Ethiopia National Strategic Framework for Pediatric HIV/AIDS Communication

September 2010 – September 2015
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List of Abbreviations

AIDS  Acquired Immune Deficiency Syndrome
ART  Anti-Retroviral Therapy
ARV  Anti-Retrovirals
BSS  Behavioral Surveillance Survey
CBO  Community-Based Organization
DBS  Dried Blood Sample
HAPCO  HIV/AIDS Prevention and Control Office
HCT  HIV Counselling and Testing
HEP  Health Extension Professional
HEW  Health Extension Worker
HIV  Human Immune-Deficiency Virus
HMIS  Health Management Information System
IPC/C  Interpersonal Communication and Counselling
M&E  Monitoring and Evaluation
MDG  Millennium Development Goals
MNCH  Maternal, Neonatal and Child Health
FMoH  Federal Ministry of Health
MTCT  Mother-to-child transmission of HIV
NGO  Non-Governmental Organization
PEPFAR  U.S. President’s Emergency Plan for AIDS Relief
PITC  Provider Initiated Testing and Counselling
PLHIV  People Living with HIV
PMTCT  Prevention of Mother-to-Child Transmission of HIV
PSA  Public Service Announcement
VCT  Voluntary HIV Counseling and Testing
WtHO  Woreda Health Office
Introduction and Background

The Pediatric HIV Communication Framework directly reflects the outputs from a four-day workshop held in Wolloso in September, 2010, under the direction of the Federal Ministry of Health, the HIV/AIDS Prevention and Control Office (HAPCO), and the Johns Hopkins University Bloomberg School of Public Health Center for Communication Programs (CCP). The framework is intended to guide and coordinate all pediatric HIV/AIDS communication efforts in the country.

Health professionals and representative from organizations implementing pediatric HIV/AIDS care and treatment services developed this framework based on a review of research, a review of existing pediatric HIV/AIDS services, and an inventory of pediatric HIV/AIDS communication job aids and materials in Ethiopia. A draft of the framework was circulated among all who participated in the four-day design workshop for review and input, which this document reflects.

Objectives:

1.1. HIV/AIDS in Ethiopia

Paediatric HIV/AIDS: As of 2010, an estimated 79,871 children 0 – 14 years of age are living with HIV in Ethiopia 40,491 males and 39,375 females. In 2010, an estimated 14,276 new HIV positive children were born; and 3,537 HIV positive children died. A significant number of these children were never tested or initiated on treatment. Among the 26,053 children who are eligible for treatment, based on 2006 WHO guideline, only 13,650 (52.4%) children had access to ART (FMoH/HAPCO February, 2010 report).

HIV/AIDS in Adults: Over 1.2 million Ethiopians are currently living with HIV/AIDS. The female HIV prevalence is 2.9% compared to only 1.9% among males (i.e. 59% are women). In the age group 15-29 years, there were more women living with HIV/AIDS than men; in the age group 30+ years, there were more men living with HIV/AIDS than women. (AIDS in Ethiopia, sixth report). In 2010, FMoH/HAPCO estimated that 90,311 pregnant women in Ethiopia were HIV positive (FMoH/HAPCO Single Point Estimate 2010).

Urban/Rural and Socio-Economic Differences: Urban residents are associated with much higher HIV infection rates than rural dwellers, and geographic regions show large differentials in HIV infection rates. Currently, the majority of people living with HIV (PLHIV) dwell in urban areas (760,475) compared to rural areas (456,432). Additionally, it appears that the trend of HIV prevalence has levelled off in urban settings, but continues to rise in rural areas (Technical Document for the 6th Report on AIDS in Ethiopia, FMoH and HAPCO, 2006).

Mother-to-Child Transmission (MTCT): In 2010, it is estimated that 90,311 pregnant women were living with HIV, while 14,276 HIV-positive children are expected to be born (FMoH/HAPCO Single Point Estimate 2010). This is due to low uptake of prevention of MTCT (PMTCT) services. In 2009, only 38% of health centers and hospitals in the country provided PMTCT services. Unfortunately, most women (68%) received antenatal care
from health posts, health centers or hospitals that did not provide PMTCT services. Among the pregnant women who attended ANC in the 1,103 health facilities offering PMTCT, 84% were tested and received their results. Thus, the overall percentage of pregnant women who got tested remains low. The proportion of those antenatal clients who tested positive was 2.1% and only 58% of the HIV positive mothers received ARV prophylaxis. (FMoH Service Delivery Data 2009/2010).

**Behavioral Prevention and Literacy Levels:** The Ethiopian Behavioral Surveillance Survey II (BSS) showed that knowledge of HIV/AIDS among the general public is reasonably high, however comprehensive knowledge and self-risk perception are low. Only 15.8% of women and 28.7% of men aged 15-49 years have comprehensive knowledge about HIV/AIDS. The comprehensive knowledge score among women was generally lower than men across all regions of the country. The study also showed significant variation of knowledge between urban and rural women—42.4% and 10% respectively. There is also a substantial level of unprotected sex practice among young adults (47% of 15 – 24 year olds did not use condoms during last sex according to BSS II), while premarital sex is quite common in the society (33% of unmarried 15 – 24 year olds were sexually active according to BSS II). Misconceptions about HIV transmission modes, ART side-effects and false cures, including the use of holy water, were also highlighted in this document. This might be due to the fact that about 67% of the adult population (15-49 years age) is illiterate, and most educational materials seem to use a fairly high literacy level (Behavioral Surveillance Survey II, 2005).

**1.2. Pediatric HIV and AIDS**

**Service Availability:** According to the Federal Ministry of Health (FMoH), there are 532 sites that provide ART services (100 public hospitals, 20 private hospitals, and 382 health centers) in Ethiopia. However, pediatric care and treatment services are offered only in some of these ART sites. Currently, more than 250 health centers providing ART services offer HIV care, treatment and services to children (FMoH Service Delivery Data, 2009/2010).

Prior to 2002, pediatric HIV care was limited to the provision of Cotrimoxazole preventive therapy. Moreover, only selected pediatric HIV/AIDS cases were treated with crushed adult tablets in few private institutions and government hospitals until pediatric ARV formulations were made available free of charge in 2005.

Although there has been a dramatic increase in number of children who are put on ART since 2005, it is estimated that by 2010 some 26,053 children in Ethiopia are in need of ARVs. Nonetheless, only about 52% of the children who require treatment are currently on ARVs (FMoH Service Delivery Data, 2009/2010). The reasons for this, according to service providers, include:

- **Manpower issues:** low provider confidence to manage pediatric patients, high staff turn-over, and low capacity of health workers to understand and cope with developmental challenges involved in caring for children (eg. dose adjustments).
- **Community knowledge, attitudes and practices:** low uptake of antenatal care services; very few women deliver in health facilities; lack of awareness about PMTCT and MNCH services; HIV/AIDS stigma and discrimination,
- **Infrastructure issues:** poor availability of chemistry and CD4 machines; unreliable drug supply; insufficient laboratory supplies; DBS for HIV DNA PCR kits distribution.
- **Systems:** DBS and blood specimen transfer challenges; limited psycho-social support services; PMTCT and MNCH services inaccessible for many; services poorly integrated and coordinated; pediatric HMIS data management poor.

**Service Utilization:** According to the 2010 FMoH/HAPCO Single Point Estimates, there are 79,871 children under the age of 15 years living with HIV (40,491 male and 39,385 female). To date, only 29,546 children have been enrolled for pediatric HIV/AIDS services and out of these only 13,650 have begun treatment with ARVs (February 2010 HAPCO Report). It is estimated that there are 26,053 children in need of ART and only 10,496 (46%) of these children are currently on ARVs (2010 FMoH/HAPCO Single Point Estimates). Older children between the age of 5 and 14 years are most likely to start on ART, while children younger than 18 months are the least likely to start the necessary treatment. According to the FMoH guidelines, all HIV positive children under one year of age should be started on ARVs because of their increased chance of leading a healthy life if treated and elevated mortality rates if left untreated. Unfortunately, these children are the least likely to get tested and enrolled in the ART program, largely because of the low uptake of antenatal care and PMTCT services.

**ART Adherence:** Little is known about adherence among children. However, it is known that approximately 23% are lost to follow up (February 2010 HAPCO Report). This is partially due to death, but other reasons for this are unknown.

**Caretaker Knowledge, Attitudes, and Practices:** Many HIV-positive children have lost one or both of their parents and if one of the parents is alive, he/she is usually HIV positive. HIV affected or infected children, particularly children who lost their mothers to AIDS, are cared for by their grandparents, or aunts and uncles. Most of these caretakers have similar levels of knowledge as others in their communities. These might include beliefs concerning the effectiveness and safety of ARVs, and the belief that HIV positive children cannot be treated, or that there is no point in treating them as they are bound to die anyway. Due to fear of rejection or stigma from their communities, caretakers often do not want to get children under their care tested for HIV. Similarly, when a child in their care tests positive, they usually do not want to disclose the test results to the child, in fear of the child disclosing his/her HIV status to the “wrong” people, or in case the child becomes depressed or angry with them. HIV-positive parents often fear disclosing their HIV status to their children because they feel guilty.

**Links to PMTCT:** Prevention of mother-to-child transmission is the best way to protect children from HIV, and to identify children in need of treatment early. 50% of HIV-positive children die before the age of 2 years. The vast majority of these deaths could be prevented with early diagnosis and initiation of treatment. However, very few women get tested during pregnancy and, among those who test positive, very few of the infants ever get tested for HIV. According to the National Health Sector Development Plan - IV (HSDP IV), parents, particularly women, need to receive comprehensive and integrated care, beginning with family planning to prevent unintended pregnancies, antenatal care that includes HIV testing and counselling, and the provision of prophylactic ARVs for HIV positive pregnant mothers and their infants, as well as early diagnosis of infants.

**Pediatric HIV/AIDS Communication Efforts:** Significant effort has gone into the provision of on-job assistance for service providers working with HIV positive children and their care takers. Some organizations have also developed various reading materials for caretakers of children living with HIV, however little has gone into educating the public about pediatric HIV/AIDS.

**1.3. Problem Statement:**

This National Strategic Framework for Pediatric HIV/AIDS Communication addresses issues surrounding low uptake of pediatric HIV services, poor adherence among pediatric ART clients, and frequent loss to follow-up in Ethiopia. At present, only 52% of HIV-positive children access the necessary services and majority of those clients are older than 5 years. Of those who start on ARVs, 23% are lost to follow up. Moreover, 50% of HIV-positive children under two are expected to lose their lives if not identified and treated at an early stage 1. The major reasons for this are:

- **Poor utilization of health services, in particular antenatal, PMTCT, and pediatric services**
- **Bleak view of AIDS among caretakers of children living with HIV**
- **Inadequate psycho-social support for HIV-positive children and their caretakers at community level**
- **Lack of confidence among caretakers in their ability to care for children with HIV, and poor attitudes**
among health care providers towards children living with HIV

- Neglect, stigma and discrimination (real or perceived)
- Poor availability and weak integration of pediatric HIV services within other health services (e.g. MNCH services, PMTCT services, ART services, VCT services)
- Inadequate resources for MNCH services, including pediatric HIV/AIDS
- Poor availability of child-friendly health care services
- Lack of pediatric HIV/AIDS focused media messages targeting caretakers of children at risk of HIV.

The FMoH has embarked on a program to integrate pediatric HIV/AIDS services with MNCH services. This will greatly improve accessibility and uptake of pediatric HIV/AIDS services. This National Strategic Framework for Pediatric HIV/AIDS Communication is designed to address behavioural and attitudinal barriers to uptake and adherence.

1.4. Conceptual Model – Pathways for Pediatric HIV/AIDS Care and Treatment

A consultative Workshop was held in Wolliso from 13 - 17 September, 2010, to develop the Ethiopia National Strategic Framework for Pediatric HIV/AIDS Communication. The development took place in partnership with communication and health experts from 15 governmental and non-governmental organizations (NGO), including clinical service providers and representatives of implementing partners.

The Framework development process employed the 'Communication Pathways Model', a conceptual communication model used worldwide and applied to the Ethiopian context. This model (shown below) envisages four domains for communication interventions:

1. Social/Political Environment
2. Service Delivery
3. Community and
4. Individuals

The National Strategic Framework is designed to identify schemes for communicating with priority audiences in each of these domains.
2. Pediatric HIV/AIDS Strategic Communication Framework Outline

2.1. Overarching Goal and Objectives

Communication interventions outlined in this Strategic Framework will contribute to the following goal and objectives:

**Goal:** All HIV-infected children will fully benefit from HIV care and treatment services.

**Socio-Environmental Objectives:**
- Policy-makers are committed to allocate adequate resources to expand availability of pediatric HIV/AIDS services and integrate with MNCH services.
- Heads of Woreda Health Offices prioritize and integrate pediatric HIV/AIDS services within their health facilities.

**Service Delivery Objectives:**
- The provision of child-friendly pediatric HIV/AIDS services in health facilities
- Availability of mid-level health professionals, who have positive attitudes towards and feel confident to deliver pediatric HIV/AIDS care and treatment services.

**Community Objective:** Community organizations and groups provide psycho-social support for HIV-positive children and their caretakers, and communities treat HIV-affected children and their families with dignity and respect.

**Individual Objectives:**
- HIV-positive children learn their HIV status in an age-appropriate manner, and adhere to treatment
- Caretakers of children under five take children under their care for HIV testing, and enroll them in ART if they are found to be HIV positive.

2.2. Guiding Principles

The Ethiopia National Strategic Framework for Pediatric HIV/AIDS Communication and its implementation will be guided by the following principles:

- Behavior change oriented: For maximum impact, communication interventions should have specific and measurable behavioural objectives, address factors that influence behaviour, and reflect a multi-channelled approach. Channels and interventions should be complementary and mutually reinforcing.
- Audience-centered: Design of messages, materials, and communication interventions will rely on a thorough understanding of the audiences for which they are intended. This includes pretesting messages and materials, as well as involving audience members in the development of approaches and materials.

- Evidence-based: Communication interventions and strategies will be based on research and lessons learned through prior and ongoing programs.
- Culturally appropriate: Communication will take into account cultural norms, beliefs, and practices that influence the uptake and adherence to pediatric HIV/AIDS care and treatment, and will be delivered in a culturally sensitive manner.
- Community participation: The engagement of communities is essential in formulating a strong response that is locally appropriate and draws on available resources. Communities must be involved in addressing stigma and care-related issues.
- Services-linked: All communication will refer pediatric HIV/AIDS clients and caregivers to service providers and/or will be implemented at the service delivery sites.
- Human rights: The framework reinforces equity of access, confidentiality of services and information, and gender-sensitivity.
- Commitment and Coordination: Commitment to building local capacity and coordinating partner efforts in pediatric HIV/AIDS communication is essential.
- Involvement of PLHIVs: PLHIV Associations are centrally positioned to contribute to the success of the pediatric HIV/AIDS program. With roles as patients, advocates, counsellors, and peers, PLHIVs are well suited to take leadership in referring children and their caretakers for pediatric HIV/AIDS services.

2.3. Creative Briefs by Audience

2.3.1. Priority audiences by domain:

**I. Socio-Political Environment:**
- a. Heads of Woreda health offices
- b. Federal and regional level policy/decision makers

**II. Service delivery:**
- a. Mid-level health professionals (nurses, health officers, midwives)
- b. Health Extension Workers

**III. Community:**
- a. Managers of community-based NGOs and Community-Based Organizations (CBOs) (including groups of PLHIV)

**IV. Individual:**
- a. Caretakers of HIV-positive children who are enrolled into HIV care and treatment services
- b. Caretakers of children under five who have not been tested for HIV
- c. Children who are HIV-positive and are on ARVs
2.3.2. Strategies by Audience for Each Domain:

Socio-Political Environment Domain

Audience 1: Federal and Regional Level Policy/Decision Makers

Most policy makers in Ethiopia are adult men living in urban areas, however, in recent years more and more women are becoming involved in the country’s policy and decision making process. They may be ministers, parliamentarians, heads of directorates and heads of regional health bureaus. These policymakers are usually older than age 30, have a high level of education, typically with a university degree or higher, and their income tends to be above the average wage. In terms of politics, they tend to be loyal to their political party and possess significant decision-making power. They also believe that Ethiopia can be transformed to a middle-income country and are interested in contributing to that goal. Most policymakers are concerned with meeting development targets. Parliamentarians who are members of the budget and health committees have the most influence on the health budget as well as its allocation within the health sector.

Policymakers are committed to growth and transformation. Healthy families and children are the cornerstone of this goal. However, policymakers may not know the significance of pediatric HIV/AIDS in this line and hence have not prioritized it.

Desired Action: Allocation of adequate resources to expand availability of pediatric HIV/AIDS services through integration with MNCH services.

Communication Objective: Policymakers will believe that pediatric HIV/AIDS is a serious problem that requires additional resources.

Key Benefit Statement: If you allocate additional resources in order to integrate pediatric HIV/AIDS services with all MNCH services, you will create healthy and productive citizens who will directly contribute to the growth and transformation of Ethiopia.

Support Points:
- Facts about the extent of pediatric HIV/AIDS
- Facts about the impact of HIV/AIDS morbidity and mortality on the economy and development
- Description and cost analysis of required interventions
- Projections of the contribution of early detection and treatment of HIV-positive children to the reduction of the HIV/AIDS morbidity and mortality rates
- Reminder of relevant Millennium Development Goals (MDGs) – MDG 4 and 6.
  - MDG 4: To reduce child mortality
  - MDG 6: To combat HIV/AIDS, malaria and other diseases

Communication Channels/Approaches:
- Briefs about the situation of pediatric HIV/AIDS in Ethiopia distributed to parliamentarians, particularly to members of the budget and health committees
- Presentations for policy-makers both at the federal and regional levels
- Newspaper, TV, and radio coverage about pediatric HIV/AIDS
- Tours (if possible) to pediatric HIV/AIDS services for policy-makers to facilitate dialogue with the caretakers and children

Audience 2: Woreda Health Office Offices (WrHO)

WrHO officers tend to be men between 25 and 50 years of age, although in recent years more and more women seem to be filling these positions. WrHO officers are public health professionals, health officers and nurses with Diplomas and/or Bachelor of Science degrees, living in relatively rural areas. Their income falls under the lower-middle class income category. WrHO officers are responsible for all health centers, health posts and community health service activities and programs in their Woreda. They value their jobs and are constantly confronted with resource constraints. They are also faced with many competing priorities, absence of skilled health workforce, lack of staff motivation and high staff turnover. Moreover, many WrHO officers may not be aware of the extent of the pediatric HIV/AIDS problem in Ethiopia, as well as Government’s activities and programs to minimise its impacts.

Desired Action: Ensuring that all health centers and hospitals in all Woredas integrate pediatric HIV testing and treatment within their MNCH services, as per recommendations of the MoH.

Communication Objective: Heads of WoHOs will believe that pediatric HIV/AIDS services are a priority and should be an integral part of the MNCH services in all health services under their jurisdiction.

Key Benefit Statement: If you prioritize the integration of pediatric HIV/AIDS services in all health facilities in your Woreda, you will be recognized for your contribution towards meeting the national and MDG targets for child health.

Support Points:
- Facts/statistics about the prevalence of pediatric HIV/AIDS
- Information on the National Guidelines for Pediatric HIV/AIDS
- Case studies/best practices from Woredas that have integrated pediatric HIV/AIDS services with MNCH services
- Information on national targets that will be met through the integration of pediatric HIV/AIDS services.

Communication Channels/Approaches:
- Print materials
- Short film/documentary on children and caretakers, who have benefited from integrated pediatric HIV services
- Meetings/conferences and workshops.
Service Delivery Domain

**Audience 1: Mid-Level Health Care Providers (Nurses, Health Officers, Midwives)**

There are approximately 20,109 nurses, 1,379 midwives and 1,606 health officers currently working in Ethiopia (FY 2001 Health & Health Related Indicators). Most nurses and midwives are women, and most clinical officers are men, with ages ranging from 25 to 45. Most have over 12 years of education, and are married with children. Most health workers are dedicated and well-respected by their communities.

For the most part, health workers care about their clients; despite difficult conditions in their work environment, such as lack of necessary equipment or medications, insufficient human resources for health, and inadequate supervision that hinders them from maximizing their potential to serve their clients. Similarly, many lack confidence to provide pediatric HIV/AIDS services, and do not consider it as a priority due to a misconception that HIV-positive children do not have hope for survival even if they receive treatment.

Although they are fairly compensated, their remuneration is not commensurate with their workload and responsibilities. Generally, they lack incentives and recognition for good performance, receive inadequate supportive supervision, and have limited opportunities for self-development or education perspectives.

**Desired Action:** Provision of child-friendly pediatric HIV/AIDS services

**Communication Objective:** Health workers will believe in the necessity and effectiveness of pediatric HIV care and treatment services, and will feel confident in their ability to provide child-friendly services.

**Key Benefit Statement:** If you treat HIV-positive children in a child-friendly manner, you will contribute towards their well-being and prosperity as well as gain recognition for your health facility and yourself.

**Support Points:**
- Summary of case studies, showing the positive effects of pediatric HIV/AIDS care and treatment
- Testimonies from HIV-positive children and their caretakers, acknowledging health workers for helping them to improve their lives
- Testimonies from health workers who provide pediatric HIV/AIDS services in a child-friendly manner
- Guidelines for child-friendly pediatric HIV/AIDS services

**Communication Channels and Approaches:**
- Print materials
- Videos
- Radio programs
- Meetings/presentations

**Audience 2: Health Extension Workers (Rural) & Health Extension Professionals (Urban)**

The country-led Health Extension Program (HEP) has trained and deployed over 34,000 Health Extension Workers (HEWs) throughout the country – two for each village (i.e. one HEW for 500 households) since 2003. HEWs are predominantly young women between the ages of 18 and 30, who are high school graduates with one year intensive training following a health promotion and disease prevention interventions package comprised of 16 key components, including maternal and child health, hygiene and environmental sanitation, referral services, and health education and communication. Health Extension Professionals are nurses who work in urban areas. The majority of these health workers come from the communities that they serve.

**Desired Action:** Ensuring that HIV-positive children are well accepted and taken care of by their communities and families.

**Communication Objective:** HEWs and HEPs will be aware of the benefits of pediatric HIV/AIDS care and treatment and refer caretakers of children at risk of HIV to pediatric HIV/AIDS services.

**Key Benefit Statement:** If you help your community to accept and provide care for HIV-positive children and their families, you will feel that you have made a meaningful contribution to your community and will earn the respect and love of your community members.

**Support Points:**
- Facts about pediatric HIV/AIDS
- Testimonies from HIV-positive children and their families
- Testimonies from HEWs and MEPs who have advocated for community acceptance and care for HIV-positive children
- Locations of pediatric HIV/AIDS services by region

**Communication Channels and Approaches:**
- Group discussions
- Radio programs
- Health education program
- Brochures, Leaflets
- Posters
**Community Domain**

**Audience:** Managers of community based NGOs & CBOs (including PLHIV groups)

In many communities, existing non-governmental community based organizations, including groups of PLHIV, are managed by local coordinators. Usually, these coordinators are men between 30 and 45 years of age. Most are married with children, have completed secondary education or higher, and earn an income slightly above the minimum wage. They are usually well accepted by their communities, and are often committed to community mobilization and ownership for change. Most of their work is resource constrained, including inadequate funding, lack of skilled manpower, and poor linkages to services.

**Desired Action:** Mobilize their communities to provide quality and comprehensive psycho-social support services for HIV-positive children and their caretakers.

**Communication Objective:** Managers of community based organizations will possess the skills and knowledge to establish and manage psycho-social support programs for HIV-infected children and their families/caretakers.

**Key Benefit Statement:** If you mobilize your community to provide psycho-social support services for HIV-positive children and their caretakers, you will be improving the quality of life for children in your community.

**Support Points:**
- Facts about pediatric HIV
- Success stories from communities that provide psycho-social support and services for HIV-positive children and their caretakers
- Testimonies from HIV-positive children and their caretakers, showing how they have benefited from psycho-social support services
- Guidelines for establishing psycho-social support services at community level
- Guide to resource mobilization for pediatric HIV/AIDS psycho-social support programs

**Communication Channels and Approaches:**
- Videos
- Group discussions/trainings
- Print materials
- Radio programs
- Exchange visits to communities with active psycho-support programs

**Individual Domain**

**Audience 1:** Caretakers of children under five who have not been tested for HIV

Caretakers of children under five years are usually their biological parents, although there are more than 5.4 million orphans in Ethiopia, of whom 804,184 were orphaned because of HIV. Many are cared for by their grandmothers, aunts or uncles. Most caretakers of under-five year olds are between the ages of 18 and 35, live in rural areas, and are poor. Many are illiterate, especially among the grandmothers.

Most caretakers of children under five do not know that children can be tested for HIV, and/or believe that it is useless to test because HIV-positive children do not live long. They are not aware that there are HIV treatment and care services designed particularly for children. Many think that HIV is a punishment from God for sins, and do not believe that innocent children under their care are infected. Moreover, even if they suspect that a child in their care might have HIV, many are reluctant to get them tested because they fear rejection and ostracism from their families and communities.

**Desired Action:** Take all children under 5 to health facilities for HIV testing.

**Communication Objective:** Caretakers of under-fives will believe that it is important to test their children for HIV and will know where to get the service.

**Key Benefit Statement:** If you get children in your care tested for HIV, they can get treatment early, and live healthy, happy and productive, lives.

**Support Points:**
- Testimonies from caretakers who have gotten their children tested for HIV (results can be both negative and positive)
- Facts about mother-to-child transmission, HIV testing and treatment for children
- Locations of pediatric testing and treatment services

**Communication Channels and Approaches:**
- Radio spots and programs
- TV shows
- Posters
- Billboards
- Signage at health facilities with pediatric HIV/AIDS services
- Health talks at health facilities and during community meetings
**Audience 2: Caretakers of HIV-positive children on HIV/AIDS care and treatment**

Most caretakers of HIV-positive children are either parents, who are HIV-positive, or grandparents and other close relatives of the child. They range from 30 – 60 years of age, are usually religious, often illiterate and poor. Most caretakers are women and have other children in their care. They often believe that HIV-positive children will die early, so they see no point in investing effort and resources in treatment. Often pediatric HIV services are far from where they reside. In addition, many fear that the community will stigmatize the child and their family if they learn about it. In an effort to prevent this, they do not usually tell the child of his/her HIV status, or inform them about what they are being treated for.

**Desired Action:** Assist the child to adhere to health provider’s instructions regarding HIV care and treatment, and disclose to the child about his/her HIV status. Disclosure of HIV status should be done in an age appropriate manner.

**Communication Objective:** Caretakers of children who are HIV-positive will feel confident that, if they follow the health provider’s instructions regarding HIV care and treatment, the child will be more likely to live a healthy and productive life.

**Key Benefit Statement:** If you assist your child to adhere to the health provider’s instructions regarding HIV care and treatment, and disclose his/her HIV status at the appropriate time, you will be helping your child to live a longer, healthier and more productive. This will ensure that both you and your child will live a more quality life.

**Support Points:**
- Testimonies of caretakers and HIV positive children
- Advice from health care workers about adherence and disclosure
- Basic facts about pediatric HIV/AIDS, care and treatment
- Encouragement to bring children to health services as prescribed by health providers and take Cotrimoxazole and ARVs daily as instructed

**Communication Channels:**
- Counseling by health workers
- Group discussions
- Videos in health facilities
- Posters
- Radio programs
- Hotline paediatrics counsellors (need to be trained)

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**Audience 3: HIV-positive children 5 – 15 years old on HIV care and treatment**

Most HIV positive children who are on care and treatment range in age from 5 – 15 years, and are both boys and girls. They are at an age where health care providers and parents can explain things to them. Most attend school, and have incomplete attendance rates due to their health situation. They may be frequently sick or suffering from uncomfortable side effects of ARVs. Most suspect that they have HIV, but have never been told about their status by the health workers or their caretakers. Once they learn that they have HIV, they often feel hopeless, believing that they will die soon. Often, they have behavioural problems and are emotionally labile. Adolescents have the additional challenge of dealing with sexual attraction and the desire to have relationships. Some are already sexually active and may not have disclosed their status to their sexual partners or use condoms, and may feel shy to discuss their sexuality with health care providers or caretakers.

**Desired Action:** Encourage children and adolescents to adhere to ARV treatment and adolescents to prevent transmission and reinfection through unprotected sex.

**Communication Objective:** Children on HIV care and treatment will strongly believe that they need to adhere to their health provider’s instructions, and will ask their health providers and caretakers about their HIV status if they have never been told.

**Key Benefit Statement:** If you adhere to your health provider’s instructions regarding HIV care and treatment and prevent transmission/re-infection, you can live a healthy and productive life and fulfil your dreams.

**Support Points:**
- Success stories (i.e. personal testimonies, witnesses, anecdotes)
- Facts about HIV/AIDS, ARVs, pediatric HIV, positive prevention and disclosure
- Establishing pediatric group discussion forums in disclosed HIV positive children

**Communication Channels:**
- Counseling
- Group discussions
- Peer clubs
- Journal writing
- Radio diaries/storybooks
- Posters at health facilities
3. Implementation

3.1. Links with Service

Implementation of this Strategic Framework will only succeed if pediatric HIV/AIDS communication is closely linked to available services. During the design workshop, partners identified two means of creating a strong linkage with services as they become increasingly available:

- Providing a list of facilities offering pediatric HIV/AIDS services to all health care providers including HEW and HEP.
- Providing referral services and other relevant information to health facilities offering pediatric HIV/AIDS services through the Wegen AIDS Hotline and the Fitun Warmline.

The Federal Ministry of Health regularly tracks availability of pediatric HIV/AIDS services through reports from Regional Health Bureaus. This information can be used to compile a list of health facilities offering pediatric HIV/AIDS services, and can be updated annually and provided to the hotline, warmline and health providers.

3.2. Research, Monitoring and Evaluation

Formative Research: This Strategic Framework is based on an existing literature review about pediatric HIV/AIDS in Ethiopia conducted by the AIDS Resource Center in 2009. However, prior to implementation, it is recommended that some formative research be undertaken to support the development of specific interventions. This should include an updated and more detailed literature review that captures new data from national surveys planned for 2010 and 2011. In addition, some qualitative research will be needed to support the development of communication interventions. For example, information derived from focus group discussions or in-depth interviews with health workers, WHO officers, Health Extension Workers, Health Extension Professionals, caretakers of children on HIV care and treatment, and HIV-positive children, will be useful in designing specific materials and activities for them. In addition, all materials and communication tools should be pretested among audience representatives prior to finalization.

Monitoring and Evaluation: In order to track progress, effectiveness, and reach of communication interventions, it is necessary to develop a strong monitoring and evaluation (M&E) system. The M&E system should measure output indicators as well as behavioural outcome indicators based on the framework objectives. Illustrative process, output, and outcome indicators could include:

Output indicators:
- Number of people reached through meetings or group discussions
- Number of radio and/or television programs / PSAs broadcast
- Number of communities implementing communication activities
- Number of communication materials produced and distributed
- Number of advocacy meetings held
- Percent of audience reached with media messages about pediatric HIV

Outcome indicators:
- Percent of audience with positive attitudes toward pediatric HIV/AIDS treatment
- Number of children under five tested for HIV
- Number of HIV-positive children taking ARVs
- Percent of parents of under-fives who know where to go for pediatric HIV/AIDS services
- Percent of WHO officers who understand and accept pediatric HIV/AIDS services as a priority
- Rate of loss to follow-up among pediatric ARV clients
- Amount of federal budget allocated to pediatric HIV/AIDS services
- Number of health facilities integrating pediatric HIV care and treatment with MNCH services

3.3. Sustainability, Roles and Resources
**References**

AIDS Resource Center, the Johns Hopkins University Bloomberg School of Public Health Center for Communication Programs, National Anti-Retroviral Therapy (ART) Strategic Communication Framework, March, 2005

Central Statistical Agency and MEASURE DHS ORC Macro, Ethiopia Demographic and Health Survey, 2005.


PMTCT and Paediatric Care and Treatment Fact Sheet Ethiopia, Estimates developed by WHO, UNFPA, UNICEF; Progress for children. A report card on maternal mortality, UNICEF 2008


(Endnotes)