NATIONAL AIDS CONTROL PROGRAMME

HIV CARE AND TREATMENT CAMPAIGN

Concept Note

1. Background

HIV continues to spread worldwide. According to UNAIDS report of 2011/2012, about 34 million people were estimated to be living with HIV worldwide, with 69% of those residing in sub-Saharan Africa (SSA). Out of the reported number of people living with HIV in SSA in 2011, 1.8 million of those were new infections.

Currently, Tanzania is experiencing a mature, generalized HIV epidemic, with pockets of super epidemics in key populations. An estimated 1.6 million people are living with HIV in Tanzania. There has been a notable decrease in HIV prevalence as reported by HIV indicator surveys, with a declining trend from 7% (THMIS, 2003-2004) to 5.7% (THMIS, 2007-2008) to 5.1% (THMIS, 2011-2012), most recently.

The initiation of the care and treatment program in 2004 has contributed significantly to the reduction in overall morbidity and mortality related to HIV and AIDS. The number of health facilities providing HIV care and treatment services has increased from 700 in 2008 to 1,029 by June 2014. As of September 2014, about 1,486,402 PLHIV were cumulatively enrolled into HIV care and treatment services (1,371,887 adults and 114,275 children). The cumulative number of PLHIV on ART during the same reporting period was 985,259 (910,860 adults and 74,399 children).

According to Tanzania's National Health Sector HIV and AIDS Strategic Plan III, there is a target to reach 90% (or 1,068,799) of eligible PLHIV on ART by the end of 2017. Moreover, the global mission is to achieve three zeros by 2015: zero new infections, zero HIV and AIDS related deaths, and zero stigma and discrimination. In 2014, the UNAIDS announced the need for three 90s: 90% of all people are tested and know their HIV status, 90% of eligible PLHIV are initiated on ART, and 90% of PLHIV on ART become virally suppressed. In addition, the Care and Treatment Campaign Task Force and USG Interagency Technical Team for HIV treatment have identified adherence and retention, treatment literacy, and paediatric HIV as priorities for Tanzania. These targets will need significant, coordinated efforts from stakeholders in order to reach the intended goals.

2. Rationale

For the past twenty five years, the health sector in Tanzania has concentrated on creating public consciousness on HIV and AIDS as well as providing services for prevention, care, treatment and support. Recently, educational programs on HIV and AIDS through mass media have reached 48 percent of men and 62 percent of women among the adult population (THMIS, 2012). These efforts have unquestionably lead to raised levels of HIV and AIDS general knowledge/awareness to over 90% in the adult population (DHS, 2010; THMIS, 2012). Furthermore, social and behavior change communication interventions have been shown to be

effective in improving a number HIV-related outcomes, including ART adherence and retention (HC3 HIV and Health Communication Evidence Review, 2015).

ART serves as both a prevention strategy against new HIV infections, as well as a treatment strategy for reducing AIDS-related morbidity and mortality. Near perfect adherence, defined as 95% adherence or higher, is required for treatment efficacy. Failure to achieve optimal adherence can result in treatment failure and/or ART resistance, which could in turn require regimen changes that increase treatment costs, decrease one's quality of life, and/or lead to progression to AIDS.

However, adherence and retention of ART-eligible clients has been a significant challenge in Tanzania. Barriers to adherence and retention include stigma, lack of social support, side effects from ARVs, lack of food, depression, alcohol use, ineffective referrals, long wait times at health facilities, and costs related to transport to health facilities, among others. Clients are often lost to follow-up, and, given scarce resources and overburdened health systems, it if often difficult to trace defaulters. Adherence counseling, disclosure to family members, social support, having a treatment supporter that reminds one to take ARVs, and alarms/reminders, on the other hand, have been shown to improve adherence and retention.

With improvements in paediatric care and treatment, an increasing number of children infected with HIV are surviving through childhood and into adolescence. However, adherence and retention in care and treatment remain critical issues, with disclosure to children by their caretakers noted as a major barrier. Many children take their ART without knowing why. As a result, they cannot participate fully in their own treatment and illness prevention, and are unable to take responsibility for their own treatment in the event of parent or caretaker death. Additionally, children who are unaware of their status are not able to develop their own adherence strategies, are not self-motivated to adhere to treatment, and do not view adherence as a shared responsibility. Children who are told their status, have a committed treatment supporter, and have social support, on the other hand, have been shown to have improved psychological wellbeing and rates of adherence and retention.

Given the above, the role of supporters of children, adolescents, and adults living with HIV has become paramount.

3. Vision

The National AIDS Control Program (NACP) and the Tanzania Commission for AIDS (TACAIDS) seek to design and implement one coordinated, branded, national, multi-channeled HIV treatment campaign targeting supporters of PLHIV and PLHIV themselves that is rolled out by all stakeholders in targeted geographic locations and health facilities.

4. Campaign Goal

Contribute to the national target of 90% of PLHIV on ART virally suppressed by the end of 2017 by increasing the proportion of adult and pediatric ART clients retained in care and treatment and adherent to ART and appointments.

5. Target Audience

a. Primary Audience

- Supporters of PLHIV (e.g. family, friends, employers, neighbors, caregivers of children and adolescents on ART, teachers)
- PLHIV (e.g. adult, paediatric, pregnant and lactating women)

b. Secondary Audience

- Health providers (e.g. CTC)
- PLHIV support groups
- Community volunteers, village health workers, peer educators
- RHMT/CHMT
- Community leaders (e.g. political, spiritual, religious, traditional healers)

6. Communication Objectives

Phase I[1] of the campaign will focus on the following knowledge, attitude and behavioral objectives:

i. Increase the % of **supporters of PLHIV** who:

- Know the importance of adherence to ART
- Remind PLHIV to take ARVs at the right times and in the right ways
- Assist PLHIV to attend scheduled appointments and tests
- Disclose HIV status to HIV positive children and adolescents
- Have non-stigmatizing attitudes toward PLHIV

ii. Increase the % of **PLHIV** who:

- Disclose their HIV status to at least one treatment supporter
- Attain 95% or higher adherence to ART
- Attend scheduled appointments and tests

[1] Future phases are dependent upon continuation of the campaign through a follow-on social and behavior change communication project, and/or transition of the campaign to other partners or donors. It is envisaged that future phases would extend the campaign target audiences, and geographic scope.

7. Theoretical Framework

The campaign will be grounded in theories of **social support**, under the premise that increased levels perceived and enacted support will result in increased levels of adherence and retention. Sample constructs of enacted support, adapted for the ART adherence and retention context from the Inventory of Socially Supportive Behaviors (Barrera, Sandler & Ramsey, 1981), include:

- Directive guidance (e.g. suggesting an action you should take, such as joining a support group)
- Nondirective support (e.g. expressing interest and concern in your well-being)
- Positive social exchange (e.g. talking with you about some interests of yours)
- Tangible assistance (e.g. giving you a ride to the health facility)

The campaign will also be based in the **Social Cognitive Theory,** which emphasizes the importance of 'reciprocal determinism' (Bandura, 1986). While environmental factors influence groups and individuals, individuals and groups can also influence their environments, and regulate their own behavior. The theory considers both a person's individual capacity to interact with their environment, as well as the capacity for *collective action* to bring about a desired outcome within a particular group. A key component of the theory is *observational learning*, in which one learns to perform new behaviors by exposure to interpersonal or media portrayals of the behaviors, especially through modeling by peers whom the observers feel are similar to themselves. Attention, retention, production, and motivation are important processes within observational learning.

Based on these theories, the campaign approach will be to model ways in which the target audience can provide support to PLHIV.

8. Behavioral Determinants

i. Challenges to Adherence and Retention

- Stigma
- Lack of social support
- Side effects
- Disclosure of HIV status (e.g. by PLHIV to supporters, and by caretakers to HIV+ children/adolescents)
- Lack of food
- Depression
- Alcohol use
- Sharing of ARVs by PLHIV
- Collecting of ARVs on behalf of others
- Ineffective/inefficient referrals/linkages when clients transfer
- Long waiting times at health facilities
- Inadequate counseling
- Costs related to transport and long distances to health facilities

i. Facilitators to Adherence and Retention

- Adherence counseling
- Disclosure to family members
- Social support
- Alarms
- Having a treatment supporter to remind one to take ARVs

9. Communication Channels

The campaign will be driven primarily at the community and health facility levels, supported by reinforcing mass media messages that model ways in which the target audience can support PLHIV.

i. Community-level

- Community resource kit (CRK) module on HIV treatment, implemented by TCDC's existing networks of CBOs and community change agents (CCAs)
- Distribution of print materials by implementing partners' existing structures (e.g. PLHIV support groups, peer educator/treatment supporter networks, CBOs/NGOs, etc)
- Promotional materials (e.g. t-shirts, give-aways)

ii. Health facility-level

- Provider job aids (e.g. to support adherence counseling)
- Posters
- Client and supporter print materials (e.g. brochures on how to be a supporter)
- Referral cards
- mHealth interventions (e.g. appointment reminders, adherence tips/information)

iii. Mass media

- Radio spots targeting supporters of PLHIV
- Radio magazine programs on local radio stations (e.g. interviews with health providers, testimonials from PLHIV)

10. Key Message Content

- Disclosure: Benefits of disclosure, importance of disclosing to HIV+ children, tips on how to disclose, how to respond to someone that discloses HIV status
- Importance of adherence
- Roles of treatment supporters and tips for adherence support, e.g.
    - Encourage anyone you know who is living with HIV to go to the CTC

- Remind PLHIV to take ARVs consistently, at the right time and in the right way – even if there are other health problems affecting the client
- Assist in procurement and/or preparation of food and a balanced diet
- Encourage and assist PLHIV to attend scheduled appointments and tests
- Accompany the client to the health facility
- Assist with transport to the health facility, support group, etc
- Encourage PLHIV to join a support group
- Help out if the client falls sick
- Encourage targeted HIV testing for sexual partners and children of PLHIV
- Discourage risky behavior, e.g. such as alcohol use, unprotected sex
- Report any transfers in health facilities, or death of the client

- Side effects: Possible side effects, importance of reporting side effects to health provider, how to manage them, that they typically subside over time
- PHDP: Discordance, targeting HIV testing of family members and sexual partners of PLHIV, risk reduction behaviors

11. Tone

Empowering, uplifting, encouraging, supportive, inspiring, united, helpful, non-stigmatizing

12. Geographical Coverage

Health facility and community level interventions will be given special emphasis in high yield sites in high HIV prevalence regions to start, with the potential for expansion as partner collaboration and funding allows. Phase I priority regions, listed in descending order of HIV prevalence according to the 2011-2012 THIMIS, include Njombe (14.8%), Iringa (9.1%), Mbeya (9.0%), Shinyanga (7.4%), and Ruvuma (7.0%). Phase II regions include Dar es Salaam (6.9%), Rukwa (6.2%), Pwani (5.9%), Katavi (5.9%), and Tabora (5.1%). Mass media interventions will be national in scope.

13. Monitoring and Evaluation

A full RM&E plan will be developed under the Treatment Campaign Task Force. Illustrative indicators and data sources are given here.

Indicators

- % of PLHIV that have disclosed their status to at least one treatment supporter
- % of caregivers that disclose status to HIV+ children/adolescents
- % of PLHIV that report receiving support from a treatment supporter
- % of people who report knowing someone living with HIV with accepting attitudes toward PLHIV

- % of people who report knowing someone living with HIV that report providing support to HIV
- % of eligible PLHIV on ART retained on appropriate ART regimen

Data Sources

- Quarterly tracking of campaign reach, recall, knowledge, attitudes, behaviors through omnibus surveys
- Media monitoring
- CBO/NGO reporting of numbers reached through community outreach activities
- Health facility data
- PLHIV exit interviews

14. Timeline

- CRK training and implementation: July 2015
- Mass media: September 2015
- National event: November 2015