



National HIV/AIDS/STI/TB Council

**NATIONAL HIV & AIDS
COMMUNICATION
AND ADVOCACY STRATEGY
(2011-2015)**

VISION 2030

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FOREWORD

Strategic communication is increasingly being recognized as an essential element of any successful health, social or development programme. When properly implemented, communication results in sustained change in policy, social norms and behaviours. Communication is also essential in overcoming barriers to access in services, or generating demand for such services. Within the context of HIV and AIDS, communication has been seen as an important input in creating awareness, and changing attitudes and perceptions, and ultimately behaviours, across the four key pillars: Prevention; Treatment, Care and Support; Mitigation; and Response Management and Coordination.

This National HIV and AIDS Communication and Advocacy Strategy (NACAS), seeks to reinforce the efficacy of communication at the different levels of behaviour change, and to increase the proportion of individuals, families, communities and institutions within Zambia utilizing available HIV and AIDS and reproductive health services across the country. Furthermore, it seeks to increase the proportion of national level policy makers and stakeholders knowledgeable of the socio-economic significance of HIV and AIDS. It is anticipated that such stakeholders will in turn mainstream HIV and AIDS in their programmes, develop appropriate policies and interventions, and devote sufficient resources to the fight against the pandemic.

The NACAS provides a framework that aligns communication with the goals and vision of the National AIDS Strategic Framework (NASF). It aims to provide strategic direction and to guide actions on those components within the scope of HIV and AIDS in Zambia that can be influenced by communication and advocacy at policy, programmatic and institutional levels. It also defines priority audiences and issues, formulates strategic direction and actions, and determines the best way to invest resources.

The Strategy is a product of the collaborative efforts of the Ministry of Health, through the National HIV/AIDS/STI/TB Council (NAC), and various partners and stakeholders. The United States Agency for International Development (USAID), through its Communication Support for Health (CSH) Project, provided technical and financial support to the development of the Strategy.

We wish to take this opportunity to thank all those who contributed to the process and, hope that the implementation of the Strategy will contribute towards the realisation of Zambia's goal in HIV and AIDS, "a nation free from the threat of HIV and AIDS."

Dr. Peter Mwaba

Permanent Secretary

Ministry of Health

ACKNOWLEDGEMENTS

This National HIV and AIDS Communication and Advocacy Strategy (NACAS) is the product of a highly consultative and collaborative process and the concerted efforts of many individuals and organisations. It began with provincial consultations that culminated in the National AIDS Strategic Framework (NASF) for 2010 – 2015, and the Zambia Country Report published in 2010. In this regard the National HIV/AIDS/STI/TB Council (NAC) would like to acknowledge all those who were involved in one way or another in the development of this Strategy. We particularly thank the United States Urgency for International Development (USAID), through its Communication Support for Health (CSH) Project, for the financial and technical support towards the process.

As NAC we are also highly indebted to numerous organisations and individuals for their respective contributions to the development of both the NASF and NACAS.

Dr. B.U Chirwa

Director General

National HIV/AIDS/STI/TB Council

ABBREVIATIONS FULL MEANING

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Clinics
ANCSS	Antenatal Clinics Surveillance Survey
ART	Anti-Retroviral Therapy
ARV	Anti-Retro Viral Drugs
BCC	Behaviour Change Communication
BCI	Behaviour Change Interventions
CAPAH-Z	Coalition of African Parliamentarians against AIDS- Zambia
CATF	Community AIDS Task Force
CBO	Community Based Organisation
CFSC	Communication for Social Change
CPA	Communication and Policy Advocacy
CSH	Communication Support for Health
CSO	Central Statistics Office
CSOs	Civil Society Organisations
CT	Counselling and Testing
DATF	District AIDS Task Force
DHS	Demographic and Health Survey
FBO	Faith-Based Organisation
GRZ	Government of the Republic of Zambia
HIV	Human Immuno-deficiency Virus
ICT	Information & Communication Technology
IDU	Injective Drug Use
IEC	Information, Education & Communication
MC	Male Circumcision
MCP	Multiple Concurrent Partners
M&E	Monitoring and Evaluation
MTCT	Mother to Child Transmission
NAC	National HIV/AIDS/STI/TB Council
NACAS	National HIV/AIDS Communication & Advocacy Strategy
NASF	National HIV/AIDS/STI/TB Strategic Framework
NGO	Non-Governmental organisation
OVC	Orphans and Vulnerable Children
PATF	Provincial AIDS Task Force
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
RLC	Radio Listening Club
SAG	Sector Advisory Group
SMS	Short Messaging System
SFH	Society for Family Health
STI	Sexually Transmitted Infection

TB	Tuberculosis
TCA	Theatre for Community Action
TV	Television
VCT	Voluntary Counselling and Testing
USAID	United States Agency for International Development
ZANIS	Zambia News and Information Services
ZCC	Zambia Counselling Council
ZDHS	Zambia Demographic and Health Survey
ZNBC	Zambia National Broadcasting Corporation

EXECUTIVE SUMMARY

HIV and AIDS continue to impact negatively on the social and economic fabric of Zambian society at individual and household levels, and across the wider community. Appreciable gains have been made in reducing the annual prevalence rate from over 25% 20 years ago to an average of 14.3% as of December 2009. However, the evidence of high incidences of infection among certain populations, and the existence of both old and emerging drivers of the pandemic demand continued interventions in prevention. Another important consideration is that over one million Zambians are living with HIV, and an equally high number of people have been decimated by the pandemic. These scenarios call for enhanced and well-coordinated efforts across all the response pillars, notably prevention; treatment, care and support; impact mitigation; and response management and coordination.

It is against this background that the Zambian government, through NAC and its partners, developed the National HIV/AIDS Strategic Framework (NASF) for 2011 to 2015. The NASF contains specific strategies across the four response pillars previously mentioned. .

Communication, guided through successive communication strategies, has been identified as a crucial ingredient to effective responses to the pandemic. The 2005–2010 communication strategy laid down a broad programme framework for communication support to the national response framework for the period. It identified the behavioural shortcomings that needed to be addressed by communication, consistent with the national priorities. However, structural and inherently technical shortcomings affected its implementation.

This NACAS has been developed in direct response to the gaps in communication and advocacy identified through national consultations, situation analyses and evaluations with respect to the national response to the pandemic. The NASF (2010) report, for instance, notes: “a key problem in the response to HIV and AIDS to date has been the lack of appropriate information available to the public.” The report further observes that “whilst informative material exists, there has also been a lot of contradictory material sending wrong messages and confusing the public. This has eroded the value of many of the interventions being implemented by various organisations throughout the country. The NAC, therefore, places high priority on effective communication as a means to achieving the goals of the NASF.”

The NACAS thus provides a broad framework within which communication and advocacy should serve as strategic inputs into the implementation of the NASF. Its implementation is also harmonious with the NASF, which runs for the period 2011–2015.

Furthermore, the Strategy has identified key behavioural communication issues and gaps to be addressed to support the achievement of positive results across the four response pillars. It thus proposes innovative, evidence-based and participatory approaches in the planning and implementation of communication and advocacy interventions. Interpersonal, digital and mass communication strategies have been considered and incorporated as interdependent and mutually supportive approaches at respective stages in the behaviour change process. The use of both old and new media has been particularly embraced in order for the interventions to be congruent with emerging trends in communicating to specific populations, especially young people.

The NACAS recommends seven objectives to address the gaps and/or weaknesses identified by stakeholders at audience, institutional and policy levels across the four pillars. At audience level gaps in awareness, knowledge, access to information, and behaviours among specific groups, have been specifically identified, and interventions to address them proposed. The incorporated M&E plan will ensure that the Strategy is effectively and efficiently implemented, monitored and evaluated by the different structures and implementers across the country.

All the proposed activities are aimed at realising the communication and advocacy goal: *Increased*

percentage of the Zambian population that are informed, engaged, empowered, and positively participating in the national agenda in prevention; treatment, care and support; impact mitigation; and, management of the national response.

For the Strategy to be effectively implemented, serious consideration should be given to harmonising the currently fragmented IEC, BCC, and communication activities within NAC, preferably under one unit or department, as part of the NACAS. An M&E expert will be specifically assigned to implement the NACAS M&E plan. The document also recommends a set of activities aimed at promoting the Strategy across the country and ensuring that it gets the necessary stakeholder support.

To be effective, the Strategy should be adequately funded through proposed funding options, notably core funding through NAC allocations from Government, or direct funding from development partners.

1.0 BACKGROUND AND INTRODUCTION

1.1 BACKGROUND TO HIV/AIDS PREVALENCE IN ZAMBIA

Twenty six years since the first AIDS case was recorded in Zambia, HIV and AIDS continue to have a devastating impact on the social and economic constitution of the country. Data available from the 2007 Demographic and Health Survey (DHS) suggests that the adult (ages 15-49) prevalence rate was 14.3%, and the mean prevalence from twenty one ante-natal (ANC) sites for clients aged 15-39 years was 16.6%. According to Spectrum estimates, adult HIV prevalence peaked in the mid-1990s at about 16% and has stayed above 14% ever since. The estimated number of new infections in children, aged 0-14 years, has reduced significantly since peaking at 21,189 in 1996, to 9,196 in 2009, which currently translates into 25 new infections per day (DHS 2007).

HIV prevalence levels in ANC clients have recently also started to decline. Between the 2004 and 2006-07, ANC surveillance surveys in 15 ANC sites (71%) showed a decrease in HIV prevalence, while six ANC sites (29%) showed increases. The largest decreases in HIV prevalence was observed among pregnant women aged 15-to 24 years of age.

The peak number of annual AIDS-related deaths among adults in 2003 was 66,272. The scale up of ART, especially among people aged 15-49 years, has contributed to a reduction of adult mortality from about 82% of total deaths in 1996 to 54% in 2007 (NAC, 2009). Estimated AIDS-related mortality in children under 14 years peaked in 2003 (14,681 deaths) and has decreased to about half (7,282 deaths estimated for 2009). This decline is a combination of lower fertility, prevention of mother-to-child (PMTCT) programmes, and paediatric anti-retroviral treatment (NAC, 2009).

1.1.1 Key Drivers of HIV transmission

The NASF (2011) notes the following as the key drivers of the epidemic, with varying degrees:

- **Low Condom Use:** Though positive changes in condom use have been reported from 1992 to 2007, lack of consistent use, especially in steady relationships and Multiple Concurrent Partnerships (MCP), is a major source of concern. The most recent data shows that consistent condom use in the 15-49 age-groups stood at 37% for females and 50% for males. The NASF target is to increase consistent condom use to 55% for females and 70% for males by 2015.
- **Multiple and Concurrent Sexual Partnerships (MCP):** Though DHS reports declines in MCP among both sexes, data from qualitative assessments on MCP behaviours strongly suggest that MCP and extramarital affairs are underreported in surveys. The NASF (2011) notes that females and males aged 15-49 who reported that they engaged in MCP stood at 35% (three in every 10) for females and 70% (seven in every 10) for males. The NASF thus aims to reduce these incidences of MCP to 10% and below for females, and 20% and below for males in the above age-groups. The DHS (2007) identified economic, cultural, social and psychological factors leading to, or encouraging MCP behaviours.
- **Low Male Circumcision (MC):** Nationally, the rate of adult MC in Zambia stands at 13% (DHS, 2007), with a national target of 21% by 2013 and 30% by 2015. Available evidence suggests that HIV prevalence in circumcised men is slightly lower than in uncircumcised men (10.8% vs. 12.5%).

- **Cultural Practices:** At community level the following culture-related practices have been proven to increase vulnerability to HIV: sexual cleansing, widow inheritance, dry sex, traditional male circumcision, pre-marital unprotected sex to prove fertility of young girls, wife sharing with kin as a sign of welcome, and separation of pubescent girls (rendering these young girls vulnerable to sexual abuse).
- **Intergenerational and Transactional sex:** According to NAC (2009) 4.5% of women and 22% of males aged 15-19 years report engaging in intergenerational sex, while 11% of females report engaging in transactional sex or exchange of money or food for sex.
- **Commercial Sex and Sexual Violence:** Commercial sex and sexual violence are also considered to be issues which add to the pandemic in Zambia. Domestic violence at the hands of a spouse or intimate partner, and the fear of such violence, has a direct and harmful impact on one's ability to start and continue using ART, or engage in discussing behaviours surrounding HIV prevention such as VCT or condom use.
- **Alcohol Abuse:** There is a body of local evidence showing that alcohol abuse leads to increased risky sexual behaviours, including MCP and lower condom use.
- **Mother-to-Child Transmission of HIV (MTCT):** MTCT is reported to account for about 10% of all new infections in Zambia. Although PMTCT services are readily available country-wide, uptake of ART by HIV positive pregnant women is still not high enough (61% as at 2009). The NASF target is thus to increase ART uptake, as a means of preventing HIV transmission in babies, from 61% in 2009 to 95% by 2015.
- **Men Having Sex with Men (MSM):** Sex between men is taboo and outlawed in Zambia. As a result it is little understood in terms of both prevalence and its contribution to annual HIV incidences. However, the DHS (2007) analysis notes that unprotected anal sex is practiced by 8% of Zambian men.
- **Other factors** such as **migration** and **mobility**, and **gender-based discrimination and inequality** also have evidence of contributing to HIV transmission (NAC, DHS, 2009). Transmission through **injected drug use** (IDU) is most likely also occurring in Zambia on a small scale. However there is no data on the size of the IDU population, frequency of drug injection, or sharing of injecting equipment. Transmission through **medical injections**, due to the introduction of disposable injection equipment, is estimated to contribute to only about 0.2% of all new infections. There is also anecdotal evidence that unsafe tattooing and scarification is taking place.

1.1.2 Emerging Challenges for BCC in HIV and AIDS in Zambia

Numerous situation analyses note that although the country has made appreciable progress in reducing the national HIV prevalence rates, a number of gaps and challenges still exist which have had an impact on the reported levels of achievement. The gaps and challenges include, but are not limited to, the following:

- National HIV prevalence rates may have stabilised but at a high level;
- Whereas the national prevalence rates have reduced over time, incidence rates are still rising among certain populations;
- There is evidence of concentrated epidemics among some specific populations - MSM, MCP, OVC, etc.

- Knowledge levels of key aspects of the pandemic’s three behaviour related response pillars (prevention; care, treatment and support; and, impact mitigation) and key drivers of HIV are reportedly low, especially among the most sexually active populations (youths and young adults). In the case of prevention, comprehensive knowledge of HIV and AIDS among the 15-49 year olds was reported at 37% nationally as of 2010 (NAC, 2010);
- Both stigma and denial are still prevalent, to a large extent due to a lack of favourable environments for PLHIV to come out in the open;
- There is marginalisation and limited voice and influence of people most affected by HIV and AIDS; and,
- There is limited provision of, and access to, numerous services and resources, particularly those earmarked for marginalised and affected target groups.

1.2 NACAS GOAL, OBJECTIVES, AND STRATEGIES

1.2.1 NACAS Goal

The proposed overall goal of the NACAS is: *Increased percentage of the Zambian population that is informed, engaged, empowered, and positively participating in the national agenda in prevention; treatment, care and support; impact mitigation; and coordination and management of the national response.*

Figure 1 (below) illustrates the proposed relationship between communication and advocacy and the four response pillars proposed in the NASF:

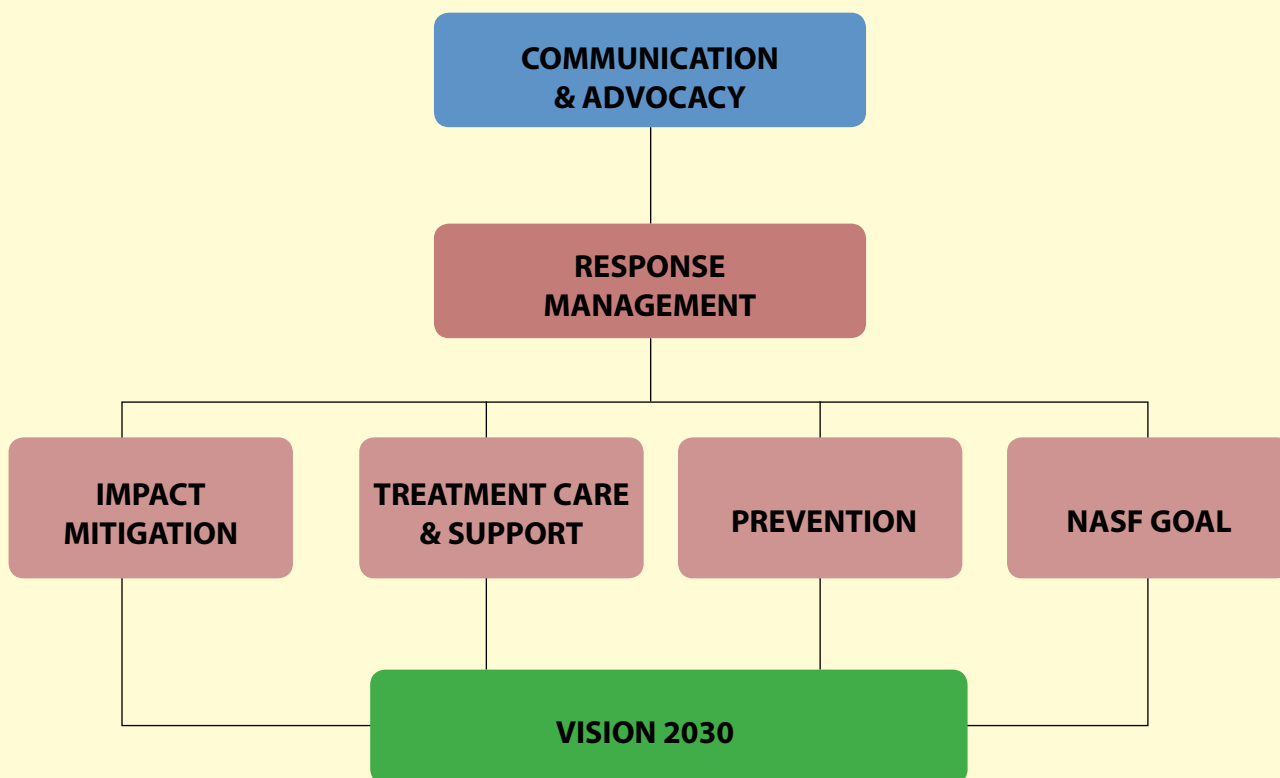


Figure 1: Relationship between NACAS and the other HIV and AIDS response pillars

1.2.2 The Strategic Objectives

Below are the NACAS Objectives at the Audience (Behavioural), Institutional, Policy and M&E levels.

1.2.2.1 Behavioural Change

- **Objective 1:** *Through greater public awareness initiatives, enable to enhance access to, and uptake of, accurate, adequate and information which supports intensified means of prevention thus reducing the annual rate of new HIV infections, particularly addressing root causes which sustain high levels of societal vulnerability.*
- **Objective 2:** *Through greater public awareness initiatives, to enhance access to, and uptake of, accurate, adequate and information which supports the acceleration of the provision of universal access to comprehensive and quality treatment, care and support for people living with HIV and AIDS, their caregivers and their families, including services for TB, STIs and other opportunistic infections.*
- **Objective 3:** *Through greater public awareness initiatives, to enhance access to, and uptake of, accurate, adequate and information which supports mitigation of the socio-economic impacts of HIV and AIDS, especially among the most vulnerable groups – orphans and vulnerable children, PLHIV and their caregivers and families.*

1.2.2.2 Institutional Change

- **Objective 4:** *To strengthen the capacities of NAC implementing partners to plan, coordinate and implement communication initiatives as a core component to support their programme goals at the national, regional and community levels.*
- **Objective 5:** *To foster prioritization and mainstreaming of HIV and AIDS communication and advocacy at various levels and among different players across the country.*

1.2.2.3 Policy Change

- **Objective 6:** *To advocate for the development of national and sectorial policies and strategies, and the harmonization of existing ones at different levels, including traditional establishments, through the dissemination of public awareness and rights based materials.*
- **Objective 7:** *To advocate for the enactment and enforcement of new and relevant laws, and the domestication of international protocols to accommodate emerging issues in the pandemic, through the dissemination of public awareness and rights based materials.*

1.2.2.4 Monitoring and Evaluation

- **Objective 8:** *To ensure effective and efficient implementation of the NACAS at national, provincial and district levels and across all sectors.*

1.2.3 Communication and Advocacy Approaches

1.2.3.1 Approaches in Communication

Appropriate forms of both interpersonal and mass communication have been recommended in this strategy in order to achieve the best results at each stage in the human behaviour change process. The functions of communication in the HIV and AIDS behaviour change chain can be summarised as illustrated in Figure 2 below.

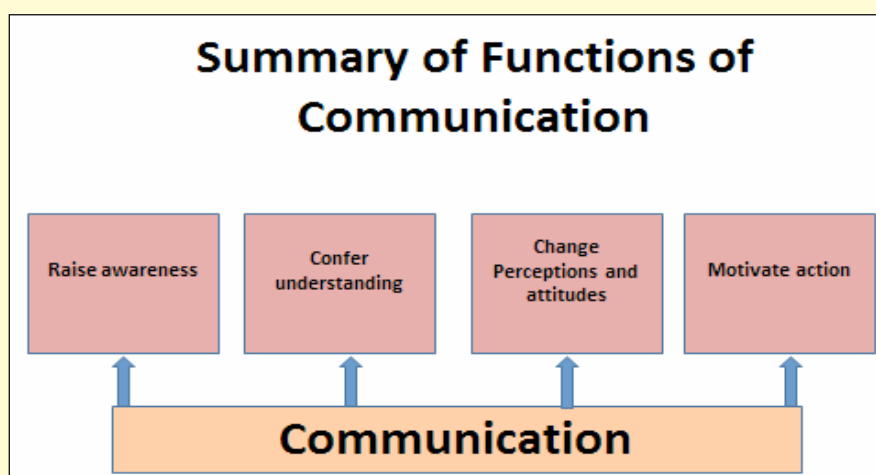


Figure 2: Functions of communication in the human behaviour change chain

1.2.3.2 Types and Choice of Media

More interpersonal communication strategies have been recommended for complex stages of the behaviour change process (change perceptions, attitude and behaviours). On the other hand, mass communication or mass media will be used largely for less complex stages, such as creating awareness and understanding of HIV and AIDS. However, overlaps are anticipated arising from the need for the two forms of communication to reinforce each other. Also, appropriate information and communication technologies (ICTs) will be used to enhance the effectiveness of each of the two main types of communication. These include internet, mobile phone communication and other emerging ICTs.

1.2.3.3 Communication Channels and Tools

Communication channels, media or tools, can be defined as modes of transmission that facilitate the exchange of information between the sender of the message and the recipient. Some of the recommended channels of communication in this Strategy are:

- a. Interpersonal or Human Communication:** This includes peer-to-peer (P2P) communication as would happen between friends, associates, colleagues or other social interaction.
- b. Community Based:** These initiatives reach a group of people within a distinct area, for instance a village, neighbourhood or a community group, based on common interests or with common characteristics. Forms of community communication include:
 - Community based media such as local newspapers, local radio stations, etc.
 - Community learning and communication groups, such as study circles and radio listening clubs.
 - Community based activities such as community theatre, drama and meetings.
 - Community mobilization, a participatory process of communities identifying and taking action on shared concerns.

- c. *Mass Media:*** These channels reach a large audience within a short period of time and include:
- Television
 - Radio
 - Newspapers
 - Magazines
 - Outdoor (posters, billboards)
- d. *Digital:*** Technological advances have seen the rapid development of media which rely upon the use of computers, telephone and other forms of interactive media. Examples include cell phones, and social media (Twitter, You-Tube, Facebook). Digital media have introduced new ways of communicating that diminish geographic distance, allow for huge volumes of communication, and provide rapid and interactive communication. The SMS platform in particular has enabled communicators to send short but precise and complete messages to target audiences. In recent times many organisations - such as WHO, UNICEF and the Zambia National Farmers' Union (ZNFU) - have utilised the system to deliver critical messages on social or business sector issues. Digital channels have the advantage of quick dissemination, which facilitates prompt interaction and great awareness in the audience.

1.2.3.4 Channel Mix Factors

The decision on the appropriate channel mix chosen for a particular activity will depend on a number of factors. Channel selection is determined not just by audience preference, but also on the intersection between campaign goals and the channel characteristics. It is, for instance, recognized that mass media is effective for creating awareness whilst interpersonal channels are superior for promoting behaviour change. ICTs on the other hand, are introduced to strengthen the two forms of communication.

Other factors to consider include:

- *Reach:* number of people the communication effort wants to target. Quick reach of a wide audience can be attained through use of mass media in areas where the audience has media access;
- *Frequency:* the number of times the message or content is to be aired or publicized. Some messages require high exposure and as a result may limit the use of certain media due to cost;
- *Proven Impact:* what is the documented success rate of a particular medium or combination of media or channels; and,
- *Cost Effectiveness:* the net benefit compared to the cost of using a particular medium or a combination of media or channels.

A multi-channel campaign, combining mass media, community events, interpersonal communication (IPC) and digital media, simultaneously enhances both reach and frequency.

1.2.3.5 Spheres of Influence for Communication and Advocacy

The interventions proposed in this strategy will address the identified communication and advocacy problems through five spheres of influence as illustrated in Figure 3 (below).

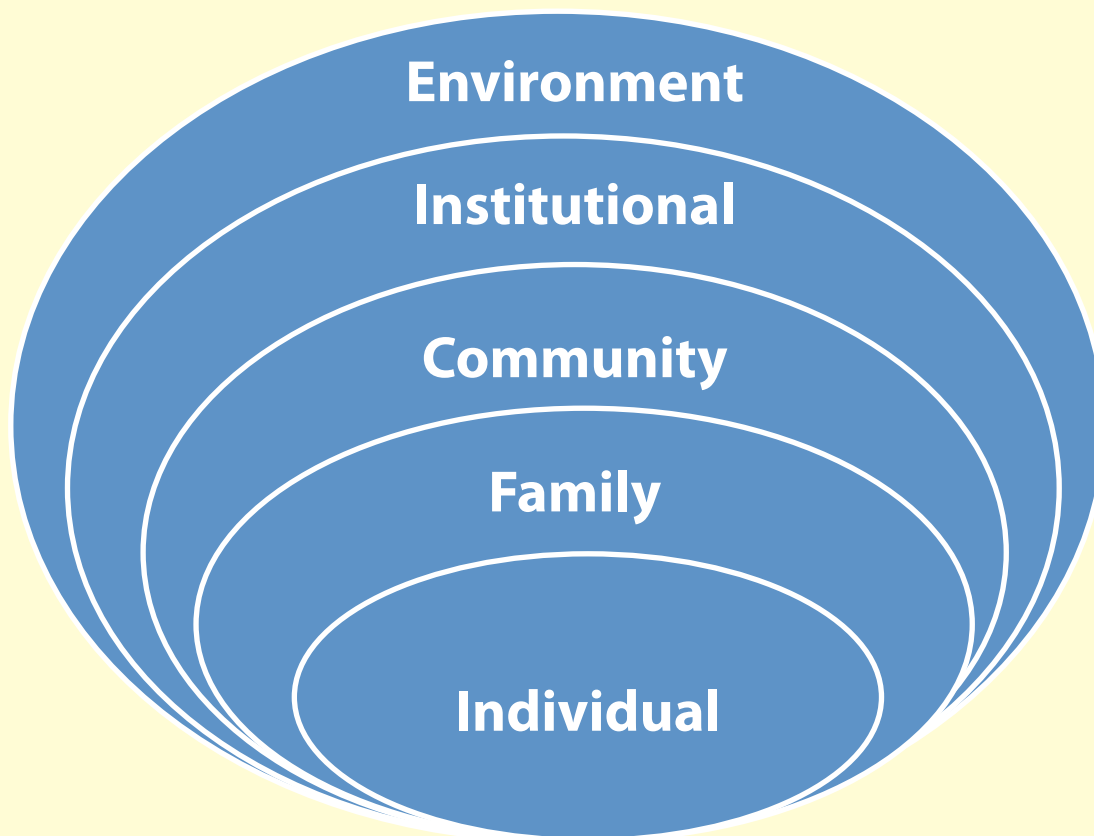


Figure 3: The five spheres of influence for communication and advocacy interventions.

The entry points for each of the spheres of influence include:

- *Individual:* Personal choices, risks, incentives, values, etc.
- *Family:* Values, choices, attitudes, incentives, risks and vulnerability, environments, etc.
- *Community:* Society values, structures, attitudes, incentives, environments, risks and vulnerability and common laws, policies and programmes.
- *Institutional:* Policies, programmes, working environments, resources, strategies, capacities and competencies.
- *Environment:* Legal and regulatory frameworks, policies, incentives, etc.

1.3 GUIDING PRINCIPLES OF THE COMMUNICATION AND ADVOCACY STRATEGY

The following principles should guide the planning, implementation and monitoring of the Strategy:

- **Results oriented:** The effectiveness of a communication effort should be ultimately determined by the health outcomes. Increased knowledge, approval and adoption of healthy behaviour should be verified through research.
- **Evidence based:** Communication planning should refer to relevant empirical data and theories to inform and guide the activities.

- **Client centred:** Target audiences should be involved in determining what their health needs are and participate in the process of shaping messages to address those needs.
- **Participation:** Client and partner involvement should be a priority throughout the communication process, including programme design, implementation and evaluation.
- **Benefit oriented:** Target audiences must perceive the benefit of adopting the targeted behaviour.
- **Service linked:** The health promotion efforts should be directed toward the promotion of specific services to ensure self-efficacy.
- **Multi-channelled:** A multi-channel approach should be used to enhance the effectiveness of communication and reach to the target audiences.
- **Technical quality:** Communication activities and products should always aim to be of the highest possible quality in messaging and production. This includes ensuring that clear and easily understood messages, whether written, spoken or otherwise, are easily drawn from the communication initiative. Pre-testing communication materials will ensure this.
- **Advocacy related:** Strategic communication should also contain advocacy focused communications interventions which target individual, family, community, institutional and policy levels to influence behaviour change.
- **Expanded to scale:** Effective communication initiatives and activities at programme level should be expanded to other levels.
- **Gender and culture sensitive:** Communication interventions should be gender and culturally sensitive at all times.
- **Sustainable:** Effective communication programmes at all levels should aspire to be sustainable.
- **Cost effective:** Communication resources should be focused towards the most effective channels.

1.4 WHO SHOULD USE THIS STRATEGY

The NACAS is a national document developed as a guide for implementing partners including NGOs, Governmental departments and agencies, faith based organisations (FBOs), community based organisations (CBOs) and any other institutions implementing HIV/AIDS interventions. The role of NAC is to *coordinate* the HIV/AIDS national response through resource mobilization, programme coordination, strategic planning, and monitoring and evaluation. This communication strategy will enhance NAC's ability to coordinate by providing a strategic plan to guide *all stakeholders* towards the implementation of a coordinated and effective national response to HIV/AIDS. By coming together under the framework of this plan, implementing organisations will be able to provide a strong and united message. The communication strategy provides the opportunity to strengthen the response to HIV/AIDS by eliminating contradictions and mixed messages

NATIONAL COMMUNICATION AND ADVOCACY RESPONSES:

2.0 SITUATION ANALYSIS SUMMARY

The development of this Strategy was informed by intensive and extensive national consultations and stakeholder meetings across the nine provinces of Zambia. A snap shot situation analysis was then executed through both comprehensive literature reviews and primary data collection from implementing partners, beneficiaries and media practitioners – both editors and reporters - from key media houses (both print and electronic).

All eleven partners interviewed for the situation analysis worked with PLHIV, OVCs, youth, service provision, sexual reproductive health, awareness creation, behaviour and attitude change, IEC materials production, and/or gender and human rights. The situation analysis focused on assessing the HIV and AIDS issues that the strategy should address, as well as communication interventions implemented by selected partners, coverage of HIV and AIDS by the main national media, and, perspectives of media practitioners on the current media responses to the pandemic. Assessment of media coverage was based on a review conducted by SHARe in from July–December 2009 (SHARe/Mbozi, 2009).

The results of the snap situation analysis are summarised in the following sections.

2.1 OVERVIEW OF GAPS IN CURRENT HIV/AIDS COMMUNICATION AND ADVOCACY INTERVENTIONS

2.1.1 Status of Communication among Implementing Partners

The situation analyses noted the following:

- *Few communication strategies:* Only two of the 11 partners interviewed for the snapshot situation analysis stated having a communication strategy.
- *Limited capacities in communication design and planning:* Most partners noted weak institutional and staff capacities in communication.
- *Limited resources for communication:* Partners noted limited resource allocation to HIV and AIDS communication activities.
- *Disjointed activities:* Partners noted disjointed and uncoordinated communication activities within their respective organisations.

2.1.2 Stakeholders' Perspectives on the Communication and Advocacy Interventions

The partners noted that national and project communication and advocacy interventions have not been very effective for the following reasons:

- Interventions have not been aligned to the national strategic frameworks (2005; 2011).

- Interventions and advocacy messages are out of date and behind current trends in HIV and AIDS;
- Communication messages are not target-oriented or specific to one audience. General communication messages are used to reach wide audiences of different gender, age, and socio-economic status;
- The national and institutional communication strategies have not had clear goals, objectives and strategies, thereby making implementation difficult and success not easily measured;
- Advocacy and communication interventions have focused too much on urban areas leaving rural areas largely underserved;
- Certain vulnerable groups, such as the blind and disabled, without realistic access to a number of services. Their concerns are not adequately advocated;
- Communication interventions have been inconsistent, not well planned, and often not fully executed;
- There have been no sustained HIV and AIDS communications campaigns. Sometimes campaigns are done during commemoration days such as the World AIDS Day;
- CSOs involved in advocacy are not well coordinated, leading to fragmented activities and messaging;
- Some HIV and AIDS messages have not been user-friendly, lacked innovation, and used inappropriate channels; and,
- Poor advocacy mechanisms in CSOs involved in communication and advocacy.

2.1.3 Stakeholder Perspectives on Advocacy

The following issues and concerns were identified as gaps in advocacy in Zambia:

- *Lack of coordination and synergies:* Activities have not been well coordinated at national and other levels, and there has been inadequate synergy among the different organizations involved in communication and advocacy;
- *Lack of stakeholder involvement and buy-in:* Previous national and institutional HIV and AIDS communication strategies failed to effectively work because stakeholders were not adequately involved in their development;
- *Inadequate political will and low prioritization of HIV and AIDS:* Despite being a national disaster, HIV and AIDS has not been accorded adequate political will and prioritization by the various actors at different levels;
- *Inadequate laws:* Limited enforcement of existing laws and the enactment of new ones to match the trends in society;
- *Lack of harmonisation between local and international protocols:* A number of international protocols have not been domesticated or harmonized, with local laws;
- *Weak institutional implementation systems and structures:* Institutions and systems responsible for delivering services have been weak and unable to perform to expectation;
- *Limited resources and technology:* Resources and technology have been too inadequate to effectively implement strategies; and,

- *Marginalisation of special groups*: Generally inadequate interventions for, and involving, special groups (such as children, women, youth, the disabled, and seniors) in HIV and AIDS interventions.

2.2 MEDIA COVERAGE OF HIV AND AIDS

Overall, the following generalisations can be made about media coverage of HIV and AIDS during the period under review (July – December 2009):

- 13% of the estimated total of stories published by all seven newspapers assessed were about HIV and AIDS;
- The quality of most of the stories lacked details, statistics and perspectives of people directly affected by the pandemic;
- Newspapers with established HIV/AIDS desks, such as the *Zambian Daily Mail*, and HIV and AIDS columns, or a combination of both, seemed to cover HIV and AIDS more consistently in terms of both quality and quantity;
- There were more articles written by in-house reporters than correspondents or freelancers, which suggests that most local newspapers are making an effort to cover the HIV/AIDS issues;
- Community radio stations had more sponsored scheduled programmes, confirming that they tend to have more space for development programmes than national media;
- The majority of both editors and reporters rate HIV and AIDS among their top priority issues to report about in their respective media. Some editors claimed to have a policy on covering the pandemic, meaning that some Zambian media are attempting to have long term and sustainable coverage of HIV/AIDS. It also suggests that there are lessons to learn within the country on how to best cover the pandemic;
- Most of the stories focused on issues of prevention. This is possibly because reporters and editors feel that prevention should be the focus of the response instead of mitigation, or that reporters and editors lack adequate understanding of mitigation.
- Many of the stories which did focus on PLHIV focused on treatment, suggesting that media practitioners may be generally aware of current national trends, in particular the two-pronged approach of both prevention and mitigation.

2.2.1 Perspectives on Factors that Hinder Effective Reporting on HIV and AIDS

Almost all the editors and reporters spoken to indicated that the greatest challenge at institutional level was lack of resources, such as finances, transport and advanced equipment, to effectively report on HIV and AIDS.

The other challenges they noted include:

- Lack of prioritisation of HIV and AIDS reporting by media houses. Reporters stated that editors described HIV and AIDS as a tired topic no longer newsworthy and often 'bury' HIV and AIDS articles inside the paper;
- Lack of specialised desks. Coverage is often limited to press conferences and invitations to scheduled events;

- Inadequate human and material resources, especially in community media. Community media rely on volunteer reporters or producers, some of whom have not undergone any formal training in journalism;
- Inadequate professional education and training opportunities for reporters. Current training does not equip trainees with in-depth skills and knowledge about HIV and AIDS;
- Competition for survival through sales and advertising revenues. “Media would rather publish or air stories that will bring in money for their organisation to survive than HIV and/or AIDS stories;”
- Some of their readers have expressed sentiments indicating they were no longer interested in HIV and AIDS stories, claiming that they have heard enough about it;
- Use of technical jargon in HIV and AIDS information in IEC materials and by experts has impaired readership’s capacity to internalize the fundamentals of HIV and AIDS stories;
- Difficulties in obtaining information from PLHIV, experts, NAC and implementing organisations; and,
- Poor relations between media and organisations involved in HIV and AIDS campaigns and elected officials.

The strategy seeks to assist media personnel in their work by recommending activities to:

- Enhance media personnel’s understanding of HIV and AIDS basics.
- Identify which issues are of priority when reporting on HIV and AIDS.
- Guide the media on which messages and tools to use to reach different audiences across the country.

STRATEGIC AND BEHAVIOUR ANALYSIS OF THE FOUR NASF PILLARS

3.0 INTRODUCTION

Zambia has one of the highest HIV prevalence rates in the world and is one of the twelve sub-Saharan countries that constitute the epicentre of the pandemic. With an adult HIV prevalence rate of 14.3% (2009), the country was ranked seventh among the countries most affected by HIV and AIDS globally (UNAIDS, 2008). The pandemic has spread rapidly across all sectors of society and threatens to reverse the socio-economic gains made since independence in 1964.

For over 25 years, the Government of Zambia and national and international organizations have committed themselves to working towards universal access to prevention, treatment, care and support. The Government's commitment has been further enshrined in the country's long-term Vision 2030 that aims to have a "nation free from the threats of HIV and AIDS by 2030." Zambia has also committed itself "to halt and begin to reverse the spread of HIV by 2015" as agreed in the Millennium Development Goals (MDGs). To actualize these aims, the NASF articulates four national priorities, aligned to SNDP, as follows:

1. To accelerate and intensify prevention in order to reduce the annual rate of infections with special attention to addressing the root causes that sustain high levels of societal vulnerability;
2. To accelerate the provision of universal access to comprehensive and quality treatment, care and support for PLHIV, their care-givers and families, including services for TB, STIs and other opportunistic infections;
3. To mitigate the socio-economic impacts of HIV and AIDS, especially among the most vulnerable groups (OVC, PLHIV and their caregivers and families); and,
4. To strengthen the capacity for a well coordinated and sustainably managed HIV and AIDS multi-sectoral response.

The sections that follow analyse the key problems and/or issues, audiences, desired changes and proposed communication and/or advocacy interventions across the four pillars.

3.1 PREVENTION

Prevention is one of the cornerstones of the national response. The NASF 2011–2015 target is to reduce the annual rate of new infections by 50% (from 82,000 in 2009 to 40,000 in 2015). To achieve this result Zambia will prioritise and implement proven interventions through a 'combination prevention' strategy. Prevention interventions focus on behavior change, addressing structural barriers and accelerating biomedical interventions. The general knowledge of HIV and AIDS has consistently improved from 97% in 2005 and to 99% in 2007. Among young people (15-24 years) knowledge on how to prevent HIV increased between 2007 and 2008 from 40.5% to 65% for females, and from 46.1% to 67% for males. However, comprehensive knowledge of HIV has

remained low. The percentage of young people who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission decreased from 48% in 2005 (51% for males and 45% for females) to 35% in 2007 (37% for males and 34% for females).

This NACAS aims to support NASF prevention goals through a combination of communication and advocacy interventions as proposed and articulated in Chapter 5.

3.1.1 Key Epidemic Drivers

- a. Multiple and Concurrent Sexual Partnerships (MCP)
- b. Low condom use
- c. Low uptake of male circumcision
- d. Reduced attendance of antenatal care leading to Mother To Child Transmission (MTCT)
- e. Low uptake of HIV counselling and testing (HCT)
- f. Intergenerational and transactional sex

3.1.1.1 Multiple and Concurrent Sexual Partnerships

Recent national reports confirm the fact that MCP behaviour is prevalent among all sexually active age-groups, and manifested through extramarital relations and secondary partners in transactional sex. Though the DHS (2007) reported declines in MCP among both sexes, data from qualitative assessments on MCP behaviours strongly suggest that MCP and extramarital affairs are underreported in surveys. The NASF (2011) noted that 35% (three in every 10) of women and 70% (seven in every 10) of men reported engaging in MCP. The NASF (2011–2015) thus aims to reduce these incidences of MCP to 10% and below for females and 20% and below for males in the above age-groups. The DHS (2007) identified economic, cultural, social and psychological factors leading to or encouraging MCP.

Desired Behaviour Changes

- *To reduce the number of sexually active individuals having more than one sexual partner (for traditional or other reasons).*
- *To increase the percentage of sexually active individuals practicing protective sexual behaviours (partner reduction and condom use) to prevent HIV infection.*

Target Audience

- *All sexually active people aged 15 – 49 in relationships*
- *Specific tribes that practice polygamy as a cultural practice*

Communication Objectives

- *To increase understanding of personal risks associated with MCP and HIV infection among the sexually active.*
- *To increase understanding of the need for protective sexual behaviours (partner reduction and condom use) among the target audiences.*
- *To increase dialogue and discourse around sexuality, MCP, condom use, and HIV testing among the target audiences.*
- *To increase the proportion of the target audience who believe it is NOT acceptable (traditionally or otherwise) for their partner to have multiple sexual partners.*

Key Promise

- *Having one sexual partner at a time can greatly reduce your risk of HIV infection and can reduce the stress/strain on your resources (time and money).*

Support Points

- *MCP is recognized as a key driver of the HIV epidemic in Zambia, especially among women and men aged 15-49*

Key Messages

- *Reduce your number of sexual partners*
- *Stick to one sexual partner*
- *Use condoms correctly and consistently with all your sexual partners*
- *Know your HIV status and that of your partner.*

Message Delivery Strategies

- *Multimedia (brochures, posters, mobile visual-units, IPC, radio/TV discussions, drama, live musical performances, Facebook/Twitter, SMS).*

3.1.1.2 Low Condom Use

Correct and consistent condom use has over 90% efficacy in reducing HIV transmission. However, condom use among the Zambian population has historically been too low to have a significant impact on HIV transmission rates. The NASF (2010) notes that in 2007, consistent and correct condom use for people ages 15-49 stood at 37% and 45% for females and males respectively. Socio-cultural norms and suspicions have traditionally undermined condom usage and can lead to unintended consequences such as introducing mistrust into a marriage or long-term relationship. For this reason, there is both external and self stigma attached to females who attempt to access condoms, or negotiate for condom use with a partner. Moreover, knowledge levels of condom use as an HIV prevention tool are also reportedly very low. Condoms are also not always easily accessed by vulnerable and marginalized groups, migrant workers and long distance drivers. There is also evidence of low uptake and use of female condoms for a variety of reasons, ranging from the stigma associated, to the acquisition of condoms by females.

Subsequently, the NACAS aims to support the NASF to reach its target of increasing consistent and correct condom use to 55% for females and 70% for males by 2015.

Desired Behaviour Changes

- *Increased percentage of sexually active individuals, including young people, who use condoms correctly and consistently with all sexual partners – including regular, trusted and long term partners.*
- *Increase the percentage of sexually active individuals who deliberate to use condoms to prevent HIV, STIs and pregnancy.*

Target Audience

- *All sexually active individuals, including married or cohabitating women and men, as well as Men Having Sex with Men (MSM).*

Communication Objectives

- *To increase knowledge of correct and consistent use of both male and female condoms.*
- *To increase public knowledge that correct and consistent use of condoms helps prevent HIV, STIs and unplanned pregnancies.*
- *To change perceptions and attitudes towards the acquisition and use of condoms – both male and female condoms.*
- *To advocate for availability of condoms – both male and female - across the country, to meet the needs of different populations including in prisons, and specifically for underserved populations (MSM).*

Key Promise

- *If you use condoms correctly every time you have sex, they will protect you from HIV, STI infections, and unplanned pregnancies.*

Support Points

- *Condoms provide over 90% protection from HIV infection and other STIs and pregnancies when used correctly and consistently.*
- *Male and Female Condoms are readily available across the country*

Key Messages

- *Use condoms correctly every time you have sex.*
- *Do not feel shy to acquire condoms; women can and should also buy condoms.*
- *Make condoms available readily and cheaply.*

Message Delivery Strategies

- *Multi-media (posters, brochures, mobile visual-units, IPC, TV/radio discussions, drama, live musical performances, Facebook/Twitter, and SMS).*

3.1.1.3 Low Uptake Of Voluntary Medical Male Circumcision (VMMC)

Recent research proves that male circumcision (MC) reduces the chances of HIV infection for males by up to 60%. To this effect, the WHO recently included VMMC as one of the global strategies for preventing HIV transmission. Zambia is one of the leading countries in Sub-Saharan Africa rolling out adult VMMC. VMMC services are now provided as part of the comprehensive HIV prevention package and integrated into male reproductive health services such as HCT, STI screening and treatment, FP and provision of condoms. Despite the evidence that MC helps to prevent HIV transmission, MC is still low (13% nationally) in Zambia. The majority of circumcised men are in North-Western Province (71%, or seven in 10 men) and Western Province (40%), with a small percentage in the rest of the country (less than 14%, one in every 10 men).

This communication strategy supports the NASF in an effort to scale up VMMC through appropriate communication and advocacy interventions, in order to reach the target of 21% of men circumcised by 2013 and 30% by 2015 nationally.

Desired Behaviour Changes

- *To increase the percentage of boys circumcised within 0-2 months after birth.*

- *To increase the percentage of males aged 13 to 39 years who seek VMMC.*
- *To reduce the percentage of males who have sex less than six weeks (before complete healing) after undergoing VMMC.*

Target Audience

- *Males aged 13-39 years*
- *Parents and guardians of boys aged 0 to 2 months*
- *All parents or guardians of boys*
- *All men, women and bo*

Communication Objectives

- *To increase levels of knowledge on the benefits of Early Infant Male Circumcision (EIMC) among parents and guardians of boys aged 0-2 months and older by 2015.*
- *To increase the percentage of men, women, boys and girls who know that MC provides only 60% protection from HIV and STIs by 2015.*
- *To increase the percentage of males aged 13-39 years who know the benefits of medical male circumcision by 2015*

Key Promise

- *VMMC reduces the chances of getting HIV and other STIs for men.*

Support Points

- *VMMC reduces the risk of HIV infection by 60%.*
- *VMMC helps to prevent cervical cancer in women.*

Key Messages

- *Take your new-born male baby to the clinic for circumcision*
- *VMMC reduces the risk of HIV Transmissio*

Message Delivery Strategies

Multi-media (brochures and posters placed at ANC, IPC, Workplace/church sensitization, TV/radio discussions, SMS, branded diapers, family planning, ANC & under five cards, billboards, and Facebook).

3.1.1.4 Mother To Child Transmission (MTCT)

MTCT reportedly accounts for 10% of all HIV transmissions nationally. 85% of women and 75% of men know that HIV can be transmitted through breastfeeding. However, only 68% of women and 56% of men know that the risk of mother-to-child transmission can be reduced by taking drugs during pregnancy (ZDHS, 2007). The risk of MTCT can be further reduced by taking a comprehensive approach to PMTCT, including: the engagement of male partners in preventing HIV infection in women, preventing unintended pregnancies in women living with HIV, and providing follow-up treatment, care and support for HIV positive women, their children and families. Providing ARVs to mothers who are HIV positive during pregnancy, and to mothers and children during labour and after childbirth, can significantly reduce the transmission of HIV from mother to child. However, as

of 2009 only 69% of HIV positive pregnant women were accessing ARVs (NASF, 2010). The NASF aims to increase this figure to 80% by 2013 and 95% by 2015.

Desired Behaviour Changes

- *To increase the number of women of child bearing age who test for HIV and get their results.*
- *To increase the number of male partners supporting their spouses in the use of family planning and other PMTCT services.*
- *To increase the number of women attending ANC in the first three months of pregnancy.*
- *To increase the number of HIV positive women accessing family planning services.*

Target Audience

- *Pregnant women*
- *Male partners of women of child bearing age (women aged 15 to 49)*
- *Young people of reproductive age*
- *General community*

Communication Objectives

- *To increase the levels of knowledge about the risk of HIV infection to babies during pregnancy, delivery and breastfeeding.*
- *To increase knowledge about the benefits of HIV counselling and testing for pregnant women.*
- *To increase knowledge on benefits of early antenatal care.*

Key Promise

- *Knowing your HIV status will help increase your chances of having an HIV negative baby.*

Support Points

- *PMTCT services are readily available across the country.*

Key Messages

- *Go for VCT as soon as you are pregnant.*
- *Go for counselling and testing as a couple.*
- *Go for ANC in the first three months of pregnancy.*
- *Men should support their partners to access ANC within the first three months of pregnancy.*
- *Every pregnant woman should know her HIV status.*

Message Delivery Strategies

- *Multi-media (brochures and posters placed at ANC, IPC, workplace/church sensitization, and TV/ radio listening and discussions clubs, SMS, billboards, Facebook/Twitter)*

3.1.2.5 Low Uptake of HIV Counselling and Testing (HCT)

Although evidence exists that early diagnosis of HIV helps to reduce the progression of HIV into full blown AIDS in PLHIV, the uptake of HCT services is extremely low in Zambia. As of 2008 (NAC, 2010), only 15.4% of the total population is reported to have undergone HCT in Zambia. Reasons for this vary from stigma and denial, to lack of knowledge on benefits of HCT, and lack of access to services. Consequently, PLHIV are unable to take early treatment while HIV negative individuals are unable to adequately protect themselves. The NACAS thus plans to support the acceleration of the uptake of HCT services in order to reach the NASF targets of 30% of Zambians who have gone for HCT by 2013, and 50% by 2015 nationally. This will be achieved through appropriate communication and advocacy interventions.

Desired Behaviour Changes

- *To increase the percentage of individuals and couples seeking HCT to 30% by 2013, and 50% by 2015.*
- *To increase the percentage of individuals who undergo regular HCT, after first testing and obtain their results, by 2015.*
- *Increase the availability of HCT services provided across the country.*

Target Audience

- *All sexually active individuals*
- *Married or cohabitating couples*
- *Parents and guardians of young children*
- *General community*
- *Policy makers*

Communication Objectives

- *To increase knowledge about the need and benefits of regular HCT to everyone by 90% from current baseline.*
- *To increase knowledge about the risk of HIV infection to everyone, including children and caregivers, by 90% from current baseline.*
- *To increase knowledge and appreciation of the need for adequate HCT services across the country.*

Key Promises

- *Timely knowledge of your HIV status will help you get effective treatment so that you can live a healthy life if you are found to be positive.*
- *Knowing your HIV status will help you lead a more enjoyable life, whether HIV positive or negative.*
- *Knowing your sexual partner(s)'s HIV status will decrease your chances of HIV infection.*

Support Points

- *HCT services are readily available across the country.*

Key Messages

- *Go for HCT and get your results*
- *Go for counselling and testing as a couple*
- *Provide adequate HCT services*
- *Enact policies and regulations on HCT*

Message Delivery Strategies

- *Multi-media mix (brochures and posters placed at ANC, IPC, workplace/church sensitization, and TV/radio listening and discussions clubs, SMS, billboards, Facebook/Twitter).*

3.1.2.6 Cross-Generational and Transactional Sex

Cross-generational sex can be broadly defined as a sexual relationship with an age difference of at least 10 years between sexual partners. It is a specific manifestation of MCP, and may take place between persons who have concurrent sexual relationships with partners their own age. Cross-generational sex has been found to be common in Zambia, particularly among young girls and considerably older men. Negotiation for safer sex is more difficult when the age differences are large. The ZDHS (2007) shows that 5% of young women, ages 15-19, have had high-risk sex with a man 10 or more years older than themselves.

Transactional sex can be broadly defined as the exchange of sex for some benefit (money, items or services of perceived value). Older men and women who are regular partners with younger men and women based on a transactional relationship are often referred to in Zambia as “sugar daddies” and “sugar mummies.” This type of sexual intercourse is associated with greater risk of contracting HIV and other STIs because of compromised power relations between men and women and the tendency to have multiple partnerships to gain more dividends.

Desired Behaviour Changes

- *To reduce the percentage of the sexually active boys and girls who engage in sexual relations with adults 10 or more years older than them, except for the sake of marriage.*
- *To reduce the number of males and females (especially boys and girls) who indulge in sex for money and/or other favours.*
- *To increase safer sex negotiation skills among women in cross generational and transactional sexual relations.*

Target Audience

- *All sexually active individuals*
- *Young boys and girls*

Communication Objectives

- *To increase knowledge and appreciation of the personal risks associated with acquiring HIV through sex with an individual who is much older and possibly has a wide sexual network.*
- *To increase understanding of protective behaviours (partner reduction and condom use).*
- *To increase dialogue around sexuality, MCP, condom use, and HIV testing.*

Key Promises

- *Abstaining from sex with a much older partner, who may have other sexual partners, and/or for favours will help you reduce your chances of HIV infection.*
- *Abstaining from sexual relations with a much older partner for favours will help you maintain your dignity.*

Support Points

- *Older sexual partners may have a larger sexual network which increases your risk of HIV*
- *Sex for money and material gain reduces your ability to negotiate for safer sex*
- *Abstinence and sex with one faithful partner, of the same generation, reduces chances of HIV infection.*
- *Potential partners of the same age group are readily available.*
- *There are other more appropriate and safe options for survival*
- *Negotiate for condom use.*

Key Messages

- *Abstain from sex with much older or younger individuals, unless in a faithful and long-term relationship.*
- *Sex for favours or money reduces your chances of negotiating safer sex.*
- *Your chances of getting HIV are much higher if you engage in sex with much older partners for favours.*

Message Delivery Strategies

- *Multimedia (ICTs, interpersonal communication and mass media).*

3.2 TREATMENT, CARE AND SUPPORT

The rapid roll-out of most treatment, care and support services has increased access and utilisation of services. By 2008, over 3,000 health facilities were providing ART, and ART services are available in all the nine provinces. Approximately 285,000 PLHIV (56% women and 44% men) were enrolled on ART by 2009. 81% of ART clients are in urban areas and 19% are from rural areas. Pediatric ART uptake also increased significantly from 2006 to 2008; 13.7% of children and infants under the age of 15 living with the virus were on ART at the end of 2006, which rose to 33% by the end of 2008. To ensure that more PLHIV access treatment, care and support, counseling and testing will be intensified. The referral system will also be improved, and service providers will be trained to maximize the utilization of the referral system to ensure that people who test positive are able to access facility and community-based treatment, care and support services.

3.2.1 Key Problem Behaviours

- Non adherence to ART
- Low levels of Couple Counselling and Testing (CCT)

- Poor health seeking behaviours (sharing medicines, etc.)
- Religious leaders that promote faith healing
- Stigma
- Gender based violence

3.2.1.1 Non Adherence To ART

Lack of strict adherence to antiretroviral (ARV) therapy is considered to be one of the key challenges to AIDS care worldwide. Estimated average rates of non-adherence to ARV therapy range from 50% to 70% in many different social and cultural settings, and the risks associated with non-adherence are extensive at both individual and societal levels. Treatment adherence has been closely correlated with viral suppression, while non-adherence contributes to the progression of HIV developing into AIDS, the development of multidrug resistance, and death. Even short-term non-adherence (as little as a day's dosage) may result in the rapid increase of the virus in the blood, which could lead to treatment failure. Adherence is perceived as a significant barrier to the delivery of ARV therapy in sub-Saharan Africa. The reasons for non-adherence range from social, cultural, economic and to structural (such as inadequate services and/or facilities).

Target Audience

- *People living with HIV*
- *Health workers*
- *Traditional leaders*
- *Religious leaders*
- *Political leaders*
- *Caregivers of PLHIV*

Desired Behaviour Change

- *All PLHIV access treatment*
- *All adults and children on ART adhere to treatment*

Communication and Advocacy Objectives

- *To increase access to information on the benefits of adherence among people on ART and their caregivers.*
- *To advocate availability of resources, services and facilities to address non-adherence to ART.*

Key Promise

- *Early treatment of HIV improves quality of life.*

Support Points

- *ART is available and free in Government health centres.*

Key Messages

- *Take ARVs consistently and correctly.*
- *Support your loved ones to adhere to their ART program (regimime).*

Message Delivery Strategies

- *Multi-media (treatment guidelines, toolkits, fact sheets, newsletters, circulars, meetings, radio, television, interpersonal communication, leaflets and posters, teaching aids and guardian's information).*

3.2.1.2 Consumption of Unhealthy Foods

Good nutrition is vital to help maintain the health and quality of life for PLHIV. Infection with HIV damages the immune system, which leads to other infections and health problems such as diarrhoea. These infections can lower food intake because they both reduce appetite, and interfere with the body's ability to absorb food. As a result, an individual can become malnourished, lose weight and be weakened. A healthy and balanced diet, as well as early treatment of infections can reduce weight loss and the impact of future infections. A person who may be receiving treatment for the opportunistic infections, as well as also being treated with combination therapy for HIV may experience difficult influences on their dietary consumption and nutrition. Good nutrition will reinforce the effect of the drugs taken. When nutritional needs are not well met, recovery from an illness will take longer. Although the facts about the relationship between nutrition and HIV and AIDS are well known, not many PLHIV have the opportunity to regularly eat healthy foods. Reasons for this are social, economic and structural.

Target Audience

- *PLHIV*
- *Health workers*
- *Caregivers*

Desired Behavioural Change

- *All PLHIV eat healthy foods.*
- *All caregivers support healthy eating habits for PLHIV.*

Communication Objectives

- *Increase the number of PLHIV who know the benefits of eating healthy foods.*
- *Increase the percentage of people with nutritional treatment literacy.*

Key Promises

- *Good nutrition will improve your health.*
- *Healthy foods make medications work well.*

Support Points

- *Healthy foods are readily and cheaply available*

Key Messages

- *Healthy foods help medicines work effectively*
- *Healthy foods improve quality of life*

Message Delivery Strategies

- *Multi-media (Interpersonal communication, newsletters, meetings, radio, television, leaflets and posters)*

3.2.1.3 Low levels of Voluntary Couple Counselling and Testing (H`CT)

Increased access to HIV testing and counselling is essential in working towards universal access to HIV prevention, treatment, care and support. Couples' testing has many benefits and supports HIV negative partners who are in relationships with people living with HIV. Couple testing could also benefit a couple in accessing and adhering to treatment, and in safely planning for children by minimising the risk of HIV transmission to their partner and/or child. Despite these benefits, few couples in Zambia go for CVCT. However, there is no data to specifically prove this other than rates for the general population which stand at 15%.

Target Audience

- *Males and females aged 15-49*
- *Caregivers*
- *Health workers*
- *Communities*
- *Policy makers*

Desired Behaviour Changes

- *Increased percentage of couples getting tested and receiving their HIV results together.*
- *Increased percentage of sexually active people undergoing CT and disclosing their HIV status to their partners.*
- *Increased percentage of couples seeking reproductive health services together (such as family planning, ART, ANC, PMTCT, etc.) as a result of CVCT.*
- *Increase the percentage of couples seeking treatment as a result of CVCT.*

Communication and Advocacy Objectives

- *Increase the number of couples who know the benefits of CVCT*
- *Increase access to information on CVCT*
- *Increase positive perceptions of and attitudes towards CVCT*
- *Advocate adequate availability of CVCT services and facilities*

Key Promise

- *Knowing your status together as a couple will help you make informed choices about your sexual health.*

Support Points

- *CVCT services are available free of charge in all GRZ health facilities.*

Key Messages

- *Go for VCT with your loved one and make sure you get your results*
- *You CANNOT know your HIV status through somebody else's HIV status*
- *Disclosure of your HIV status will enable an informed choice on treatment and fertility intentions*

Message Delivery Strategies

- *Multi-media (interpersonal communication, newsletters, meetings, radio, television, leaflets and posters).*

3.2.1.4 Poor Health Seeking Behaviours

The perceptions and habits of voluntary health seeking behaviours are some of the hindrances to early treatment of HIV and associated opportunistic infections. For example, even when people recognise the signs and symptoms of HIV or associated opportunistic infections, they will not immediately act accordingly and attend a health facility. There are many other factors which influence the perception of health-seeking behaviour such as motivational factors, fear, stigma, treatment expectations, satisfaction with health care services, decision-making for healthcare, and external barriers (e.g. financial constraints, accessibility of health services).

An example of negative health seeking behaviour is the sharing of medicines. Sharing of medicines is a major problem in Zambia and the world-over. Research shows that people share medicines for a variety of reasons, such as to help out friends and relatives who have the same health problem. Sometimes people share medicines to save money, and so disregard or are unaware of the dangers associated with this practice. Sharing medicines can lead to improper dosage and impair the ability of the medicine to work due to possible genetic differences between the people sharing. When prescribing medicines, doctors take into account all of a patient's health problems, not just the condition the medicine is for, as well as a host of other factors, such as age.

Target Audience

- *PLHIV*
- *Males with partners that are on ART*
- *Traditional leaders*
- *Religious leaders*
- *Health workers*
- *Caregivers*
- *OVC*
- *Communities*

Desired Behavioural Changes

- *Increased percentage of PLHIV voluntarily seeking health services.*
- *Increased percentage of PLHIV seeking early treatment for opportunistic infections.*
- *Increased percentage of traditional and religious leaders supporting PLHIV to seek health services.*
- *Increased percentage of PLHIV adhering to prescribed medication.*

Communication Objectives

- *Increase access to information on the benefits of seeking health services early, especially for opportunistic infections.*
- *Increase treatment literacy among PLHIV and their caregivers.*
- *Increase knowledge of HIV and AIDS to dispel myths and misconceptions that inhibit early health seeking behaviours among PLHIV.*
- *Increase information on benefits of adhering to prescribed medication.*

Key Promise

- *Early health-seeking behaviours will reduce the chances of developing complications and passing an infection to others.*

Support Points

- *Health providers are available at all health facilities to provide more information on HIV and AIDS.*

Key Messages

- *Seek early medical treatment*
- *Do not feel shy to seek medical assistance*
- *Do not share drugs*
- *Make sure to take the full course of prescribed drugs*

Message Delivery Strategies

- *Multi-media (treatment guidelines, newsletters, radio, television, interpersonal communication, leaflets and posters).*

3.2.1.5 Faith vs. Modern (Scientific) Healing

Conflicts between modern treatment (early treatment of opportunistic infections and ART) and faith based healing (faith healing) approaches frequently arise in Zambia and other developing countries. There have been cases where church members have been persuaded to abandon ART and other forms of treatment in favor of faith healing. While faith-based organisations *can* and *do* play an important role in supporting PLHIV, evidence shows that those preaching 'miracle cures' have had a negative impact on their followers.

Target Audience

- *PLHIV*
- *Religious leaders*
- *Health workers*
- *Caregivers*
- *Communities*

Desired Behaviour Change

- *PLHIV adhere to ART.*
- *Religious leaders support ART.*

Communication Objectives

- *Increase access to information on the benefits of strict adherence to ART.*
- *Increase knowledge of religious leaders on the benefits of ART, and adherence.*

Key Promise

- *Adherence to ART improves quality of life if taken correctly and consistently.*

Support Point

- *ART works*
- *ART is available and free in Government health centres.*

Key Messages

- *PLHIV should stick to their prescribed ART.*
- *Support PLHIV on ART.*
- *ARVs are effective when combined with other prescribed medicines.*
- *ART services should be readily available.*
- *ART is a modern miracle!*

Message Delivery Strategies

- *Multi-media (radio, television, IPC, billboards, leaflets, posters, and teachings aids).*

3.2.1.6 Stigma

HIV and AIDS related stigmatisation and discrimination threaten the effectiveness of HIV prevention, and care and support programmes. Stigma, both self and external, discourages individuals from coming forward for testing, and from seeking information on how to protect themselves and others, thus deepening the adverse impact of living with HIV and AIDS. People at risk of HIV infection, or already infected, may choose not to access health care, prevention and education services for fear of being stigmatised by healthcare and service providers. HIV and AIDS related discrimination affects many of the choices that PLHIV, or people at risk, make about being tested and seeking assistance for their physical, psychological, and social needs.

Target Audience

- *PLHIV*
- *Caregivers*
- *Health workers*
- *Traditional leaders*
- *Religious leaders*

Desired Behaviour Change

- *Increased percentage of caregivers and health workers supporting PLHIV.*
- *Increased percentage of religious and traditional leaders supporting PLHIV.*

Communication Objectives

- *Increase awareness on the importance of supporting PLHIV.*
- *Reduce levels of stigma.*

Key Promise

- *Reducing stigma will improve quality of life for PLHIV.*

Support Points

- *Positive attitudes towards PLHIV gives them hope and the will to live and contribute positively to society.*

Key Messages

- *HIV and AIDS is a manageable condition.*
- *PLHIV need love and care just like everyone else.*

Message Delivery Strategies

- *Multi-media (treatment guidelines, toolkits, fact sheets, newsletters, circulars, meetings, radio, television, inter-personal communication, leaflets, posters, and teacher and guardian information).*

1.1.1.7 Gender-Based Violence (GBV)

There is a growing body of evidence that shows that GBV, or the fear of it, interferes with the victim's ability to negotiate safer sex or refuse unwanted sex. Furthermore, violence against a woman can interfere with her ability to access treatment and care. In addition, GBV hinders adherence to ART and a mother's ability to make feeding choices in the event that she is HIV positive. Evidence also exists that living with HIV can also constitute a risk factor for GBV, with many people reporting experiences of violence following disclosure of HIV status, or even following admission that HIV testing has been sought. Thus a vicious cycle of increasing vulnerabilities to both GBV and HIV can be established.

Target Audience

- *Partners of PLHA*
- *Couples that are HIV positive*
- *Health workers*
- *Traditional and community leaders*
- *Religious leaders*
- *Communities*

Desired Behaviour Change

- *Reduction of GBV against PLHIV.*
- *Increased partner support for PLHIV.*

Communication and Advocacy Objectives

- *Increase awareness on the benefits of partner support for PLHIV.*
- *Advocate for policy and legal frameworks to reduce incidences of GBV amongst PLHIV.*

Key Promise

- *Reducing GBV will improve adherence to treatment for you and your partner's health.*

Support Points

- *GBV may affect ART treatment and safe sex choices.*

Key Messages

- *Support your loved ones to live with HIV and adhere to ART.*
- *GBV reduces quality of life.*
- *Women can safely declare their status to their partners.*
- *Women and their partners deliver healthy babies.*
- *Women can safely negotiate for safe sex relationships.*

Message Delivery Strategies

- *Multi-media (meetings, radio, television, billboards, drama, IPC, leaflets and posters).*

3.3 IMPACT MITIGATION

The focus for impact mitigation has been to reduce the socioeconomic impact of HIV and AIDS on individuals, households and communities. As with prevention, impact mitigation services are provided by Government and CSOs, inclusive of faith based organisations (FBOs), and in collaboration with other development partners.

3.3.1 Key Problem Behaviours

- Orphans and Vulnerable Children (OVC)
 - ✓ *Alcohol and substance abuse*
 - ✓ *Unprotected sex*
 - ✓ *Early sexual debut*
 - ✓ *Teenage pregnancies*
 - ✓ *School drop out*
 - ✓ *Child labour*

- Vulnerable households and individuals (community/home based caregivers, women, people living with disabilities, PLHIV, community leaders and faith-based leaders)
 - ✓ *Mental and physical abuse directed towards vulnerable households and individuals*
 - ✓ *Stigma practiced – both self and external*
 - ✓ *Poor health seeking behaviours*
 - ✓ *Prostitution*
 - ✓ *Unprotected sex*
 - ✓ *Substance and alcohol abuse*
 - ✓ *Practice of myths and misconceptions*
- Development partners and Government institutions (MOH/Health workers, Office of the Vice President/ Disaster Management and Mitigation Unit (DMMU), Ministry of Community Development and Social Services (MCDSS), Ministry of Sport Youth and Child Development (MSYCD), Ministry of Justice, other line ministries, GIDD, CSOs and NAC)
 - ✓ *Stigma*
 - ✓ *Poor referral systems*
 - ✓ *Providers not giving adequate information on availability of services and referral*
 - ✓ *Lack of motivation*
 - ✓ *Understaffing of key HIV and communications related personnel*
 - ✓ *Inadequate mainstreaming of HIV/AIDS in service provision*
 - ✓ *Inadequate resources and poor integration with other services*
 - ✓ *Inadequate resources to provide youth empowerment services*
 - ✓ *Inadequate implementation of human rights, policies and support services*
 - ✓ *Inadequate services, weak advocacy and coordination*
 - ✓ *Poor implementation and dissemination of policies*

3.3.1.1 Orphans And Vulnerable Children

Zambia has the second highest number of OVC in Africa. 50% of the estimated 1.3 million OVC in Zambia are as a result of HIV and AIDS, and urban children are more likely to be orphaned or vulnerable than rural children . Children at risk for abuse and exploitation are removed from parents/guardians and placed in shelters or with other family members. Approximately 19.1% of the estimated 1.3 million OVC in Zambia received external basic assistance, from Government, CSOs, FBOs, and international organisations (DHS, 2007).

Desired Behavioural Changes

- *Increased OVC school enrolment and staying in schools up to 50%, from the current 19% by 2015.*
- *Increased number of OVCs delaying sexual debut by 2 years from baseline by 2015.*

Target Audience

- *Orphaned and vulnerable children*
- *Parents*
- *Guardians*
- *Caregivers*

Communication Objectives

- *Increase knowledge of the dangers of early sexual debut by OVC.*
- *Raise awareness on the availability of services and referral systems for OVC.*
- *Increase knowledge of alternative livelihood options for OVC.*

Key Promises

- *Improved life skills of OVCs to cope with the impact of HIV and AIDS, will enable them make healthier sexual decisions.*
- *Improved care and support to OVCs will lead to equal opportunities and a healthy future.*

Support Points

- *OVC support services are available in your community*
- *OVC are the present and future leaders, making responsible choices will safeguard your life*

Key Messages

- *Learn about and utilize OVC support services in your community, and improve your livelihood.*
- *Get more information on sexuality and life skills.*
- *Alcohol and substance abuse is harmful to your health.*
- *Write your will and secure your children's future.*

Message Delivery Strategies

- *Multi-media (interpersonal communication, radio, television, print media, drama, billboards, posters, calendars, fact sheets, SMS, stickers, T-shirts, national days, national events, health talks and traditional ceremonies).*

3.3.1.2 Vulnerable Households and Individuals

Social protection programmes are targeted to reach priority groups, particularly women, children, and persons with disabilities in vulnerable situations. For the most part, it is elderly people and women who provide care to OVC, PLHIV, and relatives with chronic illnesses. Given the burden of care, the epidemic has placed heavy social and financial stress on the elderly and other caregivers.

Their capacity to cope is diminished, or nearly nonexistent. In the absence of widespread retirement and social security benefits, vulnerable households are experiencing increasing poverty as the public welfare system does not have adequate resources to meet demands for basic needs. Additionally, traditional social safety nets are also on the verge of collapsing.

The majority of Zambians, including PLHIV, work in the informal sector where services and support are not always available. Consequently given the loss of income due to illness, they are often unable to meet their basic needs. Fundamental needs such as transport and nutrition remain daily daunting challenges that contribute to many PLHIV not adhering to ART.

Desired Behaviour Change

- *Vulnerable households and individuals engaging in income generating activities.*
- *Vulnerable individuals and household utilizing accessible services in the community.*
- *FBOs and CBOs participating in stigma reduction programmes in their communities.*

Target Audience

- *Home based caregivers*
- *Women*
- *People living with disabilities*
- *PLHIV*
- *Community leaders*
- *Faith-based leaders*
- *The elderly*

Communication Objectives

- *To increase knowledge among vulnerable individuals about how to prevent HIV infection.*
- *To increase awareness and knowledge among vulnerable individuals on health services available in their communities.*
- *To increase awareness and knowledge among vulnerable individuals, health caregivers and leaders on how to reduce stigma.*

Key Promise

- *Empowering households and individuals is a fundamental requirement for reducing the impact of HIV and AIDS.*

Support Points

- *Existence of community social welfare offices in each district.*
- *Existence of social welfare policy.*

Key Messages

- *Be supportive to PLHAs and their families.*
- *Stigma hinders access to services.*
- *If engaging in sexual behaviour, protect yourself.*
- *Use health and social services available in your community.*
- *Alcohol and substance abuse are harmful to your health and a waste of valuable resources.*

Message Delivery Strategies

- *Multi-media (training package, interpersonal communication, radio, television, print media, drama, posters, calendars, fact sheets, SMS, stickers, and T-shirts)*

3.3.1.3 Development Partners and Government Institutions

The focus of impact mitigation has been to reduce the socioeconomic impact of HIV and AIDS on individuals, households, and communities. As with prevention, impact mitigation services are provided by Government and CSOs, including FBOs in collaboration with other development partners. The NACAS will help address current obstacles through appropriate communication and advocacy interventions.

Desired Behaviour Change

- *Consistent provision of resources to NASF strategies*
- *Implementation of policies*
- *Coordination of social security and social services*
- *Mainstreaming of HIV/AIDS in service provision*

Target Audience

- *GRZ (MOH/Health workers, Office of the Vice President/ Disaster Management and Mitigation Unit (DMMU), Ministry of Community Development and Social Services (MCDSS), Ministry of Sport Youth and Child Development (MSYCD), Ministry of Justice, MOE- Ministry of Education, GIDD - Gender In Development Division, MoFNP, CSOs and NAC)*
- *Development partners*

Communications and Advocacy Objectives

- *To advocate for increased and consistent support for impact mitigation*
- *To advocate for coordinated social welfare services*
- *To advocate for the reinforcement of social policies for impact mitigation*
- *Create awareness about areas requiring support for impact mitigation and social welfare services.*

Key Promise

- *Sufficient, coordinated, and sustained support is key to mitigating the impact of HIV and AIDS.*

Support Points

- *Convention on the rights of children (CRC) was ratified in 1991 and provides the legal framework for supporting Vulnerable Children.*
- *CEDAW and conventions on the rights of persons with disabilities provide frameworks for addressing issues of succession and inheritance.*

Key Messages

- *Provision of adequate resources and services for vulnerable households and individuals is Government's responsibility.*
- *Effective coordination improves quality of services for OVCs and other vulnerable populations*
- *Respecting human rights improves quality of life for all.*

Message Delivery Strategies

- *Multi-media (radio, television, print media, drama, posters, calendars, fact sheets, SMS, stickers, T-shirts and billboards).*

3.4 RESPONSE MANAGEMENT

The coordination and management of the national multi-sectoral response has focused on improving the efficiency and effectiveness of existing systems, coordination structures, and resource mobilisation. Efforts have also been made which ensure that the response system generates empirical evidence to support programming, service delivery, policy formulation, capacity development, and resource allocation decisions.

3.4.1 Key Problem Areas

- *Policy and legal environment not conducive and enabling to support the management of the HIV/AIDS response Weak coordination mechanisms and decentralisation amongst key players and partners...*
- *Inadequate mainstreaming of HIV and AIDS, Gender and Human Rights into HIV and AIDS programming...*
- *Weak M&E and research frameworks*

3.4.1.1 Policy and Legal Environment

An enabling policy and legal environment is central to the promotion of a rights-based approach to HIV and AIDS, and provides a framework that promotes rights in a manner that reduces vulnerability to infection, mitigates the impact of HIV and AIDS, and empowers communities to respond appropriately. Stigma and discrimination remain key obstacles in the national response. It is, therefore, anticipated that an improved policy and legal environment will increase the utilization of services, reduce stigma and discrimination against people living with HIV and AIDS, remove barriers that sustain the marginalization of most at risk populations, and address gender inequalities.

Target Audiences:

- *National: Head of State, Cabinet ministers, Partnership forum, Members of parliament, Sector advisory groups (SAGS), Media*
- *Community: NAC councillors, Implementing organizations, Theme/technical working groups, Decentralized constituencies (PATFS, DATFS, Ward CATFS /villages), Media*
- *Local: Local government councillors, Self-coordinating groups, Media*

Desired Policy Changes

- *Policy and legal environment for the implementation of the national multi-sectoral response to HIV and AIDS is adequately strengthened.*

Communication and Advocacy Objectives

- *To advocate for the creation of a rights-based approach to HIV and AIDS legal, regulatory and social environments.*
- *To create awareness on the areas requiring strengthening in laws, policies and regulations.*

Key Promises

- *A good legal, regulatory and policy environment will assist in reducing vulnerability to HIV and further increase uptake of services.*
- *Clear policy guidelines will enhance the ability of organisations to deliver services.*
- *Gender equalities will empower women to protect themselves from HIV.*

Support Points

- *An improved policy and legal environment will increase the utilisation of services, reduce stigma, and discrimination associated with HIV and AIDS.*
- *Support from leadership strengthens coordination and response management.*

Key Messages

- *Good leaders are committed to quality services*
- *Policy, resources and good legal frameworks are crucial to service delivery and coordination.*

Message Delivery Strategies

- *Multi-media (policy briefs, position papers, circulars, research and reports, websites, SMS, billboards, and TV/radio discussions).*

3.4.1.2 Coordination Mechanisms and Decentralisation

Fragile coordination and decentralisation of national activities have been identified as some of the key weaknesses negatively impacting the national response. Gaps in the management and coordination of the national response coupled with inadequate decentralization plans have led to ineffective activities unable to reach from national to grassroots level. There is, therefore, need to ensure that partners and national, sub-national and sectoral coordinating structures and systems are capacitated to effectively and efficiently coordinate and manage the national response at various implementation levels (e.g. national, provincial, district, grassroots).

Target Audience

- *Cabinet ministers*
- *Partnership forum*
- *Members of parliament*
- *NAC councilors*
- *Implementing organizations*
- *Sector advisory groups (SAGS)*
- *Theme/technical working groups*
- *Local government councilors*
- *Self-coordinating groups*
- *Decentralized constituencies (PATFS, DATFS, Ward CATFS /villages)*
- *Media*

Desired Policy Changes

- *Public and private sectors, partners, provinces, districts and communities are coordinating and managing the implementation of the national response at their level and in line with the NASF.*

Communication and Advocacy Objectives

- *Advocate clear policy guidelines on coordination and decentralisation.*
- *Advocate strengthening of coordination between NAC and partners.*
- *Create awareness on policy gaps and ineffectiveness.*

Key Promise

- *Strong coordination, management and decentralisation of the multi-sectoral national response to HIV and AIDS will enhance service delivery and public health policy*

Support Points

- *Decentralisation is an integral element of Zambia's national development strategy expressed through the Decentralisation Policy and SNDP.*
- *Effective decentralisation, coordination and management will systematically help to build the capacities of the various implementing organisations at different levels to manage and sustain a comprehensive response to the pandemic.*

Key Messages

- *Good policies, decentralisation and coordination enhance service delivery of public health and welfare services.*
- *Build capacities of implementing partners in managing decentralised tasks.*

Message Delivery Strategies

- *Multi-media (policy briefs, position papers, research and reports, training manuals, billboards, websites, and SMS).*

3.4.1.3 Mainstreaming of HIV and AIDS, Gender and Human Rights

Although HIV and AIDS affect everyone and every aspect of Zambian society, recent data (NAC, 2010) shows that more women than men are living with HIV (16.1% vs. 12.3% respectively), confirming a gender bias in the pandemic. Available evidence shows that biological, socio-economic and social norms contribute to women's vulnerability. Some of the existing policies, legislation, societal practices and gender inequalities also contribute to the vulnerability of women to HIV and AIDS. The Zambian Government recognizes that HIV and AIDS is a health, development and human rights issue. Yet in spite of this realization, the gender and human rights dimensions of HIV and AIDS have not been adequately mainstreamed due to a number of policy and structural constraints.

Target Audience

- *Members of Parliament*
- *Implementers of HIV/AIDS programmes*
- *NAC counselors and implementing partners*
- *Sector advisory groups (SAGS)*
- *Theme/technical working groups*
- *Self-coordinating groups*
- *Decentralized constituencies (PATFS, DATFS, Ward CATFS /villages)*
- *Media*

Desired Policy Changes

- *Sectors that have mainstreamed HIV and AIDS, gender and human rights in sectoral policies, budgets and operational plans increased to 50% by 2013 and 100% by 2015.*

Communication and Advocacy Objectives

- *Advocate policy formulation and enforcement on mainstreaming and resource allocation.*
- *Raise awareness on gaps in policies and implementation.*

Key Promise

- *Mainstreaming of HIV and AIDS, gender and human rights across all sectors will enhance effectiveness and impact of service delivery across the country.*

Support Points

- *The NASF provides clear guidelines and strategies on how to mainstream HIV and AIDS, gender and human rights.*

Key Messages

- *Gender and HIV and AIDS are human rights issues*

Message Delivery Strategies

- *Multi--media (policy briefs, position papers, research and reports, posters, brochures, TV/radio, and billboards)*

3.4.1.4 Government and Development Partners Funding

The NASF noted that the mobilisation of sufficient financial resources has significant impact on the effectiveness of the national HIV and AIDS response. Other important aspects include the timely and efficient transfer and disbursement of funds to implementing partners, and transparent management of finances with accountability mechanisms that are functional and responsive to an increasing resource envelop. The improper use of resources and lack of accountability by implementers can adversely affect funding to the health sector, thus inhibiting the scaling up of HIV and AIDS activities.

Target Audience

- *NAC counselors and implementing partners*
- *Sector advisory groups (SAGS)*
- *Theme/technical working groups*
- *Self-coordinating groups*
- *Decentralized constituencies (PATFS, DATFS, Ward CATFS /villages)*
- *Government – MOH*
- *Development partners (local, foreign, public and/or private)*
- *Med*

Desired Policy Changes

- *By 2015, NASF financial resource needs that have been mobilised and used efficiently increased to 100%.*
- *Accountability and financial management measures implemented.*

Communication and Advocacy Objectives

- *Advocate for resource mobilisation.*
- *Create awareness on gaps in resource utilisation.*

Key Promise

- *Improved funding, resources, resource tracking, and financial accountability will enhance effectiveness and efficiency of delivery systems.*

Support Points

- *There is good will and commitment from development partners, stakeholders and GRZ to improve the policy and legal environment to effectively support the HIV and AIDS response.*

Key Messages

- *Improved allocation of funds and resources enhances effectiveness and efficiency of delivery systems.*
- *Improved resource tracking and financial accountability ensures effectiveness and efficiency of delivery systems, and transparent initiatives.*

Message Delivery Strategies

- *Multi-media (policy briefs, TV, radio, position papers, research and reports)*

3.4.1.5 M&E, Research Frameworks, and Research Data

The increasing complexity of HIV and AIDS requires the use of strategic information and empirical data in decision-making on the kind of interventions and strategies to adopt. A pre-requisite to achieving this is the development of institutional applied research capacities complemented by an effective M&E system able to generate empirical evidence. However, currently both M&E and research are not being used to effectively inform decisions due to weak mechanisms for information collection.

Target Audiences:

- *Research institutes*
- *Partnership forum*
- *NAC implementing partners*
- *Sector advisory groups (SAGS)*
- *Theme/technical working groups*
- *Self-coordinating groups*
- *Decentralized constituencies (PATFS, DATFS, Ward CATFS /villages)*
- *GRZ line ministries*

Desired Policy Changes

- *The national monitoring and evaluation system for HIV and AIDS has provided 80% of indicator values for the NASF results framework by 2013 and 100% by 2015.*
- *The research national agenda is effectively and efficiently implemented to meet demand for empirical data required to validate the performance of the NASF.*

Communication and Advocacy Objective

- *Advocate the prioritisation, mainstreaming and implementation of M&E and use of research data in decision making across sectors and nationally.*

Key Promise

- *Effective M&E will enhance efficiency and effectiveness in service delivery and implementation of HIV and AIDS programmes.*

Support Points

- *M&E and HIV research data has not been efficiently used to inform programming and policy decisions .*
- *Mechanisms for information dissemination are undeveloped.*

Key Messages

- *Enhance M&E frameworks; develop and use standardised frameworks.*
- *Ensure that M&E activities and research data are relevant to policy decision making and programming.*
- *Make effective use of research data.*
- *Effective use of research data can improve service delivery and decision making.*

Message Delivery Strategies

- *Multi-media (policy briefs, meetings, position papers, research and reports, training tool kits and IPC).*

4.0 STEPS IN DEVELOPING IEC MATERIALS

Health promotion and education activities rely on a variety of well designed and effective IEC/ BCC materials to help ensure success. Every brochure, poster, video or other piece of IEC material is the product of a decision, supported by research, to deal with a specific health concern. The success and impact of IEC materials depends largely on the understanding of the target audience by the design team. Working with target audience members throughout the development of the materials, and in developing strategies for these materials, helps ensure that IEC materials meet the needs of the intended target audience.

This brief chapter offers a set of fundamental guidelines for IEC material development teams to follow in the planning, design (or adaptation), and production of IEC materials. A clear six-step approach is recommended with each step supporting the next.

The seven steps (illustrated in Figure 6) are as follows:

1. Plan
2. Develop Preparatory Activities and Materials/Media
3. Design Methods for Pre-Testing
4. Conduct Pre-Test
5. Analyse and interpret the results
6. Report and Implement (includes mass production and utilization)
7. Monitor and Evaluate

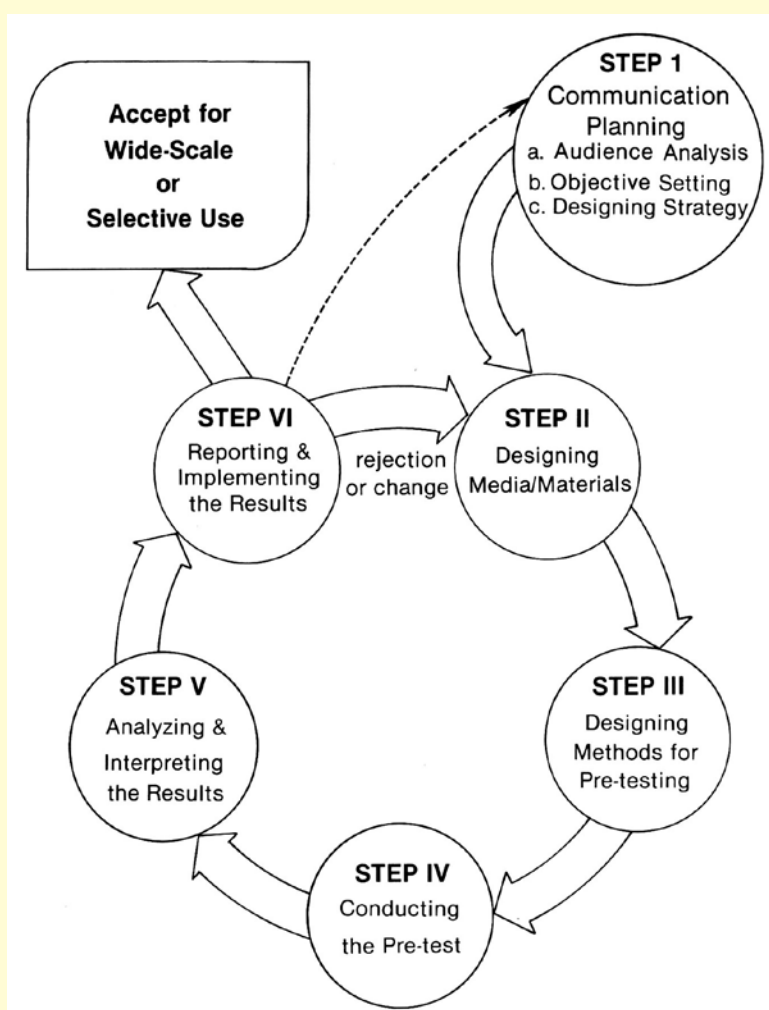


Figure 4: Framework for planning and development of IEC materials.

4.1 PLAN

Planning the communication campaign is a critical step in developing effective IEC materials. First, the current situation must be reviewed. This will include a thorough assessment of the campaign's

IEC needs, existing similar IEC materials, formulation of achievable objectives, and identification of target audiences, activities to be executed, and potential partners for implementation.

4.1.1 Situational Analysis

The first step of a situational analysis is examination and analysis of existing national policies, especially those relating to health, education and communication, and laws which may have an impact on HIV and AIDS prevention efforts. For example, a national policy against condom promotion would need to be revised in the light of the AIDS pandemic. The organizational structure and manpower available for HIV and AIDS prevention should be analysed, while communication and outreach networks, both within the government as well as among NGOs, should be assessed for use in HIV and AIDS educational activities.

Another task in building a situational analysis is the examination of existing epidemiological, cultural and behavioural data, and exploration of the existing situation from various points of view, including: past/present prevention activities and their effectiveness; extent of the spread of HIV in different groups and areas; assessment of vulnerable populations; and information relating to particular groups of interest such as demographic data, social structure, the status of vulnerable groups, and literacy levels.

Every effort must be made to fully utilize existing data from studies in various fields. However, especially when looking for information related to sexual practices, it may be necessary to conduct new studies using qualitative approaches, such as focus group discussions.

Studies can be carried out to fill gaps in information on the following subjects:

a. Structural factors:

- existing media infrastructure;
- existing policies, legislation and/or practice related to relevant matters such as HIV testing, prostitution, MSM, etc;
- existing media policy regarding dissemination of messages about sex, condoms and other controversial topics;
- existing networks and associations, such as NGOs and community organizations, targeting vulnerable populations; and,
- availability of trained human resources for IEC activities

b. Human factors:

- who is at risk;
- existing sexual behaviours and what are the desirable changes;
- factors which might facilitate or inhibit changes;
- who are the influencers for different groups;
- access to media, and media habits (viewing, listening or reading); and,
- access to and use of health services, particularly STI treatment and condoms.

In addition, the following issues must be kept in mind while planning IEC programmes:

- difficulty in talking about sex and sexuality and the need to address these issues through advocacy and education offered in a non-threatening and culturally acceptable way;
- complacency, stigma and denial, which lead to delay in action and allow HIV to spread; and,
- the need to protect and promote confidentiality with respect to persons with high-risk behaviour and those with HIV infection or AIDS.

4.1.2 Audience Analysis

Identifying and prioritising target groups for the IEC programme is of great importance. In the absence of specific targeting, IEC messages tend to be very general, non-focused and foster little to no change or action. Setting priorities is also necessary as it requires a clear understanding about which group(s) will be the focus of the campaign's limited resources.

Target groups for interventions should be identified according to criteria such as risky behaviours, population size, potential for contributing to spread of infection, and accessibility to services such as public health education, health care, etc. Populations at high risk or vulnerable to HIV infection might include:

- adolescents and youth, especially street children;
- women of reproductive age (15-45 years); and,
- known populations with a high prevalence of risky behaviours such as sex workers and their clients, truck drivers, and migrant populations.

4.1.3 Establish Goals, Objectives and Targets

Each identified target audience should have corresponding desired behavioural changes and objectives. Behavioural objectives should be stated in measurable terms, meaning it will be possible to observe and measure progress towards meeting the objectives. For example, an objective may read: "Within 12 months, consistent and correct condom use among sex workers in one fishing camp will increase by 50%;" or for IEC, "Within 12 months, 80% of sex workers will receive accurate information on correct and consistent condom use."

Realistic targets must be set for each objective, taking into account factors such as target groups characteristics, the extent of communication infrastructure, and access to information services (e.g. radio and TV ownership, access to education, availability of support services).

4.1.4 Designing the Strategy/Preparatory Activities

Essential preparatory activities include: developing possible partnership and programmatic linkages, establishing coordination for essential support services, and ensuring availability of trained manpower.

4.1.4.1 Develop Linkages

Linkages need to be established amongst Government, NGOs, CBOs and traditional establishments to encourage collaboration, integration and gathering of support for the communication interventions. Linkages with Government may be with the Ministries of Health, Education, Youth, Women and Child Welfare, Information and Broadcasting Services, Agriculture and other line

ministries. Collaborating with various ministries is a good advocacy technique to establish the necessary policies needed for planning and implementation of effective IEC programmes.

4.1.4.2 Arrange Support Services

Planning in advance for provision of health services and supplies is essential in facilitating public education and awareness. This includes physical inputs, such as availability of condoms, and services, HCT and related health services such as STI clinics and primary health care facilities. Availability services and inputs should influence the objectives and targets set for the overall programme and for specific groups.

4.1.4.3 Conduct Training

Effective implementation of the IEC strategy requires that personnel involved in implementation have the necessary knowledge and skills. Training is vital for ensuring that personnel have the ability to carry out programme activities as required. Development of communication skills trainings and appropriate training materials should be part of the development of IEC materials and campaign activities. Long-term measures could include the incorporation of an HIV and AIDS IEC component into the curricula of basic training programmes for health workers, or workers in other sectors, such as media, NGOs and education, who provide HIV and AIDS information to the public. Short-term measures could include the promotion of in-service training and ensuring that all existing training materials dealing with HIV and AIDS give consistent and correct information.

4.2 DEVELOP DRAFT/PROTO-TYPE MATERIALS

Development of 'draft' or proto-type materials is the next step in developing IEC/BCC materials. Suitable partners and specialists should be identified to assist in this process. This is especially important if distributors of the materials - Ministries or NGOs/CBOs - do not have the in-house capacity to develop appropriate IEC materials for the campaign.

In general, it is recommended that the actual development of materials should be contracted out to appropriate professionals, if available. External expertise can also be sought to undertake preliminary activities crucial to developing effective materials, such as behavioural and audience research.

Development of 'draft' materials should follow the steps below:

4.2.1 Design Messages, Choose Media and Channels

Research and feedback from target groups can be used to determine the best messages and most appropriate medium, and channels to use for a specific product or campaign (such as radio, TV, posters, interpersonal approaches, traditional media, digital media, etc). This is the culmination of the conceptualization, analysis and planning exercise. Targeted IEC research, including an analysis of existing data, and knowledge of the target group, plays an important role in selecting and defining the message, format, presentation, medium, etc., for each identified target group. At the design stage, the exact types of media communication channels, and style should be determined. A campaign should use a mix of passive (e.g. posters, print or video) and interactive media (e.g. Facebook). In many cases, folk media - such as puppetry, drama and story-telling - can be used quite effectively to support interpersonal communication. The range of communication and media options are articulated in Chapter 5 of this Strategy.

4.2.2 Develop IEC Materials

The development of 'draft' materials should be based on previous decisions about messaging, media and channels. It must be kept in mind that materials are a support tool for activities which lead to the achievement of goals and objectives. IEC materials alone will not produce behavioural change.

4.3 DESIGN METHODS FOR PRE-TEST

This process involves making a decision about the methods and tools to use for the pre-testing of the materials. A pre-test will provide the opportunity to collect feedback from the target audience on the developed materials. The techniques for pre-testing will largely depend on the type of materials produced. For example, a TV spot should be tested by using a rough story board or outline of the pictures and text. This will allow the TV spot concept to be tested prior to filming. This process should continue once the rough film has been shot. In this way, you can be assured that, as much as possible, the spot will convey the information desired as effectively as possible. Once methods and tools have been selected, a decision should be made on how the information gathered from the pre-test will be analysed.

4.4 CONDUCT PRE-TESTING OF MATERIALS

Pre-testing of materials is one of the most important steps in materials development. Pre-testing allows the evaluation of messages and materials with regard to acceptability and potential impact before large amounts of resources are used in production and distribution. Although it adds to the cost and time of producing materials, overall it prevents wastage of resources by ensuring that materials are effective. Once draft materials are developed, they are carefully reviewed with groups selected from the specific target audience. Every material to be produced and disseminated should be pre-tested.

Pre-testing will often focus on the following four factors:

Comprehension: Understanding of IEC messages is an essential step in the process to acceptance and behaviour change. Comprehension measures not only the clarity of the content, but also the way in which it is presented. Complicated or technical vocabulary may be responsible for the target audience's failure to understand the message.

Attractiveness: IEC materials should be attractive. If an IEC material is not attractive, individuals may not pay much attention to it. Attractiveness can be achieved through the use of sounds – such as music or tone – in the case of radio; visuals – colour and illustrations – in the case of graphics; and, movement, action, illumination, and animation in the case of video.

Acceptance: The messages must be acceptable to the target population. If communication materials contain something offensive, are unbelievable, or generate discord among the target audience, the audience will reject the message conveyed. Displaying cultural sensitivity is an important factor in achieving acceptance.

Involvement: The target audience should be able to identify with the IEC materials. They should recognize that the message is directed toward them. People will not pay attention to messages that they feel do not involve them. Illustrations, symbols and language should reflect the characteristics of the target audience.

Call to action: The materials should indicate clearly what the health promotion intervention wants the target audience to do. Most IEC materials promote a message that asks, motivates, or induces members of the target audience to carry out or cease a particular action. Successful IEC materials transmit a message that can be done by the target audience.

4.5 ANALYSE AND INTERPRET PRE-TEST RESULTS

This process involves analysing the results of the pre-test using appropriate techniques depending on the sizes of the samples or pre-test design and techniques. In interpreting the results it is safe to assume that if 70 per cent of the target audience understands the IEC material and message, would consider taking the action recommended, and finds the IEC material attractive, acceptable, and believable, then the materials are successful. However, if the IEC material is understood or accepted by less than 70 percent, the production team must consider making changes to the design of the material and/or the message.

There are no absolute guidelines to accomplish this. The production team must look for a balance among all the criteria used to measure the effectiveness of the material. In most cases the pre-test participants may recommend appropriate changes to make to the draft materials. The changes most commonly suggested through a pre-test deal with changes or modifications to either the form or content of the material.

A summary of the steps in material development is shown below:

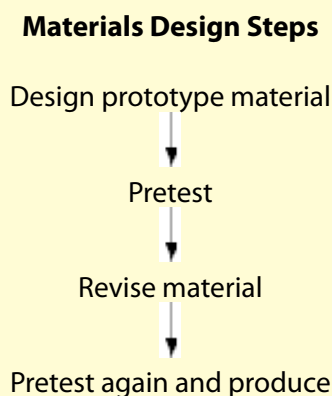


Figure 5: Summary of the materials development process.

4.6 REPORTING AND IMPLEMENTATION (MASS PRODUCTION AND UTILIZATION)

The final step involves reporting back on the results of the pre-test and taking appropriate action on the draft/proto-type material. This may entail making adjustments to the areas with identified weaknesses, or approving the materials for mass production or selective use as required.

Once the materials have been produced and distributed to the target audience, other processes, notably **monitoring and evaluation**, as described in Chapter 6, take effect.

STRATEGIES, CHANNELS, AND TOOLS

5.0 STRATEGIES AND CHANNELS FOR BEHAVIOUR CHANGE COMMUNICATION

Objective 1:

To enhance access to, and uptake of, accurate, adequate, and timely information to support the intensification of prevention initiatives in order to reduce the annual rate of new HIV infections, and with special attention to addressing root causes that sustain high levels of societal vulnerability.

Objective 2:

To enhance access to, and uptake of, accurate, adequate, and timely information to support acceleration of the provision of universal access to comprehensive and quality treatment, care and support for people living with HIV and AIDS, their caregivers and their families, including services for TB, STIs and other opportunistic infections.

Objective 3:

To enhance access to, and uptake of, accurate, adequate, and timely information to support mitigation of the socio-economic impacts of HIV and AIDS especially among the most vulnerable populations – orphans and vulnerable children, PLHIV and their caregivers and families.

These behaviour change communication objectives are predicated on the premise that, as identified in numerous national situation and audience analyses reports, gaps and problem behaviours still exist across all three behaviour related pillars of HIV and AIDS: Prevention; Treatment, Care and Support; and, Impact Mitigation. The scenario is attributable to low awareness and knowledge, and negative perceptions and attitudes, particularly among the most sexually active age groups (youths and young adults). Strategies and activities under these objectives will thus be directed towards increasing access to information in order to enhance levels of awareness and understanding to eliminate knowledge gaps. Eliminating these knowledge gaps will hopefully lead to changing of attitudes and, ultimately, behaviours. Positive changes will be expected at individual, family, community, and institutional levels.

For desired behaviour change to happen, different methods and channels – each effective at different stages of the behaviour change continuum and for achieving different goals - have been proposed in this Strategy as articulated in the following section:

- Strategic communication campaigns
- Information gathering, organization and dissemination
- Participatory development communication
- Health Promotion/Education and Social Marketing

5.1.1 Strategic Communication Campaigns

Strategic communication campaigns should be used to reach a wide range of audiences across the whole country. Their main purpose is to increase levels of awareness and knowledge and access to information. The tools for strategic campaigns provide the reach to both wider and highly targeted audiences. Both traditional and new media should be used to ensure maximum penetration of the messages. The tools used under this methodology include the following:

A. MASS MEDIA

The following mass media can be used:

i. Television

With its added advantages of sound, picture and movement, television is strategically used to showcase new developments and capture real life pictures and opinions about HIV and AIDS. The proposed TV formats include live and pre-recorded TV programmes.

- *Live TV programmes*

These programmes mainly feature medical/health experts, policy makers, scientists and other relevant HIV and AIDS stakeholders. The panel lists responds to questions and concerns raised by the viewing public. The programs also feature ordinary people who are either infected or affected by the pandemic to share their experiences on a given topic. Members of the public may interact with the panellists through phone calls, e-mails and SMS.

- *Pre-recorded TV programmes*

These programmes feature a wide range of experts or interested parties, including members of the public, who discuss selected topics related to the pandemic for the benefit of the viewing public. To make the programmes more interactive a studio audience is assembled to ask questions to the panellists.

- *Documentaries*

Documentaries are used to explore a particular topic or issue on HIV and AIDS in detail. They allow for the capturing of views, testimonies and situations of the local people, which also enables both vertical and horizontal sharing of information. Some of the documentaries can be produced in-house; while others can be produced by organizations supported by the fellowship programme under Objective 4 of this Strategy.

- *TV Spots, Promos and Jingles*

These are short – less than one minute – paid for promotion messages on a particular themes or topics. These may be considered when sending out specific messages on special days, or on the basis of reported prevalence of particular problem behaviours.

The main **target audiences** for TV are: elite primary and secondary audiences and stakeholders. This includes policy makers, political leaders, traditional and religious leaders and cooperating partners. Ordinary people with access to TV sets will also benefit.

ii. Radio – National and Community

Radio can be used to reach a larger audience and a cross section of people, including those in remote areas. Community radio in particular can be used to reach rural communities that do not receive radio signal from the national broadcasters. Community radio can also aid

the spreading of HIV and AIDS information in local languages. Currently there are over 40 Community Radio Stations spread across the nine provinces of the country, as shown in Figure 4 below.

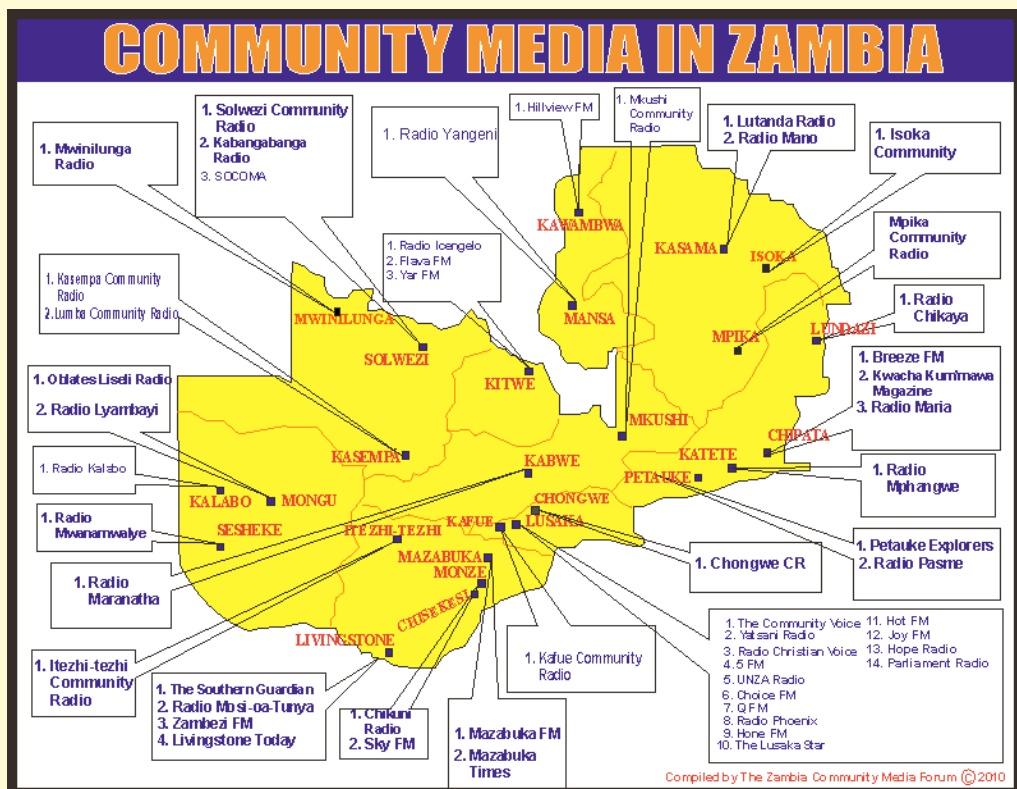


Figure 6: Community media in Zambia; to be utilised to reach the whole country.

Proposed Radio Formats

The proposed formats for television also apply to radio. Radio journalists may also be commissioned to produce radio documentaries for their respective radio stations. The commissioned journalists will receive fellowships under Objective 4 of this Strategy. Media houses may also produce stories over time through grants accorded to them through the Strategy. The primary audience for radio programmes is a cross-section of the average Zambian citizens. Secondary audiences include health providers, implementing partners and the media. Radio audiences may also include stakeholders, policy makers, traditional and religious leaders, and cooperating partners.

iii. Newspapers

Newspapers provide for the opportunity to fully explain information on new developments regarding the pandemic. Existing HIV and AIDS or health columns, such as the ones in the *Zambian Daily Mail* and *Sunday Times*, should be supported. News stories can also be supplied to various newspaper houses and new columns considered in other major newspapers and specialized magazines. The Zambia News and Information Services (ZANIS) reporters will be supported with fellowships to produce radio programmes and newspaper articles from the nine provinces for major media houses and community media across the country.

Proposed formats:

- Regular in-house news, feature articles and editorials on HIV and AIDS to increase awareness and knowledge.

- Feature stories written by fellows supported under Objective 4 of the Strategy.
- The use of existing columns and/or support to new ones in credible weeklies and community newspapers and magazines.
- Emerging topical issues will also be posted on online newspapers, including *Lusaka Times*, the *Zambian Watchdog* and *Timbuktu Chronicles*.

iv. **Press Releases**

Press releases should be used to alert media of new and emerging issues and trends in HIV and AIDS. They can also be used to inform the press about new HIV and AIDS campaigns and products. Press releases are to be written by the proposed Communication and Policy Advocacy Department of NAC. The principal audiences will be the news media houses

v. **Magazines**

Existing magazines will be supported with feature stories written by journalists that will receive fellowships under Objective 4 of the Strategy. Stakeholders should also consider initiating a specialized magazine to raise the profile of HIV and AIDS and showcase quality reporting of the pandemic. The principal audience for magazines will be members of NGO networks, policy makers, cooperating partners, medical personnel, scientists and the general public.

vi. **Posters**

Posters will be used to spread information in a more illustrated way by use of pictures, diagrams and simple written copy. Posters will be placed in strategic places such as schools, markets, churches and highly frequented public places to attract the attention of specific target readers, as well as selected institutions, such as health clinics. Target audiences for posters will mainly include the public and specially identified groups depending on the issue being communicated and location of the poster.

vii. **Billboards**

Like posters, billboards with appropriate messages on HIV and AIDS, can be erected in high traffic areas such as alongside busy roads. They should be highly attractive to capture the attention of the public. It is also recommended that the old billboards of the Ministry of Health and partners be regularly updated with new messages. The target audience will be the public in the vicinity of the billboards and motorists.

B. DIGITAL MEDIA/ICTS

The following digital media should be considered:

i. **Websites**

A website can be used for a variety of reasons, such as to provide information on the latest developments on HIV and AIDS, act as an interactive networking tool among various stakeholders, and act as a link to social networking tools such as Facebook and other platforms. The website would target CSOs/CBOs/FBOs, researchers/academicians, medical and health personnel and the public. It is recommended that NAC host such a website.

ii. **Facebook**

Facebook should be used primarily to target to young people, considering that it has rapidly become the most frequently used social networking platform by this audience. Young people are also one of the most vulnerable populations in the pandemic. Facebook pages can also

be linked to live radio programmes, enabling people to be connected to and contribute to on-going discussions, and so offers participatory component to its approach. A specific HIV and AIDS Facebook page should be created targeting youth and young adults with internet connectivity.

iii. Twitter

This tool is also participatory in its approach, and can also be linked to the website and Facebook page and allow the audience to post short text updates on HIV and AIDS via web browser, instant message, e-mail or mobile text messaging. As with Facebook, young people will be the main target for Twitter.

iv. Blogs

This tool allows for the publishing of content onto a website by anyone, and so participatory by design. People can write and submit personal experiences and thoughts about a given topic. Latest information on HIV and AIDS can also be posted. The principal audiences of Twitter and blogs should be youth, students, NGO and media networks, special interest groups, researchers, scientists, medical and health personnel, cooperating partners and academic institutions.

v. SMS

A newer innovation as a tool for health communication programming, SMS opportunities (mobile phone technologies) offer the capability of placing a cost effective, targeted health message, which can reach a vast audience, even in many remote areas. While challenges for effective SMS programming do continue to exist, the many potentials of SMS health communications arguably make this channel one of the best mediums for the health communication toolkit.

C. INTERPERSONAL COMMUNICATION

The best forms of communication are the ones that allow for face-to-face interaction with the person that is conveying the information. Effective communication of HIV and AIDS information requires direct delivery of the message to the recipient to allow for immediate feedback and clarification of certain issues. Interpersonal communication about HIV and AIDS topics will be directed at individuals mainly for immediate internalization of present and potential attitude and behaviour change. Human communication will also facilitate sustaining positive attitudes and behaviours through regular interactions at individual and group levels. The tools and formats for interpersonal communication include:

i. Popular Theatre

Popular theatre is very useful in getting information to communities, especially those who do not have access to mass media and other forms of communication. HIV and AIDS information is given a human face and a sense of realism through this channel.

Proposed Formats

This can be done through **song, music** with popular musicians, **dance** and **drama**. Live performances by popular musicians should also be staged in different locations, especially on topical days, like World AIDS Day. The principal audience could be less literate audiences, local people, youth (particularly those out of school), and persons from special interest groups, such as the blind and deaf, and the general public.

ii. Interactive dialogue

This tool will allow for free exchange of information between the sender and the recipient of the messages. The strategy will encourage two-way exchange of information, which enables target audiences to also provide their perspectives about HIV and AIDS.

Proposed Formats

The channels for interactive dialogue include:

- Peer Education
- Meetings
- Demonstrations
- Field days
- Fares
- Festivals
- Displays and exhibitions

5.1.2 Information Gathering and Dissemination

Evidence abounds that lack of proper and timely information hampers enhancement of knowledge and awareness, both of which are crucial to attitude and behaviour change. Therefore, there is a need for wide diffusion of information on HIV and AIDS across the four service delivery pillars.

Tools for Information Dissemination

i. Knowledge management (Resource centres)

Existing resource centres and libraries in various parts of the country will be used as information hubs or points where people can easily access HIV and AIDS information through publications and other materials. New health resource centres should be established in places where they do not exist. HIV and AIDS materials can be deposited in resource centres across the country.

These centres should not only contain information in local languages but also have staff that are conversant in local languages spoken in that particular locality. **Information sifting** and dissemination to specific target audiences, such as media, will have to be a critical part of knowledge management.

ii. Documentation of Best Practices

This will involve gathering, processing and disseminating best practices and case studies based on a variety of topics related to HIV and AIDS. The purpose of this activity is to enhance knowledge and behaviour change through learning what has worked or failed in related settings. Possible ways of documentation include video testimonials, and audio and print documentation.

iii. Pictures (photography)

Photographs and illustrations should be professional in nature and presented in targeted publications, at exhibitions or fares, and as slide shows to provoke perception and attitude changes. Pictures can also be published in online platforms. Primary and secondary audiences will be targeted for documentation outputs.

iv. Distribution of IEC Materials

IEC materials – notably leaflets, brochures, manuals, stickers, badges and brail materials - should be produced and distributed across the country. Some of these materials will be translated into local languages.

5.1.3 Participatory Development Communication

Participatory communication facilitates active participation of target audiences to freely discuss relevant subjects surrounding HIV and AIDS. This form of communication is best done in groups at the community level. The following are the three main tools to be used for this methodology:

i. Radio Listening Clubs and Radio Farm Forums

A radio listening club is a group of community members who come together for the common purpose of listening to radio programmes, at an agreed time of the week. A number of organisations have successfully used radio listening clubs for awareness creation and attitude and behaviour change. These clubs are also a form of social mobilization for joint actions as their motto is often: Listen, Discuss and Act. The Strategy proposes that NAC partners work with organisations involved with the existing clubs, with the possibility of setting up new ones particularly around community radio stations. Consideration should also be given to disseminating information through the Radio Farm Forums (RFF) of the Ministry of Agriculture and Cooperatives (MACO).

ii. Study Circles

Study circles are another form of group learning whereby groups meet regularly to study and discuss distributed materials. NACAS recommends that NAC partners consider collaborating with the Swedish Cooperative Centre, which has used this channel for years for agricultural and related information dissemination and training.

iii. Community Meetings

Community meetings should also be considered for imparting information and creating awareness. The target audiences for participatory communication are local people (primary audiences) at community level. The secondary targets are policy makers and service providers at different levels.

5.1.4 Health Promotion/Education and Social Marketing

This method takes advantage of popular genres of entertainment in order to disseminate old and new information about the HIV and AIDS pandemic. Health information should be integrated into theatrical performances, song and dance and other forms of entertainment.

Channels include:

- Feature films, such as *Everyone's Child* on OVCs and *Neria* on widowhood
- Soap operas
- Theatre
- Song and dance
- Drama
- Art
- Cartoons

- Comics

Other channels under mass media include:

- Adverts
- Jingles
- Promos

Channels can be used to achieve results under this methodology. Existing and effective jingles and adverts, such as those currently used in condom promotion and *Know you Partner* jingles supported by Communications Support for Health (CSH), will be learned from and scaled up.

5.2 STRATEGIES AND TOOLS FOR CAPACITY BUILDING AND INSTITUTIONAL STRENGTHENING IN COMMUNICATION

Objective 4:

To Strengthen the capacity of NAC implementing partners to plan, coordinate and implement communication activities as a core component supporting their programme goals at national, regional and community levels.

The limited capacities of implementing partners in communication and advocacy, basic knowledge about HIV and AIDS, and how to write or produce effective stories on the part of journalists, has been identified in a number of studies as a major hindrance to HIV and AIDS communication. Capacities refer to both skills and knowledge at both institutional and individual levels. Limited knowledge of, for instance, counselling and management of ART, has been identified as a key handicap in the ability of health workers to disseminate information in these areas. So too is limited capacities of implementing partners to develop and implement communication and advocacy strategies.

Capacity building or development for programming and policy officers will entail enhancing human and institutional capacities (skills and knowledge) in communication skills depending on established training needs. Some of the areas will include:

- Developing and implementing communication strategies
- Communication and presentation skills
- Working with the media
- Public speaking
- Counselling
- Developing IEC materials
- Development support communication – basics
- HIV and AIDS management
- Press Release writing

Capacity building or development will be achieved through the following interventions:

5.2.1 Short-term Training

Short term trainings will include:

- i) Sensitisation workshops
- ii) In-house on-site training
- iii) Attachments
- iv) Exchange visits
- v) Site visits
- vi) Production and dissemination of tool kits for both media and programming and policy officers.

5.2.2 Long-Term Training

Long-term training will be attained through the following strategies

- i) **Review and mainstreaming of curricula** on HIV and AIDS reporting for journalism training, and on various aspects of HIV and AIDS for health trainees and staff. For media training the Strategy should support development or upgrading of modules in development communication at both diploma and degree training levels.

5.2.3 Networking and Partnerships

Networking and partnerships will be attained through:

i. Creation and support of sectoral, national and local (decentralized) networks:

In the case of media there is need to create and support a vibrant network of journalists involved in reporting on HIV and AIDS, similar to the now defunct Zambia AIDS Journalists' Association (ZAJA).

5.2.4 Information Gathering, Organisation and Dissemination

This will involve:

- i) **Documentation of lessons** and best practices as articulated under Objective 1.
- ii) **Research and dissemination of results**
- iii) **Information sharing:** this will be attained through newsletters, website, internet, bulletins, internet-based discussion groups and others tools.
- iv) **Manuals and Tool kits:** these will be produced and/or distributed on specific topics and for specific target groups. It will include 'How-to' manuals and leaflets.

5.3 STRATEGIES AND TOOLS FOR COMMUNICATION PRIORITISATION AND MAINSTREAMING

Objective 5:

To foster the prioritization and mainstreaming of HIV and AIDS communication and advocacy at different levels and among media and non media actors at different levels across the country.

What sets AIDS apart as a growing national concern is its unprecedented impact on Zambia's

national development. The economic and social impacts of HIV and AIDS are not uniform across the country, nor within societies. Yet wherever it strikes, AIDS affects individuals, communities and sectors relentlessly, eroding human capacity, productivity and prospects. Therefore, if not effectively prioritised, mainstreamed, and controlled, HIV and AIDS could erase all the development gains the country has made over the years.

The 2001 UNGASS Declaration of Commitments instructs countries to integrate AIDS responses into their development frameworks at national, sectoral and local levels, including media and other communication related institutions and interventions. To achieve this, key stakeholders need to engage in a process of mainstreaming HIV and AIDS for multi-sectoral action in order to scale up responses. The UNAIDS notes that effective AIDS responses are premised on strong interactive links between national development instruments, National Action Frameworks for HIV and AIDS, and sector plans. This integrated development and governance approach also provides a sound basis for countries to achieve the interrelated targets of the Millennium Development Goals. Prioritization also requires that HIV and AIDS are high on the ladder of national and sectoral priorities, expressed through plans and resource allocation.

Evidence demonstrated, however, that not much has been done in terms of both the prioritization and mainstreaming of HIV and AIDS at all levels: national, sectoral and community. Through this objective it is hoped that positive results can be achieved in this area.

Strategies and Tools to Achieve Objective 5

A. MEDIA

Prioritisation and mainstreaming of HIV and AIDS for media actors will be achieved through the following methods and tools:

- Policy Advocacy
- Media Relations
- Mainstreaming Policy Guidelines

Strategies and tools for **Policy advocacy** are the same as outlined in Objectives 6 and 7. The tools or channels for Media Relations are explained below

5.3.1 Media Relations

Media communications make up a huge component of the suggested interventions and channels to be adopted to achieve the objectives of NACAS. Mass media shall be responsible for most of the information dissemination across the country. The high prevalence of community media (especially radio) across all the nine provinces of Zambia makes it imperative that media are brought on board for the Strategy to succeed. However, as noted in the situation analysis, the media have not been effectively involved in HIV and AIDS information dissemination. The reasons for this state of affairs range from lack of interest, lack of policy and strategy, to inadequate skills and knowledge of the subject. Media relations as a strategy component will, therefore, help address the situation and ensure achievement of maximum publication or broadcasting of information on HIV and AIDS as required in the Strategy.

i. Sensitization

Sensitizing the media personnel – both editors and reporters – will be another form of stimulation to provoke them to participate. The strategies to achieve this include:

- a) Workshops
- b) Site visits
- c) Organised talks
- d) Lectures
- e) Seminars
- f) Attachments

ii. **Media Briefs**

Briefings for the media is another useful method to increase knowledge and interest levels. The tools for media briefs include:

- a) Media breakfast, luncheons, and/or dinners.
- b) Policy briefs
- c) Positions papers
- d) Press Releases

iii. **Incentives & Resources**

Media personnel have often complained of lack of incentives and resources to cover HIV and AIDS and other complex issues. The NACAS will address this shortcoming through the following means:

- **Media Awards:** awards for the best media and individual reporters or editors in covering HIV and AIDS topics.
- **Media Fellowships:** cash incentives given to individual journalists to write articles on a particularly complex topic or issue, or to broadcast productions specific for audio and/or video outputs on HIV and AIDS. Fellowships will also be considered for senior and experienced journalists to be attached to media houses over a period of time as editor mentors. The fellowships will be awarded on a competitive basis.
- **Media House Grants:** these will be offered to media houses to produce programmes or articles related to HIV and AIDS over a period of time.

iv. **Specialisation Support**

Lack of specialization is another major impediment facing the media in trying to report on HIV and AIDS. As a result, very few journalists across the country are able to effectively and confidently report on HIV and AIDS.

To address the problem, NACAS recommends the following:

- a) **Support specialised HIV and AIDS desks** within select media houses: these will be supported with incentives, capacity building, information and materials on a sustainable basis.
- b) **Skills training:** this will be attained through short-term initiatives described under "capacity building".

- c) **Media Champions and icons:** respected media personalities will be co-opted into the national campaign as champions or ambassadors to speak about HIV and AIDS within media circles.

- v. **Media Advisory**

In order to increase the chances of HIV and AIDS related information being reported in the media, individual reporters will be targeted with information. Media advisories will be sent to inform these reporters about important events or information. Reporters who have shown keen interest in the subject will be specifically targeted. This tactic will also be used for advocacy purposes.

5.3.2 Mainstreaming Policy Guidelines

To support mainstreaming across the different sectors, policies and other guidelines will be produced, together with implementing organisations, on how to mainstream HIV and AIDS communication.

In the case of media actors, any initiatives of established media houses such as the *Post*, *Zambia Daily Mail* and *Times of Zambia*, should be emulated and scaled up. Community media should also be targeted.

The strategies and tools for none media actors will include:

1. Capacity Building: training in mainstreaming
2. Mainstreaming Guidelines
3. Policy advocacy

5.4 STRATEGIES AND TOOLS FOR POLICY CHANGES

Objective 6:

To advocate for the development of national and sectoral policies and strategies, and the harmonization of existing ones, at different levels, including in traditional establishments.

The multi-dimensional and complex nature of HIV and AIDS demands the development of policies and strategies that will address the pandemic in an effective way. Numerous situation analyses have pointed to gaps in policies at national and sectoral levels, such as a lack of harmonization and coordination, leading to duplicity and lack of synergies. All these shortcomings have ultimately had a negative effect on service delivery and effective management and coordination of the national response.

The NACAS recommends advocacy directed towards policy makers, MPs and Cabinet Ministers for the development of policies where gaps have been identified, and the harmonisation of existing policies and strategies, to ensure maximum impact in addressing policy which focuses on the pandemic. Traditional establishments are also key stakeholders that should be incorporated in this undertaking as well.

Objective 7:

To advocate for the enactment and enforcements of new and relevant laws, and the domestication of international protocols to accommodate emerging issues in the pandemic.

The NACAS recognizes the need for favourable social environments to support behaviour change that it seeks to attain. A good legal framework is required to guarantee the protection of human rights in the wake of the HIV and AIDS pandemic. New laws must be enacted in line with the social changes which may have emerged over time, such as gender based violence (GBV). It is equally vital to advocate for the enforcement of existing laws. Advocacy will be required to compel the Government to nationalize some of the international protocols that it has assented to, such as the African Charter on the Rights of Children and the UN Convention on the Rights of Children (UNCRC). The timeliness at which third party reports are sent to the UN General Assembly should also be improved.

Strategies and tools to achieve policy changes will include the following:

- Relations Building
- Policy Advocacy
- Social mobilisation
- Strategic Communication Campaigns

The tools for **Strategic Communication Campaigns** are articulated under Behaviour Change Communication. The tools or means for relations building, social mobilisation, and policy advocacy are outlined below:

5.4.1 Relations Building

Evidence shows that abrasive relations have often hampered advocacy. It is therefore imperative that implementing partners invest in creating and sustaining good relations with policy makers and shapers as part of advocacy

The tools or means to facilitate relations building will include:

i) **Capacity building** of policy makers and shapers through:

- Training workshops
- Exchange visits

ii) **Briefs** in form of:

- Breakfast, luncheon and dinner.
- Policy briefs
- Position paper

iii) **Sensitisation** through:

- Workshops
- Site visits
- Organized talks
- Lectures and seminars
- Provision of information

5.4.2 Social Mobilization

This methodology is premised on the need for coalition-building and community action. Through social mobilization, community members strengthen their social capital and become stakeholders, which is crucial for sustainable advocacy efforts. This method helps to empower communities to make changes for themselves, which in turn help create deeper-rooted and sustainable changes.

The tools or channels for social mobilization include:

- i. **Networking:** this is done through information sharing – web portals, website, newsletters, bulletins, groups, etc.
- ii. **Partnerships:** this is attained through networking and communication and through establishing and sustaining a data base of partners.
- iii. **Group/community mobilization:** this is done through meetings, study circles and radio listening clubs, articulated in Behaviour Change Objectives in 4.1.

5.4.3 Policy Advocacy

Policy advocacy is necessary to influence changes at institutional and social levels and for the development of appropriate laws, regulations and policies supporting these changes. It is also used to influence decisions on the distribution of resources and implementation of activities that affect peoples' lives. The principal aims of advocacy are to create policies, reform policies, and ensure that policies are implemented.

The following strategies are proposed for this approach:

- i. **Strategic Communication Campaigns:** This entails delivering messages through the media as outlined in Objective 1.
- ii. **Lobbying:** which involves:
 - ✓ Picketing
 - ✓ Letters to specific stakeholders
 - ✓ Position papers
 - ✓ Roundtable meetings
 - ✓ Presentations to Parliamentary sessions or committees, cabinet, etc.
- iii. **Production and Distribution of Information Packs.** These include:
 - ✓ Policy briefs
 - ✓ Dossiers
 - ✓ Press Releases
 - ✓ Fact Sheets
- iv. **Policy Research:** bring out issues objectively and disseminate results.

IMPLEMENTATION MODALITIES

The NACAS will run for five years, starting January 2011 and ending December 2015. A mid-term review of the strategy is proposed for the end of 2013, and a final evaluation by July 2015, in readiness for the preparation of the 2016 – 2020 NACAS, which should be ready by November 2015.

6.0 IMPLEMENTATION MODALITIES AND INSTITUTIONAL ARRANGEMENTS

6.1.1 Communication and Advocacy within NASF Structures

Communications and advocacy functions have been designed to be supportive of all the four pillars: Prevention; Treatment, Care and Support; Impact Mitigation; and, Response Management and Coordination. A separate Communication and Advocacy Technical Working Group (CATWOG), falling within the Response Management and Coordination Pillar, has been recommended. The proposed CATWOG will enhance, broaden and strengthen the mandate of the current technical committee on IEC, which has worked on an ad hoc basis. The proposed institutional set up will ensure that the communications and advocacy sub-theme is recognised in terms of resource allocation and prominence within NAC, and the entire fabric of the HIV and AIDS campaigns.

6.1.2 Coordination and Links with Implementing Partners

Given the complexity of the strategy, a widely inclusive and multi-stakeholder approach to implementation will be adopted. The major aim of the NACAS is to ensure that communication and advocacy are used to foster the desired changes – at policy, institutional and audience levels - as articulated in the NASF and other national policies. The NACAS will, therefore, be implemented alongside NASF and will be incorporated within the structures of NAC, under the Response Management and Coordination Pillar.

In order for the Strategy to be effective, harmonisation of all the currently fragmented communication and advocacy related activities will have to be considered, preferably under one Communication and Policy Advocacy (CPA) unit or department, headed by a person with relevant qualifications in communication with a good understanding of HIV and AIDS, or in public health with a good understanding of communication.

The functions of the CPA unit will include:

- a.** To coordinate all HIV and AIDS communication and advocacy activities in the Republic of Zambia, in line with the provisions of the NASF. This should ensure that all the activities of implementing partners are linked to NACAS objectives, and that the whole country adopts only ONE communications and advocacy strategy
- b.** In line with the above function, and with the support of National Technical Working Group (TWG), to act as a clearing house mechanism for all HIV and AIDS related communication in the country
- c.** To develop and oversee the functioning of the proposed TWG. This includes ensuring that the technical group is given direction, through a clear ToR, meets regularly and executes its mandate efficiently and effectively;

- d.* To be fully informed about the communication and advocacy activities of all the key HIV and AIDS implementing partners across the country. This will ensure that NAC remains informed about which aspects or outcomes of the Strategy are being pursued by the different implementing partners;
- e.* To ensure that technical and managerial capacity exists to implement communication and advocacy activities within NAC, across the country and different sectors;
- f.* To ensure that HIV and AIDS communication activities are complimentary, in order to enhance existing initiatives and prevent duplication;
- g.* To ensure mainstreaming and integration of HIV and AIDS communication activities in all the sectors of the economy, including the private sector and other non-state sectors;
- h.* To ensure that the capacity of institutions to carry out HIV and AIDS communication is enhanced;
- i.* To implement, monitor and review NACAS activities including the above; and
- j.* To be involved in resource mobilization for communication activities.

6.1.3 Coordination at Provincial and District levels

At provincial and district levels, the strategy will be coordinated through the respective task forces and specific TWGs with suitable ToRs for that level, but adopted from the National TWG ToR. The provincial and district technical working groups will embrace a wide range of stakeholders that will include local Government departments, Zambia News and Information Services (ZANIS), National Agricultural Information Services (NAIS), ZNBC, local NGOs and CBOs, churches, traditional establishments and other organisations and individuals involved in HIV and AIDS and/or reproductive health generally.

6.1.4 Outsourcing of the Communication Functions

NAC will be in charge of overall planning, implementation and coordination of all HIV and AIDS communication activities articulated in NACAS. This is mainly to ensure that all communication activities, wherever they are being undertaken, are well coordinated, planned, sustained and have a clear sense of direction. However, most of the implementation of the activities or particular outcomes of the strategy will be undertaken by implementing partner organisations – both state and non-state actors - with a proven record of experience and expertise in both communication and particular thematic area.

In delegating responsibilities or outsourcing specific tasks of the NACAS, the following competencies should be used to determine eligibility:

- Extensive experience in communication for development, proposed communication methodologies, and in working with media and other communication actors;
- Proven competencies in HIV and AIDS issues, or particular thematic areas and protocols;
- Well respected and with ability to convene different stakeholders;
- Well networked;
- Demonstrated capacity to monitor and evaluate the proposed activities in the strategy;

- Sufficient capacity to manage interventions to be delegated;
- Sound financial base;
- Strong governance structures; and,
- Perceived as non-partisan and neutral by all stakeholders.

6.1.5 Outsourcing of Advocacy Functions

With respect to advocacy, it is recommended that most of the activities under this component of the strategy be outsourced to a partner organisation or network of partners, although NAC should retain the task of overall coordination. However, whichever organisation or network is delegated will most likely have to be strengthened in order to meet the eligibility criteria prescribed above.

6.1.6 Capacities of Partners and Coordinating Structures

In order to ensure effective implementation of the Strategy, consideration will be given to enhancing the capacities of implementing partners and health staff in communication and advocacy as suggested under Objective 4 of the Strategy. Orientation on how to use the NACAS should be mandatory during provincial and district launches. Implementing partners should also be trained in the production of specific communication products, such as IEC materials and processes in launching a communication campaign. The training can be guided by the strategies suggested in Objective 4.

6.1.7 Clearing House Mechanism

Lack of a clearing house mechanism has been cited as one of the weaknesses in the current national response in communication. This Strategy recommends that the proposed communication and advocacy unit or department, with support of National TWG, takes up this function. A clearing house mechanism will ensure that, as much as possible, messages sent to the general public adhere to the national agenda, and that they are ethically correct. **Formative evaluations** and **pre-testing** of messages will be one of the guiding principles for the clearing house mechanism.

6.1.8 Working with the Media

Media practitioners and owners, in particular those at middle and senior levels, will be incorporated as partners in the Strategy. In practical terms this entails that the media will have to sit on relevant NACAS, NAC and partner communication and advocacy related committees, including the National TWG. At provincial and district levels, media will have to be represented in PATFs and DATFs respectively, and be part of the proposed clearing house mechanisms. For other levels of media relations and engagements, the interventions proposed in Objectives 4 will be the basis.

6.2 FINANCING PLAN

In order to implement the activities proposed in the NACAS, substantial financial resources will be required and should be committed. Funding partners may opt for either basket funding to the entire Strategy or support activities around a particular objective or theme.

6.2.1 Funding Options

Funding for the NACAS is expected to come from two main sources:

- a. Core funding through NAC allocations. The source of these funds could be from either the GRZ

national budget, or from development partners implementing the NASF.

- b.** Direct funding, from development partners.

The above suggestions apply to both communication and advocacy activities of the strategy.

6.3 PROMOTION

In order to be successful, the NACAS will need to be officially launched and promoted through a series of pre-launch activities. These could include promotional messages in the mainstream and community media, posters, SMSs, etc. across the country. Launch activities will be undertaken at national and provincial levels.

MONITORING AND EVALUATION PLAN

7.0 OVERVIEW OF PROPOSED M&E FRAMEWORK

Objective: *To ensure effective and efficient implementation of the NACAS at national, provincial and district levels and across all sectors.*

Monitoring and evaluation (M&E) will be essential in objectively establishing progress towards the achievement of the objectives, and in tracking the performance of the NACAS. M&E will provide the means for accountability and tracking the delivery of results. It will also offer tools for collection, collation, analysis and dissemination of results to enhance learning.

Monitoring will entail a regular collection and analysis of information during programme implementation to assist in timely decision-making, ensure accountability and provide the basis for evaluation and learning. On-going monitoring will enable NAC and implementing partners to take stock of implementation status and see if the HIV communication interventions are proceeding according to plans or if changes need to be made. Monitoring will be answering the question: “How are we doing?”

Evaluation, on the other hand, will focus on the impact of the HIV communication interventions and their outcomes. It will entail data collection at discrete points in time to systematically investigate BCC programme’s effectiveness in bringing about desired behavioural changes in the target populations. This will determine the worth or significance of the proposed communication interventions in the NACAS. Evaluation will use specific study designs and special studies to measure the extent to which changes in desired health outcomes are attributable to a programme’s interventions. Ideally, evaluation of the NACAS will require data collection at the start of the interventions (to establish a baseline) and again at mid and end points. Evaluation will be used to answer the questions: “Did the expected change occur?,” “How much change occurred?” The critical distinction between monitoring and evaluation is that the former will provide regular information during the NACAS implementation, while evaluation will assess the implementation and its success in achieving predetermined objectives.

7.1.1 What to Monitor and Evaluate

The NACAS log frame gives a detailed account of the indicators that will be monitored and evaluated over the life span of the Strategy. More specifically, as provided in the log frame, verifiable indicators will be broken down at four different levels as follows:

Activity: The specific indicators that will guide the measurement and monitoring of activities will be spelt out in the detailed **communication strategy for each campaign or BCC programme developed.**

Output: The following are some of the parameters that will guide monitoring and measurement of success of communications and advocacy outputs:

- ✓ Number of communication and advocacy materials produced, by type, during the period of the strategy;
- ✓ Number of planned events that will have taken place; and,
- ✓ Number of beneficiaries to the numerous planned interventions.

Outcome: To a large extent, the NACAS will monitor the communication and behavioural outcomes of the NASF 2011-2015. The outcome results of the NASF 2011-2015 will provide the necessary indicators to be monitored as the communication strategy will be contributing towards the achievements the NASF strategic objectives.

Some of the parameters that will guide monitoring and measurement of success of communications and advocacy outcomes include:

- ✓ Percentage of the target audience who correctly understand and internalize HIV and AIDS messages;
- ✓ Percentage of the target audience who express positive attitudes and beliefs consistent with the HIV and AIDS messages and advocacy efforts;
- ✓ Percentage of the target audiences who report having taken action or changed their behaviours as required in the strategy; and,
- ✓ Number of policies, laws and strategies developed and adopted.

Impact: The proposed indicators at the level of the NASF goal will help to monitor and measure the extent to which *the Zambian population will have been informed, engaged and empowered and positively participating in the national agenda in prevention; treatment, care and support; impact mitigation; and, national response management and coordination*

It is important to The communication initiatives and strategies fall in one of two categories: behavioural-change initiatives and social-change initiatives. Indicators designed to measure behaviour change initiatives will focus on identifying whether messages change individual, family, community and institutional behaviours. Indicators that measure social-changes will focus on establishing whether people have been inspired to make social changes through community dialogue and collective action.

Communication health campaigns, will be tracked by keeping a record of their products and basic processes or key characteristics. The products will be monitored and disaggregated by the following:

- Health topic
- Primary and secondary audiences
- Location and scale of implementation
- Communication channels used

- Length of implementation per activity
- Whether a campaign was developed based on existing evidence and/or formative research
- Whether a campaign was monitored and/or evaluated

7.1.2 Proposed Monitoring and Evaluation Model

Understanding the differences, issues, synergies and scope of HIV and AIDS in the development context is fundamental to designing monitoring and evaluation approaches. Assessing the effectiveness and efficiency of the BCC interventions will require multi-stakeholder planning and engagement. The proposed participatory monitoring model in the national HIV/AIDS/STI/TB M&E Plan 2011-2015, emphasizes an all-inclusive approach in HIV and AIDS communication planning and decision-making processes, hence the need for continuous consultations and feedback in measuring the different levels of behaviour change processes. This implies that at various stages of the monitoring and evaluation cycle different approaches and categories of stakeholders will be employed/ involved in planning and decision making processes.

7.2 MONITORING OF BCC PROGRAMMES

7.2.1. Broadcast Media

It is important to monitor whether broadcast media, such as radio and television programmes (e.g., spots and dramas), are being aired on the agreed days and times.

Output indicators related to the implementation of broadcast media should be collected and tracked, such as:

- # of radio spots aired per day/week/month
- # of radio drama episodes aired per day/week/month
- # of TV spots aired per day/week/month
- # of TV drama episodes aired per day/week/month

These indicators will be used to estimate the percentage of spots or drama episodes that were implemented according to plan. To collect this information, a media monitoring company could be contracted to track the broadcasts; however, this option may be too expensive. An alternative approach will be to engage members of the community to monitor the broadcasts by providing them with a simple tool, such as a “monitoring calendar”, to record the days and times the programme is aired. It will also be more feasible to conduct random spot checks of the broadcasts.

7.2.2. Small Media

The implementation of small media (or local media such as posters, pamphlets, dramas, and puppet shows) can be monitored by:

- Conducting observations* during random visits or spot checks to the field, to verify that the activities are indeed being implemented as intended. A simple observation checklist can be used to guide the visits and obtain the required information needed for monitoring. The frequency and location of the visits will be determined based on each particular campaign.
- Routine tracking of implementation output indicators.* It is important to agree with campaign

implementers from the beginning, which implementation output indicators will be collected and tracked routinely and by whom. Accordingly, tools for collecting and recording the information will need to be developed. Updates on the indicators should be provided in frequent progress reports (usually monthly), and can be stored in a tracking database and analysed. Descriptive qualitative information about the implementation of the campaign, including reasons why it may not have occurred as intended, should also be included in the reports.

Output indicators related to the implementation of small media should be collected and tracked, such as:

- # of materials distributed
- # of posters placed
- # of mobilization events conducted
- # of newspaper inserts

7.3 MONITORING OF CAMPAIGN REACH

7.3.1 Broadcast Media

To examine the reach of broadcast media, the implementation of rapid surveys using the Lot Quality Assurance Sampling (LQAS) methodology is recommended. Through these rapid surveys, it is possible to estimate the proportion of the audience that has been exposed to a specific radio or television programme, by sub-areas of interest (such as specific districts or urban versus rural).

There are three key reach, or exposure, indicators that should be measured by rapid surveys:

- % of audience who recall (spontaneous and aided/prompted) hearing or seeing a specific campaign;
- % of audience who recall a specific component/characteristic (spontaneous and aided/prompted), such as main character, event, jingle, logo, etc. of campaign; and,
- % of audience who recall hearing (spontaneous and aided/prompted) or seeing a specific health message of the campaign.

The rapid surveys can also be used to examine the audience's attitudes towards the campaign. It is recommended that the rapid surveys be conducted a month after the launching of the radio or television component of a campaign, so that the reach of the campaign can be ascertained early on and modification to the media plan or other aspects can be made as necessary. If information on reach is desired at other times during implementation, the rapid survey methodology can be implemented again.

LQAS Sampling Methodology

Sampling is the process of selecting a group of individuals from a population of interest so that by studying the sample we can generalize our results back to the population from which they were chosen. The two sampling methods most frequently used for rapid surveys are: two-stage cluster sampling and LQAS. The main reason for choosing LQAS is that if one needs information for sub-areas, such as districts, rural vs. urban, or programme catchment areas, it can be easily obtained. Since the reach of the campaigns may vary by different sub-areas, it will be important to report results by these different areas.

In LQAS, a random sample of 19 households (or other unit of analysis as appropriate such as villages, health centres, or schools.) is taken per “supervision area” of a programme. A sample size of 19 provides an adequate level of information for making management decisions; at least 92% of the time, it identifies whether a coverage benchmark has been reached or not.

The rapid surveys will not be nationally representative, but will provide representative information for key regions or specific targeted areas (e.g. urban vs. rural or specific communities). For each campaign, it will be important to decide for which areas information will be needed so that the sample is stratified accordingly.

7.3.2 Small Media

The reach of small media activities can also be monitored through *rapid surveys* (using the LQAS methodology). This method is appropriate if small media activities are implemented with the aim of reaching an entire local population that is too large to count, and if knowing the exact number of people reached is not necessary. The rapid surveys will provide the *percentage* of the local population that was reached or exposed to a particular activity.

Most small media are measured using output indicators, e.g.: # of audience members who participated in “X” community activities. These indicators are appropriate for specific community activities that enable the counting of participation. Some other indicators will include:

- # individuals reached through IPC activities
- # of community members present at health festival
- # of youth who participated in drama club
- # of targeted population reached with individual and/or small group level (HIV) preventive interventions that are based on evidence and/or meet the minimum standards required
- # of targeted population reached with individual and/or small group level preventive interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required.

7.4 EVALUATING BCC PROGRAMMES

Evaluation indicators can be separated into outcome and impact indicators. Outcome indicators measure changes in knowledge, attitudes, and behaviours in the audience, while impact indicators determine impact on health status (e.g., HIV prevalence and mortality). Impact evaluations require special studies with wide coverage as mentioned above.

Observable changes in behaviour, as specified in the behaviour change objectives, are a final programme outcome. Such changes are generally preceded by intermediate changes, or precursors to behaviour change, which may include: knowledge, attitudes, interpersonal communication, self-efficacy, and intention. BCC outcome indicators should include both intermediate and long-term outcomes. This is because the intermediate ones may be impacted first and if changes are shown in them, evidence of some impact is provided.

7.4.1 INTERMEDIATE AND LONG TERM OUTCOME INDICATORS

Intermediate Outcome Indicators: Knowledge, Attitudes and Intentions

- % of young people who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
- % of males and females expressing accepting attitudes towards PLHIV
- % youth intending to maintain their abstinence
- % of population who intend to seek HCT

Long-term outcome indicators: Behaviour

- Median age at first sexual encounter among young men and women ages 15-24
- % of women and men aged 15-49 who had sex with more than one partner in the last 12 months
- % of women and men aged 15-49 who received HIV test results in the last 12 months

7.5 REPORTING AND MONITORING AND EVALUATIONS TOOLS

Routine data collection will need to be incorporated in the established National AIDS Council Activity Reporting System (NARF). Data collected using the NARF and periodical reports, such as the Joint Annual Programme Reviews (JAPR) report, will mostly be at output results level. Such data will be collected quarterly and annually respectively.

Outcome data will be collected using established evaluation methodologies, such as the Sexual Behaviour Survey (SBS), the Zambia Demographic Health Surveys (ZDHS), Mid-term review of the NASF, and special surveys which may be designed to provide indicators that may not be collected using the already existing systems. This data will be collected periodically at specified intervals.

Further, monitoring data related to the inputs, processes and outputs (implementation and reach) of the campaigns will be stored and tracked in a campaign tracking database to be developed. The database will be at NAC and linked to the database at the Ministry of Health. Standardised tools for measuring campaigns will be developed.

7.6 FEEDBACK MECHANISMS

The feedback mechanisms, especially at routine (output) level, will need to be enhanced to include the data sources at district and community levels. Currently the feedback mechanisms at national level are very well established. This is evident from the preparation of periodical reports such as the Joint Annual Programme Reviews (JAPR), Mid-term NASF/Programme Reviews, UNGASS reporting and such similar national reports. The feedback loops at district and community levels have remained the weakest links.

8.0 CONCLUSION

Whereas this NACAS has provided a broad framework for undertaking communication and advocacy interventions with the support of implementing partners, its success will depend on a host of other factors. For instance, clear understanding of the underlying social, cultural, political and economic conditions in the target communities will be a major precondition. This is particularly critical for interventions in HIV and AIDS. Any actor working in HIV/AIDS must examine closely the communities where they work, and be aware of the rich social, cultural and economic diversity within Zambia. Relationships between communities, traditional leadership, district and provincial administrations, the national government and the world beyond must also be examined. The analysis should identify the strengths and weaknesses of targeted vulnerable groups, and of powerful groups whose opinions and attitudes influence social values and behaviours, and control opportunity or entry points for communication interventions within the local context. It is hoped that this NACAS will guide all organisations and individuals who wish to be involved in the fight against HIV and AIDS and ensure that appropriate and strategic communication interventions are undertaken. The NACAS may also serve as a guide, in the development of micro or sector-wide HIV and AIDS communication and advocacy strategies.

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10.0 APPENDICES

Appendix 1: Concepts and Definitions

Behaviour Change Communication

Behaviour change communication (BCC) involves the development of tailored messages and approaches to develop, promote and sustain individual, community and societal behaviour change. Cognizance is given to cultural diversity and audience reception and a multi-channel approach is employed. BCC can improve and promote dialogue at community and national levels on a wide range of health issues.

Social Marketing

Social marketing draws on the principles of commercial marketing to bring about behaviour and social change. It is based on the premise that individuals and organizations are willing to exchange resources for perceived benefits, and that commercial techniques can promote healthy behaviour and ideas. The basic components of social marketing include: creating an enticing product, minimizing price, and promoting the product in appropriate ways, through appropriate channels and in appropriate places. The promotion of condoms, in particular by Society for Family Health (SFH), is one good example of social marketing.

Health Education

Health education is designed to improve health literacy, including improving knowledge, and developing life skills conducive to individual and community health. One form of health education known as "edutainment" combines entertainment and education to disseminate information. This can take the form of soap operas, songs, cartoons, comics, theatre and other forms, which carry messages that lead to healthy behaviour. This approach can reach huge numbers and has a rapid impact. The *One Love Kwasila* radio programme is one good example of health education.

Health Promotion

Health promotion enables people to increase their control over, and improve, their health. It is an approach that involves the population as a whole in the context of their everyday lives, rather than focusing on people at risk of specific diseases, and one that is directed towards action on the determinants or causes of health and well-being. Interventions may be topic-focused (for example, sexual health promotion) or arena-focused (for example school-based health education). Health promotion can include policy advocacy, health education and a range of other communication approaches.

Policy Advocacy

Policy advocacy is a strategy to influence policy makers through persuasive communication when they make laws and regulations, distribute resources, and make other decisions that affect peoples' lives. The principal aims of advocacy are to create policies, reform policies, and ensure policies are implemented. A variety of advocacy strategies have been proposed in this Strategy, such as discussing problems directly with policy makers, delivering messages through the media, picketing, or strengthening the ability of local organizations to advocate.

Participatory Development Communication

This focuses on facilitating exchange between peers to address health issues. It has a strong capacity-building and empowering component, since the participants are responsible for informing and sensitizing their peers. Communication is the means by which individuals within a larger group or organization organise themselves around an issue. They agree that there is a problem; agree on the major causes of the problem; agree to pull their resources together in addressing these causes; and, agree on the major lessons learnt in the process.

A number of tried and tested tools for participatory communication have been proposed in this Strategy.

Social Mobilization

Social mobilization is another example of a participatory method emphasizing political coalition-building and community action. Wide community participation is necessary for members to gain ownership, so that innovations are not seen as externally imposed. Social mobilization is closely interlinked with advocacy. It strengthens advocacy efforts and relates them to social movements and social marketing activities. There is considerable overlap between these approaches and they are best used in combination. Implementing partners that wish to use this method may want to start with the basics – the behaviour that causes risk – using approaches such as behaviour change and health education. These can then be complemented with methods based on social change and participation, which empower communities to make changes for themselves. Such approaches help to create deeper-rooted change, and can avoid the entrenchment of a range of dynamics that could be unsustainable and even create dependency.

Appendix 2: NACAS Logical Framework Theme 1: Prevention

Goal and Objectives	Process Indicators	Output Indicators	Outcome Indicators
<p>Overall Goal: Increased Percentage of the Zambian Population that is Informed, Engaged and Empowered and Positively Participating in the National Agenda in Prevention; Treatment, Care and Support; Impact Mitigation; and, Response Management and Coordination.</p> <p>Objective 1: To enhance access to, and uptake of, access to information to support intensification of prevention in order to reduce the annual rate of new HIV infections with special attention to addressing root causes that sustain high levels of societal vulnerability.</p>	<p>No. of engagement, empowerment and information activities undertaken.</p> <ul style="list-style-type: none"> • # of media (mass) programmes produced and aired. • # of digital media outputs created and maintained – websites, blogs, Dgroup, etc. • # of interpersonal communication activities conducted. • # of information gathering and dissemination activities undertaken (knowledge management, IEC materials and documentation of best practices and case studies is done) • # of health promotion and social marketing activities. • # of participatory communication activities undertaken (radio listening clubs and study circles). • # social media utilized (Facebook, Twitter and You-Tube). 	<p>Increased and intensified prevention in order to reduce the annual infections with special attention to addressing the root causes that sustain high levels of societal vulnerability.</p> <p>Enhanced access to, and uptake of, information.</p>	<p>By 2015, the rate of annual new infections has reduced from 82,000 to 40,000.</p> <p>Infants born of HIV positive mothers who are infected has reduced to less than 5%.</p> <p>More people have comprehensive knowledge of HIV: Female and Male aged 15-49 years with comprehensive knowledge of HIV and AIDS has increased from 37% in 2007 to 53% in 2013, and to 74% in 2015, and increased from 35% in 2007 for people aged 15-24 years to 51% in 2013 and 70% by 2015.</p> <p>Fewer persons have multiple and concurrent partnerships: Female and male aged 15-49 in general population who had concurrent partnerships in the last 12 months reduced from 35% for female and 70% for male in 2010 to less than 10% for female and remains that way by 2015, and to 30% by 2013 for Male and to 20% by 2015.</p> <p>Among females aged 15-49, HIV infection is reduced from 16% in 2009 to 10% in 2013 and to below 8% by 2015.</p> <p>More people test for HIV and know their results: female and males aged 15-49 who ever received an HIV test in the last 12 months and know their results has increased from 15.4 % in 2008 to 30% in 2013 and 50% by 2015</p> <p>More people consistently and correctly use condoms in their last sex intercourse: females and males aged 15-49 who had more than one partner in the past 12 months who used a condom during the last sexual intercourse increased from 37% for females and 50% for males in 2007 to 45% for females to 60% for males in 2013 and 55% for females and 70% for males for males by 2015.</p> <p>More males are circumcised by a health professional: males aged 15-49 years circumcised increased from 13% in 2007 to 21% in 2013 and 30% by 2015.</p>

Goal and Objectives	Process Indicators	Output Indicators	Outcome Indicators
			<p>More HIV positive pregnant females receiving ARVS to reduce risk of transmission to child: HIV positive pregnant females who receive ART to reduce the risk of mother –to- child transmission is increased from 61% (47,175) in 2009 to 85% (72,828) and to 95% (85,655) in 2015.</p> <p>More infants born from HIV positive mothers are not infected: infants born to HIV infected mothers who are infected has reduced from 7% in 2009 to 5% in 2013 and to less than 2% by 2015</p> <p>PLHIV aged 15-49 years who reported having adopted and adhered to atleast two key HIV prevention behaviours in the last twelve has increased X percent by 2015.</p> <p>PLHIV newly tested who reported having disclosed their status to their sexual partners in the last 12 months has increased to X by 2015.</p> <p>All persons who have been accidentally or forcibly exposed to HIV are given drugs to reduce the risk of primary infection: People in need on PEP provided with PEP in accordance with national guidelines in the last 12 months remains at 100% in 2013 and 2015 (disaggregated by exposure): (occupational, rape/sexual abuse, other non-occupational)</p> <p>Fewer females and males have STIs: females and males who report having STIs in the past 12 months has reduced for females from 34% in 2007 to 17% in 2013 and to 5% in 2015 and for males from 26% in 2007 to 13% in 2013 and 5 % in 2015.</p> <p>Donated blood units are screened for HIV and other TTIs in a quality assured manner: donated blood units that have been screened for HIV and TTIs using national testing guidelines is maintained at 100% between 2010 and 2015</p>

Theme 2: Treatment, Care and Support

Goal and Objectives	Process Indicators	Output Indicators	Outcome Indicators
<p>Overall Goal: Increased Percentage of the Zambian Population that is Informed, Engaged and Empowered and Positively Participating in the National Agenda in Prevention; Treatment, Care and Support; Impact Mitigation; and, Response Management and Coordination.</p> <p>Objective 2: <i>To enhance access to, and uptake of, access to information of universal acceleration of the provision of universal access to comprehensive and quality treatment, care and support for people living with HIV and AIDS, their care givers and their families, including services for TB, STIs and other opportunistic infections.</i></p>	<p>No. of engagement, empowerment and information activities undertaken.</p> <p>#of media (mass) programmes produced and aired.</p> <p># of digital media outputs created and maintained – websites, blogs, Dgroup, etc.</p> <p># of interpersonal communication activities conducted.</p> <p>#of information gathering and dissemination activities undertaken (knowledge management, IEC materials and documentation of best practices and case studies is done)</p> <p>#of health promotion and social marketing activities.</p> <p># of participatory communication activities undertaken (radio listening clubs and study circles).</p> <p># social media utilized (Facebook, Twitter and You-Tube).</p>	<p>Accelerated the provision of universal access to comprehensive and quality treatment, care and support for people living with HIV and AIDS, their care givers and their families, including services for TB, STIs and other opportunistic infections.</p> <p>Enhanced access to, and uptake of, information.</p>	<p>More PLHIV live longer: the % of PLHIV who are alive at 36 months after initiation of antiretroviral therapy has increased to 85% by 2015.</p> <p>More PLHIV survive longer on ART: Adults (15 and older, and children (zero to 14) with HIV still live at 12 months after the initiation of ART increased for adults from 90% in 2010 to 98% in 2013 and to 98% in 2015; and increased for children from 80% in 2010 to 90% in 2013 and to 95% by 2015.</p> <p><i>More PLHIV with TB/HIV co-infection are successfully treated: PLHIV with new smear-positive TB who have been successfully treated increased from 41% in 2007 to 60% in 2013 and to 75% by 2015.</i></p> <p><i>Male and female children 0-17 years orphaned and vulnerable whose households receive at least one type of free basic external support in the past 30 days increased from 15.7% in 2008 to 25% in 2013 and 50% by 2015.</i></p>

Goal and Objectives	Process Indicators	Output Indicators	Outcome Indicators
<p>Objective 4 To strengthen the capacity of MAC implementing partners to plan, coordinate and implement communications as a core component to support their programme goals at the national, regional and community levels.</p> <p>Objective 5: To Foster prioritization and mainstreaming of HIV and AIDS at different levels and among different players across the country</p>	<p># of sensitization workshops, in-house on-site training, attachments and exchange visits conducted.</p> <p>#of sectoral, national and local (decentralized networks and partnerships created</p> <p># of documentaries (audio , print and video) produced and aired</p> <p># of resource centers established and information is shared</p> <p>#of networks or coalitions built and social mobilization done</p> <p># of lobbying activities undertaken</p> <p>#of information packs developed (policy briefs, dossiers)</p> <p># of capacity building activities undertaken</p> <p># of sensitization workshops, in-house on-site training, attachments and exchange visits conducted .</p> <p># of media briefs undertaken</p> <p>#of incentives for the media offered</p> <p>#of specialized reporting desks established</p>		<p>More PLHIV survive longer on ART: Adults (15 and older, and children (zero to 14) with HIV still live at 12 months after the initiation of ART increased for adults from 90% in 2010 to 98% in 2013 and to 98% in 2015; and increased for children from 80% in 2010 to 90% in 2013 and to 95% by 2015.</p> <p>More PLHIV with TB/HIV co-infection are successfully treated: PLHIV with new smear-positive TB who have been successfully treated increased from 41% in 2007 to 60% in 2013 and to 75% by 2015.</p> <p>Male and female children 0-17 years orphaned and vulnerable whose households receive at least one type of free basic external support in the past 30 days increased from 15.7% in 2008 to 25% in 2013 and 50% by 2015.</p>

Theme 3: Impact Mitigation

Goal and Objectives	Process Indicators	Output Indicators	Outcome Indicators
<p>Overall Goal:</p> <p>Increased Percentage of the Zambian Population that is Informed, Engaged and Empowered and Positively Participating in the National Agenda in Prevention; Treatment, Care and Support; Impact Mitigation; and, Response Management and Coordination.</p>	<p>No. of engagement, empowerment and information activities undertaken.</p>	<p>Mitigated the socio-economic impacts of HIV and AIDS especially among the most vulnerable children, PLHIV and their caregivers and families.</p>	<p>Fewer households are vulnerable: the number of vulnerable households is reduced to 50% by 2015.</p>
<p>Objective 3: To enhance access to, and uptake of, accurate, adequate and timely information to Support mitigation of the socio-economic impacts of HIV and AIDS especially among the most vulnerable groups – orphans and vulnerable children, PLHIV and their caregivers and families.</p>	<p># of media (mass) programmes produced and aired.</p> <p># of digital media outputs created and maintained – websites, blogs, Group, etc.</p> <p># of interpersonal communication activities conducted.</p> <p># of information gathering and dissemination activities undertaken (knowledge management, IEC materials and documentation of best practices and case studies is done)</p> <p># of health promotion and social marketing activities.</p> <p># of participatory communication activities undertaken (radio listening clubs and study circles).</p> <p># social media utilized (Facebook, Twitter and YouTube).</p>	<p>Enhanced access to, and uptake of, information.</p>	<p>More people receive comprehensive and quality care at home and in the community: females and males aged 15-59 who either have been very sick or who died within the last 12 months after being very sick whose households received certain free basic external support to care for them within the last year increased from 41% in 2009 to 50% in 2013 and 60% by 2015.</p> <p>More OVC receive free external basic support: OVC under 18 years whose households received at least one type of free basic external support to care for the child in the last 12 months has increased from 16% in 2009 to 25% in 2013 and to 40% in 2015.</p>

Theme 4: National Response Management and Coordination

Goal and Objectives	Process Indicators	Output Indicators	Outcome Indicators
<p>Overall Goal:</p> <p>Increased Percentage of the Zambian Population that is Informed, Engaged and Empowered and Positively Participating in the National Agenda in Prevention; Treatment, Care and Support; Impact Mitigation; and, Response Management and Coordination.</p> <p>Objective 6: To Advocate the development of national and sectoral policies and strategies and harmonization of existing ones at different levels, including in traditional establishments</p> <p>Objective 7: To advocate the enactment and enforcements of new and relevant laws and domestication of international protocols to accommodate emerging issues in the pandemic.</p>	<p># of policy advocacy activities undertaken.</p> <p># of advocacy coalitions built</p> <p># of capacity building activities undertaken.</p> <p># of sensitization workshops, in-house on-site training, attachments and exchange visits conducted.</p> <p># of relations (with media, policy makers, politicians, etc) building activities undertaken.</p> <p># of media briefs undertaken</p> <p># of media (mass, digital) programmes produced and aired.</p>	<p>Strengthened the capacity of coordinating and implementing organizations and structures and sustainably managed the HIV and AIDS multi-sectoral response.</p> <ul style="list-style-type: none"> • Policies formulated • National and sector strategies developed. • New laws enacted • Existing laws being enforced. 	<p>The total NASF service coverage targets that have been met in all the four pillars have increased to 50% by 2013 and 90% by 2015.</p> <p><i>The enabling policy and legal environment is improved: between 2011 and 2015, the enabling policy and legal environment necessary for the implementation of the national multi-sectoral response to HIV and AIDS is adequately strengthened.</i></p> <p>By 2015, NASF financial resource needs that have been mobilised and used efficiently increased to 100%.</p>

Goal and Objectives	Process Indicators	Output Indicators	Outcome Indicators
<p>Objective 4: To strengthen the capacity of NAC implementing partners to plan, coordinate and implement communications as a core component to support their programme goals at the national, regional and community levels.</p> <p>Objective 5: To foster prioritization and mainstreaming of HIV and AIDS at different levels and among different players across the country.</p>	<p># of sensitization workshops, in-house on-site training, attachments and exchange visits conducted .</p> <p>#of sectoral, national and local (decentralized networks and partnerships) created and maintained.</p> <p># of documentaries (audio , print and video) produced and aired</p> <p># of resource centres established and information is shared.</p> <p>#of networks or coalitions built and social mobilization done</p> <p># of lobbying activities undertaken</p> <p>#of information packs developed (policy briefs, dossiers)</p> <p># of capacity building activities undertaken</p> <p># of sensitization workshops, in-house on-site training, attachments and exchange visits conducted .</p> <p># of media briefs undertaken</p> <p>#of incentives for the media offered</p> <p>#of specialized reporting desks established</p>	<p>Stakeholders capacitated.</p> <p>HIV and AIDS mainstreamed.</p> <p>Sector and national policies on mainstreaming developed.</p>	<p>Stakeholders capacity to implement NASF strengthened by 2013 and remains the same by 2015.</p> <p>Between 2011 and 2015, 100% of all public and private sectors, partners, provinces, districts and communities are coordinating and managing the implementation of the national response at their level in line with the NASF.</p> <p>Sectors that have mainstreamed HIV and AIDS, gender and human rights in sectoral policies, budgets and operational plans increased to 50% by 2013 and 100% by 2015.</p> <p>By 2015, NASF financial resource needs that have been mobilized and used efficiently increased to 100%.</p>

Goal and Objectives	Process Indicators	Output Indicators	Outcome Indicators
<p>Objective 8: To ensure efficient and effective implementation of NACAS at all levels and across all sectors.</p>	<p>NACAS Launched nationally and in all the provinces. Implementation plan developed and adhered to. Annual roll out plans in place Regular monitoring and reviews undertaken. Half term review undertaken End-of-NACAS evaluation undertaken.</p>	<p>All planned activities in NACAS undertaken and its goal and objectives being met as planned.</p>	<p>The enabling policy and legal environment is improved: between 2011 and 2015, the enabling policy and legal environment necessary for the implementation of the national multi-sectoral response to HIV and AIDS is adequately strengthened.</p> <p>By 2015, NASF financial resource needs that have been mobilized and used efficiently increased to 100%.</p> <p>The national monitoring and evaluation system for HIV and AIDS has provided 80% of indicator values of the NASF results framework by 2013 and 100% by 2015.</p> <p>The research national agenda is effectively and efficiently implemented to meet demand for empirical data required to validate the performance of NASF.</p> <p>Effectively and efficiently implemented NACAS.</p>

Appendix 3: Summary of the Quantity and Quality of HIV and AIDS Print Media Coverage between July 1, 2009 and December 31, 2009.

- 1. Snapshot of Print Media Coverage of HIV and AIDS (July 1, 2009 - December 31st, 2009)**
- 2. Number of HIV and AIDS Stories Written:** 278
- 3. % of Published HIV and AIDS Stories to the total of the estimated news stories Published by all the Seven Newspapers:** 13%
- 4. Number of Front Page Stories:** 18
- 5. Distribution by type of stories:** Hard news (63%); features (12%); column articles (17%); Editorials (6%); *Letters to Editor* (2%).
- 6. Distribution between events and issue based:** 43% to 57%.
- 7. Leading Newspapers Covering HIV/AIDS:** Weekend Post (25%); the Post (24%); Times of Zambia (17%); Monitor (13%); Zambia Daily Mail (9%); Sunday Times (9%); Sunday Mail (3%).
- 8. % of Articles written by Zambian journalists (as opposed to foreign news feeds):** 85%
- 9. Sections of News where HIV/AIDS stories are printed:** Home News (50%); Features (20%); Opinion (12%); Foreign and Entertainment (7%); Business (2%); Supplement (1%); Sports (0%).
- 10. % of HIV/AIDS related stories with a positive and successful tone:** 86%
- 11. Key HIV/AIDS related Topics:** Prevention (63%); Treatment (13%); Awareness Raising (6%); Care (5%); Cure (4%); Stigma/Discrimination (3%); Research (2%).
- 12. Prevention Modes Discussed:** Condom use (70%); Prevention of Mother to Child Transmission (9%); Circumcision (4%); and Faithfulness (1%).
- 13. Newspapers with Health Reporting Desks (as of January 2009):** Zambia Daily Mail.
- 14. Newspapers with dedicated HIV and AIDS column (as of January 2009):** Zambia Daily Mail.

