

**BETTER PRACTICES IN
COMMUNICATION for Prevention of
HIV Transmission in Pregnant
Women, Mothers and their Children**

A global review from 2000 - 2002



BETTER PRACTICES IN COMMUNICATION FOR PMTCT

Overview

In May 2000, UNICEF began providing intensive technical assistance in program communication to PMTCT pilot programs in Africa and Asia. This focused response was initiated when country teams identified communication as a key component of PMTCT programming that was not being strategically addressed in the original pilot program strategies.

As of early 2003, 12 countries have requested, and received, technical assistance from UNICEF HQ in communication for PMTCT, including Botswana, Rwanda, Zambia, Myanmar, Cambodia, Uganda, Thailand, Malawi, India, Nigeria, Guyana and South Africa. Some countries have received planning visits, others have received technical assistance visits to develop a national or provincial PMTCT communication strategy, and some have received a combination of both.

With experience in providing technical assistance in PMTCT communication over the past few years, UNICEF is now documenting the “Better Practices” that are in place in some of the above countries. PMTCT is a very complex and complicated program due to the variety of very sensitive issues related to it. In addition, many countries still engage in top-down “IEC materials” production without the benefit of community-based research and participation in their communication interventions. With these barriers in mind, there are no countries that have a “Better Practice” in PMTCT communication from planning to evaluation. Therefore, this document identifies those countries that have aspects of their communication interventions that can contribute to an overall “Better Practice.”

The Zambia Experience: Excellence in community-based PMTCT research

One of the cornerstones of the UNICEF communication approach is evidence-based communication planning – understanding and utilizing the experiences, wisdom and cultural norms of communities as a foundation to address issues related to PMTCT, ANC and HIV/AIDS. Many country programs are reluctant to invest in community-based research, viewing it as a time intensive activity.

For the Zambia PMTCT program, community-based research is the cornerstone of scaling-up the program from pilot to nationwide. This commitment to research-based communication planning allows the PMTCT team to identify key behavioral barriers at individual, family and community levels and address them before PMTCT services become available in that district.

The Zambia experience has shown that research need not be an expensive and prolonged undertaking. Typically, the Zambia team completes a comprehensive district-wide KAPB study is approximately two months. An investment in PMTCT programming that is enabling the national team to address issues before service delivery is in place.

For more information on the Zambia research experience please contact: Haritiana Rakotomamonjy at hrakotomamonjy@unicef.org, or Margaret Siwale at Siwalem@coppernet.zm.

The Rwanda Experience: Excellence in team counseling & caring atmosphere

The Rwanda pilot site, Kichukiro Clinic, offers better practices in the areas of team counseling and provision of caring atmosphere within a clinic setting.

The Kichukiro clinic is a peri-urban clinic site, run by the Catholic church. The clinic serves a sizable catchment area but approximately 50% of PMTCT clients come from outside the catchment area. Word of mouth has led to a sizeable increase in prospective clientele, with some clients coming from the farthest reaches of Kigali to make use of the compassionate services offered at Kichukiro Clinic.

One of the most noticeable differences in this clinic is the simple presence of fresh flowers in the public waiting areas, examination and counseling areas, and in the in-patient rooms. Simple tin cans have been wrapped with tin foil and wild flowers picked from the vacant lot next door are always on display. The counseling area is also well planned. The space itself is set apart from the rest of the clinic so there is a level of privacy where general clinic patients are not passing through. The environment is always clean and neat and there is always someone available to answer questions for first-time users. Some clients have commented that the atmosphere at Kichukiro is one of the main reasons they come. Clients say they know they will come to a clean, pleasant place, where people are always willing to assist them.

Team counseling is another unique aspect of Kichukiro Clinic. During ANC clinics, all women are asked to attend a group viewing of a video about the PMTCT program, followed by a group counseling session where people are free to ask questions about the program and related issues. The difference in this clinic is that all other counselors on site sit in the rear of the counseling area during the group session, dressed in their special counseling uniforms. They take notes and after the group counseling is finished, they meet as a group to critique the counseling of the group counselor on duty for that day. Some counselors interviewed reported that this on-going peer review has enabled them to improve their counseling skills on a regular basis.

Peer reviews in counseling; providing a clean environment and even fresh flowers in the clinic are simple ways in which to enhance the counseling experience and increase people's desire to attend clinics regularly.

For more information on the Kichukiro Clinic experience please contact: Macoura Oulare, Nutrition/PMTCT officer at moulare@unicef.org; or Cecile Ndoli, PMTCT officer at cdoli@unicef.org; or Paul Edwards at pedwards@unicef.org.

The Malawi Experience: Excellence in PMTCT counseling training, community preparedness & youth advisory groups

The Malawi PMTCT experience is very different from other country programs. In its initial two months of operation, the pilot site saw a large increase in ANC attendance because women reported wanting to access PMTCT services. More notable, is that in the initial two months, men began coming for VCT because they had heard of a new program that offered testing; and couples began coming for pre-marital VCT. When asked if they felt competent to provide counseling in a pre-marital situation, the counselors responded that they felt very comfortable providing counseling for any situation, even discordant couples. Counselor confidence and job satisfaction was attributed to an 8-week VCT training course. First, is a two-week PMTCT course covering all aspects of PMTCT including VCT and infant feeding counseling. This is followed by a 6-week course that explores the issues surrounding counseling of women/couples, including hands-on counseling experience. This 6-week period includes 2 weeks of classroom training (theory, discussion & role play), 3 weeks of supervised “mentored” counseling, and a final week for case presentations (prepared during the previous 3 weeks), and evaluation of the participants by the training counselors. Evaluation is rigorous and not all participants end up certified to function as counselors at the respective PMTCT project site. No other country program is using such extensive counseling training and for Malawi, the uptake numbers have shown that quality counseling greatly increases program interest and uptake.

In addition to quality counseling, which is primarily done by volunteers working at the clinic sites, there was another aspect of PMTCT communication that was cited as a contributing factor to the early success of the program. Community preparedness activities had been included in the program design and communities in the pilot site catchment areas were sensitized to the importance and benefits of PMTCT before services were even available. This preparation phase within a community setting, combined with selection of volunteer counselors who were respected members of their communities, enabled the Malawi pilot site to reach much greater numbers in the initial first months, compared to any other PMTCT program in the region. Community members interviewed said they knew about the PMTCT program before it started and were looking forward to having access to such services because they understood the importance and benefits of knowing one’s HIV status. They also said that they knew they would get excellent quality counseling services because they had heard the counselors were well trained to handle all situations.

For some countries, an 8-week counseling course sounds impossible but Malawi has shown that it is possible with the inclusion of an on-site mentoring program.

In addition to the innovative counseling training and community preparedness programs, the Malawi team also included in its communication strategy, “youth advisory groups.” These advisory groups were identified as a way to keep communication interventions exciting and appropriate for young people. By having a youth advisory group working directly with the national team, young people will be able to identify meaningful ways in which their peers can access, understand the many complex issues related to PMTCT, HIV/AIDS, ANC and SRH, ultimately enabling them to utilize VCT, PMTCT and prevention services available to them.

For more information contact Roy Hauya at NAP/BCI Unit at Hauya@aidsmalawi.net, or Jane Muita at jmuita@unicef.org.

The Thailand Experience: Excellence in selection of counselors, supportive counseling management & community preparedness

One of the most challenging aspects of PMTCT is determining who makes the best counselor and how to avoid counselor burn out. Along with that question, how to supervise and manage counselors in a supportive manner is another key challenge to successful PMTCT programming.

According to key PMTCT officials at Sanpatong Hospital, in Chiang Mai, Thailand, counseling is “top priority, from the Director, down to the actual counseling staff.” Program managers go on to say “...not all staff would want to become HIV/PMTCT counselors since it is a specialized field. So we ask for volunteers from our staff to become dedicated counselors for HIV/AIDS, including PMTCT. These counselors have access to on-going training and in-service training to continuously upgrade their counseling skills. We meet weekly as a counseling team – counselors, supervisors, program managers, even the hospital director – so we can discuss how the counseling is going; counselors can discuss difficult cases, etc.” In addition, counselors meet together on an as-needed basis when they are feeling overwhelmed and in need of peer support. The hospital director has made it part of his routine schedule to meet with counselors at his facility, ensuring they have the support, training and skills upgrading they require to provide quality counseling services. As a result, on-site counselors say they love their job, a sentiment that is not commonly heard in programs where all ANC staff are expected to be counselors.

In addition to the high commitment to quality counseling, there is also a community preparedness program in the surrounding catchment areas of Sanpatong Hospital. Youth camps are held 1-2 times per year, training at least one youth per household in basic HIV/AIDS/PMTCT information, including the importance of knowing one’s HIV status. Health workers at Sanpatong Hospital say that the community preparedness program has increased PMTCT service uptake to nearly 100% because all women have an advocate within their family that can help them to understand the importance of PMTCT services.

Although the program has yet to be evaluated, the concept of household-based youth advocates seems a logical way to address HIV/AIDS/PMTCT at the community level, while at the same time, addressing youth issues related to PMTCT/SRH and HIV/AIDS.

For more information on the Sanpatong Hospital experience, please contact: Scott Bamber, UNICEF Thailand HIV/AIDS office at sbamber@unicef.org, or Dr. Siriporn Kanchana, PMTCT Focal Point Thailand MOH.

The India Experience: Excellence in addressing infant feeding issues, health worker attitudes, and creating more caring and supportive environments for HIV-affected families

The India PMTCT program has been through its pilot phase for one year, and is now in the process of scaling up at the national level. During the pilot year many important learning experiences have surfaced. For the India pilot program, the issue of HIV and infant feeding is not separate from other infant feeding policies and messages. For India, there is only one message for infant feeding – “Exclusive breastfeeding is the best infant feeding option for women, except those that, for a variety of medical reasons, may be prescribed alternative infant feeding messages.” The fact that most women in India will be unable to safely practice replacement feeds means that for India, integrating HIV infant feeding policies into existing general infant feeding policies and messages made good common sense. One overall message for the country means less confusion and misunderstanding among the public on infant feeding practices. The India team has specifically noted “for a variety of medical reasons” to take the focus off of replacement feeding always equaling an HIV-positive status. And the phrase “may be prescribed” was purposefully included to note that replacement feeding should not be seen as a frivolous decision for new mothers and should only be considered in consultation with a trained PMTCT health professional.

Health worker attitudes were also a challenge in the India pilot program. Recent research and NGO’s were reporting a high level of stigmatization and discrimination from health workers towards HIV-positive patients and VCT clients. When asked, health workers admitted that they sometimes treated patients inappropriately because they felt they were ill equipped to deal with HIV-positive patients, often citing fear of infection or a feeling of hopelessness in treating HIV-positive patients. To address this issue, the India team included an introspective session in the newly developed PMTC training module, allowing service providers to explore how they feel about treating HIV-positive patients. By asking health workers how they feel about treating HIV-positive patients, health workers can begin exploring their apprehensions and fears, identifying whether or not they are based on rational or irrational fears.

Addressing health worker fears and personal beliefs is a critical area that requires immediate attention. The India PMTCT training program shows that it is feasible to incorporate introspective training sessions into overall PMTCT/HIV/AIDS sensitization and training programs, leading to attitudinal changes and decreased discrimination within the health care system.

Perhaps the most exciting difference in the India programme is the inclusion of “Community Dialogue” into district-based PMTCT programming. By partnering with local community-based organizations, the India programme has been able to effectively incorporate community dialogue into its programming at the community level. Community dialogue is a process that fosters dialogue and collaboration within the community by assisting community members in identifying the positive aspects of their community and existing successful mechanisms, while at the same time encouraging lessons learnt on how existing social problems have been successfully dealt with. There is ample opportunity during the process for community participants to gain clearer, correct understanding of basic HIV/AIDS and PMTCT issues; and there is time for reflection and planning so that communities can begin to create more caring and supportive environments for HIV-affected families, using community-available resources. The results have been dynamic and encouraging and to date, two districts – one rural and one urban slum – have benefited from this on-going process.

For more information on the India experience please contact: Dr. Anne Vincent at avincent@unicef.org, or Dr. PL Joshi of NACO at: doctorjoshi@yahoo.com.

The NIGERIA Experience: Excellence in PMTCT communication planning & overall integration of PMTCT into the ANC system

While most countries identify communication as a key component of the PMTCT program, it is usually identified as a need when service uptake numbers are not being achieved. To this end, Nigeria stands out as a leader in overall planning for PMTCT communication.

From the beginning, the Nigeria country team has been incorporating communication into the overall program design phase. This logical planning has allowed the country team to engage in community-based qualitative and quantitative research before the development of the communication strategy. It has also allowed the country team to make last minute adjustments to the PMTCT program, based on research results, before services are in place, allowing for a more tailored approach to service delivery.

Another better practice has been identifying the need for national and state level PMTCT communication working groups, to ensure that a team approach is utilized at national and state levels to keep communication activities moving forward in a timely manner. This unique approach has enabled Nigeria to form communication teams at the state level that include key local participants such as MOH, CBO/NGOs, PLWHAs, religious & local opinion leaders, private sector, etc. This multi-sector, team approach is often talked about but rarely implemented. Nigeria's commitment to moving forward its newly developed communication strategy is clearly evident in its attempt to de-centralize PMTCT communication at state levels, so that locally appropriate interventions can be initiated from state level outward, reaching all levels of society.

One of the key global lessons learnt is the importance of integrating PMTCT into routine ANC service delivery. Nigeria is also attempting to truly integrate PMTCT into their ANC programming. Rather than focus on PMTCT as a vertical program, the Nigeria team is focusing on and promoting the "new and improved" ANC services that are now available to all pregnant women. Taking a cue from India, Nigeria is also considering the use of one main message, focusing on protecting exclusive breastfeeding, while taking the focus of replacement feeding away from HIV/AIDS and attempting to begin de-stigmatizing those women who choose replacement feeding as a result of their HIV status.

For more information on the Nigeria experience, please contact: Dr. Abiola Davies or Noma Owens-Ibie at adavies@unicef.org, or Dr. Salma Anas-Kolo at salma_anaskolo@yahoo.co.uk,

The South Africa Experience: Excellence in Community-Driven Research and Strategic Planning

While most countries identify community involvement as a key aspect of realistic, successful communication planning, South Africa's Limpopo Province took community involvement to a new level by using narrative story-telling research methodologies that enabled communities within the PMTCT catchment areas to actually identify and map out which issues the research should be looking into more deeply. A varied group of key informants came together at a narrative workshop to work with researchers to identify the environment and contextual factors that allow a woman to take advantage – or not – of PMTCT services in their communities. The resulting “stories” were then confirmed by the community and key issues were used as the foundation of individual and focus group discussions, allowing for the most comprehensive PMTCT research to date in UNICEF assisted countries.

Following the dissemination of the research results, a community engagement workshop was held so that the communities involved, service providers, and a mix of district/provincial and national stakeholders came together to use the research findings as a foundation upon which they designed a comprehensive communication strategy plan to engage communities in responding to the HIV/AIDS epidemic in a more meaningful way; while at the same time, enabling service providers and district and provincial programmers to see where they need to strengthen their support to the community and PMTCT activities.

While many other UNICEF-assisted countries have also had significant community involvement in the development of their PMTCT communication strategies, the Limpopo research and subsequent workshop provided a new model for developing PMTCT communication plans with the highest level of community participation to date. Of the 45+ workshop participants, 41% represented their communities and included: traditional healers, lay counselors, home-based care providers, care and support groups, HIV-positive networks, youth and women's groups, religious leaders, and men's groups. Of the remaining workshop participants, 20% represented the service providers from the sites; and 39% represented a mixture of stakeholders from the district, provincial and national levels.

At the close of the strategic planning workshop, service providers acknowledged that they had rarely been able to sit at the table with the communities they serve and understand how their services are perceived and received by the community. Many service providers expressed renewed commitment in being able to now shift how they provide PMTCT services in a manner that is more acceptable to their communities. In turn, the community members expressed satisfaction and pride in being able to sit side by side with service providers and health officials to better plan PMTCT services and community engagement activities. Having the opportunity to have their voices heard and respected, and seeing their thoughts clearly reflected in the final strategy were perhaps the most important outcomes of this workshop and it is the first time the community has said “come and see us in 6 months time...if we have not delivered what we developed and promised here this week, ask us why not, we will be accountable.”

For more information on South Africa's Limpopo Province experience, please contact: Doreen Shokane (Provincial Coordinator) at doreen@dhw.norprov.gov.za, or Dr. Stephen Donohue (Provincial Coordinator & Community Health Advisor) at donohues@dhw.norprov.gov.za. For detailed information on the narrative research process used in Limpopo, please contact Dr. Christine Varga at cvarga@hsrc.ac.za.

CONCLUSION

While there are not yet any comprehensive set of “Better Practices” available from one country setting, one can develop a set of better practices in PMTCT communication from this field-based survey. From the planning stage onwards a complete set of better practices should include:

1. Evidence-Based Research

Community-based and led participatory research is an integral component of any communication intervention. Beginning overall PMTCT program design with community-based participatory research has shown that issues unique to a country, province/state, or district can be addressed before PMTCT services are in place. In addition, such research provides key opportunities to bring in audience participants to guide the development of locally appropriate communication interventions aimed at advocacy, mobilization and behavior development issues. The narrative story-telling approach has proven to be instrumental in tapping into the rich resources hidden within community settings.

2. Community Preparedness & Creating Supportive Environments for HIV-Affected Families

Preparing communities for the onset of any program is good common sense and can provide insurance that the program activities are in sync with the needs and expectations of the community being served.

With PMTCT, the sensitive issues surrounding sex, relationships, infant/child care, etc. benefit greatly from in-depth community preparedness interventions. Bringing in communities as partners in PMTCT can create stronger partnerships between community and PMTCT services, thus increasing reach and uptake of service delivery for all clients, regardless of their HIV status.

Community preparedness activities can include general information and awareness-raising on the importance and benefits of PMTCT services for both HIV-positive and HIV-negative clients and partners; it can also create opportunities for local opinion leaders to become more involved and committed to supporting PMTCT and other related services; preparedness activities can also include household-to-household peer educators.

The “Community Dialogue” approach has shown powerful results in helping community members to gain correct understanding of basic HIV/AIDS and PMTCT issues. It has also shown to be effective in assisting communities to begin thinking and planning how they can come together and begin creating more caring and supportive environments for HIV-affected families. Community dialogue has also been used in the community preparation phase and acts as a dynamic tool to sensitize communities on the importance and benefits of PMTCT programmes, as well as VCT and other related services.

3. Clinic Environment

The general atmosphere of a clinic setting can greatly affect the usage of clinic services. Evidence has shown that when clinics are kept clean and neat; when patient flow is directed so that the counseling areas are more private; and where services are offered in a compassionate manner, service uptake is higher. Such improvements are not costly yet yield important results in terms of utilization of services.

4. Counseling

Counseling has proven to be a key component of successful PMTCT programming. While actual counseling training seems to be fairly uncomplicated, creating a strong cadre of highly skilled counselors has proven challenging in nearly every PMTCT country program. While some programmers may argue that counseling and communication are separate components, counseling is a form of communication within a PMTCT context and as such, there is a fine line between the two components. By strengthening both components in a complimentary manner, the quality of counseling can be improved and simple communication tools can be developed that enhance the counseling experience.

4.1 Selection of Counselors

Determining who makes the best counselor is another challenge in PMTCT programming. Evidence has shown that mass counselor training is not the most effective answer to providing quality counseling. In fact, some country programs have shown that by making counseling a voluntary choice that some health workers make, improved commitment and job satisfaction are increased. Oftentimes, overburdened health workers sometimes do not make the best counselors and in those cases, volunteer counselors have shown to be a valuable asset to PMTCT programming.

4.2 Management of Counselors

Often, the management of counselors engaged in PMTCT and HIV-related counseling is simply incorporated into existing management channels. In country programs where management provides counselors with supportive management and mechanisms where counselors can receive psycho-social support, the counseling teams appear happier and report less job burn-out.

4.3 Counseling Training

Evidence has shown that in training programs where training is on-going, and in particular, where there are on-site mentoring programs for new counselors, the quality of counseling increases greatly. In addition, uptake of VCT services increases as a result of word of mouth advertising on the quality of counseling services.

5. Integration within existing ANC services

Although PMTCT services were always envisioned as a part of overall ANC service delivery, doing so is more complicated than it sounds. With the initial focus that PMTCT requires, it often inadvertently becomes a vertical program. To better integrate PMTCT into ANC service, better practices include promotion of “new and improved” ANC services, taking the focus off of the HIV aspects of PMTCT and placing them more on the overall components of improved ANC services, including the PMTCT service package.

6. PMTCT Messages, Materials & Interpersonal Communication (IPC)

With the myriad of sensitive issues related to PMTCT, ANC & HIV/AIDS, better practices include the development of integrated communication strategies that are based on participatory rapid research that is led by communities themselves; that are guided by the needs of audience participants; that encourage more investment in IPC; and that use materials only as a support mechanism to strengthened IPC interventions, rather than as the main communication method.