Ministry of Health and Wellness
Terms of Reference
Consultancy to Develop Social Marketing Campaign to Increase ART Uptake/Adherence among Persons Living with HIV by Reducing Stigma and Discrimination

Background/Introduction

In October 2020, the Government of Jamaica, acting through the Ministry of Health and Wellness (MOHW), received a grant from the Centres for Disease Control and Prevention (CDC). The CDC issued a Notice of Funding Opportunity through a Cooperative Agreement of up to US$4m to support key programmatic areas for the National HIV Response. The Cooperative Agreement currently supports interventions under the following components:

- Prevention, care and treatment (PCT): address critical gaps in HIV diagnosis, linkage, retention and viral suppression. Emphasis will be on the scale up and expansion of index case testing (ICT)/partner notification services (PNS) as the primary case finding strategy, differentiated service delivery to improve adherence and retention, and optimization of medical care to ensure all patients become virally suppressed.
- Strategic Information (SI): focus on improving the quality, availability, timeliness and use of SI by strengthening quality assurance procedures, digitization of data collection tools and enhanced interoperability of information systems.
- Laboratory Strengthening: focus will be on improving the Lab-Clinic interface to enable more effective patient management.
- Enabling Environment and Human Rights and Stigma and Discrimination (EEHR/S&D): address discriminatory policies, gender-based violence, and other inequities that stand in the way of progress and human rights.

This consultancy falls under the EEHR/S&D component of this Cooperative Agreement specifically to reduce stigma and discrimination and increase the uptake of HIV prevention, treatment, care and support services.

WHO Treat All Policy

In 2015, the World Health Organization (WHO) recommended that antiretroviral therapy (ART) be initiated in everyone living with HIV at any CD4 cell count. This recommendation was based on evidence from clinical trials and observational studies released since 2013 showing that earlier use of ART results in better clinical outcomes for people living with HIV (PLHIV) compared with delayed treatment.[1] Several other studies have substantiated the findings that ART use in

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[1] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. World Health Organization 2015

HIV management has reduced morbidity and mortality among PLHIV. ART also improves life expectancy and quality of life for PLHIV while the resultant viral suppression reduces the risk of HIV transmission. Many countries, including Jamaica, have implemented the treat all policy. However, the uptake of and adherence (defined as following the recommendations made by the treatment provider on timing, dosage and frequency of medication taking)[2] to ART for those who have been initiated remain a challenge for many PLHIV.

Reasons for Sub-Optimal ART Uptake/Adherence

Among the reasons cited for the challenges faced by PLHIV with ART uptake and adherence is the failure of public health campaigns and HIV counselling practices to update their messaging to reflect the significant scientific advances of the last 5–10 years. In particular, information has not been fully disseminated regarding the lower side effects of the current regimens, the health benefits of early ART and the near elimination of HIV transmission by PLHIV who are virally suppressed. By way of an example, a study done in rural KwaZulu-Natal, South Africa, revealed that most young adults in the general population were unaware that ART virtually eliminates HIV transmission. Consequently, most respondents reported that they would feel uncomfortable having a sexual relationship with someone who is HIV positive even if they are on ART.

Addressing knowledge gaps about the improvements in treatment regimens and the sound reasons for early initiation is particularly important for PLHIV who present in better health and who are encouraged to initiate ART before experiencing serious HIV-related illness. The evidence shows that it is possible to attain high rates of viral suppression even for PLHIV presenting early in infection. As such, updating the messaging and information to incorporate the proven effectiveness of ART could be a simple and effective way to increase ART uptake.[3]

Despite the knowledge gaps, however, several studies conclude that stigma and discrimination-aptly defined in this context as an attribute or quality which significantly discredits PLHIV who are on ART in the eyes of their family, community, and health care providers and, in the case of discrimination, denying PLHIV the necessary social support

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[2] Bukenya, D., Mayanja, B.N., Nakamanya, S. *et al.* What causes non-adherence among some individuals on long term antiretroviral therapy? Experiences of individuals with poor viral suppression in Uganda. *AIDS Res Ther* **16**, 2 (2019). https://doi.org/10.1186/s12981-018-0214-y

[3] Shahira Ahmed, Jessica Autrey, Ingrid T. Katz, Matthew P. Fox, Sydney Rosen, Dorina Onoya, Till Bärnighausen, Kenneth H. Mayer, Jacob Bor,
Why do people living with HIV not initiate treatment? A systematic review of qualitative evidence from low- and middle-income countries, Social Science & Medicine, Volume 213, 2018, Pages 72-84, ISSN 0277-9536, https://doi.org/10.1016/j.socscimed.2018.05.048

for the consistent uptake of antiretroviral drugs-are the main reasons for the sub-optimal uptake of ART. Stigma and discrimination (S&D) are fuelled by the association of HIV with death as well as the fear of contracting it.[4]

Effects of Stigma and Discrimination on ART Uptake/Adherence by PLHIV

Many PLHIV perceive that starting ART will entail taking medication daily, forcing them to come to terms with their status, causing them distress, shame and denial in the process while also increasing the chances of (or even necessitating) disclosure to others which puts them at risk of externalised stigma. Second, PLHIV fear that being seen at a treatment facility as well as being seen taking medications can lead to rejection by current partners, peers, family, and community members. Third, in the case of women, studies have highlighted the fear of violence and exclusion as reasons for non-initiation. Fourth, research also identifies the inadequacy of social support-real or perceived-from partner, family, community, and peers as deterring PLHIV from starting treatment.

The literature is replete with evidence to substantiate the negative effects of S&D on the uptake of/adherence to ART. In Tanzania, it was noted that PLHIV were unwilling to seek treatment at the nearest health facility thereby risking irregular replenishment of their ARVs because they feared being seen by people who know them as friends and neighbours. Likewise, it was found that nondisclosure of HIV+ status to a spouse was due to fear of violence and divorce/separation which affected some women's attendance at treatment sites as they lacked the fare and were unable to justify their absence from home on clinic days. It was also found that S&D undermined social support which, in turn, makes PLHIV on ART vulnerable, for instance, to food insecurity.

S&D and ART Uptake in Jamaica

In the specific case of Jamaica, the findings of the 2020 Stigma Index revealed that 44% of participants reported that they had reasons for delaying their treatment. Participants reported that their concern that other people would find out about their status caused them to delay treatment (29%), as did their own unwillingness to deal with their HIV diagnosis (26%). Twenty-seven percent (27%) of participants reported that they have missed a dose due to fears that other people would find out about their HIV status, whereas 21% reported being afraid that health workers would mistreat them or disclose their status without permission and 16% reported already having had a bad experience with a health worker that caused them to delay their HIV treatment.

[4] Maisara Mhode, Tumaini Nyamhanga, "Experiences and Impact of Stigma and Discrimination among People on Antiretroviral Therapy in Dar es Salaam: A Qualitative Perspective", AIDS Research and Treatment, vol. 2016, Article ID 7925052, 11 pages, 2016. https://doi.org/10.1155/2016/7925052

Ten percent (10%) of participants said they do not receive their HIV care in the area where they reside. Most of the reasons volunteered for that decision revolved around concerns that if they sought care close to where they reside, their HIV status would become known to people to whom they would prefer not to disclose, whether through community members seeing them seek care, knowing someone at the facility, facility staff gossip, or unauthorised disclosure by health facility staff. Some participants also expressed concern that the facility staff would offer them substandard treatment, insult them, or judge them.[5]

Addressing S&D to Increase ART Uptake/Adherence

An effective and comprehensive response to S&D is therefore imperative for the success of treatment and care efforts. HIV-related S&D need to be addressed at all levels-the interpersonal, community, and societal levels-to positively impact the uptake of and adherence to ART. At the interpersonal level, health systems interventions should seek to reduce internalised feelings of shame due to perceived S&D at the time of eligibility to support PLHIV in making their decisions about treatment. At the community and societal levels, a community-randomized trial found that providing information on the prevention benefits of ART lowered stigma and increased participation in HIV testing. Beyond education about ART, engagement with community leaders to normalize HIV is critical to reducing stigma and discrimination. The provision of **social support**, defined as a network of family, friends, neighbours and community members that is available in times of need to give psychological, physical, and financial help, is also crucial.[6] Some studies noted the lack of community education and mobilisation efforts as factors that deterred from creating the supportive environment necessary to allow PLHIV to make better decisions about initiating treatment. Other studies have described the positive influence of strong social support from family and friends, leading to the acceptance of treatment.[7]

Objective of Consultancy:

The objective of this consultancy is to develop a **basic social marketing campaign** to address the knowledge gap about the efficacy of ART and by so doing, increase social support at the societal level for PLHIV.

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[5] Jamaican Network of Seropositives and Health Policy Plus. 2020. *The People Living with HIV Stigma Index: Jamaica.* Washington, DC: Palladium, Health Policy Plus.

[6] https://www.cancer.gov/publications/dictionaries/cancer-terms/def/social-support

[7] Shahira Ahmed, Jessica Autrey, Ingrid T. Katz, Matthew P. Fox, Sydney Rosen, Dorina Onoya, Till Bärnighausen, Kenneth H. Mayer, Jacob Bor,
Why do people living with HIV not initiate treatment? A systematic review of qualitative evidence from low- and middle-income countries, Social Science & Medicine, Volume 213, 2018, Pages 72-84, ISSN 0277-9536, https://doi.org/10.1016/j.socscimed.2018.05.048.

Campaign Goal:

To increase uptake of/adherence to antiretroviral therapy (ART) by PLHIV through stigma and discrimination reduction and increased social support.

Specific Campaign objectives:

To:

1. Address knowledge gaps about the improvements in ART regimens to increase ART uptake
2. Promote the reduction of stigma and discrimination towards PLHIV in all settings particularly family/household and community settings
3. Emphasise the importance of social support to ART uptake and adherence by PLHIV for the attainment of viral suppression
4. Articulate the benefits of adherence and viral suppression to epidemic control in Jamaica

Target Audience

Primary audience

The primary target audience are the families/household members of PLHIV as well as the members of the various communities that they interface with including the geographical communities in which they live, healthcare settings, the workplace and places of worship etc.

Secondary audience

1. Previously diagnosed HIV+ persons who have not yet started ART
    a. Those who are "healthy" and deliberately avoid starting ART
    b. Women who were previously in the PMTCT programme who were taken off ART post delivery
    c. Persons who have been lost to follow-up
    d. All other persons who were exempt based on CD4 level above 500
2. Newly diagnosed HIV+ persons

Call to action/main message

1. Encourage and support PLHIV to adhere to their treatment regimen
2. End all forms of stigma and discrimination against PLHIV for increased ART uptake/adherence and viral suppression
3. Do it for your community, do for Jamaica-support PLHIV to achieve viral suppression and the end of AIDS in Jamaica

Methodology

Formative assessment

Focus group discussions and key informant interviews will be conducted with the target audiences. People living in rural and urban areas will be included in the data gathering process. The input of key stakeholders such as sexually active men and women who are HIV negative, representatives of the multi-disciplinary care team-Adherence Councillors, Social Workers, and Psychologists-, the Jamaica Council of Churches (JCC) and other faith-based organisations and representatives of public and private sector organisations will also be consulted. Civil Society Organisations (CSOs) which offer services to PLHIV including the Jamaican Network of Sero-positives (JN+), Jamaica Forum for Lesbians, All Sexuals and Gays (J-FLAG), Eve for Life, Jamaica Community of Positive Women (JCW+), Larry Chang Center and the Jamaica AIDS Support for Life (JASL) and their clients will also participate in the consultation process.

Media Products

Traditional mainstream media remain the most popular outlets for delivering HIV-related messages according to the 2017 KABP survey. The media formats are:

- 1x 30-seconds television commercial
- 2 x 30 seconds radio commercials
- 1x 30 seconds Jingle with accompanying video
- 2 Billboard designs
- 2 video/motion graphics for social media placement
- 3 infographics for social media placement
- 2 designs/messages for placement on JUTC buses

Pretesting

Following their development, the media campaign products are to be pretested among the target audience. The results and recommendations from the pre-test report will be used to make final edits to the media products. The changes will be made to ensure that the messages and materials are appropriate and acceptable to the intended target audience. Pretesting of materials will be conducted by an independent third-party researcher with experience in conducting this type of research.

Deliverables

The media campaign products should be delivered in high-resolution large file format. All media campaign products should be delivered on an electronic storage devise e.g., a jump drive.

Scope of Work

The contracted marketing/communications consulting firm will be required to provide the following services:

1. Attend Inception Meeting to finalise scope of work. Submit Inception Report
2. Finalise Work Plan outlining each step in the project and associated timelines/cost
3. Develop FGD and KII guide
4. Recruit FGD participants and Key Informants in collaboration with the NFPB and CSOs such as JN+, JASL and Eve for life
5. Conduct five (5) focus group discussions with primary and secondary target populations and produce report:
    - 1 key population Group - *Location: URBAN*
    - 1 key population Group - *Location: RURAL*
    - 1 general population - *Location: URBAN*
    - 1 general population –Location: RURAL
    - 1 service providers (RHAs/treatment sites-Adherence Councillors, Social Workers, Psychologists etc.)
6. Develop media campaign products for placement on radio, television, social media and outdoor media.
7. Meet with the Technical Advisory Panel/Committee throughout the campaign development process.
8. Revise materials based on feedback from the Technical Advisory Panel/Committee as well as based on the recommendations of the pretesting of draft materials

Schedule of Deliverables

Deliverable	**Due Date**	**Budget %**
Inception Report and work plan outlining each step in the project, associated timelines including Draft Focus Group Discussion (FGD) and KII guide	**1st week after contract signing**	10%
Develop Focus Group Discussion (FGD) and KII guide and recruit participants, Conduct FGDs, prepare and submit Report	**8 weeks after contract signing**	10%

Deliverable	Due Date	Budget %
Attend a minimum of three (3) Meetings of the Technical Advisory Panel/Committee throughout the campaign development process. More meetings may be required depending on the circumstances	**Recurrent (Consulting firm will be advised of meeting dates ahead of time)**	
Draft scripts and artwork mock-ups for media campaign products for review and feedback: o 1 x 30 Seconds Television commercial o 2 x 30 Seconds radio commercials o 1 x 30 seconds Jingle with accompanying video o 3 infographics for social media o 2 video graphics for social media o 2 x Billboard artwork mock-up o 2 Designs/messages for placement on JUTC buses	**12 weeks after contract signing**	10%
Second draft scripts and artwork mock-ups for media products for review and feedback: o 1 x 30 Seconds Television commercial o 2 x 30 Seconds radio commercials o 1 x 30 seconds Jingle with accompanying video o 3 infographics for social media o 2 video graphics for social media o 2 x Billboard artwork mock-up o 2 Designs/messages for placement on JUTC buses	**15 weeks after contract signing**	20%
Produce media campaign products in ready formats printed and electronically for pretesting.	**16 weeks after contract signing**	10%
Revise media campaign products to reflect recommendations from pretesting	**20 weeks after contract signing**	10%
Provide final versions of media campaign products in high resolution electronic file formats on a jump drive	**22 weeks after contract signing**	10%
Present the final products of the media campaign products at the official launch	**24 weeks after contract signing**	20%

Acceptance Criteria for Deliverables

Deliverables will be approved for payment upon satisfying the following criteria:

- Attend Inception Meeting with representatives of the NFPB
- Attend technical advisory panel/committee meetings to share report findings and provide progress updates
- Deliverables are submitted on agreed dates and accompanied by a signed invoice (where applicable) as outlined in the schedule of deliverables
- Reports are written in standard English, formatted and contain Executive Summaries reflecting background, main findings, conclusions and recommendations and
- Media campaign products are delivered in specified format and on storage drive

Required Qualifications and Experience

The selected marketing/communications consultancy firm should possess the following:

- 3-5 years of operation as a marketing/communications consulting firm with proven track record (include product samples in Proposal) of producing effective high quality media campaign products across multiple mediums (e.g., traditional and social media, graphic design for billboards/fliers/posters; audio-and video-production capacity). Experience developing public services/behaviour change campaigns would be an asset;
- Team lead should possess at minimum a first degree in media and communications, marketing, social sciences or related fields
- Team lead will be responsible for coordinating the team, communications with the NFPB and the overall direction, quality and timeliness of all outputs
- Team members should possess at minimum certification or associate degrees in related fields and at least 1-year experience
- Team should consist of experienced graphic designer with background in advertisement and keen sense of how to communicate core messages effectively through images and graphic design
- Team should consist of experienced video/audio editor, preferably with ability to implement animations (e.g., in Adobe After Effects/Animator)
- Experience in development of health communications messages would be an asset
- Working knowledge of issues around HIV-related Stigma and Discrimination, HIV Prevention, Treatment and Care would be an asset
- Must have a valid TRN and TCC

Evaluation Criteria

The most suitable consulting firm will be contracted for the campaign. The consulting firm is selected by way of a bidding process based on the criteria outlined in the table below. Consulting firms attaining a score of 75% or higher will be considered:

CRITERIA	SCORE	DOCUMENTS REQUIRED IN RFP
EXPERIENCE - 60		
The Consulting firm has 3-5 years of operation as a marketing/communications consulting firm	10	
The Consulting firm has proven track record (sample products included in Proposal) of producing effective high quality media campaign products across multiple mediums (e.g., traditional and social media, graphic design for billboards/fliers/posters; audio-and video-production capacity)	20	
Each team member is qualified and experienced with regards to the Terms of Reference (minimum academic qualifications, level of experience, team composition)	. 30	
METHODOLOGY AND WORK PLAN - 40		
Clear understanding of the campaign objective seen in the technical approach, methodology and organisation.	25	Technical Response – A
Deliverables shown in the work plan are in keeping with the Terms of Reference	15	Technical Response – B (Work Plan)
TOTAL	**100**	

Format of Deliverables/Outputs

Provide final versions of media campaign products in high resolution electronic file formats on a storage drive.

Duration of Consultancy

The duration of this Consultancy, including the pre-testing of the media campaign products developed, is **six (6) months** from the date of the signing of the contract between the NFPB and the Consulting Firm.

Reporting Relationship

The Consulting Firm will report directly to the Director, Enabling Environment and Human Rights (EEHR) Unit of the NFPB and indirectly to the Technical Advisory Panel (TAP) consisting of multi-sectoral representatives who will provide oversight and guidance in the development of the campaign.

Specific Inputs to be provided by the Client

The NFPB will provide introductory letters/emails and electronic and/or printed copies of background documents to the Consulting firm.

SPECIAL TERMS AND CONDITIONS

- Any studies, reports, or other material, graphic, software or otherwise prepared by the consultant under the contract shall belong to and remain property of the NFPB.
- The data garnered from this proposal/project is the property of the EEHR Unit, NFPB. Permission must be granted before it can be used outside of this specific nature.
- All research/reports on this project must be submitted to the EEHR Unit by or before the end of the contract.
- All information related to this project (video, audio, digital, cyber, project documents, etc.) remains the property of the National Family Planning Board. Written permission must be sought from the NFPB and granted before any aspect can be used outside of its intended purpose.
- The jingle must be accompanied by a music bed/sample
- The media campaign products are being developed for multiple use across several platforms.
- Each media campaign product video should have a closing visual with the contracting agency's logo and any other logo as agreed.
- Any music used within the production of the audio-visual products (radio/TV commercials/Jingles etc.) must have full copyright access for NFPB's usage.

The videos' technical specifications must include the following:

Item	Technical Specifications	
Video	Ratio	-1280x720 -1920x1080 (HD) - 720p or 1080p
	Deinterlacing	-YES
	Codec	- H.264 / AAC
	Frame rate	- 30fps
	Video Format	- mp4
	Time Frame	- (2) 30-second videos
	Quality	- High definition (HD)