Ministry of Health

# NATIONAL EMTCT
## COMMUNICATION STRATEGY

Towards the Elimination of Mother to Child Transmission of HIV and Keeping Mothers Alive

2012 - 2015

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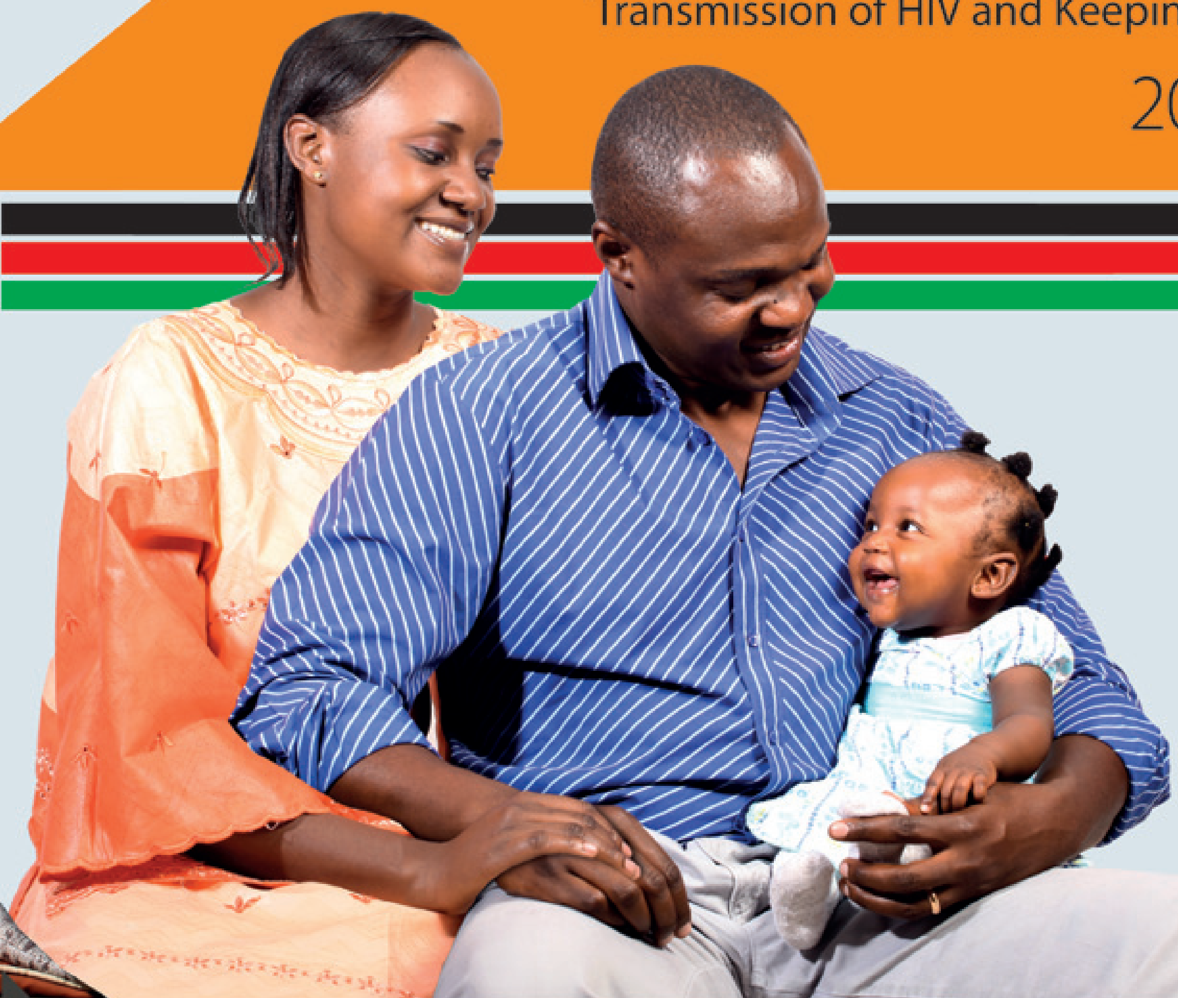

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# Foreward

The Kenya National Communications Strategic Plan 2011-2015 for the elimination of new HIV infections among children and keeping their mothers alive outlines a unified, strategic and well-coordinated campaign to deliver targets outlined on the national framework for the elimination of mother to child transmission of HIV and keeping mothers alive by 2015.

The government has an ethical obligation to provide an enabling environment for the promotion and progressive realization of universal access to health services. It's envisioned that this strategy will contribute to ensuring that everyone has access to information and does not suffer discrimination due to their health status as stipulated in the new constitution and the proposed health law .

This communication strategy draws out a road map and provides linkages with other efforts to reduce gender inequality, maternal and child deaths, improve women's access to family planning, antenatal and postnatal care and accelerates interventions to achieve gender- and health-related Millennium Development Goals and Vision 2030. The Strategy, will spearhead the campaign for eMTCT and keeping mothers alive under the slogan, ***Kata Shauri, Tulinde Kizazi*** to mobilize Kenyans to take both individual and social responsibility to prevent all new HIV infections in children and promote maternal health.

The process of developing this strategy was led by the Ministry of Health through the National AIDS/STI Control Program (NASCOP), working in collaboration with National AIDS Control Council (NACC), UN agencies, development partners and civil society organizations. This collaborative approach emphasizes the need for strengthened partnership among all stakeholders to ensure that this agenda is highly prioritized across the country. The strategy provides an opportunity for both political and technical leaders at the national and county level to act in concerted efforts to free Kenya of new HIV infections among children and promote maternal health.

I wish to thank all the stakeholders who were involved in the development of this communication strategy and look forward to its successful implementation.

HON BETH MUGO
MINISTER FOR PUBLIC HEALTH AND SANITATION

# Abbreviations

| | |
|---|---|
| AFASS | Acceptable, feasible, affordable, sustainable and safe |
| AIDS | Acquired immunodeficiency syndrome |
| ANC | Antenatal Clinic |
| ART | Antiretroviral therapy |
| BCC | Behavior Change Communication |
| CBO | Community Based Organization |
| eMTCT | Elimination of mother-to-child transmission |
| FBO | Faith-based organization |
| GoK | Government of Kenya |
| HW | Health Worker |
| HIV | Human immunodeficiency virus |
| IGAs | Income Generating Activities |
| IEC | Information, education, and communication |
| KAIS | Kenya AIDS Indicator Survey |
| KAP | Knowledge, attitudes and practices |
| KDHS | Kenya Demographic and Health Survey |
| KNASP | Kenya National HIV/AIDS Strategic Plan |
| MCH | Maternal and child health |
| MDGs | Millennium Development Goals |
| MTCT | Mother-to-child transmission |
| MVP | Millennium Villages Projects |
| NACC | National AIDS Control Council |
| NASCOP | National AIDS and STI Control Program |
| NGO | Non Governmental Organization |
| PCT | Provider-initiated counseling and testing |
| PEPFAR | U.S. President's Emergency Plan for AIDS Relief |
| PLWHA | People living with HIV/AIDS |
| PMTCT | Prevention of mother-to-child transmission |
| STI | Sexually transmitted infection |
| UNAIDS | Joint United Nations Program on HIV/AIDS |
| UNGASS | United Nations General Assembly Special Session on HIV/AIDS |
| UNICEF | United Nations Children's Fund |
| USAID | U.S. Agency for International Development |
| VCT | Voluntary Counseling and Testing |

# Preface

The Government of Kenya recognizes the importance of a national communication strategy that will guide her efforts to confront the challenges posed by Mother to Child Transmission of HIV through mobilizing all stakeholders to take action.

The constitution of Kenya 2010 recognises the right to health of all citizens with specific reference to reproductive health rights. The rights of families and communities, especially women living with HIV call, for a well integrated response that will ensure HIV, maternal health, newborn and child health, and family planning programmes work together, deliver quality results and lead to improved health.

This communication strategy is grounded on evidence on the patterns of demand and provision of maternal and child health services across the country. The plan outlines catalytic actions that will help the country to achieve targets set on the national framework for eMTCT and keeping mothers alive by 2015.

The Ministry of Health is committed to implement this strategy through the support of other government ministries, donors, implementing partners, development partners, non-governmental organizations and all Kenyans.

HEAD, NATIONAL AIDS and STIs CONTROL PROGRAMME (NASCOP)
MINISTRY OF PUBLIC HEALTH AND SANITATION

# Message from National AIDS Control Council

This National Communication Strategy for the elimination of Mother To Child Transmission of HIV lays a foundation for developing a long term approach which will strengthen Communication within the National EMCTC framework. To accomplish this, there must be an increase in the capacity and resources of EMCTC programmes at a time when global trends project diminishing resources for HIV and AIDS programmes.

Since its inception in 2000, the Prevention of Mother To Child Transmission (PMTCT) programme has recorded major successes in reducing new HIV and AIDS infections. Recognising the important role PMTCT plays in reducing new HIV infections, the National AIDS Control Council will continue to advocate for support and scale up of resources for the programme by the government, development partners and stakeholders.

Implementation of this strategy will facilitate scale up of communication programmes to enhance awareness and promote uptake of PMTCT services. It has provided innovative communication approaches to reach the target audience, give voice to their prevention needs, gain attention from policy makers, and deliver effective programmes

I therefore call upon all stakeholders to play their respective roles in the implementation of this strategy that will steer the country to attain the much aspired HIV free society.

**PROF. ALLOYS ORAGO**
DIRECTOR
NATIONAL AIDS CONTROL COUNCIL

# Executive Summary

During the UN High Level meeting on AIDS held in June 2011, the world leaders committed to the elimination of mother to child transmission of HIV as well as a twin agenda of ensuring reduction of AIDS related maternal deaths. The leaders agreed that it was unacceptable that an estimated 370,000 children were born with HIV in year 2010 despite major scientific breakthroughs that would have stopped these infections. A global plan was launched targeting 22 high countries which collectively account for 90% of pregnant women living with HIV, Kenya being among them.

The global campaign to eliminate new infections among children and keep their mothers alive by 2015 therefore was designed to outline catalytic actions that countries should adopt to strengthen their existing efforts of ensuring universal access to prevention of Mother to Child Transmission of HIV (PMTCT) services. The global plan outlines ambitious targets to guide national planning to achieve less than 5% transmission rates through the following strategies: Reducing the number of new HIV infections among children by 90%; Reducing the number of AIDS related maternal deaths by 50%; Reducing by 50% HIV incidence in Women of reproductive age (WRA) and Reducing unmet need for family need to zero among all women.

The Government of Kenya is committed to join the global countdown of ensuring children born with HIV and AIDS related maternal deaths are significantly reduced and hence developed a national framework for the elimination of mother to child transmission of HIV and keeping mothers alive by 2015. The framework outlines strategies to strengthen health service delivery, community participation, promote partnerships, advocacy and ensuring that all indicators are monitored to help report on progress.

The National PMTCT Programme was launched in 2002 in Kenya with the aim of reducing the proportion of infants infected with HIV by 20% by 2005 and 50% by 2010. The programme has since been reviewed to monitor results and address key barriers. Reports indicate that Kenya has recorded significant achievements in scaling up services and creating demand. Despite these efforts the current rate of progress is not sufficient to reach the national vision of eliminating new HIV infections among children and halving pregnancy-related deaths caused by AIDS by 2015. To accelerate and build momentum for the demand and provision of a broad range of PMTCT services in line with the global and national plans, this communication strategy is evidence based and identifies target groups and communication channels that will be prioritized to mobilize Kenyans to demand and

access services to achieve the EMTCT targets. The communication strategy will spearhead a national campaign for eMTCT and keeping mothers alive under the slogan, ***Kata Shauri, Tulinde Kizazi*** with a vision that Kenyans will be more knowledgeable, empowered and responsive to the call to take individual and collective actions towards this agenda.

The objectives of this strategy is therefore to increase knowledge and awareness that it is possible to eliminate mother to child transmission of HIV, create demand for integrated maternal, neonatal and child health services, including PMTCT and create a socially, politically and programmatically enabling environment to achieve EMTCT.

The strategy identifies primary and secondary audiences that will be targeted in this campaign. The primary audience includes women of reproductive age and their partners, pregnant women and women living with HIV. They will be targeted with contextualized messages to prevent primary infection of HIV, increase demand and access to maternal and reproductive health services. The secondary audience includes policy makers who have a key role in ensuring appropriate policies are in place, resources are allocated, provide political leadership, commitment and accountability. They are also instrumental in mobilizing citizens to demand services, provide political leadership, commitment and accountability for this agenda. The policy makers targeted will include government officials in relevant ministries including health workers, members of parliament, county governors, provincial administration and community opinion leaders.

PMTCT KAP formative Survey 2010 Research identified electronic media through radio and television as the most common channels through which information on prevention of mother transmission of HIV is relayed in addition to client interaction with health service providers. Other channels identified include print media and interpersonal communication (word of mouth) which is identified as influential in shaping behavior among individuals and social groups. Messages will be designed and disseminated through these key channels among others to empower individuals, families, and communities to make informed choices to prevent HIV transmission and unintended pregnancies, use PMTCT services, access care and support through evidence-based communication interventions.

This strategy will be monitored through existing structures such as community health committees and district health management teams. Routine monitoring will track the processes through reports and feedback from and to various stakeholders' forums such as Technical working groups meetings and other forums at the community and national level.

[2] PMTCT KAP formative Survey 2010

# Acknowledgements

The development of this Communications Strategy Plan has been a multi-sectoral and multi-stakeholder effort.

We wish to acknowledge with deep gratitude the contributions of the United Nations Family through UNICEF, for their close financial and technical support. We also thank the US Government for its support through the Centers for Disease Control and Prevention (CDC) and the President's Emergency Plan for AIDS Relief (PEPFAR).

We also thank the key resource persons from the various ministries and departments of the Government of Kenya; the Division of Reproductive Health, Division of Nutrition and Department of Health Promotions. We also acknowledge the contribution of Artful Eyes and Infotrak in the development of this Strategy.

# 1.0 Introduction

Kenya is among the 22 countries which collectively account for 90% of pregnant women living with HIV globally. Elimination of MTCT (MTCT rate of <5% among breast feeding populations or 90% reduction in mother to child HIV transmission rates by 2015) is now considered a realistic public health goal and an important contributor to achieving MDGs 4, 5 and 6 by 2015.

The eMTCT agenda is a strategic shift to catalyse prevention of Mother to Child Transmission of HIV services. EMTCT has generated robust new targets and indicators to guide national planning to achieve <5% transmission by;

- Reducing the number of new HIV infections among children by 90%
- Reducing the number of AIDs related maternal deaths by 50%
- Reducing by 50% HIV incidence in Women of reproductive age (WRA)
- Reducing unmet need for family need to zero among all women.

The government is determined to turn this vision into a reality, in line with the ***Global Plan towards the Elimination of New HIV infections in children and Keeping their Mothers Alive 2011- 2015.*** The Ministry of Health therefore developed an eMTCT framework to provide the country with the strategic direction to achieve this vision. This eMTCT communication strategy aims to mobilize an appropriate and strategic national response for scaling up and sustaining demand and supply of PMTCT services to achieve elimination targets.

Since the inception of the PMTCT program in 2000, significant progress has been made. There are now over 4,000 PMTCT sites providing PMTCT services with over 95% of pregnant women attending ANC accessing HIV Testing and Counseling (NASCOP, 2011). Of those who test HIV positive, 69% receive ARV prophylaxis for PMTCT. It's estimated that without interventions, 4 out 10 HIV infected women pass the HIV virus to their babies. With comprehensive PMTCT interventions, no child gets infected with HIV.
Therefore, no child should be infected by HIV as a result of MTCT.

[1] Demographic and Health Survey 2003; KAIS 2007; National HIV & AIDS Evaluation and Research Framework (2009/10-2012/13), 2009).

Recent programme reviews formative research (2010), Joint Review Mission report (2011), Routine program reviews showed both supply and demand challenges. The demand challenges include low PMTCT awareness, weak health seeking behavior, low skilled delivery, late first ANC attendance (15% first trimester attendance), stigma and discrimination (low disclosure), weak PMTCT community-facility linkages, social cultural beliefs and practices, high unmet need for family planning and low male involvement (<30%). The supply challenges identified are slow adoption of new PMTCT guidelines, frequent commodity stock-outs, infrastructural and equipment challenges, data quality challenges, missed opportunities for follow-up of mother-baby pairs, mixed messaging on IYCF and human resource gaps.

While concerted efforts to address the supply side challenges are going on in line with the national eMTCT strategic framework, a strategic and focused approach is critical to create demand for PMTCT services, foster an enabling social environment for increased uptake and timely access to PMTCT services and to champion HCWS to be responsive to the client's needs and provide quality PMTCT services.

Radio, television and health facilities (72%, 57% and 32% respectively) PMTCT KAP formative Survey 2010 are the most common channels through which respondents would prefer to get information on PMTCT. While it is established that radio has a leading edge over other media, the print media has an important role to play too. In all, the media bears a strong responsibility to help sensitize, educate and involve communities and individuals in the PMTCT campaign. However, Interpersonal communication (word of mouth) plays a key role in communication and shaping behavior among communities.

## 1.1 SWOT Analysis of PMTCT in Kenya

A situation analysis of the PMTCT Program reviewed the current program setup and national policies and guidelines, program support structures and system/institutional barriers towards effective implementation and optimal coverage. The report revealed the following strengths, weaknesses, opportunities and threats with regard to the national program. The SWOT analysis before has informed the development of the communication strategy, which addresses the challenges identified.

[3] Formative research (2010), Joint Review Mission report (2011), Routine program reviews
[4] PMTCT KAP formative Survey 2010

*Table 1: Kenya PMTCT SWOT Analysis*

| Strengths | Opportunities |
|---|---|
| 1. ***Strong and dynamic policy environment*** (HIV/AIDS declared a national disaster, PMTCT Guidelines released, national Aids Strategic plan). | • Able to keep up with the evolving nature of the pandemic<br>• Relatively short feedback loop, so lessons learnt can quickly be brought to bear on subsequent interventions |
| 2. ***Highly consultative policy and implementation process – multi-sectoral, multi-stakeholder approach*** | • Ability to ensure buy in and ownership among stakeholders, translating to a more energetic implementation.<br>• Strong linkages with partners e.g. donors, research agencies, community actors, etc. |
| 3. ***Availability of relevant eMTCT policy guidelines e.g. through the Internet*** | • A more informed population, leading to enlightened implementation and behavior change to the grassroots level.<br>• Using health calendar to include PMTCT in all other health initiatives and events e.g World health day. |
| 4. ***Widely decentralized implementation structures*** | • Program ownership at all levels, hence faster, better and more coordinated implementation. |
| 5. ***Clear national and regional level management, coordination and M&E structures*** | • Better coordination<br>• Integration with other health sector programs e.g. MCH |
| 6. ***Growing skills base of HWs and CHWs have improved skills*** | • Better delivery at the point of contact in the link facilities and in the families/homes |
| 7. Improved uptake of other PMTCT-related services e.g. VCT | • Possibility of a faster behavior change/turnaround or return of investment. |
| **Weaknesses** | **Threats** |
| 1. ***Varying degrees of political will-*** may change with leadership or political seasons | • Political attention may be diverted by crises or exigencies of the moment, or may change with a new administration, endangering program implementation/sustainability |
| 2. Funding and budget constraints | • Delay, stalling or underfunding of critical program implementation phases, which may affect program goal achievement |
| 3. ***Professional attrition (internal hostility among health workers)*** | • Reduced efficiency due to poor morale/sabotage<br>• Conflicting PMTCT message from healthcare personnel, leading to policy/practice disarticulation<br>• Poor priority coordination, leading to varying emphases and communications chaos |
| 4. ***Issues of sustainability*** | • Loss of focus/loss of gains and relapse after program funding ends<br>• Program goals may be hijacked or sidetracked to follow the dictates of the funding agencies |
| 5. ***Weak supply chain (drugs and test kits)*** | • Artificial shortages of drugs, affecting drug quality and motivation among intended beneficiaries<br>• Development of resistance as people on ARV miss their allotted doses, leading to escalating health costs |
| 6. ***Insufficient HR capacity, especially at lower levels*** | • Big bang, small bite national programs that bear little fruits among intended beneficiaries at the grassroots, leading to apathy and jeopardizing future health initiatives. |

# 2.0 The Communication Stategy

## Vision:

A knowledgeable, empowered and responsive society
to eliminate Mother To Child Transmission of HIV.

## Goal:

To increase knowledge, generate positive attitudes and practices to eliminate new HIV infections among children and to keep mothers alive

## Mission:

To empower individuals, families, and communities to make informed choices to prevent HIV transmission and unintended pregnancies; use PMTCT services; and access care and support through evidence-based communication interventions.

## 2.1 Guiding Principles

The Communication strategy is informed by the following principles;

### Principles of the Strategy

1. **Research-based -** Evidence from current sources form the foundation for the communication strategy e.g. KAP Survey and formative research
2. **Audience-centered approach -** Messages will be tailored to specific audience
3. **Focus on behavior and social change -** All communication interventions will focus on encouraging positive and healthy behavior and social change
4. **An integrated and comprehensive approach -** Messages will emphasize maternal and child health.
5. **Community participation, empowerment and ownership –** Will Ensure Communities are at the center of the communication strategy
6. **Use of multiple communication channels -** Multiple means will be used in different contexts to achieve intended behavior outcome.
7. **Cost-effective -** Communication resources will be optimally utilised
8. **Equity -** Use of innovation and contextualized communication channels to reach the hard- to-reach and vulnerable communities
9. **Human Rights-based -** Use communication to protect and promote human rights for optimal access to eMTCT services
10. **Sustainability -** Develop and strengthen partnerships and alliances to sustain the elimination agenda.

## 2.2 Objectives

The objectives of the communications strategy are crafted to address the needs and challenges at the three main levels, namely policy, institutional and programmatic levels.

In response to challenges identified in the PMTCT bottleneck analysis, the following key objectives have been identified

1. Increase knowledge and awareness of eMTCT to 95% by 2015
2. Increase demand to achieve 90% access to integrated MNCH services, including PMTCT by 2015
3. Create a socially, politically and programmatically enabling environment to achieve eMTCT by 2015

## 2.3 Target Audience Analysis

The regional variation in HIV prevalence, incidence, access and demand for PMTCT services in Kenya requires focused interventions that address target-specific issues to bring about change at the individual and population levels. This communication strategy will focus on the general population but targets the following key primary and secondary audiences:

### 2.3.1 Core (Primary) Audiences

The primary audience will include women of reproductive age and their partners, pregnant women, women living with HIV and policy makers. This audience will be targeted with intensified messages to prevent primary infection of HIV, increase demand and access to maternal and reproductive health services. The policy makers will be targeted for influencing policies, resource allocations, demand-creation, provision of services, political leadership, commitment and accountability for this agenda.

#### *Women of Reproductive age and their partners*

The HIV epidemic in Kenya remains largely feminized with over 700,000 women infected and a prevalence of 8% among women aged 15-49 years (KDHS 2008/9). This strategy targets women and their partners to prevent HIV infection, go for HIV testing, take up family planning to avoid unintended pregnancy, and knowledge of PMTCT services. Men will be engaged as beneficiaries and agents of change in promotion of safer sexual practices, reduction of HIV related stigma and support to pregnant women to access services across the PMTCT cascade.

### *Pregnant women and their partners*

This group will be targeted with messages to create demand and maintain them as clients of PMTCT services. There are over 1.5 million pregnancies per year in Kenya and over 85,000 deliveries by women living with HIV in Kenya (KDHS 2008/9). In addition HIV contributes to nearly 40% of indirect causes of maternal deaths (DRH program data, 2012 ). Evidence on the importance of antenatal clinic visits which create opportunity for HIV testing and general health status has been acknowledged globally. In Kenya, despite 92% of pregnant women attending at least one ANC visit, only 15% attend early (below 16 weeks). In addition, retention of pregnant women has been a challenge with only 47% four ANC visits, 44% skilled birth attendance and low postnatal attendance (KDHS 2008/9). Early and sustained ANC attendance, skilled delivery and attendance of postnatal clinic attendance will be emphasised to this group.

### *Adolescents*

Sexual activity among the adolescents poses a risk of teenage pregnancy and HIV infection. The average sexual debut in Kenya is at 22% for boys and 11% for girls, with some regions such as Nyanza as high as 64% before the age of 15 (KDHS 2008/9). The adolescent pregnancy rates at 18% and awareness of prevention of mother to child transmission at only 50% among teenagers aged 15-19 (KDHS 2008/9) shows the need for communication messages targeting this unique group. The group includes those adolescents in and out of school and special consideration to HIV positive adolescents..

### *Women Living with HIV*

The unmet need for family planning among this group is 56% compared to 26% amongst women in the general population (KDHS 2008/9). The leadership and supportive role of women living with HIV to address the unmet need of family planning and PMTCT services which are crucial to achieve eMTCT and keeping mothers alive agenda will be emphasised. This group will be targeted as primary and secondary beneficiaries of key messages.

### *Adult male*

The national male partner HIV testing at ANC is 7% (NASCOP program data 2011). In the formative research only 29% of the pregnant women were accompanied by their partners to the ANC and only half of the partners were willing to get tested. In addition, PMTCT knowledge levels for male adult were significantly lower than that of women. This group will be targeted to increase their knowledge and awareness, and to actively be involved in pregnancy (including PMTCT) and child care.

### 2.3.2 Secondary Audiences

*Health workers*

Health workers will include medical doctors, clinical officers, nurses, nutritionists, community health workers and other health professionals in daily contact with clients. They are strategically positioned to influence individual and community decisions about health- related life choices such as PMTCT. Their role is critical in the success of the overall PMTCT program.

*Policy makers at the community, county and national level*

The policy makers targeted will include government officials in relevant ministries, Members of Parliament, county governors, provincial administration and community leaders. These groups will be sensitised to influence policies, resource allocation, create demand and accountability of the community, county and national level eMTCT progress.

*Stakeholders: Operational and implementing partners*

These stakeholders include medical and health training institutions, professional bodies, development partners and civil society. They will be targeted as service providers, community mobilizers and communication agents to influence demand and provision of PMTCT services.

*Opinion leaders*

These include members of the communities in political, social, economic and religious leadership. Some of the leaders who positively influence uptake of PMTCT services include:

- *Religious leaders:* They have regular contact with community members and influence individual behaviours.
- *Community elders:* They preside over the community's cultural rites and thus have a great influence on decisions regarding child-rearing practises such as breastfeeding.
- *Local politicians:* They are opinion shapers in their communities and can influence policies.
- *Administrative officials:* Most are members of the communities and are important players in organizing forums to educate members of the public.
- *Teachers:* Most are members of the host communities and are held in high regard especially by their students and the community.
- *Youth leaders:* They are in constant contact with the younger members of the community and exert influence over them.
- *Community change agents:* These include mobilizers for social programs who have the capacity to reach out to some sections of the community that are not easily accessible.
- *Media:* The media can play a crucial role in dissemination of accurate information on eMTCT. The advent of community radio stations and vernacular broadcasts creates avenues to address language barriers that impede access to information.

*Table 2: Summary Table of Core Audiences and Sample Messages for each group'*

| Core Audience | Target Messages |
|---|---|
| *Women of reproductive age (WRA)* | Primary prevention of HIV<br>HTC<br>Family planning/contraceptive use |
| *Pregnant Women and their partners* | Early ANC attendance<br>Skilled delivery<br>Postnatal Clinic attendance<br>Exclusive breastfeeding and ARV treatment/prophyllaxis for mother and baby<br>Couple counseling and Testing<br>Financial and moral support |
| *Women living with HIV* | Adherence to medication<br>Pre-conception check up<br>Dual contraception. |
| *Adult Males* | Prevention of HIV<br>Benefits of PMTCT<br>Sero discordancy<br>Prevention of unintended pregnancy<br>Importance and support women for early ANC, skilled delivery and postnatal care for both<br>mother and baby. |
| *Adolescents* | Delay in sexual debut<br>Prevention of HIV and MTCT<br>Prevent unintended pregnancies. |
| Secondary Audience | |
| *Health workers* | Reduction of stigma<br>Improve quality of care<br>Promote m2m mentorship<br>Promoting drug adherence |
| *Policy makers at the regional (county) and national level* | Political commitment and accountability<br>Resource mobilization<br>Use position of influence/authority to promote PMTCT services |
| *Implementing partners* | Support to PLWHA<br>Institutional/ facility/community<br>support for eMTCT. |
| *Community based health providers* | Reduction of stigma<br>Defaulter tracing/adherence promotion<br>Promote/ encourage linkage with<br>support groups/system. |
| *Opinion leaders -Religious leaders, community elders, teachers, local politicians, administrative officials, youth leaders* | Reduction of stigma and discrimination<br>Advocacy, awareness and demand creation<br>Community mobilization for ownership/<br>sustainability. |
| *Media* | Advocacy, awareness and demand creation among leaders and the public to achieve eMTCT.<br>Community mobilization to sustain/own eMTCT |

# 3.0 Strategic Implementation Framework.

## Implementation Approach

The Communication Strategy has been guided by the 2010 National formative research on PMTCT. It provides the general framework on the communication on interventions. However, there is recognition that every community has its unique cultural beliefs, attitudes and practice that influence health-seeking behavior. The implementation of this strategy would therefore require behavioral analysis at community level (Annex X) to aid communities in identifying barriers and positive behavior to be promoted.

Following the behavior analysis, community feedback sessions will aid in coming up with a participatory action plan. The Implementation matrix (Table X) will assist committees in planning activities for the action plan.

## Coordination & Management

National, provincial/ county, district and community levels will have different roles in the implementation and will be required to develop plans specific to their roles. The facility-community health committees or health management boards or any other existing structures, will steer implementation in the community. They should ensure exhaustive mobilization of the community groups and all sectors such as Culture, Gender, Education, Agriculture and Administration.

The DHMT will play a supervisory role and will be responsible for convening advocacy meetings and getting feedback from the health management boards. The DHMT should ensure full engagement of the District Development Committee and civil society. Steering Committees for eMTCT will take the lead at the subnational level and will take a supervisory role.

The overall responsibility for coordination and management of communication for eMTCT at the national level lies with the Ministry of Health led by the Communication Sub-committee, which is part of the PMTCT TWG.

To ensure effective communication messages the standard national health promotion messages will be supplemented by messaging that responds to social, gender and cultural context at community level.

## Implementation Matrix

The implementation matrix of the Strategy includes the overall eMTCT communication objectives and key specific interventions. The objectives and Key Strategic Interventions are summarised in the table below, accompanied by a more detailed matrix with strategies, audience, communication channels, messages, activities and monitoring indicators.

*Table 3: Implementation Matrix Summary*

| Objective | Key Strategic Intervention |
|---|---|
| *Increase knowledge and awareness of eMTCT to 95% by 2015* | 1. Advocacy on eMTCT at national, county and community level<br>2. Sensitization of various target groups<br>3. Use of eMTCT champions |
| *Increase demand to achieve 90% access to integrated MNCH services, including PMTCT by 2015* | 1. Community Mobilization to increase access and utilization of services<br>2. Enhance partnerships within the community and between the community and the facility<br>3. Male engagement to increase access to Healthcare and optimize RH services |
| *Create a socially, politically and programmatically enabling environment to achieve eMTCT by 2015* | 1. Communication for improvement of knowledge, attitude and communication skills among Health Care Workers |
| | 1. Advocacy for health systems strengthening<br>2. Engagement of PLH in advocacy<br>3. Use of eMTCT champions |

## 3.3 DETAILED STRATEGIC IMPLEMENTATION MATRIX

OBJECTIVE 1: Increase knowledge and awareness of eMTCT to 95% by 2015

**Strategy 1:** Advocacy on eMTCT at the National, County and Community level.

| Component | Sub components |
|---|---|
| *Audience* | Parliamentarians, County Governors, and Regional administrators, opinion leaders |
| *Communication channels* | Meetings and Workshops; Print materials (fact sheets, leaflets, information pack) |
| *Key Messages* | Know the facts about eMTCT<br>Create awareness of eMTCT among constituents<br>Political  commitment and accountability<br>Resource mobilization<br>Promote creation of support systems for eMTCT<br>Use position of influence/authority to promote PMTCT services |
| *Illustrative Activities* | Forums with parliamentarians, media, opinion leaders for sensitization on eMTCT<br>Disseminate annual county fact sheets on eMTCT and community behavioural analysis  resultsFeedback meetings with the various stakeholders. |
| *Verifiable indicators* | Number of people in advocacy target group reached ,<br>Number of meetings held by Parliamentarians/Policy Makers, etc on eMTCT , advocacy print materials produced and disseminated. |

**Strategy 2:** Sensitization of various target groups

| Component | Sub components |
|---|---|
| *Audience* | Pregnant women and their partners, Women living with HIV, WRA , adult males, youth |
| *Communication channels* | • Mass media-<br>• Leaflets (could also be in local languages) & Posters<br>• Newspapers (e.g. supplements, regular column)<br>• Peer to peer communication. |
| *Key Messages* | Prevention of HIV, Knowing HIV status;<br>Early attendance of ANC and skilled delivery,<br>Contraceptive use,; Know the benefits of PMTCT |
| *Illustrative Activities* | • Community behavioural  analysis<br>• Conduct health talks and group discussions<br>• Use of peer support groups in leading discussions<br>• Provide leaflets/posters<br>• Use videos (with discussion) folk media - drama<br>• Develop appropriate region-specific communication interventions |
| *Verifiable indicators* | • Number of  community behavioural analysis  carried out Media campaign planned and launched<br>• % people tested and know their status<br>• % people compliant with ARV. |

**Strategy 3:** Use of eMTCT champions for advocacy

| Component | Sub components |
|---|---|
| *Audience* | National and regional community level champions |
| *Communication channels* | Group discussions; dialogue , education sessions, advocacy materials |
| *Key Messages* | • Counseling and Testing for HIV; Early ANC attendance, skilled delivery; safer IYCF practices; Newborn care; Contraceptive use, support Adherence to ARVs ; Reduction of stigma and discrimination |
| *Illustrative Activities* | • Exposure to health facility ,<br>• Personal testimonies ,<br>• Conduct health talks and group discussions<br>• Use of peer support groups in leading discussions<br>• Provide leaflets/posters<br>• Use videos (with discussion) |
| *Verifiable indicators* | • eMTCT champions selected and trained |

## OBJECTIVE 2: Increase demand to achieve 90% access to integrated MNCH services, including PMTCT by 2015

**Strategy 1:** Community mobilization to increase access and utilization of integrated MNCH services .

| Component | Sub components |
|---|---|
| *Audience* | Traditional leaders, PLWHA, Mother Support Groups, FBOs, CBAs, Facility Health Committees, Youth groups, PTAs, farming & fishing co-ops, men's clubs |
| *Communication channels* | Folk media; Community radio/ listening groups;<br>Community meetings, peer education |
| *Key Messages* | • Learn the facts about PMTCT (discuss benefits, address myths and misconceptions)<br>• Encourage CT for HIV<br>Early ANC attendance, four ANC visits, skilled delivery, birth preparedness and attendance of postnatal clinics<br>• Reduce stigma and discrimination especially against PLH<br>• Identify non health-promoting cultural practices and social normsas evidenced by sub-national community behavioral analysis and seek ways to change them<br>• Encourage preventative behaviors (i.e. ABCs, family planning) |
| *Illustrative Activities* | • Community dialogue<br>• Champions for eMTCT<br>• Radio programming on community stations to initiate discussion<br>• Organizing radio listening groups<br>• Drama, song and dance to initiate discussion<br>• Capacity build community facilitators |
| *Verifiable indicators* | • Number of community meetings held, groups attending meetings, topics discussed, actions agreed upon<br>• Number of radio programs, topics discussed<br>• Number of radio listening groups organized<br>• Number of meetings & discussions held, topics discussed<br>• Number of drama/song/dance performances<br>• Number of trained facilitators who are active |

**Strategy 2:** Enhance partnerships within communities and between the community and facility

| Component | Sub components |
|---|---|
| *Audience* | Community members, opinion leaders, health workers, ; CBOs;<br>Regional leaders, Community Health Workers, community midwives |
| *Communication channels* | • Meetings<br>• Community Dialogue<br>• Chief's barazas<br>• Community blackboards |
| *Key Messages* | • Communities should be responsible for the health of the mother and the child<br>• Working together enhances the ability to achieve the eMTCT goal. |
| *Illustrative Activities* | • Partnership meetings<br>• Joint action plans at facility/community levels share progress<br>• Exchange visits |
| *Verifiable indicators* | • Facility/Community joint action plan<br>• Number of community joint action plans<br>• Number of communities linked to health facility<br>• Number of reports shared<br>• Number of referrals from one organization to another |

**Strategy 3:** Male engagement to improve access to RH services throughout the continuum of care

| Component | Sub components |
|---|---|
| *Audience* | Males >15years |
| *Communication channels* | Group discussions (Clubs, religious groups, schools, anti-AIDS clubs);<br>Multimedia communication, Traditional ceremonies, social media,<br>workplace programs, Interpersonal Communication workshops |
| *Key Messages* | Know the basics of PMTCT<br>Understand the benefits of PMTCT<br>Access to RH services<br>Importance of counseling and testing for HIV, and prevention of HIV<br>Support female partners and family members to access reproductive health services, IYCF and MNCH<br>Maternal nutrition<br>Support HIV positive partners to remain in care<br>Understand negative effects of GBV |
| *Illustrative Activities* | • Talks<br>• Lobby for male friendly environments in health centers<br>Reach men in their groupings, sports activities that promote eMTCT, chiefs barazas |
| *Verifiable indicators* | • Number of talks on PMTCT involving men<br>• Number of religious gatherings holding men's talks<br>• Number of Interpersonal Communication workshops conducted among men<br>• Number of men trained in Inter Personal Communication skills<br>• Number of male-friendly health facilities & men accessing services in them<br>• % increase in couples presenting for counseling<br>• % of males with knowledge on PMTCT |

## OBJECTIVE 3: Create a socially, politically and programmatically enabling environment to achieve eMTCT by 2015.

Strategy 1: Communication for improvement of **knowledge, attitude and communication skills** among Health Care Workers

| Component | Sub components |
|---|---|
| *Audience* | Health workers |
| *Communication channels* | Meetings; Lectures; Group discussions (question/answer sessions, demonstrations/role play); Field trips; Newsletter. CMEs, Sensitisation |
| *Key Messages* | • The role of HCW in PMTCT service delivery<br>Provision of Comprehensive and friendly Services include: ANC, intra-partum, postpartum, infant feeding counseling (EBF), ARVs, growth monitoring and promotion, Immunization & malaria prevention ,Maternal nutrition, Family planning , Ca cervix screening,<br>Clear messages on PMTCT to give women esp HIV positive women. |
| *Illustrative Activities* | • Trainings: orientation, basic PMTCT, counseling & communication skills<br>• Demonstrations/role plays exchange visits<br>• Recognition of Best practices, and motivating the sites/ HCW implementing |
| *Verifiable indicators* | Sensitisation of HCW in Counseling/BCC skills:<br>Basic counseling skills, health talks, etc.<br>Client satisfaction surveys KAPs |

Strategy 2: Advocacy for Health systems strengthening

| Component | Sub components |
|---|---|
| *Audience* | Policy makers, Management teams, Development organizations and implementing partners, Health care workers, Clients, Networks of PLWHA |
| *Communication channels* | Sensitisation meetings on eMTCT., Media,<br>lobbying, publications, fact sheets. |
| *Key Messages* | Adequate funding, supplies and commodity security,<br>equipment and infrastructure, HR to implement PMTCT activities<br>Advocate for subsidized/free RH services for women universal access<br>to RH and PMTCT services through decentralized services and mobile outreaches. |
| *Illustrative Activities* | Conferences, lobby meetings, facility visits, dialogue meetings |
| *Verifiable indicators* | Number of Meetings, conferences, policies, human resource increase,<br>increase in budget allocation, scale up of services. |

**Strategy 3:** Engagement of PLHIV in service delivery and Advocacy for eMTCT

| Component | Sub components |
|---|---|
| *Audience* | PLHIV and their networks, Community members,<br>Implementing partners, Management teams and policy makers |
| *Communication channels* | Orientation/ Sensitization meetings |
| *Key Messages* | Reproductive health messages for PLHIV<br>Clear messages on PMTCT,<br>Fertility needs and choices,<br>Infant feeding (EBF), mentorship and support<br>advocate for quality services<br>Prioritize involvement of PLHIV in the response |
| *Illustrative Activities* | Meetings of PLHIV<br>Mentor mother program implemented<br>Involvement of PLHIV in the community dialogue and activities |
| *Verifiable indicators* | • Number of meetings held, mentorship programmes |

# 4.0 Monitoring and Evaluation

### 4.1 Monitoring and Evaluation Framework

Regular monitoring and evaluation of implementation activities will be done at all levels of implementation. Routine monitoring will track the processes through programmatic reports and feedback from the communities while evaluations will focus on the outcome and impact of the various interventions.

Specific monitoring and evaluation indicators have been provided for each objective in the table below.

Impact: Increased knowledge and uptake of PMTCT services

Projected Outcomes:

*Knowledge and awareness of eMTCT increased to 95% by 2015*
*Demand for integrated MNCH including PMTCT services increased to achieve 90% access by 2015*
*Enabling environment in place to achieve eMTCT by 2015*

| Objective | Strategic Interventions | Process Indicators | Outcome indicators | Source of data | Frequency of data collection | Responsible person |
|---|---|---|---|---|---|---|
| *1. Increase knowledge and awareness of PMTCT* | Advocacy on eMTCT at national, county and community level.<br>Sensitization of various target groups<br>Use of Community champions | eMTCT champions selected and active | Increase in the knowledge level on PMTCT among target groups<br>Use of Risk reduction strategies-condom use | Client exit interviews<br>KAP surveys<br>Media scans<br><br>Special surveys-DHS<br>Multiple Indicator Cluster Surveys (MICS) | Annual<br><br>After 5 years | Nascop M/E Manager<br><br>DHMT, Facility/ Community health management boards<br><br>Civil society |
| *2.Increase community action, ownership and partnership for eMTCT* | Community Mobilization to increase access and utilization of care | Documented initiatives/ in-novations by communities to improve own health<br>Active facility/ community committees<br><br>Successful Re-ferrals between facility and community<br><br>Level of active partner engagement in the community<br><br>Couple C/T | Increase in utilization of PMTCT services;<br>• Early and completeANC visits<br>• Skilled attendance at birth<br>• Postnatal clinics<br>• Proper IYCF practices<br>• Adherence to ARVs and retention in care of Positive woman and HEI<br><br>Risk reduction practices e.g condom use<br>Percentage of pregnant women whose male partners were tested for HIV in the PMTCT setting | KAP Surveys<br><br>MOH Records<br><br>Client exit interviews<br><br>Special surveys-DHS<br><br>Multiple Indicator Cluster Surveys (MICS | Annual<br><br>After 5 years | Nascop M/E Manager<br><br>DHMT, Facility/ Community health management boards<br><br>Civil society |

|  |  |  |  |  |  |  |
|---|---|---|---|---|---|---|
| ***3. Create an enabling environment*** | Communication for improvement of knowledge, attitude and communication skills among HCW | Sensitisation of HCW on communication for eMTCT | Facilities delivering quality-assured care(clinical skills, client interaction, commodity security, adequate HR, use of data to monitor response ) | Client exit interviews<br><br>Community surveys<br><br>Facility/MOH records<br><br>KAP surveys<br><br>Media scans | Annual | M&E Manager<br><br>DHMT, Facility/Community health management boards<br><br>Civil society |
|  | Advocacy for health systems strengthening | Sensitization of WLHA in eMTCT | Satisfaction of clients with PMTCT services |  |  |  |
|  | Engagement of WLHA in advocacy for eMTCT |  | Number of facilities and communities who have integrated WLHA in their response and care |  |  |  |

# 5.0 Financial Resource Requirements

## 5.1 Indicative 4-year budget

| Objective | Strategy | Activities | Budget in million Ksh'000' | | | |
|---|---|---|---|---|---|---|
| | | | Yr 1 | Yr 2 | Yr 3 | Yr 4 |
| *Increase knowledge and awareness of PMTCT* | Advocacy on PMTCT at the national, county and community level. | Coordination of meetings /workshops for decision makers | 6,000 | 6,000 | 4,000 | 3,000 |
| | Mass media campaign | KAP surveys | 3,000 | 3,000 | 3,000 | - |
| | | IEC material development & production | 16,000 | 10,000, | 10,000 | 10,000 |
| | | Media buying(TV & radio spots) | 20,000 | 20,000 | 20,000 | 15,000 |
| | Integrate communication interventions throughout the health community | Health worker training, materials supply | 15,000 | 15,000 | 15,000 | 15,000 |
| | Social Mobilisation | Social mobilization; annual PMTCT status report | 25,000 | 25,000, | 20,000 | 18,000 |
| | Peer education | Identify PMTCT champions; identify and train change agents; organize community sensitization forums | 7,000 | 5,000 | 5,000 | 5,000 |
| | SUBTOTAL | | 92,000 | 84,000 | 77,000 | 66,000 |
| *Increase ownership/ partnership for PMTCT* | Community Capacity building | Community capacity needs assessments | 3,000 | 3,000 | 3,000 | - |
| | Empower community members to spearhead PMTCT | Technical assistance for plans development | 5,000 | 5,000 | 5,000 | 5,000 |
| | Support community initiatives on eMTCT . | Training/ Orientation Workshops | 10,000 | 7,000 | 5,000 | 5,000 |
| | Strengthen the linkage among all actors in HIV and related programs | Capacity building on eMTCT among all other institutions in the community for referral, networking and collaboration | 4,000 | 4,000 | 4,000 | 4,000 |
| | Enhance partnership between health workers and community. | Organize community forums/open days and distribute literature | 10,000 | 10,000 | 10,000 | 10,000 |
| | SUBTOTAL | | 32,000 | 29,000 | 27,000 | 24,000 |
| *Create an enabling environment* | Increase HWs' PMTCT skills and knowledge | Capacity building for PMTCT and other health Institutions | - | - | - | |
| | *Advocacy* | Advocacy campaigns and lobbying for county governors, politicians, FBOs, and community leaders | 100,000 | 80,000 | 80,000 | 50,000 |
| | SUBTOTAL | | 100,000 | 80,000 | 80,000 | 50,000 |
| | TOTAL | | **224,000** | **193,000** | **184,000** | **140,000** |

Table: Behavioral analysis framework summary

| Problem behavior | Manifestation | Behaviors to promote | Barriers to ideal behavior | Factors encouraging ideal behavior |
|---|---|---|---|---|
| *Pregnant women not accepting VCT* | *May pass HIV to her baby* | *Accept VCT & related PMTCT package services* | *Partner, family, community not supportive, afraid of PLWHA* | *Community takes responsibility to make sure all women know their status and take appropriate action in PMTCT services* |
| *HIV+ mothers engaging in mixed feeding* | *Infants may become infected via breast milk* | *90 % of mother/baby pairs exclusively breastfeeding are support with appropriate ARV treatment or prophylaxis'* | *Community stigma against replacement feeding – seen as confirmation of HIV status* | *Develop community capacity and peer support & respond to families affected by HIV for EBF,* |
| *Men not supportive of pregnant partners knowing her HIV status* | *Women do not accept VCT &/or don't return for results of test* | *Men interested & involved in protection of family unit by supporting partner to accept PMTCT services* | *Community stigmas; lack of information, awareness & understanding of PMTCT issues & how they affect men and their families* | *Give men special role to play in PMTCT services, empowering them to make informed decisions & support their partners* |

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