



HURTING THE VOICES,
FRAMING THE SELVES
IN HONOUR AND RESPECT.

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SECURE THE FUTURE

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A FOCUSING ON COUNSELLOR-TO-MOTHER COMMUNICATION IN ORDER TO ENHANCE EFFECTIVENESS AND QUALITY OF PMTCT INFANT FEEDING COUNSELING IN SOUTHERN AFRICA



FINDINGS

- Mixed feeding is the norm:** including water, solids and medicine.
- Infant feeding counselling is not effective:** in preventing mixed feeding in resource-poor settings.
- Mothers' beliefs:** breast milk is not a real food, or not food enough, they do not produce enough milk, or the quality of their milk is not good enough.
- Information given:** HIV transmission through breast milk was often constructed as a certainty instead of a probability.
- Counselling:** mothers were 'just' allowed to make their choice without being actively assisted in making their decision, or they were told what to do.
- Competition:** health workers had to compete with other voices of 'infant feeding control' – especially the (female) head of the household and/or paying relatives.
- Counselling encounter:** two very different agendas were at work, with both parties entertaining fixed expectations, talking past, at, and against each other. Professional and even personal boundaries were commonly crossed.
- Health workers:** suffered burn-out, depression and rage.

INTRODUCTION

OVERVIEW

In the efforts to prevent mother-to-child transmission (PMTCT) of HIV, calls have been made to enhance quality and effectiveness of infant feeding counselling in Southern Africa (Chopra, 2004). To this end, the IFRP study design has three phases: an exploratory, anthropological (completed research) first phase which focused primarily on mothers; an action research (current pilot) second phase focusing primarily on the counsellors; and an implementation (proposed roll-out) phase focusing on training new boundary partners.

FIRST PHASE (COMPLETED RESEARCH) (BUSKENS, 2004)

BACKGROUND: Infant feeding is mostly women's business in Southern Africa, and so is infant feeding counselling. The purpose of infant feeding counselling is to support mothers to make an informed choice of either exclusive breast-feeding or exclusive formula feeding, and to adhere to this choice consistently. However, HIV-positive pregnant women carry a thousandfold burden of discrimination: as women, as HIV-positive women, and as HIV-positive pregnant women (The Papan Report, 2001). Stigma around HIV/AIDS may prevent women from effective PMTCT participation because they fear the test results and disclosure.

FIRST PHASE RESEARCH QUESTION: Who and what influences infant feeding decisions? How do perspectives and experiences of mothers and counselling health workers participating in PMTCT programmes in South Africa, Swaziland and Namibia speak to the effectiveness of PMTCT infant feeding counselling?

METHODOLOGY

Sixteen researchers conducted intensive anthropological field research in indigenous languages using a variety of qualitative techniques, over 7 months until November 2003, in 11 sites in Namibia, Swaziland and South Africa. Sites were urban, peri-urban and rural, and were characterised as low-resource settings.

A total of 150 mothers and pregnant women, 31 relatives, 92 health workers and 7 traditional leaders were formally interviewed. The data was analysed per site and in its totality, using internal and external analysis.

DISCUSSION

- Ineffective infant feeding counselling:** supported by other studies (Chopra, 2004; Shapiro et al., 2005).
- Insufficient milk syndrome:** linked to lack of self-efficacy (Scrimshaw & Cherman, 1997).
- An alternative counselling format:** that better acknowledges and manages the two competing agendas is likely to make for more successful encounters.
- Counselling that:** "guides mothers instead of either directing them or leaving them" may be more helpful, but will require significant behaviour change of counsellors, both to their counselling approach and including deeper or psychological transformation.
- The troubled relationship between the mother and health worker:** may be linked to programmatic issues, but the interpersonal problems could be framed as female gender dynamics within a patriarchal context (Cherlin, 2004).
- Over-identification:** would explain much of the lack of professional distance and health workers' emotional over-involvement and burn-out; labelling and stigmatising these mothers as 'other' can be expected as an end-point of a psychological defence mechanism to create distance (Cherlin, 2004).

BEHAVIOUR CHANGE NEEDS CONSISTENT FOCUS AND COHERENT STRATEGY

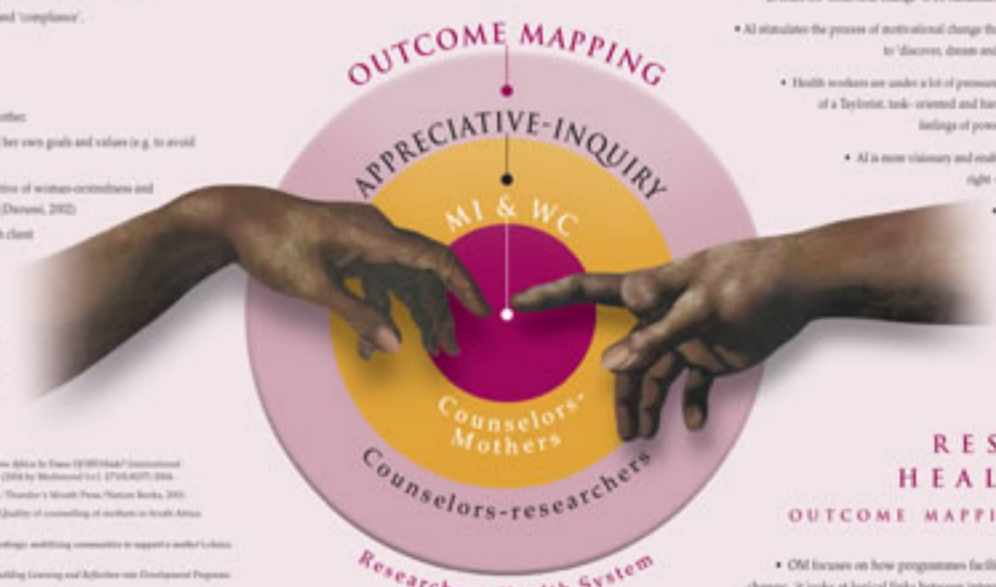
IF WE...	WANT TO...	WE NEED TO OVERCOME...	WHICH IS LINKED TO...
MOTHERS	Make an undistorted assessment of our situation and take control of our situation so that we can adhere consistently to our option of choice	Our internalised perceptions of helplessness and our lack of self-efficacy Our internalised perception of milk insufficiency: thinking that our milk is not enough, not good enough and/or not food enough	Perceptions of us women as powerless beings Junior status of women in relation to partners, family and community
COUNSELLORS	Stimulate self-efficacy in mothers	Our doubt in mothers' capacity for self-management Our need to control their behavior Our tendency to reinforce the mothers' powerlessness when we behave as 'persecutors' and 'rescuers'	Perceptions of women as powerless Our professional socialisation in didactic and instructional interpersonal behaviour (Silverman et al., 1998) Female gender dynamics in a patriarchal context
RESEARCHERS	Facilitate skills development and reflexivity in counsellors	Our doubt in their capacity for self-management and our need to control their behaviour Our attachment to the outcome of the research	A health service culture of control and task management (Van der Walt & Swartz, 2002). A research culture of prediction and control

MOTHER/COUNSELOR MOTIVATIONAL INTERVIEWING (Rollnick, Mason & Butler, 1999) & WOMEN-CENTREDNESS (Buskens, 2004)

- Recognises the meaning and sources of resistance and 'compliance'.
- Negotiates an agenda/focus for the encounter.
- Assesses clients' readiness to make a change.
- Focuses more on listening than on talking.
- Recognises and facilitates 'change talk' from the mother.
- Reflects discrepancies between current actions and her own goals and values (e.g. to avoid transmission of HIV to her infant).
- Includes the female health worker into the perspective of women-centredness and not only the female client as is accepted elsewhere (Dionisi, 2002).
- Acknowledges that internalised sexism within both client and counsellor and also within their relationship can undermine the encounter.
- Empowers both parties by clarifying roles and boundaries, leaving responsibility for behaviour change clearly with the mother while stimulating her self-efficacy; encouraging health workers to reflect on their attachment to success or control roles, and to transform their own attitudes and practices.

COUNSELOR/RESEARCHER APPRECIATIVE INQUIRY (Hammond, 1998; Hammond, 2004)

- In order for 'behaviour change' to be sustainable, it has to come from within – personal transformation.
- AI stimulates the process of motivational change through a participatory consultation process to get people to 'discover, dream and design' a better 'identity', by using 'positive' questions.
- Health workers are under a bit of pressure. Health services in Southern Africa are run on the basis of a Taylorist, task-oriented and hierarchical management regime, which has been linked to feelings of powerlessness and resentment (Van der Walt & Swartz, 2002).
- AI is more visionary and enabling than critical – intentionally focusing more on what is right – assets and capacities – than on needs, gaps and problems.
- AI also uses a technique called 'taming elephants' which enables facilitators to start discussing underlying assumptions and dynamics considered too big or too hot to even name or mention.



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RESEARCHERS / HEALTH SYSTEMS OUTCOME MAPPING (Earl, Cordes & Smythe, 2001)

- OM focuses on how programmes facilitate change rather than how they control or cause change; it looks at logical links between interventions and outcomes, because the complexity of development processes, together with the contexts in which they occur, often make it impossible to attribute results to any particular intervention.
- Outcomes are defined as changes in the behaviour, relationships, activities or actions of the people, groups and organisations with whom a programme works directly.
- The main 'outcome challenge', is formulated as the counsellors changing their counselling behaviour, rather than the compliance/behaviour of their clients (over which health workers have little control – and no right to try to control).
- The outcome challenge is tracked in a participatory and inclusive process. This self-monitoring is supported by interaction with other stakeholders (boundary partners) such as the health service management.