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ORIGINAL ARTICLE

APPLYING STRATEGIC COMMUNICATION MODEL TO HIV-AIDS COMMUNICATION CAMPAIGN IN TAMIL NADU: A CRITICAL EVALUATION

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Abstract

HIV prevalence in the state of Tamil Nadu, in South India, registered a tenfold reduction between 1990 and 2011. This paper traces HIV-AIDS initiatives of the state and seeks to locate the key drivers of the success of these campaigns. Using the Strategic Communication Model (McKee, 2004) that integrates the modernization, knowledge sharing, participatory and radical media approach to communication for social change, this study identifies and elaborates five key factors that led Tamil Nadu to successfully halt and reverse HIV epidemic. These include 1). Government role and poli6cal will collabora6on and partnership 2). Targeted interven6on and community mobiliza6on 3). Behavioural Change Communica6on strategy, advocacy, media support 4). Evidence-based programming 5). Care, support and treatment. Tamil Nadu's adoption of innovative strategies and diverse experience in comba6ng HIV-AIDS holds valuable lessons for public health interventions in many different contexts. An integration of four approaches to communication for social change was made possible by the institutional support that transcended partisan political consideration. More broadly, the role of state institutions is critical for the success of health communication campaigns, but these institutions need to work outside their institutional constraints and broaden their perspective to include participatory and radical media to be effective at the community level.

Keywords: *Strategic Communication Model, Health Communication, HIV-AIDS, India, Tamil Nadu.*

INTRODUCTION

The state of Tamil Nadu, in southern India, has been tackling the HIV- AIDS epidemic with determination, confidence, and dynamism. In the 1990s HIV epidemic posed a formidable challenge. The first HIV case was detected in Chennai, Tamil Nadu and the warnings signs were recognized early on. Tamil Nadu's response to this challenge had been innovative, instructive, drawing the attention of many leading experts (**Singhal and Rogers, 2002**).

HIV infection reached its peak in the early 90s and was showing clear signs of moving from high risk to the general population. The HIV prevalence among antenatal clinic attendees, which is considered as an indicator of prevalence in the general population, shows a decline

from 1.13 % in the year 2001 to the level of 0.25% in the year 2010 (HSS NACO 2009-). Awareness levels increased from 23% in 1993 to 93% in 2011 (NFHS 3 2005-06-From 1,2 and 3 Rounds). Today, Tamil Nadu has an estimated 150,000 people living with HIV, with only 850 new infections identified in 2011. Would these numbers be much higher had it not been for the communication initiatives embedded in the anti-HIV-AIDS campaign?

There has been very little academic systematic and holistic attempt to document and trace this movement to arrest a devastating epidemic. How did Tamil Nadu leapfrog from a high to low prevalence state? What gave the state its critical edge in tackling HIV/AIDS? What does Tamil Nadu have to offer to the rest of the world in terms of lessons learned? This paper takes a communication approach to answer these critical, instructive questions.

The research problem is located within the broad field of communication for social change and much more specific sub-field of health communication. Strategic Communication Model as developed by **McKee**, (2004) has been used as a framework for analysing the HIV initiatives in Tamil Nadu taking heed to the recommendation that "Communication strategies must be tailored to individual national settings and to the different sub-populations within each country (**McKee, 2004**)".

LITERATURE REVIEW

A major challenge in tracking the trajectories of health communication strategy is that most practitioners tend to under articulate the role of theory in informing their decisions (**McKee, 2004**). Theoretical constructs and models are helpful in improving the design and evaluation of health communication campaigns. They can be useful in identifying key factors that have contributed to the success of communication campaigns.

Health communication emerged within the broader concerns over the potential for using communications for development (**Melkote, 2001**) . There has been a shift from an individual focus to an emphasis on social change. with a number of distinct ways of thinking about the role of communication in solving the problems of health and wellbeing (**Sparks, 2007**). Four lines of arguments for how communication can support social change are relevant to the present study on HIV communication (**McKee, 2004**). The presentation below is necessarily limited, focusing on the key lessons theoretical learned from communication for social change for applied health communication.

MODERNIZATION MODEL

First, the dominant development communication paradigm, an artifact of cold war geopolitics placed considerable faith in the ability of communication, especially mass media, to bring desirable social change-the desire often defined by governments and experts. The dominant paradigm of communication and its variants made an earnest attempt to reduce global poverty, through aligning communications to national-statist agenda of development. Investment in public awareness through Information Education and Communication (IEC) campaigns to address social problems became its core strategy. The model has been justly critiqued for being, a) top-down, expert-driven approach b) equating modernization with westernization c) ignoring structural factors that contribute to inequalities. The model was mainly applied to the agricultural development and rural poverty but was extended to health communication. From this modernization paradigm, social conditions would be considered as

generally benign and public health issues such as HIV would be seen as pathological aberrations that require fixing, leaving the structural factors that lead to health inequality unquestioned (**Downing, 2001**).

Despite its shortcoming 'continuity variants' of dominant paradigm still has considerable influence, especially in the field of health communication, where expertise is still considered decisive in determining what is good for the people (**Sparks, 2007**). In the context of health, this means an emphasis on programs that ameliorate suffering through awareness creation and literacy to address the urgent needs of the people (**Nutbeam, 2000**).Social marketing strategies to promote health-HIV-AIDS initiatives would fit this model of intervention (**Go, 2003; Kalasagar, 2006**) as would be the ABC message framing. From this perspective, HIV-AIDS are a transient phenomenon, affecting the normal flow of development that needs to be removed. There was no recognition that people affected with HIV-AIDS constituent part of the social fabric of the society. In other words, the modernization model assumed that the origins of the problems are irrelevant to find 'solutions'.

KNOWLEDGE CREATION AND SHARING MODEL

The second model relates to knowledge sharing, with its emphasis on making knowledge open access. Knowledge Sharing model, which took shape under the influence of new information and communication technologies, focused on "knowledge gap" and "digital divides that limit the potential of the use of communications. The model underscored the importance of exchanging data and research, problematized the intellectual property rights regimes that restrict the free flow of knowledge. Knowledge sharing approach worked from the assumption that global and regional inequalities are a consequence of creating legal and economic fences around knowledge. The model address public health issues by supporting efforts to collect accurate data, share innovative solutions and reduce barriers to knowledge exchange. The model rests on principles of deliberative democracy and rationality along the lines of Habermas's idealized public sphere (**Calhoun, 1992**). In practical terms, the knowledge sharing model highlighted the network characteristics of communication systems and how they could create opportunities for learning and innovating.

PARTICIPATORY MODEL

Participatory model is another approach to sharing knowledge but emphasis incorporation of peoples' local and indigenous knowledge and resources along with expert knowledge. The strength of the participatory paradigm lies in its ability to take a bottom-up people-cantered approach to the question of public health (**Servaes, 1996**). Participatory models thus have been framed as empowerment communication (**White, 2004**).

There are however several challenges in implementing the participatory model. Collin Sparks identifies several problems with participatory paradigms: i) its failure to recognize "the problem of the unequal power of people at the grassroots and work to "empower" them' (**Melkote and Kandath, 2001**) ii). its failure to problematize the notion of "community"-glossing over internal conflicts and questions of representations iii). its rural poverty bias and limitation in addressing fluid notions of community under urban settings iv). its steadfastness in refusing to directly address questions of political actions-that are often required to address challenges

facing urban poor (land and housing rights for example) and v). its uncritical acceptance of the benign role of intermediaries such as NGOs.

Despite such critique, participatory paradigm manages to offer a creative alternative to individual-focused health communication and is most consistent with the democratic ideal of participation and notions of "inclusive development" (**Stiglitz, 2002**). Further approaches such as "Entertainment-Education" works from participatory assumptions and seeks to use the emotional and narrative capacity of entrainment to engineer learning and education in health communication settings (**Piotrow and de Fossard, 2003;Singhal, 2003**).

SOCIAL MOVEMENT MEDIA MODEL

The fourth model relates to social movements and the role of communication within what Downing calls "social movement media" (**Downing 2001**). The model has several variants including community media, citizen's journalism, alternative media and radical media. Within the developing countries, the model took the form of participatory paradigm, which emphasized a bottom-up empowerment approach. The task for mediated forms of communication is to give "voice to the voiceless" by identifying and articulating their needs. Clear emphasis was placed on resource poor's participation in the decision-making process that affects them and provides opportunities for exercising rights that have been traditionally denied.

John Downing's concept of "radical media" and Chris Atton extension of "alternative media" (**Atton, 2008, Downing, 2001**) take the participatory paradigm to its fullest radical potential by de-emphasizing the role of intermediaries and theoretically securing the promise of the challenge to established power relations in society (**Downing, 2001**). In its updated version, social movement media are characterized by small-scale, under-financed, empirical media and communication practices. These include not only the radical use of mainstream media but also cultural forms of expressions such as street theatre, performing arts, wall posters, etc. (Downing, 2011-ty).

Unlike the dominant paradigm, the social movement media works from the premise that some features of the society are always unjust and only by explicitly dealing with political conflict and social marginalization that we can be hope to bring social change. These realities mean that for small movements, modesty as to what can be achieved in the short term is an absolute necessity (ibid).

Social movement media are small-scale, grassroots oppositional. The use of traditional, folk media that incorporates aspects of mass culture also carries a potential for rebellious communication (**Sabarimuthu, 2010; James, 2010**). Various types of community media that focus on specific issue such as commercial sex workers' empowerment (**Dasgupta,2009**), the use of theatre and performing arts (**De_Bruin, 2003;; De_Bruin, 2000; Padma, 2000; Seizer 2005**), mimicry (**Weidman, 2010**) and religious festivals (**Sivaraman, 2011**) and posters, which DeSouza and Blamey call, "living pictures", (**Dsouza and Blamey,2005**) are prime candidates for creating spaces of oppositional communication and awareness.

Social movement media use in Tamil Nadu has a long history that can be traced to gramophone use during Indian national movement (**Hughes, 2002; Hughes, 2007**). Public address systems that use now banned cone speakers are another example of the use of unconventional media for democratic participation (**Bate, 2009**). Social movement media can

be treated as local resources that can be redeployed for reaching hard to reach groups for health communication. These alternative forms of mediatisation have the capacity to align itself with health-based social movements and mass social mobilization (**McPhail2009-nr**).

The effectiveness of social movement media depends on the success of the social movement that it articulates. There is an extensive body of research that has examined the phenomenon of health-issue based social movements (**Brown2004-w**). These studies have examined various sub-themes such as media advocacy role (**Wallack, L et al. 1993**), mental health (**Crossley, N. 2002; Brown, 2004**). Studies have also examined the radical approaches to health-based social movements that seek to resist evidence-based approaches from a postmodernist perspective (**Pope, 2003**). They have focused on 'collective-confrontational dimension' wherein the patients appear to resist expert treatment plans for various reasons. Despite these studies, very little attention has been dedicated to health social movement within media studies. If health is referred to at all they form only a part of the larger, more overtly political agenda (**Downing, 2011**).

The broad lesson from this short literature review can be summed through the words of **Collin Sparks** (2007): "The role of communication and media in the effort to improve a lot of the world's poor is, therefore, one that is integral to building a social movement. On its own, the best communication cannot succeed in changing the situation. Only when the poor are organized and confident can the problems that face them be addressed, and it is a social action that gives people confidence and organization. The media have a central role in this process because finding a public voice is one of the ways in which both confidence and organization can be built. "(Sparks, 2007)"

The four approaches outlined above are not mutually exclusive, even though from a historical perspective they have been critical of each other. Each of the approach offers some advantages to addressing public health issues, but are also restrictive. Donors and local governments focused their efforts on health awareness campaigns at various levels of decision making-individuals to policymakers (dominant paradigm). Further International Donors and Central authorities, along with experts and researchers have focused on knowledge creation (knowledge sharing model). Non-governmental Organizations and community level organizations have provided support services and engaged in advocacy communication using various local media resources (radical media use).

STRATEGIC COMMUNICATION MODEL

Given this mutual dependence and interrelatedness, many scholars have called for an integrative approach to health communication that sees each of these approaches not in oppositional terms but in its complementary roles (**Mefalopulos, 2008**). The main contention with the communication approaches outlined above is that the proposed models tend to create a sharp divide between interpersonal, group and mass communication. This assumption is understandable as the field of communication emerged with the questions over the impact of mass media. However, in dealing with the question of HIV-AIDS, the rupture between mass and interpersonal modes of communication is unsustainable. There is a need to shift focus from "media effects" to "communication effects" giving primacy to communication processes and its contribution to social outcomes.

Mefalopulos, (2008) proposed a multitrack model is rooted in two-way dialogic mode but which can recombine "the various approaches, such as information dissemination, social marketing, lobbying, edutainment, community mobilization, and others. This approach are considered "tracks" and are "intended as courses of actions or paths to be followed" (**Mefalopulos, 2008**). The choice of "tracks" depends on the needs and the timing of the targeted intervention in the project cycle. Multitrack model is an attempt to consistently recombine different approaches to communication and development and broaden the boundaries to include an integrated view of practice. The horizontal and participatory process is considered at crucial stages of health communication campaigns (**Mefalopulos, 2008**).

McKee, (2004) Strategic Communication Model provides a comprehensive mapping of different facets of health communication tailored to the HIV context. The model seeks systematic, rigorous and careful planning as opposed to more widespread "ad hoc" approach. The model "combines a series of elements—extensive use of data, careful planning, stakeholder participation, creativity, high-quality programming, and linkages to other program elements and levels, among others—that stimulate positive and measurable behavior change among the intended audience."

McKee (2004) identifies three generalizing orientation for strategic communication "1). target social norms as well as Individual behaviour 2). expand beyond ad hoc activities to a coordinated social movement and, 3). bring community-level activities to scale through a linkage with mass media. These general principles rest on the recognition that i). individual behaviour cannot be divorced from social and cultural settings and ii). there is an unequal distribution of health outcomes characterized by health inequalities in behaviour, access to information, and services to service.

Practical strategies derived from the four approaches can be seen as “toolkit” that practitioners can gainfully employ depending on the context of health communication. While communication for modernization model, can help address issues of urgency such as HIV prevention through condom use etc.; knowledge sharing model can encourage free and open access to knowledge; participatory model supports community and social mobilization. Social movement media model engages in dialogic, rights-based claims, raising issues of entitlements and unequal structural factors that influence behaviour.

Based on strategic communication model, this paper seeks to address the following research questions 1) What reasons are attributed to the success of HIV-AIDS initiatives in Tamil Nadu during the period 1993-2011 and how does communication incorporated in the process 2) What activities programs and practices were making a significant contribution to the success? What measurement and indicators were used to assess the impact and effectiveness of the strategies? What plans and visions were considered for sustainability?

METHOD

This paper adopts a case study design with the state of Tamil Nadu as a unit of analysis and boundary condition (**Yin, 2009**). Data collection was primarily carried out through in-depth interviews with key informants closely associated with HIV-AIDS initiatives in Tamil Nadu. The study relied on an analysis of various reports of the central and state governments, non-governmental organizations and behaviour surveillance survey (HSS NACO, 2009; NFHS 3, 2005-

06-From 1,2 and 3 Rounds; TANSACS, 2008, Annual Report; BSS, Reports Various Years, 1993-11; NACO, Reports Various Years- 1993-11) for validation of the factual claims made by key informants. Analytically a second order reinterpretation of the available evidence was used to locate key drivers that lead the state to reduce the prevalence and control of HIV-AIDS between 1993 and 2011.

The purpose of this analysis is to locate the key factors that enabled Tamil Nadu to achieve its goal of zero incidences of HIV-AIDS. I approached the analysis of interview data and documents in specific ways. Some documents where directly to the issues I was addressing. The interviews enabled me to trace the trajectory of communication within the overall strategy the state adopted for prevention and control of HIV-AIDS. These are like "eyewitness" accounts of movements and shifts in thinking within those involved in the providing services. As a consequence, they are selective and provide only fragmented views of practices. They require cross-checking and corroboration. Reports produced by various stakeholders I have treated as a secondary source. These provided additional data for cross-validation and further probing in interviews. I also examined the communication materials and messages produced as a part of various activities-posters, booklets, advertisement campaigns, news reports, flyers etc.

FINDINGS

Several factors contributed to Tamil Nadu's success in HIV prevention. Strong political will, given the state an early start. Through innovative targeted intervention and community mobilization programs, supported by culturally sensitive behavioural communication strategies backed by solid evidence the stakeholders were able to work as a team. Such an approach led the state to extend prevention, care, support, and treatment to all those in need. By putting people at the heart of the prevention strategy, Tamil Nadu charted a unique path to develop a "social vaccine" to arrest the spread of HIV epidemic.

KEY DRIVER ONE: POLITICAL WILL

The Tamil Nadu state government, created an enabling environment, through sustained political will, bureaucratic support, and collective leadership. The state's commitment to, HIV prevention was revealed early on, when Tamil Nadu State AIDS Control Society, was established in 1994, to coordinate, and channel resources, to key stakeholders. Following the "Three-One" Principle outlined by National AIDS Control Organization of India (NACO), Tamil Nadu built a multi-sectoral network of institutions that worked in sync to prevent HIV transmission. The "3-1-Principle" involved creating one authority, one common framework and one monitoring and evaluation systems) (NACO, Reports Various Years- 1993-11). Tamil Nadu State AIDS Control Society (TANSACS) began putting this principle into practice by partnering with several, national and international development agencies, such as USAID, APAC, Bill and Melinda Gates Foundation, Avahan, Children Investment Fund Foundation, and UNDP (**TANSACS, 2008, Annual Report**).

These partnerships, created an organic bond, between the stakeholders, especially with the vulnerable communities. A ground-breaking agreement between, Tamil Nadu State Government, the Central Government, USAID and, Voluntary Health Services(VHS) in 1996, led to the establishment of AIDS Control and Prevention Program, or APAC, that served as a catalyst for scaling up HIV prevention activities. One critical component of this strategic

partnership is the establishment of a dedicated network, of Non-Governmental Organizations (NGOs), and Community Based Organizations (CBOs)(ibid). The civil society organizations provided the last mile linkage, between the supportive institutions at the top, and the communities at the grassroots. Tamil Nadu further extended prevention programs to reach through "public-private partnerships" initiatives, with corporates, private hospitals, and condom manufacturers. The first condom social marketing program in India was built on a successful public-private partnership between APAC, condom manufacturers and local NGOs (TANSACS, 2008, Annual Report).

KEY DRIVER TWO: TARGETED INTERVENTION

At the heart of these initiatives lies an essential insight, which of targeted intervention, tailored to the needs of the most at-risk population. Targeted Intervention (TI) Programs were implemented through NGOs and involved behavioural change communication(BCC), safe sex practices, service delivery, condom promotion, community mobilization, and creation of an enabling environment for people living with AIDS (HSS NACO, 2009). The broad category of people, which receive targeted intervention included female sex workers (FSW), men having sex with men, truckers & helpers, migrant workers, and injecting drug users. There are an estimated, 64,631, female sex workers in Tamil Nadu, out of which, 44,429 have been reached through, targeted intervention as of 2011 (BSS Wave XIII, 2011). Sex workers have played a major role in the prevention of HIV transmission in Tamil Nadu, through educating themselves, their clients and peers about safe sex practices and condom use. Projects such as Shakthi Plus and Safe Plus empowered FSW while Reaching Unreached Sex Workers (RUSE) Through a Client-based Approach developed strategies to reach the unreached segments of sex workers (**NACO, Reports Various Years- 1993-11**).

Tamil Nadu realized early on, the need to target truck drivers and helpers, as they constitute, one of the high-risk groups. By 2012, the targeted intervention had covered 67% of the estimated population of 104,405 people (BSS Wave XIII, 2011. Programs such as, “Prevention along The Highway” Or “PATH”, made, pioneering attempts to, design interventions, that are tailored, to the needs and circumstances, of long distance truck drivers, and helpers. Tamil Nadu is the first State, that took concrete efforts, to provide services for Men-having- sex-with-men or MSM, and transgender through peer education model. There are over 38,00 MSM out of which more than 27,000 have been reached through, targeted intervention. Organizations such as Tamil Nadu AIDS Initiative (TNAI) invested substantial time and effort to mobilize transgender and the MSM communities (**NACO, Reports Various Years-1993-11**).

Other significant high-risk groups, reached by Targeted Intervention, includes Single Male Migrant workers (SMMW) and Injecting Drug Users (IDU). The targeted intervention contributed to increased condom use, though, promotion activities such as condom demonstration, condom negotiation skills, free distribution, and placement of condoms in traditional and non-traditional outlets. Among Female Sex Workers, condom use increased steadily, with one time partners with regular clients and with regular partners.

Further, voluntary procurement of condoms by FSW, showed a steady increase, from over 10% in 1996 to 95% in 2011. Similarly, condom use among MSM increased from 2007 to 2011across all relationship- with male paid partners, male regular partner and with casual

partners. Targeted intervention opened the space for community participation, that deepened the reach, and coverage of HIV prevention strategies. Capacities built through TI programs led to the creation of community-based organizations that fostered a participatory culture amongst the marginalized population. Propelled by community participation, the HIV testing practices, among the most at-risk population, showed a steady increase through the last decade. A self-organizing, critical mass of volunteers, peer educators and CBOs are now continuing the momentum created to create a sustainable health system (**NACO, Reports Various Years- 1993-11**).

KEY DRIVER THREE- EVIDENCE-BASED PROGRAMMING

Sound HIV intervention strategy, is built on, a strong foundation of scientific research. Tamil Nadu, developed the ability to apply evidence-based best practices effectively through Clinical Research, Behaviour Surveillance Surveys, Mapping Studies, and Monitoring & Evaluation activities (**HSS NACO, 2009**) (NFHS 3, 2005-06-From 1,2 and 3 Rounds). The state pioneered evidence-based programming, which included the first Behavioural Surveillance Survey (BSS) in India; the first mapping of high-risk population; and the first community prevalence study of sexually transmitted infections (STIs). TANSACS has been conducting, sentinel surveillance, amongst ante-natal & STI attendees, blood bank donors, high risk groups, as well as the, general population Several indicators were tracked, to provide a roadmap for focused interventions including data on knowledge-awareness levels, risk perception and behaviour, and HIV testing practices (**TANSACS, 2008, Annual Report**).

For example, data on routes of transmission enabled development of evidence-based programs such as prevention of parent to child transmission (PPCTC). In addition, Tamil Nadu carried out a geographical mapping research that painstakingly chartered high-risk districts, hotspots for FSW, MSM, and IDUs. Research also enabled development of new schemes to reach the bridge population. The link worker scheme (LWS), designed for rural risk groups is an excellent illustration of how research can guide program design. Another notable achievement of Tamil Nadu is the development of The PLHIV Stigma Index, which is the first of its kind, to quantify stigma and discrimination, experienced by people living with HIV. Research not only provided field level data but also turned into a learning tool supporting monitoring and evaluation (**TANSACS, 2008, Annual Report**).

KEY DRIVER FOUR COMMUNICATION CHANGE COMMUNICATION

From early on, Tamil Nadu recognized the significance of behavioural change communication through information, education, and awareness campaigns. HIV has framed not only as a medical disease but a social disease that requires sensitivity to moral and cultural norms, and human rights of people living with HIV. Tamil Nadu's determination to arrest the spread of HIV resulted in a series of communication campaigns targeted at high-risk groups as well as the general population. The campaigns provided a means for people to connect, to shed their sense of isolation, and share their experiences with confidence. The state adopted a strategy of localization of communication through the effective use of folk media, traditional games and publications in regional languages. Tamil Nadu adopted BCC strategies, to bring about modifications in risk behaviour, among the most at-risk population. Health BCC, information, and educational campaigns were aligned with health service delivery and gave its

audience more than a message. It empowered them.

The results of the communication strategy were positive. From the late 90s, the knowledge about HIV-AIDS and condoms, rose steadily across all most at-risk population, Female sex workers, men-having-sex-with-men, injecting drug users, truckers & helpers, and male migrant workers. Several stakeholders, including the people living with HIV, embarked on a journey to convert information into a sound argument through advocacy campaigns (NFHS Rounds Various years). The use of advocacy was central to build awareness and sensitize critical segments of society such as police, tourism, revenue, and education departments, as well as faith-based organizations. Active media support was sought to take the message to the general population, the opinion leaders, and decision makers. And the media organizations reciprocated with impressive coverage of HIV-AIDS epidemic. BCC is necessary, but not sufficient means for HIV prevention. A healthcare infrastructure is needed to make the message meaningful to the lived, experiences of the people.

KEY DRIVER FIVE--CARE, SUPPORT, AND TREATMENT

HIV care, support, and treatment were made a critical component of Tamil Nadu's health care agenda. The support came in the form of Healthcare facilities the state had built over many decades. Tamil Nadu was able to leverage its existing healthcare infrastructure to offer holistic healthcare services for MARP, PLHIV and the general population. Added to this, District AIDS Prevention & Control Unit(DAPCU), was established in 29 districts. DAPCU, became one of the key referral points for people living with HIV, especially in rural areas (**TANSACS, 2008, Annual Report**).

Further, the state established thirty Community Care Centres and thirty-eight Drop-in Centres(DIC) providing services to reduce stigma and discrimination and extend psychosocial support to the needy. Tamil Nadu pioneered the concept of integrated testing and counselling Centers that extended to HIV-TB co-infection services, Blood safety, and Sexually Transmitted Infection support. With 1471 centres, the state has the highest number of Integrated Counselling and Testing Centre (ICTC), in the country. Initiatives like the Hello Plus, extended the helpline services, especially to most at risk population (**TANSACS, 2008, Annual Report**).

Further, 156 STI clinics worked in sync with ICTCs, to deliver a range of comprehensive services. Pioneering the concept of "prevention of "parent to child transmission", Tamil Nadu's PPTCT program is recognized by NACO as the model program for the entire country. The program is reaching 94% of the Mother-Baby pair with lifesaving drugs. While Tamil Nadu, made significant strides in HIV prevention, the state valued the importance of providing, care, and support, to People living with HIV. The state established, anti-retroviral therapy, or ART Centers, to bring critical treatment services to the People living with HIV (**TANSACS, 2008, Annual Report; BSS, Reports Various Years- 1993-11**).

Tamil Nadu is moving towards mainstreaming HIV related services through programs such as Master Health Check-up. The well-established care, support and treatment facilities in Tamil Nadu, supported by mainstreaming activities, have increased the "Exposure to Treatment" across most at-risk population and PLHIV. Female sex workers, men-having-sex-with-men, injecting drug users, Truckers & Helpers, and Male Migrant Workers.

DISCUSSION

These five factors, Political Will, Targeted Intervention, Evidence-based Programming, Communication and Care, Support & Treatment has established the state as a leader in HIV Prevention. These factors are components of the strategic model of health communication that uses the advantages of each of the four major approaches to communication for social change (Inagaki, 2007). A major realization that hit upon me at the analytical stage was to find out how difficult it was to separate communication activities from other services that were provided as a part of HIV-AIDS initiatives. The strategic communication approach enabled me to take a view of communicative actions that were officially segregated but not in practice. Exchange of information between stakeholders shapes the more explicit communication campaigns design and evaluation. Based on this assessment the results of the analysis was thematized into major "drivers" framed within the strategic communication model.

CONCLUSION

Tamil Nadu is at the forefront of a new movement which believed that zero tolerance to new HIV infection is an achievable goal and then set out to chart novel pathways to get to zero. The state's experience in tackling the HIV epidemic provides a blueprint for the creation of a healthcare intervention, which can funnel ideas and innovative solutions, co-created, implemented and owned by the affected communities themselves. The HIV prevention and care model is scalable, replicable and adaptable to many health hazards. The state of Tamil Nadu has sketched a roadmap to an HIV free society, saving thousands of people living with HIV and protecting millions against the new infections.

Emergence of health communication strategies in Tamil Nadu is best understood in relations to access to communicative resources such as mass media, information campaigns (from dominant paradigm), layers of meaning people ascribe to these channels (participatory model), the circulation of information in the form of evidence relating to health behaviour (knowledge sharing model) and consequences of these flows to existing, often unjust power relations such as problems facing transgender and PLHIV (social movement media approach). An integration of these approaches was made possible by the institutional support and political will that transcended partisan political consideration. More broadly, the role of state institutions are critical for the success of health communication campaigns, but these institutions need to work outside their institutional constraints and broaden their perspective to include participatory and radical media to be effective at the community level.

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