



**I CAN**

**PROGRAM TOOLKIT**

# I Can Program Toolkit Table of Contents

<b><u>I. Introduction</u></b>	<b>4</b>
<b><u>II. Purpose</u></b>	<b>5</b>
<ul style="list-style-type: none"> <li>• What is the I Can toolkit?</li> <li>• Who is this for?</li> <li>• How to use the toolkit</li> </ul>	
<b><u>III. Key Considerations for Introducing or Scaling Communication Campaigns to Improve ART Uptake and Adherence</u></b>	<b>6</b>
<ul style="list-style-type: none"> <li>• U=U and I Can</li> <li>• Assessing Readiness</li> <li>• I Can and Condoms</li> <li>• Roles in running an I Can Campaign <ul style="list-style-type: none"> <li>o Considerations for Governments</li> <li>o Considerations for Funders</li> <li>o Considerations for Advocates</li> <li>o Considerations for Implementers</li> </ul> </li> </ul>	
<b><u>IV. I Can Campaign Research, Design, Monitoring and Evaluation</u></b>	<b>12</b>
<ul style="list-style-type: none"> <li>• I Can Campaign Goal</li> <li>• I Can Campaign Objectives</li> <li>• Research to Support the I Can Campaign</li> <li>• Key Insights from PLHIV, Health Care Workers, and Key Influencers</li> <li>• I Can Campaign Communication Objectives</li> <li>• Key audiences</li> <li>• The Role of PLHIV as Agents of Change</li> <li>• Theory of Change</li> <li>• Key Monitoring and Evaluation Indicators</li> </ul>	
<b><u>V. I Can Campaign Creative Materials</u></b>	<b>20</b>
<ul style="list-style-type: none"> <li>• Campaign Brand Architecture</li> <li>• Channel Mix</li> <li>• PLHIV as ART Champions</li> </ul>	
<b><u>VI. Operational Considerations</u></b>	<b>24</b>
<ul style="list-style-type: none"> <li>• Staffing Competencies</li> <li>• Budget Guidance</li> <li>• Stakeholders Committee</li> <li>• Stakeholder mapping, engagement and planning</li> </ul>	
<b><u>VII. Adapting the Program for Your Context or Audience</u></b>	<b>27</b>
<ul style="list-style-type: none"> <li>• Assess treatment literacy landscape: existing evidence, tools, and needs</li> <li>• Engage key stakeholders</li> <li>• Validate program audiences, behaviors, and determinants, based on identified priorities</li> <li>• Validate campaign assets for literacy, emotional appeal, audience resonance and potential for effectiveness.</li> <li>• Contract and manage a creative agency for campaign adaptations</li> <li>• Train staff and launch campaign</li> <li>• Conduct routine monitoring of campaign performance and adapt as needed</li> </ul>	

# Acronyms

ACRONYM	DEFINITION
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-retroviral therapy
ARV	Antiretroviral
CCM	Country Coordinating Mechanisms
FAQ	Frequently asked questions
FS	Flip The Script
HCW	Health care worker
HIV	Human Immunodeficiency Virus
IP	Intellectual property
IPC	Inter-personal communications
ITT	Interruption in treatment
J&J	Johnson & Johnson
KP	Key populations
LIS	Laboratory Information Systems
LOE	Level of effort
M&E	monitoring and evaluation
MOH	Ministries of health
OOH	out of home
PCR	Polymerase chain reaction
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	person/people living with HIV
PSI	Population Services International
PVC	Polyvinyl chloride
SBC	Social Behaviour Change
SOPs	Standard Operating Procedures
STIs	sexually transmitted infections
TOR	Terms of Reference
TV	Television
TX_CURR	Number of adults and children currently receiving antiretroviral therapy (ART)
TX_ML	Number of ART patients (who were on ART at the beginning of the quarterly reporting period) and then had no clinical contact since their last expected contact
TX_NET_NEW	No treatment interruption
TX_PVLS	Percentage of ART patients with a suppressed viral load (VL)
TX_RT	Number of ART patients with no clinical contact (or ARV drug pick-up) for greater than 28 days since their last expected contact who restarted ARVs within the reporting period
UNAIDS	The Joint United Nations Programme on HIV and AIDS
VL	Viral load
VLS	Viral load suppression
WHO	World Health Organization



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## Introduction

As HIV treatment programs strive to reach the UNAIDS goals of 95-95-95, creating and sustaining demand for treatment services among people living with HIV (PLHIV) is critical. When treatment was primarily offered to those who were directly experiencing illness as a result of HIV, creating motivation to start and stay on anti-retroviral therapy (ART) was straightforward. Now, as we increasingly offer ART to younger, healthier clients we are seeing a gap in demand for ART, and challenges in supporting these clients to stay on ART after starting.

In 2020, the Bill & Melinda Gates Foundation together with the President's Emergency Plan for AIDS Relief (PEPFAR) and Johnson & Johnson (J&J) invested in a new approach to demand creation for ART. Incorporating tools and approaches of strategic marketing, this approach aims to create a new "brand" for HIV treatment, that can be used across sub-Saharan Africa and potentially beyond to create demand for ART by presenting its benefits in a compelling way to PLHIV and their communities. Led by Population Services International (PSI), Ipsos Mori and Fieldstone-Helms, the Flip the Script project developed the I Can campaign, and piloted it in Malawi and Zimbabwe, countries with common challenges in sustaining long-term treatment adherence, but very different levels of viral load coverage, access to media and market sophistication. By choosing countries with very different media markets, the project developed different models for implementing the same overarching campaign, creating diverse tools and approaches for countries to choose from. This campaign has created new hope for PLHIV and a new awareness of treatment's most meaningful benefits: long life, good health and freedom from worry about transmitting the virus.

Many countries are looking for ways to increase understanding of and demand for ART, while others may already have treatment literacy programs that could be enhanced by more explicitly addressing treatment as prevention. This toolkit is designed to support replication of the I Can campaign in additional countries, but it can also be used to strengthen existing treatment literacy efforts. All materials are open source and freely available online for reproduction or adaptation. We hope you find these tools helpful in creating your own I Can campaign, and we welcome your feedback.



## **Purpose**

### **What is the I Can toolkit?**

The purpose of this toolkit is to provide practical guidance to adapt and implement the I Can campaign in any country context. The objective of the campaign is to elevate and promote the benefits of HIV treatment as prevention across a range of audiences. While the concept of "Undetectable equals Untransmittable," or "U=U," has been a powerful tool for shifting that perception in the U.S. and Europe, this highly medicalized frame has not always resonated in many countries, particularly those in Africa. The I Can campaign approach uses the language of viral suppression to communicate the same concept in a more familiar way.

### **Who is this for?**

The toolkit is for HIV practitioners and government managers who want to implement or adapt a HIV treatment literacy campaign to improve HIV treatment adherence . This toolkit is for practitioners who want to use the existing materials created for the campaign and adapt them to their context. The toolkit is best suited for country level implementation by governments, donors and their implementing partners including civil society organizations. With cross-border coordination, the toolkit may support design of a regional campaign.

The tools may also be used by advocates who seek to influence governments to adopt an I Can or similar campaign, or to influence planned or existing treatment literacy efforts that may not be communicating the benefits of treatment clearly or compellingly.

The tool may be used by funders or government leaders to plan their treatment literacy strategies or programs, or as an off-the-shelf campaign that may be adapted by their implementing partners.

### **How to use the toolkit**

The toolkit is organized into five distinct content sections. Key Considerations (section III) provides practical guidance and summarizes lessons learned for introducing or scaling campaigns to improve ART uptake and adherence. I Can Campaign Research, Design and M&E (section IV) and I Can Campaign Materials (section V) provide information about the original I Can Campaign formative research, objectives, theory of change, and key indicators, and creative assets, as designed and implemented by PSI in collaboration with the governments of Malawi and Zimbabwe. The final two sections--Operational Considerations (Section VI) and Adapting for your Context (Section VII)--provide practical guidance and key information for adapting this type of campaign.



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## III Key Considerations for Introducing or Scaling Communication Campaigns to Improve ART Uptake and Adherence

### U=U and I Can

The I Can campaign amplifies the remarkable efforts of the Prevention Access Campaign including the concept of Undetectable = Untransmissible, or U=U. Started in 2016 by PLHIV advocates, the U=U campaign pushed governments, scientists and public health experts to break the silence around the science of viral suppression so that every person living with HIV could learn that treatment would protect them from spreading the virus. This movement has given rise to profound changes in the lives of PLHIV and their sexual partners, by ending the myth that people living with the virus are permanently “vectors of disease.” It has returned dignity, hope, romance, freedom, and sexual health to millions of PLHIV throughout the world.

The notion of “undetectability” has resonated in countries where viral load testing has been common for decades and capable of determining whether or not an individual's viral load is below a very low threshold, typically 50 copies/mL of blood. However, in most countries this level of testing is not available, and patients may only learn that they are either “suppressed” (that is, their viral load is below 1,000 copies/mL) or unsuppressed (above 1,000 copies/mL). In these countries, adopting a standard of “undetectable” introduces a major roadblock in telling PLHIV that they can no longer transmit the virus, despite the fact that there is no evidence of HIV transmission among PLHIV whose viral load is below 1500 copies/mL.

The I Can campaign model was designed for sub-Saharan African treatment settings, where the concept of “undetectable” is not in common use and most patients are getting viral load tests capable of detecting to less than 1,000 copies/mL. It uses language common to those treatment settings that resonates with PLHIV. It is one of many ways to adapt the U=U concept to new settings. For more options and to learn more about Prevention Access Campaign, [visit their website](#).

## Assessing readiness

Across multiple settings, we have found that the most compelling benefit of ART is the one least clearly communicated: that PLHIV who are virally suppressed do not transmit the virus through sex. Recent research has shown that giving PLHIV this information increases adherence, self-reported viral suppression, sexual health and disclosure to partners, as well as an overall sense of well-being. **The success of any I Can campaign rests on being able to communicate this benefit clearly and compellingly.** Thus, before beginning a local iteration of the campaign, it is imperative to understand the current context in your country and to assess potential barriers to communicating this powerful message which can lead to improved well-being of PLHIV and improved ART adherence.

**There are several reasons why this benefit is rarely communicated clearly:**

- Even though the science demonstrating that viral suppression prevents transmission is very robust, not all policymakers are familiar with it. Thus there may not be consensus about communicating this message; some may be concerned that it would lead to behavioral disinhibition.
- Even where policy makers are in agreement with this message, many frontline healthcare providers are not comfortable giving it to patients: they may not fully trust the science or feel they do not understand it enough to confidently communicate it to others. They also may not trust PLHIV to consistently take their medication to maintain a suppressed viral load.
- Viral load testing is essential to demonstrate that a patient has achieved viral suppression and access to viral load testing may be limited for a range of reasons, including lack of PCR machines, reagents, trained lab personnel, and sample transport. Likewise, systems to ensure return of results to providers and patients may also be lacking.
- Many public health experts are concerned about telling patients that they cannot transmit the virus without a viral load test that is sensitive to <50 copies/mL. However, many low and middle income countries rely heavily on sampling tools that don't allow for this level of sensitivity. This leaves policy-makers in a difficult position.

The work to get key stakeholders in country aligned around this message and to resolve issues around viral load testing access can take time, but it is important in implementing a successful campaign. Those planning an I Can campaign are strongly encouraged to plan and budget for this effort. We have included a readiness assessment tool in the toolkit (see tools section Annex XXX) to help users determine the advocacy steps and resources that contribute towards a successful I Can campaign.

## I Can and Condoms

I Can campaigns focus on motivating two behaviors among PLHIV: 1) to take their medication each and every day, and 2) to visit their provider for a viral load test. Many people ask "what about promoting condom use?" While many stakeholders want to keep promoting condoms within treatment literacy campaigns, doing so for HIV prevention can have negative consequences. For many PLHIV, the ability to have safe, condomless sex is a compelling benefit of treatment. When we talk about the prevention benefit of treatment but then tell PLHIV they still have to use condoms, we risk undermining that motivation and losing patients. We recommend that I Can campaigns either do not reference condoms or mention them specifically as a way to prevent unwanted pregnancy and other STI's.

# Roles in running an I Can Campaign

## Considerations for Government

For Ministries of Health, an I Can campaign offers a tremendous opportunity to improve treatment uptake and adherence, reducing both HIV incidence and the costs associated with untreated HIV. The I Can campaign may be different than other public health communications campaigns you're familiar with, because it takes the approach of strategic marketing, which uses qualitative and quantitative research to identify the emotional and social needs of a target population, and builds a brand that will speak to those needs. In the case of I Can, we have focused on the emotional and social needs of those PLHIV who struggle with staying on treatment, and built a campaign designed to reassure them that ART can allay many of their concerns and fears.

Ministries of health (MOH) play an essential role in initiating, leading, coordinating, and ensuring the success of I Can campaigns. Not only is your leadership critical for endorsing the campaign and convening key stakeholders around it, your guidance to clinicians on issues of viral load suppression is necessary in order for the campaign to succeed.

Here are some specific roles and responsibilities that MOH will need to play in an I Can campaign

- Reaching internal alignment on the viral load suppression threshold PLHIV must reach in order to be declared "safe from sexually transmitting HIV." WHO has set this threshold at < 1,000 copies/ml.
- Communicating this threshold clearly through the health system, with guidance for ART providers on when and how to give patients the good news that, as long as they faithfully take their ARVs every day, they can no longer transmit to their partners.
- Convening HIV funders and donors to ensure alignment and harmony across investments related to treatment literacy and adherence initiatives. Funders may play a critical role in filling in gaps where MoH identifies needs for advocacy for internal alignment on viral load suppression or commodity (VL testing) availability that are necessary prior to running an I Can Campaign.
- Convening HIV communication and/or treatment literacy stakeholders to align and approve messages and create plans for disseminating the campaign messages throughout the public health system.
- Working with relevant stakeholders to address gaps in viral load testing coverage including sample collection and transportation, testing turnaround time, and results return. **Currently, many programs focus primarily on informing patients whose results are greater than 1,000 copies/mL. An I Can or similar campaign will require clear communication of positive results to patients, along with simple messages explaining the benefits of a suppressed viral load for HIV prevention and personal health.**
- Completing the readiness assessment tool, mentioned above.
- If the readiness assessment tool indicates a need for advocacy within government or other key stakeholders, government leaders should then conduct that advocacy to achieve the alignment needed for a successful campaign. **We highly recommend getting alignment before beginning implementation. A lack of alignment will delay implementation, which could incur additional costs.**
- Identifying the appropriate actors or implementers to take on the work of the campaign:
  - An entity that can be responsible for testing and refining the I Can materials for the country context and work with a creative agency to produce adapted content. This entity might be a communications department within the MOH, or an organization with strong experience in both public health and social and behavior change (particularly strategic communication). If you choose to implement through a local organization (or several), they may also support small group and individual activities at the community level, in coordination with clinics. This entity would also be responsible for developing a media plan with help from a creative agency, purchasing media time and space, and monitoring the performance of media buys.
  - PLHIV Cadres to serve as ART Champions (see program design section below) may be identified by government from existing MOH community structures. ART Champions are a key channel to support return to treatment or continued adherence to ART. Government identification and oversight of these cadres leads to sustainability of investments and competency among this cadre to support ART adherence across government programs and partner projects; however, government may delegate the role of identifying/selecting ART champions to partner entity described in the point above.
  - Actors supporting HIV treatment who will train and support clinicians to communicate I Can messages. This might be the team responsible for HIV treatment within the MOH, or an implementing partner. This toolkit includes tools developed and tested for clinical settings that can be adapted by these actors. **These tools have been shown to reduce the amount of time needed for clinicians to explain viral load suppression to patients.** If the campaign includes a social media component that engages directly with the public, a structure will also be needed to support follow-up with PLHIV who seek assistance through those platforms.

- o An entity that will be responsible for monitoring the campaign. If monitoring roll-out and performance of media buys is sufficient for the investment, the entity responsible for the mass and social media components can play this role. If you want to measure the impact of the campaign on treatment outcomes, it may be necessary to engage the strategic information department within the MOH or an additional partner. This toolkit includes an M&E plan for measuring both process, performance and outcome indicators.
- Coordination of partners. In order to succeed, an I Can campaign needs to be implemented in both the community and in clinics, as well as through mass and social media. This will require multiple actors and coordination of activities.
- Owning the campaign from the outset, particularly through endorsing and branding them with MoH logos. This supports adoption of materials by multiple partners, expands the reach and effectiveness of the campaign, and enables partners to place funder logos in support of MoH endorsed materials. This approach does require routine coordination and monitoring for quality/fidelity to the tools and key messages of the campaign in order to ensure effectiveness across all partners.
- Engagement of advocates. In many countries, advocates having been fighting for U=U policy shifts for some years. These advocates should be at the center of planning and monitoring an I Can campaign, as they will bring essential insights into what is happening in clinics as well as understanding of where policy roadblocks lie.

## Considerations for Donors

For donors supporting treatment programs, investing in I Can campaigns for treatment literacy can be a cost-effective way to improve treatment outcomes. Improving patient motivation to start and stay on ART reduces costs associated with treatment interruptions and reduces burden on providers and clinics. The I Can campaign may be different than other public health communications campaigns you're familiar with, because it uses the approach of **strategic marketing**, which uses qualitative and quantitative research to identify the emotional and social needs of a target population, and build a brand that will speak to those needs. In the case of I Can, we have focused on the emotional and social needs of those PLHIV who struggle with staying on treatment, and built a campaign designed to reassure them that ART is the solution to their concerns and fears. This approach can be more effective than traditional public health communications, but its costs and timelines may be different.

Donors play an essential role in the success of I Can campaigns beyond providing essential resources to cover their costs. By ensuring that all the key processes are adequately recognized and resourced, donors set the stage for success. Donors may also play a key convening role, especially when there are differing perspectives on messaging. Finally, donors often have access to expertise beyond what is available in a specific country; this expertise can be helpful or even essential in moving an I Can campaign forward.

Here are some specific roles and responsibilities that donors may need to play in an I Can campaign:

- Completing the readiness assessment tool, mentioned above.
- If the readiness assessment tool indicates a need for advocacy with government or other key stakeholders, conducting that advocacy alongside civil society in order to achieve the alignment needed for a successful campaign. **We highly recommend getting alignment before your partners begin implementation. A lack of alignment will delay implementation, which could incur additional costs.** In some countries, there may be entities other than the donor best placed to play this advocacy role (PLHIV networks, WHO, UNAIDS, etc.). **We do not recommend leaving this work solely to an implementing partner.** Because of the policy and cost implications of communications based on viral load testing, IP's may not be in a position to exercise the influence needed to achieve alignment. IP's can help staff and manage an advocacy process, but donors will likely need to be actively involved.
- Identifying the appropriate actors or implementers to take on the work of the campaign:
  - o An entity that can be responsible for testing and refining the I Can materials for the country context and work with a creative agency to produce adapted content. This entity would typically be an organization with strong experience in both public health and social and behavior change (particularly strategic communication). This organization may also support small group and individual activities at the community level, together with treatment partners. This entity would also be responsible for developing a media plan with help from the creative agency, purchasing media time and space, and monitoring the performance of media buys.
  - o Implementing partners supporting HIV treatment who will train and support clinicians to communicate I Can messages. This toolkit includes tools developed and tested for clinical settings that can be adapted by these partners. These tools have been shown to reduce the amount of time needed for clinicians to explain viral load suppression to patients. If the campaign includes a social media component that engages directly with the public, treatment partners may also need to support follow-up with PLHIV who seek assistance through those platforms.
  - o An entity that will be responsible for monitoring the campaign. If monitoring roll-out and performance of media buys is sufficient for the investment, the entity responsible for the mass and social media components can play this role. If you want to measure the impact of the campaign on treatment outcomes, it may be necessary to engage an

additional partner or add this to the role of the treatment partners. This toolkit includes an M&E plan for measuring process, performance and outcome indicators.

- Coordination of partners. In order to succeed, an I Can campaign needs to be implemented in both the community and in clinics, as well as through mass and social media. This will require multiple partners and coordination of activities. It may be possible for a lead implementing partner to play this role, but it may be more efficient and effective for the donor to do so. If the campaign is funded through PEPFAR, it may be appropriate for the PEPFAR coordinator to play this role.
- Engagement of advocates. In many countries, advocates have been fighting for U=U policy shifts for some years. These advocates should be at the center of planning and monitoring an I Can campaign, as they will bring essential insights into what is happening in clinics as well as deep understanding of where policy roadblocks lie and leverage points to address those.

## Considerations for Advocates

PLHIV have been advocating that governments adopt U=U policies for some years. A decision to implement an I Can campaign is a major victory for these movements. However, funding for a campaign may not mean that all relevant policy hurdles have been overcome. Advocates have an essential role to play in ensuring that I Can campaigns communicate clearly and directly that PLHIV who are virally suppressed cannot transmit the virus, and do not need to wear condoms to prevent infecting others. They can push for revisions to national guidelines and strategies in settings where funders and implementers may be more limited. Most importantly, PLHIV advocates can speak with authority about the power of learning about treatment's prevention benefits on their own lives and attitudes towards ART. **Advocates should be at the center of campaign planning and advising on implementation.**

## Considerations for Implementers

For partners experienced in health communication or SBC but unfamiliar with strategic marketing approaches, launching an I Can campaign is a great opportunity to learn some new skills. The toolkit includes campaign content for mass media, social media, and interpersonal communication, as well as tools to help you validate the underlying insights behind those materials and adapt them appropriately.

A variety of resources exist to support learning and application of social marketing to behavioral programs. Linked here are a few to get you started:

- PSI keystone design framework overview describes a strategic marketing approach to program design: <https://www.psi.org/keystone/>
- High Impact Practice Brief: Social Marketing. This brief describes the social marketing discipline and approach, and provides evidence of impact, how-to tips, priority research questions, and indicators to track performance. The brief focuses on family planning programs, but may be used by any practitioner to understand and apply the discipline. <https://www.fphighimpactpractices.org/briefs/social-marketing/>
- Advocating for Social Marketing Programs to Local Stakeholders. This brief helps demonstrate the effectiveness of social marketing in increasing the use of health commodities by target populations, and in reaching national health goals. Although the brief focuses on USAID-supported family planning programs, many of the arguments used to advocate for the intervention are applicable to other health areas, including HIV/AIDS. <https://thecompassforsbc.org/sbcc-tools/advocating-social-marketing-programs-local-stakeholders>

Because the campaign includes components for mass media, social media, communities, and clinics, it will likely be implemented by multiple partners. Here are considerations and roles for the different types of partners likely to be engaged.

## Communications or SBC Partners

This partner is likely to be responsible for testing and refining the I Can materials for the country context and working with a creative agency to produce adapted content, as well as for developing a media plan with help from the creative agency, purchasing media time and space, and monitoring the performance of media buys. You may also support small group and individual activities at the community level, together with treatment partners. Some considerations for communications partners:

- You may need to get approvals for specific message content from multiple stakeholders (MOH, National AIDS Council, PEPFAR, Global Fund CCM, networks of PLHIV, etc.). Working through existing TWGs and advisory groups can make this process more efficient, but take care to ensure that the stakeholder representatives on those groups are the right ones to represent the project back to their organization (e.g., representatives who specialize in communication may not have the ear of treatment experts within their organization). Plan for one-on-one meetings with key stakeholders in addition to meetings of these advisory boards to ensure that information is flowing appropriately. We strongly encourage donors to be actively involved in securing approvals and alignment from government stakeholders; you should ask your donor counterparts for their support from the outset of the work.
- The campaign materials are all based on insights gleaned from research and design work in Malawi, Mozambique, South Africa and Zimbabwe – the validity of the key insights has held across multiple countries, and thus the research will not need to be repeated. However, the materials may be reviewed, updated, or validated in your country to ensure the images are relevant and the language appropriate. The toolkit includes practical advice for validating and adapting materials (See Section VII), including advice on how to recruit PLHIV for testing materials before implementing at scale.
- A key component of I Can's success is having PLHIV who are doing well on ART act as champions for the campaign. These champions should feature in social media, radio and TV testimonials, and at community events. Celebrities, actors, social media influencers and family members can be good boosters, but are not replacements for people who are living with HIV. The toolkit includes tips for identifying and working with PLHIV to play this role.

## Treatment Partners

This partner is likely to be responsible for rolling out clinical and possibly community components of the I Can campaign, including training clinical and community providers to use adapted tools like the I Can Bead Bottles and the treatment roadmap. These tools are designed to make it easier and faster for providers to explain the benefits of viral load suppression. You may also play a role in monitoring the campaign's effectiveness, by tracking its impact on key indicators at your sites. Some considerations for treatment partners:

- The I Can campaign centers on the message that those PLHIV who are virally suppressed no longer sexually transmit the virus, as long as they continue to take their medication every day. Many providers struggle with this message: they may not understand the science, or they may not trust PLHIV to be adherent. Before launching the new materials, it may be helpful to conduct a values clarification exercise with staff in health facilities so that resistance to giving this message can be aired and addressed.
- The most powerful communicators of treatment's benefits are PLHIV who are successful on treatment, themselves. You may already have a cadre of expert patients who can be trained to play the role of champions for the I Can campaign. If not, it will be helpful to coordinate with other partners to identify PLHIV from the community who can play this role.
- Right now, clinics may be focused on returning viral load results for those patients who are not suppressed. However, communicating positive results to patients is equally important: it's a critical opportunity to celebrate their "non-transmittable" status and motivate ongoing adherence. You may need to work with clinic managers to determine workflows for returning results to suppressed patients along with messages about their "new status".
- Because an I Can campaign involves both national, sub-national level mass media and localized clinical and community activities, it requires considerable coordination across government and multiple partners. You'll want to plan and budget for this coordination, ensuring that your treatment experts are part of the planning, since the interventions will impact service delivery.



## IV I Can Campaign Research, Design and Creative Assets

Effective, quality social and behavior change programs are rooted in formative research and follow a rigorous design process. This section describes research and design processes used to develop the I Can campaign creative materials and approaches.

### I Can Campaign Goal

The campaign goal is to rebrand HIV treatment - reframing it from being associated with HIV and its related stigma to being aspirational and a solution to the problems that an HIV diagnosis brings. The I Can campaign positions ART and viral suppression as a way to access pre-HIV diagnosis freedoms, such as freedom to work, experience sexual intimacy, fall in love, marry and attend school. By presenting HIV treatment as route to achieving life's most important goals, the campaign motivates PLHIV to start and stay on ART. At the population level, this increased motivation can decrease morbidity and mortality among PLHIV by increasing the proportion of people on ART who are virally suppressed and increasing demand among PLHIV and providers for viral load results.

### I Can Campaign Behavioral Objectives

- Increase in clients who newly initiate treatment
- Increase adherence to ART, decrease treatment interruptions
- Increase the number of clients who re-start treatment

#### Research to Support the I Can campaign

To lay the groundwork for developing a successful campaign, we conducted research with PLHIV, their main influencers at the community level, and healthcare workers. This research identified critical barriers and motivators to starting and staying on ART, as well as knowledge of and attitudes towards viral suppression and prevention of transmission. This research was conducted by Ipsos Mori and supported by PSI.

We conducted a three phased approach:

1. A literature review to landscape current U=U campaigns in Sub-Saharan Africa; what is already out there, and how effective they are
2. A Qualitative phase in Malawi and Zimbabwe to dig deep into the lived experiences of n=24 PLHIV as well as their knowledge of ART/ emotional resonance. We also spoke to n=24 nurses and n=24 influencers such as maternal figures and aunts in the community, to uncover their scope of influencers in the lives of PLHIV and their understanding of key HIV messages;
3. A Quantitative segmentation of n=386 PLHIV and n=504 Healthcare Workers including nurses, counsellors, and community healthcare workers was conducted in order to understand who and how to target the campaign and each message.
4. Specifically, the studies aimed at understanding the following:
  - Current state of awareness of the benefits of treatment and continuity of care among young people living with HIV (PLHIV).
  - Current state of awareness of personal viral suppression status / viral load among young PLHIV.
  - The motivations for target groups to be virally suppressed and/or to take their medicine every day for life.
  - The current state of awareness of benefits of treatment, viral suppression, and continuity of care among influencers of people living with HIV, including HCW.
  - Key opportunities for health care workers to understand and counsel PLHIV on benefits of treatment, viral suppression, and continuity of care.

**Qualitative research:  
methodology and summary of findings**

Qualitative data were collected through interviews with young PLHIV (between 18-35 years), their influencers, and HCW from sampled districts across Zimbabwe and Malawi. Study participants were recruited from sampled health centers and clinics with the help of HIV treatment partner organizations. Key insights from PLHIV, HCW and Key Influencers are summarized on the next page.

## From PLHIV:

- Knowledge of treatment benefits is low. While most people had heard of viral suppression, almost none knew that ART prevents onward transmission. Many did not know that people on ART can live as long as people who don't have HIV.
- ART = HIV. Taking treatment is the key signifier of having HIV. Respondents expressed that discontinuing pills feels like a break from being HIV positive. The urge to stop taking ART grows when people feel and look healthy. ART can also feel like a punishment and virtually all participants reported keeping their medications a secret.
- Nurses could help but often miss the mark. People often cite nurses as credible sources of information, but perceive them as callous or rushed.
- Language matters. The medical terms used in the clinic can be confusing and alienating, increasing the urge to distance oneself from treatment.
- Secrecy compounds everything. Despite the fact that large numbers of people are on ART, the ongoing secrecy around it leaves people feeling isolated and fearful.
- Female PLHIV choose role models who represent independence, open-mindedness, and progress. An effective campaign takes an intersectional approach and shows female PLHIV that they too can be educated, independent, and valued members of society.
- Male PLHIV identified male role models who represent respect, financial success, and community spirit. An effective campaign shows male PLHIV that they too can be respected members of society.
- Many PLHIV enjoy the emotive experience of listening to gospel music and regard the artists as role models. PLHIV find solace in gospel music, which can help restore feelings of peace and hope.

## From HCW:

- Disconnect in perceptions. Many nurses believe that stigma against HIV is “not that bad.” This can lead to a minimizing of patient privacy concerns around ART and missed opportunities to address challenges with adhering to ART.
- Judgement over empathy. While most HCW feel care and concern for their patients, many also express strong judgment, assuming that PLHIV acquired the virus because of “sinful behaviour.”
- Language matters. The use of medical terminology is an important way for HCW to feel and be perceived as professional, even though it may confuse and alienate patients.
- Distrust of patients and of self. HCW often don't communicate that ART prevents transmission because they don't trust patients to use the information safely or because they don't feel confident that they can communicate it clearly.

## From HIV negative community influencers:

- Proximity matters. People who reported knowing someone living with HIV were very empathetic and supportive of their need to be on ART. “People who are on ART and those who are not, we are just the same.” But...
- Attitudes towards sex and marriage are the exception. While every participant said they would support a family member living with HIV, most people said they would leave a relationship if they found out their partner was positive, often because they would assume infidelity. Most said they would not have sex with someone who is HIV positive.
- Judgement over empathy. Like HCW, many assume that promiscuity is what leads to a positive status. Those who are not close to anyone living with HIV decide whether to be sympathetic based on how they assume the person became infected.
- Treatment literacy is LOW. Many still believe that treatment comes with terrible side effects. Almost no one knew that treatment prevents transmission or believed it when we told them. This sums to a perception that “HIV rules you forever.”
- PLHIV are trusted sources. All see PLHIV living healthy lives as role models, especially discordant couples. HCW and religious leaders are also trusted sources.

## Further insights gained through implementing the I Can campaign:

- Support from other PLHIV on treatment is key. PLHIV with support of others are more likely to build successful habit loops for taking medication.
- Many PLHIV are struggling with poor mental health. Effective campaigns will be sure to resonate with people when they are going through tough times or are feeling down about life and the future.
- The relationship between HCWs and PLHIV can feel transactional to PLHIV which undermines their motivation to return to the clinic. HCWs can be trained to understand the types of support different patients need at different times and offer the kind of caring attention that patients may need.
- Explaining viral load testing and suppression using tactile tools such as the B-OK bead bottles or metaphors such as a bullseye improves patient understanding and motivation to adhere to treatment regimens.

### Quantitative research: methodology and summary of findings

Ipsos Mori conducted a quantitative survey of 786 adult PLHIV and 504 Healthcare workers living in Zimbabwe and Malawi, based on the key themes emerging from the qualitative research, summarized above. These surveys enabled an understanding of the distribution of key beliefs and levels of knowledge across PLHIV and HCW, informing a psychographic segmentation of each group. In addition, the PLHIV quantitative research informed the channel selection (by reach and exposure) and trusted sources of information. The team used the PLHIV segmentation to identify a target audience for the campaign and build a brand architecture. The HCW segmentation helped identify the most commonly held misunderstandings and negative attitudes among HCW to inform the development of tools for use in clinical settings.

From the survey, we identified 5 segments of PLHIV common to each country, described in the table below. **Through stakeholder consultation, we decided to adopt segment 4 as our target segment for the campaign.**

Segment	Percent of all PLHIV	Characteristics
1	13%	<ul style="list-style-type: none"> <li>• Feels very negatively about life in general, having HIV and the future</li> <li>• Strong sense of loneliness – they feel unsupported in the community, do not trust others and feel that HCWs do not understand them</li> <li>• Have not disclosed HIV status and are not adherent to medication</li> </ul>
2	11.5%	<ul style="list-style-type: none"> <li>• Believes that the community is supportive of PLHIV and not judgemental about people taking medication</li> <li>• Understands information communicated by HCW and benefits of treatment</li> <li>• Motivated by living a normal life and protecting others</li> </ul>
3	12.5%	<ul style="list-style-type: none"> <li>• Feels negatively about having HIV and taking medication</li> <li>• Not currently adherent to medication</li> <li>• Taking treatment every day is a consistent reminder that they have HIV, and they feel out of control and unable to lead a normal life</li> </ul>
4	28%	<ul style="list-style-type: none"> <li>• <b>Negative feelings about life in general</b></li> <li>• <b>HIV still taboo in their community and they feel unsupported by the wider community, who say negative things about PLHIV</b></li> <li>• <b>Generally adherent to medication although no clear motivations to take treatment</b></li> </ul>
5	36%	<ul style="list-style-type: none"> <li><input type="checkbox"/> Positive outlook about HIV and the future</li> <li><input type="checkbox"/> Good understanding of treatment benefits and they recognise the importance of managing viral load</li> <li><input type="checkbox"/> Motivated by maintaining a healthy lifestyle and likely to be adherent to medication</li> </ul>

We identified 4 segments of HCW common to each country, described in the table below. This information was used to develop communication tools to support various provider segments, and to design empathy-based provider trainings to support improved provider counseling on ART, specifically viral suppression.

Segment	Percent of all PLHIV	Characteristics
1	39%	<ul style="list-style-type: none"> <li>• Not motivated by external factors, more likely to have a passion for helping people</li> <li>• Does not stigmatise and knows that getting HIV can happen to anyone</li> <li>• See's their role as educators and "heros" to help tackle stigma</li> <li>• Feel well respected, and do not find their job difficult, but believe religious leaders can do more to support</li> <li>• Have empathy for PLHIV rather than sympathy</li> <li>• Believes that staff shortages are a key challenge</li> </ul>
2	21%	<ul style="list-style-type: none"> <li>• Externally motivated to become a healthcare worker – motivated to earn a secure salary</li> <li>• Proud to be a HCW</li> <li>• Does not feel overwhelmed by their duties</li> <li>• Highly empathetic and sympathetic – feels sorry for PLHIV</li> <li>• Does not stigmatise and would not hide their medication if they were HIV+</li> <li>• Believes shortages (resources) is a key challenge</li> </ul>
3	26%	<ul style="list-style-type: none"> <li>• Not motivated to be a HCW, or proud to be one</li> <li>• Unsure of their role</li> <li>• Does not feel well respected and finds their job difficult</li> <li>• Feels overwhelmed with their duties</li> <li>• Believes the community is highly negative towards PLHIV and that they have a lack of knowledge about the disease</li> <li>• No willingness to help tackle stigma</li> <li>• Does not believe resource shortages are a key challenge</li> </ul>
4	13%	<ul style="list-style-type: none"> <li>• Highly motivated</li> <li>• Sees their role as an educator and hero to tackle stigma</li> <li>• Does not feel respected, finds their work difficult, but proud to be a HCW</li> <li>• Lacks empathy for PLHIV</li> <li>• Does not believe community stigmatizes PLHIV</li> <li>• Believes that people acquire HIV through promiscuity</li> <li>• Does not think religious leaders should do more to support PLHIV</li> </ul>

## Key audiences

Based on the formative research, the I Can campaign focused on segment 4 and designed a campaign to address the determinants of treatment adherence for that segment, while engaging various provider segments with empathy based training and tools to support them to perform their work where they were previously resistant, hesitant, or not confident to deliver messages about the benefits of viral suppression with ART, and information that HIV positive clients cannot transmit HIV to others through sexual contact.

The campaign's primary audience (Segment 4) is comprised of men aged 20-34 and women aged 15-30. Across East and Southern Africa, PLHIV in these demographics are less likely to have started treatment and, in some countries, achieved viral suppression. We have also adapted materials for members of

key populations (KP), who also experience lower than average rates of treatment initiation and viral suppression.

While PLHIV in Segment 4 are the primary target audience for this campaign, research told us there are two populations that have significant impact on their behavior and treatment journeys – HIV negative peers and health care workers (HCWs). Segment 4 reported real and perceived bias from their peers and potential sexual partners as a critical barrier to staying on ART. They also indicated that HCWs are their most trusted source of information about ART, followed by other PLHIV. With these influencers in mind, the campaign also targets the broader community around PLHIV, as well as the HCWs who manage ART patients.

### The Role of PLHIV as Agents of Change

In both the research conducted for the I Can campaign, as well as research done in South Africa, PLHIV expressed their disbelief that one could live a good life while on ART and challenged us to prove it. Through experimentation, we have learned that the best proof is PLHIV, themselves, notably PLHIV who are on ART and living productive, fulfilling lives. Thus, the I Can campaign includes "ART Champions," PLHIV who are trained to tell their stories with honesty and courage, as well as to provide critical information to their peers about treatment. These Champions can be existing members of the health workforce, such as expert clients, or they can be volunteers drafted from the community. For health areas such as HIV treatment where the behavioral determinant is deeply personal and the content technically complex, interpersonal communication is an essential channel. Research findings from South Africa, Malawi and Zimbabwe indicate that PLHIV are more likely to believe hopeful information about ART when it is delivered by a credible messenger, one of their own, a real life example of a person who they can aspire to be like. We recommend that a diverse range of ART Champions are recruited and trained to ensure equity of program coverage, with an emphasis on including key populations such as, men who have sex with men, transgender individuals, and people who sell sex. Training can be done for various all ART Champions together or conducted separately for distinct groups to ensure the privacy, safety and well-being of LGBTQIA individuals and people who sell sex.

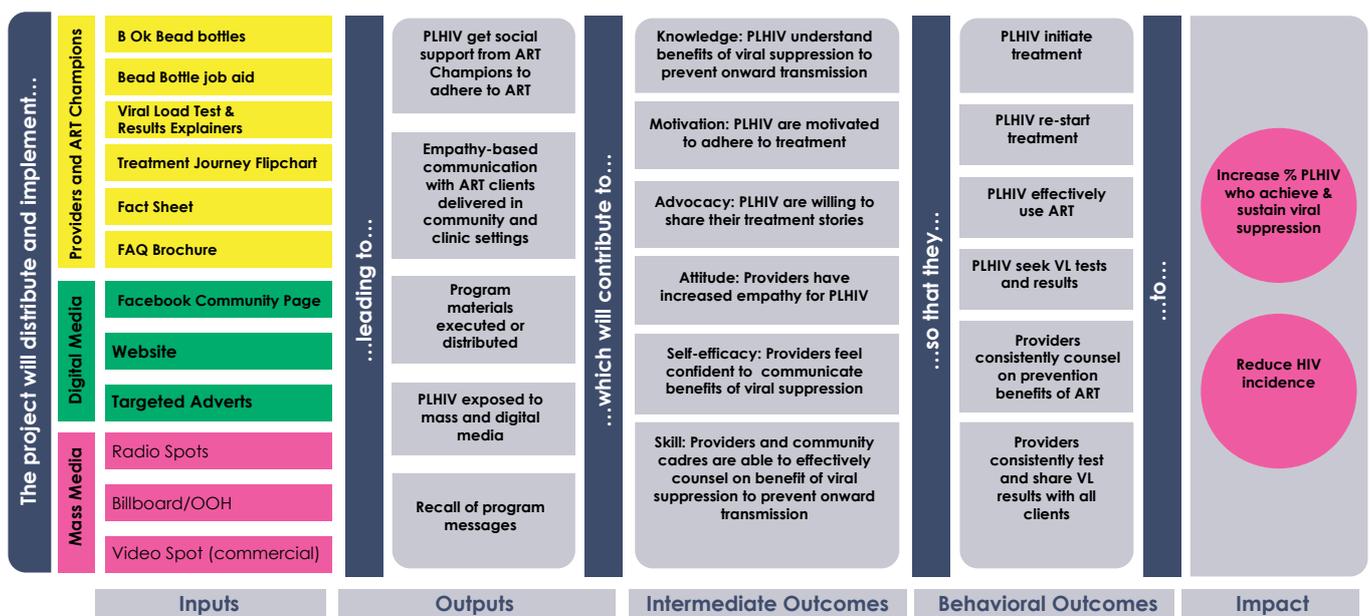
### I Can Campaign Communication Objectives

Communication objectives are key ideas that health communicators want those who interact with a campaign to take away from it. These objectives guided creative campaign development and should guide any adaptation:

- With ART adherence, I Can reclaim pre-HIV-diagnosis freedom
- With ART adherence, I Cannot transmit HIV to my partners or children
- With ART adherence, I Can reduce my viral load to the point where I cannot transmit the virus or become ill
- Viral load can be measured with a test from my health provider
- I trust my health provider to explain the benefits of treatment and help me adhere to ART

### Theory of Change

### Flip The Script I Can Campaign Theory of Change



# Key Indicators

## 1. Mass Media, Print Digital Reach and Exposure Indicators:

MEDIUM	INDICATORS
	<p>Number of people reached with I Can campaign content by channel (Radio, TV, billboard, Facebook, Google Display Network, Landing Page) age and sex</p>
	<p>Total person exposure by channel (Radio, TV, billboard), age and sex</p>
	<p>Number of people who engaged with the platforms: Facebook, Google Display Network, Landing Page (disaggregated by media platform type, age/sex) (reach)</p>
	<p>Number of stories published that include references to U=U, I Can or benefits of ART</p>
	<p>Estimated circulation/ viewer numbers for each article/ news story, radio spot, or print ad</p>
	<p>Number of radio and TV spots flighted by media house and channel</p>

## 2. Community, Provider, and Individual-Level Indicators:

Audience	Indicators	Data Collection Method
Community-Level	<ul style="list-style-type: none"> <li>% of community and religious leaders who report increased knowledge about ART and VLS</li> </ul>	Before & After Survey Qualitative In-Depth Interviews & Focus Group Discussions
Provider-Level	<ul style="list-style-type: none"> <li># providers trained in U=U messaging by district</li> <li># of job aids developed for use by providers</li> <li>% of providers who report improved self-efficacy to counsel on benefits of ART adherence</li> </ul>	Project reports Training reports Before & After Survey Qualitative In-Depth Interviews & Focus Group discussions
Individual-Level	<ul style="list-style-type: none"> <li>% of expert clients who report improved self-efficacy to counsel on benefits of ART adherence</li> <li># of expert clients trained on U=U counseling</li> <li>% of PLHIV who report increased awareness of benefits of ART adherence and VLS</li> <li>% of PLHIV who report increased knowledge about ART and VLS</li> <li>Level of client satisfaction with treatment services</li> </ul>	Before & After Survey Qualitative In-Depth Interviews & Focus Group discussions Before & After

## 3. Monitoring Impact on Treatment, Retention and VL Suppression

Data Collection Methods	Indicators
<ul style="list-style-type: none"> <li>Interrupted Time Series Analysis of key treatment indicators.</li> <li>Compare pre-post periods across key program indicators globally.</li> <li>Targeting specific sites to receive site level intervention assets and monitor changes in program indicators.</li> </ul>	<ul style="list-style-type: none"> <li>% of people newly diagnosed with HIV initiated on ART</li> <li>% of clients who attend all expected appointments (no treatment interruptions) (TX_NET_NEW), by age and sex</li> <li># of adults currently receiving ART (TX_CURR)</li> <li># of ART patients (who were on ART at the beginning of the quarterly reporting period or initiated treatment during the reporting period) and then had no clinical contact since their last expected contact (TX_ML)</li> <li># of ART patients who experienced an interruption in treatment (ITT) during any previous reporting period, who successfully restarted ART within the reporting period and remained on treatment until the end of the reporting period (TX_RTT)</li> <li>% of ART patients with a suppressed viral load (VL) result (&lt;1000 copies/ml) documented in the medical or laboratory records/ laboratory information systems (LIS) within the past 12 months (TX_PVLS)</li> <li>% of HIV-positive results among the total HIV tests performed during the reporting period</li> </ul>



## V I Can Campaign Creative Materials

This section includes all the campaign materials developed by PSI and its creative partner Fieldstone Helms. The adaptable creative outputs can be found at the links included in the toolkit. The campaign uses an integrated channel strategy featuring radio, press, digital, print and outdoor as reinforcing mediums that complement interpersonal communications (IPC) as the core intervention.

The I Can campaign features testimonial-style executions of people living with HIV who have achieved important romantic, family, work, or educational milestones because of being on treatment. These executions are delivered through a mix of media types and that mix should be informed by evidence about media usage in your target audiences and reflected in a well-considered media plan.

Above the line (TV, billboard, radio, and digital) creative materials were developed using formative research, audience insights, and the creative expertise of Fieldstone Helms. Content, tone, visuals, and scripts were pre-tested iteratively with audience members to ensure resonance, comprehension, and emotional appeal.

IPC materials for use by both HCW and ART Champions were both adopted from other successful programs and developed through design workshops with healthcare providers in Malawi and Zimbabwe. These tools, and the training that accompanies them, are the core of the campaign because successfully communicating about treatment as prevention requires one-on-one or small group interactions.

## I Can Brand Architecture

The campaign brand architecture uses a marketing lens to visualize the campaign brand's equity, character, and building blocks. The overall equity is the hook or promise offered through the campaign executions. The brand character drives the tone, framing, and look/feel of the campaign. The Brand Building Blocks are the key takeaways that we want to remain with those exposed to the campaign through various channels. In Annex 06, you can find a sample creative brief that you can use to adapt the architecture with a creative agency.



## Channel Mix

The channel mix summarizes the channels and formats that have been selected, using formative research and evidence, to deliver the campaign for the target audiences. The table below lays out channels, formats, and purpose of each asset developed through the campaign. Guidance on selecting your own channel mix can be found below in Section VII (How to Adapt the Campaign).

Channel Type	Channel	Format	Purpose	Link
Mass Media	Radio	Radio spot	Hook emotional appeal and campaign brand among men and HIV negative supporters. Hook emotional appeal among target segment and their primary influencers	
	Billboard/ OOH		Visualize campaign brand and identity.	
	TV	TV spot (commercial)	Hook emotional appeal and campaign brand among men and HIV negative supporters. Hook emotional appeal among target segment and their primary influencers	
Digital	Social Media	Facebook community page	Address XX determinants. Targeted paid adverts via google and Facebook, Campaign landing page	<a href="https://icanlivepositively.com/plhiv">https://icanlivepositively.com/plhiv</a>
Interpersonal Communication	Provider and ART Champions	Bead Bottles	Improve treatment literacy, specifically related to comprehending viral suppression. Three bottles filled with beads, which serve as a simple and tactile tool to facilitate conversations between health care workers and ART clients.	<a href="#">You Can be HIV Safe Animation explainer ENGLISH</a>
		Bead Bottle ART Champion job aid	This tool is designed to support correct and consistent use of Bead Bottles (above) to support ART champions and providers to use to explain viral suppression with ART.	
		Viral Load Explainer (bullseye)	A two-sided tent card that prompts Health Care workers to explain different viral load results to clients. The tool is designed to stay on the desks of ART providers and trigger clients to ask questions on viral load results. The back of the tool includes key points for providers to cover in counselling on viral load. Used in Malawi.	
		Viral Load Test Result Job Aid	A print material for providers and ART champions to communicate clearly with clients about how to understand viral load tests, and what viral suppression means.	
		Treatment Journey Flipchart	An A2 sized PVC banner used to anchor small group conversations. Using the bead bottle illustration overlaid on analogy of a road trip, the tool helps IPC agents and health care workers to visually describe a journey with HIV treatment, from ART initiation to undetectable viral load. (Malawi)	
		Fact Sheet	An A4 sized print material that covers What to Expect After Testing Positive for HIV, describing ART treatment literacy basics, including viral suppression (Zimbabwe)	
		FAQ Brochure	An A4 sized brochure that answers frequently asked questions (FAQ) about treatment adherence and viral load suppression. (used in Malawi)	

## ART Champions

At community level, the treatment literacy campaign is delivered through "ART Champions", a group of Interpersonal Communication agents who are doing well on treatment; trained, equipped, well supervised and whose performance is under constant review.

### **IPC Recruitment Criteria**

Aged between 18 and 40, the ART champion must be a thriving HIV positive person living within the targeted community. They must be willing to speak openly about their HIV status and ready to share their treatment journey with others. An ability to read and write helps them to understand the project job aides as well as to document performance through project data collection tools. Community acceptance of IPC agents is critical, so the ART Champion must be approved by local leadership and by the health facility team.

### **IPC Roles**

The key role of an ART Champion is to conduct one on one coaching and support for PLHIV who are having challenges with treatment adherence. The Champion builds motivation for treatment and demand for viral load testing through conducting IPC sessions in the community and disseminating the new truth of U=U using project approved tools, as described above.

### **Curriculum and training**

In order to effectively implement the I Can campaign, ART champions must receive training in: use of project materials and concepts, coaching through motivational interviewing, and sharing their testimonials. Detailed training guides and a summary agenda are provided in Annex 02



## VI Operational Considerations

This Section of the toolkit provides important operational considerations that are needed to effectively adapt the I Can treatment literacy campaign to various country contexts. The general assumption is that the countries will use the existing visual content and tools from the I Can campaign, translating them into appropriate local languages and, in some cases, change imagery or filmed content to fit context. We acknowledging that, in some countries, Ministries of Health or other key stakeholders may be uncomfortable with using content developed for other countries and require the development of completely new material the operational considerations have tried to cover this scenario to. Section X describes how to validate insights and adapt campaign materials. This section provides programmatic learnings and guidance about the operational areas required for implementing the campaign, specifically: staffing, project structure, budgeting, stakeholders and sample standard operating procedure used to implement and assure quality of planned activities.

### Staffing

The following positions are crucial for the implementation of the campaign:

1. Senior level staff to manage advocacy with MOH and other in-country stakeholders. As part of our key learning, this role is critical to lead key decisions from the introduction of the campaign to dissemination of results. Required competencies include high level advocacy, strong relationships and representational skills with senior ministry officials, and HIV treatment literacy expertise. The introduction of this campaign is only successful when various systems level factors are in place, including government approval to communicate prevention benefits of viral suppression, commodity security for viral load tests and reagents, data systems to measure changes in ART initiation or retention in care, as well as government and funder mindsets and priorities that support investment and scale in this area.
2. SBC, Marketing or Communications Manager to manage relationship with creative agency and coordinate campaign design and execution: This role is critical in assuring validation of insights, quality program adaptation, program management and accountability, and technical oversight to the campaign. This role can be merged with the above advocacy function in cases where one person has all competencies, or the position does not exist in your current structure and recruitment is necessary.
3. Research and/or metrics teams to test translations and pre-test materials: For adaptation this does not need to be a full-time position and can be outsourced.

4. Program officers: These officer(s), depending on coverage, will be tasked with the day to day running of the project and will need to be able to Train both HCW and influencers and offer supportive supervision to the frontline cadre. They should have strong emotional intelligence and experience with approaches like motivational interviewing or counseling which are crucial to the project model. Experience in SBC or demand generation programming is optimal.
5. M&E staff to develop and implement elaborate plans e.g. selecting facilities at which to track selected indicators, designing project qualitative metrics, conducting pre- and post-campaign surveys, managing media monitoring, etc.
6. Digital media community management team – digital has become a key communications channel post covid, and influencers are now touted as the new 'brand'. This cadre will play a key role in content development and online community management, as well as respond to questions and requests for assistance via social media.
7. Admin and logistics staff to support the project, typically LOE can be covered by existing staff with time allocated for your I Can campaign project.

## Budget considerations

**Staffing cost:** Assuming an adaptation of the campaign, we have estimated the percentage time costs to be budgeted under each of the recommended staff:

- o Senior level staff to manage advocacy: 15%
- o SBC, Marketing or communications manager: 50-100%
- o Research and/or metrics team to test translations: 10% or outsource services as needed.
- o ProgramOfficers/Communications Coordinator:100%
- o M&E staff: 15-30%
- o Digital media teams: 25%
- o Admin and logistics staff: 50%

**Professional Services/Agency costs:** Rolling out the campaign will require the services of several agency. Below are the key agencies that will need to be budgeted for.

- **Research agency** will validate insights, test the campaign assets, make the needed iteration for context, and ensure that the changes are pretested before rollout. The research team in the implementing organization can also take the lead to cut this cost.
- **Creative agency** will be responsible for making the recommended language and visual context changes to the campaign. Agencies charge different hourly rates for creative elements. It would be best to compare the cost vis a vis their sample works to get value for money.
- **Media planning and buying agency:** We recommend having agencies do the media planning and buying; these agencies have a better understanding of the media landscape in-country and are in a strong position to negotiate best rates for mass media placement and secure prime time slots for the campaign. The agency will typically charge a 15% fee for media planning and around 5-8% of the total placement budget for media buying.
- **Digital media agency:** Digital is a core channel for the I Can campaign; budget is required for an agency to carry out the content creation, handle paid media and be part of the community management.

**Implementation costs.** The information below sums up cost drivers for implementation, which includes common costs to implement a multi-channel campaign.

- **Campaign assets adaptation:** The core campaign assets for adaptation include the TV commercial, Radio spot, IPC job aids, and digital. Costs will cover translation into local languages and visual contextualizing. Set aside the budget for creative and production agencies to ensure you have sufficient funds for these conservative but important changes.
- **Placement costs.** This is the booking and paying for time slots of campaigns on radio and TV. The cost per slot is evidence-based reach in those countries. This varies from country to country and the media planning agency should

be there to provide the media landscape and evidence for the most appropriate channels and investments needed per channel. Quick research into the cost for a spot on TV and radio and the objective of your program e.g., coverage, reach, and timelines should help you determine the budget to put aside for mass media placement. For instance, in most countries, radio offers the best reach and coverage for both urban and rural audiences, however, rates will vary depending upon the reach of the station and the time of day. For example, in Malawi where the campaign was piloted the cost per 60-second spot is \$16 for the national stations and \$5 for community-based stations, with higher rates for prime time. However, in Kenya, a 60-second radio spot averages \$500. The case is similar to TV where the cost per TV spot in Kenya is \$1500.

- **Digital marketing** costs will focus on content creation, community management, paid media costs, and agency fees. The community management elements is crucial as it involves engaging with clients seeking services and supporting them to access these services through available services delivery point working in collaboration with the ministries of health and other implementing partners.
- **Community engagement through IPC one: one and small groups sessions.** In the I Can campaign model, mass and social media is complimented by activities that bring clear information about the benefits of viral suppression to PLHIV and their communities through one-on-one or small group activities. The costs drivers of these activities are: training health care providers and PLHIV ART champion influencers to deliver this information using tools we have developed, conducting stakeholder meetings, vehicle and petrol costs for supportive supervision/quality assurance of interventions, and printing/producing data collection tools to monitor program progress. The key cost driver is the monthly allowance for ART Champions, which vary from country-to-country e.g., \$100 in Kenya and Zimbabwe and \$60 in Malawi, coverage, and project periods. During the pilot program, the campaigns in Malawi and Zimbabwe each saturated 3 high HIV burden districts, and 15 high-traffic facilities with 2 cadres trained per facility.

We have developed a costing tool (see Annex 04) that will provide more detailed guidance on the above costs, based upon your plans and project scope.

## Stakeholders Committee

The greatest challenges with SBC, including treatment literacy programs, are mixed messaging and disharmony brought about by a lack of well-coordinated treatment literacy efforts in a country. To avoid this, stakeholder engagement, coordination, and alignment are key. The I Can campaign fashioned as a regional campaign benefited a lot from a two-tier stakeholder engagement plan consisting of Global stakeholder committees and country advisory committees. We recommend the development of a stakeholders' engagement body that will support the roll-out and implementation of the campaign, where this coordination mechanism does not already exist. Below are key pointers to consider.

- **Map out all the relevant stakeholders** whose perspectives will be helpful across all the campaign phases from design to dissemination of results. Try to include SBC or communication representatives as well as advocates, clinicians, supply chain leaders, and other disciplines to ensure a holistic committee that can iron out barriers across the consumer journey.
- **Develop Terms of Reference** once you have identified the right membership of the stakeholders at various levels. TOR should be co-designed with the stakeholder group and include transparent operational procedures and work plan. Please see a sample of the project Global Stakeholders TOR in Annex XXX.
- **Craft Standard Operating Procedures** to implement the campaign in a standardized manner, which is critical for a communication campaign. The campaign's efficacy is dependent on its adherence to the innovative approaches it employed like designing from insights, human-centeredness, and the use of strategic consumer marketing techniques. These approaches are well addressed in how we tested and contextualized the campaign's mass media and community engagement tools to how we recruit, and train ART Champions.

See annexes for additional information on Pretesting, and recruitment and training of ART champions (Annex 05), and ART Champions Training Manual (Annex 02).



I CAN

## VII Adapting the Program for Your Context or Audience

This section guides you through the process to adapt the I Can Campaign to your context and audiences. We have drawn from existing program adaptation guidance such as [PSI's Keystone Design Framework](#) and [The Compass for SBC How-to Guide on How to Adapt SBCC Materials](#).

- Conduct situation analysis to assess treatment literacy landscape. This will help you define the problem, its severity and causes in your context; the people most affected by the gaps in treatment literacy; and factors affecting desired behavior (ART adherence or provider communication about treatment as prevention). This is done by reviewing existing evidence, tools, and needs. Guidance on how to conduct a situation analysis can be found here: <https://thecompassforsbc.org/how-to-guides/how-conduct-situation-analysis>
- Engage key stakeholders and assess readiness to adopt the campaign's key messaging in your context. Use the readiness assessment tool in Annex XXX
- Conduct an audience analysis to identify priority audiences for the campaign, and validate program audiences, behaviors, and determinants. <https://thecompassforsbc.org/how-to-guides/how-do-audience-analysis>
- Review the sample creative brief in Annex 06 of this toolkit, and update it based on your key audiences and context.

- Validate campaign assets for literacy, emotional appeal, audience resonance and potential for effectiveness.
  - o First, determine whether adaptation is appropriate to your audience and context based on audience needs, the campaign objectives in Section III, and the sample creative brief. This is a key step in determining: 1) whether to adapt the campaign materials, 2) deciding on your channel mix based on evidence of best channels to reach your audience, and 3) how much effort will be required to adapt to your context.
  - o The creative agency or media buying partner should take lead in developing an evidence based channel strategy. Useful information to guide channel strategy development includes: national census and media consumption data, existing client insight collected on their preferred media channels and times they are most receptive to information, the budget available and timeline for campaign.
  - o Determine modifications needed for each material. Focus on words, visuals, and formats of media in your channel mix.
  - o Consider costs and resources. Assess whether sufficient time, staffing and financial resources are available to adapt the material or product and achieve the communication objectives.
  - o Decide on the specific materials to adapt for your context and audience.
    - Adapt resources for your key audiences.
  - o Use your adapted creative brief to guide the process.
  - o Adapt materials using standard materials design processes such as Keystone Design Phase, or [The Compass for SBCC how-to develop SBCC creative materials](#). You follow the same steps to adapt materials as you do to design them outright.
  - o Pre-test concepts and draft materials with your primary audience.
  - o Revise and finalize the materials.
  - o Alternately, you can hire a creative agency to adapt the materials that you have determined are suitable for your program. They would follow a similar process to those listed here.
- Print and produce materials.
- Train staff in use of revised campaign tools, with focus on provider and ART champion IPC (using the ART Champions Training Curriculum in Annex 02) and digital media leads.
- Launch campaign.
- Conduct routine monitoring of campaign performance and adapt as needed.

## Tips & Recommendations

- Always start by analyzing the audience's needs and listening to their perspective on what content will work for them.
- Find out if there is a local SBCC or relevant communication/ health promotion technical working group for the development of SBCC materials. Technical working groups often share materials and expertise. They are also useful for identifying partners with whom to collaborate during and after the adaptation process.
- Useful tips on Channel Mix Selection or Prioritization based on your timeline and budget:
  - Spend more where there is highest return on investment: Carefully consider budget allocations. Media markets differ from country to country, for Malawi and Zimbabwe, the bulk of media budget was allocated to radio which is the highest reach medium in the two markets.
  - Have clear objectives per channel: Each channel selected has unique attributes and contributions to the overall strategy. Have very clear objective and roles that each channel will play and ensure all channel compliment each other.
  - Be consistent but don't be boring : A good media strategy will take into account the different in-channel executions or formats. Stay creative and find interesting ways to engage your audience within the channel they prefer but make sure to maintain a consistent look and feel for the brand/campaign.
- If the decision has been made to translate written material, it is important to hire professional translators who:
  - Are able to write well in their native language.
  - Have the necessary technical and cultural knowledge.
  - Can translate for meaning (instead of a literal translation, i.e., word for word).
  - Are experienced in writing for lower literacy audiences.
- Resources exist to support adapting materials for lower literacy audiences. You can find some of them here:
  - <https://www.thecompassforsbc.org/sbcc-tools/adapting-materials-audiences-lower-literacy-skills>
  - <https://thecompassforsbc.org/sbcc-tools/writing-text-reach-audiences-lower-literacy-skills>
  - <https://thecompassforsbc.org/sbcc-tools/visual-and-web-design-audiences-lower-literacy-skills>
- For further information on communication materials design, seek out guidance from well established resources on health communication such as:
  - <https://www.thecompassforsbc.org/sbcc-tools/making-content-meaningful-guide-adapting-existing-global-health-content-different>
  - <https://thecompassforsbc.org/sbcc-tools/simply-put-guide-creating-easy-understand-materials>
  - <https://www.thecompassforsbc.org/sbcc-tools/making-health-communication-programs-work>

The image features a vibrant yellow background with three large, overlapping white circles. The circles are arranged in a way that they create a complex, abstract pattern of overlapping shapes. The text 'THANK YOU' is positioned in the lower center of the image, rendered in a bold, dark blue, sans-serif font. The overall composition is clean and modern.

**THANK YOU**