THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH AND SOCIAL WELFARE

NATIONAL AIDS CONTROL PROGRAMME

THE HEALTH SECTOR

HIV & AIDS COMMUNICATION STRATEGY

2008 - 2015

THE HEALTH SECTOR HIV AND AIDS COMMUNICATION STRATEGY 2008-2015

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquire Immune Deficiency Syndrome
AMREF	African Medical Research Foundation
ARV	Antiretroviral
CHACC	Council HIV and AIDS Control Coordinator
CBO	Community Based Organization
CDC	Centers for Diseases Control and Prevention
CSO	Civil Society Organization
DACC	District AIDS Control Coordinator
DHS	Demographic and Health Survey
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
FHI	Family Health International
GTZ	Tanzania German Programme to Support Health
HIV:	Human Immune Deficiency Virus
IEC	Information Education and Communication
MoHSW	Ministry of Health and Social Welfare
NACP	National AIDS Control Programme
NGO	Non- Governmental Organizations
PATH	Program for Appropriate Technology in Health
PLHIV	People living with HIV
PSI	Population Services International
RACC	Regional AIDS Control Coordinator
SPW	Student Partnership Worldwide
STRADCOM	Strategic Radio Communication for Development
TACAIDS	Tanzania Commission for AIDS
TAHEA	Tanzania Home Economics Associations
THIS	Tanzania HIV/AIDS Indicator Survey
THMIS	Tanzania HIV/AIDS and Malaria Indicator Survey
T-MARC	Tanzania Marketing and Communication Company
UNDP	United Nations Development Program
USAID	United State Agency for International Development
WAMATA	Walio katika Mapambano Dhidi ya VVU/ UKIMWI Tanzania

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AKNOWLEDGEMENT

The Ministry of Health and Social Welfare, through the National AIDS Control Programme (NACP), wish to recognize and acknowledge the great support that was received from various stakeholders, towards the development of the Health Sector, HIV and AIDS Communication Strategy. The Ministry is especially grateful, to those who contributed in the development process, both technically and financially. Since it is not possible to list everyone, we wish to recognize the great contributions made by the United States Govermnet, collaborating partners, as well as, other organizations and institutions both local and international that were involved in this process.

The development of this Strategy, was precceded by a situational analysis, that was conducted in 8 regions of Tanzania Mainland, to establish a comprehensive status of communication activities on HIV and AIDS, in the health sector. The results of this analysis, played a major role in the development of the strategy. We take this opportunity, to thank the respondents and participants, from Arusha, Dar es Salaam, Dodoma, Iringa, Kigoma, Mara, Mtwara and Shinyanga, for volunterring their information.

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Dr. Deo M. Mtasiwa
Chief Medical Officer
December 2010

FOREWORD

The National response against HIV and AIDS in Tanzania, has been in place for the past twenty fives years. During this period, the health sector has played a very critical role, in creating public awareness on HIV and AIDS, as well as, in providing services for prevention, care, treatment and support.

The health sector has made extensive engagement with various players, in the HIV and AIDS response, since the beginning of the epidemic, in the early 1980's. Many of the players were involved in the information, education, and communication activities. The declaration of HIV and AIDS epidemic, as a national disaster by President Benjamin Mkapa, in 1999, called upon all Tanzanians, to intensify their efforts in prevention and control of the epidemic. The establishment of the Tanzania Commission for AIDS (TACAIDS), in 2000, institutionalized a national framework, for the coordination of the national multisectoral response, against HIV and AIDS.

During the past twenty years, the number of communicators has been growing very fast focusing mainly on health sector related HIV and AIDS interventions. The health sector interventions, include; Blood safety, STI management, HIV counseling and testing, ART access, PMTCT and Male circumcision. Most of these interventions, require procurement of equipment, supplies, drugs and other commodities, and have to be provided by trained health personnel. The promotion of these services, through various communication activities, requires an existence of a functional health care system , including a competent workforce. In view of this, the health sector has seen the need, to streamline communication activities, that promote the existing services, in order to improve the accountability of players.

Based on the results of the HIV and AIDS Communication situation analysis, that was conducted in eight regions, (Arusha, Dar-es-Salaam, Dodoma, Iringa, Kigoma, Mara, Mtwara and Shinyanga), the Ministry of Health and Social Welfare, through the National AIDS Control Programme (NACP), has identified the strengths and weaknesses, gaps, as well as, best practices, on HIV and AIDS communication, within Tanzania.This communication strategy, addresses the communication and information gaps, that were identified in the conducted situation analysis.

The Health Sector HIV and AIDS Communication Strategy, will be the blueprint for communication on prevention, care and treatment services, for the period 2008 to 2015. It is expected to improve, promote and strengthen the communication activities, among different players and stakeholders who are involved in the national response to HIV and AIDS, within the health sector.
It is our hope that, all players will utilize this strategy, in planning, implementing and evaluating HIV and AIDS Communication interventions, in Tanzania.

Blandina S. J. Nyoni
Permanent Secretary
Ministry of Health and Social Welfare
December 2010

GOALS AND GUIDING PRINCIPLES

Communication goal:
Empower individuals, families and communities at large to make informed choices to prevent further spread of new HIV infection, unintended pregnancies and promote utilization of the existing HIV and AIDS services including access to care and support through effective IEC/BCC strategies. Each strategic objective, its corresponding strategies, audience, channels, messages and activities are described in details throughout the document.

Purpose of Communication Strategy:
The Health Sector Communication strategy on HIV and AIDS provides a guide, ideas and directions to the IEC/BCC interventions at national, regional and district levels, in addressing key issues which hinder utilization of existing HIV and AIDS services. This document is also meant to be user-friendly and provide a simple framework for guiding communication activities among players.

Guiding principles:
In order to be more focused it was necessary to set a few guiding principles for effective implementation of activities. The following are the principles:

1. **Evidence Based**
   Evidence based information and data form the foundation for the communication strategy as this will direct communication interventions around HIV and AIDS aspects.

2. **Audience centered approach.**
   Communication activities should focus on specific audiences with specific messages rather than just using generic messages for the entire country. Messages must therefore be tailored to each respective audience.

3. **Focus on Behavior change, not merely giving information.**
   It is evident that knowledge alone is not enough to change one's behavior. Communication interventions should therefore focus on encouraging positive and healthy behavior change rather than just giving information.

4. **Integration and comprehensive approach.**
   Linkages between communication programmes and service delivery are central for effective communication.

5. **Community participation, empowerment and ownership.**
   Community participation is central during implementation of this strategy. A two way process between the health care workers and the community must be in place to ensure feedback is received from the community and that every community is prepared through on going consultation at every level of implementation.

6. **Use of multiple communication channels.**
   Not a single channel of communication will be sufficient to ensure that HIV information is disseminated widely. A balance must be struck between mass media, community and facility level channels. Each should be complementary to the others and mutually reinforcing in their messages.

7. **Partnerships and Coordination of all players is paramount.**
   All implementing partners must work in a coordinated manner with NACP and across one another. Communication goals and strategic objectives will be similar among all of our players and should therefore be guided by this document and its messages.

8. **Dynamic environment**
   Emerging issues, successes and challenges must be considered as they arise and inform the future direction of activities on an on-going basis. What works today in our communication may not necessarily work tomorrow. Programme implementers must keep this reality in mind while being flexible to changes in order to be more effective and result oriented.

SECTION 1

BACKGROUND

1.1 The need for a Communication Strategy to support the Health Sector HIV and AIDS interventions

The HIV and AIDS awareness/knowledge level has risen from below 5.7% in the early 1980s, to over 90% in recent years in the adult population (DHS 2004). These apparent achievements are as a result of a number of communication interventions (popularly referred to as IEC activities) which have been implemented throughout this period of the epidemic by different actors in the country. The focused communication interventions to specific vulnerable populations undoubtedly have contributed significantly to the behaviour change processes resulting in the reduction of the HIV prevalence rates over time. The government's desire is to reduce the prevalence rates to decimal levels. This can only be achieved through concerted efforts by all players through the Multisectoral response and especially through effective communication strategies by all actors.

The Tanzanian community is currently accessing HIV and AIDS information from many different sources. Occasionally some of this information demand extra services to be provided or implemented by the health sector. The services demanded, often require the government to increase its own service inputs through procurement of supplies and commodities and putting in place appropriate mechanisms for delivering the additional services which have been promoted by such partners. This is the case especially when such services or commodities are just promoted but not provided by the same organizations or institutions.

It is from this understanding that the need to develop a National Communication Strategy for HIV and AIDS in the Health Sector 2008 – 2015 in Tanzania Mainland was envisaged.
In preparation for the development for the strategy the need for understanding what is on the ground in regard to HIV and AIDS information and communication was assessed through a situation analysis study. The overall goal was to establish a comprehensive picture of the current communication practice, ranging from production of communication messages and materials to direct communication with audiences using such materials and others within the health sector.

It is this information which was used in the development of the Health Sector HIV and AIDS Communication Strategy to support implementation of the Health Sector HIV and AIDS Strategic Plan (HSHSP II) 2008 – 2012.

1.2 The Situation Analysis findings

Two main approaches were used in carrying out the situation analysis study. First, a detailed questionnaire was sent to all the organizations identified by NACP to be the main partners in HIV and AIDS communication. The questionnaire sought to elicit information about their communication practice – audiences, objectives and channels, the formulation of messages, pre testing, monitoring and evaluation. The second was a field study covering eight purposefully selected regions - Arusha, Dar es Salaam, Dodoma, Iringa, Kigoma, Mara, Mtwara, Shinyanga.

It involved in depth interviews with individuals who provide HIV and AIDS education and personal health services, as well as representatives of organizations involved in HIV and AIDS control activities. The interviews sought to elicit information about their HIV and AIDS communication practice with individuals and collectives. In depth interviews were also conducted with key informants who were selected for their affinity with the audiences of the communication interventions. These included patients seen at HIV and AIDS Care and Treatment Clinics, Politicians and Administrators at the district, and local levels, including Religious Leaders. The thrust of the interviews was to obtain some information about what people in their communities made of the HIV and AIDS messages and materials reaching them.

1.3 Highlights of the findings from the questionnaires from major Communication Partners:

Most current communication interventions target high risk groups for HIV prevention.
Other groups which are targeted include the general population, parents, influential adults, Government officials,

community and traditional leaders, health care workers, and HIV infected adults and children.
The geographical coverage of the communication interventions is varied. In some cases it is nationwide. This means that the messages can not be tailored to address audiences in specific local situations. All reporting players however reported that they did pre- test their materials extensively and covered urban and rural populations as well as age groups.

Formative research was not always used to inform the identification of the communication challenges; rather most of the players derived their communication challenges and objectives from official government documents such as the National Multisectoral Framework and the Health sector HIV and AIDS strategy. They also cited the Tanzania HIV and Malaria Indicator Survey (THMIS 2007 – 8).

All the players who responded to the questionnaire welcomed the proposed Health Sector HIV and AIDS communication strategy. They indicated that it would guide their operations and facilitate coordination and harmonization of the communication interventions of different players. They expressed frustration with the prevailing situation which is free for all to communicate messages. They expressed the view that it is a situation in which conflicting messages co-exist because not all players espouse orthodoxy in HIV and AIDS, which is confusing to the general public.

Not all the responding players monitored and evaluated their communication interventions. Fear arousal and loss – framing of messages persist but some players reported using the gain – frame for crafting messages and materials.

1.4 Highlights of the findings in interviews with frontline communicators.

The frontline communicators include health personnel working in health facilities, Regional and District AIDS Coordinators, and leaders of CBOs/NGOs working in the field of AIDS.
The main intervention areas in which these players are engaged in are as follows:

- Promotion of condom use
- Changing of cultural norms about age disparate sex
- Promotion of PMTCT
- Prevention of sexual transmission of HIV
- Prevention of HIV transmission in health care settings
- IEC activities
- Provision of material and emotional support for Home based care.

The main issues of concern for these players were:

- Stigma and discrimination
- Reluctance and opposition to using condoms
- Continued occurrence of new HIV infections
- Manifestations of incorrect use of ARVs
- Lack of involvement of men
- Low acceptance and uptake of HIV testing
- Elimination of customs and traditions associated with HIV infection

Problems and setbacks faced by the players who were interviewed included the following:

- Many people are unwilling to disclose their HIV status to their partners
- Some people are not willing to accept their positive HIV test results
- Some patients discontinue use of ARVs
- Some people want to be tested without going through counselling
- Some people on ART do not take their ARVs according to instructions

- Some people rely on traditional medicine instead of getting tested and accessing ART
- Some people do not believe that condoms provide protection against infections.
- Continued opposition to condom use due to religious beliefs and misconceptions about condoms
- Persistence of the belief that AIDS is caused by witchcraft
- Pornographic videos continue to be shown
- Persistence of erroneous belief that NGOs which are active in HIV and AIDS control are in it for money only
- Low capacity of the players to produce relevant IEC materials
- Lack of equipment and supplies, mainly transport and funds for effective performance of their activities

Most of the communicators mentioned specific materials produced by the major communicators and others as having been useful to them. They also reported of communication methods which were underutilized for disseminating HIV and AIDS messages, largely due to financial constraints and lack of expertise in their use. The methods include:

- Traditional songs and dances
- Videos
- Plays
- Group discussions and role play

Most of the players currently involved in HIV and AIDS communication field did not have any formal training in health communication and indicated that they needed to be trained. Some of them indicated specifically that they needed assistance in developing communication materials of relevance to their local situations.

1.5 Highlights of interview findings with key informants in the community

Comprised political/administrative leaders, religious leaders and persons living with HIV and AIDS (PLHIV) the findings include the following:

1.5.1 Communication messages and materials

The key informants identified communication messages and materials from which community members had learned a great deal about HIV and AIDS, organizations whose communication materials were found to be very informative and effective, as well as materials and messages which were confusing.

1.5.2 Changes that occurred in the communities

The key informants recognized many changes which have occurred in the communities, and attributed them to the HIV and AIDS communication activities. These included:

- Increased up take of the HIV testing services
- Declining numbers of deaths due to AIDS
- Declining level of stigma
- More HIV infected persons were becoming open about their status
- There was an increasing rate of condom use

1.5.3 Awareness of the presence of HIV and AIDS educators who do not practice what they teach/say

Most of the key informants were aware that some of the Educators of the HIV and AIDS did not practice what they said, and this was of concern to them.

1.6 The role of social structural and vulnerability factors

New infections appear to occur among young girls. Studies of sexual behaviour among adolescent girls show that even girls from well to do families do engage in sexual activities that expose them to the risk of HIV infection. For them poverty may not be the underlying factor. They have other needs, including satisfying sexual desire. Girls from wealthy families may desire things which are much more of sentimental/symbolic value rather than material value.

Many informants did not recognize the role of social structural and vulnerability factors associated with the HIV infections of young girls, they simply blamed the girls who get infected for their sexual behaviour.

This is also true about married women who get infected with HIV. These women were blamed for being unfaithful. This has resonance in the context of discordance where between 30 and 40 per cent of the infected couples are

couples where the female partner is the infected one. The question is why should they be unfaithful?

The common perception has been that unfaithful males are the main link between high risk groups and the general population. Lack of sexual satisfaction during conjugal sex is increasingly becoming recognized as an important factor that needs to be addressed in order for mutual faithfulness among partners to be realized.

1.7 Factors that hinder access to VCT and ART, and ART adherence

They identified factors within the heath services which hinder access to services, and factors about ARVs which impede adherence with the regimen.

The informants blamed the reluctance of some people to access counseling and testing services on cumbersome testing procedures. They were reluctant to have to go through counseling, and asked to be tested without counseling, alleging that for pre-test
counseling amounts to a rehash of what they know about HIV transmission. They also expressed concern for the apparent lack of confidentiality in the health facilities which is confounded with stigma.

Some people are put off by HIV and AIDS education which appears to arouse fear of the disease. Educators lack the capacity to be able to frame the education for behavior change in terms of the benefits rather than the costs of the behaviour.

The issue of poor adherence for the ARV regimen was taken up with the informants. Food insufficiency was ranked top. Lack of correct understanding of drug use was ranked second. Third and fourth factors were that ARVs have a difficult regimen and that they have inherent problems which result in adverse side effects for some people.

1.8 Listening to, and viewing HIV and AIDS programmes jointly with children

The situation analysis explored attitudes towards joint listening by adults and children to and viewing HIV and AIDS information, education and communication programmes on the radio and television. Most of them did not mind listening to and viewing HIV and AIDS programs jointly with their children. For some this provided an opportunity to make sure that the children paid attention and to clarify issue for them.

SECTION 2 THEMES AND STRATEGIC OBJECTIVES ADDRESSED BY THE COMMUNICATION STRATEGY

2.1 Themes: Six themes have been distilled from the Situation Analysis findings. They constitute the communication challenges that are pivotal for this communication strategy. These are:

- Theme 1: Challenges posed by the diversity of cultural and situational risk factors for high risk behaviour and HIV infection in the Tanzanian population.
- Theme 2: Challenges of promoting the use of HIV and AIDS services effectively.
- Theme 3: Challenges posed by the health workforce and their personal behaviour for HIV prevention.
- Theme 4: Challenges posed by legal and other constraints to serving and communicating with children and adolescents.
- Theme 5: Challenges of stigma and discrimination.
- Theme 6: Challenges of empowering PLHIV for positive health, Dignity and prevention

Under each of these themes are numbers of strategic objectives, as follows:

2.1.1 Theme 1: Challenges posed by the diversity of cultural and situational risk factors for high risk behaviour and HIV infection in the Tanzanian population.

2.1.1.1 Strategic objective 1.1: Efficacious HIV and AIDS communication messages developed and disseminated, targeting defined audiences and segments in particular geographic settings, and socio-cultural contexts.

2.1.1.2 Strategic objective 1.2: The capacity of NACP – IEC Unit strengthened for providing leadership and carrying out supervision of the communication process through all the stages.

2.1.1.3 Strategic objective 1.3: Motivation created among all those involved in producing and disseminating HIV and AIDS communication materials to adhere to the principles of producing efficacious communication materials and their evaluation.

2.1.1.4 Strategic Objective 1.4: The major communication partners and frontline communicators motivated and enabled to design and to implement communication campaigns that take into account the cultural context in which their audience live, and to draw on local forms of communication and expression to engage the audience.

2.1.1.5 Strategic objective 1.5: The capacity of health workers and HIV and AIDS communicators to explain to people the complex issues of risk assessment and risk reduction and to motivate them to take appropriate measures, including going for HIV testing and adhering to treatment regimen, as well as positive prevention.

2.1.2 Theme 2: Challenges of promoting the use of HIV and AIDS services effectively.

2.1.2.1 Strategic objective 2.1: Skills and performance deficits for HIV and AIDS service delivery among service providers in CTCs and VCT centres, as well as other health facilities identified and addressed.

2.1.2.2 Strategic objective 2.2: Capacity of persons on ARVs and the general population built to understand the complex science and technology of ART.

2.1.2.3 Strategic objective 2.3: Capacity built for health workers for interpersonal communication, patient education, and motivating clients to go for HIV testing and to adhere to treatment regimen, and motivation created for observance of healthcare ethics in their work.

2.1.2.4 Strategic objective 2.4: Advocacy undertaken with Local and Central Government to put in place conducive and safe working environments in health facilities, including incentives and negative sanctions to facilitate effective performance by service providers.

2.1.2.5 Strategic Objective 2.5: Utilization of VCT services (counseling and testing), uptake of ARV and adherence to the ART regimen, acceptance of management of STIs, uptake and adherence to the regimen for PMTCT, male involvement in PMTCT, and medical male circumcision promoted.

2.1.3 Theme 3: Challenges posed by the health workforce and their personal behaviour for HIV prevention.

2.1.3.1 Strategic objective 3.1:.Health workers motivated to adopt HIV preventive behaviour including HIV testing, accessing PEP if exposed, and taking ARVs where appropriate.

2.1.3.2 Strategic objective 3.2: Health workers, including AIDS educators, motivated to be role models for HIV preventive behaviour in the communities.

2.1.4 Theme 4: Challenges posed by legal and other constraints to serving and communicating with children and adolescents.

2.1.4.1 Strategic objective 4.1: Capacity built for HIV and AIDS communicators for effective communication with children and adolescents, and for health workers for providing counseling, testing and ART services to them.

2.1.4.2 Strategic objective 4.2: Advocacy for policy changes and legal reforms undertaken to facilitate recognition of the vulnerability of children and adolescents and direct targeting of children and adolescents with HIV interventions.

2.1.5 Theme 5: Challenges of stigma reduction.

2.1.5.1 Strategic objective 5.1: Community members enabled to recognize and motivated to shun stigmatizing words/speech and stigmatizing behaviour towards PLHIV, and about HIV and AIDS.

2.1.5.2 Strategic objective 5.2: PLHIV empowered to assert their human rights for association with other people and for participating in other forms of social engagements in order to make stigmatizing tendencies in the community untenable.

2.1.6 Theme 6: Challenges of empowering PLHIV for positive Health, Dignity and prevention.

2.1.6.1 Strategic objective 6.1: Positive Health, Dignity and prevention understood and voluntarily practiced though meaningful involvement of PLHIV in positive leadership, participation and advocacy

2.1.6.2 Strategic objective 6.2: Positive Health, Dignity and prevention correctly understood by health workers plicy mekers and community members.

SECTION 3 STRATEGIC OBJECTIVES AND THEIR IMPLEMENTATION

3.1 Theme 1: Challenges posed by the diversity of cultural and situational risk factors for high risk behaviour and HIV infection in the Tanzanian population.

Preamble:

- Major communication partners do not segment the target population, they ignore the epidemiological diversity of the HIV epidemic and varied socio-cultural risk profiles:
  - ❖ They cover entire country or several regions with same messages, using same materials.
  - ❖ Messages are not tailored to specific communication needs.
- Messages are generic, and cannot be expected to "move" specific segments of the audience.
- Formative research and pre-testing of messages not systematic.
- Some front line communicators have no training in communication.
- Key informants complained about incomplete or confusing messages.

3.1.1 Strategic objective 1.1: Efficacious HIV and AIDS communication messages developed and disseminated, targeting defined audiences and segments in particular geographic settings, and socio-cultural contexts.

BOX 1: EFFICACY AND EFFECTIVENESS.

The efficacy of an intervention is what is possible to achieve using a particular intervention under ideal conditions, such as the laboratory setting. Effectiveness is what is achieved in field conditions where so many things can interfere with the intervention process.

3.1.1.1 Messages Concepts:

- Using a condom during sex can be pleasurable sex, have an open mind and be creative.
- Using a condom correctly during sex is always better; it can be fun, and neither party has to worry much afterwards.
- Sexual relationship with an older man can be both materially rewarding and safe, but you should get him to act responsibly and allow you to insert a female condom if he cannot put on a male condom.
- Sex with your spouse can be hot. Don't be bound by restrictive norms of conjugal sex.
- Sex has to be mutually satisfying to both parties. Cast away your norms for conjugal sex and have hot sex together.
- Talk about it and have fun! Spouses often have sex even when both of them don't want it. Naturally such sex becomes perfunctory.
- Anal sex may be tantalizing for you and not necessarily for her; if she consents however, you need to use a condom to make it safe for her and for you.
- Multiple and concurrent sex may be exciting and pleasurable, but unfettered sex with your spouse or main partner can equally be exciting and pleasurable without the attendant hustles of the former.

BOX 2: CONFRONTING THE SEXUAL MODE OF HIV TRANSMISSION

Since the sexual mode of HIV transmission accounts for most of the HIV infection in this country the proposed communication strategy must address this factor head on, and the HIV prevention messages must be about it. Despite the epidemiological diversity of the epidemic the bottom line is that people in different social situations get infected as a result of exposure due to engaging in unprotected sex – penile vaginal and penile anal, whether between men or between men and women. This fatal sex could be with sex workers, it could be sex between older men and younger girls, sex with own spouses and regular sexual partners, and the phenomenon of discordance of sero-status between couples attests to this.

People engage in concurrent multiple partner sexual relationships for many reasons but the desire for heightened excitement and sexual pleasure are paramount. This motivation for sexual pleasure needs to be acknowledged, and people should be given the skills for making sexual relations in monogamous and faithful relationships highly pleasurable instead of being boring.

Preference for unprotected sex is often driven by the desire for deeper sexual satisfaction. Condoms and other forms of safer sex need to be eroticized, and should not be promoted simply because of their protective efficacy in relation to HIV and STI infections.

So far HIV and AIDS communication in Tanzania has been largely fettered by considerations of cultural sensitivity. This communication strategy should lead to breaking the mold. Tanzanians should not be left to succumb to infection simply because AIDS educators -both formal and informal- have to censor themselves lest they offend cultural norms of not talking about sex explicitly.
We should not be resigned to believing that we cannot change people's sexual behavior, and hence embark on HIV prevention measures which do not require change in sexual behavior, such as treating STIs which are a co-factor for HIV infection, getting men circumcised in order to reduce the chances of getting infected during sexual intercourse with an infected partner, and preventing an infected mother from infecting her child by offering PMTCT services, instead of trying to prevent her from getting infected in the first place. We now have people who prefer to engage in what they know to be high risk sexual escapades and demand to be given PEP afterwards! Unfortunately the model of emergency contraception does not apply. PEP given to prevent infection due to non-occupational exposure has been found to have serious side effects, including diabetes and liver damage.

BOX 3: SOME BASIC "SEXUAL HEALTH FACTS FOR LIFE."

- **Intergenerational sex poses higher risk for HIV infection for the younger partners.**
- **Anal sex between males and females poses higher risk for HIV infection for both partners,**
- **A woman is more likely to be infected with HIV by an infected man if they have anal sex.**
- **The presence of STIs causing ulceration or breaks in the skin (syphilis and herpes), and STIs that stimulate an immune response in the genital area (Chlamydia and gonorrhea) increase the risk of HIV infection.**
- **Alcohol consumption in anticipation of having sex with non regular partners of unknown sero-status impairs the resolve and capacity for correct use of condoms.**
- **Hurried and vigorous sexual intercourse is more likely to cause abrasions to both parties, and may facilitate HIV infection if one partner is infected.**
- **Dry sex, regardless of the mechanism used to achieve the dryness, is more likely to cause abrasions to both partners, and may facilitate HIV infection if one partner is infected.**

3.1.1.2 Audience:

Individuals and groups with clearly defined risk profiles in specific social-cultural contexts

3.1.1.3 Channels:

Multi media approaches, selected on the basis of clearly understood ability to reach and to appeal to specific audiences.

3.1.1.4 Activities:

- ❖ Review of epidemiological data to map out geographic variation in the spread of HIV.
- ❖ Identify clusters of behavioral and socio-cultural affinity.
- ❖ Organize sexuality workshops at the work place and in communities where people can attend with their partners, to make it acceptable for couples to talk about safer and pleasurable sex when they are alone.
- ❖ Sensitize cultural and moral custodians about the importance of sexual pleasure within marriage and with main partnerships and to redefine the norms for conjugal sex.

3.1.2 Strategic objective 1.2: The capacity of NACP – IEC Unit strengthened for providing leadership and carrying out supervision of the communication process through all the stages.

BOX 4: PRINCIPLES OF PRODUCING EFFICACIOUS MESSAGES.

- **Conduct formative research to understand the communication needs of the expected audience.**
- **Segment the audience and seek to understand the communication of each segment of the audience.**
- **Craft messages to target the determinants of involvement in high risk factors identified during formative research.**
- **If PR organizations or other production firms will be charged with the responsibility for producing the messages and materials, it is necessary to develop a creative brief. This defines the objective of the intended communication, and draws upon the results of the formative research about the communication needs of their audience and their circumstances , and it serves as a guide for those who will draft the scripts, design the posters, and prepare display materials. which defines the objectives**
- **Produce different versions of the messages to enable you to change the messages periodically in order to sustain the attention of the audience.**
- **Use the gain framing approach rather than fear arousal in crafting the messages.**
- **Pretest the messages with a sample of people that are similar to the target audience.**
- **Disseminate the messages through channels that are widely used by the target audience.**
- **Select dissemination channels that allow for exposition of the messages or immediate feedback are preferable to those that require a high level of media literacy to be understood.**
- **Monitor the message dissemination in order to uncover possible misunderstandings or hidden messages that become apparent.**
- **Evaluate the effects of the communication and determine factors associated with unexpectedly high or low levels of effects.**

3.1.2.1 Message:

A strong IEC Unit in the NACP is necessary for providing leadership and carrying out supervision of the communication process in all its stages.

3.1.2.3 Channels:

Briefs about the expanded role of the IEC Unit

3.1.2.1 Activities:

- ❖ Conduct advocacy wwand lobbying for allocation of additional personnel and financial resources;

- ❖ Deploy Advisory Committee members innovatively in support of the IEC Unit's role and responsibilities.

3.1.3 Strategic objective 1.3: Motivation created among all those involved in producing and disseminating HIV and AIDS communication materials to adhere to the principles of producing efficacious communication materials and their evaluation.

3.1.3.1 Messages:

- Formative research should lead to identification of the determinants of the audience's Behaviour, to be targeted by the messages.
- Avoid generic messages, tailor the messages to the communication needs of specific segments of the audience.
- The messages should be delivered in such a manner as to get the recipients to attend to them and to comprehend the content of the message.

3.1.3.2 Audience:

The major communication partners All health workers and AIDS educators who are involved in direct and indirect HIV and AIDS communication

3.1.3.3 Channels:

- Orientation Seminars
- Skills building workshops
- Fact sheets about the design and implementation of formative research, crafting of messages, and dissemination of messages, monitoring and evaluation to determine:
  - ❖ If changes in knowledge, attitudes and Behaviour were effected
  - ❖ The magnitude of the changes effected
  - ❖ If the changes can be attributed to the intervention

3.1.3.4 Activities:

- ❖ Segment their audience into meaningful subgroups to facilitate tailored messages.
- ❖ Use theory as a conceptual foundation.
- ❖ Use a design approach that is targeted to the audience segments.
- ❖ Utilize effective channels widely viewed by and persuasive for the intended audience.
- ❖ Conduct process evaluation design that reduces threats to internal validity and allows causal inferences about campaign intervention impact to be made.
- ❖ Conduct sensitization seminars and workshops,
- ❖ Conduct skills building workshops, especially for health workers involved with patient education and direct communication in health care settings and in community settings.

3.1.4 Strategic Objective 1.4: The major communication partners and frontline communicators motivated and enabled to design and to implement communication campaigns that take into account the cultural context in which their audience live, and to draw on local forms of communication and expression to engage the audience.

3.1.4.1 Messages:

- Culture per se should not be conceptualized as a problem or a barrier to behavior change, rather it should be seen as an opportunity for engagement, because no culture is static.
- If culture is a factor in transmission of HIV, it follows that prevention and care require that culture itself

be the medium of changing harmful cultural practices by engaging with the cultural meanings that people create for themselves.

- The cultural approach incorporates and engages the prevailing values, beliefs, and traditions of the audience as members of particular communities and societies and has high resonance with them.

- Culture can offer a real benefit if it is seen as an opportunity for action and engagement with communities, rather than as a barrier to HIV prevention, and use of HIV and AIDS services.

- Respect needs to be shown for different ways of seeing and living in the world, on valuing cultures, cultural expression and identity and their fundamental roles in people's lives.

3.1.4.2 Audience:

Major communication partners, Frontline communicators.

3.1.4.3 Channels:

- Radio drama, soap opera, and theatrical performances
- Songs, dance and oral testimony

3.1.4.4 Activities

- ❖ Carry out a survey in clearly demarcated cultural regions, of cultural groups, troupes, organizations and institutions which have specific roles for entertaining, performing rites of passage, including burial ceremonies.
- ❖ Commission social and cultural anthropologists endowed with cultural competence to engage with these institutions to explore for windows of opportunity for cultural transformation.
- ❖ Identify respected "culturally positive deviants" to engage with the custodians and practitioners of these rites of passage in a dialogue meant to find out how they can be transformed.
- ❖ Develop creative briefs on HIV transmission, prevention care and support to guide theatre artists, song composers to guide them in producing plays and songs that take into account the cultural context.

BOX 5: THE NEED FOR A CULTURAL APPROACH FOR HIV AND AIDS PREVENTION AND CARE.

There are four levels at which culture intersects with HIV and AIDS:

- **Culture as context factors specific to local life – beliefs, value systems, history, geography, social hierarchies, gender, faiths, and concepts of time.**
- **Culture as content languages, practices, objects, traditions, clothing, and heritage.**
- **Culture as method, the medium or cultural forms that projects will use to engage communities, e.g. drama, dance, proverbs, song, music, radio and television.**
- **Culture as expression of the intangible, creative elements of culture that connects with beliefs, values, attitudes, feelings and ways of viewing the world.**

If culture is a factor in transmission and impact, it follows that prevention and care require a cultural approach. HIV and AIDS strategies need to be viewed through a cultural lens. Such strategies must resonate with a community's sense of who it is.

Adapted from "What's culture got to do with HIV and AIDS?
Findings, No 7, February 2007
HEALTHLINK WORLDWIDE.

3.1.5 Strategic objective 1.5: The capacity of health workers and HIV and AIDS communicators to explain to people the complex issues of risk assessment and risk reduction and to motivate them to take appropriate measures, including going for HIV testing and adhering to treatment regimen, as well as positive prevention.

3.1.5.1 Messages:

- Communication is the main tool you have for enabling the people you serve to act in their own true interests.
- Failure to communicate effectively on your part should not be used to blame the people for not being able to understand and to follow your advice.

3.1.5.2 Channels:

- Print and electronic media.
- Communication skills building workshops.

3.1.5.3 Activities:

- ❖ Produce lecture notes about communication and distribute them to health workers and AIDS educators.
- ❖ Conduct communication skills building workshops.

3.2 Theme 2: Challenges of promoting the use of HIV and AIDS services effectively.

Preamble:

- Health workers do not keep abreast with developments in the HIV/AIDS field.
- Some health workers admitted to being ignorant about issues in HIV prevention, communication and AIDS management.
- Non adherence to ARV regimen wrongly attributed to the carelessness of those taking ARV.
- The complexity of the ARV regimen not appreciated by health workers and PLHIVs as a factor contributing to non adherence.
- Censorial attitudes by health workers towards patients with STIs and HIV.
- Lack of confidentiality in the health services.
- Cumbersome procedures and established routines for accessing health services put some people off, and they turn to drug stores and free standing private laboratories as well as traditional and faith-healers.

3.2.1 Strategic objective 2.1: Skills and performance deficits for HIV and AIDS service delivery among service providers in CTCs and VCT centres, as well as other health facilities identified and addressed.

3.2.1.1 Messages:

- You may have genuine grievances about your working conditions and remuneration, but you should not let these concerns lead you to providing poor quality services.
- It is counterproductive for clients and patients to be mobilized to seek some service only to find that service providers are not ready to provide the service.
- HIV and AIDS have subtle impacts, on the mental frame of PLHIV, particularly when they face stigma and discrimination in the community on a daily basis; they may fail to treat you with respect; but you still have to talk to them with empathy.
- The HIV/AIDS field is a rapidly changing field; you need to keep abreast with developments in the field in order to continue providing acceptable quality care.

3.2.1.2 Channels:

- Meetings
- Electronic and print media

3.2.1.3 Activities:

- ❖ Develop and produce Print and electronic materials
- ❖ Disseminate Print and electronic materials
- ❖ Conduct seminars/workshop for Health workers
- ❖ Design checklists for, and conduct supportive supervision.
- ❖ Design a range of incentives and negative sanctions to reinforce proper conduct of service providers.

BOX 6: THE COMPLEXITY OF THE LIFE-LONG TREATMENT WITH THEARV REGIMEN:

We are where we are in ART and ART delivery thanks to the concerted activism of People Living with HIV Worldwide – both in the form of advocacy and demonstrations against Government authorities as well as violent confrontations with scientists. A lot of work still needs to be done in coming up with user friendly formulations of ARVs.

Here at home our own medical scientists and health authorities could do more by trying to fit this complex drug in our largely illiterate cultures dominated by traditional and fatalistic beliefs and attitudes. They could remove cumbersome procedures in accessing ARVs, and redefine the eligibility criteria.

In this strategy the focus is on people taking ARVs, the general population and health workers. We are calling for capacity building for those on ARVs and those around them to understand the complex nature of the drugs and the regimen, and not to blame themselves if they find that they cannot cope, and for those around them to support them morally and materially in this life long undertaking.

We are asking health workers to be more sympathetic with the plight of those who are taking ARVs rather than blaming them for poor adherence, and to enable those who cannot wait to become eligible for ARV to be more realistic not only of the health improvements which ARVs can provide but also of what it means to be on ARVs.

The benefits of ART to patients and their families are enormous, even if long term treatment cannot be guaranteed. Patients should not start taking ARVs only to be left to stop simply because they cannot cope with the complex regimen. Some need a great deal of social support, including food supply to be able to adhere to the regimen.

3.2.2 Strategic objective 2.2: Capacity of persons on ARVs and the general population built to understand the complex science and technology of ART.

3.2.2.1 Messages:

- It is not your fault if you have problems taking ARVs correctly.
- Improvement for those on ART is for all intents and purposes a cure, but stopping to take the drug can be disastrous.
- All medicines are poisons, but ARVs are much more so. Take them only as directed.

3.2.2.2 Audience:

- Persons on ART
- The general population.
- Policy Makers

3.2.2.3 Channels:

- Print and electronic media,
- Group meetings,
- Interpersonal communication.

3.2.2.4 Activities:

- ❖ Compile a list of frequently asked questions about ART
- ❖ Compile a list of reasons patients give for poor adherence
- ❖ Identify policies and practices concerning ART that need to be changed
- ❖ Production of direct communication material
- ❖ Implement direct communication with audiences.

3.2.3 Strategic objective 2.3: Capacity built for health workers for interpersonal communication, patient education, and motivating clients to go for HIV testing and to adhere to treatment regimen, and motivation created for observance of healthcare ethics in their work.

3.2.3.1 Messages:

- Communication is the main tool you have for enabling the people you serve to act in their own true interests.
- Failure to communicate effectively on your part should not be used to blame the people for not being able to understand and to follow your advice.
- How you relate to clients may pose a barrier to utilization of services,
- Some set procedures for service provision may pose barriers to utilization of services,
- Breach of confidentiality is unethical, and poses barriers to utilization of services.
- When patients open up to you, both physically and verbally don't let them down. If you keep what you see and hear in strict confidence you will earn their respect and trust.
- Can your patients explain correctly to their loved ones what you taught them about their condition and their medication? You need to do better.

3.2.3.2 Audience:

- Service providers
- Supervisors

3.2.3.3 Channels:

- Print materials
- Skills building workshops
- Orientation seminars

3.2.3.4 Activities:

- ❖ Conduct skills building workshops for service providers on interpersonal communication and patient education.
- ❖ Conduct orientation seminars for service providers on health care ethics.
- ❖ Conduct orientation seminars for supervisors to carry out supportive supervision encompassing interpersonal communication and observance of health care ethics
- ❖ Develop a plan for the continuing education and provision of updates in HIV and AIDS communication
- ❖ Arrange with Institutions of Higher Learning to design and offer courses in Health Communication at different levels.

3.2.4 Strategic objective 2.4: Advocacy undertaken with Local and Central Government to put in place conducive and safe working environments in health facilities, including incentives and negative sanctions to facilitate effective performance by service providers.

3.2.4.1 Messages:

- Not all service providers are health professionals who are trained for self regulation and independent action; they need supportive supervision, and sometimes negative sanctions may have to be applied to get them to perform in accordance with their training.

3.2.4.2 Audience:

- Health authorities.

3.2.4.3 Channels:

- Briefs about factors associated with delivery of poor quality care and breach of health care ethics. Patient satisfaction research reports.

3.2.4.4 Activities:

❖ Conduct advocacy and lobbying, using the briefs and patient satisfaction reports with health authorities to allocate sufficient funds for supportive supervision, and to take appropriate measures when complaints are received from clients and patients about a health facility, a department, or individual health workers.

3.2.5 Strategic Objective 2.5: Utilization of VCT services (counseling and testing), uptake of ARV and adherence to the ART regimen, acceptance of management of STIs, uptake and adherence to the regimen for PMTCT, male involvement in PMTCT, and medical male circumcision promoted.

3.2.5.1 Messages:

(i) VCT:

- Getting to know your own HIV status through HIV testing is a major responsibility and service you owe yourself, as it allows to make realistic plans for your life, and the choices you make to protect yourself.
- Do not make assumptions about your HIV status by making reference to the HIV status of sexual contacts; the phenomenon of discordance is real.

(ii) ARV:

- There are eligibility criteria for getting ARV, seek the advice of your CTC doctor or nurse about getting ARVs.
- ARVs are very portent medicines, take them as directed.

(iii) STIs:

- Self medication for any type of STIs can be dangerous. Consult a medical practitioner who will examine the condition, identify the type of STIs you have and prescribe the appropriate medication for you.
- If you have to buy your medicine for STIs make sure you buy enough medicine for the full course of medication, and don't stop taking the medicines simply because the symptoms have subsided.

(iv) PMTCT:

- PMTCT services make it possible for an HIV infected mother not to infect her unborn child.
- It is incumbent upon the spouse or partner of the infected mother to understand the full range of PMTCT services and to support her in implementing the PMTCT strategies.

(v) Medical Male Circumcision:

- Getting circumcised reduces drastically the chance of getting infected during sexual intercourse, go for it as an additional package for HIV prevention.
- Make Circumcision has many other health benefits for you and your partner.

3.2.5.2 Audience:

- Community members

3.2.5.3 Channels:

- Print and electronic media, especially leaflets, mass rallies, edutainment.

3.2.5.4 Activities:

- ❖ Compile a list of reasons put up for not using these services in specific socio- cultural contexts.
- ❖ Craft messages to debunk the reasons for not using the services.
- ❖ Disseminate the messages.

3.3 Theme 3: Challenges posed by the health workforce and their personal behaviour for HIV prevention.

Preamble:

- Inability of the health workforce to become role models of HIV preventive behaviour undermines their credibility as HIV and AIDS educators.
- The health workforce not consistently practicing universal precaution principles in the workplace, and not readily accessing PEP, VCT, and ART services.

3.3.1 Strategic objective 3.1:. Health workers motivated to adopt HIV preventive behaviour including HIV testing, accessing PEP if exposed, and taking ARVs where appropriate.

3.3.1.1 Messages:

- You are at double risk of HIV infection at work and in the community.
- Get tested for HIV infection to know your status.
- Do not discriminate infected patients you serve because the risk of getting infected is extremely low if you follow universal health care precautions.
- The main risk of HIV infection is through accidental needle stick injuries, particularly if the injury is deep, is made with hollow bore needle, and the source patient has high viral load.
- Avoid having unprotected sex with partners of unknown HIV serostatus.

3.3.1.2 Audience:

- Health workers.

3.3.1.3 Channels:

- Print and electronic materials, Seminars.

3.3.1.4 Activities:

- ❖ Develop and produce Print and electronic materials
- ❖ Disseminate Print and electronic materials
- ❖ Conduct seminars/workshop for Health workers.

3.3.2 Strategic objective 3.2: Health workers, including AIDS educators, motivated to be role models for HIV preventive behaviour in the communities.

3.3.2.1 Messages:

- Actions speak louder than words
- Your audience expects you to set an example of health behaviour
- You lose credibility as an educator if members of the audience find out that you do not practice what you tell them.

3.3.2.2 Audience:

- Health workers
- HIV and AIDS Educators

3.3.2.3 Channels:

- Print and electronic materials and Seminars

3.3.2.4 Activities:

- ❖ Develop and produce Print and electronic materials
- ❖ Disseminate Print and electronic materials
- ❖ Conduct seminars/workshop for Health workers.

3.4 Theme 4: Challenges posed by legal and other constraints to serving and communicating with children and adolescents.

Preamble:

- Some health service providers claim they are not trained to provide VCT and ART services to children and adolescents who are legal minors.
  - ❖ They cannot give informed consent.
- Own infection status or of parents/guardians infection status not disclosed to children and adolescents.
  - ❖ Some children/adolescents take ARV without knowing that they live with HIV.
- Children and adolescents not targeted with appropriate messages crafted and packaged to appeal to them to facilitate formation of preventive behaviour and behaviour change

3.4.1 Strategic objective 4.1: Awareness created for HIV and AIDS communicators for effective communication with children and adolescents, and for health workers for providing counseling, testing and ART services to them.

3.4.1.1 Messages:

- Break the culture of silence, talk to children and adolescents about HIV and AIDS.
- It is not right for children living with HIV to be on ART and not be told about their HIV status, especially when they don't feel that there is something wrong with them.
- Give correct and complete information about HIV and AIDS to children and adolescents, especially those who are infected.
- Children should not assume that their mothers who infected them, or their parents who succumbed to HIV and AIDS must have been infected through sexual promiscuity, and have to be embarrassed about it.
- Encourage children to report any undue attention, including inappropriate touching, and words of endearment from older people; such behaviour could be the precursors of child sexual abuse, and subsequent exposure to HIV infection.
- Children and adolescents are legal minors, but this does not mean that they should be tested without knowing what is going on, and least of all, be put on ART without their HIV status being disclosed to them.
- Do not tell other school children about the HIV status of a particular child or of the child's parents because playing with that child does not pose any risk of infection for them.

3.4.1.2 Audience:

- Health workers,
- Parents and guardians,
- school teachers.

3.4.1.3 Channels:

- Print and electronic media, in particular comical and cartoons.

3.4.1.4 Activities:

- ❖ Develop messages and materials.
- ❖ Disseminate the materials to health workers, parents and guardians, school teachers.
- ❖ Conduct workshops with health workers and teachers.
- ❖ Arrange for briefing about the legal aspects of providing care to legal minors.

3.4.2 Strategic objective 4.2: Advocacy for policy changes and legal reforms undertaken to facilitate recognition of the vulnerability of children and adolescents and direct targeting of children and adolescents with HIV interventions.

3.4.2.1 Messages:

- South Africa has done it; they have a heavy Child AIDS burden, and so have we; we can also put in place a mechanism for treating our infected children ethically?

3.4.2.2 Audience:

- Policy makers and legislators.

3.4.2.3 Activities:

- ❖ Compile cases of unfair treatment of children who are infected, and of the implications of children not being allowed by health workers and their parents to know their HIV status while taking ARVs.
- ❖ Use the cases to advocate for reforms
- ❖ Lobby policy makers in the Health Sector, Ministry of Gender and Children, Legislators.

3.5 Theme 5: Challenges of stigma reduction.

Preamble:

- Stigma still constrains access to VCT and ART services.
- Stigma still constrains disclosure of infection status to sexual partners and significant others.
- Stigma and discrimination contribute to the plight of PLHIV in the community and within the health services.

3.5.1 Strategic objective 5.1: Community members enabled to recognize and motivated to shun stigmatizing words/speech and stigmatizing behaviour towards PLHIV, and about HIV and AIDS.

3.5.1.1 Messages:

- If you know the basic facts about HIV and AIDS you will not be afraid of the information the you got infected through casual contacts with an infected person.
- PLHIV did not necessarily get infected by engaging in immoral behaviour or improper sex.
- Gossip, name calling and voyeurism make PLHIV face social isolation from family, friends and the community. Desist from such behaviour.
- Your words and actions may be stigmatizing.
- Getting infected is not necessarily the responsibility of PLHIV, the sexual encounter may have been with a spouse, it might have been coerced, and some may have been raped.

3.5.1.2 Audience:

- Community members

3.5.1.3 Channels:

- Print and electronic media
- Group meetings in the community

3.5.1.4 Activities:

- ❖ Compile a list of stigmatizing words and actions in the community.
- ❖ Organize group meetings in the community.
- ❖ Invite PLHIV to give personal testimonies of the stigma they face.
- ❖ Invite local artists to compose songs and plays to be performed during community meetings, or to be shown as video, or to be aired in local FM Radio Stations and TV stations.

BOX 7: ESSENTIAL KNOWLEDGE TO EMPOWER PEOPLE NOT TO STIGMATIZE THOSE WHO ARE INFECTED WITH HIV:

- **HIV is not a contagious disease; one cannot get infected by having purely social contacts with an infected person;**
- **Getting infected during sexual intercourse with an infected person is more likely when she or he has a high viral load, such as very early in the progression of the disease or during the AIDS disease period;**
- **There are therefore specific circumstances in which HIV can be transmitted through blood sperms or virginal fluid;**
- **If a person gets infected the disease progresses slowly through different stages, and she or he is potentially infectious at all these stages;**
- **A person who gets infected can live for a very long time before the signs and symptoms of the disease become noticeable and he/she can infect other sexual contacts during this period;**
- **HIV infection cannot be acquired through ordinary social contacts;**
- **A mother can transmit HIV infection to the unborn child in the womb or to the baby during the birth process, or through breast feeding; but the chances of such a mother infecting her child is reduced considerably by accessing PMTCT services;**
- **There is a difference between HIV and AIDS; you can identify a person who has AIDS by looking but not someone who has HIV;**
- **One needs to take the HIV test to find for sure about one's infection status;**
- **The HIV test does not show the virus in the same way that a malaria test shows the parasites;**
- **Negative HIV test results do not necessarily mean that there is no infection, and hence the need to repeat the test after a prescribed time period;**
- **ARVs do not clear the virus from the body, but can boost immunity and reduce the viral load substantially.**

BOX 8: NON-DISCLOSURE, DISCORDANCE AND HIV TRANSMISSION

A spouse or partner may have legitimate fears about the consequences of disclosing her or his HIV positive status to the partner. This couple may therefore continue to engage in unprotected sex, thereby putting the uninfected partner at the real risk of getting infected. Where there has been no disclosure by the infected partner the uninfected partner or the partner with unknown HIV status may not be motivated to get tested in order to establish their own HIV infection status. He or she may therefore not be in position to protect him- or herself from getting infected. The possibility of one member being infected while the other one is not –the situation of discordance of infection status among the partners - may also not be recognized. Disclosure of positive HIV status by an infected spouse to the partner is thus a prerequisite for the couple taking specific measures for the protection of the uninfected partner.

3.5.2.1 Messages:

- The main cause of stigma is incomplete knowledge, fear of AIDS and death; since you know much more about HIV and AIDS, you should educate members of your family, friends and community members about it.
- PLHIV are stigmatized for their perceived immoral behaviour and improper sex. Tell your family members, friends and community members that you did not do any immoral behaviour or engage in improper sex.
- You should resist stigma and discrimination, and you should not accept the norms and values that label you as having negative differences, do not accept that you deserve to be treated poorly and unequally.
- Point out the stigmatizing words and actions about the disease or about you yourself, because some people may not be aware of their stigmatizing actions.
- Be assertive and insist on your human and legal rights being upheld, and be prepared to press charges who deliberately call you names or discriminate you in any way.
- Disclose your sero-status as soon as you find out that you are infected, don't wait to do so until the signs and symptoms of the disease become visible.

3.5.2.2 Audience:

- PLHIV

3.5.2.3 Channels:

- Meetings and workshops
- Print and electronic media

3.5.2.4 Activities:

- ❖ Organize assertive skills building workshops and sensitization meetings about human and legal rights of PLHIV
- ❖ Disseminate information about prevalent forms of stigma and discrimination, and successful measures which PLHIV elsewhere have used to fight against stigma and discrimination.

3.6 Theme 6: Challenges of empowering PLHIV for positive Health, Dignity and prevention.

Preamble: PLHIV are under pressure from health workers and members of society to live lives of piety - presumed to be positive prevention.

- Health workers and community members deny them their human right to privacy.
- Some PLHIV blamed for spreading HIV infection deliberately.
- Some PLHIV do not appreciate that positive prevention is beneficial to them.
- Non adherence to ARV regimen wrongly attributed to the carelessness of those taking ARV.
- The complexity of the ARV regimen not appreciated by health workers and PLHIVs as a factor contributing to non adherence.

3.6.1 **Strategic objective 6.1:** Positive prevention understood and voluntarily practiced by PLHIV as a liberating and assertive factor.

3.6.1.1 Messages:

- Everybody lives by faith, do not burry yourself in misery, life continues and you have the right to live it to the full as long as your body can take it.
- Do not take stigmatizing speech and behaviour from those around you while lying down; speak out, and press charges for stigmatization and discrimination.
- Do not give people around you any opportunity to discriminate you. Do not do anything that might be construed as your effort to infect others deliberately.
  Your health and well being comes first. Avoid the possibility of re-infection with other strains of the HIV.
- If you can, disclose your HIV status to those around you. You will be in a better position to fend off any moves to engage you in high risk behaviour.
- Avoid using your infection status as a ploy to elicit sympathy and to obtain charitable assistance.

- For sure the HIV infection did not start with you, and obviously you got from somewhere or from someone, but this is no excuse for exposing your unsuspecting contacts to the infection. Be a force for curbing the spread of the infection rather than a vehicle for its source.

3.6.1.2 Audience:

- PLHIV, health providers and policy makers

3.6.1.3 Channels:

- Print and electronic media
- Interpersonal communication and patient education with PLHIV

3.6.1.4 Activities:

- ❖ Compile and disseminate stories or biographical sketches of PLHIV who have managed to come out and about their testimonies.
- ❖ Conduct public viewing of interviews and testimonies of PLHIV who have suffered from and survived the stigmatization and discrimination in their communities.
- ❖ Conduct skills building workshops on assertiveness and negotiation necessary for upholding one's legal and human rights for groups of PLHIV

3.6.2 Strategic objective 6.2: Positive prevention correctly understood by health workers and community members.

3.6.2.1 Messages:

- Positive prevention does not mean some form of quarantine imposed on PLHIV.
- Every body is supposed to do every thing in moderation, not just PLHIV.
- PLHIV should be left alone to make informed choices about the lifestyle they wish to pursue; they should not be coerced to be abstinent or to be teetotalers.
- PLHIV have the right to privacy; their HIV status should not be made public glibly, and neither should they be coerced to disclose their status to the public.
- HIV status is no harbinger of imminent death, and PLHIV should not be coerced into devout religious observance, and neither should such religious observance be made a condition for obtaining some forms of assistance.
- PLHIV should not expose themselves to re-infection with other strains of HIV by engaging in unsafe sex.
- PLHIV should disclose their status to prospective sexual contacts so that they can, in turn, make informed choice to have sex or not, give consent if they so wish, and protect themselves by engaging in safer sex practices.

3.6.2.2 Audience:

- Health workers,
- AIDS educators, and community members.

3.6.2.3 Channels:

- Workshop with health workers about health care ethics
- Print and electronic media

3.6.2.4 Activities:

- ❖ Compile a list of the injunctions PLHIV receive from health workers and other concerned people as to how they should live their lives, and the significance of those injunctions.
- ❖ Produce messages and materials to debunk the injunctions.
- ❖ Disseminate the material widely in the community.

SECTION 4

CROSS CUTTING CHALLENGES

4.1 Challenge A: Addressing Multiple and Concurrent Sexual Partnerships (MCP).

Preamble: Understanding why people have multiple and concurrent or overlapping sexual partnerships is key to efforts to change behavior.

4.1.1 Messages should address the following factors which are associated with MCP:

- Women and men cite dissatisfaction with their primary partnerships, sexually and otherwise;
- Dissatisfaction is attributed to lack of communication and romance.
- Confounders include partner's lack of skills in love making, monotony, domestic discord, and desire for variety in partnerships, and sexual practices.
- The economic factor for women is important though not paramount.
- For some women/men MCP constitute insurance against loss of one's main partner.
- MCP may be a strategy to find the "right" partner.
- MCP may be revenge in response to the infidelity -proven or presumed- by one's main partner.
- For some women involvement in MCP is fueled by the perception that modernity allows for freedom to behave like men by having multiple partners.
- MCP is facilitated by a culture that allows polygamy and promotes the belief that men's sexual drives reflects prowess.

4.1.2 Messages should also capitalize on the following positive aspects:

- Many people realize that having getting involved in MCP is risky for infection with HIV and STI.
- To discourage involvement in MCP it may be counterproductive to accuse the partner of infidelity, rather one should invoke the importance of protecting the family against HIV and against leaving children as orphans.

4.2 Challenge B: Addressing Age Disparate Sexual Partnerships.

Preamble: Education given to adolescents and young women should not be limited to prevention of HIV, STIs and pregnancy; it should also address the positive aspects of sex, in particular mutually pleasurable sex with a loving partner.

4.2.1 Messages should address the following factors that are associated with relationships with older men:

- Older men are preferred because of their economic ability to give substantial presents.
- Relationships with older men are asymmetrical with the young women lacking or having less power to negotiate for safer sex.
- Having unprotected sex with older men carries higher risk for HIV infection due to the much longer history of sexual activity and extensive sexual network of the man.
- The higher HIV prevalence among young women in Tanzania and other sub Saharan African countries compared to that among young men implies that young women get infected by older men, and they in turn infect the young men.

4.3 Challenge C: Addressing Commercial Sex.

Preamble: A distinction should be made between women who choose prostitution/sex work as a means to achieving some social and economic goals and those who are forced into it by drugs or lack of support to meet the necessities of daily living; not every commercial sex worker wishes to be rescued.

4.3.1 Messages should address the following factors associated with commercial sex work:

- Commercial sex workers (CSWs) should not simply be seen as a vectors for HIV and STIs, they are also at risk of being infected by HIV and STIs.
- CSWs and their clients both wish to avoid contracting HIV and STIs.
- CSWs may also have emotional partners and lovers whom they may wish to protect from infection.
- CSWs may neglect sexual health considerations if they need money urgently, or if clients entice them by offering higher pay for unprotected sex.
- There may be intense competition between csws for clients, making demands for unprotected sex by clients –vaginal and anal- more likely to be met.
- Clients or CSWs may be drunk or may not care about their own sexual health or that of others and not insist on safer sex.

4.3.2 Messages should also capitalize on the following positive aspect:

- Commercial sex transactions involve negotiation about price and other arrangements, and this provides an ideal time to negotiate about safer sex.
- The need for safe sex is more likely to be accepted by clients and csws because both parties acknowledge they have sex with other partners.

4.4 Challenge D: Addressing sex between men (MSM).

Preamble: Quitting having sex with fellow men may not be a realistic choice for every one because sexual orientation is not purely a matter of learning and neither is it driven purely by lack of opportunities for sex with women.

4.4.1 Messages should take into account the following factors:

- Condoms also provide protection against infection with HIV and STIs during sexual intercourse with fellow men.
- The receptive partner is at higher risk for HIV infection than the insertive partner.
- Men who have sex with men may also enjoy other forms of non-penetrative sex.

4.5 Challenge E: Addressing Intravenous Drug Use.

Preamble: It easier to prevent exposure to drugs than it is to get people off drugs.

4.5.1 Advocacy should focus on:

- Getting members of society to accept the reality of drug use among the youth, and that even their own loved ones may be at risk of getting into drugs
- Getting the Police and other law enforcement authorities to crack down on both the small distributors and the drug barons;
- Getting health authorities to institute harm reduction measures for those who are already addicted to drugs.

4.6 Challenge F: Addressing the vulnerability of People with Disabilities.

Preamble: People with disabilities are at varying levels of risk for HIV infection because some of them are difficult to target with HIV/AIDS education by virtue of the nature of their disabilities and lack of methods for communicating with them, while others may be perceived as safe sexual partners who are less likely to be infected because many people stigmatize them and do not see them as desirable sexual partners.

4.6.1 Advocacy should focus on:

- Getting the special schools for people with disabilities to mainstream HIV and AIDS education in their curricula;
- Getting members of the general society to protect people with disabilities from those who may wish to exploit them sexually.

- Building capacity among health workers and AIDS educators for communicating with people with disabilities.

4.7 Challenge G: Promoting Safer Sex, including Condom Use.

Preamble: For many people different forms of non-penetrative sex constitute foreplay. They are not alternatives to penetrative sex. Furthermore, use of condoms does not fit in their perception of pleasurable sex.

4.7.1 Messages and advocacy should focus on:

- Creating the association in the mind of men and women between condom use with responsible behavior.
- Ensuring the availability of a wide range of condoms, in terms of thickness, width, length, colour, aroma and lubrication to cater for different concerns and needs among prospective male condom users.
- Ensuring the availability of affordable female condoms.
- Non penetrative sex such as intercrural sex and mutual masturbation can be pleasurable and lead to orgasm.
- Dispelling myths about masturbation and promoting the practice as the safest form of sex, especially if it does not involve shared gadgets.
- For some people masturbation is the only safe sex.

SECTION 5 ISSUES REQUIRING POLICY RESPONSES

Both during field work for the situation analysis and in the two consultative workshops concern was expressed about the under mentioned issues. Many hold the Government to be responsible for ensuring that no one's health should be sacrificed for the political expedience of a liberalized drug market and democratic dispensation, because not everybody is in position to distinguish between fact and opinion.

5.1 Issue No. 1: Free for all HIV and AIDS communication.

There are so many conflicting messages which reach the people, and confuse the people. Some of them are driven by religious motives, and other by greed or the profit motive. While health communication can enable people to make informed choice, this may be confounded by the perceived credibility of the communicators. Furthermore, not everybody accepts science as the last authority in these matters.

5.2 Issue No. 2: Advertising by Traditional Healers, and claims by Faith Healers.

Granted that some traditional healers have proven remedies for opportunistic infections that immune comprised individuals succumb to, including those with herbs which actually boost the immunity of PLHIV, akin to ARVs, many respondents and workshop participants found the claims which some traditional healers make to be totally unacceptable and liable to mislead those who have taken ARVs because they promise complete recovery. Faith Healers on their part promise instant healing from AIDS and admonish those who go for such miracle cures to abandon ARVs, warning that continued medication with ARVs amounts to lack of faith.

5.3 Issue No.3: Self medication with over the counter drugs, including antibiotics, for treating STIs.

People with STIs may have genuine concerns about the sensitive nature of their ailments, and the tendency to be treated shoddily by the health personnel, and hence the tendency to avoid seeking proper medical care and going to buy over the counter medicines including antibiotics from pharmacies and drug stores. There may be a financial disincentive of having to pay for medical consultation and for laboratory investigations. Health communication can help such people to appreciate the advantages of seeking proper medical care, or to ensure that they purchase and take the entire dose, and not just what they can afford but many respondents and workshop participants expressed the view that such education should be reinforced by a policy or an enforceable law that criminalizes this form of self medication. The alternative would be to provide training for diagnosis and prescription in pharmacy courses of all levels and to legitimize such practice by pharmacist and drug vendors, although this would have to contend with the profit motive of selling to the customer the amount of drugs he or she can afford, knowing very well that she or he may not come back for the remainder of the dose. The bottom line is that many would wish to see zero tolerance for the purchase of non-prescribed medication for STIs.

SECTION 6

IMPLEMENTATION FRAMEWORK

6.1 Introduction

Implementation framework is a pre- requisite for the effective implementation of a strategic plan since it spells out clearly the roles and responsibilities of persons/institutions during the period of execution.

Good governance is also a key element for successful implementation of planned activities at all levels. Good Governance which simply means the process of decision making and the process by which decisions are being implemented (or not implemented) is essential in the implementation of any Strategic plan.

Participation of men and women that include disabled people is a key cornerstone of good governance. Participation could be either direct or through legitimate intermediate institutions or representatives.

Accountability is another key requirement of good governance not only in the governmental institutions but also in the Non-governmental institutions as well as the Private sector and the Civil Society Organizations
Good governance has eight major characteristics: It is participatory, consensus oriented, accountable, transparent, responsive, effective and efficient, equitable and inclusive and follows the rule of law. It ensures that corruption is minimized, the views of minorities are taken into account and that the voices of the most vulnerable in the society are heard in decision-making. It is also responsive to the present and future needs of society.

6.2 Roles and Responsibilities in implementing the strategic plan at different levels:

6.2.1 National Level: The MOHSW and NACP Roles

- **Leadership roles:**
  The NACP will play a role of leadership by negotiating and directing partners with comparative advantages for taking a lead role in implementing specific strategic objectives of the Communication Strategy.

  NACP will play a role of coordination by working with partners who will prepare and submit Actions Plans of the activities to be implemented (Planned activities will include outputs, process indicators and monitoring process)

  NACP will play a role of informing the recipients about the communication materials produced by NACP and those produced by partners through print and electronic media.
  NACP will play the role of liaising and informing TACAIDS on communication interventions that are being implemented in the country.

6.2.2 National Level: The MOHSW and NACP Responsibilities:

- Sharing and reporting to TACAIDS
  NACP has the responsibility of sharing with TACAIDS the final Communication strategy. NACP is required to report, on yearly basis, the progress of the implementation of the Communication strategic plan

- **Formulation of policy guidelines**
  The NACP has the responsibility of formulating policy guidelines that will assist all partners to develop quality communication messages. This will be executed in collaboration with all partners who are involved in developing and disseminating HIV and AIDS messages

- **Capacity building.**
  NACP has the responsibility of building the capacity of RACCs, DACC, RCHACCs, CHACCs, service

providers and Partners dealing with HIV and AIDS Communication interventions. This will assist all stakeholders in HIV and AIDS Communication to have special skills in developing and delivering quality materials/messages that will influence behaviour change. To enhance the capacity building and subsequently have good results, cascade process will be used: NACP will train first the RACCs and selected Communication Partners in HIV and AIDS at the regional level. The RACCs and selected Communication Partners in HIV and AIDS will be given the responsibility of being the regional TOTs in their respective regions. For each region the TOTs will train all DACCs, CHACCS and all Communication Partners in HIV and AIDS who are working at the district level including service providers offering services at all health facilities (government, FBOs and Private Health facilities

The DACCs, CHACCs and Communication Partners in HIV and AIDS at district level will build the capacity of Ward and Village Health committees' members, Multi-sectoral AIDS Committees' at Ward and Village levels as well as the community members themselves (selected groups eg. Community representatives).

Staff who were trained in Communication skills at Iringa Institute will be incorporated in this program as TOTs at regional and district levels after a short refresher course

- **Monitoring messages developed by NACP**

  The NACP will follow up at the regional and district levels the materials sent to ensure that they are being disseminated, distributed and used as planned

  RACCs and DACCs are required to write a report (Quarterly Report) on material received, sent and disseminated to the respective districts by indicating where the materials were sent and disseminated as well as reporting on the persons who received the materials sent. An annual report will be written and sent to NACP describing if there is any behaviour change observed following communication interventions

- **Monitoring materials developed by partners**

  The NACP will follow up very closely the messages developed by partners by revising them with Partners before they are sent to the regions and districts. RACCs, and DACCs will assist the NACP to follow up materials distributed by partners and will report accordingly to the NACP

- **Monitoring organizational efficiency**

  NACP will monitor closely the efficiency of partner organizations that deal with the development of HIV and AIDS communication materials/messages.

  Important issues that the NACP will be monitoring are as follow:

- The effectiveness of the messages to influence the change of behaviour.
- The ability of sensitizing a large number of population especially those who live in the rural areas

  Feed back from NACP to the partners as well as to the RACCs and CHACCs is essential in order to keep them motivated and thus enhance the continuation of reporting to NACP

6.2.3 Regional level

6.2.3.1 Roles and Responsibilities of the Regional Commissioner, Regional Administrative Secretary, Regional Medical Officer

- Leadership roles:

  The Regional Commissioner provides the overall political support for the implementation of HIV and AIDS while the Regional Administrative Secretary (RAS) provides the leadership of programs that are being executed in the region .

  The Regional Medical Officer (RMO) provides Technical leadership on issues relating to health in the region.

- Regional Responsibilities:

  The Regional Medical Officer has the responsibility of providing supportive supervision to all districts in the region. He also reviews and consolidates districts plans and budget for onward submission to MOHSW (NACP). The Regional AIDS Control Coordinator (RACC) is the overall HIV and AIDS Program manager

in the region. He coordinates and manage the Program at the regional level. He is also involved in planning and budgeting for activities that will be implemented in the region.

- **Monitoring messages developed by NACP/partners**

  The Regional AIDS Control Coordinator (RACC) will follow up very closely the dissemination of messages developed by partners as well as those developed by the NACP. The RACC will be obliged to report to NACP the outcome of the dissemination of the messages

  •RACCs will follow up at the district level the materials sent to ensure that they are being distributed and used as planned

  •RACCs will be obliged to report on material received and disseminated to the districts (quarterly basis), and eventually the report should be sent to the NACP and to the Regional Medical Officer by indicating where the materials were distributed and disseminated as well as reporting on the persons who received the materials sent

- Monitoring organizational efficiency
  RACC will monitor closely the efficiency of partner organizations that deal with the development of HIV and AIDS communication materials/messages at regional level.

  Important issues that the RACC be monitoring is:
  • The effectiveness of the messages to influence the change of behaviour.
  • The ability of sensitizing a large number of population especially those who live in the rural areas
  • RACC will provide feed back to the partners as well as to the RHMT members in order to keep them motivated and thus enhance the continuation of sending the report to him

6.2.4 District level

6.2.4.1 Roles: District Commissioner, District Administrative Secretary, District Medical Officer, District Executive Director

- Leadership roles:
  The District Commissioner provides the overall political support for the implementation of HIV and AIDS at the District level. The District Executive Director (DED) provides the overall direction of all programs in the District level The District Medical Officer (DMO) provides Technical leadership on issues relating to health at the District level

- District Responsibilities:
  The District Medical Officer (DMO) with his team: The Council Health Management Team (CHMT) provides supportive supervision to the district health facilities that include all Health Centres and Dispensaries in the District. level including Faith. Based as well as Private Health Centres and dispensaries

  The District Executive Director approves all district plans and budgets including HIV and AIDS district plans.

  The CHMT in collaboration with the DACC will be responsible for developing an HIV and AIDS plan and budget. In collaboration with the CHMT members, DACC will also be responsible for the co-ordination of the implementation of planned activities of the Communication strategy interventions and will monitor all activities accordingly. The monitoring report will be submitted every three months to the DMO and to the RACC.

- Monitoring organizational efficiency (For those working at the district level)
  DACC will monitor closely the efficiency of partner organizations that deal with the development of HIV

and AIDS communication materials/messages at District level.

Important issues that the DACC will be monitoring include:

- ❖ The effectiveness of the messages to influence the behaviour change.
- ❖ The ability of sensitizing a large number of population especially those who live in the rural areas

DACC is required to provide feed back to the partners as well as to the DMO and CHMT members in order to keep them motivated and thus enhance the continuation of sending the report to him

6.2.5 Community Level

6.2.5.1 Roles: Leadership roles:

Ward Executive Officer (WEO), Councilors, Village Executive Officer (VEO) and Hamlet leaders provide the overall direction of all programs/interventions at the Ward level

6.2.5.2 Responsibilities

• Ward Executive Officers will assist in Community mobilization and will participate in developing plans and budget that will be forwarded to the District level.

• Councilors (Selected by the Community Members) will review and approve developed plans and budget. They are also required to review HIV and AIDS by-laws that have been passed and agreed upon by the community. They will also oversee the implementation of the planned activities at the community level

• Village Executive Officer (VEO) will assist in Community mobilization and will participate in developing plans and budget that will be forwarded to the Ward level

• Hamlet Leaders will also assist in Community mobilization and will participate in developing plans and budget that will be forwarded to the Village level.

• Ward Executive Officers, Councilors, Village executive Officers and Hamlet leaders will be oriented on how to conduct monitoring of communication interventions (planned activities). They will also be oriented by the DACC and CHACC on how to write a correct and meaningful reports on communication interventions

• DACC and CHACC will meet and discuss with Community representatives and Community members with the aim of making them participate and own fully the HIV and AIDS program at the community level

PROVISO: Because of the late launching of the Communication Strategy within the HSHSP time period, a stepwise approach in implementing the strategy might be used. The available time should be used to concentrate in a few regions and districts, especially in the high prevalence areas, where tangible trends in Behaviour change right direction can be demonstrated.

SECTION 7

SPECIFICATION OF IMPLEMENTATION OF ACTIVITIES

Strategic objectives and Activities	Days/ Sessions	Unit cost	Units	Total cost
Strategic Objective 1: Efficacious HIV and AIDS communication messages developed and disseminated, targeting defined audiences and segments in particular geographic settings, and socio-cultural contexts.				
Activities: ▪ **Review of epidemiologic data to map out geographic variation in the spread of HIV** 15 Persons will be involved in reviewing epidemiological data. Five days will be required to accomplish the task .The activity will take place in Dar-es-Salaam				
▪ **Identify clusters of behavioural and socio-cultural affinity:** 10 Persons will be given the task of identifying cluster of behavioural cultural affinity in 5 regions (3 selected districts for each region for 15 days **in the first year):**				
Strategic objective 1 (continue)				
▪ **Determining the determinants of behaviour and communication needs** 5 Researchers will be engaged for 15 days to determine determinants of behaviour and communication needs				
▪ **Crafting and pre testing messages:** 5 Researchers will be engaged for 10 days to determine determinants of behaviour and communication needs				

Strategic Objectives and Activities	Days/ Sessions	Unit cost	Units	Total cost
Strategic objective 1.2: The capacity of NACP – IEC Unit strengthened for providing leadership and carrying out supervision of the communication process through all the stages.				
Activities: ▪ **Conduct advocacy and lobbying for allocation of additional personnel and financial resources** -Partners in HIV and AIDS (NGOs) to Conduct Advocacy meetings at Central level, at regional level in 7 regions				
▪ **Deploy Advisory Committee members innovatively in support of the IEC Unit's role and responsibilities.** -NACP to deploy Advisory committee members innovatively				
Strategic objective 1.3: Motivation created among all those involved in producing and disseminating HIV and AIDS communication materials to adhere to the principles of producing efficacious communication materials and their evaluation.				
Activities: ▪ **Segment audience into meaningful subgroups to facilitate tailored messages.** -NACP and Partners in HIV and AIDS to assist Message formulators to segment audience into meaningful subgroups to facilitate tailored messages.				
▪ **Use theory as a conceptual foundation** -NACP and Partners in HIV and AIDS to assist Message formulators to use theory as a conceptual foundation				

Strategic Objectives and Activities	Days/ Sessions	Unit cost	Units	Total cost
▪ **Use a design approach that is targeted to the audience segments** -NACP and Partners in HIV and AIDS to assist Message Formulators to use a design approach that is targeted to the audience segments				
▪ **Utilize effective channels widely viewed by and persuasive for the intended audience.** -NACP and Partners in HIV and AIDS to assist Message formulators to utilize effective channels widely viewed by and persuasive for the intended audience.				
▪ **Conduct process evaluation design that reduces threats to internal validity and allows causal inferences about campaign intervention impact to be made**. -NACP and Partners in HIV and AIDS to conduct process evaluation design that reduces threats to internal validity and allows causal inferences about campaign intervention impact to be made.				
▪ **Conduct sensitization seminars and workshops,** -The RACCs and selected Communication Partners in HIV and AIDS (Regional TOTs) to conduct seminars/workshops for health workers in 7 regions				
▪ **Conduct skills building workshops, especially for health workers involved with patient education and direct communication in health care settings and in community settings.** -The RACCs and selected Communication Partners in HIV and AIDS (Regional TOTs) to conduct seminars/workshops for health workers in 7 regions				

Strategic Objectives and Activities	Days/ Sessions	Unit cost	Units	Total cost
Strategic Objective 1.4: The major communication partners and frontline communicators motivated and enabled to design and to implement communication				
campaigns that take into account the cultural context in which their audience live, and to draw on local forms of communication and expression to engage the audience.				
Activities ▪ **Carry out a survey in clearly demarcated cultural regions, of cultural groups, troupes, organizations and institutions which have specific roles for entertaining, performing rites of passage, including burial ceremonies.** -NACP to hire 2 Researchers to conduct a survey in clearly demarcated cultural regions, of cultural groups…..				
• **Commission social and cultural anthropologists endowed with cultural competence to engage with these institutions to explore for windows of opportunity for cultural transformation.** -NACP to hire 2 social and cultural anthropologists to perform the task -NACP to disseminate the results				
• **Identify respected "culturally positive deviants" to engage with the custodians and practitioners of these rites of passage in a dialogue meant to find out how they can be transformed.** -NACP to engage 5 Researchers to conduct the activity in 5 districts -NACP to disseminate the results through electronic and print media				

Strategic Objectives and Activities	Days/ Sessions	Unit cost	Units	Total cost
▪ **Develop creative briefs on HIV transmission, prevention care and support to guide theatre artists, song composers to guide them in producing plays and songs that take into account the cultural context.** -NACP and Partners in HIV and AIDS (NGOs) to develop creative briefs guidelines on HIV transmission, prevention care and support to guide theatre artists - NACP and Partners in HIV and AIDS (NGOs) to distribute guidelines to artists				
Strategic objective 1.5: The capacity of health workers and HIV/AIDS communicators built to enable them explain to people the complex issues of risk assessment and risk reduction and to motivate them to take appropriate measures, including going for HIV testing and adhering to treatment regimen, as well as positive prevention.				
Activities ▪ **Produce lecture notes about communication and distribute them to health workers and AIDS educators.** -NACP in collaboration with Partners in HIV/ AIDS to produce lecture notes -NACP and Partners in HIV/AIDS to distribute lecture notes to Health workers				
▪ **Conduct communication skills building workshops.** The RACCs and selected Communication Partners in HIV and AIDS (Regional TOTs) to conduct seminars/workshops for health workers in 7 regions				

Strategic Objectives and Activities	Days/ Sessions	Unit cost	Units	Total cost
Strategic objective 2.1: Positive prevention understood by health workers and community members.				
Activities ▪ **Conduct public viewing of interviews and testimonies of PLHIV who have suffered from and survived the stigmatization and discrimination in their communities.** RACCs, RHACs, DACCs and CHACs to conduct public Viewing of interviews and testimonies of PLHIV				
▪ **Conduct skills building workshops on assertiveness and negotiation necessary for upholding one's legal and human rights for groups of PLHIV** -The RACCs and selected Communication Partners in HIV and AIDS (Regional TOTs) to conduct seminars/workshops for health workers in 7 regions				
Strategic objective 2.2: Positive prevention understood and voluntarily practiced by PLHIV as a liberating and assertive factor.				
Activities ▪ **Compile a list of the injunctions PLHIV receive from health workers and other concerned people as to how they should live their lives, and the significance of those injunctions.** 20 Research Assistants to compile cases for unfair treatment and for hiding the status of HVI/AIDS to affected children in 10 districts				
Strategic objective 3.1: Community members enabled to recognize and motivated to shun stigmatizing words/speech and stigmatizing behaviour towards PLHIV, and about HIV and AIDS.				

Strategic Objectives and Activities	Days/ Sessions	Unit cost	Units	Total cost
Activities: ▪ **Compile a list of stigmatizing words and actions in the community.** 10 Research Assistants to compile a list of stigmatizing words and actions in the community (10 districts)				
▪ **Organize group meetings in the community to disseminate the findings.** NACP, HIV and AIDS Partners at district level including DACCs and CHACS to organize group meetings in the community (Ward and village levels) with the aim of disseminating the list of stigmatizing words and actions in the community.				
▪ **Invite PLHIV to give personal testimonies of the stigma they face.** NACP, HIV and AIDS Partners at district level including DACCs and CHACs to organize a PLHIV meeting in 10 districts to give personal testimonies of the stigma they face.				
▪ **Invite local artists to compose songs and plays to be performed during community meetings, or to be shown as video, or to be aired in local FM Radio Stations and TV stations.** NACP to organize a meeting where Artists will be given a different task according to their specific skills				
Strategic objective 3.2: PLHIV empowered to assert their human rights for association with other people and for participating in other forms of social engagements in order to make stigmatizing tendencies in the community untenable.				
Activities ▪ **Organize assertive skills building workshops and sensitization meetings about human and legal rights of PLHIV** RACCs, DACCs (TOTs) and communication specialists (who were trained in Communication skills at Iringa Institute) to organize assertive skills building workshops and sensitization meetings about human and legal rights of PLHIV in 7 regions				

Strategic Objectives and Activities	Days/ Sessions	Unit cost	Units	Total cost
▪ **Disseminate information about prevalent forms of stigma and discrimination, and successful measures which PLHIV elsewhere have used to fight against stigma and discrimination.** RACCs, DACCs (TOTs) and communication specialists (who were trained in Communication skills at Iringa Institute) to organize assertive skills building workshops and sensitization meetings about human and legal rights of PLHIV in 7 regions				
▪ **Invite PLHIV to give personal testimonies of the stigma they face** -DACCs in 10 districts to invite PLHIV to give personal testimonies of the stigma they face (at Ward and Village levels)				
▪ **Invite local artists to compose songs and plays to be performed during community meetings, or to be shown as video, or to be aired in local FM Radio Stations and TV stations.** -DACCs in 10 districts to invite local artists to compose songs and plays to be performed during community meetings.				
Strategic objective 4.1: Awareness created for HIV/AIDS communicators for effective communication with children and adolescents, and for health workers for providing counseling, testing and ARTxz services to them.				
Activities: ▪ **Develop messages and materials**. -NACP, HIV and AIDS Partners to develop electronic and print materials -Print developed materials				
▪ **Disseminate the materials to health workers, parents and guardians, school teachers.** NACP, HIV and AIDS Partners, RACCs, RHACs, DACCs and CHACS to disseminate electronic and print materials to parents, guardians and school teachers.				

Strategic Objectives and Activities	Days/ Sessions	Unit cost	Units	Total cost
▪ **Arrange for briefing about the legal aspects of providing care to legal minors** NACP, HIV and AIDS Partners, RACCs, RHACs, DACCs and CHACS to brief the regional, district and community authorities about the legal aspects of providing care to legal minors in 7 regions				
Strategic objective 4.2: Advocacy for policy changes and legal reforms undertaken to facilitate recognition of the vulnerability of children and adolescents and direct targeting of children and adolescents with HIV interventions.				
Activities: ▪ **Compile cases of unfair treatment of children who are infected, and of the implications of children not being allowed by health workers and their parents to know their HIV status while taking ARVs.** 14 Research Assistants to compile cases of unfair treatment of children who are infected in 7 regions				
▪ **Use the cases to advocate for reforms Partners in HIV and AIDS (NGOs) to Conduct Advocacy meetings at Central level, at regional level in 7 regions** -NACP, HIV and AIDS Partners, RACCs, RHACs, DACCs and CHACS to conduct Advocacy meetings for reforms at central regional and district levels				
Strategic objective 5.1:.Health workers motivated to adopt HIV preventive behaviour including HIV testing, accessing PEP if exposed, and taking ARVs where appropriate.				
Activities: ▪ **Develop and produce Print and electronic materials** -NACP, HIV and AIDS Partners to develop electronic materials -Print developed materials.				

Strategic Objectives and Activities	Days/ Sessions	Unit cost	Units	Total cost
▪ **Disseminate Print and electronic materials** -NACP, HIV and AIDS Partners, RACCs, RHACCs, DACCs and CHACCS to disseminate electronic and print materials				
Strategic Objective 5.2: Health workers, including AIDS educators, motivated to be role models for HIV preventive behaviour in the communities.				
Activities ▪ **Develop and produce Print and electronic materials** NACP, HIV and AIDS Partners to develop electronic materials Print developed materials				
▪ **Disseminate Print and electronic materials** -NACP, HIV and AIDS Partners, RACCs, DACCs to disseminate electronic and print materials				
Strategic Objective 6.1 Skills and performance deficits for HIV/AIDS service delivery among service providers in CTCs and VCT centres, as well as other health facilities identified and addressed.				
Activities ▪ **Develop and produce Print and electronic materials**: NACP, HIV and AIDS Partners to develop electronic materials Print developed materials				
▪ **Disseminate Print and electronic materials** -NACP, HIV and AIDS Partners, RACCs, DACCs to disseminate electronic materials in 7 regions -Print developed materials				

Strategic Objectives and Activities	Days/ Sessions	Unit cost	Units	Total cost
▪ **Conduct seminars/workshop for Health workers.** The RACCs and selected Communication Partners in HIV and AIDS (Regional TOTs) to conduct seminars/workshops for health workers in 7 regions				
▪ **Design check lists for, and conduct supportive supervisions** -NACP, HIV and AIDS Partners, RACCs, RHACCs, DACCs and CHACCs to design a checklist for supportive supervision -NACP, HIV and AIDS Partners, RACCs, DACCs, CHACCs to conduct supportive supervisions				
▪ **Design a range of incentives and negative sanctions to reinforce proper conduct of service providers** NACP, HIV and AIDS Partners to design a range of incentives and negative sanctions to reinforce proper conduct of service providers				
Strategic Objective 6.2: Capacity of persons on ARVs and the general population built to understand the complex science and technology of ART.				
Activities: ▪ **Conduct skills building workshops for service providers on interpersonal communication and patient education.** RACCs, DACCs and communication specialists who were trained in Communication skills at Iringa Institute (Regional and District TOTs) to build the capacity of service providers on interpersonal communication and patient education.				
▪ **Conduct orientation seminars for service providers on health care ethics.** RACCs, DACCs and communication specialists who were trained in Communication skills at Iringa Institute at Iringa (Regional and District TOTs) to build the capacity of service providers on health care ethics				

Strategic Objectives and Activities	Days/ Sessions	Unit cost	Units	Total cost
▪ **Develop a plan for the continuing education and provision of updates in HIV and AIDS communication** -NACP and HIVand AIDS Partners to collaborate with the Continuing Education Section at the MOHSW to provide updates in HIV and AIDS communication.				
▪ **Arrange with Institutions of Higher Learning to design and offer courses in Health Communication at different levels.** -NACP to collaborate with the Continuing Education Section at the MOHSW to design and offer courses in Health Communication at different levels.				
Strategic Objective 6.3: Capacity built for health workers for interpersonal communication, patient education, and motivating clients to go for HIV testing and to adhere to treatment regimen, and motivation created for observance of healthcare ethics in their work.				
▪ **Conduct skills building workshops for service providers on interpersonal communication and patient education in 7 regions** RACCs DACCs and communication specialists (Regional and District TOTs) will build the capacity of service providers				
▪ **Conduct orientation seminars for service providers on health care ethics** RACCs DACCs and communication specialists (Regional and District TOTs) to orient service providers on health care ethics				
▪ **Conduct orientation of service supervisors to carry out supportive supervision encompassing interpersonal communication and observance of health care ethics** RACCs DACCs and communication specialists (Regional and District TOTs) to orient service supervisors to carry out supportive supervision				

Strategic Objectives and Activities	Days/ Sessions	Unit cost	Units	Total cost
▪ **Develop a plan for the continuing education and provision of updates HIV and AIDS communication** -NACP in collaboration with the Continued Education Section to develop a plan for the continuing education and provision of updates HIV and AIDS communication				
▪ **Arrange with Institutions of Higher Learning to design and offer courses in Health Communication at different levels.** Collaborate with Zonal Training Centres to design and offer courses in Health Communication at different levels				
Strategic Objective 6.4: Advocacy undertaken with Local and Central Government to put in place conducive and safe working environments in health facilities, including incentives and negative sanctions to facilitate effective performance by service providers.				
Strategic Objective 6.5: Utilization of VCT services (counseling and testing), uptake of ARV and adherence to the ART regimen, acceptance of management of STIs, uptake and adherence to the regimen for PMTCT, male involvement in PMTCT, and medical male circumcision promoted.				
Activities: ▪ **Compile a list of reasons put up for not using these services in specific socio-cultural contexts**. NACP to hire 5 Research Assistants who will compile a list of reasons put up for not using these services in specific socio-cultural contexts. The compilation will be done in 7 regions.				

Strategic Objectives and Activities	Days/ Sessions	Unit cost	Units	Total cost
▪ **Craft messages to debunk the reasons for not using the services.** -Participants to develop messages to debunk the reasons for not using the services will include: NACP staff, HIV/AIDS Partners, FBOs, RACCs, DACCs, District and ward Multisectoral committee's members.				
▪ **Disseminate the messages.** -NACP and Partners in HIV and AIDS to disseminate messages through print and electronic media