Comprehensive National HIV Communications Strategy for Zimbabwe:

2019-2025

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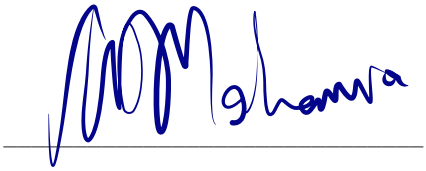
Foreword

Communication on public health issues play a pivotal role in our efforts to leave no one behind and see 90% of people living with HIV to know their status; 90% of those living with HIV on lifelong antiretroviral therapy; and 90% to achieve viral load suppression by 2020. Social behaviour change communication provides a pillar of support to ensure that not only programmatic targets are met, but also that there is informed demand for health products and services for different community groups.

As HIV programmes in Zimbabwe move closer to the 'last mile' of attaining sustainable control of the epidemic, it is crucial that we employ 'a business unusual' approach that seeks to refine our focus and targeting approaches. Significant progress has been made over the years, and this includes 'first-class' innovations in demand generation such as the 2015 IPSOS VMMC market research. This sought to map a man's journey to circumcision and identify points at which interventions could be strategically placed, using consumer market research approaches. Investments have been made over the years in conducting Empathy, Insights and Prototyping (EIPs) for various HIV prevention programmes that have made it possible to understand clients' perspectives and needs in their quest to seek health services and products. However, these innovations have not covered all the HIV programmes.

With these innovations and promising approaches, gaps still exist and some of the programmes continue to miss their targets. Specific population groups such as men, adolescents and key populations are lagging behind. With this in mind, the MoHCC with its partners in 2018 set to harmonise the communication approaches with the one key realisation that it is generally the same population groups that are being targeted with the different HIV programmes. Certainly, an opportunity exists in a unified communication approach, that is client-centred and traced through the client's health journey.

It is the Ministry's firm belief and hope that the development of this Comprehensive National HIV Communications Strategy will contribute effectively to improved reach of different population groups and create sustained demand for health products and services. This will in turn contribute to a greater impact on the epidemic and improved outcomes for population groups in Zimbabwe. My appeal is for all relevant stakeholders to rally behind this new approach and work together in raising the bar of social and behaviour change communication through joint implementation of this strategy document.



Dr. Agnes Mahomva
Permanent Secretary, Ministry of Health
and Child Care

Abbreviations

ABYM	Adolescent Boys and Young Men
AGYW	Adolescent Girls and Young Women
AM	Adult Men
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
AW	Adult Women
CCP	Comprehensive Condom Program
DHIS	District Health Information System
eMTCT	Elimination of Mother-To-Child Transmission of HIV
FSW	Female Sex Worker
GBV	Gender-Based Violence
HCD	Human-Centred Design
HRH	Human Resources for Health
HTS	HIV Testing Services
IEC	Information, Education and Communications
IPC	Interpersonal Communications
IPV	Intimate Partner Violence
M&E	Monitoring and Evaluation
MoHCC	Ministry of Health and Child Care
MSM	Men Who Have Sex With Men
NAC	National AIDS Council
NGO	Nongovernmental Organisation
PEP	Post-exposure Prophylaxis
PLHIV	People Living With HIV and AIDS
PMTCT	Prevention of Mother-To-Child Transmission of HIV
PrEP	Pre-exposure Prophylaxis
PWD	People With Disabilities
SBCC	Social Behaviour Change Communications
SEM	Socio-Ecological Model
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TB	Tuberculosis
TBA	Traditional Birth Attendant
UN	United Nations
VMMC	Voluntary Medical Male Circumcision
YM	Young Men
YW	Young Women
ZNASP	Zimbabwe National AIDS Strategic Plan
WHO	World Health Organisation

Definitions of Key Terms and Phrases

Advocacy: A process undertaken by citizens to influence and transform power relations with the purpose of achieving policy changes or allocation of resources that benefit specific populations.

Audience Archetype: Fictional characters, created out of insights from exploratory discussions including stakeholder workshops and client interviews that exemplify certain attributes. They make the abstract concept of the "target audience" personal and human. They build an empathetic understanding of how people experience their health journeys to guide implementers in developing relevant interventions.[1]

Communications Programming: A systematic approach that helps align communications with programme priorities. An authentic and credible communications programme can help persuade and inform key stakeholders by defining critical audiences, audience-specific objectives and critical messages and then determining how to deliver the messages through select channels over a specific period of time, ending with feedback and evaluation of effectiveness.[2]

Human-Centred Design: A creative approach to problem-solving that starts with people and ends with innovative solutions that are tailor-made to suit their needs. With empathy and understanding for each target audience, interventions can be designed from each audience's point of view, so as to be more readily embraced.[3]

Journey Map: A visual representation of the process a person goes through to accomplish a goal. The journey map allows stakeholders to "walk a mile in the client's shoes" and is a powerful tool to shift the focus from "What do we want?" to "What does the client need?"

Key and Vulnerable Populations: The World Health Organisation (WHO) and UNAIDS define men who have sex with men (MSM) and female sex workers (FSWs) as key populations affected by HIV as a result of their behaviours which put them at risk. People with disabilities (PWD), young people and women are considered to be in a state of vulnerability because their living conditions put them at increased risk for HIV.[4]

Communications Matrix: Audience, Barrier and Behavioural Analyses, and Communications Objectives: This chart summarises goals, barriers and facilitating factors for each target audience and includes communications objectives, illustrative indicators and illustrative messages.

Men Who Have Sex With Men: Men, including those who do not identify themselves as gay or bisexual, who engage in sexual activity with other men.

People With Disabilities: An umbrella term used to describe impairment, including physical, developmental, intellectual, mental or cognitive impairment or a combination of these.

Social Behaviour Change Communications (SBCC): SBCC is a comprehensive approach to promote and enable changes in attitudes, social and cultural norms, beliefs and knowledge to inspire and empower people to make healthy choices. SBCC focuses not only on individual behaviour, but also on community and policy dialogues to promote collective action.

Transactional Sex: Transactional sex refers to nonmarital, noncommercial sexual relations in exchange for material support or other benefits and is a common practice among adolescent girls and young women; it also occurs with adolescent boys and young men.

Executive Summary

Current HIV prevention, care and treatment communications efforts globally and in Zimbabwe have traditionally been programme-led and target people who need specific services, presenting vertical, standalone or parallel interventions. Zimbabweans have complex lives and access services in an integrated manner along their health journey, not in silos, hence the need to design integrated communications. To fully support the country, in meeting the extended 90-90-90 targets, requires a major shift in designing and implementing HIV prevention, care and treatment communications efforts from a vertical, programmatic approach to a client-centred, life-stage approach. The result is a better understanding of the barriers people face, their motivations, and influencers of their health decisions to know where and how to reach them with appropriate interventions.

Grounded in research and human-centred design, this Comprehensive National HIV Communications Strategy puts the client at the centre of all efforts to show how programmes often overlap requiring communications to be client-centred rather than programme-centred. The client-centred approach provides visibility to the person's experience with the highs (motivators) and lows (barriers) of accessing HIV prevention, care and treatment services and reveals areas of prioritisation for communications interventions and collaboration with service delivery to make their journey easier. Moreover, illuminating these priorities allows implementing partners to design more efficient and cost-effective strategies by identifying gaps and reducing overlaps in existing programming interventions to generate demand for HIV prevention, care and treatment services. By looking at the lives of specific target groups and following them along a journey of health-seeking behaviour, this strategy reveals the complexity of human life by unpacking the needs of 11 target audiences: adolescent girls and young women, adolescent boys and young men; adult women and men; MSM; FSWs; people with disabilities; influencers; and providers. The target audiences are overarching, and implementers will need to identify

sub-segments for further refinement. With a more comprehensive understanding of individual needs, available solutions can be presented to help prevent and treat HIV, allowing the programme to revolve around the needs of the person.

To create change at various levels of the socio-ecological model, the strategic objectives centre around the following themes: policy and advocacy, systems and structures, culture and community, and individual practices. Ultimately, this strategy delivers the tools that programmers, funders and implementers need to design, plan and implement a unified voice and holistic approach to HIV communications with communications objectives, illustrative messages and illustrative indicators.

> *"The Comprehensive National HIV Communications Strategy puts the client at the centre of all efforts to show how programmes often overlap, requiring communications to be client-centred rather than programme-centred..."*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CHAPTER 1.

Background and Introduction

The Comprehensive National HIV Communications Strategy for Zimbabwe: 2019-2025 is the guiding framework for implementing integrated HIV communications interventions and activities. It recognises the importance of a holistic approach to the integration of communications approaches and linkages between HIV prevention, care and treatment programmes, connecting the individual from one programme to the next depending on where they are along their health journey.

Despite progress made towards achieving the 90-90-90 targets, there is no overarching framework guiding comprehensive HIV social and behaviour change communications activities. Stakeholders recommended the development of a Comprehensive National HIV Communications Strategy, aligned with the Zimbabwe National AIDS Strategic Plan, and focused on supporting the achievement of its vision of ending AIDS by 2030.

1.1 Rationale for the Comprehensive National HIV Communications Strategy

HIV Communications Programming Gaps in Zimbabwe

Despite the successes of individual HIV programmes, the current vertical approach to programming has resulted in missed opportunities and a lack of integrated social behaviour change communications (SBCC) strategies targeting young people, key and vulnerable populations, and men. Overall, HIV prevention, care and treatment communications in Zimbabwe lack a robust comprehensive and integrated advocacy and communications strategy addressing key barriers and motivators at various stages of clients' health journeys. Whilst the Voluntary Medical Male Circumcision (VMMC) programme has a communications strategy, it is a standalone strategy with no clear linkages to other HIV prevention strategies such as the Comprehensive Condom Programme (CCP) or HIV Testing Services (HTS). The VMMC strategy does provide best practices and guidance for a client-centred approach, developed using participatory and human-centred design by reviewing audience segmentation and the client's journey. There are currently no other communications strategies for HIV prevention, care and treatment.

"An integrated, people-centred approach is crucial to the development of health systems that can respond to emerging and varied health challenges..."

~ World Health Organisation

A Client-Centred Approach

As depicted through key insights in the human-centred design (HCD) audience journey maps, people start their journey with HIV programming at different stages, have different motivators and barriers, and need encouragement, support, resources, information and answers along the way of seeking HIV prevention, care and treatment services. Inadequate support during the health journey can impede, or worse, reverse progress. These key insights along with the highs (motivators) and lows (barriers) illuminate areas of prioritisation for communications strategies and where coordination efforts with service delivery can make access to HIV prevention, care and treatment services easier. This strategy is designed to follow people along the stages of their journey offering programme implementers key insights for more effective behaviour change communications interventions.

Behaviour Change

Research confirms that behaviour change takes time and is not linear—a key concept considered in the development of this strategy. Behaviour change is a process that requires discovering the value of the specific behaviour, resolving barriers and leveraging motivations. This process requires information and messages to be delivered through multiple channels over sustained periods of time. An integrated approach to behaviour change and communications has the following potential benefits:

- **Clients:** focuses on priority barriers and motivators, thereby facilitating a more sustainable behaviour change and positive health outcomes.
- **Funders and implementers:** reduces gaps and overlaps, and improves coordination among programmes for demand generation and uptake of products and services.

1.2 Evidence and Research in Existing Communications Strategies

Strategies for Effective HIV Communications

Research reveals how evidence-based communications consistently increases knowledge and changes beliefs, attitudes and cultural/gender norms.[5] Communications interventions, in conjunction with policy and advocacy changes, and biomedical interventions that improve service delivery can synergistically affect outcomes in behaviour. Effective communications strategies related to HTS, VMMC, Elimination of Mother-to-Child Transmission (eMTCT), condom use and Care and Treatment are shown in Table 1.

Table 1.
Evidence of Effective Communications Strategies: Approaches and Impacts[5]

APPROACH	IMPACT
Combination strategies and multi-channel approaches that create general awareness at mass media level with on-going structured IPC approaches and community participation	Increases testing, condom use, VMMC
Higher exposure to communications intervention	Increases dose-response for uptake of services
Increased school-based programmes with more general focus on SRH	Improves outcomes, increases gender equity
Use of peer educators with lived experience, combined with peer support groups	Increases testing, condom use, retention in care and decision to VMMC, especially in vulnerable and key populations (young people, MSM, sex workers)
Celebrity endorsements with lived experience	Shifts social norms, reduces stigma and encourages uptake of prevention, care and treatment
Involving men early in ANC visits	Improves condom and testing uptake when coupled with consistent counselling
Training community members to be ART expert clients relieves human resources for health (HRH) shortages	Relieves HRH shortages especially in rural areas, and increases retention on ART, while reducing community stigma and improving quality of life for PLHIV
Radio (talk shows, dramas, adverts)	Is consistently a strong way to reach people across all socio-economic backgrounds to spark IPC and change social norms and increase HIV knowledge, particularly about condom use

Abbreviations: ANC, antenatal care; ART, antiretroviral therapy; HRH, human resources for health; IPC, interpersonal communications; MSM, men who have sex with men; PLHIV, people living with HIV/AIDS; SRH, sexual and reproductive health; VMMC, voluntary medical male circumcision.

1.3 Purpose of this Communications Strategy

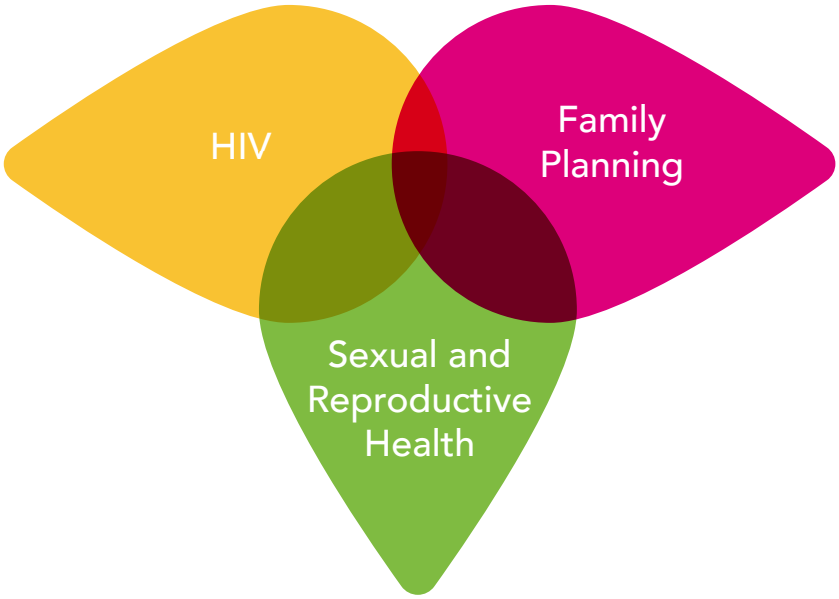
This strategy provides a deeper understanding of client needs, barriers and motivators to design targeted and integrated communications interventions. It creates communications linkages across HIV programmes—HTS, CCP, pre-exposure prophylaxis (PrEP), VMMC, eMTCT, and Care and Treatment—in Zimbabwe. It aims to be a comprehensive communications platform for HIV prevention, care and treatment that outlines the key elements relevant for each priority audience. By developing standardised approaches to promote individual behaviour, community and policy dialogues, and collective action, this strategy seeks to:

- Generate demand for sustainable uptake of HIV prevention, care and treatment services
- Encourage integrated communications and programme linkages
- Influence positive social and cultural norms surrounding HIV and sexual and reproductive health (SRH)

Integration with Other Health Areas

Integration of HIV services with other health areas such as family planning and sexual and reproductive health is a critical part to ensuring comprehensive care and a client-centred approach. It ensures that programmes can meet clients at different stages along their health journey. Through integrated patient-centred approaches and messages, clients will be linked to health care more relevant to their needs and thus will have better health outcomes.

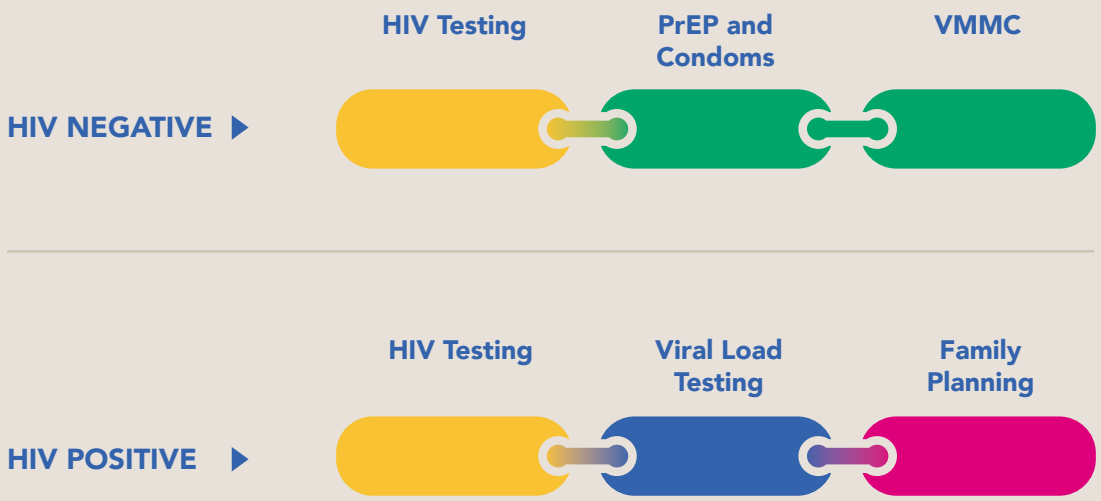
Figure 1.
Integration of Health Communications



Linkages to HIV Programmes

The HCD approach highlights the linkages between HIV programmes (and other health programmes) across the selected audiences and their life course perspective. These important transition periods between programmes are underpinned by individual life circumstances and are subject to different influences, barriers and motivations. The transitions also indicate an area of opportunity for programme implementers to design specific linkages to ensure that clients do not discontinue services from one programme to the next.

Figure 2.
Linkages Across Programmes



This strategy supports the Zimbabwe National AIDS Strategic Plan (ZNASP) 2015 – 2020 to apply evidence-based approaches to:
(1) contribute to the reduction of new HIV infections;
(2) improve the quality of life for all Zimbabweans;
(3) reduce HIV- and AIDS-related stigma through improved knowledge, attitudes and socio-cultural norms.

1.4 Who Will Use the Strategy?

This strategy may be used by a variety of stakeholders involved in HIV communications programming in Zimbabwe, including:

- **Programme planners, implementers and health care workers:** To develop communications strategies, interventions and social mobilisation activities tailored to specific audiences.
- **Officials, policymakers and government entities:** To align recommended HIV communications activities for partners and stakeholders delivering HIV programming throughout the country.
- **Funders:** To illustrate the need and feasibility for integrated strategies to generate demand for HIV health services with maximum impact and cost-efficiency.

1.5 Strategy Development Process

Literature reviews were conducted using global frameworks, peer-reviewed literature, and additional country- and regional-level publications. Peer-reviewed country- and regional-level data specific to HIV behavioural patterns, values and preferences were included along with Zimbabwe's existing HIV policy, operational and communications strategies across all levels of HIV prevention, care, and treatment.

This strategy featured a participatory HCD process. This included workshops with stakeholders and Technical Working Group members to evaluate target audience behaviours, identify objectives and strategies, and design targeted messages and journey maps. Key findings were triangulated with data collected through one-on-one key informant interviews with funders, implementing partners, ministry officials and nongovernmental entities as well as data collected through HCD workshops and dialogues with target audiences in their environments.

85 Key stakeholders to develop the audience archetypes and journey maps

30 Technical Working Group members to determine communications objectives, projected activities and behavioural goals

250 People engaged through target audience dialogues to gain insights on barriers and motivators

25 Communications specialists to develop a core set of illustrative messages for testing

70 People engaged through target audience dialogues to validate illustrative messages

Audience Selection

Target audiences were derived from HIV programme data and estimates, risk profiles and social and behavioural norms. Target audiences were aligned to the various HIV prevention, care and treatment programmes in Zimbabwe. Programme implementers can select which audiences will apply to their specific programmes as needed. These are broad audiences to guide programme implementers and allows them to identify sub-segments within the overarching audience. For example, there are different segments of AGYW, such as, those who sell sex and those involved in transactional sex that programmers need to further develop different interventions for separately using guidance from this strategy.

As highlighted in the previous sections, this strategy has been designed to support the next phase of Zimbabwe's HIV response. In the following chapters, more information is provided about how evidence-based communications interventions, supported by client-centred insights, make the client journey easier and links them to the appropriate health care to improve health outcomes.

Table 2.
Target Audiences with Associated Risk Profiles

Target Audience	Examples of Sub-segments within the Target Audience	Risk Profile	Linkages to HIV Programmes
Men who have sex with men (MSM)	Bisexual, transgender, gay, transactional sex	Unsafe sexual practices, substance abuse, unknown HIV status, stigma, confidentiality, provider bias, criminalising laws	PrEP, HIV testing, condoms and lubricants, treatment
Female sex workers (FSWs)	Mobile populations	Stigma, confidentiality, provider bias, higher pay for unprotected sex	PrEP, HIV testing, PEP, condoms, treatment, family planning
People With Disabilities (PWD)	Physical/hearing/sight disability, cognitive/ intellectual/mental health disability	Stigma, confidentiality, provider bias, infrastructure barriers	Family planning, HIV testing, treatment, condoms, VMMC, PrEP, PEP
Adolescent girls and young women (AGYW)	AGYW participating in transactional sex, in school, out of school	Transactional sex, age mixing, multiple concurrent partners, at risk for gender-based and intimate partner violence, lack of comprehensive sexual and reproductive health care (SRH), low adherence to treatment, provider bias	Family planning, condoms, HIV testing, PrEP, treatment
Adult women (AW)	Serodiscordant relationships, unknown partner status, pregnant and lactating women	Serodiscordant relationships, lack of autonomy in decision-making, at risk for gender-based and intimate partner violence	Family planning, HIV testing, PMTCT, PrEP, treatment
Adolescent boys and young men (ABYM)	ABYM in school, out of school	Low risk perception, experimental sexual behaviour, lack of comprehensive SRH, low adherence to treatment	HIV testing, VMMC, condoms, treatment
Adult men (AM)	Miners, truck drivers, commercial farmers, prisoners	Age mixing, low condom use, multiple partners, uncircumcised, low rates of HIV testing	HIV testing, condoms, treatment, VMMC
Influencers	Traditional, religious, community leaders	Lack of HIV and SRH knowledge, deep-seated traditional and religious beliefs and values	Social support, advocacy for uptake of services
Health service providers	Doctors, nurses, community health workers	Stigma towards key and vulnerable populations, provider/client communications, occupational risk	PEP, values exploration, SBCC for health providers

Abbreviations: PEP, post-exposure prophylaxis; PrEP, pre-exposure prophylaxis; VMMC, voluntary medical male circumcision; PMTCT, prevention of mother-to-child transmission; SBCC, social behaviour change communication.

CHAPTER 2.

Situation Analysis

2.1 Overview of the HIV Epidemic

An estimated 1.3 million people in Zimbabwe are living with HIV, of which females account for 60%. HIV prevalence among adults aged 15-49 years has declined by more than half in the last two decades, from 32.4% in 1997 to 13.33% in 2017.[6]

Disparity in HIV prevalence by sex is most pronounced among young people aged 20-24 years, with HIV prevalence among females (8.1%) being three times higher than males (2.7%).[7] Higher prevalence has been reported among inmates (28%),[8] FSWs (57.1%)[9] and MSM (23.5%).[9] Overall HIV incidence has been declining; it is currently at 0.47% among adults aged 15-64 years (0.33% among males and 0.60% among females), as reported in 2016.[7] However, the data show certain sub-populations are at greater risk than others: adolescent girls and young women (AGYW), FSWs, MSM, discordant couples and casual heterosexual sex partnerships.[10]

Key Drivers of the Epidemic in Zimbabwe[11, 12, 13, 14, 15, 16]

- Low HIV risk perceptions among populations at risk
- Low uptake of HIV services by key populations and men
- Limited client confidentiality (health worker disclosure or lack of privacy at the clinic)
- Lack of provider sensitivity towards at-risk vulnerable and key populations
- Stigma and discrimination associated with people living with HIV and AIDS (PLHIV) and key and vulnerable populations
- Perception or reality of lack of access to products/services (quality of free condoms, availability and information about PrEP, long clinic wait times, limited clinic hours)
- Inadequate support and follow-up services for HIV-negative clients

Impact of the National Response

Zimbabwe is implementing a comprehensive multisectoral response to the HIV epidemic, aiming at achieving zero new infections, zero HIV-related deaths and zero discrimination. Accordingly, Zimbabwe has joined the rest of the world on a "fast-track" strategy to end the epidemic by 2030.[17]

Table 3.
Fast-Track Targets to End HIV by 2030

TARGETS	2018	2020
Reduction in HIV incidence (baseline 2010)	81%	90%
Reduction in HIV incidence among children (baseline 2009)	3%	1%
Reduction in Stigma (baseline 2010)	60%	90%
Reduction in AIDS-related deaths (baseline 2010)	82%	90%

A survey conducted in 2016 revealed that 74% of the estimated people living with HIV had been tested and knew their HIV status, 87% of those living with HIV who had been diagnosed were on treatment and 87% of those on treatment were virally suppressed.[17] Performance is better for females compared to males, signalling more efforts are needed to ensure that men are tested, linked and retained in care with good adherence. Zimbabwe's significant progress towards achieving 90-90-90 targets (Table 3) has resulted in new targets being set to reach 95-95-95.

Despite this progress, gaps still do exist and should be addressed comprehensively, that is, from treatment coverage; to viral load suppression in adolescents; to missing men, particularly those under 35 years; to clinical cascades in key populations. All these gaps underscore the need for a comprehensive communications strategy that targets key audiences in an integrated manner and also promotes linkages to other health programmes within the HIV prevention care and treatment cascade.

A detailed situation analysis for each target audience will be outlined in Chapter 4 of this strategy, including how to reach these populations, which will contribute towards epidemic control in Zimbabwe.

2.2 Communications Landscape in Zimbabwe

According to the Zimbabwe All Media & Products Survey (ZAMPS), there continues to be a sharp divide between urban and rural media users across a wide variety of communications choices. Data[18] from the second half of 2018 show more people watch TV in urban areas (73% urban and 33% rural); DSTV has a national penetration rate of 26% (39% urban and 15% rural) and ZBCTV has a national penetration rate of 24% (35% urban and 15% rural).

Radio has similar distribution of listeners between urban and rural areas (57% urban and 58% rural); stations with the highest penetration include Radio Zimbabwe (35%), Star FM (11%), and National FM (17%). Newspaper readership is higher in urban areas (34% compared to 13%) and outdoor media seen by urban and rural viewers is highest for billboards and posters, followed by street pole advertising.[18]

Internet access in rural areas remains low compared to urban areas (21% rural and 51% urban) and is driven largely by demand for personal communications.

Access to Internet by Age Range

48% 21-25 years of age

44% 26-30 years of age

41% 15-20 years of age

YouTube (14% national; 18% urban; 6% rural) and Gmail (14% national; 17% urban; 8% rural) are the most commonly browsed internet sites. WhatsApp (97%) and Facebook (48%) are the most common social media platforms in both urban and rural areas.[18]

The country has experienced growing coverage of the telecommunications network, with approximately 84% of households in rural areas owning a mobile phone,[19] and mobile penetration estimated at 95.6% in 2015.[20] As such, leveraging the potential of mobile technology such as mHealth and RapidPro[21] and related platforms can significantly contribute to access and dissemination of information as well as generate demand for services while encouraging people to seek care. Among young people, a rapid U-Report survey conducted as part of the consultation with young people aged 15-24 years showed that young people preferred mobile phone–based communications platforms over newspapers.[22]

While printed information, education and communications (IEC) materials (brochures, posters, leaflets, cards and newsletters), billboards, and street banners have been used in health promotion, there is limited evidence about their effectiveness in Zimbabwe.[22] Health care workers, community health cadres (village health workers), social mobilisers and local community leaders can serve as communications channels for effective social and behaviour change communications using local community structures, community gatherings, theatres, drama, ceremonies, community groups, special/sporting events and forums.

CHAPTER 3.

Theoretical Models

Changing individual behaviour involves complex and dynamic processes in structures that cross every layer of a person's life from families and communities to larger societal structures. At every level, these structures can either facilitate or inhibit health-seeking behaviour.

To account for this complexity, several evidence-based theories, models and frameworks informed the development of this strategy. This also aligns with increasing evidence showing that demand-generation interventions based on theories are more effective and sustainable than those without a theoretical base, especially when multiple theories and concepts are considered.[23]

Socio-ecological Model

The socio-ecological model (SEM) is a framework for understanding how behaviour is impacted by the interaction of personal and environmental factors. Evidence consistently points to the effectiveness of a combination of interventions across the entire SEM spectrum (Figure 3) when designing and implementing behaviour change communications strategies.

The SEM was applied directly to the development of the communications interventions to ensure mobilisation and commitment of political and social resources for change at the political, social, and individual levels.

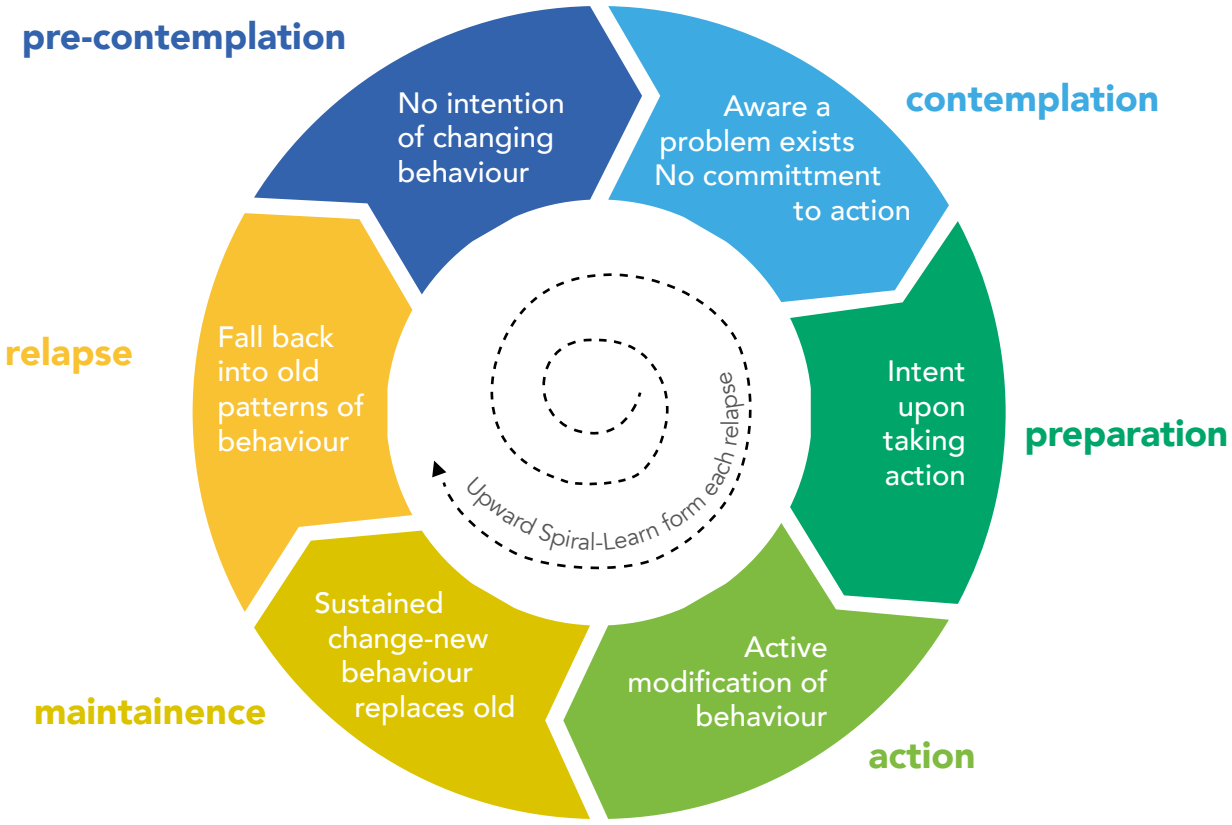
Figure 3.
Socio-ecological Model[24]

Stages of Change Model

The Stages of Change Model (also called the Transtheoretical Model), focuses on the decisions and stages that individuals go through when considering a change in behaviour. It assumes that behaviour change is neither swift nor decisive, but rather a continuous, cyclical process of consideration. At each of six stages of change,[25] different possible interventions may move an individual to the next level, ultimately resulting in behaviour change.

The Stages of Change Model (Figure 4) drove the development of individual journeys taken by the archetypes created in this strategy, which were then used to create messages to address key barriers at various levels of change.

Figure 4.
The Stages of Change Model[26]

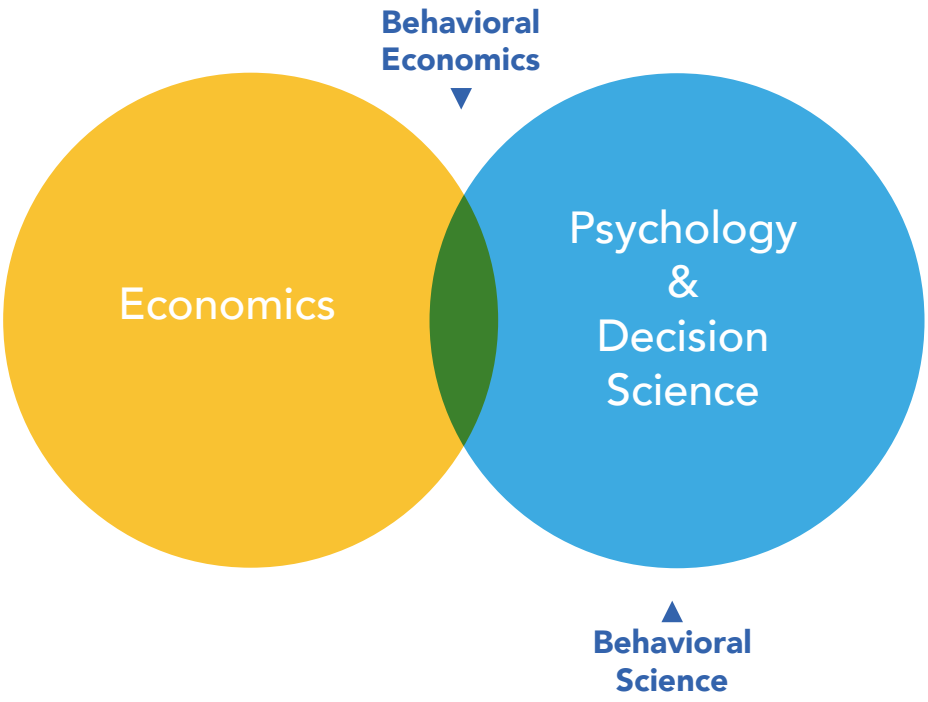


Transtheoretical Model of Change
Prochaska & DiClemente

Behavioural Economics

Behavioural economics, a method of economic analysis, is a way to consider the implications of social, cognitive and emotional factors coupled with financial incentives (monetary or otherwise) that influence health behaviour decision-making (Figure 5).[27] Behavioural economics explains, for example, why people cannot miss work to visit a health care facility, or why someone could have unsafe sex for financial gain.

Figure 5.
Behavioural Economics



Circle of Care Model

The Circle of Care Model (Figure 6) is a framework for understanding how social and behaviour change interventions can be used along the service delivery continuum.[28,29] It demonstrates how demand generation for services and service delivery are inextricably linked. The Circle of Care Model directly informed the development of the overarching strategies and entry point services in client journeys, as well as the development of communication links between HIV programmes in those journeys by raising the importance of positive client experiences and improved provider interactions to encourage adherence and maintenance.

Figure 6.
Circle of Care Model

Source: Health Communications Capacity Collaborative. Abbreviation: SBC, social behaviour change.


HAIR CUT
KEY CUTTING

CHAPTER 4.

Comprehensive National HIV Communications Strategy

4.1 Guiding Principles

This strategy is guided by the following key principles:

1. Evidence-based communications

Implementing communications strategies and best practices that have been demonstrated to increase knowledge, influence attitudes, promote social norms change, and produce desirable behaviours.

2. Client-centred approach

Ensuring that the communications strategy is designed from the client's perspective to reflect their needs at each stage of their health journey and lives, with appropriate messages deployed to generate demand for HIV prevention, care and treatment services.

3. Integrated approach

Advocating for integrated communications approaches and messages that create demand for health products and services along the continuum of prevention, care and treatment across multiple sectors.

4. Human rights–based approach

Ensuring that key and vulnerable communities have access to information and services through innovative communications channels.

4.2 Vision and Mission

Vision:

Improved health for all Zimbabweans accessing high-quality HIV prevention, care and treatment to end AIDS by 2030.

Mission:

Providing client-centred, evidence-based demand creation and advocacy interventions through a standardised, comprehensive communications approach to HIV prevention, care and treatment.

4.3 Goals

The goals of this communications strategy are aligned with overall goals of the Zimbabwe HIV programme as outlined in the Zimbabwe National AIDS Strategic Plan:

(1) reduce new HIV infections;

(2) reduce AIDS-related deaths;

(3) reduce HIV- and AIDS-related stigma.

4.4 Communications Strategic Objectives

To carry out the vision of the strategy, communications strategic objectives were derived from recurring themes throughout the analysis (Appendix A). These themes—central tenets of the communications strategy—led to four communications strategic objectives, which have been matched to the socio-ecological model to affect change at the following levels: Policy and Advocacy; Systems and Structures; Culture and Community; Individual Practices.[30]

Communications strategic objectives one, two and three highlight key activities that will be addressed at different levels to support the dissemination and implementation of the strategy itself. However, communications strategic objective four allows implementers to design and implement their own activities (by selected audiences) in accordance with funded programmatic work using the strategies and audience analyses outlined in Chapter 4.4.2. Activities that cut across all audiences are provided as guidance for planning purposes.

Policy and Advocacy: Advocates for new or improved laws and policies that improve health access.

Communications Strategic Objective 1: Increase knowledge and change attitudes and perceptions about the specific needs of key and vulnerable populations in order to advocate for a more enabling environment for seeking HIV prevention, care, and treatment services.

Key Activities	1. Develop information toolkit for policymakers and media bodies. 2. Engage with policymakers and media bodies to discuss key and vulnerable populations. 3. Develop policies to inform providers about key and vulnerable populations, such as, including KP provider training in mentorship curriculum.
Illustrative Indicators	1. Percentage of respondents who report that they are more aware of the specific needs of key and vulnerable populations seeking HIV prevention, care and treatment services. 2. Percentage of policymakers/media bodies reached with messages/campaigns on the specific needs of vulnerable populations who then advocate for the needs of vulnerable populations. 3. Number of guidelines/regulations/policies developed/ amended to improve the enabling environment of vulnerable populations accessing HIV prevention, care and treatment services.

Systems and Structures: Addresses rules, regulations or processes that impact communications delivery.

Communications Strategic Objective 2: Advocate for comprehensive and integrated HIV communications approaches and messages across implementing partners, funders and government agencies.

Due to the new comprehensive approach to HIV communications, the focus of this objective is to popularise and promote the use of this strategy, including branding the strategy itself.

Key Activities	Dissemination 1. Create a brand (logo and identity) for the Comprehensive National HIV Communications Strategy. 2. Post strategy to Ministry of Health and Child Care website and partner websites. 3. Present strategy at National AIDS Council meetings. 4. Develop a standardised presentation for quarterly Provincial Health Team and District Health Team meetings, Prevention Partnership Forum, PMTCT Partnership Forum, Treatment and Care Partnership Forum and Adolescent SRH Forum. 5. Orient health promotion officers and district health officers to cascade the strategy throughout the provinces and districts. 6. Develop a media kit and press release and hold a press conference. 7. Deliver strategy outside health agencies, including to other ministries, religious groups, chiefs' councils and parliament for better collaboration. Implementation 1. Develop communications materials (including formats for PWD) for field offices, and train community members and providers. 2. Develop an interactive mobile app/microsite. 3. Develop a sensitisation presentation on using the strategy for different levels and a standardised approach to help partners develop and align plans with the strategy. 4. Develop a mechanism to monitor and ensure compliance of the comprehensive communications strategy.
Illustrative Indicators	1. Number of advocacy campaigns on comprehensive HIV and SRH communications approaches conducted (disaggregated by geography, national/provincial/district, type of audience [implementing partner, funders, government agencies]). 2. Number of advocacy tools developed to increase the use of comprehensive HIV and SRH communications approaches. 3. Percentage of target audience who report using comprehensive HIV and SRH communications approaches to increase uptake of HIV prevention, care and treatment services. 4. Percentage of policymakers/media bodies reached with messages/campaigns on the specific needs of vulnerable populations who then advocate for the needs of vulnerable populations. 5. Number of guidelines/regulations/policies developed/amended to improve the enabling environment of vulnerable populations accessing HIV prevention, care and treatment services.

Culture and Community: Addresses key influencers in local institutions, support systems and formal and informal networks that impact information and communications delivery.

Communications Strategic Objective 3: Enlist support from providers and health care workers, traditional, religious and community leaders, to be change agents in their communities for communication of HIV prevention, care, and treatment services.

Key Activities	1. Map religious and traditional bodies to prioritise interventions based on geographic distribution, information gaps, population needs, doctrine, etc. a. Establish calendar, membership and mandate of existing religious bodies and incorporate interventions into agenda of their regular meetings. 2. Develop sector-specific comprehensive information toolkit through a consultative process for distribution with communities. 3. Disseminate the toolkit. 4. Train providers on client-centred care for each and every client, regardless of sexual orientation, religious beliefs, level of ability, age, gender or profession.
Illustrative Indicators	1. Number of providers, health care workers as well as traditional, religious and community leaders who participate in HIV comprehensive communications activities at community level. 2. Percentage of providers and traditional, religious and community leaders who express accepting attitudes around community members accessing HIV prevention, care and treatment services.

Individual Practices: Addresses key characteristics of the individual person that impact behaviour change.

Communications Strategic Objective 4: Deliver messaging and communications approaches that align with the journey of HIV prevention, care, and treatment for targeted audiences.

Since this is an overarching strategy document, detailed activities targeting specific audiences and programmes will be left for implementers to assign as funding allows. The following activities apply to all target audiences across HIV programmes.

Key Activities	1. Conduct targeted outreach campaigns that will assist in finding those who do not routinely intersect with medical systems, such as key populations, young men and young women. Targeted outreaches must reach into the communities efficiently to find these population groups. The targeted outreaches will include: a. Moonlight outreaches targeting key populations, adult men and women, young men and women. These outreaches will be performed every quarter. b. Conduct specific outreaches that align with calendar events such as World AIDS Day and school holidays. 2. Hold peer-to-peer dialogue/conversations with communities and leaders. a. These general dialogues will be held within communities/districts whereby all target audiences may be present. Thus, dialogues will be tailored to comprehensive HIV prevention, care and treatment issues and be performed every quarter across all districts. 3. Develop highly targeted communications material to appeal to selected audiences a. Communications material will be developed covering HIV prevention, care, and treatment services that are available for all populations. However, design and content will vary according to the target population. IEC materials will be highly targeted, especially for key and vulnerable populations, to ensure visuals and content reflect the target audience as closely as possible. i. Conduct multimedia campaigns targeting AGYW, KPs, and other vulnerable populations b. Use a long-format, storytelling approach to address deep-seated social and behavioural norms. c. Develop radio campaigns featuring dramas and talk shows: i. Testimonials highlighting expert client experiences ii. Stigma-reduction messages for vulnerable populations d. Develop social media campaigns (including video, memes, etc.) featuring dramas: i. Testimonials highlighting expert client experiences ii. Stigma-reduction for vulnerable populations
Illustrative Indicators	1. Percentage of target audience with accurate knowledge of HIV prevention methods (condoms, PrEP, VMMC) and benefits 2. Percentage of target audience who know where to access a) HIV testing services, b) condoms, c) PrEP, d) VMMC, e) ART, f) SRH services 3. Percentage of target audience who know how to use condoms consistently and correctly 4. Percentage of community members expressing accepting attitudes of adolescents accessing HIV and SRH services 5. Percentage of target audience expressing self-efficacy for accessing health services 6. Percentage of target audience who are satisfied with provider health service delivery 7. Number of people exposed to HIV and SRH health awareness messages/campaigns

Research conducted by Johns Hopkins Center for Communication Programs[5] provides an overview of evidence-based interventions which may be applied (Table 4).

Table 4.
Evidence-based Communications Interventions

PROGRAMME	INTERVENTION
CCP	• Combination strategies and multi-channel approaches with structured IPC activities and community participation • Partner communications and involving men early in ANC visits • Peer-educator IPC with lived experience combined with peer support groups • Activities developing condom skills for adolescents
HTS	• Combination strategies and multi-channel approaches with structured IPC activities and community participation • Partner communications and involving men early in ANC visits • Peer-educator IPC with lived experience combined with peer support groups
VMMC	• Peer-educator IPC with lived experience combined with peer support groups
eMTCT	• Partner communications and involving men early in ANC visits
Treatment	• Peer-educator IPC with lived experience combined with peer support groups • Celebrity endorsements with lived experience • Community members to be ART expert clients relieves health worker shortages • Partner communications and involving men early in ANC visits
General HIV prevention, care and treatment and SRH	• Higher number of communications interventions • School-based programmes with more general focus on SRH • Celebrity endorsements with lived experience

Abbreviations: CCP, comprehensive condom programme; IPC, interpersonal communication; HTS, HIV testing services; PEP, post-exposure prophylaxis; PrEP, pre-exposure prophylaxis; VMMC, voluntary medical male circumcision; eMTCT, elimination of mother-to-child transmission; SBCC, social behaviour change communication. ANC, antenatal care; ART, antiretroviral therapy; SRH, sexual and reproductive health.

4.4.1 How to Use the Tools in this Strategy

This strategy is a practical guide to help MoHCC structures and implementing partners design, plan and facilitate programming activities and messaging directed at key target audiences. To plan an intervention or outreach, begin with the cross-cutting activities noted above in Communications Strategic Objective 4 and then proceed to the sections about specific audiences for additional support tools including:

- Audience Problem Behaviours Versus Desired Behaviours: Use this tool to gain an understanding of what the literature says about key problem behaviours/practices as well as key behaviours/practices to promote.
- Communications Matrix: Audience Barriers, Behavioural Analyses and Communications Objectives: Use this tool to plan communications interventions targeting specific audiences with a comprehensive set of information based on a theoretical journey (by HIV status) for each audience, including barriers, facilitators, illustrative messages and indicators for each stage of the journey. Illustrative messages for the alternative HIV status are also included.
- Audience Archetype: Use this tool to develop an understanding of a typical person in the target audience to build empathy for their situation and give context to the issues affecting behaviour change.
- Journey Map: Use this tool to develop an empathetic understanding of a client's complex health journey and prioritise opportunities for communications interventions and collaboration with service delivery to make the journey easier and move forward to access services.

4.4.2 Sub-Strategies for Communications Strategic Objective 4

Key and Vulnerable Populations

Men Who Have Sex With Men

MSM: Situation and Behavioural Analysis

HIV prevalence among MSM in Zimbabwe is 31%,[8] MSM and their associated risks and prevalence of HIV/STI remain understudied. Biological, behavioural (anal sex) and legal factors put MSM at 28 times higher risk of HIV infection compared to the general population.[15] Among MSM who do not self-identify as MSM, a perception of having low risk for HIV further compounds their risk.

Health Care Services

MSM report discrimination by health care providers including denial of care, poor-quality care, breach of confidentiality or coercion into accepting certain services.[15] This leads to MSM seeking alternative services from expensive private providers or traditional healers, leading to possible delays and complications. Additionally, communications and sensitisations are required for health care workers to understand the health care needs of MSM including screening, examination and management for all forms of STIs, stigma, violence and mental health.

Research suggests that MSM have higher levels of depression and psychosocial stress due to stigma, discrimination and violence perpetrated by family, friends and social institutions; worries of sexual identity development; self-hatred and poor self-esteem, which may result in MSM abuse of drugs or alcohol and other destructive behaviours. Lack of empowerment and inability to negotiate safe sex among MSM, including in relation to transactional sex further exacerbates mental health struggles and conflict. The WHO recommends MSM support groups and men's organisations for social and peer support.[32]

Stigma, Discrimination and Criminalisation

Stigma, discrimination and criminalisation perpetuate secrecy and MSM hiding their sexual behaviours from friends, family and providers, which limits access to health services and information. Due to social and cultural norms, some MSM maintain the appearance of having a "normal life" with wives and girlfriends, while struggling with internal conflict. MSM also fear legal ramifications of sharing the truth of their identity, further limits access to health services.

> *Fear of HIV-related stigma owing to a potential HIV-positive status disclosure is a deterrent to HIV testing among gay men and other men who have sex with men and transgender women.*[16]

Table 5.
Men Who Have Sex With Men:
Synopsis of Problem and Desired Behaviours and Practices

PROBLEM BEHAVIOURS/PRACTICES	DESIRED BEHAVIOURS/PRACTICES
• Delays in seeking health services and fear of stigma and discrimination; lack of (awareness and) access to MSM-friendly health care services • Risky sexual behaviours; larger number and rapid exchange of partners, including transactional sex • Fear in taking PrEP for its association with HIV; people might think he is taking ARVs • Inconsistent and incorrect use of condoms and lubricants • Fear of attending local clinic for HIV testing and services due to stigma and lack of provider confidentiality • Does not disclose his sexual behaviours to providers, or anyone else for fear of stigma, criminalisation, as well as his own self-discrimination	• Have comprehensive and correct knowledge of HIV prevention, care and treatment, and available MSM-friendly services, including services and commodities to reduce risk, such as HIV testing, PrEP and ARV treatment • Seek/use HIV prevention (self-testing, condoms, water-based lubricants and PrEP), care and treatment services and products • Reduce MSM-and HIV-related stigma and improve supportive environments to ensure adequate social support; encourage MSM support groups and positive and affirming social environments for MSM • Seek MSM-friendly health care services; improve provider sensitivity, privacy and confidentiality for MSM • Empower all men to challenge societal homophobia and internalised homophobia • Improve awareness for STI, HIV, TB, and hepatitis B and C prevention, testing and counselling, and treatment services • Encourage screening, management and referral for mental health disorders such as depression and psychosocial stress • Advocate for safe sex

Abbreviations: ARV, antiretroviral; MSM, men who have sex with men; PrEP, pre-exposure prophylaxis; STI, sexually transmitted infection; TB, tuberculosis.

NAME: George

AGE: 22

RELATIONSHIP: Bisexual, girlfriend

HIV STATUS: HIV negative

"I'm not gay-I'm just having sex with men for money. I'm not really at risk of HIV, as I've got a girlfriend."

GOALS

» To get tested for HIV
» To get initiated on PrEP
» To use condoms consistently and correctly and prevent STIs; to use water-based lubricants

BEST WAY TO REACH ME

» Social media (SMS, WhatsApp, YouTube)
» Peer mobilisers
» Friends

INFLUENCERS

» Peers
» Girlfriend
» Peer mobilisers
» Television (perpetuates stigma)

GEORGE REPRESENTS A BIGGER POPULATION WHO:

» Is not clear on the risk factors of HIV

» Feels like since he has a girlfriend that his relationship is not very risky

» Has a sugar daddy who gives him money to help pay for university and his phone

» Is not comfortable with his own sexuality, so he can't discuss it with health care workers who do not accept or understand his sexual orientation/preferences

» Feels that he needs to conceal his sexuality and behaviour with his sugar daddy from everyone—he fears discrimination, violence and criminalisation (impacts mental health)

» Is more concerned about getting his girlfriend pregnant than getting HIV

» Feels money is a big motivator, and when men are going to pay more for sex without a condom, he will agree

» Often lacks sufficient health and treatment literacy, but is interested to learn

» Wishes that providers were more understanding and could better provide accurate health and treatment information

Abbreviations: PrEP, pre-exposure prophylaxis; STI, sexually transmitted infection.

Disclaimer: The photographs in this material are used for illustrative purposes only; they do not imply any particular health status, attitudes, behaviors, or actions on the part of any person who appears in the photographs.

Men Who Have Sex With Men Journey Map: George, 22 years old, HIV negative

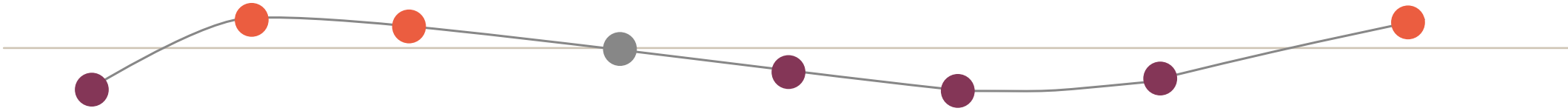
About this map: This is a theoretical high-level health journey for a man who has sex with men (MSM) interacting with HIV programmes, which may overlap or be sequential. The journey map reveals his experience and what he might be doing, thinking and feeling along the way that impact his desire and ability to access services

The purple, orange and gray dots indicate the highs/positive emotion (motivators) and lows/negative emotion (barriers) of the journey. These help the reader of the map prioritise opportunities for communications interventions and collaboration with service delivery to make the journey easier

Trusted information sources: Health workers, peer educators, LGBTI organisations and NGO workers;
Other sources: Friends, social media, TV, radio

HIV Testing Services — Prevention: PrEP — Prevention: Condoms

Positive emotion
Neutral emotion
Negative emotion



George's Experience

Doing: Goes to class at university; hooks up with his sugar daddy

Thinking: I hope people do not find out that I have sex with men for money. Is this normal?

Feeling: Conflicted, Stressed, Worried

Doing: Sees his girlfriend; has sex without a condom

Thinking: I have a normal life – I have a girlfriend; my sugar daddy is just a source of income

Feeling: Relieved, Relaxed

Doing: Hears health worker talk about testing at university. Gets tested; HIV-negative result

Thinking: I am so relieved, I'll never do anything risky ever again. How can I protect myself?

Feeling: Reassured, Happy

Doing: Reads PrEP brochure

Thinking: Can I ask for PrEP? The health worker didn't seem to think I need it, but I couldn't tell her I sleep with men – she would judge me

Feeling: Unsure, Worried, Conflicted

Doing: Looks up PrEP online

Thinking: I am convinced this would be good for me. How do I ask for it?

Feeling: Scared, Unsure, Embarrassed, Defeated

Doing: Seeks care at a private provider; asks about PrEP

Thinking: That was an embarrassing conversation, but now I have PrEP!

Feeling: Humiliated, Shy, Embarrassed

Doing: Quietly takes free condoms at the clinic when no one is around

Thinking: I hope nobody sees me taking these condoms – that would be embarrassing

Feeling: Shy, Nervous, Anxious, Relieved

Doing: Talks to girlfriend about using condoms; would help prevent pregnancy

Thinking: I wonder if she has been tested for HIV? I don't like using condoms

Feeling: Empowered, Confident, Informed

Key Insights

Stigma and Low Risk Perception: Societal and family expectations place a lot of pressure on his psychological struggles associated with his sexual identity. However, he wants to finish university and have a family one day. Having sex with men is only for money and because he does not see himself as gay, he couldn't be at risk for HIV

Provider Bias and Knowledge Is Power: He does not identify with PrEP marketing campaigns. He assumes it's for other people, but not someone in his situation. After getting a better understanding of at-risk behaviours and reading a flyer showing someone he could identify with, he was more motivated to go for HIV testing and PrEP. Despite the provider resisting his request for PrEP, he persevered and now he feels empowered because it can minimise risk of HIV acquisition (and now he understands his risk)

Empowerment and Feeling in Control: Like other men, he wants to be in control and in charge of his destiny. He feels that now that he is on PrEP, he does not need to worry about condoms because his risk for HIV is very low. But he does not understand the risks for other STIs and how that might impact his health and his partners. Increasing his knowledge while enabling his ability to stay in control and feel like a man can increase uptake of condom use

Abbreviations: LGBTI, lesbian, gay, bisexual, transgender, intersex; MSM, men who have sex with men; NGO, nongovernmental organisation; PrEP, pre-exposure prophylaxis; STI, sexually transmitted infection.

Communications Matrix: Men Who Have Sex With Men

DESIRED CHANGES*	TO GET TESTED FOR HIV	TO INITIATE PrEP; ADHERENCE	TO USE CONDOMS CORRECTLY AND CONSISTENTLY AND PREVENT STIs; TO USE WATER-BASED LUBRICANTS
Barriers	• Low risk perception • Lack of self-efficacy • IEC material not inclusive/relevant • Fear of a positive result • Provider and community stigma towards MSM • Lack of awareness or access to MSM-friendly HIV testing services • There is a culture of multiple concurrent partnerships that is 'normalized' in the LGBTIQ community	• Lack of knowledge • Low risk perception • Inaccessibility of PrEP, including for adherence • Fear of PrEP side effects	• Lack of knowledge on how to use condoms • Unfavorable attitudes and perceptions of condoms • Perceived high cost of private sector condoms, e.g. Durex • Perceived low quality of free condoms • Lack of access to condoms and water-based lubricants • Low perceived benefit of condom use while on PrEP
Facilitating Factors	• HIV self-testing • Peer influence and support • Knowledge of services following an HIV-positive test result • Existence of KP-friendly services, including provider-delivered HIV testing	• Staying HIV negative • Peer influence and support • Talk about sex in positive ways (reduce fear-based approaches) • LGBTIQ community is a closed community; once you access the community you can spread the message easily	• Fear of STIs • Peer influence and support • Availability of condoms in different price ranges
Communications Objectives	1. Increase HIV risk perception and the benefits of knowing one's HIV status from which to access prevention and treatment 2. Increase awareness of MSM-friendly services and self-efficacy to seek health services 3. Improve self-awareness and empowerment at individual level	4. Improve knowledge, attitudes and perceptions of the benefits of PrEP and PEP for HIV prevention 5. Improve knowledge, attitudes and perceptions of the benefits of initiating ARV treatment immediately following an HIV diagnosis and attaining and maintain viral suppression 6. Increase risk perception among MSM 7. Increase perceived value of condoms while on PrEP 8. Increase peer support and positive social environment for MSM, regardless of HIV status	9. Increase knowledge of consistent and correct use of condoms 10. Increase positive attitudes and perceived value of condoms 11. Increase awareness of where to access condoms

Illustrative Messages	• We are the future, let's get tested now • Stay in control, get tested today • Get tested regularly-stay healthy • Get tested, know your status, protect yourself by using PrEP and condoms	• I understand my risk—now I take PrEP • Taking PrEP helps me to be prepared • PrEP prevents HIV transmission by 90%	• Use PrEP and condoms consistently and correctly to protect yourself from HIV • Condoms allow you to enjoy safer sex with peace of mind • Spice it up with a condom that suits your mood
Illustrative Messages for desired change for HIV positive MSM: To get initiated on ART and stay virally suppressed*			
• Being HIV positive is not the end of the world—take your medication to stay healthy • I have HIV and it is undetectable because I take my medication • I found a support group to help me stay on treatment, and I feel better • Taking my medication helps me keep my viral load low, reducing the risk of transmission to my partner			
Illustrative Indicators	1. % of MSM who can recall the risk of HIV re-infection and STIs 2. # of IEC materials developed and distributed that are inclusive and relevant for MSM 3. % of MSM who report high self-efficacy for accessing health services 4. % of MSM with accurate knowledge of HIV prevention methods and benefits 5. % of MSM who agree that condoms provide effective protection against (a) STIs and (b) HIV 6. % of MSM who report that they know how to use condoms correctly and consistently 7. % of MSM who report that they know where to access (a) PrEP and (b) condoms 8. % of MSM who report the use of condoms in the last 3 sexual encounters and consistent use of condoms as a barrier method of HIV prevention		

* For simplicity, all content within this matrix matches the HIV status and journey of the archetype. However, a desired change along with matching illustrative messages have been identified for the alternative HIV status.

Abbreviations: ART, antiretroviral therapy; ARV, antiretroviral; IEC, information, education and communications; LGBTIQ, lesbian, gay, bisexual, transgender, intersex, queer/questioning; MSM, men who have sex with men; PEP, post-exposure prophylaxis; PrEP, pre-exposure prophylaxis; STI, sexually transmitted infection.

Female Sex Workers

FSW: Situation and Behavioural Analysis

HIV prevalence among female sex workers in Zimbabwe is 57.1%, which is nearly five times the rate of the general population.[8] There are an estimated 4,000 new HIV infections among FSWs annually.[35] In Zimbabwe, 30% of men aged 30-49, 25% of married men and 19% of men with secondary or more education reported having sex with a commercial sex worker.[33] Sex workers and their clients are at high risk of HIV due to the large number and rapid change of sexual partners, high rates of STIs, dry sex and sex during menses.[34] Other contributing factors include unsafe working conditions and violence (by law enforcement officials, intimate partners and clients), the inability to negotiate condom use, social stigma and discrimination and criminalised work environments.[35] Public and private humiliation are significant challenges for sex workers that prevent them from seeking health care services and support from their communities.[36]

The HIV care cascade for FSWs is lagging behind the general population as only 64% of those living with HIV know their status, 68% of those who know their status are currently on treatment and 77% of those on treatment are virally suppressed. More needs to be done to ensure that FSWs are tested and linked to prevention and treatment services and are supported to adhere to treatment.[37]

Financial Barriers

Research on sex work has shown that the price of sex without a condom can be four times the price of sex with a condom.[34] Often sex workers fear losing a client if they insist on sex with a condom. Other financial limitations are access to condoms and medications. Often sex workers do not have enough condoms to match the number of clients. Moreover, despite antiretrovirals (ARVs) being provided for free, the transport costs and user fees (e.g. council clinics) required are enough to make the medications unaffordable and inaccessible. Due to economic conditions and the lack of employment opportunities,[34] many women feel stuck in sex work even if they would like to have the opportunity for other forms of work.

Health Care Services

Many sex workers use local clinics in emergencies only—they prefer clinics specific for sex workers as they feel more understood. In general clinics, sex workers fear stigma and do not feel comfortable disclosing their profession. Data report that less than half of FSWs diagnosed with HIV went for referral assessment and ART initiation and that only 14% attended more than one appointment.[36]

Table 6.
Female Sex Workers:
Synopsis of Problem and Desired Behaviours and Practices

PROBLEM BEHAVIOURS/PRACTICES	DESIRED BEHAVIOURS/PRACTICES
• Inconsistent use of prevention methods • Larger number and rapid exchange of partners • Transient nature looking for more clients; some sex workers move around to hot spots, e.g. tobacco auctions, mines or trucking routes; some will leave for weeks at a time to go with a trucking client • Insufficient privacy and inconsistent schedule for taking HIV treatment • Exposure to violence; disempowered to insist on use of condoms • Does not seek preventive services; lack of (awareness and) access to sex worker-friendly health care services • Fear in disclosing HIV-positive results to clients • Fear around attending local clinic for HIV testing due to lack of provider confidentiality; financial barrier to seek services further away with an unknown provider • Misuse of drugs or alcohol	• Reduce risky behaviours that increase risk of HIV infection • Increase awareness and understanding of risk (especially for women negotiating transactional sex who might not consider themselves a sex worker) • Seek/use HIV prevention (testing, self-testing, male and female condoms, lubricants and PrEP), care and treatment products and services • Identify supportive environments to ensure adequate social support; reduce stigma • Seek HIV testing, including HIV self-testing for themselves and partners • Empower sex workers with knowing their human rights • Advocate for safe sex • Providers to deliver empathetic, female-friendly and confidential care • Increase awareness of income-generation programs and projects • Improve knowledge of HIV risk among clients of sex workers; modified attitudes and perceptions about risk; use of prevention methods during interactions

Abbreviation: PrEP, pre-exposure prophylaxis.

NAME: Tsitsi

AGE: 24

RELATIONSHIP: Has children and a long-term boyfriend

HIV STATUS: HIV positive

"I want to use condoms with my clients, but they will pay me more money not to. Even when I tell them I'm HIV positive, they don't believe me because I look healthy."

GOALS

» To achieve viral load suppression
» To use condoms consistently and correctly
» To prevent unplanned pregnancy

BEST WAY TO REACH ME

» SMS, WhatsApp
» Sex worker Queens, peers
» Peer educators

INFLUENCERS

» Queens
» Clients
» Peers

TSITSI REPRESENTS A BIGGER POPULATION WHO:

» Has clients who prefer not to use condoms and will pay her more money for sex without one; her boyfriend also doesn't want to use condoms

» Travels to clients (tobacco farmers, truck drivers, miners)

» Describes health as staying free of illness and looking healthy and having beautiful skin

» Feels she can talk about health with her peers and at sex worker clinics

» Is more worried about earning money than having safe sex

» Can't get her ARVs refilled when she's away from her health facility

» Doesn't know her rights as a patient and has a low level of self-efficacy when seeking services; she keeps her work a secret from her family

» Seeks services far away from her home so that the provider won't know her

» Tells the health care worker that she is married to explain that her husband gave her the STI

» Gets a lot of information from peer educators (especially when they come to her work environments such as bars, sex worker 'Queen' and via WhatsApp group texts; she also spends time at church)

» Thinks HIV self-testing is a good way for her long-term boyfriend to get HIV tested

Abbreviations: ARV, antiretroviral; STI, sexually transmitted infection.

Disclaimer: The photographs in this material are used for illustrative purposes only; they do not imply any particular health status, attitudes, behaviors, or actions on the part of any person who appears in the photographs.

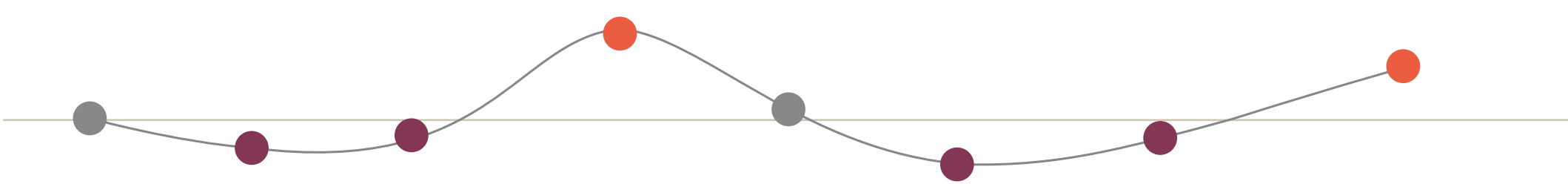
Female Sex Worker Health Journey Map: Tsitsi, 24 years old, HIV positive

About this map: This is a theoretical high-level health journey for a female sex worker interacting with HIV and SRH programmes, which may overlap or be sequential. The journey map reveals her experience and what she might be doing, thinking and feeling along the way that impact her desire and ability to access services

The purple, orange and gray dots indicate the highs/positive emotion (motivators) and lows/negative emotion (barriers) of the journey. These help the reader of the map prioritise opportunities for communications interventions and collaboration with service delivery to make the journey easier

Trusted information sources: Sex worker 'Queens', WhatsApp groups, peer educators, health workers at sex worker clinics;
Other sources: radio and TV, peers

Care and Treatment | Prevention: Condoms | Family Planning



Tsitsi's Experience

Doing: Fixes her hair, goes to work

Thinking: I wish there were other job opportunities so I could leave sex work

Feeling: Frustrated, Ambivalent, Resolved

Doing: Takes the bus to pick up HIV medications at the health facility

Thinking: I can not afford the clinic user fees or transport fees to collect my ARVs

Feeling: Worried

Doing: Travels to hot spots to find more clients

Thinking: It's hard for me to take my ARVs regularly because of my erratic schedule and I share a room when I travel, but I want to stay healthy

Feeling: Defeated, Lost, Worried

Doing: Gets ready for work, fixes herself up

Thinking: "No condom, no sex" that's my moto; I do not want to get re-infected with another strain of HIV

Feeling: Empowered, Optimistic, Proud

Doing: Goes to work at the bar from 6pm to 6am

Thinking: I need to stay sober so that I can negotiate safe sex

Feeling: Determined, Nervous

Doing: Has unprotected sex with a client

Thinking: I hope I do not get pregnant; but I needed the extra money and he paid more to have sex without a condom

Feeling: Angry, Stressed, Frustrated

Doing: Goes to the clinic for a pregnancy test

Thinking: I need to get on birth control pills, but I am worried that the provider will know my HIV status and tell other people

Feeling: Worried, Self-Protective, Frustrated, Lost, Ashamed

Doing: Talks to the provider at sex worker clinic and discusses birth control methods; learns about the female condoms

Thinking: I am glad to learn more about the female condoms; I wonder if there are additional options

Feeling: Empowered, Relieved, Educated

Key Insights

Limited Opportunities: When her husband found out she had HIV, he divorced her and kicked her out. She turned to sex work to support her children. Though she is motivated to stay healthy for her children, she often can not afford the fees associated with transport and ARVs, and also feed her children. She wants to find other work, but employment opportunities are limited

Financial Barriers: Worrying about money triggers unsafe behaviour because men pay more money for condomless sex. Staying sober helps her have more power to negotiate condom use, though sometimes when she discloses her HIV status, clients do not believe her and still do not want to use a condom. Women's empowerment and access to high-quality condoms combined with education and awareness for men about HIV risk factors are helpful strategies to encourage condom use

Privacy and Confidentiality: Client confidentiality, privacy and provider stigma, in addition to costs (time away from other needs and financial expenses like transport and fees) prevent her from seeking services from health clinics. She does not want to get pregnant as it will impede her ability to work

Abbreviations: ART, antiretroviral therapy; ARV, antiretroviral; FSW, female sex worker; SRH, sexual and reproductive health.

Communications Matrix: Female Sex Workers

DESIRED CHANGES*	TO ACHIEVE VIRAL SUPPRESSION	TO USE CONDOMS CORRECTLY AND CONSISTENTLY	TO PREVENT UNINTENDED PREGNANCY
Barriers	• Provider and community stigma towards sex workers • Self-stigma • Client privacy and confidentiality • Low knowledge of viral load (what it is, where to get tested and benefits of suppression) • Side effects from medications (feel dizzy, sick, etc.) • High mobility; transient and inconsistent schedule • Lack of privacy to take medications • Long turnaround for viral load results	• Clients refuse to use condoms • Clients pay more money for not using condoms • Clients do not perceive risk because sex worker looks healthy • Perceived difficulty using male and female condoms	• Lack of knowledge of appropriate and available family planning methods • Side effects of family planning methods (bleeding, weight gain)
Facilitating Factors	• Desire to be healthy to support children • Viral load testing availability • All public health facilities provide ART	• Desire to stay healthy • Sex worker queen's endorsement • Peer influence • Availability and accessibility of male and female condoms	• Availability of family planning IEC material • Low cost of family planning methods • Wide availability of family planning and counselling services in public, private and specialised (sex worker) facilities
Communications Objectives	1. Reduce self-directed stigma and health worker stigma and discrimination 2. Increase knowledge, attitudes and perceptions on the importance of viral load testing and disease progression, including how ART alters disease progression 3. Increase knowledge, attitudes and perceptions of ART side effects 4. Increase knowledge of where to access ART medications	5. Increase knowledge of risk of HIV reinfection and STIs 6. Increase knowledge on benefits of consistent and correct use of male and female condoms 7. Increase self-efficacy to negotiate for condom use	8. Increase knowledge, attitudes and perceptions of appropriate and available modern family planning methods

Illustrative Messages	• I always carry my medication with me so I do not miss a dose • I adhere to my medication to stay healthy • Keep the viral load low—stay healthy and maintain the good looks • Being adherent to your medications and using condoms consistently and correctly keeps you healthy, and prevents reinfection	• No condom, no sex • Use lubricant to prevent condom breakages • Don't compromise, condomise • It is my right to negotiate for safe sex—I use condoms • Stay in control, use condoms to prevent STIs and unplanned pregnancy • I am an empowered woman—I use a condom always	• Use family planning services to protect yourself from unplanned pregnancies • Children by choice, not by chance • My health, my responsibility
Illustrative Messages for desired change for HIV negative: To maintain negative HIV status through prevention methods (PrEP, condoms, STIs, PEP)*			
• Taking care of my health is my business—I am using PrEP • My health and my future are in my hands—I take PrEP medicines daily • PrEP helps me to be in control of my health/life • I understand my risk—I take PrEP • No condom, no sex • Lubricants help to prevent condom breakages • It is my right to negotiate for safe sex—I use condoms • Don't compromise, condomise • Stay in control—use condoms • Prevent STIs—use condoms • Worried about sexual violence? Ask about PEP • If you have been a victim of sexual violence, using PEP within 72 hours can reduce risk of contracting HIV			
Illustrative Indicators	1. % of target audience expressing accepting attitudes to female sex workers accessing HIV and sexual reproductive health services 2. % increase in female sex worker satisfaction with provider services 3. % of target audience with accurate knowledge of (a) HTS, (b) HIV prevention, (c) care and treatment, (d) viral load testing, (e) how ART alters disease, (f) HIV medication side effect management and (g) family planning methods side effect management 4. % of female sex workers who report knowledge of where to access (a) HIV testing, (b) HIV prevention, (c) care and treatment, (d) viral load testing services and (e) family planning methods and services 5. % of female sex workers who can recall the risk of HIV re-infection and STIs 6. % of female sex workers who report that they know how to use condoms consistently and correctlyy 7. % of female sex workers who agree that condoms provide effective protection against (a) unintended pregnancy, (b) STIs, (c) HIV and (d) all 8. # of female sex workers accessing family planning methods		

* For simplicity, all content within this matrix matches the HIV status and journey of the archetype. However, a desired change along with matching illustrative messages have been identified for the alternative HIV status.

Abbreviations: ART, antiretroviral therapy; IEC, information, education and communications; PEP, post-exposure prophylaxis; PrEP, pre-exposure prophylaxis; STI, sexually transmitted infection.

People With Disabilities

PWD: Situation and Behavioural Analysis

People with disabilities, the community's most vulnerable individuals, generally face greater challenges and risks compared to others in equal geographical or economic conditions. Treatment of PWD is deeply rooted in cultural and social norms that perpetuate the belief that PWD have been bewitched or cursed, as well as being based on ignorance. PWD face social discrimination, are often regarded as inferior, and lack social inclusion. For example, their birth may not even be registered, leading to restricted opportunities and lack of identity.

Girls and young women with disabilities are at an even greater disadvantage than men. Described as 'doubly disabled,' they face not only the inequality of being disabled but also discrimination from traditional gender roles.[38] They are also at greater risk for sexual abuse and violence.

Lack of Access to Education

Lack of education in general puts PWD at a disadvantage with obtaining basic health information. The majority of PWD do not have access to school, either because of limited resources at the school for adaptive learning, limited skills of teachers for PWD, transportation challenges, societal stigma or financial limitations. Since PWD typically do not receive basic sexual and reproductive or health education, they are at a disadvantage to understand how to protect themselves from unplanned pregnancies, HIV and other STIs.

"Nothing for me without me."

PWD and the Health Care Community

In addition to common barriers, PWD face further challenges when seeking access to health care services: provider stigma, transport challenges and financial limitations. PWD often have challenges getting to the clinic due to mobility issues—transport with a wheelchair, inability to travel long distances on crutches, or inability to travel alone (blind)—or competing priorities of caregivers. Clinic infrastructure poses additional challenges, such as lack of wheelchair ramps or accessible toilets. Other challenges include inadequate communications modalities such as braille, video or audio messages, or providers that know sign language. People with developmental disabilities (i.e. intellectual disability, autism and other similar conditions) are especially at risk due to their need for support around healthy decision-making.

Other grave challenges for PWD are inadequate provider/client communications and empathy. Many providers (and caregivers) assume incorrectly that PWD do not have sex, and therefore do not need family planning methods or HIV and STI testing. PWD want to be part of the planning for their health but often experience discrimination from providers in the form of lack of participatory care. Lastly, in addition to the other challenges they face, PWD face financial limitations. Limited work poses a threat to the financial means to pay for transportation and for HIV prevention, care and treatment services.

Table 7.
People With Disabilities: Synopsis of Problem and Desired Behaviours and Practices

PROBLEM BEHAVIOURS/PRACTICES	DESIRED BEHAVIOURS/PRACTICES
• Delays in seeking health services; fear of stigma and discrimination • Limited understanding of their rights • Community stigma or self-discrimination; lack of understanding and sensitivity of PWD by community members • Do not seek support (such as community health workers, social support) • Risky sexual behaviours; does not negotiate safe sex • Inability to make healthy decisions independently (developmental disabilities) • Mobility and communications limitations or impairments to seeking services	• To be informed: improve knowledge, attitudes and perceptions around family planning; seek and use family planning method • Reduce risky behaviours and seek or access prevention (self-testing, male and female condoms, lubricants and PrEP), care and treatment • Seek supportive services; reduce stigma and improve supportive environments to ensure adequate social support • Empower PWD with knowing their human rights • Providers to deliver empathetic, client-centred and confidential care • Caregivers to advocate for PWD; increase self-efficacy of PWD • Use STI and HIV testing, counselling and treatment services • Negotiate and practice safe sex

Abbreviations: PrEP, pre-exposure prophylaxis; PWD, people with disabilities; STI, sexually transmitted infection.

NAME: Caroline

AGE: 20

RELATIONSHIP: Boyfriend

HIV STATUS: HIV negative

"People act like I cannot do anything. I can do everything that others do—it just takes me a little more effort."

Abbreviations: PrEP, pre-exposure prophylaxis; PWD, people with disabilities.

GOALS

» To start a family planning method
» To get tested for HIV
» To get initiated on PrEP and use condoms

BEST WAY TO REACH ME

» Radio
» Print media
» Social media (SMS, Facebook, Instagram)

INFLUENCERS

» Caregivers
» Peers with the same disabilities
» Health care workers

CAROLINE REPRESENTS A BIGGER POPULATION WHO:

» Feels less worthy to ask for what they need because of self-discrimination and societal stigma
» Worries about going for an HIV test and testing HIV positive
» Feels accessing services is difficult – transportation is difficult with the wheelchair and there are few sidewalks for the wheelchair; health facilities do not have infrastructure (like ramps and toilets) for her
» Believes that providers should recognize that people with disabilities are people too with the same rights as everyone else, and deserve individualized care
» Feels some people discriminate against her because they believe her disability is a curse from God; it is hard to make friends, have support and get access to information
» Feels that service providers do not understand that people with disabilities have sex
» Feels that the community does not understand how to offer the support that they need
» Feels that home visits are the best way to access health care workers
» Spends time at home and church
» Has fears that could be addressed by continued counselling by health care workers
» Is most receptive to information from health care workers and peers with similar disabilities
» Thinks being healthy means living in a clean environment, eating well, having a clean water supply and sanitation, and good roads
» Wishes that providers were more understanding and could better provide accurate health and treatment information

Disclaimer: The photographs in this material are used for illustrative purposes only; they do not imply any particular health status, attitudes, behaviors, or actions on the part of any person who appears in the photographs.

People With Disabilities Journey Map: Caroline, 20 years old, HIV negative

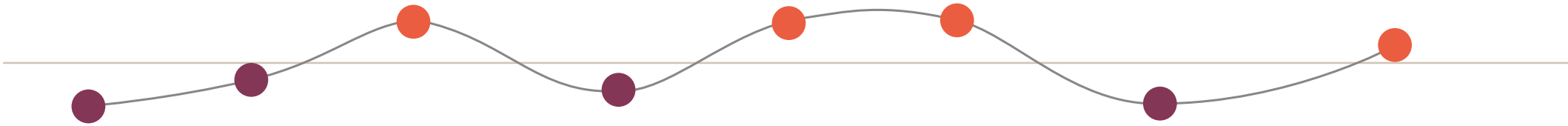
About this map: This is a theoretical high-level health journey for a female person with a disability interacting with HIV and SRH programmes, which may overlap or be sequential. The journey map reveals her experience and what she might be doing, thinking and feeling along the way that impact her desire and ability to access services

The purple, orange and gray dots indicate the highs/positive emotion (motivators) and lows/negative emotion (barriers) of the journey. These help the reader of the map prioritise opportunities for communications interventions and collaboration with service delivery to make the journey easier

Trusted information sources: People at the hospital and other health workers (i.e. community health workers);
Other sources: Caregivers, peers with same disabilities

	Family Planning	HIV Testing Services	Prevention: PrEP, Condoms

Positive emotion
Neutral emotion
Negative emotion



Caroline's Experience

Doing: Has unprotected sex with her boyfriend

Thinking: I hope I do not get pregnant

Feeling: Worried, Insecure, Disempowered

Doing: Talks to a health worker about family planning

Thinking: I wish I could go to the clinic, but it's so hard – they do not have ramps for my wheelchair and I can not use the bathrooms

Feeling: Uncertain, Frustrated

Doing: Goes to health clinic and talks to health care worker about family planning

Thinking: I want to participate in decision-making about my health; I want to learn about all the options

Feeling: Determined, Motivated

Doing: Talks with church friends about HIV testing

Thinking: I feel like other people do not understand what I need

Feeling: Frustrated, Defeated, Misunderstood

Doing: Goes for a health education talk with an NGO that helps people with disabilities

Thinking: I feel like health workers at the clinic do not understand me; I can only turn to NGOs that support people with disabilities

Feeling: Comfortable, Relaxed, Content, Informed

Doing: Goes to the clinic and requests an HIV test

Thinking: I want to be informed about my HIV status

Feeling: Empowered, Confident

Doing: Gets test results and talks to health worker about PrEP. Reads brochures and looks up PrEP online

Thinking: I do not understand why health workers think that people with disabilities do not have sex

Feeling: Feeling: Frustrated, Annoyed

Doing: Goes to another health worker who works with people with disabilities; gets PrEP and condoms

Thinking: I feel better knowing that I am in control of my HIV status and that I can protect myself. Soon I will talk to my boyfriend about getting tested

Feeling: Relieved, Empowered, Confident, Secure

Key Insights

Infrastructure Barriers: She learns about health from community health workers and representatives of people with disabilities; hears family planning messages on the radio. But she needs infrastructure support to increase her ability to access services. She is frustrated that people make decisions about her health without her input and that no one is advocating for policy changes to make it easier for her

Stigma: She internalises a widely held community belief that she is bewitched or cursed because of her disability. She feels judged by health care workers who lack sensitivity to her disability and can not communicate effectively with her. She is often told that someone like her should not be having sex, hindering her ability to seek health services

Targeted Communication Is Key: Wants to stay HIV negative and feels she can have more control with PrEP instead of asking her boyfriend to use condoms. But she is worried about asking for PrEP because she does not know any other person with a disability taking it. Rarely does she see any health messaging that has been modified for people with disabilities – e.g. visual impairments (braille), hearing impairments (videos with subtitles), sign language interpreters

Abbreviations: NGO, nongovernmental organisation; PrEP, pre-exposure prophylaxis; PWD, people with disabilities.

Communications Matrix: People With Disabilities

DESIRED CHANGES*	TO START A FAMILY PLANNING METHOD	TO GET TESTED FOR HIV, GET INITIATED ON PREP AND USE CONDOMS
Barriers	• Community and providers think PWD are not sexually active • Lack of basic information on SRH and in the appropriate formats (braille, audio messages, sign language interpreters) • Schools where they might access SRH education are not equipped to include PWD • PWD do not know where to access health services • Community infrastructure not equipped for people with limited mobility • Providers not capacitated to help PWD • Limited power, gender inequality	• Facilities not designed for PWD—no access to ramps for wheelchairs, toilets inaccessible • Societal and cultural beliefs that PWD have been cursed or possessed by evil spirits • Religious norms around sexual behaviour • Health care worker stigmatisation and imposing personal beliefs on clients • Cost and distance to access services • Lack of basic information on HIV • Low risk perception
Facilitating Factors	• Parents/guardians/caregivers who understand the rights of their children with disabilities • Adults who are informed and understand the rights of a person with a disability • Advocacy at all levels for people with disabilities • Infrastructure designed to incorporate people with disabilities (bathrooms and ramps at clinics; transportation modified for wheelchairs and crutches) • Communications modes and IEC materials to accommodate those with hearing or visual impairments (braille, audio messages, videos with subtitles, etc.) • Acceptance by community members of the unique needs of those with disabilities • Reduced community stigma towards those with disabilities • Client-centred care and provider training to accommodate people with disabilities and their caregivers	
Communications Objectives	1. Increase positive community perceptions of PWD 2. Increase provider's awareness of client-centred care for PWD 3. Increase self-efficacy of PWD to access health services 4. Increase political will for PWD-friendly infrastructure at health facilities	

Illustrative Messages	ADVOCACY FOR INCLUSION IN DECISION-MAKING • My right, my choice; disability is not an inability; I can have a planned family • Nothing for us, without us, include me in every stage • Patient-centred care involves the patient in decision-making for their health FAMILY PLANNING/HIV • Family planning is a right for all women—including those with disabilities • Seek family planning and HIV services to protect yourself from unplanned pregnancy and HIV • I am empowered—I can make my choices on family planning methods • HIV testing is my right • I am in charge of my life—I know my HIV status PROVIDER • Promote the use of family planning methods to prevent unplanned pregnancy • I trust you to provide me with good care • Being disabled does not mean I am sick
Illustrative Messages for sub-desired change for HIV positive: To get initiated on ART and stay virally suppressed*	• Being HIV positive is not the end of the world—take your medication to stay alive and healthy • My family is supportive so taking my medication is easy • I have HIV and it is undetectable because I take my medication • I found a support group to help me stay on treatment, and I feel better • Now I understand why taking my HIV medication is so important—I can live a long, healthy and normal life • I take my HIV medications to keep my viral load low—that reduces the risk of transmission to my partner • Undetectable equals untransmissible
Illustrative Indicators	1. % of community members who report positive perceptions of PWD 2. # of providers trained on client-centred care for PWD 3. % of PWD who report that providers are client-centred in delivering health services to PWD 4. % of PWD who report high self-efficacy for accessing health services 5. % of national budget allocated to improve PWD infrastructure at health facilities

* For simplicity, all content within this matrix matches the HIV status and journey of the archetype. However, a desired change along with matching illustrative messages have been identified for the alternative HIV status.

Abbreviations: IEC, information, education and communications; PrEP, pre-exposure prophylaxis; PWD, people with disabilities; SRH, sexual and reproductive health.

Adolescent Girls and Young Women

AGYW: Situation and Behavioural Analysis

Numerous factors create a risk of HIV infection for AGYW, including low risk perception, limited access to prevention methods and lack of comprehensive HIV information. The risk is compounded by gender norms, age mixing, multiple concurrent partners and transactional sex. HIV prevalence among young women (ages 20-24) is 8.1%—almost three times higher than HIV prevalence among young men (2.7%)[7] despite similar HIV prevalence rates (2.8%) between ages 10-14,[39] indicating that AGYW are at extreme risk of contracting HIV. Additionally, outcomes among AGYW who are HIV positive are worse compared to other population groups because of lack of disclosure, stigma and discrimination, and poor adherence.

Age Mixing and Transactional Sex Increase HIV Risk

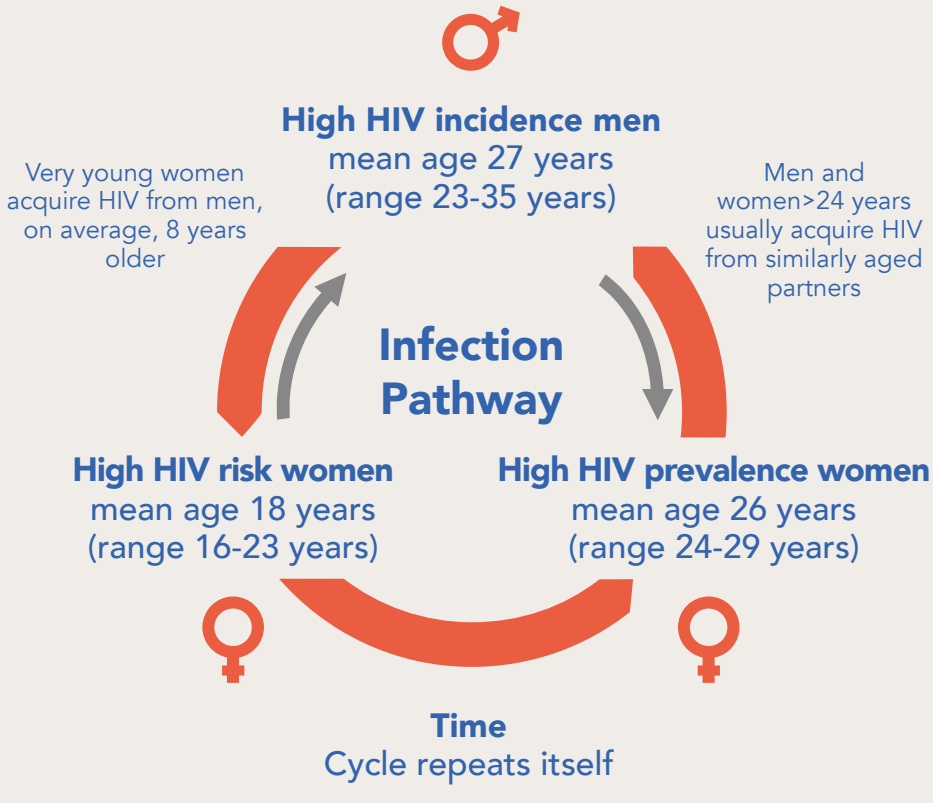
Younger women acquire HIV from older men, compared to women ages 24 and greater who typically acquire HIV from partners their own age.[40,41] In 2015, 21.2% of (urban and rural) women ages 20-24 reported having a sexual partner 10 or more years older. [42] Moreover, from the years 2010 to 2015, the rate of age mixing in sexual relationships has increased.[11]

Women typically engage in transactional sex due to economic vulnerability and gender inequality. Transactional sex is more prevalent than sex work; evidence shows the percentage of AGYW in Africa who engage in transactional sex ranges from 2.1% to as high as 52%.[43] Those engaging in transactional sex (unlike sex workers) do not perceive themselves as high risk, and their urgency to seek HIV services tends to be low.

Gender norms and intimate partner violence (IPV) are exacerbated by age mixing and transactional sex, limiting a woman's ability to advocate for safe sex and increasing the risk of violence by disclosing an HIV-positive status.[44] This can also lead to poor adherence and worse treatment outcomes, perpetuating the cycle of HIV transmission.

Research shows that information and education on HIV and family planning is inadequate for AGYW. Only 51% of adolescent girls aged 15-19 have comprehensive and correct knowledge of HIV,[39] and knowledge of family planning is only 41% in young people.[42] HIV testing coverage is also low (58%) among sexually active adolescent girls (15-19 years),[39] even though 40% of girls have had sex before the age of 18 years and 21% have begun child bearing before they reach 20 years old.[42]

Figure 7.
Infection Pathway



Approximately one in three women living with HIV report experiencing at least one form of discrimination related to their sexual and reproductive health in health care settings.[16]

Table 8.
Adolescent Girls and Young Women:
Synopsis of Problem and Desired Behaviours and Practices

PROBLEM BEHAVIOURS/PRACTICES	DESIRED BEHAVIOURS/PRACTICES
• Risky sexual behaviours: early sexual debut, age mixing, multiple sex partners, low rates and inconsistent use of condom[11,41] • GBV and IPV reduce ability to disclose testing (fear of accusations, distrust) and results to partner • Unsafe sex; GBV and IPV; lack of empowerment to negotiate safer sex[11]; low risk perception; young people fear pregnancy more than HIV[45] ; lack of comprehensive and correct knowledge of HIV • Does not learn about SRH and HIV; HIV education and communications designed for adults; lack of communications and education for adolescents in a tailored, specific way that is acceptable, accessible and effective[11] • Does not seek supportive services; weak community structures (especially at grassroots) and networks of women living with HIV[46] • Does not seek advice about SRH and HIV; poor communications between adolescents and parents; parents have inadequate information and tools for dialogue with their children[11] • Is non-compliant with medications; gap between knowledge and practice of adhering to medication: lack of disclosure, insufficient social support, unreliable sources of time and financial barriers[11] • Does not go for HIV testing • Does not seek pregnancy services, i.e. ANC visits; unfavorable attitudes and perceptions or limited knowledge among pregnant and lactating women and community members about the benefits of ANC/PMTCT[46]; socio-cultural and religious beliefs inhibit use of modern health services	• Reduce risky behaviours: age mixing, lack of and inconsistent condom use, early sexual debut, unintended pregnancy • Seek HIV prevention (self-testing, male and female condoms, and PrEP), care and treatment • Negotiate and practice safe sex • Effective parent-adolescent communications about SRH and HIV prevention, care and treatment[47] • Seek and access supportive environments; reduce stigma and improve supportive environments to ensure adequate social support, education and available treatment regimens tailored to adolescent lifestyles • Improve knowledge of accessibility to HIV testing services; provider sensitisation to reduce provider stigma related to SRH and HIV in adolescents • Providers to deliver empathetic, client-centred, female-friendly and confidential care • Enhance male involvement in ANC/eMTCT • For men to reduce risky behaviour (multiple partners, unprotected sex, etc.) and to seek HIV testing

Abbreviations: AGYW, adolescent girls and young women; ANC, antenatal care; eMTCT, elimination of mother-to-child transmission of HIV; GBV, gender-based violence; IPV, intimate partner violence; PMTCT, prevention of mother-to-child transmission of HIV; PrEP, pre-exposure prophylaxis; SRH, sexual and reproductive health.

NAME: Mercy

AGE: 17

RELATIONSHIP: Has an older boyfriend

HIV STATUS: HIV negative

"My boyfriend said we don't need to use condoms because they're for promiscuous people and a sign of distrust."

GOALS

» To access sexual and reproductive health services
» To get tested for HIV
» To initiate PrEP and use condoms

BEST WAY TO REACH ME

» Radio
» SMS, Whatsapp
» Community dialogue

INFLUENCERS

» Parents, grandmother
» Boyfriend
» Sister, friends

MERCY REPRESENTS A BIGGER POPULATION WHO:

» Worries about being able to pay for school so she has an older boyfriend who gives her money

» Doesn't know enough about the risks of HIV; she doesn't realise that having an older boyfriend means she is at high risk and should use condoms

» Worries more about getting pregnant

» Thinks being healthy means not having physical pain and having beautiful skin

» Gets health information from friends and social media

» Finds that health workers and radio are the most trustworthy sources of information

» Talks to health workers, mother, aunt, sister about her general health

» Doesn't trust neighbors or community members to know about her health

» Goes to the traditional healer first or tries home remedies when sick

» Worries about getting tested for HIV and having an HIV-positive result and wonders if she will be able to have children and a normal life if she becomes positive

» Feels like having a mentor or more life skills will help her move forward in life and health

Abbreviations: PrEP, pre-exposure prophylaxis.

Disclaimer: The photographs in this material are used for illustrative purposes only; they do not imply any particular health status, attitudes, behaviors, or actions on the part of any person who appears in the photographs.

Adolescent Girl Health Journey Map: Mercy, 17 years old, HIV negative

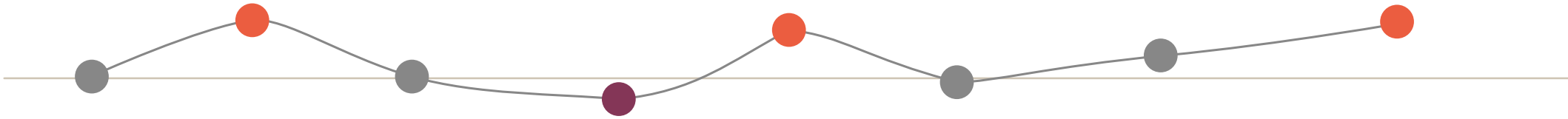
About this map: This is a theoretical high-level health journey for an adolescent girl interacting with HIV and SRH programmes, which may overlap or be sequential. The journey map reveals her experience and what she might be doing, thinking and feeling along the way that impact her desire and ability to access services

The purple, orange and gray dots indicate the highs/positive emotion (motivators) and lows/negative emotion (barriers) of the journey. These help the reader of the map prioritise opportunities for communications interventions and collaboration with service delivery to make the journey easier

Trusted information sources: Radio, health facility/health workers, school programmes, grandmother, mother, sister; **Other sources:** Church/pastor, prophets, information sessions in the community (IPC), guidance and counseling teachers, text books at school

	Family Planning	HIV Testing Services	Prevention: PrEP, Condoms

Positive emotion
Neutral emotion
Negative emotion



Mercy's Experience

Doing: Has unprotected sex with her older boyfriend

Thinking: I think I need to get on the pill; I do not want to get pregnant

Feeling: Curious, Optimistic, Pensive, Frightened

Doing: Talks to the health care worker or friends about contraceptive options. She hears about HIV testing

Thinking: I will be so relieved once I know I will not get pregnant

Feeling: Relieved, Happy

Doing: Picks up birth control pills; hears more about HIV testing

Thinking: I wonder if I should get tested for HIV

Feeling: Curious, Slightly worried, Fear of the unknown

Doing: Goes for testing

Thinking: I hope I am HIV negative, I do not think I could be HIV positive; my boyfriend says I am his only girlfriend

Feeling: Worried, Anxious, Scared

Doing: Goes to see her boyfriend

Thinking: I am relieved that I do not have HIV; that must mean my boyfriend does not either

Feeling: Relieved, Happy

Doing: Talks to a community health worker about PrEP

Thinking: I do not think I need PrEP; I got tested for HIV and I do not have it; my boyfriend is healthy too

Feeling: Indifferent, Not interested

Doing: Talks with her sister about her boyfriend; her sister tells her about PrEP and condoms

Thinking: Why would I need PrEP? My boyfriend said I am his only girlfriend and since I am on birth control now, I do not think we need condoms

Feeling: Aloof

Doing: Thinks about PrEP and that her sister said it might be helpful; considers learning more. Searches PrEP on the internet

Thinking: If PrEP would be good for me then why didn't the health care worker talk to me about it? I have heard people talking about the blue pill – what if someone sees me taking it and thinks I have HIV?!

Feeling: Curious, Perplexed, Pensive

Key Insights

Low Risk Perception: She has limited information about sexual and reproductive health and HIV; her parents have never talked to her about it. Her biggest worry is about getting pregnant, not getting HIV. She is worried that her boyfriend will leave her if she is pregnant and what the community and her family will think of her

Financial Barriers and Knowledge Is Power: She is scared to get tested and to tell her boyfriend about her status for fear he will hurt her, leave her or not pay her school fees if she is HIV positive. She has been dating her boyfriend for a couple of months, she trusts him and believes that he is not sleeping with anyone else. She believes that if she tests HIV negative that her boyfriend is HIV negative also. She does not have a clear understanding of her risk for HIV

Confidentiality and Stigma: She is terrified that someone will see her at the clinic picking up medications and talking to the nurse. She is worried that one of the health workers will tell people in the community that she is taking PrEP; the health worker told her she is too young to be having sex; she feels judged and frustrated

Abbreviations: IPC, interpersonal communication; PrEP, pre-exposure prophylaxis; SRH, sexual and reproductive health.

Communications Matrix: Adolescent Girls

DESIRED CHANGES*	TO ACCESS SEXUAL AND REPRODUCTIVE HEALTH SERVICES	TO GET TESTED FOR HIV	TO INITIATE PrEP AND USE CONDOMS
Barriers	• Lack of adequate information on ASRH • Lack of privacy, confidentiality and friendliness at the local health facilities • Stigma and discrimination from family, community and provider about ASRH • Social and cultural norms preventing parents/ guardians conversations with adolescents about ASRH • Trust issues (that use of a condom implies lack of trust in her relationship) • Fear that her parents will find her family planning method • Ill preparedness on the first sexual encounter • Lack of confidence to introduce condom use	• Limited comprehensive information about HIV • Age of consent for testing • Societal stigma and discrimination • Poor parent-child communication on ASRH and HIV • Lack of perceived risk of HIV • Fear of HIV-positive result • Lack of privacy and confidentiality at the local health facility	• Limited knowledge or inability to access PrEP • Incorrect and inconsistent use of condoms • Inability to negotiate condom use • Societal stigma related to accessing in public facilities • Affordability of socially marketed and private sector condoms
Facilitating Factors	• Peer support • Availability and accessibility of relevant information on ASRH • Adolescent-friendly services	• Peer/community support • Privacy and confidentiality at the clinic • Adolescent-friendly service provider • Availability and accessibility of age-appropriate information on the importance of HTS • Accessibility of HIV self-testing	• Peer support • Privacy and confidentiality at the clinic • Adolescent-friendly services • Enhanced adherence counselling • Adequate knowledge on the benefits of PrEP
Communications Objectives	1. Increase knowledge on access and importance of ASRH services 2. Reduce stigma and discrimination around accessing ASRH services 3. Improve self-efficacy to access ASRH services	4. Increase knowledge on where to access ASRH services 5. Increase knowledge of benefits of accessing HIV services 6. Improve positive perceptions and attitudes on accessing HIV services 7. Reduce societal stigma and discrimination around accessing HIV services 8. Improve self-efficacy to go for HIV testing 9. Increase perceived social/peer support for adolescent girls to go for HIV testing 10. Increase risk perception of HIV	11. Increase knowledge on the importance of HIV prevention methods such as PrEP and condoms 12. Improve perceived value of benefits of condom use 13. Increase self-efficacy to use condoms consistently and correctly 14. Increase knowledge of where to access condoms 15. Reduce embarrassment of accessing condoms

Illustrative Messages	• There is more value in seeking modern contraceptive services • Use family planning services to learn about safe and effective contraceptives that suit your life • I decide when to start a family—for now I am using condoms and pursuing my career • Protect a girl—provide her information and reproductive health services (for providers) • My friends and I have been empowered. We visited a health centre for modern contraceptive services • I am a girl and I am responsible—using modern contraception is my choice • Children by choice, not by chance—use a modern contraceptive method	• I might be at risk of HIV—I need to be tested • I overcame my fears—I got an HIV test • There is life after testing—know your status • Adolescent girls and young women account for 1 in every 4 HIV infections—talk about sexual and reproductive health with your daughters • Adolescent girls and young women account for 25% of total HIV infection—stop sexual violence against girls. (general message for community) • Testing is not as far away as you think—I got tested here in my community • I am in control, I make the decision to get tested for HIV • Use family planning services, get tested for HIV, take care of your health	• Ask about PrEP when you go for HIV testing or family planning services • Protect yourself from HIV, use PrEP and condoms consistently and correctly • Girls, do not leave it up to the man-you also need to say, 'Let's use a condom' • When it comes to unprotected sex, my no remains a no • I am a girl, I am in charge, you play it by my terms—I condomise • Taking care of my health is my business—I am using PrEP • You may experience some side effects in the first few weeks of taking oral PrEP These are temporary and manageable • My health and my future are in my hands—I take PrEP medicines daily • I am in control. I use PrEP • I understand my risk—now I take PrEP
Illustrative Messages for desired change for HIV positive Adolescent Girl: To get initiated on ART and stay virally suppressed*	• I have accepted my HIV positive result, despite how I got it, and I am starting my treatment today • I adhere to my treatment, I feel great • My loved ones know my status, I have all the support I need • I will never stop my HIV treatment - my life depends on it • Life goes on for people with HIV, I am living proof		
Illustrative Indicators	1. % of target audience with accurate knowledge of HIV prevention and adolescent sexual and reproductive health services 2. % of target audience expressing accepting attitudes to adolescent girls accessing HIV and sexual reproductive health services 3. % of adolescent girls who report high self-efficacy for accessing HIV and sexual and reproductive health services 4. # of providers trained on person-centred care for adolescents 5. # of community dialogue meetings held to sensitise communities on the importance of HIV and sexual reproductive health services for adolescents 6. # of adolescent health network support groups formed 7. # of adolescent girls exposed to age-appropriate messages on HIV and sexual and reproductive health services for adolescents		

* For simplicity, all content within this matrix matches the HIV status and journey of the archetype. However, a desired change along with matching illustrative messages have been identified for the alternative HIV status.

Abbreviations: ART, antiretroviral therapy; HTS, HIV testing services; PrEP, pre-exposure prophylaxis; SRH, sexual and reproductive health; STI, sexually transmitted infection.

NAME: Anna

AGE: 24

RELATIONSHIP: Married, pregnant

HIV STATUS: HIV positive

"How can I be sure that my baby isn't sick, and will I be able to breastfeed like healthy women do?"

GOALS

» To access ANC services and get tested for HIV
» To initiate ART and prevent mother-to-child transmission
» To become virally suppressed

BEST WAY TO REACH ME

» TV
» NGO workers
» Health care providers

INFLUENCERS

» Husband
» Mother and sister
» Traditional healer

ANNA REPRESENTS A BIGGER POPULATION WHO:

» Is worried about getting tested and finding out she's HIV positive; is worried about whether her husband will kick her out of their home
» Wants to live a healthy life and wants her children to be healthy
» Thinks being healthy means having a long life, not getting sick and eating good food
» Views health and beauty as something that is important to her, especially to have good skin
» Talks to her sister about sexual health but doesn't trust her friends
» Spends her time at home, beauty shops and the markets
» Seeks general health advice from relatives, then goes to traditional healers; goes to the clinic last
» Fears death, sickness, and the unknown
» Worries that health care workers will be rude to her
» Feels like knowledge is power, but is limited to doing what her husband approves of
» Feels that it would be helpful to have information about sexual health for couples
» Wishes her husband would go for couples testing, but he refuses; when she was HIV negative, he claimed they shared the same status; she heard that some men prefer HIV self-tests and hopes to convince him to try it
» Hides ARVs in her shower cap so that her husband does not find them

Abbreviations: NGO, nongovernmental organisation; ARV, antiretroviral.

Disclaimer: The photographs in this material are used for illustrative purposes only; they do not imply any particular health status, attitudes, behaviors, or actions on the part of any person who appears in the photographs.

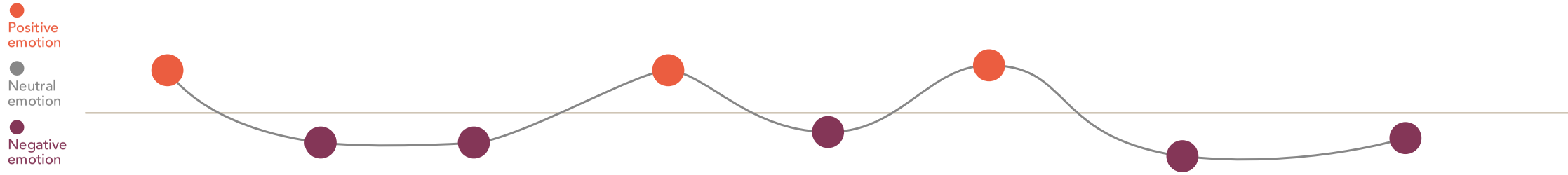
Young Woman Health Journey Map: Anna, 24 years old, pregnant, HIV positive

About this map: This is a theoretical high-level health journey for a young woman interacting with three HIV programmes, which may overlap or be sequential. The journey map reveals her experience and what she might be doing, thinking and feeling along the way that impact her desire and ability to access services

The purple, orange and gray dots indicate the highs/positive emotion (motivators) and lows/negative emotion (barriers) of the journey. These help the reader of the map prioritise opportunities for communications interventions and collaboration with service delivery to make the journey easier

Trusted information sources: Hospitals, health facility, TV, DREAMS programme, NGOs that teach people about health, church;
Other sources: radio, friends, family, traditional/faith leaders, village health workers, internet, SMS messages (Econet)

Antenatal Care and HIV Testing Services → Prevention of Mother-to-Child Transmission → Care and Treatment: Viral Load



Anna's Experience

Doing: Goes with her husband to talk to the village chief about her pregnancy

Thinking: I hope my husband agrees for me to go to the clinic so they can check on the baby

Feeling: Hopeful, Optimistic, Nervous

Doing: Goes to clinic with her husband and she gets tested; husband does not test

Thinking: Why won't my husband agree to do the test?

Feeling: Preoccupied, Optimistic, Overwhelmed

Doing: Returns for next ANC visit without husband; receives HIV-positive result

Thinking: How did this happen? I've only had sex with my husband. I am afraid he will send me back to my village

Feeling: Worried, Scared, Betrayed

Doing: Talks to health worker about ARVs. Learns that she can deliver a healthy baby

Thinking: I want my baby to be healthy

Feeling: Motivated, Informed

Doing: Goes to church; talks to women about what to expect for having her baby

Thinking: I feel worried that my baby will be sick, but I can not talk to anyone about it

Feeling: Conflicted, Scared

Doing: Delivers a healthy baby

Thinking: I am so relieved; do I need to keep taking these medications?

Feeling: Relieved, Sleep-deprived, Tired

Doing: Takes baby for a check-up. Talks to health worker about ARVs

Thinking: My baby is still at risk for HIV if I do not take my medication?!

Feeling: Worried, Scared

Doing: Takes medications continually, though she tries to hide her medications so her husband does not see

Thinking: How do I get my husband to get tested?

Feeling: Concerned, Secretive

Key Insights

Fear of Disclosure: Accessing ANC services is a big barrier because she lacks support from her husband due to social and cultural/religious norms and financial stresses; she needs his permission. If she is HIV positive, she fears being blamed for bringing it into the relationship, which could result in domestic violence. Couples counselling and couples testing are helpful to provide education and promote HIV testing to husbands

Knowledge Is Power: She wants to deliver a healthy baby, free from HIV and responds to messages focused on what she can do to protect her baby. Sticking with ARV treatment has great success in preventing mother-to-child transmission, though rates of transmission significantly increase at 18 months to 7% from 6 weeks 3.6%

Couples Counselling and Family Support: Getting her husband and family involved in her care can have a big impact on her ability to follow through with ARV treatment. She wants more support from her husband, so getting his involvement through counselling and male role models is a key factor in her ability to keep her viral load low and suppressed

Abbreviations: ANC, antenatal clinic; ART, antiretroviral therapy; ARV, antiretroviral; NGO, nongovernmental organisation; PMTCT, prevention of mother-to-child transmission of HIV.

Communications Matrix: Young Women

DESIRED CHANGES*	TO ACCESS EARLY ANC AND GET TESTED FOR HIV	TO INITIATE ART AND PREVENT MOTHER-TO-CHILD TRANSMISSION	TO BECOME VIRALLY SUPPRESSED
Barriers	• Lack of information on HIV and SRH • Provider imposing personal beliefs on clients • Limited power, gender inequality • Lack of basic information on sexual and reproductive health and HIV • Religion • Peer influence	• Disclosure of HIV status to partner • Provider not friendly/lack of confidentiality • Shortage of staff/providers • Self-stigma • Fear, denial • Power dynamics in relationships • Lack of comprehensive knowledge on ART	• Cost and distance to access ART services • Fear of disclosure to partner • Lack of knowledge on benefits of viral load suppression • Self-stigma • Pill burden and fatigue
Facilitating Factors	• Empowerment to encourage husband to get tested • ANC as entry point for accessing services, including knowing HIV status • Family planning (child spacing)	• Partner testing • Disclosure • Supportive family/community • Active male involvement • Easy access to ART • Integrated services	• Positive peer influence • The desire to protect her baby • Partner and family support
Communications Objectives	1. To change negative cultural beliefs related to accessing ANC services early 2. To change negative gender norms/roles to improve male involvement in ANC 3. Increase self-efficacy to access ANC and HIV services	4. Improve knowledge, attitudes and perceptions on PMTCT 5. Increase knowledge on where to access treatment services 6. Improve perceptions on the importance of male and family support in female sexual and reproductive health	7. Improve knowledge, attitudes and perceptions about access to viral load monitoring services 8. Improve knowledge, attitudes and perceptions on the importance of viral load testing, disease progression and how ART alters disease progression
Illustrative Messages	• Get tested today and live long to take care of and protect your family • HIV testing is available at any health centre—get tested now	• Do not delay, protect your unborn child, get on treatment now • Disclosing my HIV status is not easy, but protecting my unborn child is more important	• Take care of your health, take your medications and get virally suppressed • Being HIV positive is not the end of the world—take your medication to stay alive and healthy

Illustrative Messages	• I have the right to make informed choices about my health • Book early for ANC (as soon as you know that you are pregnant, at least before 12 weeks) to protect yourself and your baby from HIV • The decisions you make today as a mother will affect your child's future, so book early for ANC • Book early for ANC, adhere to ARV treatment, practice safer sex and increase chances of delivering an HIV negative, healthy baby	• HIV positive? Pregnant? Get HIV medication at your local clinic • HIV-positive women can give birth to an HIV-negative baby—protect your baby by starting HIV medication now • Ensure that you administer the recommended ARV prophylaxis to your new born infant as prescribed and supplied by the health care worker • An HIV exposed infant will be tested for HIV at birth if high risk, 6 weeks of age, 9 months of age and 6 weeks post weaning	• My family is supportive, so taking my medication is easy • Support your loved ones on HIV treatment for better treatment outcomes • I have HIV and it is undetectable because I take my medication • I found a support group to help me stay on treatment—I feel better • Now I understand why taking my HIV medication is so important—I can live a healthy and normal life • I take my HIV medications to keep my viral load low—that reduces the risk of transmission to my partner • A virally suppressed person is just the same as any other stable person with a chronic illness • I am virally suppressed-I am at peace
Illustrative Messages for desired change for HIV negative: To maintain negative HIV status through prevention methods (PrEP, condoms, PEP)*			
• Book your pregnancy before 12 weeks • Get tested for HIV & syphilis together with your partner • If HIV negative ensure that you get a retest in the third trimester, 6 weeks post delivery and every 6 months during the breast-feeding period • Ensure that you have 8 ANC contacts as recommended by the health facility and also follow recommended postnatal visits • Seek social and family support for ANC and PMTCT services • Deliver at health facility and/or by a skilled birth attendant • Exclusively breast feed your baby for the first six months of life and introduce complementary feeds from six months of life and continue breast feeding for up to 2 years • The baby should receive appropriate immunizations as advised by the health care worker • Use dual family planning methods (family planning method and condoms) to prevent unplanned pregnancy • Ensure that you are screened for cancer of the cervix at 6 weeks post delivery		
Illustrative Indicators	1. % of providers expressing accepting attitudes to clients accessing ANC and HTS services 2. # of providers trained on patient counselling and value clarification 3. # of dialogue meetings held with religious and community leaders 4. % of ANC attendees who report high self-efficacy for accessing ANC and HIV services 5. % of target audience with accurate knowledge of HIV medications (prevention and treatment) to prevent PMTCT 6. % of young women who report that they know where to access information and services for HIV 7. % of target audience who report positive perceptions of the importance of male and family support in sexual and reproductive health 8. % of young women who report that they know (a) where to access viral load services, (b) importance of viral testing and (c) how ART alters disease progression		

* For simplicity, all content within this matrix matches the HIV status and journey of the archetype. However, a desired change along with matching illustrative messages have been identified for the alternative HIV status.

Abbreviations: ANC, antenatal care; ART, antiretroviral therapy; HTS, HIV testing services; IEC, information, education and communications; PEP, post-exposure prophylaxis; PMTCT, prevention of mother-to-child transmission of HIV; PrEP, pre-exposure prophylaxis; SRH, sexual and reproductive health.

Adult Women

AW: Situation and Behavioural Analysis

HIV prevalence among women continues to increase between ages 25-29 (14.3%) and 30-34 (22%) and peaks between ages 40-44 (29.6%).[7] Adult women at highest risk of HIV infection include those in serodiscordant relationships or with a partner of unknown status, and pregnant and lactating women due to unsafe sexual practices; gender-based and intimate partner violence (GBV and IPV); social, cultural and gender norms. Low condom use among married couples and sexual networks—including husbands who have young girlfriends or visit sex workers—contribute to the increased risk of HIV infection among adult women.

Gender-Based and Intimate Partner Violence

GBV and IPV—including physical, sexual or psychological harm or suffering—is a violation of basic human rights and a key driver of the HIV epidemic. Women ages 25-29 experience the highest rate (42.4%) of ever experiencing physical violence (since age 15); moreover, 13% to 16% of women ages 25-49 have ever experienced sexual violence.[33] Substance abuse (such as high levels of alcohol consumption) and determinants such as husband's/partner's education (higher levels of education correlate with lower rates of abuse) are linked to higher levels of abuse.[33] These data represent gender, social and behavioural norms that contribute to a woman's inability to advocate for protecting herself, including for safe sex, increasing her risk for HIV infection.

Social, Cultural and Gender Norms

A patriarchal society in Zimbabwe inhibits women's ability to contribute equally to society and relationships, leaving them disempowered in terms of safer sex, health decision-making and financial stability. Employment among adult women ages 25-49 is 55% to 65%, lower than that among men (89% to 92%), which limits their authority and decision-making capabilities.[33]

Studies also found that in sub-Saharan Africa women lack autonomy to make decisions about HIV testing and services.[48] In Zimbabwe, women describe the fear of domestic violence and divorce for accessing HIV services without consent from their husband. If a woman tests positive for HIV, her husband might blame and abuse her for bringing HIV into their relationship.

Serodiscordant Relationships

In Zimbabwe, 9% of couples are in a serodiscordant relationship, where the man is HIV positive and the woman is HIV negative,[33] and more than a third (38%) of new infections are among people in stable relationships.[48] Couples counselling and HIV testing have been shown to reduce heterosexually transmitted HIV infections that would otherwise occur, but uptake for couples counselling tends to be low.[49]

Table 9.
Adult Women:
Synopsis of Problem and Desired Behaviours and Practices

PROBLEM BEHAVIOURS/PRACTICES	DESIRED BEHAVIOURS/PRACTICES
• Does not seek HIV, family planning or pregnancy services • Unfavorable attitudes and perceptions and limited knowledge among pregnant and lactating women and community members about (the benefits of) ANC/PMTCT,[46] SRH and HIV prevention methods (HIV testing/self-testing, male and female condoms, VMMC, PrEP) • Socio-cultural and religious beliefs inhibit use of modern health services • Has unprotected sex with her husband; low HIV risk perception • Does not/cannot negotiate safe sex; powerlessness/lack of empowerment to negotiate safer sex and condom use[45]; low condom use among married couples • Husbands do not want to get tested for HIV; low rate of partner testing[45] • Fear of GBV/IPV for disclosing HIV negative or positive results to partner or family[46] • Poor adherence to medications; gap between knowledge and practice of adhering to medication; lack of disclosure; insufficient social support; financial barriers	• Improve awareness, knowledge, perceptions, attitudes and use of HIV prevention (self-testing, male and female condoms, and PrEP), care and treatment • Use of SRH services to prevent unintended pregnancy and promote the need for ANC/PMTCT • Seek community supports to enhance self-efficacy to access HIV prevention, care and treatment services • Negotiate and practice safer sex • Providers to deliver empathetic, female-friendly and confidential care • Seek safe and secure HIV couples counselling and testing • To go for ANC visits and HIV testing

Abbreviations: ANC, antenatal care; GBV, gender-based violence; IPV, intimate partner violence; PMTCT, prevention of mother-to-child transmission of HIV; PrEP, pre-exposure prophylaxis; SRH, sexual and reproductive health; VMMC, voluntary medical male circumcision.

NAME: Shamiso

AGE: 35

RELATIONSHIP: Married but doesn't know her husband's status

HIV STATUS: HIV negative

"I know my husband has girlfriends. How long can I stay HIV negative when I don't know my husband's status?"

GOALS

» To seek family planning services and get tested for HIV
» To initiate PrEP
» For her husband to get tested for HIV

BEST WAY TO REACH ME

» Social networks
» Radio
» Health workers

INFLUENCERS

» Friends
» Spouse, sister and mother
» Health workers

SHAMISO REPRESENTS A BIGGER POPULATION WHO:

» Values family, church, friends and social status

» Thinks being healthy means living a long and healthy life – being there for her children as they grow up

» Spends most of her time at work and at home

» Gets information from radio, internet, SMS (Econet) and women's groups; she trusts information on health from radio and health workers

» Doesn't trust talking to her friends and other relatives about health

» Gets information from church/prophets and traditional healers

» Is motivated to stay healthy for her children

» Believes her husband's friends are a negative influence on his health and HIV prevention

» Thinks HIV self-testing could make testing easier for her husband

Abbreviations: PrEP, pre-exposure prophylaxis.

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Adult Woman Health Journey Map: Shamiso, 35 years old, HIV negative

About this map: This is a theoretical high-level health journey for an adult woman interacting with HIV and SRH programmes, which may overlap or be sequential. The journey map reveals her experience and what she might be doing, thinking and feeling along the way that impact her desire and ability to access services

The purple, orange and gray dots indicate the highs/positive emotion (motivators) and lows/negative emotion (barriers) of the journey. These help the reader of the map prioritise opportunities for communications interventions and collaboration with service delivery to make the journey easier

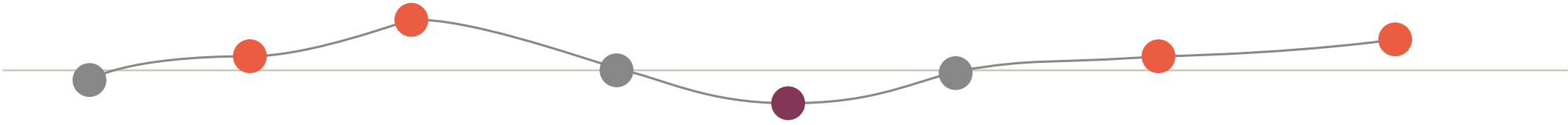
Trusted information sources: Hospitals, health facility, TV, DREAMS programme, NGOs that teach people about health, church;
Other sources: Radio, friends, family, traditional/faith leaders, village health workers, internet, SMS messages (Econet)

Family Planning and HIV Testing Services

Prevention: PrEP

HIV Testing Services: Partner Testing

Positive emotion
Neutral emotion
Negative emotion



Shamiso's Experience

Doing: Sees the health care worker about family planning

Thinking: I do not want to get pregnant. I know my husband has many girlfriends

Feeling: Optimistic, Stable

Doing: Talks to health care provider about family planning options and HIV testing

Thinking: I should probably get tested; I do not know my husband's status

Feeling: Determined, Proactive

Doing: Gets tested; receives HIV-negative result. Starts family planning method

Thinking: I am so glad it is negative; I want to continue to protect myself

Feeling: Empowered, Relieved

Doing: Hears about PrEP; reads brochure

Thinking: Maybe PrEP could be good for me

Feeling: Informed, Optimistic

Doing: Talks to the health worker about PrEP, but they have very little information

Thinking: Who else can I talk to about PrEP?

Feeling: Confused, Conflicted, Frustrated

Doing: Goes to an HIV clinic to begin PrEP

Thinking: I am so relieved that I can protect myself

Feeling: Empowered, Happy

Doing: Hears a radio drama about partner testing with her husband

Thinking: I hope that he is paying attention to the radio programme

Feeling: Hopeful, Optimistic

Doing: Talks to her husband about getting HIV tested; he agrees

Thinking: I am so glad we heard that radio drama, it made it easier to talk about HIV testing

Feeling: Relieved

Key Insights

Integration of HIV with Family Planning Services: Having two children already, she is concerned about being able to afford more. She is interested in a family planning method. This is an entry point to HIV testing and an opportunity for her to understand her risks. She wants her and her husband to know each other's status. Programmes should take advantage of opportunities to integrate HIV testing with family planning services

Increase Awareness of PrEP: She is concerned about the stigma associated with taking PrEP; she does not want people/husband to think that she is taking ARVs for HIV. Misinformation and lack of access to information about PrEP can impede adoption of this effective HIV prevention method. She would like to have the most up-to-date information, so she can feel confident. When she starts PrEP, she hides the pills so her husband won't find them

Couples Counselling and Testing: Uptake for HIV testing is low among men. Therefore, HIV testing and counselling supports mutual disclosure and empowers couples to make informed decisions together about HIV prevention and reproductive health. Awareness campaigns and radio dramas about couples testing are a way to decrease stigma and normalise testing among those in committed relationships

Abbreviations: ARV, antiretroviral; NGO, nongovernmental organisation; PrEP, pre-exposure prophylaxis; SRH, sexual and reproductive health.

Communications Matrix: Adult Women

DESIRED CHANGES*	TO SEEK FAMILY PLANNING TO PREVENT UNPLANNED PREGNANCY AND GET TESTED FOR HIV	TO ACCESS HIV PREVENTION METHODS, SPECIFICALLY PREP	TO GET PARTNER TESTED FOR HIV
Barriers	• Cost and distance to health facility • Health worker attitude - lack of respect • Religious beliefs and practices • Gender norms • Fear of disclosure of HIV test and negative or positive result	• Lack of awareness and knowledge of PrEP • Providers see her as high-risk • Self-stigma, fear or denial • Myths and misconceptions about PrEP • Fear that being seen taking pills equates to being HIV positive • Fear of side effects and negative attitude of health workers • Cost and distance of medication refill	• He believes he is not at risk, so he doesn't want to get tested • HIV stigma and gender-based violence • Cost and distance and time to seek services • Fear of disclosure and fear of losing the relationship
Facilitating Factors	• Quality, friendly and respectful services • Privacy and confidentiality • Supportive spouse • Reduced/affordable costs • Positive peer influence • Use of ambassadors/champions	• Staying healthy • Living longer • Supportive family, partner, community • Testimonials from satisfied peers	• Reduced cost and distance to health facilities • Couples counselling and testing • Influence from traditional healers, religious leaders and community elders
Communications Objectives	1. Increase positive community perceptions of women accessing family planning 2. Increase positive provider attitudes and perceptions about women accessing health services	3. Increase knowledge, awareness, attitudes and perceptions of PrEP among at-risk populations and providers	4. Increase positive community perceptions about couples counselling and testing

Illustrative Messages	• Take care of your health – use family planning services, get tested for HIV and protect yourself • I care about my family. I want to know my status • In my social circle, we talk about HIV testing • My HIV status does not affect my relationship with God • My partner and I choose when to have a baby—all of my children are planned • Children by choice, not by chance	• Protect yourself - know your status, take PrEP and prevent other STI infections • I take care of my health—I use PrEP • Taking care of my health is my business—I am using PrEP • I learnt how to manage the side effects—now I feel great • My health and my future are in my hands—I take PrEP medicines daily • I am not afraid of being in control. I use PrEP • I am PrEP'ed • I understand my risk—now I take PrEP • My health is my responsibility, so I take PrEP	• Break the silence of HIV. Begin by talking with your partner • Know your partner's status, protect yourself • I talked to my partner about HIV and we went together to get tested • It was not easy to talk to my partner about HIV, but we saw a counsellor together and developed a shared understanding • My partner is my best friend. We talk about everything, including our HIV status
Illustrative Messages for sub-desired change for HIV positive: To get initiated on ART and stay virally suppressed* • Being HIV positive is not the end of the world—take your medication to stay alive and healthy • My family is supportive so taking my medication is easy • I have HIV and it is undetectable because I take my medication • I found a support group to help me stay on treatment—I feel better • Now I understand why taking my HIV medication is so important—I can live a long, healthy and normal life • I take my HIV medications to keep my viral load low—that reduces the risk of transmission to my partner • It is in the best interest of my family to stay health, so I am on ART • I take my medication, so I can stay healthy and see my grandchildren grow			
Illustrative Indicators	1. % of community members who report positive perceptions of women accessing family planning methods 2. % of clients satisfied with provider attitude when delivering health services 3. % of providers who report positive attitudes for women accessing HIV services 4. % of adult women who can recall benefits of HIV prevention methods including PrEP 5. # of providers trained on identifying and screening at-risk populations 6. % of adult women who report having talked to their partner about the benefits of couples counselling and testing 7. # of partners of adult women who report having heard of messages about couples counselling and testing		

* For simplicity, all content within this matrix matches the HIV status and journey of the archetype. However, a desired change along with matching illustrative messages have been identified for the alternative HIV status.

Abbreviations: ART, antiretroviral therapy; PrEP, pre-exposure prophylaxis.

Adolescent Boys and Young Men

ABYM: Situation and Behavioural Analysis

HIV prevalence among adolescent boys (15-19 years) and young men (20-24 years) tends to be low (2.5% and 2.7%, respectively), but the rate steadily climbs until it peaks at 28.1% among men ages 45-49 years.[7] Almost a third of boys (30%) have had sex before the age of 18 years, but HIV testing coverage is low at 35%.[39]

Inadequate and limited access or inability to read comprehensive HIV prevention, care and treatment information, along with myths and misconceptions, contribute to ABYM's risk of HIV infection. ABYM are shy to talk about sex, which limits their ability to acquire information about HIV prevention, care and treatment. A man's need to feel in control underpins his behaviour (see adult men sub-strategy for more information). When seeking HIV prevention, care and treatment, ABYM feel less in control because of a lack of knowledge and fear about the process of an HIV test and pain associated with the needle prick, preventing uptake of services. Additionally, fears of an HIV-positive result, partner disclosure, and losing a relationship compound the anxiety around HIV testing. Moreover, ABYM worry about how they are seen in the community, including the implications such as not being able to work or have a healthy family one day. Regarding condoms, ABYM worry about the shame and embarrassment of how to access them at shops, taking free ones from the clinic, partner perception of condom quality and how to use them properly. Furthermore, ABYM fear being seen at the clinic and worry about health care workers disclosing his status to his friends and family, which further inhibits HIV prevention, care and treatment service uptake.

Peer Influence, Mutual Support and Social Proof

Peers have a high level of influence (positive and negative) about SRH and HIV information and behaviour. They are driven by the opinions and actions of their peers; social proof and peer acceptance can influence their decisions towards doing things together. Mutual support reduces the fear of shame and regret because they are all doing it together.[41] Moreover, for those who have not had sex yet, anticipated sexual debut can provide motivation to get circumcised because of perceptions about sexual benefits.

Cultural and religious norms including those enforced by traditional healers, pastors and elders can negatively influence ABYM (and people in general) in seeking HIV prevention, care and treatment if the services fall outside the doctrine or their beliefs. Religious leaders who preach abstinence often fail to believe that people in their congregation engage in behaviours that predispose them to HIV infection. Anecdotally, men report gauging HIV risk based on appearance and familiarity and assume the HIV status of his partner if her results are HIV negative.

Table 10.
Adolescent Boys and Young Men:
Synopsis of Problem and Desired Behaviours and Practices

PROBLEM BEHAVIOURS/PRACTICES	DESIRED BEHAVIOURS/PRACTICES
• Limited knowledge about HIV and prevention methods • Inconsistent and incorrect condom use; low risk perception for themselves and that of women they have sex with • Risky sexual behaviours: multiple sex partners, sex with sex workers • Fear of using a condom incorrectly in front of partner • Low rates of HIV testing • Does not disclose status to sex partners; fear in disclosing HIV-positive results to partner or family; lack of access to age-appropriate counselling on partner disclosure • Does not seek health services; lack of empowerment related to interactions with providers • Socio-cultural and religious beliefs and doctrines leading to perceptions of masculinity; "hyper-masculine" attitudes and behaviours (multiple sex partners, domestic violence, etc.) in an effort to assert their manhood	• Practice safe sex and reduce risky behaviours such as multiple partners, sex with sex workers, inconsistent condom use • Improve knowledge, attitudes and perceptions of HIV prevention (HIV testing/self-testing, condoms and PrEP), treatment and care • Seek and use HIV prevention (self-testing, male and female condoms, and PrEP), care and treatment • Engage with male mobilisers and community-based health care providers as a bridge to the health care system • Providers to deliver empathetic, client-centred, male-friendly and confidential care • Disclose HIV testing and status to partner

Archetype: Adolescent Boy

NAME: James

AGE: 16

RELATIONSHIP: Has a girlfriend

HIV STATUS: HIV negative

"Will it hurt me? Will leave a scar? What if I get an erection while the wound is healing?"

GOALS

» To get tested for HIV
» To use condoms consistently and correctly
» To get circumcised

BEST WAY TO REACH ME

» Social hangouts
» Peer networks
» Social media

INFLUENCERS

» Anyone with high social status
» Friends
» Uncle, father, older brother

JAMES REPRESENTS A BIGGER POPULATION WHO:

» Is motivated by social proof and driven by the opinions and actions of their peers

» Feels shy buying or taking free condoms, making it difficult for them to use them consistently and correctly

» Is influenced by aspirational needs to mimic high social status individuals such as musicians and athletes, or other well-known wealthy individuals (i.e. drug dealers and gangsters)

» Thinks group support provides them a mutual support mechanism and reduces fear of shame and regret

» Feels their anticipated sexual debut can be seen as a motivation to get circumcised

» Is most receptive to communication via social media

» Wants peer educators to talk to them where they are – at the pool hall, and other local hang outs

» Has difficulty accessing HIV services because of poverty, stigma, not being able to comprehend the HIV information

» Feels confidentiality, privacy and security are important

Abbreviations: VMMC, voluntary medical male circumcision.

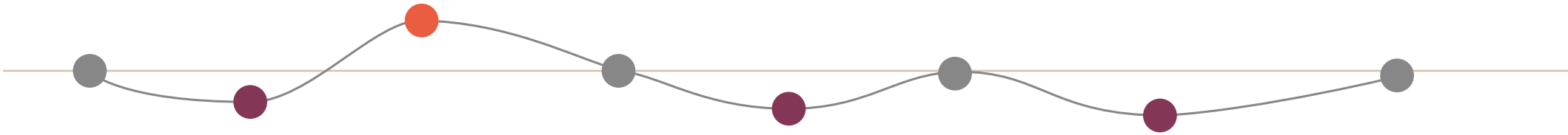
Disclaimer: The photographs in this material are used for illustrative purposes only; they do not imply any particular health status, attitudes, behaviors, or actions on the part of any person who appears in the photographs.

Adolescent Boy Health Journey Map: James, 16 years old, HIV negative

About this map: This is a theoretical high-level health journey for an adolescent boy interacting with three HIV programmes, which may overlap or be sequential. The journey map reveals his experience and what he might be doing, thinking and feeling along the way that could impact his desire and ability to access services

The purple, orange and gray dots indicate the highs/positive emotion (motivators) and lows/negative emotion (barriers) of the journey. These help the reader of the map prioritise opportunities for communications interventions and collaboration with service delivery to make the journey easier

Trusted information sources: Teachers, parents, providers, digital media, peer networks, radio programmes, posters and billboards, community health workers, celebrities/football players/musicians with lived experience;
Other sources: Radio music programmes, TV, posters and billboards, community health workers

	HIV Testing Services	Prevention: Condoms	Prevention: VMMC
Positive emotion Neutral emotion Negative emotion			
James' Experience	**Doing:** Goes to school. Spends time with his friends, playing sports and hanging out with his girlfriend **Thinking:** Why would I need to get tested for HIV? The girls I've had sex with looked healthy **Feeling:** Indifferent, Ambivalent, Not worried	**Doing:** Talks about HIV testing with a health worker who visits his school **Thinking:** Maybe I should get tested for HIV to be sure I do not have it **Feeling:** Nervous, Anxious	**Doing:** Goes for testing at the youth center health clinic; talks to the health worker about testing and condoms. Gets tested and is HIV negative **Thinking:** If I test to be HIV negative I will never do anything risky like have unprotected sex ever again **Feeling:** Relieved, Happy, Optimistic
		Doing: Gets free condoms from the health worker; talks to his friends and girlfriend about using condoms **Thinking:** I wonder if sex will feel good using a condom; I wonder what my girlfriend will say **Feeling:** Neutral, Ambivalent, Curious	**Doing:** Uses condom with his girlfriend, but he didn't know how to use it and it breaks **Thinking:** I do not understand why it broke; I wish I knew how to use it properly **Feeling:** Frustrated, Embarrassed, Angry, Defeated
			Doing: Talks to a peer educator at the pool hall **Thinking:** I have been hearing people talk about VMMC, but I have heard it is painful **Feeling:** Curious, Interested
			Doing: Talks to his older brother and uncle about VMMC. Asks them if they are circumcised **Thinking:** If I were to do the procedure, would it be painful? Maybe it is worth the pain because it can protect from HIV transmission **Feeling:** Unsure, Curious, Fearful
			Doing: Reads brochures about VMMC; talks to friends at school about it; asks them if they are circumcised **Thinking:** Maybe I would do the procedure if some of my friends do it too **Feeling:** Unsure, Ambivalent, Informed
Key Insights	**Social and Cultural Norms:** Social and cultural norms make it difficult for him to talk about sexual and reproductive health. He fears being tested for HIV because of past behaviours (e.g. unprotected sex) that have put him at risk. He worries that if he is HIV positive he will have HIV-positive children and that he won't be able to work to support his family. He worries that his status would be leaked by health workers	**Social Proof/Peer Influence:** Social acceptance is important to him; he worries about being made fun of by his peers if he admits not knowing how to use a condom. He gets most of his information from school teachers/counsellors, friends or health workers. He needs information on how to use condoms correctly. He wishes his parents received health information about his needs so that they could understand him better	**Feeling of Control:** He is most worried about the pain of VMMC and the risks associated with the procedure. It can take two years or more to adopt VMMC from awareness to completing the procedure. It takes time, and feeling in control is the most important thing to him. Generally, he would like additional health information, not limited to VMMC

Abbreviations: SRH, sexual and reproductive health; VMMC, voluntary medical male circumcision.

Communications Matrix: Adolescent Boys

DESIRED CHANGES*	TO GET TESTED FOR HIV	TO GET AND USE CONDOMS CONSISTENTLY AND CORRECTLY	TO GET CIRCUMCISED
Barriers	• Lack of comprehensive information on HIV and SRH • Low perceived risk • Peer pressure • Fear of positive result • Lack of privacy and confidentiality at the local health facility • Stigma and discrimination • Age of consent • Attitude of service provider • User fees for SRH services	• Stigma associated with accessing condoms • Lack of knowledge on how to correctly use the condom • Peer pressure not to use condoms • Lack of access to condoms • Misperceptions about condom brands and quality • Lack of variety in public-sector condoms • Social and cultural norms preventing parents/ guardians conversations with adolescents about sexual and reproductive health	• Fear of pain • Lack of peer support • Myths and misconceptions especially on foreskin disposal • Lack of parental support for consenting to procedure • Accessibility of services • Lack of age-appropriate communications approaches and information on SRH, HIV and VMMC
Facilitating Factors	• Peer support • Availability of information on the benefits of HTS and STI prevention • Availability of adolescent-friendly services and provider • HIV Self Testing	• Adolescent-friendly services • Peer support • Increased self-efficiency on how to use condoms • Access to condom varieties	• Peer and social support • Availability of services • Knowledge of HIV and SRH
Communications Objectives	1. Increase knowledge, attitudes and perceptions on access and benefits of HIV and SRH services 2. Reduce stigma and discrimination from family and community members 3. Increase self-efficacy to access HIV services 4. Increase risk perception of HIV	5. Improve attitudes and perceived value of condom use by adolescents 6. Increase knowledge on how to use condoms consistently and correctly 7. Increase knowledge of and improve attitudes and perceptions of where to access condoms	8. Improve age-appropriate knowledge of VMMC 9. Increase positive community attitudes and perceptions on access to VMMC services
Illustrative Messages	• Know your HIV status, seek testing and protect yourself • I overcame my fears and went for HIV testing • My peers are getting tested for HIV—so should I • I am my own man—I went for an HIV test	• Make informed decisions—use condoms correctly and consistently • Cool guys do not compromise—they condomise • All condoms are safe and effective—use one condom each time • My future is bright—I condomise	• Protect yourself and get circumcised • I am cool and smart—I am circumcised • I am in control of my health—I got circumcised • You may experience some pain after VMMC, but it is manageable. You will not be bed-ridden

Illustrative Messages	• HIV testing is available in my community—my friend and I got tested Messages for Parents: • It is in the best interest of your child to get him or her tested for HIV • Teach your children to take responsibility for their health encourage them to get an HIV test	• First time in the game? Play by the rules, wear a condom	• My friend got circumcised, I can do it too • I got circumcised because it is the smart thing to do—now my friends are circumcised too • More and more people are getting circumcised in the community including famous people like and MPs • There is pain but it is manageable; you can get help with the pain using pain medicine and there are tips for how to reduce pain • You should expect pain on injection, during erections, day 2, and upon bandage removal • I'm circumcised, I condomise, my game is safe
Illustrative Messages for desired change for HIV positive Adolescent Boy: To get initiated on ART and stay virally suppressed* • I have accepted my HIV positive result, despite how I got it, and I am starting my treatment today • I adhere to my treatment—I feel great • My loved ones know my status—I have all the support I need • I will never stop my HIV treatment—my life depends on it • Life goes on for people with HIV—I am a living proof • My friend is HIV negative; I am HIV positive, but we both have bright futures ahead of us!			
Illustrative Indicators	1. % of target audience with accurate knowledge of HIV and adolescent sexual and reproductive health services 2. % of target audience expressing accepting attitudes to adolescent boys accessing HIV and sexual reproductive health services 3. % of adolescent boys who report high self-efficacy for accessing HIV and sexual and reproductive health services 4. % of adolescent boys who report increased HIV health risk perception 5. # of people reached with age-appropriate messages on importance of HIV and sexual and reproductive services for adolescent boys 6. % of adolescent boys who agree that condoms provide effective protection against (a) STIs and (b) HIV 7. % of adolescent boys who report that they know how to use condoms consistently and correctly 8. % of adolescent boys who report that they know where to access condoms 9. # of adolescent boys exposed to age-appropriate messages on HIV and sexual and reproductive health services for adolescents 10. # of providers trained on client-centred care for adolescents 11. # of community dialogue meetings held to sensitise communities on the importance of HIV and sexual reproductive health services for adolescents		

* For simplicity, all content within this matrix matches the HIV status and journey of the archetype. However, a desired change along with matching illustrative messages have been identified for the alternative HIV status.

Abbreviations: ART, antiretroviral therapy; HTS, HIV testing services; PrEP, pre-exposure prophylaxis, SRH, sexual and reproductive health; STI, sexually transmitted infections; VMMC, voluntary medical male circumcision.

NAME: Lawrence

AGE: 24

RELATIONSHIP: Married

HIV STATUS: HIV negative

"I feel fine—I don't think I need to go to the doctor. I don't have time to go. I'm too busy looking for work."

GOALS

» To adopt health-seeking behaviour
» To get tested for HIV
» To increase use of HIV preventive methods

BEST WAY TO REACH ME

» Social media
» Bars
» Peer educators

INFLUENCERS

» Community elders, celebrities
» Peers/friends
» Girlfriend, wife

LAWRENCE REPRESENTS A BIGGER POPULATION WHO:

» Looks at the appearance of women to determine if they are healthy and their potential HIV risk

» Dreams of being permanently employed

» Worries most about being able to financially support his family

» Feels like it's important to be healthy so that he can make a living for his family

» Spends time at work, at the bar or hanging out with friends

» Ignores bulk SMS

» Pays attention to group (health) text messages; he has joined WhatsApp and Facebook

» Feels that counselling services, support groups and understanding the benefits of HIV treatment could resolve some fears for HIV testing

» Trusts health workers for information though he worries about being judged and criticised when he's at the clinic

» Waits to see what happens if he has discharge and an infection. If it gets worse he'll ask friends or a traditional healer; will go to clinic last

Disclaimer: The photographs in this material are used for illustrative purposes only; they do not imply any particular health status, attitudes, behaviors, or actions on the part of any person who appears in the photographs.

Young Man Health Journey Map: Lawrence, 24 years old, HIV negative

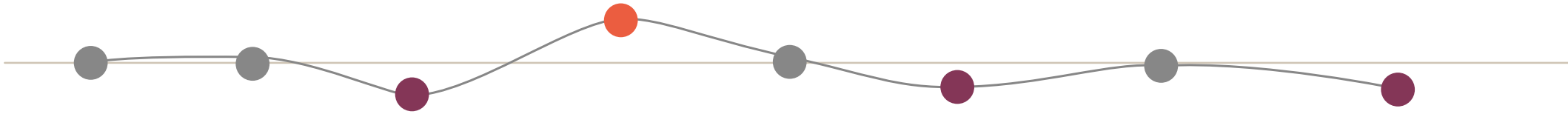
About this map: This is a theoretical high-level health journey for a young man interacting with three health and HIV programmes, which may overlap or be sequential. The journey map reveals his experience and what he might be doing, thinking and feeling along the way that impact his desire and ability to access services

The purple, orange and gray dots indicate the highs/positive emotion (motivators) and lows/negative emotion (barriers) of the journey. These help the reader of the map prioritise opportunities for communications interventions and collaboration with service delivery to make the journey easier

Trusted information sources: Health care workers;
Other sources: Radio, TV, internet, friends, clinic

Health Seeking Behaviours | HIV Testing Services | Prevention: VMMC, Condoms

Positive emotion
Neutral emotion
Negative emotion



Lawrence's Experience

Doing: Talks with community elders about the roles of a man in the household; accompanies his wife to an ANC visit

Thinking: If the chief tells me I should go to my wife's ANC visit, I will go, but I do not have time to go to the doctor for my health

Feeling: Indifferent, Supportive, Informed

Doing: Goes to ANC visit while heading to town to look for work

Thinking: I hope I can get work this week. Work can be so unpredictable

Feeling: Hopeful, Optimistic, Worried

Doing: Returns to another ANC visit and gets tested for HIV

Thinking: I hope I did not get HIV from sleeping with my girlfriend

Feeling: Wants to complete his test quickly so he can go find work

Doing: Returns to clinic for test; result is HIV negative

Thinking: What a relief

Feeling: Happy, Relieved, Confident, Relaxed

Doing: Talks to health worker about health and HIV

Thinking: It seems like everyone is talking about health, but mostly I am worried about finding work

Feeling: Indifferent, Ambivalent

Doing: Talks with a peer educator at a sporting event about VMMC and condoms

Thinking: Why would I need to use condoms? Why would I get circumcised?

Feeling: Unsure, Perplexed, Confused

Doing: Considers using condoms when he sees his girlfriend in town

Thinking: Maybe I could use condoms when I see my girlfriend like the health worker said

Feeling: Indifferent

Doing: Reads brochures about VMMC and how it can prevent HIV transmission

Thinking: How would I explain getting circumcised to my wife?

Feeling: Informed, Pensive, Nervous

Key Insights

Low Risk Perceptions: He is more worried about finding work and sees himself as healthy and strong, so health-seeking behaviours are difficult to justify. He is more likely to seek general health services such as blood pressure or other checks than HIV services, where he perceives himself as low risk

Feeling of Control: Feeling in control is the most important thing to him. He does not want to get tested for HIV - he does not see what the benefit is to him. He worries that if he is HIV positive then his life will be over; he will have to disclose to his wife that he is been having sex with other women and possibly recognise that he could have given HIV to her and in turn, his children. Hearing testimonials from men like him who got tested and describe their journey, whether positive or negative, is helpful for him to feel in control. Self-testing and couples testing could improve the feeling of control and acceptability for him

Men as Providers: He is preoccupied with providing for his family. He is more worried about finding work than thinking about his health. He wants to stay healthy to support and take care of his family. Celebrities with lived experience and other people, such as brothers and uncles, have influence on his decision to choose HIV prevention methods; he is most likely to be receptive to health information coming from health workers

Abbreviations: ANC, antenatal care; ARV, antiretroviral; PrEP, pre-exposure prophylaxis; VMMC, voluntary medical male circumcision.

Communications Matrix: Young Men

DESIRED CHANGES*	TO ADOPT HEALTH-SEEKING BEHAVIOUR	TO GET TESTED FOR HIV	TO INCREASE USE OF PREVENTIVE METHODS (VMMC, PREP, CONDOMS)
Barriers	• Feeling of power over health; no need to take action unless very sick • Lack of time and money • Low desire to spend money on health • Competing priorities for income-generation over health-seeking behaviours • Stigma around being seen at a health facility • Low risk perception for any health-related matter • Transport fees • Low cost/benefit for health-seeking services	• Low risk perception • Lack of access to male-friendly HIV testing services • Lack of time to access services because services offered during working or school hours • Assuming status based on partner's status • Fear of knowing status and uncertain future • Fear if HIV positive they might have transmitted it to wife and children • Transport fees	• Unaware of PrEP • Fear of stigma • Promiscuity associated with condom use • PrEP associated with positive HIV status / people assume they are ARVs • Lack of male-friendly services • Negative attitude of public-sector service providers • VMMC—worried about the pain of procedure, recovery, concerns from partner as to why he needs it
Facilitating Factors	• Availability of free and male-friendly services • Supportive women who advocate for seeking services • Peer support • Endorsement from community and religious leaders • Services offered at places where they are hanging out at sports events, bars	• Testimonials from PLHIV • Local or national celebrity ambassadors for HIV testing services • HIV self-test kits (targeted distribution) • Comprehensive HIV education • Favorable community norms • Availability of free services • Locally available services	• Targeted condom distribution at universities, sports bars • Timely service • Edutainment, sports, arts • Awareness campaigns using mid-media activities, community-level events • Social clubs
Communications Objectives	1. Increased self-efficacy to seek health services 2. Increased perception of health risks due to unhealthy behaviours	3. Improved perception of HIV risk 4. Improved awareness, attitudes and perceptions of health services available for young men 5. Increased knowledge of where to access community HIV services, including HIV self-testing	8. Increase knowledge, attitudes and perceptions of all HIV prevention methods available and where to access them 7. Reduced stigma associated with adopting HIV prevention methods
Illustrative Messages	• I do not take chances with my health—I see a provider before it gets worse • You only live once. See a health care worker when you are not feeling well • Prevention is better than cure—seek medical advice today and protect yourself and family • A dose of prevention is a lifetime of better health—condomise	• A dose of prevention is a lifetime of better health—get tested for HIV • I am a responsible man, I know my HIV status • 1 in 5 young men are HIV positive—know your status • HIV testing and counselling are available at your nearest health facility	• A dose of prevention is a lifetime of better health—use PrEP and condoms • Unprotected sex is risky—use condoms all the time • Condoms allow you to enjoy safer sex with peace of mind • Do not go 'downtown' without a condom

Illustrative Messages	• Prevention and treatment are less expensive than missing work • Stay healthy, stay working—prevention is key • Take time to visit your nearest health facility—it is worth the investment	• Know your HIV status—it's the starting point to securing a healthy future • Having more than one sex partners puts you at increased risk of getting HIV—get tested today • Having sex with a partner whose status you do not know puts you at risk—get tested as a couple today • Even if you are HIV+ you can protect your family and have healthy children • I understand that I am at risk of HIV, so I got tested	• I am PrEPared—I use PrEP • Reduce the risk of HIV by 60%—get circumcised today • I am in control of my health—I got circumcised • No pain no gain—get the cut for 60% protection against HIV • Be strong and cool—brave the pain like a man and get circumcised • More and more people are getting circumcised in the community including famous people like and MPs • Your chief has given us their support to come speak to you about VMMC • (for PrePex) You should expect pain on day 2, 3, 4, 6 upon erection, and then again on removal. You will not be bed-ridden • You should expect pain on injection, during erections, day 2, and upon bandage removal • Foreskins are disposed in line with the Human Tissue Act
Illustrative Messages for desired change for HIV positive: To get initiated on ART and stay virally suppressed*	• Being HIV positive is not the end of the world—take your medication to stay alive and healthy • My family is supportive, so taking my medication is easy • I have HIV and it is undetectable because I take my medication • I found a support group to help me stay on treatment—I feel better • Now I understand why taking my HIV medication is so important—I can live a long, healthy and normal life • I take my HIV medications to keep my viral load low—that reduces the risk of transmission to my partner		
Illustrative Indicators	1. % of young men who report high self-efficacy for accessing health services 2. % of young men who report increased health risk perception due to unhealthy behaviours 3. # of young men presenting for HIV prevention services 4. % of young men who can name at least two HIV services available for them 5. % of young men who report that they know where to access HIV testing and prevention services 6. % of target audience expressing accepting attitudes to young men accessing (a) VMMC, (b) PrEP and (c) condoms 7. % of young men who report that they know where to access HIV prevention services (a) VMMC, (b) PrEP and (c) condoms		

* For simplicity, all content within this matrix matches the HIV status and journey of the archetype. However, a desired change along with matching illustrative messages have been identified for the alternative HIV status.

Abbreviations: ART, antiretroviral therapy; ARV, antiretroviral; PLHIV, people living with HIV; PrEP, pre-exposure prophylaxis, VMMC, voluntary medical male circumcision.

People living with HIV who perceive high levels of HIV-related stigma are 2.4 times more likely to delay enrolment in care until they are very ill.[16]

Adult Men

Adult Men: Situation and Behavioural Analysis

Men have higher HIV prevalence rates than women later in life (from ages 50-54 onwards) and peak at 28.1% between ages 45-49.[9] HIV prevalence is high among specific groups of men including migrant agricultural workers (26%), commercial farmers/estates (21%), and prisoners (28%).[48]

Viral load suppression among adults is the lowest among HIV-positive men ages 25-34 (40.1%), followed closely behind by men ages 15-24. Overall, 72.1% of males ages 15-64 years are aware of their HIV status, 88% of those men are on treatment, and 82.5% of those men are virally suppressed.[7]

Men's Perceptions of Healthcare

Men perceive health care as feminine, which contradicts notions of masculinity. Given that most health care workers are women, men potentially feel uncomfortable seeking health care. This dynamic makes it difficult for men to ask for HIV information and education and to ask sensitive questions.

Privacy and Confidentiality

Involuntary disclosure through privacy or confidentiality violations in clinics and among health care workers discourages men's desire to access services. Many clinics are not conducive to privacy where rooms are sometimes shared or separated only by a curtain. Men fear neighbours or friends might see them at a clinic and then gossip.[41]

Financial Challenges

In addition to the challenges of needing to be in control, men are faced with other challenges associated with being the head of the family and the provider. Economic stressors impact not only financial but also emotional aspects of a man's life. Evidence shows that as the provider for the family, men are more worried about their livelihood and supporting their families than seeking HIV services. These economic stressors can also push men towards the adoption of "hyper-masculine" attitudes and behaviours (multiple sex partners, domestic violence, etc.) and require some men to work far from their homes for prolonged periods. This separation from family exposes them to additional relationships and/or sex with sex workers and substance and alcohol abuse. Further, they are concerned about being away from work—since most clinics are open during working hours—and the transport fees required to get to and from the clinic.[50]

Men are complex individuals facing many challenges in life.[41] It is critical to identify opportunities for engaging them with empathy and meet them where they are along their journey with male-friendly services and attitudes of non-judgement.

Table 11.
Adult Men:
Synopsis of Problem and Desired Behaviours and Practices

PROBLEM BEHAVIOURS/PRACTICES	DESIRED BEHAVIOURS/PRACTICES
• Risky sexual behaviours: multiple sex partners, sex with sex workers, and/or sex with younger women • Embarrassment of using condoms incorrectly inhibits use • Incorrect and inconsistent use of condoms; use condoms with casual sex partners until they become familiar[41]; limited use of HIV and prevention methods; low rates of HIV testing and circumcision • Are not involved as partner in family health, e.g. attending antenatal clinic • Low risk perception for themselves and their partners • Fear in disclosing HIV-positive results to partner or family; lack of access to counselling on partner disclosure • Inability to be forthcoming in interactions with providers • Socio-cultural and religious beliefs and doctrines leading to perceptions of masculinity; "hyper-masculine" attitudes and behaviours (multiple sex partners, domestic violence, etc.) in an effort to assert their manhood	• Create positive peer influence • Improve attitudes, perceptions and comprehensive and correct knowledge of HIV including risks related to risky behaviours: multiple partners, sex with sex workers, inconsistent condom use • Seek out and use HIV self-testing • Increase engagement with male mobilisers and community-based health care providers as a bridge to the health care system • Access HIV testing as part of other health services, i.e. general health check-ups, blood pressure testing, etc. • Increase community perception of the need for male-friendly services; reduce HIV-related stigma • Providers to deliver empathetic, client-centred, male-friendly and confidential care • Disclose HIV testing and results to partner

NAME: Terrence

AGE: 38

RELATIONSHIP: Married, and has a girlfriend

HIV STATUS: HIV positive

"I work away from my family. Sex is an escape from being in the mines all day."

GOALS

» To practice safe sex
» To get tested for HIV
» To initiate treatment and become virally suppressed with regular viral load testing

BEST WAY TO REACH ME

» Sport events
» Bars, social/community gatherings
» Musical shows

INFLUENCERS

» Wife
» Peers, friends
» Health workers

TERRENCE REPRESENTS A BIGGER POPULATION WHO:

» Is more concerned with working to provide for his family (including mother) than to get tested for HIV; stress can make him revert to bad habits – counselling could help him
» Thinks being healthy means having decent accommodation, communication and transport means and having money for food and clean water
» Values his health because he can prepare for the future
» Doesn't feel comfortable going to the health clinic; is more likely to go the traditional healer first
» Feels like going for health screenings is a waste of time because he will lose work wages
» Worries about knowing his status because if he is HIV positive it will break down his family; he also worries that others will know his status
» Seeks comforts and escape through sex with his girlfriends or sex workers
» Has a younger girlfriend to reinforce his feeling of manhood
» Enjoys going to watch soccer, musical shows at beer halls
» Feels food shortages and lack of money impact his adherence with medications
» Has trouble talking with partner about his health

Disclaimer: The photographs in this material are used for illustrative purposes only; they do not imply any particular health status, attitudes, behaviors, or actions on the part of any person who appears in the photographs.

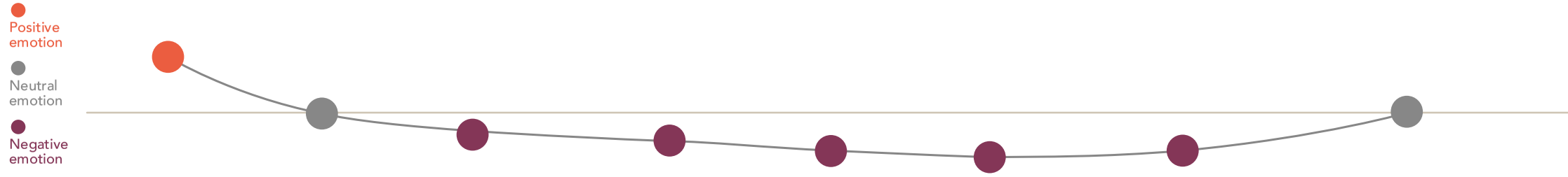
Adult Man Health Journey Map: Terrence, 38 years old, HIV positive

About this map: This is a theoretical high-level health journey for an adult man interacting with community norms and HIV programmes, which may overlap or be sequential. The journey map reveals his experience and what he might be doing, thinking and feeling along the way that impact his desire and ability to access services

The purple, orange and gray dots indicate the highs/positive emotion (motivators) and lows/negative emotion (barriers) of the journey. These help the reader of the map prioritise opportunities for communications interventions and collaboration with service delivery to make the journey easier

Trusted information sources: Health workers;
Other sources: Brother, celebrities, uncle

Prevention | HIV Testing Services | Care and Treatment: ARVs, Viral Load



Terrence's Experience

Doing: Goes to class at university; hooks up with his sugar daddy

Thinking: Why should I change what I am doing? I am happy

Feeling: Content, Relaxed, Happy

Doing: Spends time watching sports after work

Thinking: Being with younger women is part of what men do, what's the big deal?

Feeling: Indifferent

Doing: Goes to work. Does not feel well

Thinking: I am worried that I am sick; I can not take time off work

Feeling: Sick, Worried

Doing: Asks some of his friends about discharge

Thinking: I might need to go to the clinic, but I can not take time off work

Feeling: Fatigued, Ill

Doing: Goes to the traditional healer for herbs

Thinking: Should I go get tested for STIs?

Feeling: Worried, Frustrated

Doing: Goes to the clinic; gets diagnosed with gonorrhea and tested for HIV. Results are HIV positive

Thinking: How am I going to support my family?

Feeling: Worried, Depressed

Doing: Reads about HIV; talks to the health worker about treatment.

Thinking: How did this happen to me?

Feeling: Hopeless, Insecure, Angry, Out of control

Doing: Takes medications when he remembers

Thinking: I can not remember to take all of these medications, but I try when I can

Feeling: Indifferent, Annoyed

Key Insights

Social Norms: He has been exposed to older men having relations with younger women for his whole life, so it seems normal and accepted. He likes feeling like a provider to his younger girlfriend – it makes him feel manly. There are no perceived benefits to ending a relationship with a younger woman

Proximal Services: He is more concerned with finding consistent work than with taking care of his health and sees little benefit to knowing his HIV status, so do not expect him to go out of his way to seek health services. To reach him effectively, meet him where he is already: the bar, sports venues, community functions, even the pharmacy. When he is relaxed, he is more willing to listen and respond to health messages from a peer leader, pastor or health worker

Feeling of Control/Feeling Strong: The feeling of control is the most important thing to him. Control has three dynamics: time (takes time for beliefs to form and emotions to rise), preservation (of a man's healthy status and self-identity), and certainty (of process and outcomes). He does not want people to know his status and heard that getting on medications when still healthy can help him stay strong so he can work and support his family, which is a big motivator for staying adherent. He worries about what to tell his wife

Abbreviations: STI, sexually transmitted infection.

Communications Matrix: Adult Men

DESIRED CHANGES*	TO PRACTICE SAFE SEX	TO GET TESTED FOR HIV	TO INITIATE TREATMENT AND BECOME VIRALLY SUPPRESSED WITH REGULAR VIRAL LOAD TESTING
Barriers	• Societal and cultural norms that accept and/or promote multiple relations • Proving a sense of manhood by taking on younger sex partners • Low risk perception • Does not want to use condoms or go for VMMC	• Access to male-friendly HIV testing services • Financial implications (travel cost, loss of wages to go for testing) • No benefit for knowing status • Increased emotional trauma from knowing status • Low risk perception • Testing by proxy (partner status) • Long wait times for services • Perception of feminine environment at the clinic	• Poor adherence • Lack of knowledge about where to access services • Stigma of being seen at the clinic and everyone assuming the reason is for HIV • Loss of time and wages • Worries about money and medication • Limited knowledge about viral load, etc. • Long turnaround time for results
Facilitating Factors	• Availability of information about risks that adult men pose to younger women • HIV infection rates of men to younger women • Obligation to protect women and not abuse their power as men • Knowledge on HIV reinfections • Positive masculinities, e.g. through religious and cultural institutions • Shift in social norms—unacceptability of older men to be with younger women	• Positive peer influence • High risk perception • Availability of male-friendly HIV testing services	• Availability of ART at any public facility • Women supporting health-seeking behaviours • Differentiated care model
Communications Objectives	1. Increase knowledge about the risks and dangers of relationships between older men and young women 2. Increase perception of HIV risk	3. Increase self-efficacy for accessing HTS and all HIV prevention, care and treatment services 4. Increase awareness, attitudes and perceptions on the benefits of early diagnosis and routine couple testing 5. Increase knowledge, attitudes and perceptions of where to access community HTS, including HIV self-testing	6. Increase knowledge, attitudes and perceptions about viral load, disease progression and how ART interrupts disease progression 7. Increase knowledge about where to access viral load testing services
Illustrative Messages	• I am a responsible man, I do not abuse my power by having sex with a young woman • Positive African culture promotes protection of women and girls. Child relations is a violation of human rights	• I understand my risk, so I get tested for HIV • Your partner's HIV status is not yours—get tested Responsible men know their status, get tested today	• Be adherent to your medications to stay healthy – get virally suppressed and seek information from your health care provider • Staying on medications keeps you healthy and able to work

Illustrative Messages	• Would you want an older man with your daughter? Then why are you with his? • Protect yourself, protect others, use a condom • My health is my responsibility, I condomise	• Knowledge is power. I am in charge of my life—I know my HIV status • HIV services are available near you, get tested today • Your family is important—get tested, know your status, protect yourself and protect them • Start treatment early and avoid getting sick • New medications now available for treatment have fewer side effects—start ART with confidence	• I adhere to my treatment, I am at peace and continue to work productively to provide for my family. I do not have to do this alone—I can get support from family and friends to stay on treatment • Want to stop HIV in its tracks? Take your medication and be virally suppressed
Illustrative Messages for desired change for HIV negative: To access HIV prevention methods (VMMC, condoms, STI)*	• Unprotected sex is risky—use condoms all the time • Make it fun, make it sexy and safe—use a condom • It takes a real man to wear a condom • Protect yourself—use PrEP • If you are having sex without a condom, you are at risk for HIV • Together we can take action to stop the spread of HIV • Reduce the risk of getting HIV by 60%—get circumcised today • I am in control of my health—I got circumcised • There is pain associated with VMMC, but it is manageable with painkillers. You will not be bed-ridden • Prevention is life insurance • More and more people are getting circumcised in the community including famous people like and MPs • Your chief has given us their support to come speak to you about VMMC • You should expect pain on injection, during erections, day 2, and upon bandage removal • This is a government initiative. The doctors performing VMMC have been trained and certified by the MoHCC on how to perform the procedure according to WHO standards • Foreskins are disposed in line with the Human Tissue Act		
Illustrative Indicators	1. % of community members expressing negative perceptions to relationships between older men and young women 2. % of adult men who report increased HIV health risk perception 3. % of adult men who report high self-efficacy for accessing HTS and HIV prevention, care and treatment services 4. % of target audience who recall the benefits of early diagnosis and routine couple testing 5. % increase in the number of people testing for HIV as couples 6. % of adult men who report that they know where to access HTS (including HIV self-testing), HIV prevention and care and treatment services 7. % of target audience with accurate knowledge of HIV services and benefits of ART		

* For simplicity, all content within this matrix matches the HIV status and journey of the archetype. However, a desired change along with matching illustrative messages have been identified for the alternative HIV status.

Abbreviations: ART, antiretroviral therapy; HTS, HIV testing services; PrEP, pre-exposure prophylaxis; STI, sexually transmitted infection; TB, tuberculosis; VMMC, voluntary medical male circumcision.

Influencers

Influencers (Pastors):
Situation and Behavioural Analysis
Influencers such as religious and political leaders, traditional healers, traditional birth attendants (TBAs) and other opinion leaders have a great deal of authority in their communities. As such, they can also guide and influence attitudes and behaviour change related to HIV and other health topics such as prenatal care and family planning.

Weak Links to Healthcare
Although community members may seek health advice from influencers, the influencers are often not trained and lack accurate, up-to-date health-related information. Coupled with weak links between health facilities and the community, social-cultural norms and beliefs are not always in tandem with recommended messages and practices about HIV and health in general.[45] Fortunately, there are some influencers with connections to the health care system, such as chiefs, headmen and pastors, who have the ability to provide direction and guide the community towards opportunities for better health. For example, in some areas, they direct men to attend ANC visits with their wives and support them through pregnancy, labour and delivery.[13]

Religion and Health
While religious leaders are seen as a credible source of information, religion and health have a complicated relationship. In general, religious leaders believe their role is to preach the Bible and feel their congregation do not want to learn about HIV and SRH at church. Moreover, they believe that people in their congregations are not infected or affected by HIV and that AIDS can be cured through faith healing. Furthermore, pastors and religious leaders believe that MSM have evil spirits and that sex workers are lazy or need "cleansing"—preferring to pray for them than help them understand health services that could support them.[35]

Table 12.
Influencers:
Synopsis of Problem and Desired Behaviours and Practices

PROBLEM BEHAVIOURS/PRACTICES	DESIRED BEHAVIOURS/PRACTICES
• Lack of comprehensive and correct knowledge about HIV and sexual and reproductive health, and benefits of various interventions • Doctrines that "oppose" adoption of healthy behaviours and safe sexual practices • Church/religious driven stigma and discrimination • Absence of initiative for their own health; lack of role modeling for safe sexual practices and healthy behaviours • Religious leaders do not talk about sexual health or other HIV-related topics during sermon; feels people only come to church to hear the word • Incorrect or limited knowledge around needs of key populations including MSM, FSWs, PWD and young people (15-24 years)	• Endorse positive attitudes and perceptions and comprehensive and correct knowledge of HIV, SRH, including PMTCT • Be role models for good health and healthy behaviours; improved knowledge, attitudes and perceptions for improving their own health and health-seeking behaviour • Reduce stigma and improve supportive environments to ensure adequate social support for people living with HIV, adolescents, FSWs, MSM and PWD and for people to seek general health services • Improve awareness, attitudes, perceptions and knowledge of linkages to the health care system; referrals, education, etc.

Abbreviations: ANC, antenatal care; FSW, female sex worker; MSM, men who have sex with men, PMTCT, prevention of mother-to-child transmission of HIV; PWD, people with disabilities

NAME: Jerry

AGE: 42

INFLUENCER TYPE: Pastor

HIV STATUS: Unknown

"People come to church to be edified, exalted and comforted. I can't talk about sex on Sundays."

GOALS

» To be a good role model
» To be able to articulate correct information about HIV
» To support key populations and to be an advocate for people to seek health services

BEST WAY TO REACH ME

» Church meetings
» Pastor gatherings and meetings
» Social gatherings

INFLUENCERS

» Fellow pastors
» Congregation
» Wife

JERRY REPRESENTS A BIGGER POPULATION WHO:

» Has a hard time separating their personal values from other people in the congregation

» Is deeply rooted in social and cultural norms

» Believes that gay men are possessed by evil spirits and sex workers are lazy

» Enjoys being seen as a source of information and enjoys discussing health; wants to pray for people who are sick

» Invites church members to attend health talks on Saturdays since he is not comfortable talking about things like HIV and condoms on Sunday during his sermon

» Is provided health information by health workers in the community

» Worries that people will ask questions that he does not have answers to; sometimes he does not have correct information

Disclaimer: The photographs in this material are used for illustrative purposes only; they do not imply any particular health status, attitudes, behaviors, or actions on the part of any person who appears in the photographs.

Influencer (Pastor) Journey Map: Jerry, 42 years old, HIV status unknown

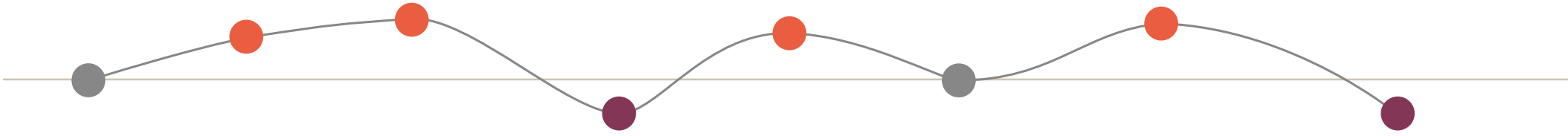
About this map: This is a theoretical high-level health journey for a male pastor interacting with his congregation and HIV health services, which may overlap or be sequential. The journey map reveals his experience and what he might be doing, thinking and feeling along the way that impact his desire and ability to refer people for services

The purple, orange and gray dots indicate the highs/positive emotion (motivators) and lows/negative emotion (barriers) of the journey. These help the reader of the map prioritise opportunities for communications interventions and collaboration with service delivery to make the journey easier

Trusted information sources: The Bible, other pastors
Other sources: Wife, radio, congregants

	Community Role Model	Quality Information	Health Seeking Behaviours

Positive emotion
Neutral emotion
Negative emotion



Jerry's Experience

Doing: Meets with families, prepares his sermon

Thinking: I wish I could help everyone in my congregation

Feeling: Peaceful

Doing: Delivers Sunday sermon; does not talk about SRH or HIV during sermons

Thinking: People do not want to hear about condoms at church – they want to hear about the Bible

Feeling: Empowered, Happy

Doing: Attends a men's dialogue in the community

Thinking: I enjoy talking about topics with men in the community

Feeling: Confident, Happy

Doing: Discusses health topics, including HIV, with people who seek advice

Thinking: I hope they do not ask me questions that I do not know about

Feeling: Unsure

Doing: Attends pastor meetings; learns about HIV

Thinking: I am happy to have learned more about HIV and "key populations."

Feeling: Confident

Doing: Prays with couple who seeks advice

Thinking: People in my congregation do not get HIV

Feeling: Relaxed, Content

Doing: Hosts a Saturday health talk

Thinking: People do not want to learn about health on Sunday, but on Saturdays they will come for health talks

Feeling: Happy, Engaged, Informed

Doing: Attends key population sensitisation training; begins to help sex workers and learns about their lives

Thinking: I thought sex workers were lazy; now I see that's not the truth

Feeling: Remorseful, Guilty

Key Insights

Protecting His Flock and Growing His Congregation: He does not want to hear about health, especially sex and condoms. Sex before marriage does not exist and his religious beliefs won't even allow him to talk about it. He wants more people to seek advice from him; he is motivated by growing his congregation so he does not want to scare people away with talk about sex

Healing Is His Calling: He also likes being a source of advice and information for people, however he often lacks the correct and accurate information related to health topics, especially HIV and SRH. He responds to statistics about his community, but wants simplified ways to receive it and share it with his congregation. He feels Saturdays or church socials are okay to talk about HIV and SRH, but he won't do it at Sunday sermon

A Cultural Custodian of His Community: He wants a healthy community; believes he can help, but he wants to be the one to manage spiritual health and let providers handle physical and medical health. He believes people come to him to be edified, exalted and comforted, so if he can refer people to seek health, it must align with his values

Abbreviations: MSM, men who have sex with men; SRH, sexual and reproductive health.

Communications Matrix: Influencers (Pastors)

DESIRED CHANGES*	TO BE A GOOD ROLE MODEL	TO BE ABLE TO ARTICULATE CORRECT INFORMATION ABOUT HIV	TO BE AN ADVOCATE FOR HEALTH SERVICES (INCLUDING HIV PREVENTION, CARE AND TREATMENT) IN THE COMMUNITY
Barriers	• Religious doctrine/beliefs • Cannot talk about sex and condoms • Sex before marriage doesn't exist	• Lack of information/understanding of basic HIV information • Lack of comfort talking about it	• Community does not perceive pastors as health advocates • Community does not accept pastors speaking outside of the doctrine
Facilitating Factors	• HIV-positive pastors who can become ambassadors for change • Do not lead with HIV/health prevention—lead with information of how to protect the community	• Simplification of health information related to HIV • Statistics about HIV in general and in the community • Addressing myths and misconceptions about HIV and sexual health	• For pastors to be aligned with the three reasons people come to church: edified (increase spiritual information), exalted (joyful, lifted up) and comforted
Communications Objectives	1. Increase awareness of HIV in the community 2. Improve positive attitudes and perceptions about sexual and reproductive health	3. Improve knowledge, attitudes and perceptions about HIV and basic health 4. Increase accessibility of HIV and SRH information	5. Improve community attitudes and perceptions about community leaders being health advocates

Illustrative Messages	• Break the silence about HIV and SRH to reduce stigma and discrimination in your congregation/ community • Talking about sexual and reproductive health and HIV takes the fear away and helps bring about change • Make sure your congregation/community feels accepted, welcome and protected, no matter who they are or what their HIV status is	• Create an enabling environment for open communications with accurate information about HIV • Help protect your flock/community by preparing them for pre- and post-HIV test by delivering correct information about HIV • Know the difference between fact and fiction	• Let's work together and have a combination approach when delivering health—you do spiritual, we will do medical • The soul is housed in a body that needs care • Extend your role as a spiritual counsellor by connecting your congregation to health services • Extend your role as a community leader by connecting your community to health services
Illustrative Indicators	1. # of community dialogues on HIV and sexual and reproductive health 2. % of target audience who report positive attitudes around HIV, sexual and reproductive health 3. # of people exposed to HIV awareness messages/campaigns 4. % of target audience with accurate knowledge of HIV and sexual and reproductive health 5. % of target audience who report that they know where to access information and services for HIV and sexual reproductive health 6. % of target audience who report that community leaders are effective health advocates		

Abbreviations: SRH, sexual and reproductive health.

Providers

Providers: Situation and Behavioural Analysis
Providers, including doctors, nurses, medical officers and others health care workers, face many challenges and extensive demands on their time—such as pressure to meet high yield targets, high staff turnover, burnout associated with limited number of providers (to client ratio)—which often impacts the quality of care required to meet clients' extensive needs.[51] These challenges—combined with the lack of quality information and skills caring for key populations—leave providers with limited resources, inadequate skills, incomplete knowledge, and ultimately the inability to provide client-centred care. Compounding that, poor infrastructure to support privacy and confidentiality and supply chain issues, which limit access to essential medications and technologies, leads to low levels of provider and client satisfaction. Another key challenge that providers face is poor health seeking behaviour among clients coupled with the preference for alternative medicines (traditional and faith-based), leading to delayed and reduced uptake as well as inefficient utilisation of services.

Personal Values
Providers' attitudes and practices have many challenges rooted in their own personal beliefs, formative education and the medical culture, which is traditionally hierarchical and conservative with strong norms around work and culture, making change difficult.[52] Conflicting personal values around unmarried and young people having sex, FSWs, MSM and PWD can impact greatly their ability to provide equitable and client-centred care. Reports show that health workers have negative views about children with HIV;[53] other reports show that clients feel shunned by providers and that people living with HIV are treated differently than others, having sometimes to wait until everyone else has been seen to be provided care.[16] Other cultural beliefs such as PWD or MSM being possessed by evil spirits or bewitched further stigmatise these clients, reducing the providers' ability to accept, understand and deliver client-centred care.

"A quarter of people living with HIV report experiencing some form of discrimination in health care."[16]

Quality Information

Providers need accessible, correct, evidence-based and timely information to facilitate client education, counselling and delivery of quality services. Along with the immense demands placed on them to provide care, it can be difficult to stay abreast of changes to guidelines, treatment protocols and standards of care—ultimately making it difficult for them to provide a high standard of care. It is critical that they receive information in a manner that is easy to digest and apply to practice.[46] Additional strategies that can support providers include: general improvements in community members' knowledge and practices around HIV and SRH; improving parental responsibility to talk about health with their children; and having the medical community (i.e. doctors) educate key community influencers on comprehensive, accurate information about HIV and related health topics.

Table 13.
Providers:
Synopsis of Problem and Desired Behaviours and Practices

PROBLEM BEHAVIOURS/PRACTICES	DESIRED BEHAVIOURS/PRACTICES
• Lack of comprehensive information on HIV • Inability to deliver comprehensive HIV and SRH information and services due to either lack of time, resources, attitudes and perceptions, and/or knowledge • Project personal values when delivering care due to limited understanding of and empathy towards adolescents, unmarried women, FSWs, MSM and PWD • Competing priorities (e.g. heavy workload, administrative duties, etc.) and lack of empathy impact client-centred care • Limited ability to communicate effectively with clients • Perceive PrEP to be a product for FSWs and MSM; lack of understanding and promotion of PrEP, including stigma about use	• Provide client-centred care without projecting personal values or beliefs • Strengthen client feedback mechanism and use of data to improve quality of care • Facilitate empathetic communications and deliver client-centred care to all clients, including adolescents, unmarried women, FSWs, MSM and PWD • Protect client confidentiality and define task-sharing responsibilities • Deliver complete client education and information and mentorship to clients about HIV and SRH • Advocate for HIV prevention methods (HIV testing/self-testing, PrEP, VMMC, male and female condoms)

Abbreviations: FSW, female sex worker; MSM, men who have sex with men; PrEP, pre-exposure prophylaxis; PWD, people with disabilities; SRH, sexual and reproductive health; VMMC, voluntary medical male circumcision.

NAME: Janet

AGE: 32

PROVIDER TYPE: Nurse

HIV STATUS: Unknown

"If I test positive, will my colleagues tell the others? What do I do if I also become the patient?"

GOALS

- To treat all patients with dignity and respect
- To delivery high quality information and counselling to clients
- To be a good role model to clients and get tested for HIV

BEST WAY TO REACH ME

- Through other health care workers and providers
- Trainings and workshops
- Radio

INFLUENCERS

- Other health care workers and providers
- District Health Officers
- Pastor

JANET REPRESENTS A BIGGER POPULATION WHO:

- Is overloaded with clients, making it difficult to spend a lot of time on health education and prevention methods with clients
- Has a hard time separating their personal values from client care related to key populations or other assumptions/ judgements
- Suffers needle prick injuries from work-related incidents from time to time and worries about her own risk of HIV
- Is afraid to get tested but knows she should
- Wonders how often other providers get tested for HIV but feels like providers aren't part of the "general populations" that HIV programmes are designed for
- Feels that occupational supports are needed for providers to protect them from HIV
- Is so overwhelmed with the number of patients she needs to see that she doesn't have time to worry about herself
- Is tied to the hierarchy and rigid nature of science and medicine; to change behaviour needs to shift attitudes and perceptions, in addition to knowledge, supports and resources
- Values peer influence, key opinion leaders and medical associations to learn about products and services

Disclaimer: The photographs in this material are used for illustrative purposes only; they do not imply any particular health status, attitudes, behaviors, or actions on the part of any person who appears in the photographs.

Provider Journey Map: Janet, 32 years old, HIV status unknown

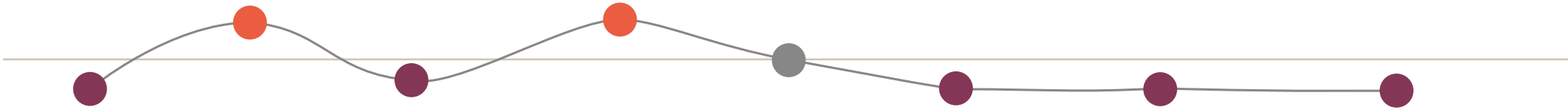
About this map: This is a theoretical high-level health journey for a female provider interacting with clients and HIV programmes, which may overlap or be sequential. The journey map reveals her experience and what she might be doing, thinking and feeling along the way that impact her desire and ability to deliver services

The purple, orange and gray dots indicate the highs/positive emotion (motivators) and lows/negative emotion (barriers) of the journey. These help the reader of the map prioritise opportunities for communications interventions and collaboration with service delivery to make the journey easier

Trusted information sources: Other providers; specialty providers; more senior nurses; nursing school leaders;
Other sources: Church/pastor, prophets, village leaders; hospital administrators

Provider Sensitisation — Quality Information — HIV Testing Services

Positive emotion
Neutral emotion
Negative emotion



Janet's Experience

Provider Sensitisation

Doing: Sees a high number of patients every day; she is the only nurse on staff

Thinking: There aren't enough hours in the day to give all of the patients adequate time

Feeling: Overwhelmed, Frustrated, Daunted

Doing: Attends a sensitisation training for key populations

Thinking: This is important and I understand what they are saying

Feeling: Encouraged, interested

Doing: Continues to see patients; does not apply new skills from training

Thinking: It's hard to remember the questions that I learned about high-risk clients; I do not have time to worry about it.

Feeling: Wants to finish the day

Quality Information

Doing: Goes to a training and reads new HIV treatment guidelines

Thinking: I am happy there is new information and I can share it with my clients

Feeling: Engaged, Interested

Doing: Implements new treatment guidelines, but does not have all of the materials and information to share with clients

Thinking: I wish I had better tools to educate clients

Feeling: Indifferent, Ambivalent

Doing: Conducts HIV test and shares HIV information pamphlets with clients; pricks herself with a needle

Thinking: I hope I do not contract HIV

Feeling: Worried, Upset, Frustrated

HIV Testing Services

Doing: Starts taking PEP to prevent transmission from the needle prick

Thinking: I pray that I do not have HIV

Feeling: Worried

Doing: Uses a self-test kit to check her status

Thinking: I do not want my colleagues to know if I am HIV positive; I wouldn't want anyone in my community to find out

Feeling: Worried, Private, Insecure

Key Insights

Provider Behaviour Change: She may project her own values onto her clients. Despite knowing people have their own needs, she is influenced by her environment. Sensitisation trainings and mentorship are opportunities for her to become more skilled at working with high-risk key populations who are so stigmatised that they often do not share their lifestyles with her. Despite her being trained, she does not even know when to use her new skills

Dissemination of Information: She feels there is a lack of targeted information readily available for specific audiences, including basic sexual and reproductive health information and HIV services. She wants to deliver quality information to her clients in the form of targeted patient education about adherence and prevention (e.g. PrEP). She wants to be trained on up-to-date information

Occupational Health: She is worried about her own occupational risk for HIV from needle pricks and the stigma around HIV-positive providers. Health workers are in need of support and workplace programmes for HIV prevention, care and treatment due to the risks of occupational exposure to HIV

Abbreviations: PEP, post-exposure prophylaxis; PrEP, pre-exposure prophylaxis.

Communications Matrix: Providers

DESIRED CHANGES*	TO TREAT ALL PATIENTS WITH DIGNITY AND RESPECT (KEY POPULATIONS, YOUNG PEOPLE, ALL RELIGIONS)	TO DELIVER HIGH QUALITY EDUCATION AND COUNSELLING TO CLIENTS	TO BE A GOOD ROLE MODEL TO CLIENTS AND GET TESTED FOR HIV
Barriers	• Conflicting personal attitudes and practices • Service delivery environments not set up for client privacy and confidentiality • Lack of information and skills on how to manage different populations • Lack of occupational support network • Infrastructure does not support the delivery of integrated care • Resource constraints compromise the delivery of up-to-date quality services	• Staff shortage—not enough providers (lack time with clients) • Burdensome administrative work • Lack of knowledge on all HIV prevention, care and treatment information • Lack of accessibility to quick reference documents for updated guidelines • Lack of provider-patient counselling techniques • Lack of access to basic HIV health education materials for clients	• Self-stigma about health providers who are HIV positive • Worry about social status • Fear of being tested by a colleague • Social pressure—perception that providers are the example of perfect health
Facilitating Factors	• Empathy • Identifying with the community they serve • Mentorship and support from management	• Service integration to improve client flow, integrated counselling (e.g. FP and HTS)	
Communications Objectives	1. Increase positive perceptions about diverse community needs 2. Increase knowledge, attitudes and perceptions about the importance of client-centred care, including client privacy and confidentiality	3. Improve accessibility all HIV prevention, care and treatment information and health education materials 4. Increase knowledge, attitudes and perceptions about all HIV prevention, care and treatment services 5. Improve knowledge, attitude and perceptions of provider-patient counselling techniques	6. Increase knowledge, attitudes and perceptions of occupational risk for HIV 7. Increase awareness for providers to know their status 8. Reduce self-stigma about provider HIV status and stigmatizing attitudes toward clients

Illustrative Messages	• My personal beliefs and attitudes should not interfere with patient care • I treat all my patients with dignity and respect • I value clients' privacy and confidential information • I treat people and provide care—I do not judge • Being a provider means I treat all patients the same • Be "adolescent competent"—get trained in adolescent health • Communicate clearly and encourage adolescents (all patients) to talk openly • Respect their privacy and confidentiality • Empower young people to make decisions about their health • Make people feel welcome and safe at your health centre	• Task sharing and triaging my patients reduces workload • Applying new learnings and skills from training improves quality of care • I give health education for the prevention of disease • I enjoy learning about the good that other providers are doing	• Like my patients, I must also know my status • Being a provider can be risky business—I need to know how to protect myself • My safety is my priority in the provision of health service. PEP helps me stay safe
Illustrative Indicators	1. % of providers expressing accepting attitudes to diverse community health needs 2. # of people accessing HIV services (HIV testing, ART, PrEP, VMMC, PMTCT, Condoms,) and SRH services (FP) following a communications campaign 3. % of target audience who report that providers are person-centred on client's health needs 4. # of providers trained on (a) HIV testing, (b) HIV prevention, (c) care and treatment, (d) viral load testing, (e) client confidentiality, (f) client counselling techniques and (g) occupational risk for HIV 5. % increase in client satisfaction with provider's respect for client confidentiality 6. % of providers who report that they have access to information on HIV prevention, care and treatment 7. % of target audience who report positive perceptions about providers getting tested and disclosing their HIV status		

Abbreviations: FP, family planning; HTS, HIV testing services; PEP, post-exposure prophylaxis.

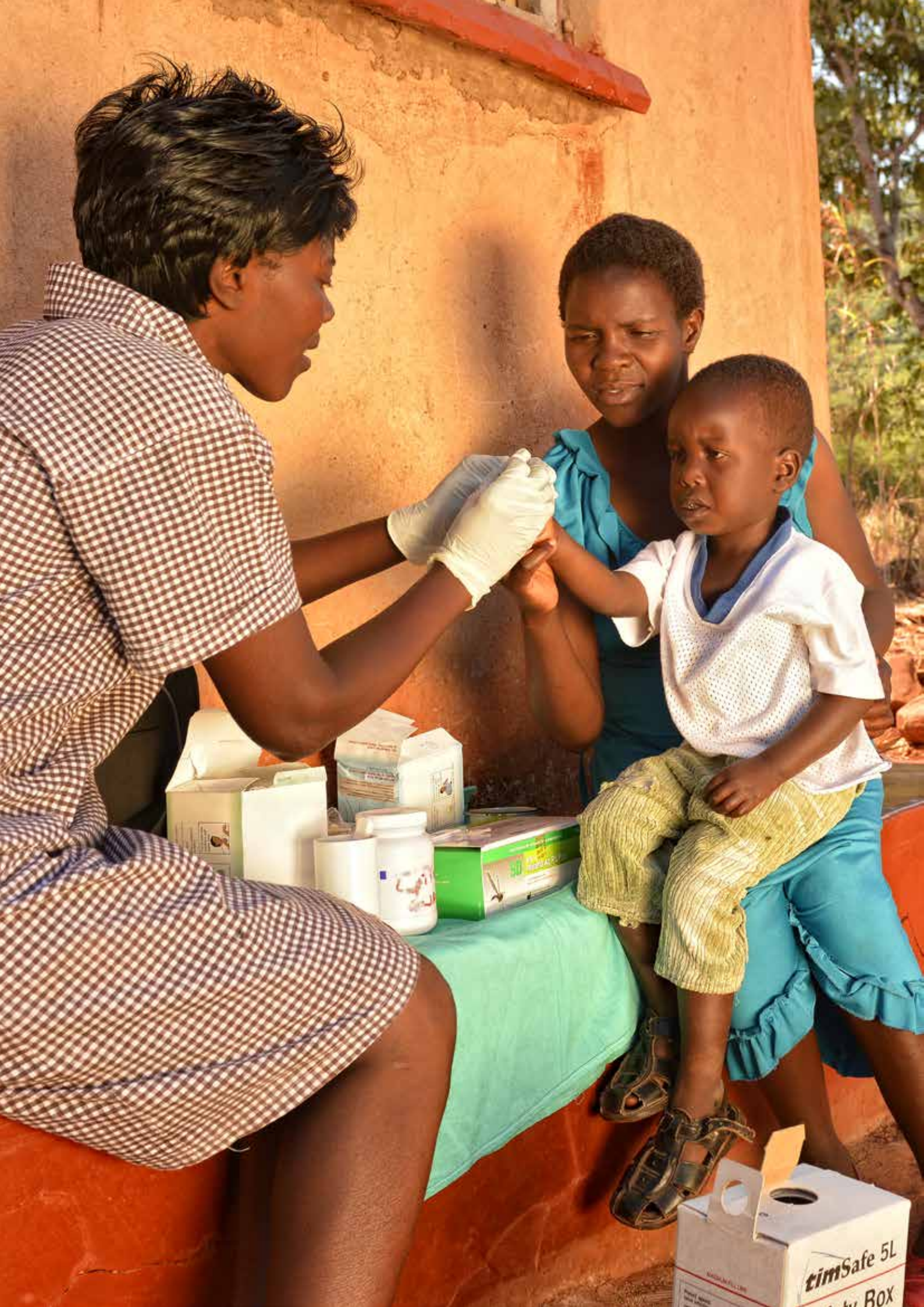
CHAPTER 5.

Monitoring and Evaluation

To effectively measure the achievement of communications objectives for each audience, a logical framework approach was adopted to measure results at the output, outcome and impact levels. For each of the overarching and audience specific communications objectives, the strategy identifies a combination of both illustrative output and outcome indicators. Output indicators measure the immediate results of communications activities, whilst outcome indicators measure desired changes in attitudes, behaviours, norms and beliefs. To monitor output results, the strategy will utilise both quantitative and qualitative methods such as reviewing IEC materials distribution, distribution logbooks, client exit surveys, training reports, service statistics, and questionnaires, etc.

The strategy will use quantitative and qualitative evaluation methods to answer specific questions on the impact of communications activities on knowledge levels, attitudes and beliefs about HIV/AIDS, stigma and discriminations against people living with HIV/AIDS, and risk behaviours among the different target audiences. The strategy will as much as possible utilise existing data sources such as the Demographic Health Survey, and other behavioural surveillance or special studies.

The output and outcome indicators suggested in this strategy are illustrative. A detailed standard monitoring and evaluation (M&E) framework will be developed to standardise indicators and indicator definitions, data collection tools and methods, and reporting to the MoHCC. The MoHCC, implementing partners and donors will be guided by the M&E framework during strategy performance review meetings to draw lessons learnt and inform strategy improvements. A data quality strategy/plan will also be developed to strengthen the quality of data collected and reported to the MoHCC.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CHAPTER 6.
Costing

With all strategies, costing is an important element that provides an understanding of financial feasibility of operationalising the plan. For this strategy, an activity-based costing approach was utilised to assign costs for three years (2019-2021) by each of the four main communications strategic objectives (Figures 8 and 9).

Communications Strategic Objective 4, which highlights the 11 target audiences covered in the strategy, covers costing for cross-cutting activities only. These activities apply to all target audiences across HIV programmes and were costed to highlight what would be required to execute them.

Key Costing Assumptions

1. All costing utilised US$ as the official base currency.
2. Activities will be performed year-on-year unless specifically stated to be carried out over an estimated period.
3. All creative work will be covered by a central cost separate from activities.
4. Activities shown for Communications Strategic Objective 4 are for cross-cutting objectives only.
5. A zero cost assigned to an activity states that the activity will be performed by personnel or items acquired within existing structures as part of business as usual routines or activities and thus will not incur a cost to it.

Figure 8.
Summary of Activity-Based Costing by Each of the Four Communications Strategic Objectives

HIV COMMUNICATION STREATEGY ZIMBABWE 2019-2021 COSTING	2019	2020	2021	TOTAL
Total cost of Communication Plan	$437,143.00	$371,693.00	$371,693.00	**$1,180,529**

Cost by Objective	2019	2020	2021	Total	% Total
1. Increase knowledge and change attitudes and perceptions about the specific needs of key and vulnerable populations in order to advocate for a more enabling environment for seeking HIV prevention, care, and treatment services	$1,675	$1,675	$1,675	$5,025	0.43%
2. Advocate for comprehensive and integrated HIV communications approaches and messages across implementing partners, funders and government agencies	$62,950	$-	$-	$62,950	5.33%
3. Enlist support from providers and health care workers, traditional, religious and community leaders, to be change agents in their communities for communication of HIV prevention, care, and treatment services	$2,500	$-	$-	$2,500	0.21%
4. Deliver messaging and communication approaches that align with the journey of HIV prevention, treatment and care for targeted audiences	$370,018	$370,018	$370,018	$1,110,054	94.03%
Total	$437,143	$371,693	$371,693	**$1,180,529**	

Cost of Cross Cutting Activities	2019	2020	2021	Total	% Total
Outreach campaigns	$4,584	$4,584	$4,584	$13,752	1.2%
Hold peer-to-peer dialogues/conversations with communities & leaders	$20,056	$20,056	$20,056	$60,168	5.4%
Development of IEC material	$6,000	$6,000	$6,000	$18,000	1.6%
Bulk SMS	$12,000	$12,000	$12,000	$36,000	3.2%
Multi-media campaigns	$327,378	$327,378	$327,378	$982,134	88.5%
Total	$370,018	$370,018	$370,018	**$1,110,054**	

Figure 9.
Complete Strategy Costing by Communications Strategic Objective

Sub-objectives	Activities	Nat	Prov	Dist	Budget Assumptions	Indicator/target	Unit cost	Annual Quantity			Annual Cost			Total Cost
								2019	2020	2021	2019	2020	2021	
1. Increase knowledge and change attitudes and perceptions about the specific needs of key and vulnerable populations in order to advocate for a more enabling environment for seeking HIV prevention, care, and treatment services											$1,675	$1,675	$1,675	$5,025
Systems and Structures: Addresses rules, regulations or processes that impact communication delivery	Development of information toolkit for policymakers and media bodies	x			Design toolkit, twice per year	1. % of respondents who report that they are more aware of the specific needs of key and vulnerable populations seeking HIV prevention, care and treatment services	$150	2	2	2	$300.00	$300.00	$300.00	$900
		x			Print data toolkit, twice per year (100)		$200	2	2	2	$400.00	$400.00	$400.00	$1,200
	Engage with policy makers, to discuss key & vulnerable populations	x			Annual meeting with policy makers (1 x 25 pax), refreshments, per diems	2. % of policymakers/ media bodies reached with messages/campaigns on the specific needs of vulnerable populations who advocate for the needs of vulnerable populations	$975	1	1	1	$975.00	$975.00	$975.00	$2,925
	Advocate for the inclusion of KP provider training in mentorship curriculum	x			Half day meeting with MoHCC stakeholders to discuss inclusion	3. # of guidelines/ regulations/policies developed/amended to improve the enabling environment of vulnerable populations accessing HIV prevention, care and treatment services	$-				$-	$-	$-	$-

Sub-objectives	Activities	Nat	Prov	Dist	Budget Assumptions	Indicator/target	Unit cost	Annual Quantity			Annual Cost			Total Cost
								2019	2020	2021	2019	2020	2021	
2. Advocate for comprehensive and integrated HIV communications approaches and messages across implementing partners, funders and government agencies.											$62,950.00	$-	$-	$62,950
Dissemination Culture and Community: Addresses key influencers in local institutions, support systems and informal networks that impact information and communication delivery	Create a Logo for the strategy				Acquiring a design consultant to design logo	1. # of advocacy campaigns on comprehensive HIV and SRH communication approaches conducted (disaggregated by geography; national/ provincial/district, type of audience (implementing partner, funders, government agencies) 2. # of advocacy tools developed to increase the use of comprehensive HIV and SRH communication approaches 3. % of target audience who report using comprehensive HIV and SRH communication approaches to increase uptake of HIV prevention, care and treatment services	$5,200	1	0	0	$5,200.00	$-	$-	$5,200
	Posting strategy to MoHCC & Partner websites				Stategy will be digitally uploaded to MoHCC and patner websites for all to download		1	0	0	$-	$-	$-	$-	$1,200
	Presentation at National NAC meetings				Creation of powerpoint presentation for quarterly meetings at chosen forums		1	0	0	$-	$-	$-	$-	$2,925
	Developing a standardised presentation for quartley Provincial Health Teams & District Health Team, Prevention Partnership Forum, PMTCT partnership forum, Treatment & Care Partnership Forum, Adolescent Sexual Reproductive Health Forum meetings				Creation of powerpoint presentation for quarterly meetings at chosen forums. Printing of presentation will be done on A4 size x 300 per quarter		1	0	0	$600.00	$-	$-	$600	$-

Imple-mentation Culture and Community: Addresses key influencers in local institu-tions, support systems and in-formal networks that impact information and communication delivery	Develop marketing materials (including formats for PWD) for field offices, training community members and providers				Posters x 5000 (all facilities), Brochure 15000 (all facilities)		$50,950	1	0	0	$50,950.00	$-	$-	$50,950
	Develop an interactive app/ microsite				Acquiring consultants to design of digital application housing strategy for download with a microsite to provide more information		$6,000	1	0	0	$6,000.00	$-	$-	$6,000
	Develop sensitisation presentation on using the strategy for different levels and standardised approach to help partners develop and align plans with the strategy				Half day meeting within quarterly Health Promotion officers meeting. 80 pax with refreshment		$100	1	0	0	$100.00	$-	$-	$100
	Develop a mechanism to monitor and ensure compliance of the comprehensive communications strategy				1 day meeting to be held between MoHCC and funders		$-	1	0	0	$-	$-	$-	$-

Sub-objectives	Activities	Nat	Prov	Dist	Budget Assumptions	Indicator/target	Unit cost	Annual Quantity			Annual Cost			Total Cost
								2019	2020	2021	2019	2020	2021	
3. Enlist support from providers and health care workers, traditional, religious and community leaders, to be change agents in their communities for communication of HIV prevention, care, and treatment services.											$2,500.00	$-	$-	$2,500
Individual Practices: Addresses key characteristics of the individual person that impact behaviour change	Map religious and traditional bodies to prioritise interventions based on geographic distribution, information gaps, population needs, doctrine, etc	X			Once off, done by a chosen team to meet and map out faith based bodies	1. # of traditional, religious and community leaders who participate in HIV comprehensive communication activities at community level 2. % of community leaders who express accepting attitudes on community members accessing HIV prevention, care and treatment services	$-	1	0	0	$-	$-	$-	$-
	a. Establish calendar, membership and mandate of existing religious bodies and incorporate into agenda of their regular meetings	X			Once off and performed after map out of faith based bodies		$-	1	0	0	$-	$-	$-	$-
	Develop sector specific comprehensive information toolkit through a consultative process for distribution with communities		X		Design Information toolkit for communities		$500.00	1	0	0	$500.00	$-	$-	$500
					Print & distributed x1000 per community & religious body		$2,000.00	1	0	0	$2,000.00	$-	$-	$2,000
	Dissemination of the toolkit			X	Partners to disseminate within their meetings with religious leaders		$-	0	0	0	$-	$-	$-	$-

4. Deliver messaging and communication approaches that align with the journey of HIV prevention, treatment and care for targeted audiences.											$370,018.00	$370,018.00	$370,018.00	$1,110,054.00
Cross Cuting Activities: The following activities apply to all target audiences across HIV programmes. To access specific activities for each audience, please see individual audience profiles	Outreach campaigns: Evening outreaches will target KP's, adult man & woman, young man and woman & inlfuencers. Daytime outreaches will allow targeting of all populations. These will be performed every quarter			X	Costs associated are lunch/dinner personnel, fuel, accomodation, toll gates, per diems Marketing required: IEC material (brochures, fliers, posters for combination prevention services)		$1,146.00	4	4	4	$4,584.00	$4,584.00	$4,584.00	$13,752.00
	Hold peer-to-peer dialogue/ conversations with communities & leaders: These will be held within communities/ districts were by all populations may be present thus dialogues will be tailor made to combination prevention issues or services and be performed every quarter across all districts			X	Costs associated are bus reimbersements, lunches for personnel facilitating, fuel, toll gates Marketing required: IEC material (brochures, fliers, posters for combination prevention services)		$2,507.00	8	8	8	$20,056.00	$20,056.00	$20,056.00	$60,168.00
	Development of IEC material: IEC material will be developed covering HIV prevention care and treatment services that are available for all populations, however design may very according to population barriers				Costs associated: creative cost of designing brochures, posters, fliers, tshirts and banners Printing costs of brochures, fliers, tshirts and banners, printing done once per year and distribution done per quarter		$3,000.00	2	2	2	$6,000.00	$6,000.00	$6,000.00	$18,000.00

Sub-objectives	Activities	Nat	Prov	Dist	Budget Assumptions	Indicator/target	Unit cost	Annual Quantity			Annual Cost			Total Cost
								2019	2020	2021	2019	2020	2021	
4. Deliver messaging and communication approaches that align with the journey of HIV prevention, treatment and care for targeted audiences.											$370,018.00	$370,018.00	$370,018.00	$1,110,054.00
	Bulk sms: These may be sent to any or all populations across different mobile network operators				Costs associated: 0.03c per sms sent with a maximum of 150 characters		$3,000.00	4	4	4	$12,000.00	$12,000.00	$12,000.00	$36,000.00
	Multi-media campaigns: Use long format, storytelling approach to address deep-seated social and behavioural norms				Briefing of agency of any campaign to be performed to ensure conceptualiza-tion is done to align brief to outcomes. This will include, tes-timonials, cam-paigns involving script writing for radio and TV, creative visuals for newspaper adverts, social media adverts		$10,000.00	2	2	2	$20,000.00	$20,000.00	$20,000.00	$60,000.00

				X	Testimonials campaigns that will be aired on TV, radio, social media run over a 3-6 month period highlighting various populations and their experiences with HIV prevention, care and treatment services Costs associated are: creative design for newspaper adverts social media posts, script writting. Media booking includes: News paper placement, radio placement, TV placement, social media placement, billboard placement		$7,300.00	9	9	9	$65,700.00	$65,700.00	$65,700.00	$197,100.00

Sub-objectives	Activities	Nat	Prov	Dist	Budget Assumptions	Indicator/target	Unit cost	Annual Quantity			Annual Cost			Total Cost
								2019	2020	2021	2019	2020	2021	
4. Deliver messaging and communication approaches that align with the journey of HIV prevention, treatment and care for targeted audiences.											$370,018.00	$370,018.00	$370,018.00	$1,110,054.00
					Sensitivity campaigns particularly for KP's and vulnerable populations that will be aired on TV, Radio, Social media run over a 3-6 month period highlighting the need to for behavioural change in order to ensure the get HIV prevention, care and treatment services Costs associated are: creative design for newspaper adverts social media posts, script writting Media booking includes: news paper placement, radio placement, TV placement, social media placement, billboard placement		$52,750.00	3	3	3	$158,250.00	$158,250.00	$158,250.00	$474,750.00

					Dramas around all populations that will be aired on either TV, Radio and Social media running for 30min on TV and 15min on radio over a 1 month period highlighting aspects such as life journeys of populations or risk perception around HIV and how HIV prevention, care and treatment services will assist their lives Costs associated are: creative design for newspaper adverts social media posts, script writting Media booking includes: news paper placement, radio placement, TV placement, social media placement, billboard placement		$22,608.00	1	1	1	$22,608.00	$22,608.00	$22,608.00	$67,824.00

Sub-objectives	Activities	Nat	Prov	Dist	Budget Assumptions	Indicator/target	Unit cost	Annual Quantity			Annual Cost			Total Cost
								2019	2020	2021	2019	2020	2021	
4. Deliver messaging and communication approaches that align with the journey of HIV prevention, treatment and care for targeted audiences.											$370,018.00	$370,018.00	$370,018.00	$1,110,054.00
		X			Talk shows will be performed on TV or radio, that will cover a 30min period on TV and 15min period on radio running for 1 month periods Covering aspects key to populations regarding HIV prevention, care and treatment Costs associated are: production manager fee, cast fee, script writing. Media booking includes: radio placement, TV placement, social media placement, DJ mentions, presenter training		$60,820.00	1	1	1	$60,820.00	$60,820.00	$60,820.00	$182,460.00
Total											$437,143.00	$371,693.00	$371,693.00	**$1,180,529.00**

Implementers will need to identify and cost activities for their specific programmes as needed. However, in keeping the client-centred approach, a population-based costing strategy should be considered to account for a comprehensive approach to HIV communications in Zimbabwe. See Appendix B for a costing summary by each Communications Strategic Objective.

Costing Recommendation: Population-Based Costing Approach

To achieve the vision of the client-centred approach highlighted in Communications Strategic Objective 4, implementers may want to consider a population-based funding mechanism, whereby activities are assigned within each programme according to the different target audiences served. Through this method, implementers can easily ensure specific populations are being adequately funded within each programme. More than one activity may be placed for one particular population running for each programme. Table 14 highlights how such a costing model may be developed in order to achieve this.

Table 14.
Sample Population-Based Costing Approach

PROGRAMS	POPULATIONS AND ACTIVITIES						
	AB	AG	YM	YW	FSW	MSM	Total
PrEP	Activity	Activity	Activity	Activity	Activity	Activity	Xxxxx
Condoms	Activity	Activity	Activity	Activity	Activity	Activity	Xxxxx
HTS	Activity	Activity	Activity	Activity	Activity	Activity	Xxxxx
eMTCT	Activity	Activity	Activity	Activity	Activity	Activity	Xxxxx
Treatment	Activity	Activity	Activity	Activity	Activity	Activity	Xxxxx
VMMC	Activity	Activity	Activity	Activity	Activity	Activity	Xxxxx
Total by Population	xxxxx	xxxxx	xxxxx	xxxxxx	xxxxx	xxxxx	Xxxxx

Abbreviations: AB, adolescent boy; AG, adolescent girl; eMTCT, elimination of mother-to-child transmission of HIV; FSW, female sex worker; HTS, HIV testing services; MSM, men who have sex with men; PrEP, pre-exposure prophylaxis; VMMC, voluntary medical male circumcision; YM, young man; YW, young woman.

CHAPTER 7.

Recommendations

The strategies, activities and key messages outlined in the previous sections of this strategy are envisaged to contribute towards control of the HIV epidemic, resulting in improved health outcomes for Zimbawe. However, communications efforts alone will not be enough to overcome all the identified barriers to behaviour change. Key gaps have been identified that inhibit the demand-generation efforts in HIV prevention, care and treatment and these gaps will need to be addressed through various interventions. Although not all are directly communications related, these interventions will contribute positively towards the communications goals and objectives. Intervention areas include:

Service Delivery

- Develop a provider (health care worker, nurse, doctor, pharmacist, etc.) communications strategy for HIV prevention, care and treatment, as providers require behaviour change to deliver and facilitate high-quality, evidence-based and current HIV prevention, care and treatment.
- Increase health care worker accountability for patient confidentiality, privacy and sensitivity to not inhibit people from seeking services.
- Enhance safe work spaces for providers through occupational health and harm reduction efforts for HIV prevention, care and treatment; develop and disseminate occupational health guidelines.
- Increase number of and access to service delivery locations for adolescent-, male-, and key population–friendly services.

Infrastructure

- Improve infrastructure—roads, transportation, building structures (ramps, bathrooms, service delivery rooms)—to improve mobility for PWD when accessing health services.

Educational System

- Improve combination HIV and SRH, including GBV, conversations and curricula in schools.

Target Audience Sub-Segments

- Identify and evaluate behaviours, perceptions and attitudes at an in-depth level for the different sub-segments within each audience, specific to individual programme needs. For example, within the young women audience, these can be further refined or analysed as young women selling sex and young women in transactional sex. In this regard, programmes can then provide further analysis and structure the communications efforts based on the refined analyses.
- HIV prevention, care and treatment programmes can apply information provided in this strategy as a baseline toward the development of specific implementation activities and in-depth messaging as needed to accomplish desired programmatic goals.

CHAPTER 8.

Conclusion and Next Steps

This is the first known comprehensive HIV prevention, care and treatment communications strategy conceived and produced in Zimbabwe. Every effort was made to ensure involvement from the widest possible range of stakeholders including funders, implementers, MoHCC and community stakeholders as well as peer leaders and organisers. However, the core component that makes this strategy truly unique is not that it may be the first nor that it involved so many stakeholders. What makes this strategy different is the driving force behind its entire contents: the individual people of Zimbabwe. Using a human-centred design approach allowed for an empathetic and thorough analysis of the complex nature of people's lives. As a result, the strategy is client-centred instead of programme-centred. Instead of looking for people who fit the programme, this strategy identifies a programme that fits the needs of the person based on a life-stage approach to their own personal health journey related to HIV prevention, care and treatment.

It is designed to be a practical guide for anyone in the field delivering HIV services. We hope that individual partners and implementers can use this strategy as a launching pad for specific HIV prevention, care and treatment communications efforts to ensure a unified voice and seamless delivery of comprehensive HIV services that match the complex and nonlinear ways that people go about their lives.

The next steps are to design an implementation plan with partners focusing on key activities to drive the communications strategic objectives and a monitoring and evaluation plan for the communications strategy.

Appendices

Appendix A:

Overarching Strategic Objectives of the Comprehensive National HIV Communications Strategy

SOCIO-ECOLOGICAL LEVEL OF CHANGE	STRATEGIC APPROACH	STRATEGIC OBJECTIVE	STRATEGIC OBJECTIVE
Policy and Advocacy	1. Policymaker Awareness	Increase awareness about the specific needs of key and vulnerable populations to advocate for a more enabling environment for seeking HIV prevention, care and treatment services	• Age of consent currently limits adolescents younger than 16 from accessing health services • HIV outcomes cannot be achieved without addressing child protection violations and other social and economic factors • MSM and LGBTIQ Zimbabweans face hardships accessing services and being open about their sexuality without risking criminal and social persecution • PWD are often the last in line for resources and services—from poor infrastructure to a lack of sexual protections • Sex workers are at increased risk for HIV because of stigma and discrimination as well as lack of supportive legislation, policy and funding and community empowerment addressing violence

Systems and Structures	2. Multisectoral Integration	Advocate for comprehensive HIV and SRH communications approaches and messages across implementing partners, funders and government agencies	• Current HIV programming and funding is delivered through a siloed approach, which limits the integration of services, delivery and the continuum of care • Lack of coordination among different authorities such as education, labour, transportation, faith-based organisations, nongovernmental organisations • Lack of packaging of health service platforms that promote integration of overall health and well-being
Culture and Community	3. Integration with Influencers	Leverage existing relationships with traditional, religious and community leaders to be change agents and provide a holistic communications approach for HIV prevention, care and treatment services	• Influencers lack basic information (understanding HIV, community statistics for risk prevalence) • Influencers lack self-efficacy to articulate complex medical information around HIV and SRH • Influencers are population-wide sources of information for health and wellness
Individual	4. Client-centred	Deliver messaging and communications approaches that align with the journey of HIV prevention, care and treatment for targeted audiences	• Lack of a unified voice and combined strategy for communicating about all HIV prevention, care and treatment efforts • Programme approach fails to consider the integrated journey of life that is nonlinear and crosses multiple programme points • Piecemeal communications strategy has left some programs falling behind in reaching key strategic goals towards achieving 90-90-90 • Revitalisation of HIV prevention, care and treatment requires addressing key and vulnerable populations

Abbreviations: LGBTIQ, lesbian, gay, bisexual, transgender, intersex, queer/questioning; MSM, men who have sex with men; PWD, people with disabilities; SRH, sexual and reproductive health

Appendix B:

Costing Summaries by Communications Strategic Objectives

1. Increase knowledge and change attitudes and perceptions about the specific needs of key and vulnerable populations in order to advocate for a more enabling environment for seeking HIV prevention, care, and treatment services					**$150.00**
ACTIVITY	**BUDGET ASSUMPTIONS/COST INCURRED**	**UNIT COST**	**UNIT**	**QUANTITY**	**TOTAL COST**
Activity 1.1	**Development of information toolkit for policymakers and media bodies**				
Assume	Design toolkit, twice per year				
	Design of toolkit	$150.00	1	1	150
Activity 1.2	**Development of information toolkit for policymakers and media bodies**				**$200.00**
Assume	Print data toolkit, twice per year (100)				
	Print A4 data toolkit x 100	$2.00	1	100	200
Activity	**Engage with policy makers, to discuss key & vulnerable populations**				**$975.00**
Assume	Annual meeting with policy makers (1 x 25 pax), refreshments, per diems				
	Meeting refreshments	$100.00	1	1	100
	Per diems	$35.00	25	1	$875.00
Activity	**Advocate for the inclusion of KP provider training in mentorship curriculum**				**$-**
Assume	Half day meeting with MoHCC stakeholders to discuss inclusion				
	Meeting	$-	0	0	0

2. Advocate for comprehensive and integrated HIV communications approaches and messages across implementing partners, funders and government agencies					$5,200.00
ACTIVITY	**BUDGET ASSUMPTIONS/COST INCURRED**	**UNIT COST**	**UNIT**	**QUANTITY**	**TOTAL COST**
Activity	**Create a logo for the strategy**				
Assume	Acquiring a design consultant to design logo				
	Desiner briefing	$200.00	1	1	200
	Designer hourly fee	$50.00	5	20	5000
Activity	**Posting strategy to MoHCC & partner websites**				**$-**
Assume	Stategy will be digitally uploaded to MoHCC and patner websites for all to download				
	Partner website post	$-	0	0	0
	MoHCC website post	$-	0	0	0
Activity	**Presentation at national NAC meetings**				**$-**
Assume	Creation of powerpoint presentation for quarterly meetings at chosen forums				
	Meeting for presentation	$-	0	0	0
Activity	**Developing a standardized presentation for quartley Provincial Health Teams & District Health Team, Prevention Partnership Forum, PMTCT partnership forum, Treatment & Care Partnership Forum, Adolescent Sexual Reproductive Health Forum meetings**				**$600.00**
Assume	Creation of powerpoint presentation for quarterly meetings at chosen forums. Printing of presentation will be done on A4 size x 300 per quarter				
	Presentation development	$-	0	0	0
	Printing of presentation	$2.00	1	300	$600.00

2. Advocate for comprehensive and integrated HIV communications approaches and messages across implementing partners, funders and government agencies

ACTIVITY	BUDGET ASSUMPTIONS/COST INCURRED	UNIT COST	UNIT	QUANTITY	TOTAL COST
Activity	**Train health promotion officers, district health officers and provincial nurse officers to cascade through out the provinces and districts**				**$100.00**
Assume	Half day meeting within quarterly Health Promotion officers meeting; 80 pax with refreshment				
	Meeting refreshments	$100.00	1	1	$100.00
Activity	**Develop a media kit and press release to hold a press conference**				**$-**
Assume	Powerpoint and PDF designed media kits for information for media bodies				
	Development of presentation	$-	0	0	0
Activity	**Deliver the strategy outside health agencies including other ministries, religious groups, chief councils and Parliament for better collaboration**				**$-**
Assume	Half day meetings to be held with various government agencies to disseminate strategy				
	Meeting with stakeholders	$-	0	0	0
Activity	**Develop sensitisation presentation on using the strategy for different levels and standardised approach to help partners develop and align plans with the strategy**				**$100.00**
Assume	Half day meeting within quarterly Health Promotion officers meeting. 80 pax with refreshment				
	Meeting refreshments	$100.00	1	1	$100.00

Activity	**Develop marketing materials (including formats for PWD) for field offices, training community members and providers**				**$50,950.00**
Assume	Posters x 5000 (all facilities), brochure 15000 (all facilities.				
	Design of sign laguage posters	$150.00	1	1	$150.00
	Design of sign laguage brochure	$150.00	1	1	$150.00
	Design of braille brochure	$150.00	1	1	$150.00
	Printing of sign language poster	$2.00	1	5000	$10,000.00
	Printing of sign language brochure	$0.70	1	15000	$10,500.00
	Printing of braille brochure	$2.00	1	15000	$30,000.00
Activity	**Develop an interactive app/microsite**				**$6,000.00**
Assume	Acquiring consultants to design of digital application housing strategy for download with a microsite to provide more information				
	Consultant development fee	$6,000.00	1	1	6000
Activity	**Develop a mechanism to monitor and ensure compliance of the comprehensive communications strategy**				**$-**
Assume	1 day meeting to be held between MoHCC and funders				
		$-	0	0	0

3. Enlist support from providers and health care workers, traditional, religious and community leaders, to be change agents in their communities for communication of HIV prevention, care, and treatment services					$-
ACTIVITY	**BUDGET ASSUMPTIONS/COST INCURRED**	**UNIT COST**	**UNIT**	**QUANTITY**	**TOTAL COST**
Activity	**Map religious and traditional bodies to prioritise interventions based on geographic distribution, information gaps, population needs, doctrine, etc**				
Assume	Once off, done by a chosen team to meet and map out faith based bodies				
	-	$-	1	1	$-
Activity	**a. Establish calendar, membership and mandate of existing religious bodies and incorporate into agenda of their regular meetings**				**$-**
Assume	Once off and performed after map out of faith based bodies				
		$-	1	1	0
Activity	**Develop sector specific comprehensive information toolkit through a consultative process for distribution with communities**				**$500.00**
Assume	Design information toolkit for communities				
	Design of toolkit	$500.00	1	1	$500.00
Activity	**Develop sector specific comprehensive information toolkit through a consultative process for distribution with communities**				**$2,000.00**
Assume	Print & distributed x1000 per community & religious body				
	Printing of toolkit	$2.00	1	1000	$2,000.00

Activity	**Dissemination of the toolkit**				**$-**
Assume	Partners to disseminate within their meetings with religious leaders				
		$-			0

4. Deliver messaging and communication approaches that align with the journey of HIV prevention, treatment and care for targeted audiences.					**1,146.00**
ACTIVITY	**BUDGET ASSUMPTIONS/COST INCURRED**	**UNIT COST**	**UNIT**	**QUANTITY**	**TOTAL COST**
Activity 1	**Outreach campaigns: Evening outreaches will target KP's, adult man & woman, young man and woman & inlfuencers. Daytime outreaches will allow targeting of all populations. These will be performed every quarter**				
Assume	Costs associated are lunch/dinner personnel, fuel, accomodation, toll gates, per diems. Marketing required: IEC material (brochures, flyers, posters for combination prevention services)				
	Per diems for personnel	$30.00	1	8	240.00
	Lunch/dinner	$15.00	1	8	120.00
	Toll gate	$2.00	1	4	8.00
	Fuel	$1.45	1	40	58.00
	Accommodation (bed & breakfast)	$90.00	1	8	720.00

4. Deliver messaging and communication approaches that align with the journey of HIV prevention, treatment and care for targeted audiences

ACTIVITY	BUDGET ASSUMPTIONS/COST INCURRED	UNIT COST	UNIT	QUANTITY	TOTAL COST
Activity 2	**Hold peer-to-peer dialogue/conversations with communities & leaders: these will be held within communities/districts were by all populations may be present thus dialogues will be tailor made to combination prevention issues or services and be performed every quarter across all districts**				**2,507.00**
Assume	Costs associated are bus reimbersements, lunches for personnel facilitating, fuel, toll gates. Marketing required: IEC material (brochures, flyers, posters for combination prevention services)				
	Bus reimbursement	$20.00	1	100	2,000.00
	Lunch/dinner	$15.00	1	4	60.00
	Fuel	$1.45	1	300	435.00
	Toll gates	$2.00	1	6	12.00

Activity 3	**Development of IEC material: IEC material will be developed coverin HIV prevention care and treatment services that are available for all populations, however design may very according to population barriers**				**65,500.00**
Assume	Costs associated: creative cost of designing brochures, posters, flyers, tshirts and banners. Printing costs of brochures, flyers, tshirts and banners, printing done once per year and distribution done per quarter				
	Creative development cost	$1,000.00	1	1	1,000.00
	Tshirts	$10.00	1	2000	20,000.00
	Caps	$9.00	1	2000	18,000.00
	Brochures	$0.60	1	30000	18,000.00
	Flyers	$0.10	1	50000	5,000.00
	A2 posters	$0.70	1	5000	3,500.00

Activity 4	**Bulk SMS (i.e. Econet health tips)**				**3,000.00**
Assume	Monthy slots				
	Bulk sms booking mobile network operator	$0.03	1	100000	3,000.00

4. Deliver messaging and communication approaches that align with the journey of HIV prevention, treatment and care for targeted audiences

ACTIVITY	BUDGET ASSUMPTIONS/COST INCURRED	UNIT COST	UNIT	QUANTITY	TOTAL COST
Activity 5	**Multi-media campaigns Use long format, storytelling approach to address deep-seated social and behavioural norms**				**10,000.00**
Assume	Briefing of agency of any campaign to be performed to ensure conceptualization is done to align brief to outcomes. This will include, testimonials, campaigns involving script writing for radio and TV, creative visuals for newspaper adverts, social media adverts				
	Creative conceptualization	$10,000.00	1	1	10,000.00
Activity 5.1	**Multi-media campaigns Use long format, storytelling approach to address deep-seated social and behavioural norms**				**7,300.00**
Assume	Testimonials campaigns that will be aired on TV, radio, Social media run over a 3-6 month period highlighting various populations and their experiences with HIV prevention, care and treatment services. Costs associated are: creative design for newspaper adverts social media posts, script writting. Media booking includes: newspaper placement, radio placement, TV placement, social media placement, billboard placement				
	Produce TV testimonials	$2,000.00	1	1	2,000.00
	Produce radio advert testimonial	$600.00	1	1	2,000.00
	Produce social media testimonials	$500.00	1	1	500.00
	TV placement	$1,000.00	1	1	1,000.00
	Radio advert booking (60 sec)	$2,000.00	1	1	1,000.00
	Social media management	$800.00	1	1	800.00

Activity 5.2	**Multi-media campaigns Use long format, storytelling approach to address deep-seated social and behavioural norms**				**52,750.00**
Assume	Sensitivity campaigns particularly for KP's and vulnerable populations that will be aired on TV, radio, social media run over a 3-6 month period highlighting the need to for behavioural change in order to ensure the get HIV prevention, care and treatment services. Costs associated are: Creative design for newspaper adverts social media posts, script writting. Media booking includes: newspaper placement, radio placement, TV placement, social media placement, billboard placement				
	Radio production (60 sec)	$600.00	1	1	600.00
	Radio booking adverts	$2,000.00	1	4	8,000.00
	Newspaper & adverts	$4,310.00	1	5	21,550.00
	TV production (2 min)	$2,000.00	1	1	2,000.00
	Billboard production	$1,500.00	1	9	13,500.00
	Billboard booking	$700.00	1	9	6,300.00
	Social media booking	$800.00	1	1	800.00

4. Deliver messaging and communication approaches that align with the journey of HIV prevention, treatment and care for targeted audiences

ACTIVITY	BUDGET ASSUMPTIONS/COST INCURRED	UNIT COST	UNIT	QUANTITY	TOTAL COST
Activity 5.3	**Multi-media campaigns Use long format, storytelling approach to address deep-seated social and behavioural norms**				**22,608.00**
Assumption	Dramas around all populations that will be aired on either TV, radio and social media running for 30 min on TV and 15 min on radio over a 1 month period highlighting taspects such as life journeys of populations or risk perception around HIV and how HIV prevention, care and treatment services will assist their lives. Costs associated are: creative design for newspaper adverts social media posts, script writting. Media booking includes: newspaper placement, radio placement, TV placement, social media placement, billboard placement				
	2 x Radio presenters	$500.00	1	1	500.00
	Radio drama production (15 min)	$650.00	1	4	2,600.00
	Radio media slots	$1.00	2	4	8.00
	TV production (30 min)	$15,000.00	1	1	15,000.00
	TV media slot	$1,000.00	1	5	5,000.00
	Production manager & cast	$2,000.00	1	1	2,000.00

Activity 5.4	**Multi-media campaigns Use long format, storytelling approach to address deep-seated social and behavioural norms**				**60,820.00**
Assume	Talk shows will be performed on TV or radio, that will cover a 30 min period on TV and 15 min period on radio running for 1 month periods. Covering aspects key to populations regarding HIV prevention, care and treatment. Costs associated are: production manager fee, cast fee, script writting. Media booking includes: radio placement, TV placement, social media placement, DJ mentions, presenter training				
	2 x Radio presenters	$500.00	1	1	500.00
	Radio drama production (15 min)	$650.00	1	8	5,200.00
	Radio media slots	$4,140.00	1	8	33,120.00
	TV production (30 min)	$15,000.00	1	1	15,000.00
	TV media slot	$1,000.00	1	5	5,000.00
	Production manager & cast	$2,000.00	1	1	2,000.00

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