Draft Document based on the first Working Group Meeting Of Communication, advocacy and Social Mobilization Group

Participants list

Sh Mayank Agrawal, Former JD(IEC), NACO- Convener
Ms Akhila Sivadasa, CFAR- Chairperson
Dr Brijendra Singh, NACO
Sh Rajesh Rana,NACO
Ms Prachi Garg, NACO
Sh. Sudarshan Negi, TSG (Condoms)
Ms Sonalini Mirchandani, Communication Hub
Sh. Ashish Singh, BBCWST
Ms Sanjanthi Velu, JHU-CCP
Dr Ilenchezian, APAC
Sh Rajeev Verma, MASA
Ms Devaki Nambiar, PHFI
Ms Nirupama Sharma, Consultant
Sh. Amitav Bhattacharya, Banglanatak.com
Sh Sanjeev Kumar, Consultant
Ms Vasudha Rao, TCIF
Sh Rudrajit Das, UNICEF
Nandini Pillai, Nossal
Sh J.S.Yadav, CMF
Bilal Ahmed, NACO
Sh Anand Tiwari, UNAIDS
Madhu Sharma, NACO
Kamlesh, Consultant
Suresh Nair, JHU-CCP
Ruchi Lall- AIDSTAR-ONE
Vibhu Garg- AIDSTAR- ONE
David Hausner- AIDSTAR- ONE
Sharada Prasad- AIDSTAR- ONE

A PARADIGM SHIFT FOR NACP IV: STRATEGIC COMMUNICATION

To begin with, we wish to highlight the overarching importance of **strategic communication** as an approach appropriate to achieving NACP IV's goal of *'Accelerating Reversal and Integrating Response'*

What does strategic communication mean? It means recognizing the centrality of an agenda and a master plan while defining and determining communication initiatives and efforts. At one level, then, we are focusing on communicating the best message, through the right channels, measured against well-considered organizational and communications-specific goals. At another level we are also stating that decisive outcome, such as reversal of the epidemic and integration of response, is not possible if key constituencies from communities most affected by the epidemic, service providers, program implementers and policy makers do not see the benefit of pursuing the key goals of the programme, enhance engagement, make decisive personal choices and taking positive actions to achieve better health. As such communication is not strategic if it only informs; it must also mobilise, advocate and reform.

Strategic communication is more than just ensuring the mandate to be cross-cutting and integral. It is about shaping an agenda, having a plan and not just responding or reacting and more importantly being able to unify the programme, despite its hierarchical design or in-built priorities, key components and related components and ensure proper allocation of efforts, including explaining contradictions, crisis and internal dynamics of the programme. It must ensure that accurate information is communicated to ensure that the intended meaning emerges for diverse audience and an ownership is created. More importantly, it recognizes the key role of a strategic framework in order to integrate cross-cutting principles such as gender equality, human rights of marginal populations, social inclusion, guaranteeing continuum from prevention, care and support for treatment and recognizing HIV as a development issue.

In making this shift from an Information-Education-Communication to a Strategic Communication approach, NACP IV will go beyond programme communication, focus on structural barriers caused by violence, social exclusion, development and social divide and the hierarchical systems of privileges and social marginalization. Today we need to unify the message but also ensure the right synergy between the priorities perceived by communication and those perceived by the programme. And that they become indivisible when it comes to identifying the Key Faces and Key Voices of the programme.

WHAT WORKED AND DID NOT WORK IN NACP III

The goal of NACP III was to halt and reverse the HIV epidemic in India. To this end, the goals of Information-Education-Communication (IEC) efforts centred around motivating behaviour change among populations identified as "at risk;" raising awareness and risk perception of HIV and condom use among youth and women in the general population; generating demand for health services; and creating an enabling environment for prevention, care, and support.

In preparing its vision for the role of communication in NACP IV, the Working group on IEC noted some progress made towards these goals and identified gaps during this period, summarized as follows:

Guidelines made, but capacity building/implementation weak and unmonitored
Operational guidelines were developed, detailed Annual Action Plan formats were introduced at the SACS level and efforts made to consolidate one state plan…
BUT…
regular trainings could not be conducted to upgrade the skills of the IEC officers both at national and state levels. Further, greater synergy was needed between the IEC plans and plans of other programme components.

Rollout Synchronisation effort and key partnerships developed, but material dissemination not smooth
A professional media-buying agency taken on board for optimizing media planning, implementation and monitoring.[1] A national campaign calendar was introduced to synchronize roll out of mass media campaigns with mid-media, outdoor, inter-personal and ground mobilization…
BUT…
Supply of campaign design and materials to SACS required streamlining to avoid delays in program roll out.

Multiple target populations reached, but some unevenly, some not, while others are emerging
Theme-wise IEC materials were developed and distributed to address different population segments such as HRGs, bridge populations, youth, women, PLHIV, etc. and in particular, to promote service utilization (i.e. Integrated Counselling and Testing Centres (ICTC), Antiretroviral treatment (ART) centres, and Sexually Transmitted Infection (STI) clinics)…
BUT …
Systematic data are lacking (see next point); available data suggest wide variation in

[1] Campaigns were developed thematically to cover different programme components such as condom promotion, voluntary counseling & testing, PPTCT, ART, STI, HIV-TB, blood donation, stigma & discrimination.

awareness levels among and within states, between men and women, rural and urban areas on multiple indicators. Moreover, little materials exist for key vulnerable populations such as trans-genders as well as they do exist, at least in some states other key target groups such as family members of PLWHA, and a growing number of young adults and adolescents.

Some but only sporadic participation of these community groups in the designing and development of the materials.

Some community led processes of IEC message development were successfully initiated and completed, i.e. communication materials and software (videos and other multi-media) were produced by and for the "at-risk" groups (TGs/MSM/sex workers),, focussing not just on didactic behaviour-change messages but talking about their communities, their difficulties, and a move towards empowerment…

BUT…

These efforts were few and not sustained, and have not been mainstreamed either in NACO's practices or acknowledged in the general population. Rather than producing new media software, focus should be on disseminating and expanding the reach of existing software developed through community-led and driven processes on mass and local media

Partnerships for legislative HIV advocacy established with some gains, but some topics and concerted action elusive

Legislative fora have emerged in various Indian states for raising awareness around HIV. Importantly, moreover, NACO put its support behind a larger legislative move petitioned by civil society related to sexual minority rights …

BUT…

Many legislators hesitant to address more stigmatising aspects of HIV and wider acceptance and endorsement of sexual minority rights. Overall the advocacy element needs to be strengthened and should be a major focus of activities going forward.

Monitoring and evaluation prioritised, but operationalization at field and systems levels needs to be streamlined

Indicators were developed and included in the Surveillance and Information Management System (SIMS) and many campaigns evaluated on Knowledge Attitude Practice indicators…

BUT…

Field level monitoring and data reporting and flow requires streamlining. Documentation needs to be strengthened so that the best practices and initiatives at the SACS level do not go unnoticed.

Outlines of change for NACP IV

In looking at what has been accomplished to date, it is important to take into account the changed scenario of HIV in India currently, and, importantly variations with regard to the epidemic and local context across regions and populations in India. With this in mind, we propose the following broad principles:, . **This is**

1. Institutionalisation of strategic communication through transparent, participatory and quality processes, ensuring continuity between guidelines and capacity building, between planning and dissemination, and between prevention and treatment, prioritizing key populations (such as women, transgenders, prisoners, street children and/or care-givers) and topics (such as stigma, service demand generation, and integration with livelihood and economic security)

2. Emphasis on generating and utilising evidence beginning with systematic communication needs assessments in high and low prevalence states and districts, conducting research throughout program life cycles (formative, monitoring, summative), as well as, importantly, disseminating findings in the public domain, and translating findings into actionable points and principles for stakeholders mentioned in 1.

3. Integration of the strategic communication paradigm with other focal points and key stakeholders in NACP IV from the initial stages of drafting NACP IV, through to program operationalization, implementation, and evaluation. In particular, ensuring synergy and convergence across NACP components and integration of NACP in a larger (universal)[2] health system framework.

This implies:

Addressing marginalized segments – Special efforts will be made to address the populations that are at higher risk but remained largely unreached during NACP-IV such as sexual minorities, OVC, street children, children at railway stations, minors engaged in sex work, prison inmates, hidden and mobile sex workers.

Deepening Engagement with the communities – The target populations will be involved at various stages i.e. from the development of communication tools and interventions to feedback to ensure a more responsive and decentralized approach. The planning and delivery process, both at the NACO and SACS level will be calibrated accordingly.

Integrated and comprehensive approach - Linkages between communication programmes and service delivery will be central for effective communication. Networking with NRHM and other health & relevant ministries will be the key in NACP IV.

[2] Here we take note of the larger direction of India's 12th Plan, which is orienting itself towards achieving universal health coverage.

Advocacy – Advocating with policy makers to ensure that 'structural issues' in programmes are addressed and HIV is mainstreamed into stake holding ministries and departments would also be stepped up. Further, advocacy with the media, civil society groups, religious bodies, industries (engaging both formal as well as non-formal sector workers) would be carried out to further strengthen the partner base to reach out to the general population.

A Gender-based response to HIV - The communication strategy will consider an expanding view of gender and sexuality (going beyond male/female binaries), risk as societal vulnerability, gendered experiences of living with HIV/AIDS, gender norms and stereotypes, including caregiving roles and intra-household dynamics, individual HIV/AIDS related health –illness or death within the family, and responses to the epidemic at individual, community or national level. Messages will be tailored to all genders so that the onus is not left only on women and sexual minorities, especially in issues such as condom negotiation as male condoms are easily available.

The way forward

Some key areas that need to be deliberated at the regional consultation and the second meeting of the Working Group before a five-year strategic plan for Communication Plan emerges. These are:

- What are **aspects of the epidemic** in your region/population that are important for us to consider now, from a communication standpoint (who is especially vulnerable? Who is not being reached?)
    - What sub segments are emerging with special communication needs and requirements within the broader high risk / vulnerable segments
- What are **aspects of epidemic response** in your region/population that are important for us to consider (in terms of keeping them, building them, changing them, etc. Who's been reached? Who's doing the reaching out?)
    - Experiences with communication processes at the ground level- interpersonal communication, interactive mid media communication, and such like
    - Communication interventions that were seen to be impactful, sensitive, and memorable, and conversely those that inadvertently enhanced stigma or generated misgivings
    - Continued challenges perceived in the communication context- barriers, and proposed methods to overcome these
- What is the **goal** you envision in the next 5 years?
    - How much progress has been made to date towards this goal?
- What are the **key themes for communication** in the next 5 years (eg. Stigma, social protection, PPTCT, legal reform, HIV and livelihood, early treatment, Tis)?
- What kind of **an (enabling) environment makes communication work**? (eg. norms, social structures, power dynamics, legal structures, other ministries, departments, etc.)
    - Are there/what changes in your region (do) you anticipate/fear will arise during NACP IV?
    - What kind of communication institutions and relationships need to exist to support your work/priorities
- What **evidence** is missing that is relevant to communication?
    - Are there best/poor practices in communication (types of studies, methodologies, partners, dissemination) we should know about?
- How (**with whom) do we follow up** if we have questions?
    - Consider how to establish longer term networks and lines of communication/feedback

Preliminarily, subject to regional consultations across groups and with civil society as well as additional meetings of this working group, we propose the following activities:

- Communication Needs Assessments (in most of the states were last conducted in 2003-04) to have updated assessment of the message requirements of the target audience (segment-wise and geographically), sources of information, channels for communication, media habits, knowledge levels, risk perceptions, influences and opinion leaders, barriers

and motivators to change. It will also help develop a better understanding of link between message design and reception by the communities on the current IEC materials for making necessary changes and will be done through community participation. The CNAs should be ideally completed before the launch of NACP-IV.

- Communication planning at the district level, with activities planned based on vulnerability analysis, vetted at the state level by the state plans should be by all stakeholders
- Use of a variety of communication channels especially new media such as mobile phones, internet, electronic information kiosks, local cable, community radio and cinema advertising in sync with traditional mass media i.e. TV, radio and newspapers.
- Regular campaigns with on-ground mobilization of people through interpersonal activities supported by mid-media and outdoor interventions
- Strengthening of inter-personal communication component of TIs, ICTCs, ART centres, STI clinics, CCC and DIC
- Maximise reach through folk media, IEC Vans, Rural Exhibitions etc, integrating messages with Bollywood and other popular film/ folk songs.
- Development and implementation of evidence-based, target population and area specific strategies to address changing communications needs
    - Focused and intensified BCC interventions for socially and epidemiologically vulnerable groups.
- Collaboration, training, oversight (vigilance), and support of the media (i.e. press)
- Convergence with Health Missions (National Rural Health Mission and the incumbent National Urban Health Mission) and other convergence and mainstreaming missions
- Placing special emphasis on stigma and discrimination through active endorsement of and solidarity with Greater Involvement of People with AIDS (GIPA)
- Effective monitoring through use of the yearly calendar, monthly meetings at the state level, integration of annual action plans on IEC with other state plans, and prioritization of districts based on monitoring inputs.
- Development of key indicators for evaluation on behavior change (awareness, usage of services, knowledge level, risk perception, attitudes, practices); advocacy with media, religious institutions, ministries, corporate sector, public private partnerships and legislative bodies; social mobilization, gender equity, service utilization, health outcomes, as well as stigma and discrimination
- Training and capacity building of NACO, SACS and strategic management on strategic communication including program management from inception to dissemination, evidence use and generation, monitoring and evaluation
- Decentralized training and ongoing support for frontline educators and counselors on strategic communication, various IEC materials, in addition to support for mobilization and advocacy