that the two variables are correlated.

Relationship between IEC and CD4 is positively correlated with a Pearson correlation coefficient of r= 0.039. The relationship between IEC & Duration on ART start as indicated from Pearson correlation coefficient table, IEC is negatively correlated to duration on ART start with r= 130. The p value is greater than .05 which shows that the two variables are significantly correlated.

The relationship between MSG members improve HIV positive mothers The Pearson correlation result show MSG improve their positive members have relation to IEC with correlation coefficient of r = 0.058. The p value or the significant level is.001 which means their relation is still significant.

The relationship between address information current uptake of PMTCT as indicated from the table, the result indicated that address information and reason for current uptake of PMTCT are positively related with r = .048 and the p value of the significant level is greater than 0.05. The relationship of two variables is strongly significant.

The relationship between relation of MSG after a member factors affecting HIV positive women as indicated from Pearson correlation coefficient relation of MSG after a member is negatively correlated to factors affecting HIV positive women with r =- 0.046. The p value is greater than .05which shows that the two variables are significantly correlated. Because the relation decreases when there are factors affecting HIV positive mothers. The Pearson correlation result reason for not disclose factors affecting HIV positive mothers uptake of PMTCT depicted that reason for not disclose have a negative relationship to factors with correlation coefficient of r = 0.037. The relationship between factors affecting reason for not use PMTCT service as indicated from the table, the result indicated that factors affecting PMTCT service reason for not use PMTCT are positive related with r = 0.043.

4.2. Discussion

MSGs have greater contribution by addressing information about the uptake of PMTCT service for HIV positive mothers. For this reason, many of HIV positive mothers bore HIV negative children. This study focused on the contribution of MSG in improving HIV positive mothers' uptake of PMTCT service. The contributions of 10 MSGs in 10 health centers in 10 Woredas in South Gondar and West Gojjam Zones in improving the uptake of PMTCT service of HIV positive mothers were included.

In this study the researcher found MSG members' addressing of PMTCT service information for HIV positive mothers was 86.8%. During the observations and interview, MSG members addressed information with different Media. From the tables shown, the researcher can see information addressing for HIV positive mothers with different media especially by community conversation, coffee ceremony and others. Regarding addressing Information properly (Laboke and etal, 1999) stated that the successful MSGs can provide information, encouragement and support. In similar research (study) conducted in (Beak and etal, 2001), it has been stated that by addressing information and giving emotional support for HIV infected pregnant post partum women ,utilizations of PMTCT service (ICASA, 2011) can be improved.

The study shows MSG would scale up and the greater source of information address for HIV positive women on PMTCT. The study shows community conversation, radio, TV, and others are necessary to address information.

According to the study, MSG program has helped HIV positive members to use PMTCT service and this was expressed by 85.2% of the health professional participants .This indicated that most of MSGs have helped HIV positive mothers to use PMTCT services by advocating them and addressing information on the uptake of PMTCT. EDHS, (2011) indicated that MTCT can be reduced by taking special drugs during pregnancy and for this they need necessary information. According to knowledge of MSG (Pfizer,2012), stated that: The program achieved substantial coverage of both pregnant and postpartum women, with almost 60 percent of women reporting that a mentor mother talked with them at least once while the women were pregnant or during their last pregnancy.

According to Information communication and Education the relationship between IEC & duration on ART start as indicated from Pearson correlation coefficient table, IEC is negatively correlated to duration on ART start with r= 130. The relationship between MSG members improve HIV positive mothers the Pearson correlation result show MSG improve their positive members have relation to IEC with correlation coefficient of r = 0.058. The relationship between address information current uptake of PMTCT as indicated from the table, the result indicated that address information and reason for current uptake of PMTCT are positively related with r = .048 .

Regarding MSG Members Improvement in the Uptake of PMTCT: In this study MSG members have given their wetness on the improvement of HIV positive mothers' uptake of the PMTCT service and that HIV positive mothers show significant improvement in the quality of their life. 84.6% respondents have agreed that MSG members have improved HIV positive mothers' uptake of the PMTCT service. Pfizer (2012) supported that, at all its sites, m2m seeks to improve the uptake and outcomes of established PMTCT treatment programs.Regarding improvement in the quality of life of the HIV positive women, 76.3% MSG members responded that HIV positive mothers have shown improvement in their life.Labok,M. & Krasovice,K.1990; Rodriguez-Gracia,R,etal,1988;Seel, and et al 1991, supported the above research, thatthe goal of MSG strategy is reduce mother-to-child transmission by empowering HIV-positive mothers and mothers-to-have informed decisions about their reproductive health and the health of their babies. Data obtained from interviews and observations show the same result. In addition, 84.3% of professional respondents said MSG program brought significant improvement in the quality of life of HIV positive mothers.

Regarding CD4 counts the respondents said that they know that with in short months ago, 57.9% of HIV positive mothers show above 500ml.cubic CD4 count and there is no less than 200ml.cubic CD4 count. The discussant members and the observer cheeked that MSG members have improved HIV positive mothers' uptake of the PMTCT service. Health and related professionals responded that MSG program brought significant improvement in the quality of

life of HIV positive women. Other studies by (Laboke and etal, 1999) gave their witness and stated the goal of MSG strategy is to reduce PMTCT by empowering HIV positive mothers. United Nation General Assembly set a target for 80% of pregnant women and their children to have access to PMTCT service. FHAPCO annual best practice abstract book (FHAPCO,2012) supports this study that increasing access to more efficacious PMTCT regimens including ART for eligible women can improve the quality of maternal and child health services.

MSG contribution: majority of the respondents (88.9%) stated that MSG contributes for uptake of PMTCT service. In relation to PMTCT service accessibility to the target populations, 86.1% of the health professional respondents responded that the service was accessible. The National Net Work of Positive Women show, MSG helped to reduce the burden the health care providers face. Similar study conducted by Meaza, (2011) and she states that MSG provides basic MSG training to mentor mothers who have delivered babies through PMTCT to share their life experience to newly HIV positive pregnant mothers. 88.9 % health professionals responded that MSG program contributes to create suitable environment for PMTCT service.

On the other hand 56.5% of the respondents have agreed that the current MSG structure has succeeded in providing appropriate quality of PMTCT service. The other 43.5% have disagreed to the present structure. Their reasons were based on the idea that this should not only be done at health center level but also this should also be done at health post level. Health Extension workers have given different support for MSG group. Then, health professionals were asked whether they agree or not MSG program strengthened health care service by training health extensions workers in MSG related activities 87% of the have agreed with HEW training.

According to the qualitative part of the study from the open ended questions, interview responses and observations, MSG members address information for HIV positive mothers and give advice through coffee ceremony and peer education. During the observation, it was seen that materials and models had reached at most PMTCT service sites. In addition to that most of HIV positive mothers bore HIV negative children through PMTCT service that service giver professionals fulfilled. This research predicted that at the end of 12 months, the number of HIV positive pregnant women CD4 count will increase from 53.8% to 90%. The number of pregnant women receiving ART increased from 59% to 83%. After the interventions, the number of exposed

infants who was tested HIV negative increased from 85% to 100%. Then there are some factors that affect MSGs' facilitation on the uptake of PMTCT service.

87% respondents agreed that MSG program strengthened health care service by training health extension workers in MSG related activities. Other studies, Ethiopian health and nutrition institute (2012) state that, health extension workers working in the community at the health post level are the backbones to deliver the service for the community. They work moving from house to house providing education, advice for the pregnant women to use PMTCT service.

Regarding factors affecting, Factors affecting HIV positive mothers' uptake of PMTCT service are factors which affect HIV positive mothers not to use PMTCT services and create the gaps between MSG and PMTCT service for sustainability. The study shows there are factors affecting HIV positive mothers' uptake of PMTCT service and gaps between MSG and PMTCT services. The reasons for current uptake of PMTCT service are: 86(37.6%) professional counseling support 70(30.6%) sharing of peer experience and 66(28.8%) comfortable health service. This shows professional counseling, peer education information and comfortable PMTCT services are very necessary. Other study ICASA(2011) shows that ART increased from 50% to 83% and the number of clients lost to follow up reduced from 58.7% to 10.7%. Stigma related cases have also reduced.

The MSG members responded in different ways to the reasons for not disclosing conditions to MSG members officially: 100(43.7%) responded that the reason is fear of lack of confidentiality, 89(38.9%) fear of stigma and discrimination and 33(14.4%) due to no need of service providers' help. On the other side, there are many other barriers that have not been fully studied, such as limited use of antenatal and postpartum services, that is, HIV-related stigma and discrimination, the uneven quality of care in antenatal and obstetric settings, and insufficient partner and community involvement (Ethiopian health and nutrition HIV projection, 2011;FHAPCO Strategic plane,2011).

MSG members gave responses on the reasons why HIV positive mothers don't use PMTCT service: 60(26.2%) respondents said that the reason is lack of confidentiality, 47(20.5%)

responded it is due to partners' disagreement, 65(28.4%) stated that the reason is stigma and discrimination and 53(23.1%) responded that PMTCT service is far from the homes of HIV positive mothers. Many other studies show that social influence such as the actions of others affect women's thoughts and actions towards PMTCT. Moth et al. found that pregnant women did not disclose their HIV status to relatives for fear of stigma and discrimination.Regarding Institutional-level barriers to PMTCT, stock-outs of drugs, lack of health care workers, and poor HIV counseling, have been widely addressed in the medical literature as well (Karen, 2013).

According to facility data, the uptake of at least one ANC visit among pregnant women was good in 2010 (81%), yet only 10% of pregnant women in Ethiopia accessed skilled birth attendance in 2011, and the maternal mortality ratio in 2010 was high (350/100,000)(Laboke and etal, 1990).83.3% respondents responded that there are factors of affecting HIV positive mothers' uptake of PMTCT service. MSG members' relationships with neighbors and family members do not continue as before. This is identified by 64.5% of the respondents. There are factors for thisthe first ones are the beliefs and values the community has for HIV positive mothers. Stigma and discriminations, distance between health centers and other obstacles make gaps between MSG and PMTCT services. Similar study Ethiopian health and nutrition research institute (2012), indicated that in Ethiopia it has little contact with health care system and a limited use of antenatal and post partum service. Karn,H. stated that Generally, stigma, discrimination and others become factors affecting PMTCT service. Regarding the distance between the MSG members and health service, the studies shows that 34.2% HIV positive women have to walk between 5km-10 km and 20.6% of them 10 km and above. 55.7% of HIV positive mothers are married. Most of interviewee responses showed that more partners do not agree with their wives to be member of MSG.
The study from (Nwuba, 2011) stated that strengthening health system is vital in addressing the challenges of limited health service that pregnant women especially in rural areas face.

The qualitative part of the study shows the same result as the quantitative part. From the factors and challenges affecting PMTCT service, social stigma and discrimination are the problems of HIV positive mothers. Partner's involvement is very small and that makes obstacles. Distance between homes of mother living with HIV and PMTCT health centers is another factor. Because of this, PMTCT service was not given at the health extension health post level. In addition to

their response Msellati,P.(2009) stated that' HEWs are trusted members of the communities in which they work and live. They work house-to-house, providing education and preventive care and encouraging use of the HCs for care. As part of their existing scope of work, HEWs visit households monthly and are expected to know the gestational status of all women in their catchment areas, as well as to attend all births.

The relationship between relation of MSG after a member factors affecting HIV positive women as indicated from Pearson correlation coefficient relation of MSG after a member is negatively correlated to factors affecting HIV positive women with r =- 0.046. The p value is greater than .05. This shows that the two variables are significantly correlated. Because the relations decrease when there are factors affecting HIV positive mothers. The Pearson correlation result reason for not disclose factors affecting HIV positive mothers uptake of PMTCT depicted that reason for not disclose have a negative relationship to factors with correlation coefficient of r = -0.037. The relationship between factors affecting reason for not use PMTCT service as indicated from the table, the result indicated that factors affecting PMTCT service reason for not use PMTCT are positive related with r = 0.043. Generally the relationship of the study questioners supported each other.

CHAPTER FIVE:

5. Summary,Conclusion & Recommendations:

5.1. Summary:

The study project, “Contribution of mother support groups in improving PMTCT service” a case of south Gondar and west Gojam Zones, North West Ethiopia focuses on how HIV positive mothers uptake of PMTCT service, addressed HIV/AIDS information’s to improve PMTCT service, the barriers and factors affecting MSG contribution in improving uptake of PMTCT service.

After preparing and conducting the study proposal I did the research project by using IGNOU study project manual. According to my proposal time schedule, I prepared, presented and collected questionnaires quantitatively and qualitatively. Data were collected with a representative of 228 MSG members and 108 health and related professionals with two Zones, 10 Woredas with 10 health centers. During data collection, I attentively follow up and supervise the data collectors. After data were collected, I turn my focus of attention on the processing of the data. During data processed data were collected, edited, coded, prepared action of master charts and analyzed. The collected data were presented in tabular form and analyzed with the help of statistical techniques and I presented with tabular and graphical.

According to the research, the following results are obtained,: MSG members got and addressed PMTCT service information for HIV positive mothers. Contributions of MSG members improved uptake PMTCT service. By those reasons, MSG members and HIV positive mothers’ life improved. Even though MSG members addressed information’s and they improved PMTCT service and their life, there were factors that made barriers to used PMTCT service effectively.

During my discussion, I was focused on the major findings of the interpretation of data and important review of literatures related to the problem. I tried to confirm whether the major findings supported or not.

5.2 Conclusion:-

This study identifies the contribution of mother support groups in improving PMTCT service, a case of south Gondar and west Gojam Zones. The main objective of this study is to find out the contribution of MSG in improving PMTCT service uptake of HIV positive mothers. Data collected with a representative of 228 MSG members and 108 health and related professionals with two Zones, 10 Woreda with 10 health centers. The methods of data's were collected quantitatively and qualitatively.

The findings suggested that mothers support groups play the greater contribution in improving the uptake of PMTCT service of HIV positive mothers. For this improvement MSG contribution was good. To strengthen MSG programs and to help HIV positive mothers at health post level respondents agree health extension workers train about MSG programs and PMTCT service. The study shows MSG members improvement in the uptake of PMTCT service. According to their greater contribution by addressing information, MSGs and their members knew about PMTCT service. MSGs members directly participate and contribute their experience for uptake of PMTCT service.

MSG program address PMTCT information for HIV positive mothers with 86.8%. According to this study MSG members play the greater role for HIV positive mothers to advocate and to improve the HIV positive mothers' uptake of the PMTCT service. Most of the respondents gave their witness that they have got PMTCT knowledge through MSG and developed positive attitude towardsPMTCT service.

In addition to these, MSG program has significant improvement in the quality of life of HIV positive women. MSG members improved HIV positive mothers' uptake of PMTCT service, there and others life. According to factors affecting HIV positive mothers' uptake of PMTCT service there are factors which affect HIV positive mothers not to use PMTCT services and create the gaps between MSG and PMTCT service for sustainability. MSG members responded the reasons for not disclosing conditions to MSG members officially. The reason is fear of lack of confidentiality, fear of stigma and discrimination and due to no need of service providers' help.

On the other side, there are many other barriers that have not been fully studied, such as limited use of antenatal and postpartum services, that is, HIV-related stigma and discrimination, the

uneven quality of care in antenatal and obstetric settings, and insufficient partner and community involvement. Some HIV positive mothers go greater than 10 km to use PMTCT service. Even though health extensions can help MSG members there is no such MSG service at health post at Kebele label. There are factors affecting cause gaps between HIV positive mothers and PMTCT service.

5.3. Recommendations

Based on the analyses and findings of the study the researcher forwarded the following key recommendations.

- Health sectors and concerned bodies should encourage MSG members to use PMTCT service and the contribution of MSG on the HIV positive mothers' uptake of PMTCT service should be sustainable.
- Health sectors and concerned bodies should scale up MSG programs across all Kebele health post level in the form of MSG development group and/or MSG one to five government organization.
- Health sectors and concerned bodies in collaboration with the local community should be advocate to resolve those factors affecting HIV positive mothers' uptake of PMTCT service that make gaps between MSG and PMTCT service.
- Further clinical and social studies should be held on factors affecting HIV positive mothers' uptake of PMTCT service.

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Annexes

1**. Annex – 1** English version questionnaire

ST/Mary University /IGNOU MSW program.

Questionnaire on The contribution of MSG in improving the PMTCT service up take of mothers living with HIV and AIDS in south Gondar and west gojam zones, North West Ethiopia.

Woreda10and10 Health center's name ----------

Consent form

My name is ----------. I am here just for a brief discussion a study to be conducted in south Gondar and west gojam zones, health center MSG and health Professionalisms.

The purpose of this study is to assess the contribution of MSG in uptake of PMTCT service. To get this information, I am going to give you to answer some questions that are not difficult to answer. Since participant for this study are selected randomly among MSG members AND health professionals. Your name will not be written in this form and will never be used in connection with any of the information you tell me. You don't have to answer any questions that don't want to answer and you may end this interview at any time you want. A code number will identify every participant.We would appreciate your help in responding to our questions. The interview will take about 25-30 minutes. I hope having taken your time you will give me genuine information to all my questions. Any question which is not clear for you please ask me for clarification.May I get your permission to continue my interview?

I have read the consent form above and clearly understood the purpose and anticipated benefit of the research. I hereby need to assure with my signature below that me, without any coercion or forceful act by the research team, have decided to voluntarily participate in the study to

contribute my part in the effort being made for the betterment of VCT service utilization among teachers in secondary high schools.

No/	Questionaire	Alternatives	Sign (X)

If you have something to ask concerning the study, you can contact the principal investigator:

NAME WUBIE ZEWDIE

PHONE NO:

0918017980

E-MAIL:wubiezewdie@yahoo.com

Part –ONE: socio-demographics of MSG

101	Residence of the respondent	1. Rural	
		2. Urban	
102	Respondents age	___ Years	
103	What is your religion?	1. Orthodox	
		2. Muslim	
		3. protestant	
		4. catholic 5. Other (specify_____	
104	What is your ethnicity?	1. Amhara	
		2. Tigre	
		3. Oromo	
		4. Others specify_____	
105	What is your educational status?	1. Can't read & write	
		2. Read and write only	
		3. Primary school(1-8)	
		4. Secondary(9-12)	
		5. 12^{+1} and above	
2106	What type of occupation you are currently engaged in?	1. house wife/house work	
		2. merchant	
		3. daily laborer	
		4. government employee	
		5. others _____	
107	How much your family monthly income?	<500birr	
		>500birr	
108	Information education communication	1. radio only	
		2. TV only	
		3. News paper	

		4.Pamphlet	
		5.Pear teaching	
		6.Community conversation	
109	Martial status,	Married	
		Single	
		Widowed	
		Divorced	
110	Duration of follow up at ART clinic	Pre-ART	
		<6months 6months-11months 12months -23months	
		24months -35months	
		>35months	
111	Number of children born	1st	
		2nd	
		3rd	
		4th	
112	Distance from the nearest health institutions	<5km	
		5km-10km	
		>10km	
113	Current CD4 count	<200ml	

		200ml-349ml	
		350ml-499ml	
		500ml-900ml	
		>900ml	
114	Most of now you use got health service	Health post	
		Health center	
		Hospital	
101	Sex	1.Male	
		2.female	
102	Age	___ Years	
103	Educational status	6. Below grad 9^{th}	
		7. Secondary(9-12)	
		12^{+1} and	
		12+2 and above	
104	Religion	1. orthodox	
		2. Muslim	
		3. protestant	
		4. catholic	
		5. Other (specify_____	
105	ethnicity?	1. Amhara	
		2. Tigre	
		3. Oromo	
		4. Others specify_____	
106	How much your family monthly income?	_____birr	

107	Martial status,	Married	
		Single	
		Widowed	
		Divorced	

Part three- Questionnaire For MSG members

No Alternative questions	Yes	No	I don't know
305-Do MSG members address PMTCT service information for HIV positive mothers?			
306. Do MSG members improve the HIV positive mother's uptake of the PMTCT services			
307. Has the MSG program significant improvement in the quality of life the HIV positive women? If so how?			
308.what are the reasons for the current uptake of PMTCT service?			
1-professional counseling			
2-peer experience			
3-comfortable health service			
4-others			
Questions for health and related professionals'	**Yes**	**No**	I don't know
309 Are the PMTCT services accessible to the target population?			
310 Does the MSG program help HIV positive mothers to use PMTCT service?			
311- Has MSG program contributed to create suitable environment for			

PMTCT service? If so how			
312- Has the MSG program brought significant improvement in the quality of life of HIV positive women? If so how?			
	Agree	Disagree	
13-/MSG program strengthened health care services by training health xtension workers in MSG related activities.			
14.The current MSG structure succeeded in providing appropriate uality PMTCT services			

Factors affecting MSG and PMTCT service Questioners for MSG Members

No Alternative questions	Yes	No	I don't know
315-After you became a member of MSG, does your relationship with your neighbors continue as before?			
Q316- Are there factors affecting HIV positive mothers' up take of PMTCT service? if so how?			

Q317-What are the reasons for HIV positive women not disclosing officially that they are MSG members?			
a)fear of lack of confidentiality	b)fear of stigma and discrimination	c)no need of service provider help	d)others

Q318-What is the reason that some of HIV positive mothers don't use PMTCT service?				
a)Lack of confidentiality	b) partner disagreement	c) fear of stigma and discrimination	d) PMTCT service fear for HIV positive mothers	e) others

No	open ended
	What are the basic factors those HIV positive mother's do not use PMTCT service?

	After you became a member of MSG, What is your relationship with your neighbors?

	Interview
	What are the factors affecting HIV positive mothers' uptake of PMTCT services?
	What is the knowledge of HIV positive mothers' towards PMTCT services?

1	Are the PMTCT services accessible to the target population?
2	is the MSG program help to use PMTCT service for HIV positive mothers
3	has MSG program contribute to create suitable environment for PMTCT service? If so how?
4	/ Has the MSG program brought significant improvement in the quality of life of HIV positive

		women? If so how?

No	Alternatives questioner
1	/MSG program strengthened health care services by training health extension workers in MSG related activities.
2	The current MSG structure succeeded in providing appropriate quality PMTCT services

No	open ended questioner
1	What are the communities based care and support for MSG to uptake PMTCT service? ……. …… …… …… ……
2	What are the gaps between MSG and PMTCT service for sustainability? …….. …… ……
3	How do you reach information for MSG members? …… …… ……
No/	**Questions for interview**

1	What are the roles of MSG in relation to the HIV positive mother's uptake of PMTCT services? ……. …….. ……
2	What is the attitude of HIV positive mothers' towards PMTCT services? ……. …… ……