EVALUATION OF VOLENTARY COUNSELING AND TESTING SERVICE IMPLEMENTAION IN PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HUMAN IMMUNO DIFFICENCY VIRUS PROGRAM AT SHEBE-SOMBO DISTRICT,SOUTHWEST ETHIOPIA

BY

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Abstract

Background: - Current Global estimates show that 33.3 million people infected with HIV, and every day over 5700 persons die from Acquired immunodeficiency syndrome. Mother-to-Child Transmission is by far the largest source of Human immunodeficiency virus infection in children under the age of 15 years. In Shebe-Sombo District Prevention of Mother to Child Transmission service consumption at Antenatal care was not satisfactory. Assessing the level of service implementation helps for program improvement.

Objective of the evaluation: - To assess the level of implementation of voluntary counseling and testing service in prevention of mother to child transmission of Human immunodeficiency virus.

Evaluation methods: - The study was conducted at Shebe-Sombo District with a case study design nested survey in it. The study focused on the process of the counseling and testing of prevention of mother-to-child transmission of HIV service using formative approach. It was conducted from January 28 −February 11/2011 involving different data collection technique including 117 client exit interviews, A community survey with a sample of 418, 13 expert interviews, and 12 observations. Qualitative data were analyzed manually by summarizing into key thematic area and quantitative data were cleaned, edited, entered and analyzed using SPSS version 16.0 Software.

Result. Availability of resource is found 60.4% which is fair according to the pre sated criteria and judgments where as the accessibility dimension is scored 75.5% that is acceptable in relation to the pre sated criteria and judgments. Acceptability dimension achieved the value of 91.9% and the accommodation dimension attain the value of 88.1% which is satisfactory for both dimensions according to the pre sated criteria and judgments.

Conclusion and recommendations The overall level of program implementation is acceptable. However, inadequate number of trained health workers on the program, few number of health facilities which provides the service, lack of standard recording and reporting formats, manuals, guidelines and distance of service site from the pregnant women residence was affecting the program. All the issues found as constraints needs for immediate correction.

Key words: - Evaluation, Voluntary counseling and testing, Shebe-Sombo District, Availability of resource, Accessibility, Acceptability and Accommodation of service.

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Acronyms

AIDS----------Acquired Immune Deficiency Syndrome

ANC----------Antenatal Care

ART----------Anti retro-viral therapy

ARV----------Antiretroviral drug

BCC----------Behavior Change Communication

FHEW----------Female Health Extension worker

FP----------Family Planning

HAPCO---------- HIV/AIDS Prevention and Control Office

HF ---------- Health Facility

HP----------Health Post

HIV---------- Human immunodeficiency Virus

IEC----------Information, Education, Communication

MCH----------Maternal and Child health

MTCT----------Mother to child transmission

NGO----------Non Governmental organization

OI---------- Opportunistic Infection

PLWHA ---------- People Living With HIV/AIDS

PMTCT----------Prevention of Mother- to Child Transmission

STI----------Sexually Transmitted Infection

VCT----------Voluntary Counseling and Testing

WHO----------World health organization

Chapter-1 Introduction

1.1 Background

Current Global estimates show that 33.3 million people infected with HIV, and every day over 5700 persons die from AIDS because of inadequate access to HIV prevention and treatment services (1). Mother-to-Child Transmission (MTCT) is by far the largest source of HIV infection in children under the age of 15yrs and the virus can be transmitted during pregnancy, labor, delivery, or after child's birth during breast feeding. Vertical transmission of HIV mostly occurs during labor and delivery and in a population which has traditional practice of breast feeding, it accounts for more than one third of all cases of MTCT (2).

Sub-Sahara African countries are more heavily affected by HIV/AIDS than any other region of the world. An estimated 22.4 million people are living with HIV in the Sub-Sahara region about two thirds of the global total. In 2008 around 1.4 million people died from AIDS in sub-Sahara Africa and 1.9 million people become infected with HIV since the beginning of the epidemic and more than 14 million children have lost one or both parents to AIDS(3).

In Ethiopia HIV prevalence rate in 2010 is 2.4%. Currently there are more than 1.2 million (45% male and 55% female) PLWHA and 75,420 HIV positive pregnant women are anticipated in Ethiopia (4). The estimated number of new adult AIDS cases was 137,949. The number of new HIV infection was 128,922 (353 per day) including 30,338 HIV positive births (5). There were 134,450 (368 per day) AIDS related deaths including 20,929 children under 14 years (83.6% under age five).The number of AIDS orphans age less than 17 reached 744,757.The number of PLWHA, in need of antiretroviral treatment (ART) was 277,757 including 43,055 (15.5%) children aged less than 14 years.(4,5).

Oromia National Regional State being one of the most populous regions in the country is one of the highly exposed regions. According to the single point HIV prevalence estimate, the HIV prevalence in Oromia is estimated at 1.5% (1.8% female and 1.2 male) in 2009. The HIV prevalence among the urban populations estimated at 6.1% (7.3%in female and 4.9% in males).The corresponding estimate among rural population was 0.6%(0.7% in female and 0.5% in male)(6).

The Government of the Federal Democratic Republic of Ethiopia is committed to reducing the spread of HIV/AIDS and addresses the consequences of the epidemic in the population. The national HIV/AIDS policy was enacted in 1998; and in 2001, the National HIV/AIDS Council declared HIV a national emergency. The National HIV/AIDS strategic framework calls for a multi-sectoral response, guaranteeing rights of all people living with HIV/AIDS, and facilitating the supply and use of antiretroviral drugs. Ethiopia has adopted the WHO/UNICEF/UNAIDS 4-pronged PMTCT strategy as a key entry point to HIV care for women, men and families. Technical interventions, including antiretroviral medications, essential obstetric care, health system management and resource allocation, and gender bias are part of the national comprehensive PMTCT program. Addressing all four prongs has potential to interrupt the cycle that leads to MTCT at several points (4).

Table1: National strategies for PMTCT, Ethiopia, 2007

Prong	National Strategy
Primary prevention of HIV infection	Communication for behavior change (ABC approach) to protect reproductive men and women from becoming infected with HIV and other STIs Provide voluntary counseling and testing services following the National HIV Counseling and Testing Guidelines - Promote correct and consistent use of condoms - Encourage open discussion on reproductive health issues between parents and their children - Early diagnosis and treatment of STIs
Prevention of unintended pregnancy among HIV infected women	- Provide family planning counseling integrated into all potential PMTCT and VCT service sites

Prevention of HIV transmission from infected women to their infants	- Ensure availability of antiretroviral drugs and other appropriate supplies for PMTCT - Provide testing and counseling services integrated with ANC, labor & delivery and postnatal care - Safer obstetrical practices - Provide appropriate counseling on infant feeding and support exclusive breastfeeding
Treatment, care and support of HIV infected women, their infants and their families	- Provide ART for women with advanced disease - Provide pregnant women not eligible for ART with effective PMTCT regimens - Ensure appropriate follow-up of infants born to HIV positive women including: OI prophylaxis and early infant diagnosis - Provide HIV testing for family - Link PMTCT with care and support initiatives organized for infants and HIV infected women

Source; Guidelines for Prevention of Mother-to-Child Transmission of HIV in Ethiopia, 2007

1.2 Statement of the problem

According to the 2009 report, significant progress in the area of PMTCT has been made during the past several years. In 2008, 45% of the estimated HIV-infected pregnant women in low- and middle-income countries received at least some antiretroviral (ARV) drugs to prevent HIV transmission to their child (5).

In Ethiopia rates of HIV testing of pregnant women with in the context of PMTCT reached 16% in 2009.Though 86% of ANC sites offer PMTCT service. A total of 104,646 pregnant women attended ANC at PMTCT sites all over the country, out of these only 33,613 received pre-test counseling out of which 19,848 accepted testing. The result of about 1253 of those tested turned HIV positive and of these 588 received NVP for themselves and 359 received NVP for their infant. Moreover, the report also revealed there is drop out along the cascade of the PMTCT program components (7).

According to 2009/10 first quarter Shebe-Sombo District health office report, there are 4800 pregnant women, 1243 new first ANC attendants, 484 pregnant women counseled for HIV, 258 pregnant women tested and post test counseled for HIV and 7 HIV positive pregnant women have had linked to ART clinic (8).This show that the voluntary counseling and testing service in PMTCT program is less than 50% which initiated this evaluation. Access to HIV test as early as possible during pregnancy enables pregnant women living with HIV to benefit from the necessary interventions to reduce the risk of transmitting HIV to their children (4).

This study was aimed at determining the reason of low number of pregnant women attending voluntary counseling and testing service in PMTCT program in relation to the expected pregnant women in the district, to assess the level of implementation of VCT and to explain the observed level of implementation of VCT service in PMTCT program.

1.3 Program Descriptions

1.3.1 Program context

The first PMTCT service providing health facility in the District was Shebe health center which started in 2008. PMTCT program was designed to fit into ANC, delivery and post natal, maternal and child health services in the study area. Presence of multi-sectoral PMTCT task force, good partnership with NGOs, increased donor interest, high level of international and national government commitments and free offer of supplies and drugs which show that the program has political and social support from local to Zonal health office.

1.3.2 Rational for the Program

Prevention of Mother-to-Child Transmission (PMTCT) is the main strategy of prevention of HIV to children (2). The strategy involves four pillars namely prevention of HIV infection in women of reproductive age, prevention of unintended pregnancy (family planning services), prevention of transmission during pregnancy and labor, and prevention of transmission through breast milk (4,9).

1.3.3 Level of program development

The program started in Ethiopia in 2003, well headed of the ART program that started in early 2005(4). The service was functioning in Shebe-Sombo District since 2008 and it is in the implementation stage. In the District, there are two health centers which started PMTC of HIV program (Shebe and Sombo health centers) functioning with one PMTCT nurse per day. In the District there are also different HIV/AIDS program like VCT, PIHCT, ART and TB/HIV program that competes for recourse with the PMTCT services (8).

1.3.4 Program components

The program components are inputs (such as infrastructure, equipment supplies, human resource, finance, referral systems and recording and reporting formats), activities (like counseling of pregnant women , Testing of pregnant women, providing ARV for positive pregnant women, Referring pregnant women for counseling and testing) outcomes(such as increased uptake of ARV to HIV positive pregnant women for PMTCT, increased uptake of ARV prophylaxis for newborns of HIV positive mothers and increased prevalence of safe child feeding practice among HIV positive mothers)and impact (like Reduce morbidity and mortality due to HIV among children and Improve quality of life of pregnant HIV positive women and their child)

1.3.5 Program logic model

Problem statement:-Mother-to-child transmission of HIV is the cause of HIV infection in children (4). On average one third of children from HIV positive mothers will acquire the infection without intervention (1). Voluntary counseling and testing service in the PMTCT by the pregnant women was small (8) and from literature review finding the evaluator was not able to find any published article on PMTCT in the District.

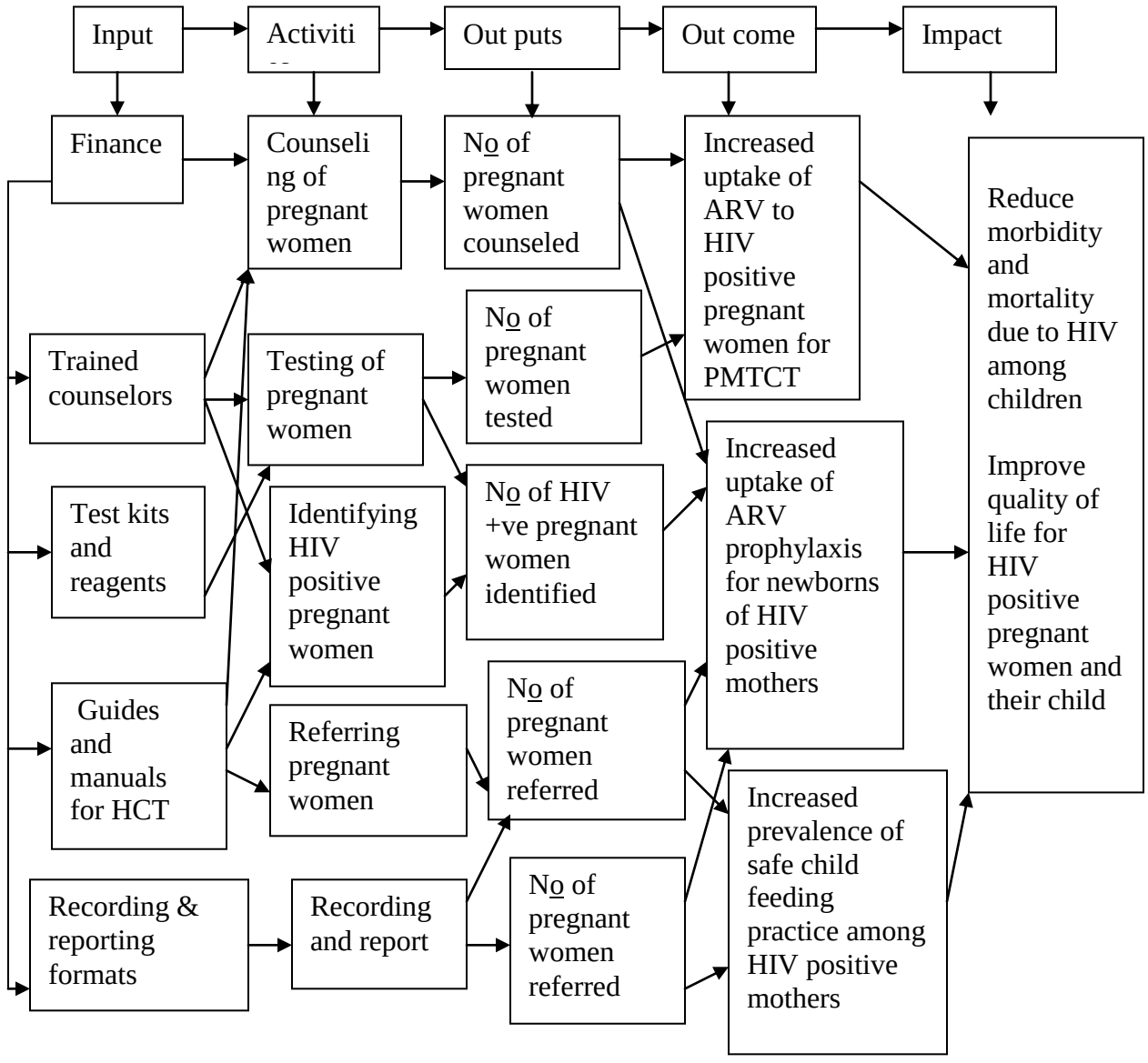

Figure1: logic model of voluntary counseling and testing service in PMTCT program, Shebe-Sombo District, southwest Ethiopia, Feb.2011

1.6 Objective of the Intervention in the district

1.6.1 General objective

- To contribute in the reduction of vertical transmission of HIV from mother to child in Shebe-Sombo District by 2010/11

1.6.2 Specific objectives

- To increase ANC service utilization by pregnant women in Shebe-Sombo District from 60% to 75% at the end of 2010/11.
- To pre-test counsel 96% of pregnant women in Shebe-Sombo District who came to ANC by the end of 2010/11.
- To test 96% of pregnant women in Shebe-Sombo District who came to ANC by the end of 2010/11.
- To pos-test counsel 99% of pregnant women in Shebe-Sombo District who tested for HIV in ANC by the end of 2010/11.
- To enroll on ART 100% of positive women who counseled and tested in Shebe-Sombo District for HIV/AIDS by the end of 2010/11.

1.7 Rationale of the evaluation

Program evaluation is necessary to gain information about program effectiveness and to identify areas for program improvement. It also helps program planner to identify barriers to successful program implementation (10). This evaluation critically explored factors that affect voluntary counseling and testing service in PMTCT program. It further explained the reasons why some antenatal care service attendees did not use the voluntary counseling and testing service in PMTCT program. Finally, depending on the findings, recommendations were forwarded for the stakeholders to act appropriately on the identified gaps to the program improvement and use as an input for other evaluation.

Chapter-2 Stakeholders description

Stakeholders are individuals or groups who have direct interest and may affect by the program evaluated or evaluation's results. They play a role in determining the direction by identifying concern and issue to address in evaluating the program with selecting the criteria that used in judging of its value (11).

2.1 Stakeholders identification and involvement

Stakeholders of PMTCT intervention in Shebe-Sombo District identified through the interview of the health office manager in the district. The principal evaluator met individually and consequently identified their role and interest in the evaluation. The key stakeholders of PMTCT program identified in the district were, Jimma zone health office**,** Shebe-Sombo district health office**,** Management for health system**,** Global found**,** Health workers (program staff) and Communities (Beneficiaries)

2.2 Stakeholder participation

The stakeholders were participated throughout the evaluation process particularly in developing evaluation question, judgment parameters and criteria setting to the evaluation.

2.3 Stakeholders perspective to use the finding

The principal evaluator discussed with stakeholders specifically, the district health office manager and HIV coordinator about the utilization of the findings and they have had positive response towards the utilization of findings.

2.4 Communication with stakeholders

The communication with stakeholders from the beginning of evaluability assessment until the analysis of result and progress of the evaluation result held through official letters, meetings and telephone.

Table2: Stakeholder Assessment and Engagement matrix, Shebe-Sombo district, southwest Ethiopia, Feb.2011

Stakeholder	**Role in the program**	**Role in the Evaluation**	**Perspectives in the evaluation**	**Means of communication**
Jimma zone health office	Resource allocation Supportive supervision Capacity building	Identify evaluation questions Utilization of findings Data source	Interested to know whether services are given as intended. Want to use findings for future program improvement.	Interview Letter
Shebe-Sombo District health office	Facilitator Supportive supervision Training	Identify evaluation questions Decide evaluation criteria Data source Utilization of findings	Interested to know the gaps and weak nesses in service provision -Wants to use findings for future program improvement.	Interview Meeting Telephone Letter
Management science for Health	Training and support	-Identify evaluation questions - utilization of findings	Wants to know whether resources are available and areas where it can give support.	- Interview - telephone - Letter
Global fund	Fund supply for care and support	-Identify evaluation questions -Data source -Utilization of findings	Wants to make sure whether services are given as intended and to use findings for future program improvement.	- meeting - telephone
Program staff	Pre-test counseling Testing Post test-counseling	Select evaluation question Describing program activities. Use eval. result	Use evaluation findings for program improvement. Data or information provider	Interview Meeting Cell phone Observation at work place
Beneficiaries (communities)	Service users	Data source	Wants to make sure that they are getting the right service.	Observation at work place Interview

Chapter- 3 Literature review

An estimated 370000 children under 15years infected with HIV in 2009, mainly through mother-to-child transmission. About 90% of these MTCT infections occurred in Africa where AIDS is beginning to reverse decades of steady progress in child survival (12). Testing during antenatal period offers several advantages including early counseling on the prevention of MTCT and on maintaining health to take steps to prevent exposing partners, to plan for treatment and follow up for the baby, to receive support, to treatment of STIs and care for other infections (4, 13).

In-depth interviews study conducted in South Africa identified missed opportunities for HIV testing in antenatal care due to shortages of test kits; insufficient staff assigned to HIV services; late payment of lay counselors, with consequent absenteeism (14). Few researches conducted in some parts of sub-Sahara Africa on PMTCT to determine coverage, to see problems and challenges and find out solution for programmatic effectiveness. In Kenya a hospital based observational study over one year period among 3564 pregnant women with first ANC visit to see coverage of the neverapine in the existing PMTCT model they found 2516 a counseling rate of 71% and 2483 a testing rate of as high as 97%, 348 (14%)were HIV positive (15). In Uganda evaluation of a five years performance of hospital PMTCT program to identify potential reasons affecting its uptake; they found a 76% testing rate and a 79.9% acceptance of test result (16). In Zimbabwe, PMTCT program up take using routine monitoring data collected over 2½ years was found that 92.9%(n = 2137) were counseled and 74.3% (n = 1588) received post test counseling, while only 24% received complete mother –to-child antiretroviral prophylaxis(17). Similarly in one year cohort of 3136 ANC attendant in Malawi 96% were pretest counseled and 95% under went HIV testing (18). A cross-sectional study conducted in Ethiopia also show that 304 mothers counseled for HIV test then 95% were tested and 90% were received their result (19).

A cross-sectional descriptive study conducted in Namibia show that a very low uptake of VCT (< 10%) was recorded during the pilot PMTCT program and this was attributed primarily due to the lack of trained counselors (20). Other cross-sectional study

conducted among pregnant women following ANC in Tanzania on attitudes to voluntary counseling and testing, the majority concern of women were the reaction of their male partners to the possibility of a positive HIV test and low confidence in the confidentiality of HIV testing(21).

Many mothers do not participate in PMTCT programs due to 1/ missed opportunities to offer or low uptake of voluntary counseling and testing (VCT) during routine ANC. 2/Refusal to be tested for HIV both pregnant women and partners. 3/inadequate acceptance of ART offered to HIV positive women at ANC. 4/poor adherence to take home ARV for mother and newborn when given to HIV positive women at ANC.5/insufficient use of facility based delivery where improved obstetric practice can be used and ART for mother and newborn have been studied as barriers to participation(22).

A cross sectional study in Burkina Faso revealed that up to as much as 53% of pregnant women declared to know the existence of MTCT risk reminding the existence of wide knowledge gap (23). In community-based survey on knowledge and attitude towards VCT in northwest Ethiopia on 992 residents, it indicated that most of the interviewed individuals were lacking the correct knowledge on mode of transmission and prevention measures (24).

Denial of HIV positive test result is common among women and even some do not believe that ARV prophylaxis is effective in preventing MTCT of HIV (13). Reasons for refusing include concerns over privacy and confidentiality, stigma attached to the HIV test and fear of positive result (25). Fear of stigma and discrimination against people living with HIV/AIDS discourages some women from taking protective measures that can greatly reduce the risk of MTCT, such as to find out their HIV/AIDS status, seeking counseling if they are HIV positive and pregnant, taking ARVs while pregnant or choosing not to breast-feed (26).

Study in Kenya, show only 29% of HIV infected women who received post test counseling at 23rd and 24th weeks of gestation collated nevirapine at 34th week and only 20% of infected women eventually took the drug in labor, partly due to the time lag between testing and providing the drug(15).

A study conducted in western Amhara, Ethiopia show that 304 mothers counseled, 95% tested and 90% were received their result (19). And also progressive assessment of the pilot implementation sites of Hareg project in Ethiopia revealed that 50% of HIV positive pregnant women received complete course of ARV prophylaxis to reduce risk of PMTCT (27). The expected change that the program accomplish is that the target population of PMTCT program will have comprehensive knowledge and increase demand for related services like voluntary testing and counseling, child feeding practices, safe delivery and FP(4). Although the recent HIV/AIDS surveillance estimates indicate some encouraging signs in that the epidemic is stabilizing, the observed changes are not sufficient enough compared to the desired goals of the response against the epidemic (5).

Generally integrating PMTCT with ANC service will increase counseling, testing, collecting of HIV test result and taking the ARV drug which realizes the PMTCT service and brining its desired effects. However, the access of the service near to the clients' residence and lack of proper distribution of resource, stigma and discrimination, low health service utilization and loss to follow up were the area that needs to give attention to attain the desired goals against the epidemic.

Chapter- 4 Evaluation Questions and Objectives

4.1 Evaluation questions

- Are the necessary resources available for voluntary counseling and testing service in PMTCT program? If not, why?
- Do pregnant women in Shebe-Sombo District have access to voluntary counseling and testing service in PMTCT program? If not why?

4.2 Objective of the evaluation

4.2.1 General objective

1. To assess the implementation level of voluntary counseling and testing service in prevention of mother-to-child transmission of HIV program at Shebe-Sombo District, 2010

4.2.2 Specific objectives

- To assess availability of resources to voluntary counseling and testing service in PMTCT program at Shebe-Sombo District.
- To determine accessibility of voluntary counseling and testing service in PMTCT program to pregnant women at Shebe-Sombo District
- To determine acceptability of voluntary counseling and testing service in PMTCT program by pregnant women at Shebe-Sombo District
- To assess accommodation of voluntary counseling and testing service in PMTCT program to pregnant women at Shebe-Sombo District

Chapter-5 Evaluation methods

5.1 Study area and period

The study was conducted in Shebe-Sombo District, from January 28 −February 11/2011. Shebe-Sombo is one of the 17 districts in Jimma zone. The District town (Shebe) is located 50 km southwest of Jimma town. It has bordered by SNNPR in South and Southeast, Seka-Chekorsa District in North, Northeast and East, and Gera district in the West and Northwest. According to the report of the District health office, it has a total population of 120,900 with 61,538 (50.9%) females and 59,362(49.1%) males with in 20 rural and one district town Kebele. The district has four health centers and 20 health posts (8).

5.2 Evaluation focus and approach

This evaluation is process evaluation. It focuses on HIV testing & counseling component of the third prong of PMTCT strategy (prevention of HIV transmission from pregnant women to their infants). It assessed availability of resources for the program, accessibility and acceptability of the program and also accommodation of service delivery to pregnant women in the health centers.

The approach of this evaluation is formative. Formative evaluation is employed for program improvement during the implementation or planning phase, both strengths and weaknesses of the program identified and help to adjust and enhance interventions.

5.3 Evaluation dimensions

The evaluation questions were trying to identify the access of the ANC/PMTCT program to the pregnant women in relation to the standards and national guideline. Access defined by Roy Penchansk, D.B.A and J.William Thomas as a concept of representing the degree of `fit` between the clients flow, need and the system (28). According to their explanation access has five dimensions except affordability (because voluntary counseling and testing service in PMTCT program is free service) four of them have used and defined as:-

1 Availability: - The relationship of the volume and type of existing services (resources) to the clients volume and type of needs. So the availability of adequate number of health facilities, trained health workers and test kits assessed during evaluation.

2 Accessibility:-Assess relationship between the location of supply and the location of clients, taking account of client transportation resources and travel time and distance.

3 Acceptability:-The relationship of clients attitudes about personal and practice characteristics of existing providers and service as well as to the provider attitude about acceptable personal characteristics of clients

4 Accommodation: - The relationship between the manner in which the supply resources are organized to accept clients (including appointment systems hours of operation, walk-in facilities) ability to accommodate to these factors and the clients perception of their appropriateness (28).

So being the program evaluation held at the service delivery site and community, the evaluation dimensions are more of assessing pregnant women access to ANC service, voluntary counseling and testing service in PMTCT program by pregnant women following ANC, the implementation of HIV counseling and testing to pregnant women in ANC and HIV test result acceptance by pregnant women following PMTCT program.

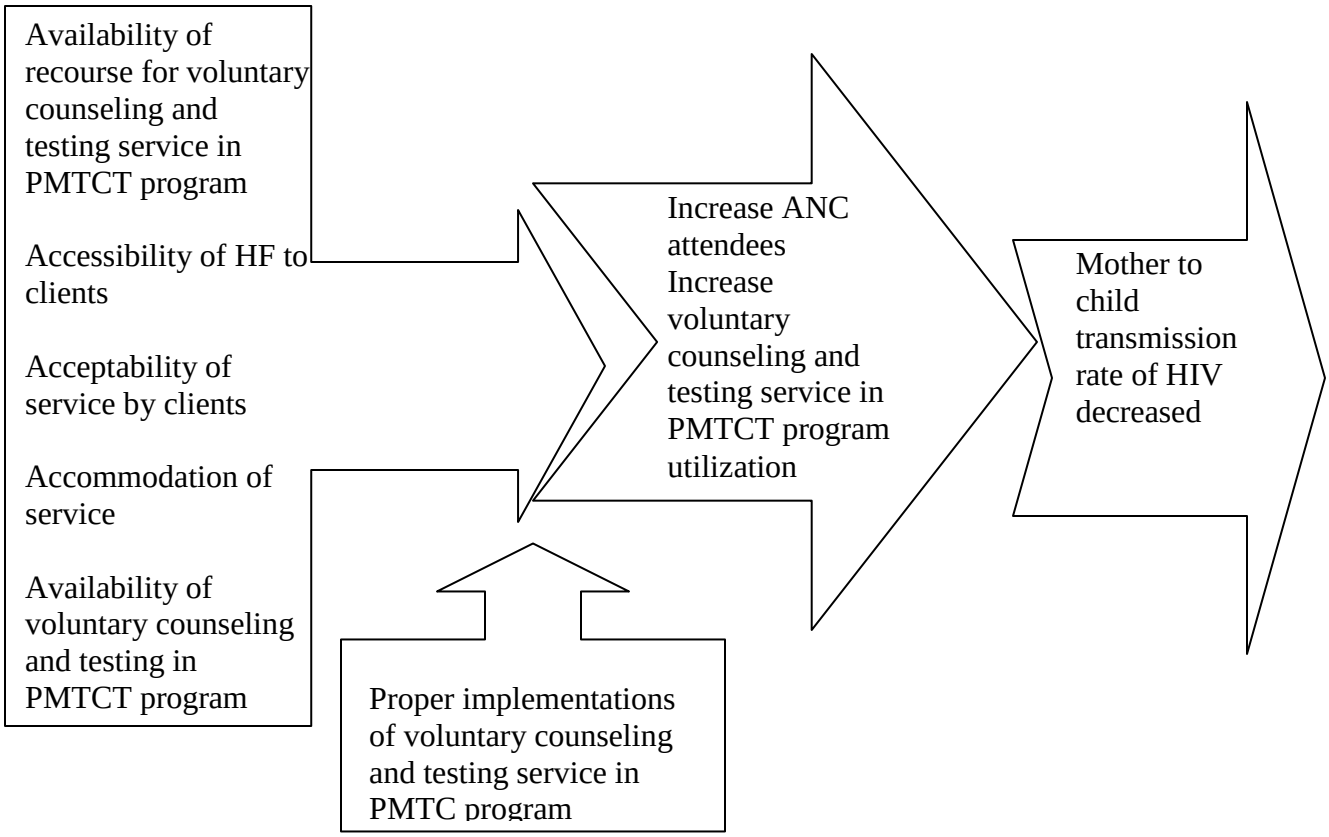

Figure2: Conceptual framework for the evaluation of voluntary counseling and testing service in PMTCT program, Shebe-Sombo district, southwest Ethiopia, Feb. 2011

5.4 Evaluation Design

A case study design which is most likely to be appropriate for "how" and "why" questions (29) with a nested survey in it. Quantitative and qualitative data collection methods were implemented using client exit interview and survey questioner and in-depth interview guide and observation chick lists.

5.5. Source population

- **Health facility: -** All health facilities found in the District, which were giving voluntary counseling and testing service in PMTCT program to the pregnant women.
- **Pregnant women:-** Women who were receiving and not receiving voluntary counseling and testing service in PMTCT program in the District
- **Health workers: -** All PMTCT counselors who worked in the area at least for 3 months.
- **Managers**: - Managers of the health centers, health post, District, Zonal health department.

5.6 Study population

- Health facilities that were giving ANC/ PMTCT.
- Pregnant women who were provided, not provided or refused pre &/or post test counseling service during the data collection period.
- Counselors who were working in the health facilities during the study period at least 3 months.
- Managers of the health institutions: head of the health center, health post, Zonal health department.

5.7 Study units

Selected PMTCT implementing health facilities in the District, health Professionals, pregnant women participated in exit interview and community survey

5.8 Sample size and Sampling technique

Purposive sampling was used to take the two PMTCT providing health centers in the district. Because they were the only PMTCT service sites in the District and they were working since 2008 to deliver PMTCT service in the district. For survey of pregnant women and exit interview, sample size (n) was determined based on single population proportion.

$$n = \frac{Z^2 \alpha/_2 \, P\,(1-P)}{E^2}$$

Where n = Sample size

P = Proportion of pregnant women who have accessibility to PMTCT service is 50%, to take maximum sample size

E = margin of error

$Z^2\alpha/_2$ = Z-score value at 95% confidence interval

Then $n = \frac{(1.96)^2 * 0.5(1-0.5)}{(0.05)^2}$

n =384

384 + 10% of non-respondent rate, (38) =422

For client exit interview of pregnant women, attending voluntary counseling and testing service in PMTCT program the same formula was used but the ratio of ni: N (from the preceded 3 months PMTCT performance report analysis which is on average 161 pregnant women are using voluntary counseling and testing service in PMTCT program pre month and taking as the total source population for exit interview) was greater than 10%, then the finite population correction was used. So final sample size (nf) for exit interview was

$$nf = \frac{ni}{1+\frac{ni}{N}}$$

$$= \frac{422}{1+\frac{422}{}}$$

161

= 117 exit interviews conducted

Thus the calculated sample size for community survey and exit interview were distributed proportionally to 6 randomly selected kebeles using lottery method and for the two PMTCT providing health centers selected purposively.

Table 3: Summary of Methods, Sample size and Sampling technique, Shebe-Sombo District, southwest Ethiopia, Feb. 2011

Method	**Sample size**
Survey of pregnant women not attending ANC/PMTCT services	422
Client exit interview of all pregnant women attending PMTCT service	117
Expert interview	13
Direct observation	12

Table 4: Sampling distribution of survey among six randomly selected kebeles, Shebe-Sombo District, southwest Ethiopia, Feb. 2011

Name of kebele	Total number of pregnant women expected in each Keble	Sample size of pregnant women not attained ANC/PMTCT interviewed from each Keble using house to house visiting
Halosebaka	368	81
Migrabaso	320	70
Sombodaro	375	83
Anjaganbo	245	54
Demagumacho	322	71
Allogodante	288	63
Total	1918	422

Table 5: Sampling distribution of client exit interview in the two PMTCT providing health centers, Shebe-Sombo District, southwest Ethiopia, Feb., 2011

Name of health centers	Total number of pregnant women expected to attain PMTCT services in the PMTCT providing health centers	Sample size of exit interviewed from each health centers
Shebe health center	66	66
Sombo health center	51	51
Total	117	117

5.9 Inclusion and Exclusion criteria

All pregnant women who came for the first time to the ANC in the study period were included in the client exit interview. For community survey, pregnant women who didn't attend ANC service and live in the kebeles for more than three months were included by interviewing house to house visit in each Keble to obtain the calculated sample size by using house to house visiting.

5.10. Data collection technique

Quantitative and qualitative data collection methods were implemented using structured and semi-structured questioner, in-depth interview guide and observation checklists. Two health professionals (one BSc cNr and one HO) trained on PMTCT were recruited for supervision and five diploma clinical nurses were assigned for data collection from pregnant women. Counselor-client interaction observation, expert interview and inventory of resources were conducted by principal investigator. The instruments were adapted from tools for HIV voluntary counseling and testing March 2000 UNAIDS (30) and Baseline assessment tools for preventing mother-to-child transmission (PMTCT) of HIV (31). Exit interview and community survey tools were translated to Afan Oromo and retranslated to English by different persons and compared with the original one to

maintain the consistency. All data collectors and supervisors who can speak Afan Oromo were recruited from other place of study district (Jimma and Seka town) to minimize the information bias.

5.10.1 Counselor-client interaction observations

Principal evaluator observed all available counselors at the PMTCT sites using checklist while they were giving counseling service on both pre-test and pos-test counseling session using one counseling session every other day to check coverage of basic points of counseling explained in the national guideline 2007(8).The observation was take place depending on the 2000 VCT manuals of WHO which recommends 3-5 observations session per facility (30). Interviewer explained objective and the purpose of the study for counselor and client to have consent in the observation sections.

5.10.2 ANC/PMTCT site resource observation

Principal evaluator observed the two PMTCT providing and two non PMTCT providing health centers and six health posts selected randomly using lottery method. (Shebe, Sombo, Keshe and Muchi health centers and H/saboka, A/ganbo, A/godante, S/daro, M/baso and D/gumacho health posts). The PI using checklists observed physical structure of the ANC/PMTCT site and resource after asking permission from facility managers.

5.10.3 Expert interview

Expert interview were selected purposively for information rich individuals about the service. Two counselors one from each health center working at the PMTCT providing site, one district HIV expert, four health center managers and six health extension workers from 6 health posts were included for expert interview. The availability and sustainability of resource supply, number of counselor training on PMTCT and continuity of the service were included in the checklist and conducted by principal evaluator.

5.10.4 Client exit interview

All pregnant women who came from January 28−February 11/2011were interviewed by PMTCT trained nurses in the two health centers using structured questioners to provide clients with an opportunity of explaining how service delivery was conducted and what can be done.

5.10.5 Community survey:

It was conducted in 6 (six) kebeles selected randomly by lottery method of pregnant women who didn't attend PMTCT services by interviewing house to house visit. The calculated sample was distributed proportionally to the number of pregnant women in each Keble and then the number was divided to the number of house holds in each Keble to obtain the sampled house. Interview was conducted by diploma cNr using structured questioner by interviewing house to house to identify reasons that make them not to attain the voluntary counseling and testing service in PMTCT program.

Table 6: Information matrix for the evaluation questions, indicators and source of information, Shebe-Sombo District, Jimma zone, southwest Ethiopia, Feb. 2011

Evaluation questions	**Indicators**	**Source of information**
1 Are the necessary resources available for voluntary counseling and testing service in PMTCT program? If not, why?	Number of HFs constructed and functional	Interview of program staff and Observation
	Number of HFs which have two and above HWs	Interview of program staff , expert interview & observation
	Number of HFs which have minimum ANC materials	Interview of program staff & Observation
	Number of standard recording and reporting formats	Interview of program staff & observation
	Number of health care workers trained on PMTCT	Interview of program staff & district HIV expert
	Number of HF which provide PMTCT	Interview of program staff , Interview of District HIV expert and Observation
	Number of health facility with separate counseling rooms	Interview of program staff & observation
	Number of valid test kits in the PMTCT providing health facility (at least one unopened	Interview of District HIV expert and program staff & Observation

	and unexpired box)	
	Number of PMTCT manuals	Interview program staff & observation
	Number of PMTC guidelines	Interview of program staff & observation
	Number of health facility with waiting area	Interview of program staff, client exit interview & observation
2. Do ANC attending pregnant women in Shebe-Sombo district have access to voluntary counseling and testing service in PMTCT program? If not why?	Proportion of clients who perceived counseling room was private and confidential	client exit interview
	Proportion of pregnant women who didn't complain distance to PMTCT service site from their residence	Survey, client exit interview and district HIV expert interview
	Proportion of pregnant women who have alternative transportation mechanism from their residence to the nearby PMTCT center	Survey ,client exit interview and district HIV expert interview
	Proportion of clients who believe adequate time is allocated for the PMTCT service	client exit interview and observation
	Proportion of Pregnant women satisfied with the counseling	client exit interview
	Proportion of pregnant women believe adequate time for PMTCT counseling	client exit interview
	Proportion of pregnant women who came only for PMTCT	client exit interview

5.11 Data Quality control

To keep the quality of data, the instruments were adapted from tools for HIV voluntary counseling and testing March 2000 UNAIDS (30) and Baseline assessment tools for preventing mother-to-child transmission (PMTCT) of HIV (31). Exit interview and community survey tools were translated to Afan Oromo and retranslated to English by different persons and compared with the original one to maintain the consistency. All data collectors and supervisors who can speak Afan Oromo were recruited from other place of study district (Jimma and Seka town) to minimize the information bias.

Pre-test of tools on 10% of client exit interview and community survey questioner were performed at Seka-Chekorsa District and checked for the sequencing, understandability of the question for the respondents and to estimate the total time that the instrument had take and rearrangement was done on sequence of questioner. Evaluation team members were trained at Shebe-Sombo District health office for two days about the objective of the evaluation, ethical issues, data collection methods, tools and procedures.

Two supervisors were responsible to supervise the exit interview and community survey data collection and the principal evaluator had had daily communication with the supervisors and solved problem in data collection process.

5.12 Data management and analysis

Different data management methods were employed. The quantitative data were checked for completeness and consistency and cleaned and coded before entry. The final data file was brought together and entered to SPSS version 16 for analysis. Recoding and re-categorizing was done for relevant variables as needed. Descriptive statistics such as means and proportions were calculated and findings were presented using frequency tables and graphs. The qualitative data were analyzed manually by summarizing into key thematic area and presented as a narrative summary and used to answer the why quotations that need explanations. Data from different sources were triangulated. In addition, data were used complementarily to assess different aspects of the overall degree of implementation. Judgment matrix and the national guideline for PMTCT 2007 were used for the purpose of judging the program's performance. The questionnaires and the soft copy of the data with multiple back ups are kept by the principal evaluator.

5.13. Matrix of analysis and judgment

Justification of evaluation findings were based on evidence gathered and judgments agreed up on values or standards set by stakeholders. Values or standards were sated using degree of relevance of the dimension to the program after discussion with district HIV expert and health center managers. Then the value of each dimension divided to the perspective indicators. (Annex 1)

Table 7: Judgment matrix and criteria for evaluation dimensions, Shebe-Sombo District, southwest Ethiopia, Feb. 2011

Dimensions	**Degree of relevance to the program**	**Value given**	**Criteria**	**Judgment**
Availability	RRRR	200	≥85%	Satisfactory
Accessibility	R	50	71%-84%	Acceptable
Acceptability	RR	100	51%-60%	fair
Accommodation	RR	100	≤50%	critical
Total	9R	450		Note:-decimals was round up to the nearest whole number

R= Relevance of the dimension to the program then the number of R show that the degree of relevance to the program.

5.14. Ethical issues

Letter of ethical clearance was taken from Jimma University, College of Public Health and Medical Sciences Ethical Committee to Jimma zone health office and Shebe-Sombo district health office. Official letters from the District health office to the health centers, Keble leaders and data collectors were provided. During data collection all respondents were informed about the purpose and advantages of the evaluation to the community, asked their permission and informed verbal consent was obtained privately and individually prior to the interview and the information gathered kept properly. Moreover, data from the study subjects were kept confidential and clients were also informed that declining to participate in the study would not affect them from the service.

5.15 Evaluation dissemination plan

After analyses of the result it will be presented to Jimma University for discussion, following that possible correction will be made on the evaluation finding. After having approval by the University one day workshop will be arranged with stakeholders about the result at the district health office and the copy of the report will be submitted for District health office, Jimma zone health office and Jimma University.

5.16 Operational definitions

***Acceptability*:** Client's attitude toward the PMTCT service program from the perspectives of clients.

Accessibility: Relationship between the location of supply and the location of clients, taking account of client transportation resources, travel time and distance from the perspectives of clients.

***Accommodation*:** The relationship between the manner in which the supply resources are organized to accept clients from the perspectives of clients and health providers

Alternative transportation mechanism: It refers to public or private transporting means used for transportation.

Appropriate rooms: - separate ANC/PMTCT room having chairs, tables, IEC material, and Tap water supply

Availability: refers the availability of separate room for counseling & testing, trained counselor, test kits (KHP, StAT pak, uni-gold, capillary tube and glove) drugs from the perspectives of district HIV expert and health providers

PMTCT Counselors: Counselors trained on PMTCT of HIV and provide counseling and testing services.

Experts: PMTCT counselors and HIV managers who work in the District

Guideline: a booklet which is developed by MOH having detailed guiding rules to provide PMTCT in Ethiopia one for each health facilities

Standard Health facilities: It refers that the number of rooms more than three, cemented floor and having health workers more than two.

Manuals: Sheet of paper developed by MOH showing counseling and testing procedure and testing algorism one per PMTCT providing health facilities

Minimum ANC material: That contains at least one, weight scale, height scale, blood pressure, feto-scop and fundal height measuring apparatus.

Satisfaction: when the provided services, counseling, testing, confidentiality and waiting time satisfy client desire.

5.17 Limitation of the evaluation

Counselor bias during observation may occur due to overt observation and short period of data collection, Pregnant women with negative test results from exit interview may give biased information because of their emotion and social preferences and the main focus of the evaluation was on the HIV counseling and testing process of PMTCT program which is difficult to judge the whole cascade of the PMTCT program.

Chapter-6 Results

6.1. Availability of Resources

Availability of resources (input) to provide voluntary counseling and testing service in PMTCT program in the district was assessed based on the national PMTCT guideline. According to the guideline, PMTCT services should be implemented at all facilities with capacity to offer them, and integrated with other services. The observed health facilities are functional, have two and above health workers with a minimum of ANC materials in the facilities. In Shebe-Sombo District there are 2 health facilities providing counseling and testing of HIV for PMTCT, 4 PMTCT trained counselors working in the two ANC/PMTCT providing health centers. As explained by the expert *"this was due to the turn over of trained staffs and there were no frequent chance of PMTCT training*" Availability of separate counseling room was found in one health center. Inventory of materials revealed availability of test kits (i.e. KHP, Stat Pack and Uni-gold) and capillary tubes. There was no stock out of test kits for the last 6 months but PMTC nurses reported that *"the shortage of glove*." There were no any PMTCT manuals and guideline in the two ANC/PMTCT health centers. Experts explained for these that *"less distribution and handing of the guideline by individuals as their own."* Waiting area is available in the two health centers providing voluntary counseling and testing service in PMTCT program. The results of judgment matrix for availability of resources for voluntary counseling and testing service in PMTCT program in Shebe-Sombo District were presented as follow (Table 12).

Table 8: Result and judgment matrix for resource availability dimension at Shebe-Sombo District, Jimma zone, southwest Ethiopia, Feb. 2011

Indicator	**Category**	**Frequency**	**Achieved value**	**Wt given**	**Result**	**Criteria &Judgments**
Number of HFs constructed and functional (n=10)	yes	10	10/10	20	20	≥85%
	no	0				
Number of HFs which have two	yes	10	10/10	15	15	

and above HWs (n=10)	no	0				Satisfactory 71%-84% Acceptable 51%-70% fair ≤50% critical Decimals round up to the nearest whole number
Number of HFs which have minimum ANC materials (n=10)	yes	10	10/10	15	15	
	no	0				
Number of HFs providing (n=4)	yes	2	2/4	25	12.5	
	no	2				
Number of Health care workers trained on PMTCT	Needed	12	4/12	25	8.3	
	Found	4				
Number of health facility with separate counseling room	Needed	2	1/2	25	12.5	
	Found	1				
Number of health facility with valid test kit(at least one unopened and unexpired kit from each)	Needed	2	2/2	25	25	
	Found	2				
Number of health facility with standard recording and reporting formats	Needed	2	1/2	15	7.5	
	Found	1				
Number of health facility with PMTCT manuals	Needed	2	0/2	15	0	
	Found	0				
Number of health facility with PMTCT Guideline	Needed	10	0/10	15	0	
	Found	0				
Number of health facility with waiting area	Needed	2	2/2	5	5	
	Found	2				
Total Availability dimension				200	120.8	60.4% Fair

6.2 Accessibility of service

In order to assess accessibility of voluntary counseling and testing service in PMTCT program to pregnant women in Shebe-Sombo District, community survey and client exit interviews were conducted.

6.2.1 Socio-demographic characteristics of community survey respondents

A total of 418 pregnant women were responded to the questionnaire with a response rate of 99%.The median and the mean age of the respondents were 28 and 28.4 respectively. Majority of the respondents 281 (67.2%) were in the age group of 25 to 34. Muslims were the dominant participants of the study 373 (89.2%) followed by Orthodox Christian 42(10%) and greater amount 394(94.3%) were married. Regarding their educational background, 212 (50.5%), 89(21.8%) and 99 (23.4%) of the respondents were unable to read and write; only read and write and 1-6th (Table 9).

Table 9: Socio-demographic characteristics of pregnant women in survey, Shebe-Sombo District, Jimma zone, southwest Ethiopia, Feb.2011

Socio-demographic characteristics(n=418)	**Number**	**Percent**
Age		
15-24 Years	89	21.3
25-34 Years	281	67.2
35 -49 Years	48	11.5
Total	418	100
Educational Status		
Unable to read and write	212	50.5
Only read and write	89	21.8
Grade 1- 6	99	23.4
Grade 7 and above	18	4.3
Total	418	100
Religion		
Muslim	373	89.2
Orthodox	42	10.0
Other	3	0.8
Total	418	100
Marital Status		
Married	394	94.3
Single	16	3.8
Widowed	8	1.9
Total	418	100

6.2.2 Socio-demographic characteristics of client exit interview respondents

A total of 117 pregnant women were participated in the exit interview. The median and the mean age of the respondent was 25 and 24.7 respectively**.** Out of the respondents 57(47.7%) and 50(42.7%) were in the age group of 15 - 24 and 25-34 respectively. Ninety six (82.1%) of them were Muslims, followed by orthodox 21(17.9%). And the great number of them was married 116(99.1%). Regarding their educational background, 68 (58.1%), 33(28.2%) and 10(8.5%) of the respondents were unable to read and write, 1-6th grade and above 7th grade (Table10).

Table10: Socio-demographic characteristics of pregnant women in exit interview, Shebe-Sombo District, Jimma zone, South-west Ethiopia, Feb.2011

Socio-demographic characteristics(n=117)	**Number**	**Percent**
Age		
15-24 Years	57	48.7
25-34 Years	50	42.7
35 -49 Years	10	8.6
Total	117	100
Educational Status		
Unable to read and write	68	58.1
Only read and write	6	5.1
Grade 1- 6	33	28.2
Grade 7 and above	10	8.5
Total	117	100
Religion		
Muslim	96	82.1
Orthodox	21	17.9
Total	117	100
Marital Status		
Married	116	99.1
Single	1	0.9
Total	117	100

Two hundred sixty four (63%) of the respondents from survey didn't complain distance of PMTCT centers from their residence and 48(11.5%) complain lack of alternative means of transportation mechanism. One hundred one (95%) of the pregnant women from exit interview didn't complain distance of PMTCT centers from their residence and 54(46%) complain lack of alternative means of transportation mechanism. The expert

explained about the distance that *"the two PMTCT service sites are found on the main road which passes From Jimma to Bonga through the district. So these health centers not easley accessible to most of the Kebles those very far from the main road."* Generally the average Accessibility dimension value was 75.9% which is acceptable according to the preset judgment criteria.

Table11: Survey result of accessibility dimension, Shebe-Sombo District, South-west Ethiopia, Feb., 2011

Indicator(n=418)	**Frequency**	**Achieved value**	**Wt given**	**Result**	**Criteria &Judgments**
Number of pregnant women who did not complain distance of PMTCT center	264	264/418	30	18.9	≥85% Satisfactory 71%-84% Acceptable 51%-70% fair ≤50% critical
Number of pregnant women who have alternative transportation mechanism from their residence to the nearby PMTCT center	370	370/418	20	17.7	
Total Accessibility dimension			50	36.6	73.2% Acceptable

Table12: Exit interview result of accessibility dimension, Shebe-Sombo District, South-west Ethiopia, Feb., 2011

Indicator(n=117)	**Frequency**	**Achieved value**	**Wt given**	**Result**	**Criteria &Judgments**
Number of pregnant women who did not complain distance of PMTCT center	111	111/117	30	28.5	≥85% Satisfactory 71%-84% Acceptable 51%-70% fair ≤50% critical
Number of pregnant women who have alternative transportation mechanism from their residence to the nearby PMTCT center	63	63/117	20	10.8	
Total Accessibility dimension			50	39.3	78.6% Acceptable

6.3 Acceptability

Result of exit interview of pregnant women indicated that majority 104(88.9%) of the respondents believe that adequate time was allocated for PMTCT counseling. Among the interviewed 113 (97%) perceived that they have satisfied with the counseling. However from client-counselor interaction observation the average time used for counseling and testing was 10 minutes and out of 6 pre-test counseling observations only on three and two session discussed about risk reduction and PMTCT, support service and importance of ANC respectively. Generally the acceptability dimension of the evaluation has scored 91.9 % which is satisfactory according to the preset criteria and judgment.

Table13: Result and judgment matrix for Acceptability dimension at Shebe-Sombo District, Southwest Ethiopia, Feb., 2011

Indicators(n=117)	**Achieved value**	**Wt given**	**Result**	**Criteria and Judgments**
Proportion of pregnant women believe that adequate time is allocated for PMTCT counseling	104/117	60	53.3	≥85% Satisfactory 71%-84% Acceptable 51%-70% fair ≤50% critical
Proportion of Pregnant women who were satisfied with the counseling	113/117	40	38.6	
Total Acceptability dimension		100	91.9	91.9 % Satisfactory

6.4 Accommodation

A total of 117 pregnant women participated to asses the accommodation of voluntary counseling and testing service in PMTCT program (Socio-demographic characteristics of participants presented on table 10). Result of exit interview indicated that majority103 (88%) of the respondents did felt confidential and privacy during PMTCT counseling. Among participants 97 (81%) were satisfied with the waiting time to get the service. Almost all 115 (98%) of them thought that they perceived satisfaction with the convenience of PMTCT working hours. From exit interview 5(five) pregnant women at Shebe health center suggested that **"***the health professionals at ANC should have to be two and above in number to support each other's not to be fastening at the examination, counseling and testing process."* Accordingly the accommodation dimension has got the value of 88.1% which is satisfactory in relation to the preset judgment criteria.

Table14: Result and judgment matrix for Accommodation dimension at Shebe-Sombo District, Southwest Ethiopia, Feb. 2011

Indicators(n=117)	**Achieved value**	**Wt given**	**Result**	**Criteria and Judgments**
Proportion of pregnant women who perceived counseling room is private and confidential	103/117	25	22.0	≥85% Satisfactory 71%-84% Acceptable 51%-70% fair ≤50% critical
Proportion of pregnant women satisfied with the waiting time to get the service	97/117	50	41.5	
Proportion of ANC attendants satisfied with the convenience of PMTCT working hours	115/117	25	24.6	
Total Accommodation dimension		100	88.1	88.1% satisfactory

The Overall judgment matrix of the dimensions

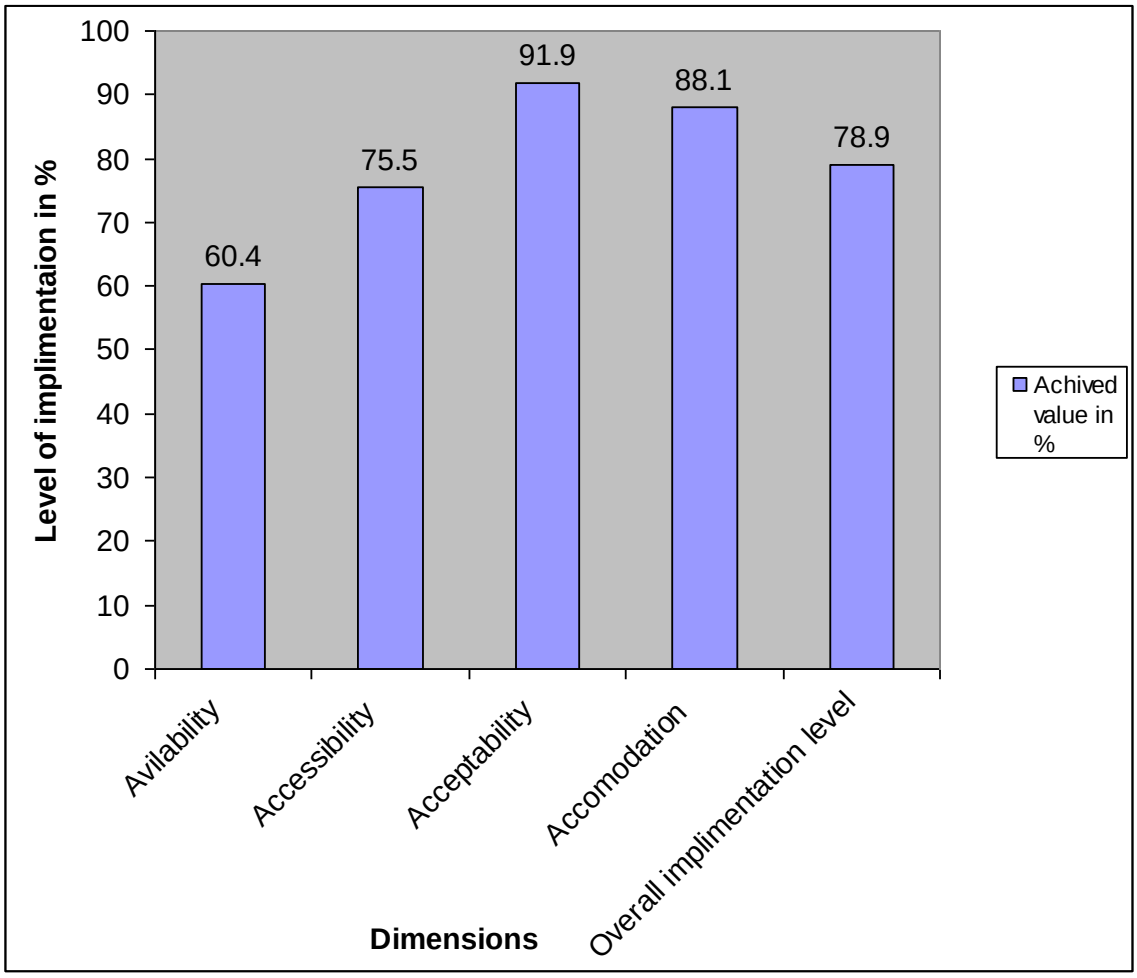

Figure3: Values of dimensions of voluntary counseling and testing service in PMTCT program implementation at Shebe-Sombo District, Southwest Ethiopia, Feb. 2010/11

Chapter -7 Discussions

This evaluation study tried to assess the implementation level of voluntary counseling and testing service in PMTCT program at Shebe-Sombo District. Program access was measured using analysis and judgment matrix, which was developed with discussion of stakeholders and agreed up on it.

The dimensions assessed include; availability**,** accessibility and acceptability of the service with the national guideline and performance standard and accommodation of services to the clients need**.** The levels of these different dimensions of the program were judged based on a preset judgment criteria and parameters.

7.1 Availability of resources

Availability of resource is a foundation for successful program implementation because program activities cannot be performed without adequate resources. Therefore, it is very important to ensure availability of adequate resources in program implementation. Availability of necessary resources to provide voluntary counseling and testing service in PMTCT program in Shebe-Sombo District was assessed using 11(eleven) indicators

There are 4 health centers and 20 health posts constructed and functional. The health posts have two FHEWs and fulfill 100% coverage of the health post to all kebeles. This is in congruent to HSDP-III which states that one health center with five health posts (31). According to the national guideline at least 60% of the technical staff should be trained on PMTCT (4). Even though there were trained counselors working at the PMTCT service site during the observation at the two health facilities, the situation found in the District was only 33.2% of technical staffs were trained on PMTCT which is below the guideline. As explained by the counselors and head of the facilities, *˝this was due to the turn over of trained staffs and there were no frequent chance of PMTCT training*". This situation forced the health facility managers to assign health workers who trained on PMTCT to work at night and day, which decrease the transferring of enough information and increases missed opportunity.

National PMTCT guideline state that there should be continuous supply of the HIV test kits which contain KHB, STAT pack, uni-gold, capillary tube, blood lancet and gloves (4). During inventory a minimum of one valid test kits were available in the facilities.

However, the PMTCT counselors explain that *"interruption and shortage of glove make them to face challenges with pharmacy store man because glove is not free supply that could affect the implementation of the service."* Regarding to the availability of test kits, it is found to be satisfactory (100%) according to the preset judgment criteria. The finding was similar with study conducted in 2009 at Karamara Hospital (33).

Guideline was not available at the study site and counselors didn't use it during counseling. One of the PMTCT nurse explained that *"there is no distribution of the guideline"* anther nurse in different health center say that *"they have the guideline but lost to found it in the PMTCT room."* This is not in line with the national guideline which states the guideline should be available in all health care facilities providing PMTCT services and to those planning to provide the service(4). The result of this evaluation is similar with study conducted in 2009 at Kara-Mara Hospital and Arsi, Oromia region (33, 34).

Standard recording formats were also not found in Sombo health center which is against to the national guideline (4). Neither report formats nor PMTC manual found in the two health centers during the evaluation period which is different from the guideline (4). From expert interview it was explained that *"less distribution and handing the guideline by individuals as their own."* Generally according to the preset criteria and judgment availability dimension was scored 60.4 % which is fair but less than the evaluation findings conducted in 2009 at Arisi 73.1% and at Bahir Dar 76.9% (34, 35). This could be due to the setup difference between facilities.

7.2 Accessibility

A total of 535 pregnant women from community survey and exit interview were participated identify accessibility of voluntary counseling and testing service in PMTCT program. Sixty three per cent (63%) of the respondents from survey and 95% of participants in exit interview didn't complain distance of PMTCT centers. Concerning about the alternative transportation mechanism to the PMTCT service site 11.5% from the survey and 46% of respondents from exit interview didn't have alternative means of transportation. The district HIV coordinator said that *"the two PMTCT sites are found on the main road which passes From Jimma to Bonga through the district. So these health*

centers are not easley accessible to most of the Kebeles those far from the main road." However, health system organization in the district is implemented according to the HSDP-III that says one health center to five health post to decentralize health delivery system (32).However, the PMTCT service is not implemented in relation to the national guideline which state that those health facilities which have potential to deliver PMTCT program should implemented integrating with ANC service (4).

7.3 Acceptability

One hundred four (89%) of the respondents from exit interview reported that adequate time was allocated for PMTCT counseling, whereas from observation of client-provider interaction it was found that the average time used for counseling and testing was 10 minutes and out of 6 pre-test counseling observations only on three and two session discussed about risk reduction and PMTCT, support service and importance of ANC respectively. According to the national guideline these show that there is problem about transferring of enough information to client which needs to be discussed during counseling. National guideline stated points(Anex-8) to be discuses during pre-test counseling and post-test counseling (4). Missing to discus about support services, antenatal care and its advantage and about PMTCT service may increase drop outs in the antenatal care and delivery services.

Majority (97**%)** of the pregnant women interviewed responded that they satisfied with the counseling. However, on observation of client counselor interaction on pre and post test counseling important points were not included (Anex-8) which is stated on the national guideline (4) even if all of the pregnant women interviewed have negative result which makes them and the counselors happy and satisfy. However, the transferring of most information to the client is not considered by the counselors. This might be due to lack of refresher training to the counselors and lack of external and internal supportive supervision of the counselors which is complained by all counselors during the interview.

Generally according to the preset criteria and judgment the acceptability dimension of the evaluation has scored 91.9% which is satisfactory and higher than the study conducted in Addis Ababa; 2008, which is 71.4% (36). This difference could be due to the relatively increased information access due time gap b/n the study.

7.4 Accommodation

Adequate space for auditory and visual privacy is important for PMTCT service, in particular for maintaining confidentiality during counseling and testing of pregnant women (31, 37). The result of this study showed that majority 88% of clients was comfortable with privacy and confidentiality of counseling room. This finding differs from study conducted in Kenya, 2005 which is found that 97% of clients considered the privacy in counseling room to be good (38). Inadequate privacy and confidentiality violates clients' rights that their information should remain between the counselor and counselee only (4, 31). With regards to the waiting time in the health facilities 97(81%) of the respondents from exit interview replied it was short. However, 5 pregnant women at Shebe health center suggested that "*the health professionals at ANC should have to be two and above in number to support each other's not to be fastening at the examination, counseling and testing process."* Ninety eight per cent (98%) of pregnant women were satisfied with the convenience of PMTCT working hours that is appropriate hours of operation were set. The evaluation finding is higher than study conducted in Mozambique; 2004 reported that 73.6% of clients found hours of operation to be convenient (37). This difference may be socio-cultural variation of study participants in the countries.

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Chapter- 8 Conclusion and recommendations

8.1 Conclusion

In general, the implementation level of voluntary counseling and testing service in PMTCT program in the District is acceptable in relation to the preset criteria and judgments. The resource availability dimension of the program was judged fair. All resources that are recommended by the national guideline were available except for inadequate number of PMTCT trained health workers and absence of PMTCT manuals and guidelines.

With regard to accessibility, although it was found to be acceptable according to the agreed upon criteria, however there are pregnant women missing from voluntary counseling and counseling service in PMTCT program due to distance and lack of alternative transportation system.

Acceptability of PMTCT service also found and judged satisfactory according to the preset criteria. However it was influenced by less focus on the points to be discuses during counseling by counselors which is pronounced by less points raised during direct observation. Regarding to the accommodation of PMTCT service to pregnant women, it was judged to be satisfactory according to the preset criteria and judgment.

8.2 Recommendations

- The District health office together with the Zonal health office should have to provide training for more technical staffs on PMTCT
- The District health office together with the Zonal health office better to expand the counseling and testing service of PMTCT which can help to increase the number of pregnant women counseled and tested for HIV and also decrease missed opportunity of HIV positive pregnant women from the intervention program
- The District health office, Zonal health office and MSH need to distribute national guideline, manuals and recording formats to the health facilities.
- The District health office, Zonal health office, MSH and global found need to provide refresher training to update the counselors on the guidelines. This can

help the counselors to include points that are important for the counseling and testing procedures.

- The District health office and Zonal health office would better to provide equal amount of gloves, test kits and capillary tubes that can be used for one testing procedure.
- Counselors have to use the guideline while they are providing the PMTCT services to include basic information during pre-test and post-test counseling sessions.

Chapter-9 Meta-evaluation

Evaluation standards are means to contribute to professionals of evaluation that enhance the credibility, quality and trustworthiness of evaluation. These standards are grouped in to four which includes utility, feasibility, propriety and accuracy (40). So these standards were considered during the development of the proposal, data collection and analyses of the result.

9.1 Utility

Stakeholders were identified through discussion with district HIV expert and they were involved throughout evaluation process. Thus the findings will be used by the primary user of the evaluation finding and other stakeholders to improve the program.

9.2 Feasibility

The evaluation procedure was made practical, Planed and conducted with anticipation of the different position of various interest group and cost effectiveness was considered throughout the process.

9.3 Propriety

The evaluation was ensured to be legal/ ethical. Initially the proposal was approved by advisors and then consent letters was obtained from Jimma University, college of public health and medical sciences ethical committee. The evaluation was designed and conducted to respect and protect the rights and welfare of human subjects during data collection.

9.4. Accuracy

The program was described and documented clearly and accurately. All the evaluation procedures designed in the protocol was applied to obtain unbiased and desired information. The data collection, processing, and reporting were systematically done. Quality control strategies were carried out properly. Data was collected from several sources using multiple data collection methods. The qualitative and quantitative data were appropriately and systematically analyzed.

Reference List

1. UNAIDS. Report on the Global AIDS Epidemic, 2010 www.unaids.org/documents/2010 Accessed on 6/08/2010
2. WHO. Antiretroviral therapy for HIV infection in infants and children,2010 www.pedaids.org/puplications/toolkits Accessed on 9/08/2010
3. UNAIDS and the millennium village. Elimination of mother-to-child HIV transmission in sub-Sahara Africa,2008
4. Federal HIV/AIDS prevention and control office. Guidelines for prevention of mother-to-child transmission of HIV in Ethiopia, 2007 http://www.etharc.org/aidsineth/publications/singlepointprev_2007.pdf Accessed on 5/8/2010
5. Ministry of Health. National HIV/AIDS prevention and control office. single point HIV prevalence estimate June, 2007 Accessed on 5/8/2010
6. AIDS in Oromiya Data base. www. Org.et/aidsinoromiaa. Accessed on 15/10/2010
7. WHO, Strategic vision 2010-2015. Preventing mother-to-child transmission of HIV to reach the UNGASS and millennium development goal
8. Shebesombo district health office. Annual HIV/AIDS report,2009/10
9. Global HIV prevention working group. Bringing HIV prevention to scale:An urgent Global Priority 2007 . www.global hiv prevention.org/… /pwg.HIV prevention report final pdf. Accessed on 5/6/2010
10. Project SRAR. Study designs for program evaluation,2006 http://www.nationalservice resources.org Accessed on 3/08/2011
11. Carol H. Evaluation methods for studying programs and policies, Second editions ,Harvard University,1998
12. UNAIDS. Report on the Global AIDS Epidemic, 2010
13. Temu F., Nkungu D. Motivation to seek voluntary counseling and testing services among married or cohabiting clients January 2004.
14. Sprague C. Health System weaknesses Constrain Access to PMTCT and maternal HIV services in South Africa: qualitative Enquire 2010 http://www.aidsrestherapy.com/pdf/ Accessed on 6/8/2010

15. Marlee T., Ann Q., Fabia M and Kishor M. Mother-to- child HIV transmission in resource poor settings how to improve coverage? AIDS volume 17(8) may 23, 2003.
16. Nuuagbe .B. Challenges faced by health workers in implementing the prevention of mother-to-child HIV transmission (PMTCT) program in Uganda, ;2007
17. Freddy.P. Prevention of mother-to-child transmission of HIV: evaluation of a pilot program in district hospital in rural Zimbabwe,2008
18. Fyson B. Acceptability of voluntary counseling and HIV testing but unacceptable loss to follow up in a prevention of mother to child transmission program in Malawi, 2009.
19. Tilahun W. Utilization of PMTCT service among pregnant women in western Amhara region. April 2007 Addis Ababa, Ethiopia
20. Maria N. Factors affecting Voluntary Counseling and HIV testing among pregnant women in Tsumeb District, Oshikoto Region, Nambia. University of the Western Cape. November 2006
21. Global AIDS Alliance. Experience of prevention of mother-to-child Transmission of HIV in Rural Tanzania, September 2009.
22. WHO. Antiretroviral drugs for treating pregnant woman and preventing HIV infection in infants, 2005 www. Who int/HIV/en
23. Consortium of CRDA and World AIDS Campaign. National workshop on`` Universal Access to HIV/AIDS Prevention, Treatment, Care and Support, 2010 WWW. Etharc org/pmtct/resources/pmtct curriculum Eth. Him. Accessed on 6/8/2010
24. Isaac A. and Solomon S. Prevention of mother-to-child transmission of HIV, www. Per far. Gov/press/79674.htm.
25. Federal HIV/AIDS Prevention and control office. Annual Performance Report of Multisectoral HIV/AIDS Response 2009/10, http://www.etharc.org/resorces Accessed on 3/10/2010
26. Berhne Y. Women's health in rural setting in societal transition in Ethiopia, Department of community health, Addis Ababa,2009 http://wwwsciencedirect.com
27. Hareg project. Prevention of mother-to- child transmission (PMTCT) of HIV/AIDS in Ethiopia,September 15,2004-december31,2007 Intrahealth intentional/ http;//wwwprim2 org/prime2/pdf. Accessed on 6/8/2010

28. Penchansky R,Thomas JW. The concept of Access; Definition and Relationship to consumer Satisfaction Medical care.1981
29. Robert K yin. Case study Research design and methods. Third edition applied social Research methods series, volume 5,1998
30. UNAIDS. Tools for evaluating HIV voluntary counseling and testing. Geneva, 2000 http://www.unaids.org .Accessed on 5/11/2010
31. Family health international. Baseline assessment tools for preventing mother-to-child transmission(PMTCT) of HIV/AIDS,Augest,2003 Accessed on 6/8/2010
32. Federal ministry of health. Health sector strategic plan (HSDP-III) 2005/6-2009/10 planning and programming Department 2005
33. Suleko S. Process evaluation of PMTCT service implementation in Karamara Hospital, Somali regional state, Eastern Ethiopia 2010 ,unpublished
34. Ayalneh D. process evaluation of HIV counseling and testing of prevention of mother-to-child transmission against the national guideline in Arsi zone ,southeast Ethiopia,2008 ,Unpuplished
35. Tesfa D. Evaluation on prevention of mother-to-child transmission of HIV program implementation in Bherdar special zone ,2008, unpublished
36. Hussen I, Ahmied A. status of ANC-linked HIV counseling & testing as intervention for PMTCT in public health facilities in Addis Ababa: quality of HIV counseling given to pregnant women for PMTCT, *[Ethiop. J. Health Dev2009: 23(3): 190-198]*.
37. Health Alliance International/UNICEF. Prevention of Mother-to-Child Transmission of HIV in Manica and Sofala Provinces, a Quantitative and Qualitative Project Evaluation. Final Evaluation Report, Maputo, Mozambique, 2004
38. Moth I A, Ayayo A B C O, Kaseje D O. Assessment of utilization of PMTCT services at Nyanza Provincial Hospital, Kenya, J of Social Aspects of HIV/AIDS July, 2005
39. Lyatuu MB, Msamanga GI, Kalinga AK. Clients' Satisfaction with Services for Prevention of Mother-to-Child Transmission of HIV in Dodoma Rural District; E. African J of Public Health December, 2008
40. The Joint committee on standards for educational evaluation. Program evaluation standards, July 2004

Annex-1 Indicators definition

Availability of resources

1 Number of HFs constructed and functional

Numerator: *Number of HF* constructed and functional

Denominator: *Number of HF observed*

2 Number of HFs which have two and above HWs

Numerator Number of HFs which have two and above HWs

Denominator Number of HFs observed

3 Number of HFs which have minimum ANC material

Numerator Number of HFs which has minimum ANC material

Denominator Number of HFs obseved

4 Number of health care workers trained on PMTCT

Numerator Number of health care workers trained on PMTCT

Denominator Total number of health worker in the health centers

5 Proportions of HCs providing PMTCT

Numerator Number of HCs providing PMTCT

Denominator Total number of Health centers

6 Availability of separate counseling rooms

Numerator Number of health facility with separate counseling room

Denominator Total health facilities observed during evaluation

7 Number of health facility with valid test kits (at least one unopened and unexpired box in each PMTCT site)

Numerator: Number of health facilities with valid test kit

Denominator: Total health facilities observed during evaluation

8 Number of health facility with standard recording and reporting formats

Numerator: Number of health facilities with standard recording and reporting formats

Denominator: Total health facilities observed during evaluation

9 Number of health facility with PMTCT manuals

Numerator: Number of health facilities having manuals

Denominator: Total health facilities observed during evaluation

10 Number of health facility with PMTCT guidelines

Numerator Number of health facilities with PMTCT guideline

Denominator Total health facilities observed during evaluation

11 Number of health facility with waiting area

Numerator: Number of Health facilities having waiting area

Denominator: Total health facilities observed during evaluation

Accessibility of service to pregnant women

1 Proportion of pregnant women who didn't complain distance of PMTCT center from their residence

Numerator Number of pregnant women who didn't complains distance of PMTCT center from their residence

Denominator Number of pregnant women participated in the interview

2 Proportion of pregnant women who have alternative transportation mechanism from their residence to the nearby PMTCT center

Numerator Number of pregnant women who have alternative transportation mechanism from their residence to the nearby PMTCT center

Denominator Number of pregnant women participated in the interview

Acceptability of service by pregnant women

1 Proportion of pregnant women who believed adequate time for PMTCT service

Numerator Number of pregnant women who believed adequate time for PMTCT service

Denominator Total number of pregnant women participated in the interview

2 Proportion of pregnant women satisfied with the counseling

Numerator Number of pregnant women satisfied with the counseling

Denominator Total number of pregnant women participated in the interview

Accommodation of service to pregnant women

1 Proportion of pregnant women who perceived counseling room was private and confidential

Numerator Number of pregnant women who perceived counseling room was private and confidential

Denominator Total number of pregnant women participated in the interview

2 Proportion of pregnant women satisfied with the waiting time

Numerator Number of pregnant women satisfied with the waiting time

Denominator Total Number of pregnant women participated in the interview

3 Proportion of pregnant women satisfied with the convenience of PMTCT working hours

Numerator Number of pregnant women satisfied with the convenience of PMTCT working hours

Denominator Total Number ***of*** pregnant women participated in the interview

Annex-2: Judgment matrix for evaluation dimensions out of 450, Shebe-Sombo, 2011

Dimensions	Value	Indicators	Wight given	Achievement in %	Criteria and judgments
Availability		Number of HFs constructed and functional	20		
		Number of HFs which have two and above trained HWs	15		

	200	Number of HFs which have minimum ANC materials,	15		≥85% Satisfactory 71%-84% Acceptable 51%-70% fair ≤50% critical Note:- decimals was round up to the nearest whole number
		Number of health care workers trained on PMTCT	25		
		Number of HF which providing PMTCT service	25		
		Number of health facility with separate counseling rooms	25		
		Number of health facility with valid test kits (at least one unopened and unexpired box in each PMTCT site)	25		
		Number of health facility with standard recording and reporting formats(at least one)	15		
		Number of health facility with PMTC manuals (least one)	15		
		Availability of at least one PMTC guidelines	15		
		Number of health facility with waiting area	5		
Accessibility	50	proportion of pregnant women who didn't complain distance of PMTCT center			
		proportion of pregnant women who have alternative transportation mechanism from their residence to the nearby PMTCT center	20		
Acceptability	100	Proportion of pregnant women believe adequate time for PMTCT counseling	40		
		Proportion of Pregnant women satisfied with the counseling	60		

Accommodation	100	Proportion of pregnant women who perceived counseling room was private and confidential	25		
		Proportion of pregnant women satisfied with the waiting time	50		
		Proportion of pregnant women satisfied with the convenience of PMTCT working hours	25		
Total	450		450		

Annex-3: Client exit interview Questionnaire

Jimma University, College of Public health and Medical science Department of Health planning & health service management, Health monitoring & evaluation unit

Introduction

Hello. My name is _____. I am here on behalf of Jimma University, Jimma zone health department and Shebe-Sombo district to assist in collecting data related to Maternal and child health care, particularly on PMTCT service which will take 15-20 minutes. The evaluation of PMTCT implementation planned to identify service barriers that can give opportunity for improvement. Hence, this evaluation intended to serve as

basis for decision in service improvement for PMTCT implementation, including the continuum of care for HIV + pregnant women and HIV exposed infants.

I would like to know how you feel about the service delivery that you received at this facility and comment on both strength and weakness of service delivery to support the program.

The information you provide is completely confidential and anonymous. There will not be your name or personal identifier in any part of this study. Your participation is completely voluntary and you do not have to answer any questions you do not want to. We assure you that the information will not be used for any other purposes and shall support PMTCT service improvement and address the needs of ANC clients like you. If you choose not to participate, your services will not be affected in any way. The health care provider won't be told what you said and regardless of the opinions you have, you can get the service required**.**

Do you have any questions?" [Answer questions.]

Do I have your agreement to participate? YES..... NO --------, if yes continue.

Date_____ Started time_____

Section I.

1 Code of health facility_____

2 Region _____

3 District _____

4 Name of health facility _____

5 Type of facility (health centers, HP)

6 Department/unit (01=ANC/MCH; 02=maternity ward; 03=postpartum; 04=Laboratory; 05= Pharmacy; 06=others)

A. Questions for Clients:

II. Socio- demographic characteristics questionnaires

1. What is your age? ----------

2. Marital status

1/ Single 2/. Married 3/ Separate/Divorce 4/ Widowed

3. Do you have an occupation?

1/ No job 2/ Professional 3/ Merchant 4. Others, specify it-----

4. Religion

1/ Moslem 2/ Orthodox 3/ Protestant

4/others, please specify it----------

5. Educational Status

1/ Unable to read & write 2/ Only read & write 3/ 1-6 grade 4/ 7-12 Grade 5/ 12+

III. Exit interview Questionnaire

6 What services did you come for? (Multiple responses allowed)

1. I am ill, for treatment 2. HIV counseling & testing

3. First ANC 4. Follow up ANC

5. TT vaccination 6. Other, specify _____

7 Is HIV transmitted from mother to child? 1. Yes 2. No

8 If yes, when? 1. During pregnancy 2. During labor & delivery

3. During breast feeding 4. Others _____

9What is your level of satisfaction by the communication skill of the counselor?

1/ Very satisfied 2/ Satisfied 3/ Neutral

4/ Unsatisfied 5/ Very unsatisfied

10 If not satisfied, why_____

11 Do you satisfied that you had adequate information to make a decision about HIV testing? 1. Yes, enough information

2. Yes, partially satisfied

3. The counselor made the decision for me

4. No, not enough information

12 What is your level of satisfaction by the post-test counseling?

1. Very satisfied 2. Satisfied 3. Neutral

4. Unsatisfied 5. Very unsatisfied

13 Do you believe that the counselors are technically competent?

1. Very competent 2. Competent 3. Neutral

4. Incompetent 5. Very incompetent 6. Do not know

14 If not competent, why_____

_____

15 Are the counselors served you with respect & dignity?

1. Strongly agree 2. Agree 3. Neutral

4. Disagree 5. Strongly disagree

16 If you do not agree, why _____

_____

17 Do you think that the health workers keep confidentiality of your medical information including the HIV status?

1. Strongly agree 2. Agree 3. Neutral

4. Disagree 5. Strongly disagree

18 If you do not agree, why _____

_____

19 Do you think that the counseling room is sound-proof & the doors/windows are closed, that you speak with your counselor without any fear that others will see or hear you? 1. Yes 2. No

20 Do you think that the waiting area is comfortable for you to wait?

1. Yes 2. No

21 If No, Why _____

22 Did you feel you had adequate time with the counselor to get all the information you wanted to know? 1. Yes 2. No

23 Did you feel you could ask the counselor questions if you wanted to?

1. Yes 2. No

24 What do you feel about the waiting time between your first arrival at this facility and the time you received the service? 1. Short 2. Long

25 If long, what to be corrected _____

_____

26 How did you travel to the health facility? (Multiple answers possible)

1. On foot 2. By bus (public transport)

3. On horse back

27 How far did you travel from your home to reach the facility? (for single trip estimate) _____ Hours (multiple response is possible).

1. The HF is easily accessible for me (distance).
2. The HF is at a reasonable distance
3. The HF is not easily accessible for me (distance)

28 If not accessible, what do you suggest? _____

_____

29 Do you wish you had a different counselor? 1/ Yes 2/ □ No

30 If yes, 1/ Different sex 2/ Older 3. Younger

31 If a friend or relative were pregnant, would you recommend that she came for HIV testing? 1/ Yes 2/ □No

32 If No,for q31, Why?

_____

33 Would you recommend the HIV testing to any one else?

1/ □Yes 2/ No

34 If yes, for q 33 1. Partner/husband 2. □friend 3. □family member

4. □others_____

35 Will you return for ANC follow up &/or to check your HIV test result after 3 months?

1. Yes 2. □No 3.□Don't know

36 If no, why _____

_____

37 Why most pregnant mothers are not utilizing the PMTCT service?

1. Fear of stigma and discrimination 2. Fear of their husband
3. Ignorance/lack of awareness 4. Inaccessibility of the service site
5. Fear of the unknown 6. No service at weekends
7. Other _____

General comments _____

_____

Interviewer Name _____Date _____

Sign _____

Annex-4: Community survey Questionnaire

Jimma University, College of Public health and Medical science Department of Health planning & health service management, Health monitoring & evaluation unit

Introduction

Hello. My name is _____.

I am here to conduct process evaluation of the Prevention of Mother-to-Child Transmission. I would like to ask you questions which may take 15-25 minutes about your personal feeling as well as about the service. I would also like to ask your opinion of the PMTCT service in general. All the information you provide will help us and the sites

staffs improve the services. I will not mention your name and all information you provide will be kept confidential.

I realize how limited your time is and greatly appreciate you taking the time.

Do you have any questions for me?

Instructions for interviewer

• Administer this tool to pregnant women who does not have ANC follow

• If more than one answer is acceptable, make sure to probe by asking "anything else?"

You will find instructions in the instrument when this is required

Date_____ Started time_____

Section I.

1 Code of health facility_____

2 Region _____

3 Woreda _____

4 Name of health facility _____

5 Type of facility (0=referral hospital; 1 health centers, HP)

6 Department/unit (01=ANC/MCH; 02=maternity ward; 03=postpartum; 04=Laboratory; 05= Pharmacy; 06=others)

A. Questions for Clients:

I. Socio- demographic characteristics questionnaires

1. what is your age----------

2. Marital status

1/ Single 2/. Married 3/ Separate/Divorce 4/ Widowed

3. Do you have an occupation?

1/ No job 2/ Professional 3/ Merchant 4. Others, specify it-----

4. Religion

1/ Moslem 2/ Orthodox 3/ Protestant 4/ Catholic

5/ others, please specify it----------

5. Educational Status

1/ Unable to read & write 2/ Only read & write 3/ 1-6 grade 4/ 7-12 Grade 5/ 12+

6. Have you ever heard about the presence of ANC service in the health facilities?

1/ yes 2/ no

7. If yes q6 why you don't attained the service? Justifications ----------

---

8 Have you ever heard about HIV/AIDS before? 1/Yes 2/ No

9 If yes q8 where did (do) you hear about it? From: (Do not read the alternatives. More than one response is possible)

1 Friends 2 Relatives 3 School teachers 4 Health institutions 5 Radio 6 Television

10 Can HIV is transmitted from one person to another? 1/ Yes 2/ no

11 If yes q10 please specify: (Do not read the alternatives. More than one response is possible)

1 Sexual intercourse 2 Getting injections 3 Blood transfusions 4 Mother to child during pregnancy 5 Mother to child during delivery 6 Mother to child through breast milk

7 I do not know 8 Others (specify)

12. Have you ever heard how Mother to Child Transmission of HIV can be prevented?

1/ Yes 2/ No

13 Do you support the idea that every pregnant woman should be screened for HIV?

1/ Yes 2/ No

14 If yes q13 have you screened 1/ yes 2/ no

15 If no q13 why you are not screened? _____

16 What do you think is the reason that pregnant women following ANC will not be voluntary to provide blood samples for HIV testing?

1 Afraid of copping with Positive HIV status

2 Afraid of the consequences (in the community) of knowing that they might be positive

3 Do not like to give blood at all 4 The religious faith does not permit it

17 Have you ever discussed about HIV/AIDS with husband, health personnel, or other people in the last 6 months? 1/ yes 2/ no

18 If yes q17 with who do you discussed?

1 Husband 2 Health Personnel 3 Other People

19. How far did you travel from your home to reach the facility? (for single trip estimate) _____ Hours (multiple response is possible).

1. The HF is easily accessible for me (distance).
2. The HF is at a reasonable distance

3. The HF is not easily accessible for me (distance)

20. If not accessible, what do you suggest? _____

21. How did you travel to the health facility if you want? (Multiple answers possible)

1. On foot 2/ By bus (public transport) 3/ On horse back

22. If on foot how much time does it takes? ____hrs____ minuets

23. Why most pregnant mothers are not utilizing the PMTCT service?

1. Fear of stigma and discrimination 2. Fear of their husband
3. Ignorance/lack of awareness 4. Inaccessibility of the service site
5. Other _____

General comments _____

_____

Interviewer Name _____Date _____

Sign _____

Annex-5: Interviewing program managers

Jimma University, College of Public health and Medical science Department of Health Planning & health service management, Health monitoring & evaluation unit

Introduction

Hello. My name is _____.

I am here to conduct process evaluation of the Prevention of Mother-to-Child Transmission. I would like to ask you questions about your personal feeling as well as about the service you have just gave. I would also like to ask your opinion of the PMTCT service in general. All the information you provide will help us and the sites staffs

improve the services. I will not mention your name and all information you provide will be kept confidential and it may take 15-20 minutes

I realize how limited your time is and greatly appreciate you taking the time.

Date_____ Started time_____

Part one.

1 Code of health facility_____

2 Region _____

3 Woreda _____

4 Name of health facility _____

5 Type of facility (0=referral hospital; 1 health centers, HP)

Part two: Questionnaire for managers of the facility or the person most knowledgeable about the ANC /PMTCT/relative service

1. How long the ANC service at your facilities?

2. At your site, is there any protocol, guideline and what to saying regarding PMTCT?

A yes b/ no

3. If yes, what is it (ask verification)? ----------

4. Are clients referred to another site? If yes How is the referral system organized? ----------

5. How are PMTCT and its components organized at the ANC, maternity, child, FP and PMTCT site? ----------

6. Have stock outs been a problem that can be used in PMTCT service? If so, can you describe? ----------

7. What are the proportions of pregnant mother who utilize the PMTCT from that antenatal care attendee in the last two year? ----------

10. What are the packages of the PMTCT program that the health services provided? Describe the activities of the program? If not all why not served? ----------

11. What is the Sources of information about PMTCT? (program manager, professionals, documents, or observations that provide information for the inquiry)----------

12. Do you have any intervention/activity regarding PMTCT service at community based like out reach service, IEC etc.?

13. If yes? Describe what type of activities conducted and ask verification? ----------

14. Do you have enough trained human resources at all levels? 1/ yes 2/ no

15. How do you train or get the training chance to health professionals at your health facility? ----------

16. What was the process of training conducted at your facility or else where? How?

17. Do you have selection criteria to select the providers to be train? Ask verification?

18 How do you sustain the human resources at all levels? Do you have any strategy to sustain the train human resources at your health facilities? ----------

19. If there is shortage of trained man power, what is the consequence effect on the program access? (Is that having an impact on less access of the service by the target groups?) ----------

20. How do you monitor the program at each level (ANC, PMTCT, maternity, child health unit and other related service to PMTCT)?

21 Would you say that the community knows of your program? 1/yes 2/ no

22 If yes, would you say that it supports the program? ----------

23. What will be the general comments to improve the access of the service by target groups and community at large? ----------

24. Is there collaboration among the stakeholders especially on improving the access of the service at your site? 1/ yes 2/ no

25. If yes, how? ----------

26. Which staff works directly with the clients? ----------

27. What are the qualifications/backgrounds of the staff (social workers, Nurses Clinicians, etc.)?----------

General comments _____

_____

Interviewer Name _____Date _____

Sign _____

Annex-6: Question to focal person working at antenatal, PMTCT,

Jimma University, College of Public health and Medical science Department of Health planning & health service management, Health monitoring & evaluation unit

Introduction

Hello. My name is _____.

I am here to conduct process evaluation of the Prevention of Mother-to-Child Transmission. I would like to ask you questions about your personal feeling as well as about the service you have just gave. I would also like to ask your opinion of the PMTCT service in general. All the information you provide will help us and the sites staffs

improve the services. I will not mention your name and all information you provide will be kept confidential.

I realize how limited your time is and greatly appreciate you taking the time to speak with me.

Do you have any questions for me? If not continue

Date_____ Started time_____

Part one.

1 Code of health facility_____

2 Region _____

3 Woreda _____

4 Name of health facility _____

5 Type of facility (0=referral hospital; 1 health centers, HP)

Part two ANC/PMTCT operating hours and organization

6. Approximately what proportion of women in the catchments area visit the ANC at least once during a new pregnancy on the past one year? Ask verification

---

_____

7. What is the average number of ANC visits made per pregnant woman? ----------

8. What are the ANC's hours of operation?

a) Opening time _____ am/pm b) Closing time _____am/pm

9. How many days per week are ANC services offered? ----------

10. How are "new" and follow-up ANC visits organized?

10.1 All visits are together

10.2 Provided on same days but at different hours

10.3 Offered on separate days of the week

11. How many midwives/nurses are usually assigned to the ANC on any given day? ------

---

16 How many examination rooms are there for ANC checks? _____

17. On average, how much time does a woman spend at the ANC?

17.1 For the first ANC visit? _____

17.2 For follow-up ANC visit? _____

18. Are there labor and delivery services at this facility? 1/ yes 2/ no

19. If yes approximately what proportion of women attending ANC return to deliver at this facility? _____

…

II. Prevention of mother-to-child transmission services

20 Which of the following PMTCT-related services are offered at your site?

20.1 Ongoing counseling 1/ Yes 2/ No

20.2 If No, are women referred for these services? 1/ yes 2/ no

20.3 Infant feeding counseling 1/ Yes 2 No

20.4 If No, are women referred for these services 1/ Yes 2/ No

20.5 ARV prophylaxis 1/ Yes 2/ No

20.6 If No, are women referred for these services? 1/ Yes 2/ No

20.7 Safer Obstetric practices (observe) 1/ Yes 2/ No

20.8 If No, are women referred for these services? 1/ Yes 2/ No

20.9 Caesarean section offered as an option for PMTCT 1/ Yes 2/ No

20.10 If No, are women referred for these services? 1/ Yes 2/ No

20.11. If ARV prophylaxis is offered, please state which one----------

21. As far as you know, do national guidelines on PMTCT exist? a/ Yes b/ No

22. If yes, ask to see a copy. 1/ yes seen 2/ not seen

23 Is the protocol used consistently? 1/Yes 2/ No

24. If NO, why not? _____

<u>HIV testing</u>

25. Where does HIV testing of pregnant women for PMTCT take place?

25.1All testing and confirmations done on site at the ANC/MCH

25.2 Preliminary tests done on site; confirmations sent to other lab

25.3 Blood drawn at ANC/MCH; testing carried out in other lab

25.4 All blood drawn and testing carried out in other lab

25.5 At a designated VCT Unit

26 Who performs the HIV test?_____

27. When do women receive their results?

1/ same day 2/ within a few days 3/ at their next scheduled ANC visit

4/ Other Specify

28. What is the time interval between receiving the sample and the results being available? Circle if the time is in minutes, hours, days, and weeks.

_____minutes / hours / days / weeks

Counseling for partners and couples

Infrastructure, equipment and supplies

29. How many rooms are used for HIV/PMTCT counseling and related issues?

30. Please describe where the counseling room is in relation to the ANC/MCH.

Testing rooms

31. Are the following conditions and supplies available where blood draw/testing takes place?

	Yes, observed---	yes, not observed---	not available
31.1 Gloves	_____	_____	_____
31.2 Sharp's box	_____	_____	_____
31.3 Disposable needles and syringes	_____	_____	_____
31.4 Running water	_____	_____	_____
31.5 Hand washing items (hand soap or disinfectant)	_____	_____	_____

Annex: 7 Resource inventory chick list

Jimma University, College of Public health and Medical science Department of Health planning & health service management, Health monitoring & evaluation unit

Observation of supplies will take place after completion of tool

	Yes	No	Not applicable	not offered at site
01 Weighing Scale	------	-----	------	------
02 Height Scale	-----	-------	-------	-------
03 Blood Pressure				

apparatus ------ ------- ----- ---------

04 Fundal Height

Measurement --- --------- ------ -------- ----------

05 Feto-scope

06 ARV tablets ---------- ---------- ---------- ---------

07 ARV syrups ---------- ---------- ---------- ----------

08 HIV rapid test kits ---------- ---------- ---------- ---------

09 Test kit 1 ---------- ---------- ---------- ----------

10 Test kit 2 ---------- ---------- ---------- ----------

11 Test kit 3 (tie breaker) --------- ---------- ---------- ----------

12 Lancets for rapid testing -------- ---------- ---------- ----------

13 Infant formula ---------- ---------- ---------- ----------

14 IEC materials ---------- ---------- ---------- ----------

15 Condoms ---------- ---------- ---------- ----------

16 How often do you run out of the following PMTCT supplies each month?

Never/ rarely (i.e., 1 day a month) A few times per month Often-

17 Prophylaxis ---------- ---------- --------

18 HIV rapid test kits ---------- ---------- -------

19 Lancets for finger pricking ---------- ---------- ----------

20 Infant formula ---------- ---------- ----------

21 IEC materials ---------- ---------- ----------

22. Condoms ---------- ---------- ----------

<u>Human resources and training</u>

23. Providers/type of providers

Providers include those working in all of the areas of MCH

24 Total numbers of providers ----------

25 Midwives number ----------

26 Nurses number ----------

27 Doctors number ----------

28 Laboratory staff number ----------

29 Others in number ----------

Interviewer name_____ Date _____signature_____

Annex -8: Checklist for observation form of PMTCT counseling session

Jimma University, College of Public health and Medical science Department of Health planning & health service management, Health monitoring & evaluation unit

Introduction

Observer instructions: obtain permission from the patient as well as the health provider before beginning to assess the interaction between them Make sure that the provider knows that you are not there to evaluate him/her and that you are not an expert to consult during the session.

Hello, my name is _____. I am representing Jimma University. We are carrying out an evaluation of health facilities that provide PMTCT services with the goal of finding ways to improve service access. I would like to observe your consultation in order to better understand how PMTCT service is provided in the district. This information is completely confidential and no names will be taken. You may choose to stop the observation at any time. May I be present at this consultation? If yes, continue but if no, stop

Section I. Facility identification

1 Code of health facility_____

2 Region _____

3 Woreda _____

4 Name of health facility _____

5 Type of facility (health centers, HP)

Services Provided: -	Pre-test counseling	1. Yes	2. No
	HIV testing	1. Yes	2. No
	Post-test counseling	1 yes	2 N o
Types of counseling:-	One-on-one	1. Yes	2. No
	Couple	1. Yes	2. No
	Group	1. Yes	2. No

Start & end time of consultation respectively _____ AM/PM

Section I1 Profile of counselor**:**

1 Sex: - 1. Male 2. Female

2 Position 1. Midwife 2 Clinical nurse 3. Others_____

3 Trained on PMTCT 1. Yes 2. No

4 For how long did you provide PMTCT services (in months)? _____

Section I1 General counseling environment

How adequate was the privacy? (Check all that apply)

5 . Separate room 1. Yes 2. No

6. Door closed 1. Yes 2. No

7. Out of earshot of other clients 2. Yes 2. No

8. Interruption 1. Yes 2. No

For each of the questions listed below, make a tick (√) that most appropriately reflects your assessment of what happened during the interaction.

Large Group/Small Group/Individual/Couple Pre-Test Session (PMTCT Guideline)

Pre-Test Session	Yes	No
Benefits of testing		
Testing process		
Discordance and partner HIV testing		
Risk reduction		
PMTCT, support services, and antenatal care		

HIV-negative Post-test Counseling:

Post-test Counseling:	Yes	No
Provide HIV test result		
Partner HIV testing and Disclosure		
Risk reduction		
Antenatal and postnatal care and safe delivery		
Exclusive breastfeeding		
Infant follow and care		
Provide referral/take home information		

HIV-positive Post-test Counseling:

Post-test Counseling:	Yes	No

Provide HIV test result and support		
CD4 count and screening for OIs		
ARV prophylaxis/treatment using CD4 or clinical criteria		
Exclusive breastfeeding for 6 months and safe breastfeeding practices		
Partner HIV testing and disclosure		
Risk reduction		
Antenatal and postnatal care and safe delivery		
Treatment and support services for client and family		
Infant follow up and importance of early infant diagnosis		

General comments _____
_____
Interviewer Name _____Date _____
Sign _____

Annex -9: Exit interview questioner in Afan Oromo

Jimma University, College of Public health and Medical science Department of Health planning & health service management, Health monitoring & evaluation unit

Gaaffilee qinda'aa maamiltoota da'umsa duratiif

Unka walii galtee

Ragaan funaanudhaaf namootni raga sassaaban unka walii galtee maamiltoota wajjiin karaa Ogeessa raawatu. Ogeessi tajaajilicha kennuu erga kaayyoo qorannicha hubatee booda maamiltootaf ibsa. Odeeffannon funaanamu kan jalqabu erga maamiltootni irratti walii galanii booda. Fedhii yoo dhaban maamiltootni itti hirmaachu dhiisu danda'u.

Akkam oltan/bultan. Maqaan ko_____

Gaaffii fi deebin isiin wajjiin taasisu odeeffannoo tajaajila da'umsa duraa as keessatti kennamu argachuuf na gargaara. Fooya'insa tajaajila as keessatti kennamuufis ni fayada ogeessotni tajaajila kana kennaan kaayyoo gaaffi kana isinitti himaniiru natti fakaata. Haala tajaajila argattani ilaalchisee gaaffii muraasa akkan isin gaafadhuuf yeroo akka naaf laattan kabajanan isin gaafadha. Maqaa keessan hin galmeessu, odeeffannoon isi irraa argamus dhoksadhaan eegama. Gaaffii deebisu hin barbaanne deebisu dhiisuu dandeessu yoo isinitti hin toles gaaffii fi deebi keenya addan kutuu dandeessu. Yoo irratti walii galtan unka kana irratti malateessa.

Maqaa raga funaana/tu _____

mallattoo _____

mallattoo tajaajilamaa_____

1 Lakk dhabataa faayaa_____

2Aanaa_____

3 Maqaa dhabataa faayaa_____

4 Gosaa dhabataa fayaa(0 hospitala referalaa,1 buufata fayaa,3 kelaa fayaa)

5 Garee yalaa(1 ANC,2 kutaa yalaa hadholi,3 kutaa tajajilaa da'umisaa bodaa,4 kutaa laboratory,5 kutaa farmasii,6 kan biroo)

Gafilee tajajilamitotaf

Gafilee halaa waligala irrati

1 Umuriin kee meqaa_____

2 Halaa ga'elaa 1.kan herumite 2.kan hin herumine 3.kan adaan batee 4.kan abban mana du'e

3 Hojii qabdaa 1.hojii hin qabu 2.hojetaa motumaa 3. Dalidala 4.kan biroo,ibsi_____

4 Amantii 1. Musilima 2.ortodoxii 3.protestantii 4. Katolikii 5. Kan biroo_____

5 Sadarikaa barnotaa 1. Baresuuf dubisuu kan hin dandenyee 2. Baresu fi dubisu qofa kan danda'u 3.kutaa 1-6 4.kutaa 7-12 5.12+

6 Tajaajila akkamii berbade dhufte?(debiin tokkoo ol ni dend`ama)

1 waan na dhukkubef, yaaliif

2 gorsa fi qorannoo HIV tiif

3 Qoranno da`umsa durajalqabaa

4 Hordofii qornnoo da`umsa dura

5 talaallif

6 kanbira,ibsi _____

7. HIVn hadha irraa da`immatti ni derbaa?

1 Eeyyee 2. Lakkii

8. Yoo gafii 7'f eeyye jetee ,yemmuu kami?

1 Yeroo ulfaa

2 yeroo cininsuu fi da`umsaa

3 yeroo harma hoosisuu

4 kan biroo ibsi _____

9. Danaeetti hasawaa gorstuutti hagam gammaddeetta?

1 baay`ee gammaderra

2 gammaderra

3 giddu-galeessa

4 hingammanne

5 baay`ee hin gammanne

10 Yoo hin gammanne ta`e, maaiif _____

11 waa`ee qoraannoo HIV murteessuf odeeffnnoo gahaa argachuu keettiga`mmadeetta ?

1Eeyyee,odeeffannoo gahaa

2 Eeyyee,hanga tokko gammadeera

3 gorsitu/gorsaatu naf murteesse

4 lakki, odeeffannoo gahaa miti

12 Gorsa qorannoo boodatti hagam gammmaddeetta ?

1 baay`ee gammaderra

2 gammaderra

3 giddu-galeessa

4 hingammanne

5 baay`ee hin gammanne

13 Gorsitu/gorsaatu ogummaa gahaa qaba jittee ni yaaddaa?

1 Eeyyee 2 lakkii

14 Yoo lakki ta`e g 13 maalif_____

15 Gorsitu/gorsaatu kabajaan si tajaajile/te ?

1 cimssee waliigala

2 waligala

3 Giddu galessa

4 wali hingalu

5 cimsee waliihingalu

16 Yoo waliin hingalle,g15, maaliif _____

17 Ogeeyyiin fayyaa odeeffannoo fayyaa keetii bu aa HIV dabalatee iciitii ni eegu jette yaadda?

1 cimssee waliigala

2 waligala

3 Giddu galessa

4 wali hingalu

5 cimsee waliihingalu

18 Yoo waliin hingalle,g17, maaliif _____

19 Kutaa gorsii itti kennamu kun kan sagalee alatti hin basnee fi foddaa/balballi isaa cufaa waan ta`eef,soda tokkomalee gorsaa/tu kee waliin osoo namni bira si hin argiin ykn hindhaga`in hasa`era jette ni yaadda?

1 eeyyee 2 lakki

20 Bakki dabaree eeggachuuf turte kun mijawaa dha/

1 eeyyee 2 lakki

21Yoo lakki jette g20 ,maalif _____

22 Odeeffannoo baruu barbaadde hunda argachuuf gorsa/tu waliin yerro gaha ta`ee debeersera jettee yaadda?

1 eeyyee 2 lakkii

23 Gorssa/tu gaaffi barbaadde gaafchuu ni dandessa ture ?

1 eeyyee 2 lakkii

24 Waa`ee yerro turtii keeti, erga dhabata fayya geesse kaasee hanga tajaajila argatuutti,maal jetta ?

1 gabaaba 2 dheera

25Yoo dheeraa ta`e maaltu sirrawuu qaba ? _____

26 Maalin gara dhabatta fayya demitta yeroo demu baribadu?

1. Milaan 2. Konkolattan 3. Faridaan

27 Mana ketti ka'atte dhabataa fayaa sitti dhiyoo jiru ga'uuf sa'atti meqaa si fudhatta(gari-tokke qofaaf)_____(debiin tokko ol ni danda'amma)

1 dhabatiin fayyaa bay'ee natii dhiyoo dha

2 dhabatiin fayyaa natii dhiyoo dh 3 dhabatiin fayyaa bay'ee natii fagoo dha

28 Yoo fagoo ta`e, maal haa ta`u jetta? _____

29 Goras/yu biroo oso ture/te ni hawwitaa?

1 eeyye 2 lakki

30 Yoo eeyye jettee g29 1 saala addaa 2nama gudda

31 Hiriyan ykn firr kee yoo ulftate, akka dhuftee qoramtu ni taasifta?

1 eeyyee 2 lakki

32 Yoo lakki jette g31, maalif? _____

33 Qorannoo HIV nama biraaf akka godhamu yaadda?

1 eeyyee 2 lakki

34 Yoo eeyyee ta`e g33 1abba warra 2 kadhima 3 miseensa maati

4 kan biroo _____

35 Qorannoo da`umsa duraa fi/ykn bu`aa qorannoo HIV ji`a sadi boda mirkanasuuf ni debita? 1 eeyyee 2 lakki 3 hinbeeku

36 Yoo lakki jettie g35, maaliif? _____

37 Hadholeen ulifaa heduun maliif tajajilaa qoraano dhigaa HIV/ADSI hadha irra gara muchatti akka hin dabareef kenamutti mallif hin fayadamaan jette yadda?

1 Uummatiin nu qolatta jedhaan waan yadanif

2 Abban mana isaan waan hin hayamminef

3 Waan hubanoo hin qabneef

4 Taajajilicha waan hin ariganeef

5 Sodaa hin bekamineef

6 Waan tajajilichi guyya sambatta hin jireef

7 Kan biro_____

Yaada waliigalaa _____

_____

Maqa gaafte _____ guyya _____mal _____

Annex 10: Survey questioner in Afan oromo

Jimma University, College of Public health and Medical science Department of Health planning & health service management, Health monitoring & evaluation unit

Helloo, Ani Maqaan koo----------

Ani kanaan dhufeef qorannoo wa'ee ittisa dadarbina HIV hadha irra gara muchaati ta'u rawwachuuf dha. Wa'ee tajaajilichaa ilaalchisee gaffilee wa'ee tajaajilicha waan isiin yadaanii fi isiinitti daga'aame daqiiqa 15-25f isiin gaafadha. Odeeffanoo isiin nuuf keennitan kun hundi tajaajilichi akka foyya'uu taasisuuf dha. Kanaaf, maqaan keessan hin galma'u akkasumaas yaadni isiin keennitaan ichitiin isaa eegama dha.

Yeroo keessan akkaan fudhadhe na gala, haata'u iyyu malee yeroo keessan waan isin jala gubateef isinaan galeetefadha. Gaffii na gaafatan qabduu?

Ajaaja gaffileedhaaf

Gaffilee kana hadholii Hordoffii tajaajila da'umsaa duraa fudhachaa hin jiree

Guyyaa_____ yeroo itti jalqabe_____ yeroo itti dhume____

1. Godinaa_____
2. Anaa_____
3. Gendaa_____

I. Gafilee halaa waligala irrati

1. Umuriin kee meqaa_____
2. Halaa ga'elaa 1.kan herumite 2.kan hin herumine 3.kan adaan batee 4.kan abban mana du'e
3. Hojii qabdaa 1.hojii hin qabu 2.hojetaa motumaa 3. Dalidala 4.kan biroo,ibsi_____
4. Amantii 1. Musilima 2.ortodoxii 3.protestantii 4. Katolikii 5. Kan biroo_____
5. Sadarikaa barnotaa 1. Baresuuf dubisuu kan hin dandenyee 2. Baresu fi dubisu qofa kan danda'u 3.kutaa 1-6 4.kutaa 7-12 5.12+
6. Akkaa tajajili da'umisaa duraa yeroo ulifaa dhabilee fayaatii kenamu dhagesse betaa? 1.Eeyye 2. Lakki
7. Yoo gatii 6'f eeyye jetee maalif tajajilicha hin hordofinere**?** Ibsi_____

8. Wa’ee HIV/Aedisii duraan dhagesse bektaa? 1.eeyye 2. Lakki

9. Yoo debiin kee gafii 8’f eeyye ta’e essa dhagesee?(filaano hin dubisiin debiin tokko ol ni danda’amma)

   9.1 hiriyotta koo irra

   9.2 firra irra

   9.3 barsisaa mana barumisaa irra

   9.4 dhabataa fayyaa irra

   9.5 radio irra

   9.6 televishiin irra

10. HIV’n nama namatii ni daribaa? 1. Eeyye 2. Lakki

11. Yoo debiin kee gafii 10’f eeyye ta’e adda basii(filaano hin dubisiin debiin tokko ol ni danda’amma)

   11.1 qunamitii salaatiin

   11.2 limee waranachuun

   11.3 dhigaa nama biroo irra fudhachun

   11.4 hadhaa irra garaa muchatii yeroo ulifaa

   11.5 hadhaa irra garaa muchatii yeroo da’umisaa

   11.6 hadhaa irra garaa muchatii yeroo harimma hosisuu

   11.7 hin bekuu

   11.8 kan biroo_____

12. akkataa HIV’n hadhaa irra garaa muchatii akka hin dabareef ittin ittisaan dhagesee betaa? 1.Eeyye 2. Lakki

13. yaada dubarittotin ulifaa hundinu qoranoo dhigaa HIV/AIDS'f gochuu qabu jedhuu ni degeritta? 1.eeyye 2. Lakki

14. yoo debiin kee gafii 13'f eeyye ta'e hatii qoratamitettaa? 1.Eeyye 2. Lakki

15. yoo debiin kee lakki ta'e **maaliif?**_____

_____

_____

16. dubarttoni ulifaa taajajilaa da'umisaa duraa hordoofan maalif qoraano dhigaa HIV/ADSIIf maalif feedhi dhabuu jette yadda?

    16.1 yoon qabadhee akkamin ta'a jedhani waan sodattanif

    16.2 yoon qabadhee ummatiin na qoolifatta jedhaan waan yadaanif

    16.3 dhigaa keenu tasuuma waan hin baribaneef

    16.4 ammantiin waan dhorikuuf

17. wa'ee HIV/AIDS abba mana kee ykn hojetta fayyaa ykn namotta birro waajiin ji'otta 12'n darbee keessa mari'atte betaa? 1. Eeyye 2. Lakki

18. yoo debiin kee gafii 17'f eeyye ta'e enyuu wajiin mari'atte?

    18.1 abba mana

    18.2 hojetta fayya

    18.3 nama biroo

19. Mana ketti ka'atte dhabataa fayaa sitti dhiyoo jiru ga'uuf sa'atti meqaa si fudhatta(gari-tokke qofaaf)_____(debiin tokko ol ni danda'amma)

19.1 dhabatiin fayyaa bay'ee natii dhiyoo dha

19.2 dhabatiin fayyaa natii dhiyoo dha

19.3 dhabatiin fayyaa bay'ee natii fagoo dha

20. yoo sitti dhiyoo mitti ta'e yadaa akkami latta?_____
_____
_____

21. Maalin gara dhabatta fayya demitta yeroo demu baribadu? 1. Milaan 2. Konkolattan 3. Faridaan

22. yoo milaan ta'e sa'atti meeqa_____daqiqaa meeqa _____si fudhatta?

23. Hadholeen ulifaa heduun maliif tajajilaa qoraano dhigaa HIV/ADSII hadha irra gara muchatti akka hin dabareef kenamutti mallif hin fayadamaan jette yadda?

    1. Uummatiin nu qolatta jedhaan waan yadanif
    2. Abban mana isaan waan hin hayamminef
    3. Waan hubanoo hin qabneef
    4. Taajajilicha waan hin ariganeef
    5. Sodaa hin bekamineef
    6. Waan tajajilichi guyya sambatta hin jireef
    7. Kan biro_____

Yaada waliigalaa _____
_____

Maqa gaafte _____ guyya _____mal _____