# COMMUNICATION STRATEGY FOR USAID/E, PREVENTIVE CARE PACKAGE FOR HIV/AIDS PROJECT

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**List of Acronyms**

| | |
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| ARC | AIDS Resource Center |
| ART/ARV | Anti-retroviral/ Anti-retroviral therapy |
| BCC | Behavior Change Communications |
| COP | Chief of Party |
| CTX | Cotrimoxazole prophylaxis |
| EDHS | Ethiopian Demographic and Health Survey |
| FMOH | Federal Ministry of Health |
| GIS | Geographic Information System |
| GOE | Government of Ethiopia |
| HAPCO | HIV/AIDS Prevention and Control Office |
| HEEC | Health Extension and Education Center |
| HCT | HIV Counseling and Testing |
| IEC | Information, Education, Communication |
| INH | Isoniazid Prophylaxis |
| IPC | Interpersonal Communications |
| I-TECH | International Training and Education Center on HIV |
| JHU | Johns Hopkins University |
| M&E | Monitoring and Evaluation |
| MOH | Ministry of Health |
| NGO | Non-Governmental Organization |
| OI | Opportunistic Infection |
| PEPFAR | President's Emergency Plan for AIDS Response |
| PLWHA | People living with HIV/AIDS |
| PMTCT | Prevention of Mother-to-Child Transmission |
| PSI | Population Services International |
| SCMS | Supply Chain Management Services |
| SNNPR | Southern Nations, Nationalities and People’s Region |
| USAID | United States Agency for International Development |

# I. Situation analysis

a) Project background

Population Services International (PSI) with Population Council and IntraHealth International started the Preventive care Package (PCP) project to contribute to reduce morbidity and mortality due to opportunistic infections (OIs) among adults and children living with HIV/AIDS in Ethiopia and to enable them to lead healthier, longer lives. The Project will achieve this goal by increasing the use of preventive care products and services by People Living with HIV/AIDs (PLHA) in Ethiopia. The Primary Target Group for this project is adults and children living with HIV/AIDS in Ethiopia who are aware of their HIV status, and who are within the catchment area of the Federal Ministry of Health (FMOH) network model. Children will be targeted through their principal care givers. Health professionals, community agents and care givers (including family members) therefore form a secondary target group for capacity building, particularly for IPC and counseling skills in order to increase the effectiveness and sustainability of the intervention.

The project will identify and address specific behaviors of adult and children PLHA that pre-disposes them for opportunistic infections. The project's behavior change communication will use both mass media and interpersonal communication (IPC) channels to promote behaviors such as: drinking treated water using Safe Water System (SWS), washing hands, sleeping under net, correct and consistent use of condom, adhering to clinical services and eating balanced food using innovative messages that build on determinants of behavior change. Training of health care providers, caregivers and community distributors in the various components of the preventive care package as well as interpersonal communication (IPC) skills will build their capacity to support the adoption of preventive behaviors to reduce opportunistic infections among PLHA.

In order to deliver effective health communication, this communication strategy is developed to guide communication activities related to the project. All communication messages will undergo a systematic and proven development process. An array of communication materials will be adapted and developed for PLHA as well as specialized materials for providers and counselors. During the first round the preventive care package will be provided for free to PLHA and their care givers. These kits will be distributed through two principal channels – health facilities and community based channels.

b) Health problem - HIV/AIDS and opportunistic infections

The HIV pandemic created unprecedented burden on the economies and health care systems of affected countries, particularly in sub-Saharan Africa, where prevalence is highest. According to the 2005 Ethiopia Demographic and Health Survey (EDHS) around 1.4% of Ethiopians age 15-49 are HIV positive. HIV prevalence in the country is 2.1 %, with 7.7% prevalence in urban and 0.9 % in rural. HIV prevalence among women is nearly 2%, while for men 15-49, it is just under 1%. In general, HIV prevalence in Ethiopia is higher among women than men (DHS, 2005).

According to the single point estimate published by ministry of health (MOH) and HIV/AIDS Prevention and Control Office (HAPCO) in 2007, it was estimated that 977,394 people are living

with HIV/AIDS in Ethiopia. The number of adult HIV positive population is estimated to be 1,037,267 in 2008 while the number of HIV positive children (0-14 years) is estimated to be 68,136. Annual AIDS deaths of adult PLHA are 58, 290 while for children PLHA annual deaths is 9,284 (HAPCO & MOH, 2007). As of August 8, 2008, the national HIV/AIDS Prevention and Control Office (HAPCO) reports 114,125 persons are on ART in Ethiopia, including an estimated 6,160 children. The current estimate of people requiring antiretroviral therapy is 258,264 and of these 6% (15,716) are children, (HAPCO & MOH, 2007).

HIV causes progressive depletion of the CD4 T cells, resulting in conditions known as opportunistic infections or malignancies. More than 90% of these are responsible for AIDS morbidities and mortalities. Main areas affected are the nervous, gastro-intestinal and respiratory systems, and the skin. The level of immunity determines the occurrence and type of opportunistic infections. In general milder infections, such as herpes zoster and other skin infections, occur early whereas serious life- threatening infections such as CNS toxoplasmosis and cryptococcal meningitis occur later with severely declined immunity. Some life threatening infections, such as pneumonia and TB, may occur early as well as later. When TB occurs later it is atypical, more disseminated and more extra pulmonary.

Prophylaxis and early treatment of other infections were clearly shown to improve the quality and length of life of people living with HIV, even before the advent of HAART. However, opportunistic infections continue to cause morbidity and mortality in HIV/AIDS patients even after ART. Some patients do not have a sustained response to antiretroviral agents for multiple reasons, including poor adherence, drug toxicities, drug interactions, or initial acquisition of a drug-resistant strain of HIV-1. Therefore OIs continue to cause substantial morbidity and mortality in patients with HIV-1 infection despite use of ART

In order to contribute to reduction of mortality and morbidity due to OIs major desired prevention areas of the project are safe hygienic practices (washing hands) and use of Safe Water System (SWS) to prevent diarrhea, malaria prevention, using condom to prevent re-infection, eating nutritious food to boost immunity and adherence to clinical services.

c) Assessing PCP kit elements in the environment

The PCP team together with the communication team assessed the preventive care package kit elements currently in the environment. It is found that condoms and soaps are highly available while water guard and PUR are moderately available. However, SWS container has the lowest availability of all kit elements. Target groups of the project can afford to buy elements during replenishment. The kit as a whole may not be acceptable due to stigma and discrimination. Among kit elements condom has lowest acceptability due to religious and social factors. Soap and SWS container are highly acceptable while water guard is moderately acceptable.

Socio-economic and political factors that could limit future project activities were also assessed. The social fact that might limit the project activities are stigma or discrimination, religion, illiteracy, condom misconceptions and gender issues on decision making. Economically, poverty

and inflation are expected to affect replenishment activities. On the other hand policy changes on NGOs and political instability can become obstacles for kit distribution.

**SWOT analysis:**

Preliminary planning to develop effective health communication for the project began with an analysis of **S**trengths and **W**eaknesses of the human, technological, communication and financial resources available as well as the **O**pportunities for and **T**hreats to an effective environment (SWOT)**.** Conducting the SWOT review provided insights into existing resources and information, potential weaknesses that could undermine the project if not addressed, and threats to success that must be addressed in program development.

| | |
|---|---|
| Strength<br>▪ PSI's experience in social marketing and Behavior Change Communication (BCC)<br>▪ Availability of budget<br>▪ Strong built relationship with media agencies, stakeholders, NGOs, GOs<br>▪ Well experienced and committed staff<br>▪ Favorable working environment and team work<br>▪ Well-established organizational structure<br>▪ Existing collaboration between various projects<br>▪ Availability of information to the specific project<br>▪ Existence of various outlets | Weaknesses<br>▪ Lack of unity of order between projects<br>▪ Delayed base-line research<br>▪ Lack of in-house communication production materials (video camera, television…)<br>▪ Lack of central documentation and resource area<br>▪ Lack of available transportation/vehicles<br>▪ Lack of enough budget for communication materials |
| Opportunities<br>▪ Regional experience on Preventive Care Package (PCP)<br>▪ Partners commitment to share experiences, provide existing facilities or structures<br>▪ Existence of communication and training materials from partner organization<br>▪ Demand for PCP kit elements<br>▪ Existence of local factories producing kit elements<br>▪ Favorable government policies and procedures on HIV/AIDS | Threats<br>▪ Policy changes of donors and partners lack of commitment to adhere to previous consensus<br>▪ Donors delay in response to project request<br>▪ Lack of quality of printing agencies and inability to meet deadline<br>▪ Lack of manufacturing industries for SWS container |

**Potential audiences:**

Primary audiences are adult PLHA and children PLHA while care givers, community distributors and health professionals are secondary audiences. The regional focus of PCP project would be Addis Ababa, Amhara, Oromiya, SNNPR and Tigray. Urban and semi-urban areas of the above regions will be the major intervention areas of the project to distribute the kit with communication inserts. The Preventive Care Package kit elements will include water guard, soap, condom, SWS container, Oral Rehydration Salt (ORS), De-worming and Insecticide Treated Net (ITN) in Malaria epidemic areas. In assessing degree of use of kit elements of PLHA to prevent OIs, it is found that there is low use of water guard, condom, SWS container, ORS, de-worming and ITN while there is average use of soap.

PCP project staff together with communication team identified various characteristics of potential audiences' based on desk review of existing researches and professional expertise.

a. Adult PLHA:

The project focuses on adult PLHA i.e those who are at the age of fifteen and above. It encompasses all PLHA from all marital status, occupation, economic status and educational level. Adult PLHA value their health, family, social acceptance and religion. They aspire to have quality life, live longer (healthier life), see success of their children, integrity of their family and get married. Their major needs could be financial, clinical services, psychosocial, nutritional and protection.

Their attitude towards life differs on their stages of HIV status acceptance. Those who are at the denial stage are pessimistic while those who are at the acceptance stage try to be positive but their hope for the future is too limited. Most PLHA are characterized by emotional instability and sometimes can get depressed. They are skeptical and conservative in their life style since they perceive themselves to be in higher risk of OIs.

b. Care givers:

According to the project, care givers are individuals taking care of children PLHA and those who are between the age of fifteen and above. Since caregivers are from all parts of the society, their income ranges from low to high and education level from illiterate to literate.

Most care givers would like to see the success and improved health of their children. They need financial and psychosocial support and clinical services for their children. They are compassionate and sympathetic towards their children but sometimes get frustrated when the health of their children deteriorates. Caregivers are careful for their children since they perceive their children to be higher risk of OIs.

**Behavioral determinants of audiences**

Brain storming session was conducted based on existing desk review to identify behavioral determinants or reasons of PLHA for not practicing desired behaviors.

a. The PLHA or their care givers don't practice safe hygienic practices due to lack of awareness even if they have SWS container. Most consider tap water safe, never cover their containers and dip cups into the container whenever they want to take water. Low susceptibility is the other major reason for not practicing safe hygienic practices especially hand washing. Therefore, ***threat and knowledge*** are selected as major behavioral determinants for communication to address these issues.
b. Most PLHA don't sleep under net due to low risk perception to malaria, misconception or inability to afford to buy nets. Two major behavioral determinants were identified as reasons of PLHA for not sleeping under net. These are ***threat and belief***.
c. Condom utilization among PLHA is low due to misconception about effectiveness of condom, abstinence or low risk perception of re-infection. ***Knowledge and threat*** are the major behavioral determinants for low use of condom among PLHA.
d. Most PLHA could not eat nutritious food due to lack of awareness to prepare nutritious food in an easy way. Therefore ***knowledge*** is selected as a major determinant to enable PLHA to prepare nutritious food in a simple way.
e. It is crucial for PLHA to adhere to clinical services such as ART, OIs treatment and others. However, PLHA are unable to adhere to clinical services due to negligence, stigma or discrimination, poor accessibility and lack of user friendly services. Therefore, ***Threat and subjective norm*** are selected as the major reasons for not adhering to clinical services.

**Summary of audience profile**

a. Adult PLHA:

Alemitu, a thirty-two years old lady who lives in Bahir Dar, has learned that she is HIV positive two years ago. Her late husband, Kebede, died of the same disease six years ago. Mrs. Alemitu by then a housewife was left to raise their four kids with retirement payment of her husband. Although life was a struggle for her, she managed her home well until she became too ill to do anything. It was by then she was told her HIV status and was put on Anti-retro Viral Therapy (ART). She was counseled by a nurse how to prevent opportunistic infections by using safe water system, use of insecticide treated net, safe hygienic practices, eating nutritious food and adhering to clinical services.

Alemitu regained her health after three months of taking ART and started working as a cleaner in a private organization. However, she complains by saying "I've four children to raise and I don't have time to stick to the counseling the nurse gave me. I drink tap water and try to eat any food I get". Alemitu sometimes forgets about her clinical appointments when she gets busy. Although she was devastated when she was bed ridden two years ago, Alemitu aspires to live longer to see the success of her children and get married if she gets a partner with the same HIV status.

b. Child PLHA and caregiver:

Melat, a seven years old baby girl, lives in Dire Dawa with her grandmother Zeritu who takes care of her. Melat is HIV positive and has lost both of her parents due to HIV three years ago. Since then her grandmother is her care giver who provides her with food, clothing, education and ART which is given for free. Zeritu makes a living by renting her house. She is very caring and compassionate to Melat who is her only granddaughter. Sometimes she gets frustrated when

Melat is really sick. Zeritu always tries to practice safe hygienic practices to prevent Melat from diarrhea. However, Zeritu and her family drink tap water claiming that it is safe to drink. They also don't consistently use ITN to prevent Malaria. Zeritu attends church regularly to pray to see improved health of her grand daughter.

**Positioning statement**

In order to brand the PCP project, the project was expressed in three ways based on its objectives. These are quality life, perspective and positive future. The three selected program expressions were further refined using the" 4R's" PSI has been using for branding exercises. These are re-expression, related world, random link and revolution.

Quality life went through the four R's and two brand name options were picked. These are ***Life art/Art of life (Yehiwot tibeb)*** and ***Healthy future***. Perspective went through the same process and ***live out wisdom*** was picked as another option for brand name. Finally, ***Happy day (Fikat)*** was picked as an option from positive future. Short listed brand names for the project were therefore: Art of life (Life art), Healthy future and Happy day (Fikat). Tag line options were live beyond survival, aspire better tomorrow and live out wisdom.

After going through in-house assessment, the BPCP team has chosen the brand name Fikat (Happy day) which can be written in Amharic as **ፍካት**. The tagline options were discarded since they don't make much sense when translated in Amharic. So a tagline was recreated in Amharic that has a meaning "Due to our better health, let our day be bright". It is read in Amharic as "Betenachen Yibralegn kenacene" and written like "**በጤናችን ይብራልን ቀናችን**".

# II. Strategic Communication Design

1. Communication overview

The project's generic communication, including both IPC and mass media, will help to create demand for kit elements as well as promote positive behaviors by addressing key determinants through activity-driven peer education, radio series and community events. The IPC, as communication approach that takes place between a trained agent and a member or several members of a specific target population, can be combined with direct product demonstrations and even create opportunities to significantly increase the likelihood of correct use of kit elements.

Product-specific communication will target adult and children PLHA, care givers and other population using inserts such as brochures and booklets. Promotional materials and activities will depend on research and extensive audience input, and will support promotion of PCP kit elements

Key project stakeholders and implementing partners such as the Government of Ethiopia, PEPFAR and non-PEPFAR partners, and members of the target groups themselves, will have an opportunity to provide important feedback on the communication materials at various points in the program development process.

2. Design

Behavior change communication programs often define three levels of objectives:

a. Behavior change objective: increasing use of preventive care products and services among children and adult PLHA.
b. Communication objectives

- Improving knowledge of PLHA and care givers about safe water system and hand washing and increasing their threat susceptibility to diarrhea
- Increase threat susceptibility of PLHA to OIs to enable them to adhere to clinical services, use of ITN in malaria epidemic areas, use of x-worm every six months and Oral Dehydration (ORS) whenever a person suffers from diarrhea.
- Change misconceptions about malaria prevention and promote the use of ITN among PLHA
- Improving knowledge of adult PLHA about effectiveness of condom
- Increasing susceptibility of PLHA about re-infection to promote correct and consistent use of condom with their sexual partner
- Improving knowledge of PLHA and care givers about eating nutritious food to boost their immunity
- Addressing subjective norm of PLHA that reduces their adherence to clinical services due to fear of discrimination

c. Channels and tools:

Among the three major communication channels, Mass Media, Interpersonal communication and community channels, specific communication channels for the project were identified through brain storming session. Two types of communication will be done; product-specific and generic communication. For product-specific communication, inserts will be developed to inform how to use products. Interpersonal communication (IPC) materials specific to product will be developed for service providers. Point of sale materials will also be used to promote products.

For generic communication, Information Education Communication (IEC) materials will be developed to transmit information to promote desired behaviors that reduce OIs. Radio and TV spots will also be used on top of brochures, leaflets and posters. Print materials will be developed to assist peer educators through Mother Support Groups (MSG), PLHA association and voluntary care givers.

d. Key messages themes

*Product-specific communication*
Get your preventive care package today & protect yourself from OIs by using:

- Wuha agar/PUR,
- SWS Vessel
- LLITN,
- Condoms
- ORS and X-worm

*Generic communication*
As someone living with HIV, you're more susceptible to OIs. So

- Use ITN to prevent malaria
- Practice safe hygienic practices to prevent diarrhea
- Use condom correctly & consistently to prevent re-infection
- Eating clean and cooked nutritious food
- Adhere to clinical services
- Use ORS and x-worm

## III. Development and pre-testing

During development of materials the creative team will work to get a sense of what type(s) of image(s) or script outline to use for production of communication materials. This needs discussion with an artist and/or script writer or selected ad agency. Once the message brief is provided to the artist or advertisement agency, materials will be produced.

However, communication material will not be completed without pre-testing the content, design, color of the material. Therefore, to ensure that the communication concepts and materials are well adapted to the intended audience i.e. adult PLHA and care givers of children PLHA, two to three Focus Group Discussion (FGDs) from each group, composed of eight to ten members will be conducted with representatives from each group to give their opinion on aspects such as design and color of the material, understanding the content, accuracy of information presented, credibility of the people expressing themselves through the material, the kind of reactions induced by the content and etc. FGDs will be conducted in A.A and major regional towns.

The pre-test for radio, television and other communication materials will be conducted by PSI communication department staff on January. After pre-testing, possible changes will be done incorporating appropriate feedbacks. If the changes are significant, a second detailed pre-test might be needed before finalizing them and approve campaign with stakeholders.

## IV. Implementation and monitoring

a. Radio spots will be placed on selected national and regional radio stations such as radio Fana, Sheger FM 102.1, Ethiopia radio, Bahirdar FM and Debub FM 100.9. The TV spots will be aired on Ethiopian television.
b. The billboards will be placed or erected on the selected hot spot areas.
c. Inserts will be placed in the preventive care package.
d. Point of sale materials will be disseminated in commercial outlets.
e. IPC materials will be used during training, peer education session and community out reach activities.

IPC materials developed will be monitored by collaboration of peer educators, training supervisors, volunteers, communication staff and partner organization. Reports will be collected from implementing organization. Monitoring for radio and TV spots will be done by media agencies.

## V. Management Consideration

a. Collaborating Partners

The Preventive Care Package Project team – consisting of PSI, IntraHealth and Population Council – was assembled strategically based on the complementary nature of each partner's core competencies and abilities to contribute to project objectives. The Project team members have strong collaboration with HAPCO and MOH at federal and regional levels, including autonomous government agencies such as the HEEC (for approval of communication messages). The project will be fully integrated with a wide range of existing PEPFAR partner activities that are focused on palliative care to PLWHA, including those already implemented by PSI (pilot preventive care packages), IntraHealth (palliative care through health centers), and Columbia University, I-TECH, and Johns Hopkins University (all providing palliative care through hospitals).

As prime contractor, PSI will be ultimately responsible for coordination of all activities, as well as collaboration with relevant GOE departments and other implementing partners. PSI will have overall responsibility for financial oversight and achievement of project objectives.

b. Roles and Responsibilities of Each Partner

***IntraHealth:*** will provide significant input into strategic planning for the project, including supporting the development of the preventive care package, and lead capacity building efforts to improve preventive care at the health facility level (including both health centers and hospitals within the health network model) through training on preventive care communication approaches and distributing healthy living kits. IntraHealth will also support the distribution of information and healthy living kits through their Mother's Support Groups that have formed around PMTCT centers, as well as income generating activities for members through re-supply of kit elements.

***The Population Council:*** will lead the monitoring and evaluation component of the project, including quantitative baseline and end of project surveys designed to measure utilization,

effectiveness and impact of the Preventive Care Package on beneficiaries through different distribution channels and across different beneficiary sub-groups.

***PSI:*** will manage the overall project, co-ordinate the support to the GOE in the development of a preventive care package, lead the development of a communication strategy and materials, supply chain management for healthy living kits and formation of partnerships for the re-supply of elements of the kit through commercial and community-based channels.

## VI. Evaluation- Tracking Progress and Evaluation Impact

Pop Council will lead the monitoring and evaluation component of the project using end of project surveys designed to measure utilization, effectiveness and impact of the preventive care package on beneficiaries and behavior change communication component.

Monitoring would focus on whether the implementation of activities spelled out in the work plan was actually carried out (process evaluation or monitoring). In the evaluation impact assessment of whether the objectives set forth in the strategy were achieved.

## Annexes

1. Characteristics of potential audiences

| **Potential audiences for communication: Adult PLHAs and care givers** | | |
|---|---|---|
| **Geographic Characteristics** | | |
| Regions | Addis Ababa, Amhara, Oromiya, SNNPR, Tigray | |
| City Size | Urban and semi-urban towns of above regions | |
| Population density | Urban and semi-urban | |
| Season | All season | |
| **Demographic Characteristics** | | |
| | Adult PLHA | Care givers |
| Sex | Female/Male | Female/male |
| Age | Fifteen and above | Fifteen and above |
| Marital status | Unmarried, married, separated, divorced, widowed | Unmarried, married, separated, divorced, widowed |
| Income | Low to high | Low to high |
| Education | Illiterate to higher literate | Illiterate to higher literate |
| Occupation | Students, Unemployed, self-employed, civil servants, uniformed, construction laborer | Students, Unemployed, self-employed, civil servants, uniformed, construction laborer |
| **Psychological/Psychographic characteristics** | | |
| | Adult PLHA | Care givers |
| Values | Health, family, social acceptance and religion | Family, relationships, mental satisfaction |

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|---|---|---|
| Aspiration | To have quality life, live longer (healthier life), see success of their children, integrity of family, get married | To see the success and improved health of their children |
| Needs | Financial need, clinical services, psychosocial, nutritional, protection | Financial, clinical services for their children, psycho-social |
| Attitude | Attitude towards life:<br><br>Denial stage: pessimistic<br><br>Acceptance stage: lack hope | Attitude towards their children life:<br><br>Don't see much hope |
| Emotion | Emotional instability, moody, depressed | Compassionate, generous, frustrated, desperate, sympathetic |
| Life style | Skeptical, careful (conservative) | Careful |
| Perception towards health problem | High risk perception of OIs | High risk perception to OIs |
| **Socio-cultural characteristics** | | |
| | Adult PLHA and care givers | |
| Language | Tigrigna, Ormoiffa and Amharic | |
| Religion | Christian, Muslim, atheist, others | |
| Ethnicity | All ethnic groups | |
| Social class | Low to high | |
| Degree of use | | |
| | Adult PLHA and care givers | |
| Common use rates | • Low use of water guard<br>• Average use of soap<br>• Low use of condom<br>• Low use SWS container<br>• Low use of ITN | |