

## **B.2 THE BCC STRATEGY OF THE HUMSAFAR TRUST**

Developed by the Humsafar Trust, Mumbai

The Humsafar Trust, established in 1994, has twelve main components in its functioning. The main work is within the community where it runs a drop-in center at Vakola municipal market building with counseling rooms and a help-line for information on sexuality, male STIs and HIV/AIDS.

The Humsafar Trust (HST) undertakes advocacy with other segments of society like lawyers, teachers, academics and college students. It has started a short course on gay issues for the postgraduate students for clinical psychology at Bombay University's Kalina Campus. It sensitized trade union leaders to issues round homosexuality and its social implications last year and also closely collaborates with the Lawyer Collective, an NGO of the legal profession fighting for human rights.

HST has an extensive street outreach service where more than 30 trained street outreach workers man public sex-sites to build rapport, offer information on sexual health and distribute condoms and health literature on men seeking sex with other men (MSM).

HST runs India's few STIs clinics specifically for gay men and MSM where oral and anal checkups are offered for STIs besides HIV tests after pre-test counseling. A one-window offer of prompt care, post-test counseling and after care on diets and change of life styles is offered at Sion Hospital for such men and has been extended to other hospitals. The clinic also offers voluntary testing (VCTC) facilities funded by NACO.

The HST center houses one of the largest libraries on homosexual issues with over 1000 books, newsletters, research papers and magazines on homosexual subjects. It has been donated books and rare research papers on the subject by various people from India and abroad and are in the process of cataloguing them for research purposes. It is open to research students on sexuality and gender.

### **BACKGROUND:**

Acquired Immune Deficiency Syndrome (AIDS) has been recognized as one of the critical health and development concerns of this century. Caused by the Human Immuno Deficiency Virus (HIV), the infection and the syndrome have taken pandemic proportions.

The communication needs of the target group with regard to STD / HIV / AIDS intervention program and suggest the communication needs of the population, especially the high vulnerability groups, which would aid in designing communication programs that focus on the media component of the HIV / AIDS prevention strategy including planning, formative research, message development, material design, pre-testing, dissemination, implementation and monitoring would specifically lead to devising appropriate communication strategies with regard to HIV / AIDS and STDs of the priority target audiences in Maharashtra with particular reference to desire behavior change from a state of "Unaware" to "Ready for behavior change".

### **Men who Have Sex with Men (MSMs)**

Description: Men who have sex with men (MSMs) are a diverse and often hard to reach group, spanning across nearly all age groups and socio-economic backgrounds. MSMs include youth experimenting with sex who find male partners more available than women and cheaper than sex workers; bisexual men who marry and father children while continuing to have sex with men; and a tight-knit, core group of men who self-identify as self-identified homosexuals (gays, homos, kothis) MSMs. This core group shares a strong subculture, include special vocabulary that allows them to communicate with each other. However, many other MSMs hide their behavior from others, even from their families, realizing that society strongly disapproves. Because of this, we can assume that MSMs are more numerous than most people realize it. For the purpose of the five studies, MSMs were defined as any man who has sex (manual/anal/oral) with any other man/men in the last six months before the survey.

Within the groups of both self-identified and hidden MSMs, there are several sub-groups and sub-communities. These include jogtas, kothis, male commercial sex workers, self-identified gay and bisexual men, as well as many others. It is beyond the scope of this document to fully describe this complex scenario of fluid identities; however, there is a noted need for further research on the subject as is outlined in the strategic plan matrices.

Demographic Profile: Slightly more than half of the MSMs studied in the BSS are between 20 years and 29 years. The education levels of the MSMs in the study are fairly high. Overall, as many as 44% of the MSMs reported that they have studied beyond the secondary school level. Only about 5% of the respondents are illiterate. Nearly three-fourths of the MSMs interviewed during the survey are engaged in some form of economic activity, and close to 42% have a full time job with the Government or non-Governmental agency. Seventeen percent are self-employed, about 13% are working on a part-time basis, and close to 4% are students but engaged in some economic activity. A significantly high proportion of the respondents (47%) reported traveling often to places outside the city (BSS).

Current availability and needs of the MSM community of communication regarding STD / HIV/ AIDS. And also communication requirements for PLWHA. What kind of communication campaign would the target audiences most prefer? (The extent and depth of information, story telling, giving examples, etc.)

What communication channels would be most preferred to deliver the message? (Media channels – TV, Radio, Newspaper – pamphlets, leaflets, street plays, skits community meetings, individual counseling)

The areas of enquiry in order to gain an in-depth insight into the psychology and inner working of the group with regard to HIV/AIDS.

It is realized that the community and stakeholder involvement is imperative to carry out the communication needs assessment. It is proposed to involve 'community consultants' (MSMs) for interfacing with the community. These 'community consultants' would be influential people from within the target groups. This process will also facilitate interaction with the community in the language they understand, enhance their ownership of the research and hence reduce the gap between **research and intervention**.

The communication strategy plan proposes to develop a comprehensive communication strategy that will include a review and analysis of existing IEC material, and pre-testing and development of new material as needed. The peer leaders and workers will use printed material like re-

designed games, flip-charts, brochures and pamphlets extensively in their inter-personal and group discussions”.

The complete communication ‘package’ would also consist of pamphlets from the Lawyers Collective on legal issues around HIV/AIDS, implications of Section 377 IPC and sexual harassment.

Taking these above factors in mind, the pre-tests of the already existing IEC material revealed that for one-on-one communications, the pamphlets and brochures / booklets would be small enough to carry around in one’s pocket / brief-case / shoulder jhola, profusely illustrated and brief texts.

Care and support needs to be started from **outside** the community, as there is too much homophobia and lack of self-worth within the community. One communication strategy would be to try and get phone to **trust one another** in the community.

How does the communication strategy increase self-worth and thus set up community hierarchies to work for care and support? Resource books, openness about HIV and the OI that they generate. Is that enough? Not determined thru FGDs.

Folk theatre and drama is an excellent method as MSM love ‘drama’ and ‘theatre’. Humsafar Center’s most popular programs are ‘artistic’ programs like ‘fancy dress, Mr. India, Mr. Handsome, Dance and Nautch-Gaana competitions, etc. These are not just popular are immensely helpful in community formation.

## **BACKGROUND OF SEX TRADE AND MSM – THE COMMONALITIES**

The organized sex trade in Maharashtra has played a critical role in the spread of STIs and HIV, both in Maharashtra and in India. Commercial sex workers represented a high-risk group in terms of their behaviors, both from the point of view of infection and its spread. Organized brothels in Mumbai along with diffused commercial sex sites, coupled with the massive numbers of individual’s migrant to the highly developed state in search of work, have drastically impacted the spread of HIV throughout the country. The sex workers themselves also come from both within and outside the state.

Coupled with the sex trade and industrialization, social marginalization of groups such as sex workers, MSMs and hijras (Eunuchs) makes prevention efforts with these extremely vulnerable groups all the more difficult. Social norms and mores also make it difficult to broach the subject in wider society, particularly with women and young people. Generally in India and Maharashtra there is a negative, closed environment, not so conducive to health-seeking behaviors, information sharing, and open discussion about sex and sexuality.

**Knowledge and Attitudes to STI / HIV / AIDS and PLWHAs:** Overall, about three-fifth of respondents reported that they had heard of STIs. The percentage of MSMs aware of any STI and found at around 70% in Pune and Sangli as compared to about 49% in Mumbai and Thane. Amount MSMs who have heard of STIs, 38% in compared with about one-fourth of the respondents who reported the same symptoms in Mumbai and Thane. Only a small proportion of the respondents reported that they had a genital discharge during last six months before the survey (approximately 7%).

Nearly 85% of the MSMs interviewed are aware of HIV/AIDS. Among those who were aware of HIV/AIDS, 87% of those interviewed in Mumbai and Thane could identify consistent condom use as a method of reducing the risk of contracting HIV, as compared with 55% in Pune and Sangli. Only about 53% of all respondents however could correctly reject the two most common misconceptions about HIV / AIDS (that HIV can be transmitted by mosquitoes or by sharing meals with an HIV infected person).

Finding from the CAN suggest that there are many other incorrect beliefs. Although most MSMs have multiple partners, many believed that anal sex is not a dangerous behavior, since they have heard no mention of it in previous communication campaigns or materials about HIV/AIDS. As a result, they do not see the need to use condoms at all. Others believe oral sex is not risky as long as they do not swallow the semen. Still others use condoms erratically, believing they can identify “safe partners”. These erroneous beliefs increase MSMs risk of HIV infection; the risk is also increased due to behaviors described in the section below.

**Risk behaviors:** In terms of sexual history, about 6% of the MSMs interviewed during the BSS had their first sexual experience with any male partner before 11 years of age; however, the mean age at first sex with any male partner is close to 17. Most of the MSMs interviewed during the survey in both the study areas reported “friends” as their first male partner (40%). Nearly one-third of MSMs in Mumbai and Thane and 24% in Pune and Sangli reported a neighbor as their first male partner. About 20% of the respondents in Pune and Sangli and 12% in Mumbai and Thane had a relative as their first male sexual partner. About 22% of the MSMs were interviewed during the survey in both study areas report that sex with their first male sex partner was forced.

Very few MSMs interviewed both in Mumbai and Thane and Pune and Sangli reported having any regular male sexual partner. On the other hand, nearly 28% of the MSMs interviewed during the survey in Mumbai and Thane as well as Pune and Sangli reported to have sex (manual / oral / anal) with any male commercial partner and that nearly 25% of the respondents reported to have any male commercial anal sex partner during the last one month. Some 22% of the MSMs interviewed during the survey had multiple male commercial anal sex partners during last 30 days before the survey.

The reported number of non-regular partner among MSMs is much higher than their reports of regular and commercial partners. The BSS data indicates that the percentage of MSMs with multiple male non-regular anal sex partners in the last one-month was as high as 75%. As many as 92% of the MSMs interviewed reported having multiple male anal sex partners during the last one month before the survey.

With regards to condom use, the pattern was generally inconsistent, and reasons for inconsistent or non-use was largely due to the belief that condoms are not necessary. Another important reason reported by MSMs is that condoms are not easily accessible. Overall, 58% of the MSMs who had at least one male commercial sexual partner during the last one month before the survey reported using condoms the last time they had anal sex with a male commercial partner. Also, about 73% of the “last time condom non users” in Mumbai & Thane and 50% in Pune and Sangli reported that they did not like using condoms. About 26% of the respondents in Mumbai and Thane who did not use condoms in the last sexual act with a commercial partner mentioned “partner’s objection” as the reason for not using condoms last time. Overall, about 36% of the respondents, who had at least one male non-regular partner in last one month before the survey, reported using condoms every time they had anal sex with their entire male non-regular partner during last six months survey.

In term of alcohol consumption and substance abuse, there were slightly higher rates of alcohol consumption as compared with other populations groups studied. Overall, nearly three-fifths of the MSMs interviewed during the survey were found to have ever consumed alcohol. Approximately 8% of the respondents reported to take alcohol every day in the past one month before the survey. Overall, about 14% of the MSMs interviewed during the survey reported to have ever tried any drug, the proportion being significantly higher in Mumbai and Thane (22%) compared to Pune and Sangli (6%).

When discussing MSM behaviors, we cannot forget that there are several men, within and outside of those who self-identify as MSMs, who practice anal sex with men. There is anecdotal evidence of significant levels of MSM activities in areas where large numbers of men are congregated (e.g. migrant labor slums, college hostels, army/navy/military, etc). There are also many heterosexual men who have anal sex with both men and women, and it is known that anal sex is the most risky practice in terms of HIV. These issues should be mainstreamed into all communication activities in HIV prevention, and further research on the subject should also be conducted.

### **COMMUNICATION PROFILE:**

Media Use, Access, and Preferences: The MSMs in the studies were avid consumers of media and had much to say about it. They enjoy portrayals of active, muscular men and appreciate films showing gay or lesbian life, because they feel these increase the general publics understand of their situation. MSMs who work directly with them do a good job in communicating through posters, pamphlets, media and interpersonal events targeted to them, as well as in condom distribution and instruction in condom use. MSMs continue to need targeted communication. The importance of condoms for anal sex needs to be included in all HIV/AIDS prevention communication, not only for identified MSMs but also in communication with the general population.

### **HIJRAS**

The CAN is the only study of the five that looked at Hijras as a specific group, separate from MSMs. For this reason, there is only descriptive information and some findings on their communication profile available and summarized below. Clearly, more research is needed to better understand this group that is highly vulnerable to HIV infection.

**Description:** The hijras of India are a religio-ethnic community who renounce male sexuality, identify with the creative power of the Mother Goddess (Renuka or Yellamma) and with Shiva. The traditional occupation of a hijra is a performer. They are known by various terminologies in India. In Maharashtra they are called Khala, Janana, Gandu, Khoja, Baila, Mamu, Gandu, Mausi. The majority of Hijras is born biologically male, but has the option of astration. The castration is not compulsory through generally, castrated hijras are accorded higher status within their community. For the most part, hijras are forbidden from having contact with the outside world. Their significant relationships are with their guru, or nayaks. Unlike a cult with a single guru, the Hijra community has thousands of gurus, each of whom in turn has a guru. About half of all hijras are someone's guru. The guru takes responsibility for the welfare of the chela, or student, and the chela promises loyalty and obedience to the guru.

Between peers, hijras have relationships akin to mother-daughter to sister-sister relationships. Most hijras also have one or more “mothers”. Unlike a guru-chela relationship, the “daughter” is not bound to a specific rule of obedience, but the relationship is one of mentor-mentoree. Like one can have “mothers” one can also have “sisters” – people who are of equal rank, and who want to declare to the community that they are close friends. This declaration is also a single that no one should attempt to come between them.

The two major categories of hijras are satla-kotis and jogtas. Satla-Kotis are effeminate homosexual men from India who dress up as a woman, marry and perform a role of wife. Firiyas / Pantis (Straight looking gay men) are men who have sex with kotis, dress, act like ‘real man’, and perform the role of husbands to their koti. They have their own language called the koti rivaz, which is adapted from the hijra community, which they often lapse into when they are together. The jogta is the male equivalent of the devadasi. Like the devadasi system in western India, the jogta tradition arose from the need of the priestly class to keep a firm hold over the caste system that is prevalent in Maharashtra and all over India. Jogtas are the keepers of temples dedicated to the Goddess Renuka or Yellamma. Young boys are offered to the deity for prayers granted by their families. The priests exploit the jogtas for work at the temple (like cleaning) and also as their personal domestic help. In short, they are like bonded labor. At the same time, quite often these individuals decide to become a jogta on their own accord.

Jogtas claim that they are treated with more respect compared to other hijras. Like other eunuch sub-communities, the jogtas too have a cohesive community. They however, do not change or choose their ‘guru’(The leader / head of the clan) – tradition binds them to a stronger sense of loyalty. The jogtas also do not go clapping or begging for alms or singing / dancing during religious and other functions. Unlike the majority of hijras, the jogtas can also marry women and lead a family life, sustaining themselves on offerings at the temples and at festivals. Although there is no restriction on taking up a respectable vocation, many of them resort to sex work because of their financial condition. This is a segment that is very prone to getting HIV / AIDS due to professional hazard and little knowledge regarding the disease.

**Risk Behaviors:** Hijras in this study said condoms were not used with their permanent partners, and that alcohol was frequently consumed, increasing their risk of unsafe behavior. The strong desire most Hijras have to feminize themselves (through expensive sex change or breast implant operation) may make them take risks if extra money can be earned through sex without condoms.

#### **Communication Profile:**

Media Use, Access and Preferences: This assessment shows that Hijras unique life style presents special needs and great opportunities for communication with regards to STIs / HIV/AIDS. Most importantly, hijras noted that it is essential that messages and information come from within their own community. They were adamantly opposed to outsiders coming in and conducting programs or interventions among them. Due to their closely-knit community and somewhat structured social order, they are much more comfortable with peer educators from within or possibly messages / programs coming from their gurus or nayaks. Hijras have many ideas about how more effective STIs/HIV/AIDS prevention communication could be done among them to meet their needs. They do not believe that television is best medium for transmission of messages directed towards them.

## Behavior Change Communication (BCC)

Specific, well-researched, multi-media interventions need to be strengthened in Maharashtra to bring about primary behavior change. These approaches must be rooted in community or key group perceptions and beliefs and must involve these groups in their formulation and execution, especially where the object is common norm change. Often the “hidden norms” on sexual behavior matters are not openly recognized and conflict greatly with the stated or public norms of community members and commonly “gatekeepers”.

The participant analysis, above, provides an outline of those involved in the program of behavior and social change at the community level for such sub-program. For HIV/AIDS prevention and care in Maharashtra, the list of potential audiences is long and has to be segmented for each issue, as noted above and on the matrices that follow.

**Possible strategies:** Behavior development and behavior change and social change is possible through strategic communication interventions that are well founded on research and involve those most affected. The strategies reflected on the planning frameworks that follow include;

**Participatory methods at the community level:** Participatory Learning and Action methods, which involve community members in mapping the problem according to their own perceptions or Appreciate Inquiry methods, that start from the community’s positive strengths and the history of dealing with similar threats. It appears that in Maharashtra, this kind of communication intervention has been under-used and programs need to acquire new skills to do it well.

**Entertainment education through radio, television and print:** Many Maharashtrians can be reached through mass media and programmers have planned for an expansion of these efforts in the plans outlined below. Entertaining TV and radio formats such as drama, variety shows, animation and other formats, such as music videos and comic books, can be employed to inform and motivate people. Such methods can be used to address stigma, to communicate specific prevention messages in a balanced “ABC” approach, to underline the need for care and support and to create demand for services, such as VCT and STI diagnosis and care.

**Use of community – level media channels:** Entertaining formats will also be used at the community level through video shows, theatre, music, dance, story telling, games, etc. are all possible channels that need to be expanded for the fight against HIV/AIDS. Many NGOs are already involved in such methods. It should be noted however, that it is difficult to control message quality and integrity through such channels and that “grass roots” programmers must be trained in these issues. Training standards and monitoring is requested is required to achieve quality and integrity of messages and to control “system loss” when techniques are passed on from one organization to another to lower levels. Further more, interchange with audiences on the issues is needed after theatre or video shows in order to capitalize on their learning and attention. Very often, it is this discussion and reflection that furthers knowledge and attitudes changes, inducing self-reflection and behavior change.

**Interpersonal communication and counseling:** It is noted that in Maharashtra a great deal of attention is needed to strengthen this channel, especially in relation to young people accessing services such as STD treatment, access to condoms and VCT services,

as they expand. All efforts in service expansion will fail if service providers remain unfriendly and uncommunicative. In addition, clients should be taught their rights to friendly service provision through appropriate communication strategies.

**Distance education:** In order to quickly reach health care providers and other field workers with the knowledge, motivation and skills they need for HIV and AIDS prevention, diagnosis and care, distance education through radio and TV is proposed. Such education can be carried out through popular, entertaining formats that have proven more effective than didactic methods. They will be backed by support materials for service providers.

**Balanced ABC media approaches:** New communication efforts should be linked to marketing concepts and principles to promote the sale of subsidized condoms. It is assumed that people will value and likely use condoms more if they actually purchase them. Plans are in place to increase this approach in Maharashtra. Generic marketing has shown to be effective in a number of countries and has increased sales of socially marketed brands. However, as the discussion has indicated above, it is important to develop an approach which properly segments audiences and delivers a balanced “ABC” message approach instead of focusing on condoms promotion alone. Condom-centric approaches have not proven successful in decreasing HIV incidence in many contexts.

**Life skills education:** Such systems may be in-or out-of school for youth Maharashtra has made a good start at developing a school-based system that should be strengthened and expanded. Components on gender equity and sexual debut, as well as an A-B must be emphasized, in addition to C-Condom use Parents must also be educated on the issues so they are supportive of the learning process their children are exposed to. Such approaches are also useful for community-level adult interaction and learning, including processes for key vulnerable groups. The participant in the strategy development workshop reflected on the possible use of packages such as the “Journey of Hope” facilitation kit from Ghana on “ABC” choices. The “Stepping Stones” manual for gender analysis for statewide adaptation. Similar packages are already in use in Maharashtra and should be considered for scaling up.

**Peer education:** One approach to building knowledge, motivation and life skills, peer education, is a crosscutting method in the detailed plans that follow. It is one of the most popular approaches for the workplace with youth and with vulnerable groups such as FSWs and MSM. However, peer education also requires a great deal of training and monitoring to be effective and issues such as sustainability of systems must be addressed. Youth peer educators, by definition, soon become too old to be peers and must be replaced. This has costly training implications. Peer education may be especially when integrated with friendly RH services for youth or other vulnerable groups. Balanced “ABC” approaches can be integrated into peer education.

**Workplace and outreach programs:** Reaching many of the vulnerable groups in Maharashtra requires that programs reach out into the places people work and live. Such approaches can more effectively reach both static workers, such as migrant workers in factories, as well as mobile workers and marginalized groups, such as truckers, street children and “floating” SWs.

**Hotlines and interactive ITC:** Telephone hotlines are already being used in Maharashtra to counsel people on risk behaviors, VCT and other services are available. The plans call for a scaling up of such activities. Likewise, since Maharashtra is a relatively well-resource state in communications infrastructure, interactive media that link informations, services and counseling through internet technology is recommended.

## **BCC**

### **Knowledge**

Percent of population with no incorrect beliefs about HIV/AIDS/STIs  
 Percent of population who know HIV prevention methods  
 Percent of population who can correctly identify at last 3 symptoms of STIs  
 Percent of population who know methods of preventing mother-to-child transmission of HIV.  
 Percent of the population who can identify nearest health service site (CT, DTI, RH)

### **Attitudes**

Percent of population with accepting attitudes towards PLWHA  
 Percent of population who perceive themselves to be at risk of HIV infection

### **Behavior**

Percent of population discussing HIV/AIDS, Sex and Sexuality  
 Percent of population who had higher risk sex in the last year  
 Percent of population who used a condom in last higher risk sex  
 Percent of men having commercial sex in the last year  
 Percent of population requesting HIV test, receiving a test and receiving test results  
 Percent of population appropriately diagnosed and treated  
 Percent of STI patents receiving advice on condom use and partner notification and referral to HIV testing services

<b>PROGRAM AREA : MSMs and Behavior Change Communication</b>
<b>OBJECTIVE I:</b> To increase correct knowledge on STIs/HIV/AIDS, and safe sex practices to improve motivation and develop skills for HIV prevention.
<b>OBJECTIVE II:</b> To increase condom use with all partners.
<b>OBJECTIVE III:</b> To decrease the prevalence STIs in MSMs.
<b>OBJECTIVE IV:</b> To improve the quality and availability of counseling, treatment and healthcare services available to MSMs.
<b>OUTCOME INDICATORS:</b>
<ol style="list-style-type: none"> <li>1. Percent of MSM who know HIV prevention methods (Measure).</li> <li>2. Percent of MSM with no incorrect beliefs about AIDS (Measure).</li> <li>3. Percent of MSM who perceive themselves to be at risk of HIV infection.</li> <li>4. Percent of MSM able to correctly identify at last 3 symptoms of STIs (CHW).</li> <li>5. Percent of MSM reporting condom use in the last sex experience and in all sex experiences with commercial, regular and non-regular partners.</li> </ol>

6. Percent of MSM seeking STI treatment from qualified healthcare professionals.
7. Percent of MSM requesting an HIV test, receiving a test, and receiving test results (Measure).
8. Percent of voluntary walk-in SWs tested and counseled at VCT centers.
9. Percent of MSM who can correctly locate the nearest VCTC, STI clinic and nearest condom outlet (CHW)
10. Percent of MSM with accepting attitudes among the population towards HIV positive persons and PLWHA (CHW / HCP)
11. Percent of qualifies HCPs reporting MSM clients.
<b>PRIMARY AUDIENCE:</b> MSM
<b>SECONDARY AUDIENCE:</b> Partners, spouses, HCPs
<b>TERITARY AUDIENCE:</b> Community and religious leaders, local police, local HCPs
<b>FIELD WORKERS:</b> Peer educators, counselors, outreach workers

<b>PROGRAM AREA: Care and Support Advocacy : PLWHA and HCPs</b>
<b>OBJECTIVE I:</b> To increase resources and treatments available to PLWHA (People Living with HIV/AIDS), and their families including support groups, treatments (Including antiretroviral therapies (ARTs) and other services.
<b>OBJECTIVE II:</b> To increase the involvement of PLWHA in care and support programming.
<b>OBJECTIVE III:</b> To improve the quality of counseling and treatment standards in health care settings (Private and Public) for PLWHA and for those getting tested including standardized, friendly, accessible and affordable services. Services should include STI/HIV treatment and prevention, HIV care and support services, VCTC services and general reproductive health counseling and care along with a strengthened referral network.
<b>OBJECTIVE IV:</b> To create non-discriminatory workplace policies.
<b>OBJECTIVE V:</b> To increase support for alternative systems of medicine in the treatment and care and support of PLWHA (People Living with HIV/AIDS), and their families.
<b>OBJECTIVE VI:</b> To increase support for search on best practices in care and support including home and community-based care.
<b>OBJECTIVE VII:</b> To sensitize and influence communication agencies, NGOs, Government agencies and other launching communication programs to have more effective, well-researched and responsible communication messages that seek to reduce stigma and discrimination against PLWHA.
<b>OBJECTIVE VIII:</b> To sensitize the media and media gatekeepers to increase accurate reporting on HIV/AIDS issues, portray responsible sexual behavior in their programming and sensitively project images of people living with HIV/AIDS.
<b>OBJECTIVE IX:</b> To increase the number of trained providers managing HIV/AIDS patients at home.
<b>OUTCOME INDICATORS:</b>
1. Increased resources available including new treatments for PLWHA.
2. Number of new services offered to PLWHA.
3. Proportion of PLWHA involved in programming.
4. Quality standards of care established and disseminated.
5. Number of health facilities with the capacity to deliver appropriate care to HIV infected patients.
6. New policies written (anti-discrimination, quality of care and support)

<p>7. Number of articles, shows or spots (radio and TV) with accurate, sensitive reporting regarding PLWHA.</p> <p>8. Number of primary care givers trained in managing HIV/AIDS patients at home.</p>
<p><b>PARTNERS:</b> Health care administration (Public and Private), MOHFW, Government, MSACS, MDACS, AVERT, HCP, NGOs, policy and decision makers, donors, medical associations, communication agencies, religious leaders / associations.</p>
<p><b>ALLIES:</b> Media, Educational Administrators, Industries (Including CII), informal labor sector, cooperatives (sugar, cotton and milk), celebrities, politicians / political parties, National human rights commission, National commission of women, pharmaceutical companies, Judiciary, law enforcement agencies.</p>
<p><b>GATEKEEPERS:</b> Health care administration (public and private), MOHFW and other ministries, hospital trust, media, politicians, religious bodies, law enforcement agencies, officials in the unorganized labor force, cooperatives.</p>

Strategic Communication Model

