

Adolescent Topics

**Social and Behaviour Change Communication
in an Era of Combination Prevention**

SUMMARY REPORT

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-retroviral Therapy
CBI	Community Based Intervention
CP	Combination Prevention
CSE	Comprehensive Sexuality Education
DFID	Department for International Development
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe Women
EHP SA	Evidence for HIV Prevention in Southern Africa
ESA	East and Southern Africa
HIV	Human Immunodeficiency Virus
IPV	Intimate Partner Violence
MARPS	Most at Risk Populations
MDGS	Millennium Development Goals
PEPFAR	United States President's Emergency Plan for AIDS Relief
PITC	Provider-initiated Testing and Counselling
PrEP	Pre-exposure Prophylaxis
RCT	Research and Clinical Trial
SBCC	Social and Behaviour Change Communication
SDGs	Sustainable Development Goals
STI	Sexually Transmitted Infection
TASP	Treatment as Prevention
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
VMMC	Voluntary Male Medical Circumcision
WHO	World Health Organisation

1. Introduction

Adolescents and HIV in ESA

Adolescents and young people in eastern and southern Africa (ESA) are highly affected by HIV and AIDS, with an estimated 2.7 million people aged 15 to 24 years living with HIV. This is more than half the youth HIV population across the globe^{1 2}.

Girls are disproportionately affected - they are more than two-and a half times more likely to be infected with HIV than boys of the same age. For example, in Swaziland, 15.6 percent of young women are HIV-positive, compared to 6.5 percent of young men³. In sub-Saharan Africa three in every four new infections in the 15-19 year age group were among girls.

To compound the crisis, today's population in eastern and southern Africa (ESA) is the largest and youngest ever, with 66% of the region's total population being under the age of 30 years.⁴ This "youth bulge" means a looming HIV crisis among adolescents.

Despite these startling statistics, when it comes to effective HIV prevention programming, this population group is being left behind. The current body of evidence available on effective adolescent and youth prevention packages in ESA remains limited, particularly in the light of increasing acknowledgement that the replication of packages that are not context-specific will not be effective and that adolescents require tailored interventions.

About this review

In 2015 EHPsa commissioned MannionDaniels to review the role of social and behaviour change communication (SBCC) in combination prevention programmes for adolescents in eastern and southern Africa. This review is a shortened version of the technical report. Two evidence briefs on the same topic are available on the EHPsa website at <http://www.ehpsa.org/critical-reviews/sbcc>.

This summary report is accompanied by a critical review of definitions of adolescence and the need for age disaggregation, which is available at: <http://www.ehpsa.org/critical-reviews/age-disaggregation>.

The original technical report employed qualitative techniques, including: key informant interviews with 48 relevant stakeholders at global, regional, and country levels; and an analysis of country case studies. More in-depth insights were obtained from informants in three focus countries of Malawi, South Africa and Tanzania.

Due to the broad nature of the topic, the review limited its thematic focus in the following ways:

- Combination prevention: the review focuses on biomedical and behavioural prevention, although important structural factors are also considered.
- Biomedical prevention: the review focuses on two types of prevention technologies - VMMC and PrEP.
- SBCC approaches: the review focuses on four approaches - mass communication, interpersonal communication, community mobilisation and comprehensive sexuality education.
- Adolescent and youth combination prevention packages: the review focuses on a limited range identified in the three insight countries including: DREAMS (regional), and She Conquers (South Africa), as well as a small number of non-combination prevention programmes and studies to triangulate evidence of good practice.

1 UNICEF website: https://www.unicef.org/esaro/5482_HIV_prevention.html

2 UNICEF website: <https://data.unicef.org/topic/hivaids/adolescents-young-people/#>, 2016

3 *ibid*

4 UN Department of Economic and Social Affairs, Population Division, World Population Prospects: The 2015 Revision, 2015

The review is aimed at policy makers and practitioners working in HIV prevention with adolescents and young people, primarily in ESA. It presents relevant evidence and provides selected recommendations to enable EHP SA to further its work with policy makers and planners in this area.

This review will argue that while SBCC does not usually have a direct, measurable effect on rates of new HIV infection, it does play a critical role in addressing the behavioural and structural barriers which prevent individuals and groups from making safe choices regarding their health. Furthermore, SBCC is necessary to achieve and maintain more effective application of emerging biomedical, behavioural and structural prevention tools.

This review has also found that while the climate for adolescent HIV prevention has never been stronger, the weak policy and investment environment for SBCC is a substantial constraint. Strengthening SBCC programmes will be critical to HIV prevention for adolescents. A recent UNAIDS report states that, “defunding such programmes... entails a risk of reducing communication about HIV in severely affected communities and increasing risk behaviours, which may offset the benefits of biomedical programmes.”⁵

2. Definitions and framework

Adolescence

This paper defines adolescents and young people as: a phase of life when a person moves from dependence (childhood) to independence (adulthood).

An age-based definition of 10-24 years was used to span and overlap with varying UN definitions of adolescents (10-19 years) and youth (15-24 years). It must be noted that there is currently a lack of clarity and consistency in how adolescents are defined and how HIV data about adolescents is disaggregated⁶.

Social and Behaviour Change Communication (SBCC)

SBCC refers to the use of communication to change behaviours by influencing knowledge, attitudes and social norms. It coordinates messaging across a variety of communication channels to reach multiple levels of society – individuals, communities and policymakers⁷.

SBCC represents one of the six basic programmes highlighted under the UNAIDS investment approach⁸. The UNAIDS 2014 Guidance Note on social and behaviour change, which is targeted at addressing sexual behaviours in high HIV prevalence countries (particularly in the ESA region), stresses that SBCC programmes must go beyond information dissemination and individual awareness, knowledge and skills (IEC).

This means that SBCC is a social process based on an understanding of the perceptions and beliefs that are barriers (or incentives) to behaviour change, and seeks to increase knowledge or change attitudes through a process of communication. To succeed, SBCC programmes need to identify their audience and develop targeted programmes for particular sub-groups such as adolescents, disaggregated by age and gender. SBCC programmes also need to be based on evidence of what works and have a clear theory of change.

5 UNAIDS. HIV Prevention among adolescent girls and young women. UNAIDS, Geneva 2016

6 See EHP SA Critical Review on age definitions at <http://www.ehpsa.org/critical-reviews/age-disaggregation>

7 Johns Hopkins Center for Communications Programs. <https://ccp.jhu.edu/social-behavior-change-communication/>

8 UNAIDS. Social and Behaviour Change programming. 2014 Guidance Note. UNAIDS, Geneva.

SBCC has long been seen as a key approach within combination prevention (CP)⁹ and guidance on CP indicates opportunities for SBCC in a number of programme areas. SBCC is expected to be critical for achieving the UNAIDS prevention targets which are described in more detail in Annexure 1.

The early decades of the HIV response saw SBCC communications programmes at national and regional level funded handsomely by donors. However, the value of these types of programmes have been debated in recent years. Stakeholders began to question what were seen as “high” costs of SBCC, the limited evidence base on its role in HIV prevention, and its relevance alongside promising new tools for biomedical and structural prevention.

Combination Prevention

Combination Prevention (CP) was described by UNAIDS in 2010¹⁰ as the guiding global framework for implementation of HIV prevention. CP recognises there is no single solution to HIV prevention, but that a range of interventions are required in order to achieve lasting changes. It is based on three key pillars:

1. **Biomedical prevention:** This uses a mix of clinical and medical approaches to reduce HIV transmission including treatment as prevention (TasP), voluntary male medical circumcision (VMMC), prevention of mother to child transmission (PMTCT), use of condoms, and pre-exposure prophylaxis (PrEP).
2. **Behavioural prevention:** This addresses risk of HIV transmission firstly by reducing risky behaviours such as poor, incorrect or inconsistent condom use, multiple and concurrent partners and age disparate partnerships. Secondly, it increases health-seeking behaviour such as testing and treatment adherence.
3. **Structural prevention:** This seeks to address the social and societal factors that make individuals or groups vulnerable to HIV infection. These can be social and cultural; political, legal and economic; or factors to do with the physical environment.

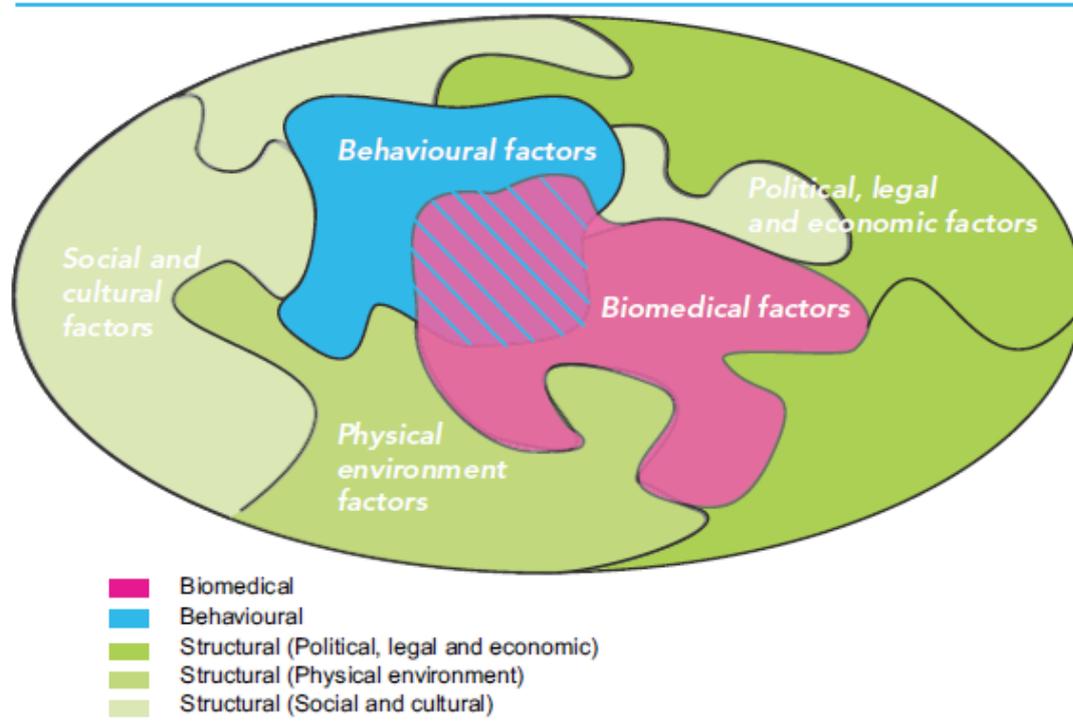
This understanding, in turn, rests upon the complex and interlocking causes of HIV risk and vulnerability as illustrated by UNAIDS¹¹ below.

9 UNAIDS. Fast-tracking combination prevention: towards reducing new HIV infections to under 500,000 by 2020. 2015 Geneva

10 UNAIDS. 10. Combination Prevention. A Discussion Paper. 2010, UNAIDS, Geneva. http://files.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/JC2007_Combination_Prevention_paper_en.pdf

11 UNAIDS *ibid*

Figure 1. Interacting causes of HIV risk and vulnerability



Since 2010 ideas about combination prevention have evolved considerably. The 2014 UNAIDS Fast-Track strategy¹² is based on a nuanced understanding of HIV epidemics and provides more focussed guidance on combination prevention, including targeting of interventions. This approach recommends that:

- HIV prevention efforts should be focussed geographically on locations with high rates of transmission.
- Focussed combination prevention packages should offer a mix of proven high-impact prevention interventions. These are identified, for the ESA region, as condom provision, immediate provision of antiretroviral therapy, pre-exposure prophylaxis, (PrEP) and voluntary medical male circumcision (VMMC).
- HIV prevention programmes should focus on priority populations and address social, gender and age groups with the largest numbers of new infections. Priority populations for ESA are identified as a combination of key populations and adolescent girls/young women and their partners.

The guidance provides several examples of combination HIV prevention packages for different contexts for example for MSM, sex workers and high-prevalence sites in southern Africa. Combination prevention programming in ESA for adolescents and youth have been evolving in alignment with this new approach. Tailored interventions based on a contextualised understanding of priority populations in their geographical locations are growing in number (see 3.5 below).

In recent years the concept of combination prevention has been challenged, and a new framework suggested: the HIV prevention cascade.^{13 14} The HIV prevention cascade stresses the overlap between biomedical, behavioural and structural interventions, and proposes an alternative approach of looking at supply-side, demand-side and adherence interventions. Like the HIV treatment cascade, it identifies key steps in the cascade and provides a framework for designing interventions and monitoring progress at these

12 UNAIDS 2015 Reference Paper: Fast-tracking combination prevention. UNAIDS. Geneva. 2015. http://www.unaids.org/sites/default/files/media_asset/20151019_JC2766_Fast-tracking_combination_prevention.pdf

13 Hargreaves J et al. The HIV prevention cascade: integrating theories of epidemiological, behavioural and social science into programme design and monitoring. *Lancet HIV* 2016; 3: e318–22

14 Krishnaratne, S et al. Interventions to strengthen the HIV prevention cascade: a systematic review of reviews. *Lancet HIV* 2016; 3: e307–17

different points. Steps in the cascade are: at risk, risk perceived, take up intervention, adhere to intervention, intervention efficacious. A mix of biomedical, behavioural and structural interventions may be used at each stage. The HIV prevention cascade may be used at national or individual levels.

The most recent UNAIDS guidance, the HIV Prevention Roadmap¹⁵, 2020, stresses that combination prevention is essential for adolescent girls and young women and should include information; demand generation; comprehensive sexuality education; education; economic empowerment (e.g. cash transfers); addressing harmful gender norms and gender-based violence and access to SRH. The HIV Prevention Roadmap is being used to galvanise progress on HIV prevention in the ESA region.

3. The role of SBCC in combination prevention

3.1 The changing role of SBCC in Combination Prevention

In the 2010 UNAIDS model of combination prevention¹⁶, SBCC was a stand-alone pillar that included behavioural strategies to promote risk reduction including: HIV testing and risk reduction counselling; behaviour change communication to promote partner reduction, condom use, partner reduction, uptake of HIV testing and counselling etc; HIV education; interpersonal communication (including peer education and persuasion); and social marketing of prevention commodities etc.

However, the shift in the global guidance on combination prevention, discussed above, has been significant for the role of SBCC. For example, SBCC is not identified as a high impact intervention in the most recent UNAIDS combination prevention strategy of 2015¹⁷. This document does, however, note that programmes using communication and social change approaches can be effective. It provides several research references that show “some limited evidence of effect”, in terms of measurable biological end points, of SBCC related to:

- HIV testing services;
- peer education;
- mass-media communication;
- school-based sexuality education, and
- income generation programmes and behavioural counselling.

The strategy argues that, while these SBCC interventions cannot be relied upon as single HIV prevention strategies, they may increase the impact of biomedical strategies and have supportive functions. The guidance specifically cites:

- Mass and interpersonal communication, which have been critical for demand generation for all HIV services; and
- Comprehensive Sexuality Education (CSE), which has influenced HIV-related knowledge, skills, attitudes and behaviours and has benefits for sexual and reproductive health and rights.

It also quotes research showing that combinations of social change and communication interventions, designed for specific populations and contexts, have enhanced both the adoption of HIV prevention behaviours and the uptake of services. Furthermore, addressing community empowerment and mobilisation; and structural barriers are described as critical elements of combination.

The UNAIDS 2016 HIV prevention guidance¹⁸ for adolescent girls and young women refers to the 2010 guidance and is clear that social and behaviour change interventions are part of the core combination prevention package. These include intensive social and behaviour change interventions to address risk and gender norms, as well as to promote health seeking behaviour. The guidance also recommends schools-based programmes, community mobilisation, mass media and mHealth interventions.

¹⁵ UNAIDS. HIV Prevention 2020 RoadMap. UNAIDS, Geneva, 2017. <http://www.unaids.org/en/resources/documents/2017/hiv-prevention-2020-road-map>

¹⁶ UNAIDS, 2015, op cit

¹⁷ ibid

¹⁸ UNAIDS. HIV prevention for adolescent girls and young women. UNAIDS 2016, Geneva. http://www.unaids.org/sites/default/files/media_asset/UNAIDS_HIV_prevention_among_adolescent_girls_and_young_women.pdf

Advances in biomedical technologies have been central to the changing understanding of SBCC in CP. The past decade has seen diversification in biomedical tools available to support prevention interventions. These include pre-exposure prophylaxis (PrEP), voluntary medical male circumcision (VMMC), and treatment as prevention (TaSP). When tested in trials or pilot situations these tools have demonstrated marked success in preventing HIV transmission^{19 20}. These successes have in a real sense led to the “re-medicalisation” of HIV prevention: as the evidence for new biomedical prevention technologies mounts, it becomes increasingly difficult to justify budgets for behavioural interventions and the investment of major donors has declined.

The shifting concept of SBCC - from an essential stand-alone pillar of combination prevention to playing an important support role in biomedical interventions – has had a profound impact on policy and programming in the ESA region. It has left some confusion among practitioners and policymakers alike and has resulted in a range of different approaches being taken. Key informants to this review confirmed this, with one donor concluding that there is a need for a complete re-think, to enable a fusion between social drivers and the biomedical possibilities.

Nevertheless, the review found several examples of successful approaches to SBCC – both as part of combination prevention packages and as stand-alone programmes – in the ESA region. These are described in greater detail below.

3.2 SBCC in biomedical prevention

As noted above, SBCC is now frequently integrated into biomedical prevention packages in operational research or real-world programming.

The approach however tends to use “optimised” SBCC tools with a relatively narrow scope, and it is not clear whether the selection of SBCC tools is based on current evidence of “what works”. For example, in a number of biomedical programmes, key informants highlighted that SBCC approaches now tended towards a limited range of interpersonal techniques such as counselling, a short knowledge and skills component, and sometimes use of mobile SMS reminders. In principle, this approach may be important if it offers cost effectiveness and facilitates scale. However, in light of the gaps in our knowledge of what works, a focus on innovation and evidence-based packages is critical to quality programmes. It will be essential to examine and compare the effectiveness of different SBCC optimised packages within biomedical prevention, and better understand their role in improving acceptance, demand, uptake and adherence within the prevention and treatment continuum.

Evidence on the role of SBCC in two biomedical strategies in VMMC and PrEP is summarised below.

Voluntary Male Medical Circumcision

While significant progress has been made in ESA since VMMC was introduced, annual figures for circumcision declined in eight countries between 2014 and 2015. This indicates a need to reinvigorate focus on the barriers to demand and uptake.²¹ It may also point to the need to maintain promotion and knowledge of VMMC with new generations as they enter adolescence.

The review identified a clear role and need for SBCC to enhance enabling factors and mitigate deterrents to VMMC - specifically around fear and pain perception; partner knowledge and support; and dispelling myths and misconceptions.

There is already good evidence for the contribution of SBCC in VMMC. For example, a study in Zimbabwe showed that mass media, and targeted inter-personal communication played a critical role in correct

19 UNAIDS, Fast-tracking combination prevention: towards reducing new HIV infections to under 500,000 by 2020, 2015, available at (http://www.unaids.org/sites/default/files/media_asset/20151019_JC2766_Fast-tracking_combination_prevention.pdf) p.18

20 Njeuhmeli E, et al, (2014) Lessons learned from scale-up of voluntary medical male circumcision focusing on adolescents: benefits, challenges and potential opportunities for linkages with adolescent HIV, sexual, and reproductive health services. *Journal of AIDS*. 2014 Jul 1;66 Suppl 2:S193-9

21 UNAIDS, Prevention Gap Report 2016. 2016 UNAIDS, Geneva. (<http://www.unaids.org/en/resources/documents/2016/prevention-gap>), p.6

knowledge, and intention to circumcise. Over 68% of men (with no differences by age) had heard of VMMC as a HIV prevention intervention.²² In this study 71% cited radio as a key source of information followed by newspapers (28%). The role of interpersonal communication was also important with 28% highlighting promotion through health and community workers and via peers and relatives (26%). Another study in Zimbabwe and Tanzania also showed increased VMMC uptake as a result of SBCC programmes²³.

Pre-Exposure Prophylaxis

PrEP has been proposed as a key tool for prevention amongst high-risk populations, including young women and girls. However, as PrEP is a more recent prevention technology than VMMC, there is a limited body of evidence on its uptake and effectiveness amongst adolescents and young people. Nevertheless, from experience to date on adolescent ART programmes and early PrEP trials, it has been shown that there is a need for SBCC to generate demand, to inform and educate and promote adherence to PrEP.

There are at least 12 current demonstration projects and trials involving PrEP and adolescents in the region. Many of these include SBCC approaches such as:

- Motivational interviewing and counselling;
- Empowerment sessions including life skills and comprehensive sexuality education; and
- Adherence clubs, SMS reminders.

In all cases SBCC packages share common approaches.

- They have been optimised in order to increase cost effectiveness and enable scale up post-trial; and
- They recognise the need for enabling factors beyond PrEP, such as negotiation skills, sexual and reproductive health, and livelihoods.

As interventions are still under development, it was not possible for the review to evaluate the quality of content or efficacy of these packages.

3.3 SBCC and structural prevention

Structural interventions target the socio-economic determinants of vulnerability and risk. They fall into three categories – socio-cultural; political, legal and economic and environmental.

There is extensive evidence for the link between structural drivers and HIV transmission, and in recent years research has also provided increasing evidence about the effectiveness of various structural interventions in reducing HIV transmission such as cash transfers and transforming gender norms in different contexts.

There is a clear overlap between SBCC approaches and socio-cultural structural interventions. For example, empowerment and other programmes to reduce gender-based violence could be described as both structural interventions and SBCC programmes, in that they incorporate SBCC strategies and approaches.

In practice, the review found that SBCC approaches and tools were being interwoven into combination prevention packages to address structural risks, and that mixed method approaches, which include a structural component, are considered to be more effective than single-method approaches. For example, DREAMS Tanzania is adapting the SASA community-based GBV and HIV prevention model, which will complement efforts to strengthen GBV reporting and referral at community level. Girl Power in South Africa is complementing an empowerment curriculum on life skills, economic empowerment, and SRHR with a cash transfer pilot.

3.4 SBCC and adolescent risk

As indicated above, there are significant opportunities for integrating SBCC into biomedical HIV prevention programmes. However, there is still a specific need for SBCC programmes to address the particular behavioural determinants of adolescent HIV risk. This is highlighted by persistently high incidence in many countries and communities, and modelling studies that have shown that core biomedical interventions

²² This exceeded average HIV prevention knowledge levels in the region. Hatzold K Mavhu W Jasi P et al, Barriers and motivators to voluntary medical male circumcision uptake among different age groups of men in Zimbabwe: Results from a mixed methods study, PLoS ONE, May 6. 2014. <https://doi.org/10.1371/journal.pone.0085051>

²³ Njeuhmeli E, et al, 2014, op cit

alone are not sufficient to “end HIV”²⁴. This section identifies both the need for SBCC and its proven efficacy in addressing these risks.

Both the literature and key informants identified particular areas that need to be addressed in varying contexts. These include:

- Early sexual debut;
- Age disparate relationships;
- Incorrect or inconsistent condom use;
- Multiple and concurrent partnerships; and
- Low risk perception and health seeking behaviour including adherence to ART.

It is important to note that the review came across very few recent peer-reviewed studies of adolescent and youth-focused SBCC interventions in the region. The review focussed on the four approaches for which there was most evidence:

- Interpersonal communication;
- Mass communication;
- Community mobilisation; and
- Comprehensive sexuality education

These approaches are of course not limited to addressing the dimensions of adolescent risk and can also be employed in the services of demand creation etc for biomedical interventions.

Interpersonal communication

This approach involves various types of one-to-one or small group communication, led by a trained facilitator or counsellor. There is much evidence in the literature^{25 26 27} that demonstrates the effectiveness of interpersonal communication for HIV prevention and all key informants saw it as a critical component of effective SBCC packages for HIV prevention.

Interpersonal communication was also seen as important in programmes geared towards improving uptake and adherence to treatment and services. However, it was seen as a costly form of SBCC, which made it less attractive to bring to scale.

Mass communications

This involves a range of media to communicate messages to larger audiences via print, radio, television, internet and mobile devices. Mass media has been seen as an important tool for scale, but is regarded as less effective in generating skills, self-efficacy and changes in social norms due to the limited exchange and dialogue possible in many interventions. However, when combined with participatory elements these types of programmes have shown promise and have been widely implemented in the region in programmes such as Soul City, Straight Talk and LoveLife.

A meta-analysis of HIV prevention mass media interventions from 1986-2013 found that media campaigns were associated with an increase in self-reported condom use, transmission knowledge and prevention knowledge. The magnitude of the effects also increased with the length of the campaign.²⁸

Key informants to this review, including policymakers and SBCC practitioners, regarded mass media as important, particularly when it is possible to link it to popular, accessible tools and social media platforms used by adolescents and young people. This is supported by UNAIDS 2015²⁹ guidance which identifies several examples of successful mass communications programmes.

24 The Swaziland HIV Investment Case, UNAIDS, Nercha, TSF, 2015 (unpublished) as an example here.

25 Albarracin D et al, A test of major assumptions about behaviour change: A comprehensive look at the effects of passive and active HIV-prevention interventions since the beginning of the epidemic, *Psychology Bulletin*, 2005: 131 (6): 856–897

26 Fonner VA, et al. Voluntary Counselling and Testing for Changing HIV-related Risk Behaviour in Developing Countries, *Cochrane Database Systematic Review*. 2012;9:CD001224. doi:10.1002/14651858. CD001224.pub4.

27 Tomori C et al, A Role for Health Communication in the Continuum of HIV Care, Treatment, and Prevention, *Journal of AIDS*, 2014 vol: 66 pp: 306-310

28 Lacrox JM et al. Effectiveness of mass media interventions for HIV prevention, 1986-2013: A Meta-Analysis, *Journal of AIDS*, 2014, 66 Supplement 3: S329 - 40

29 UNAIDS 2015, op cit

In this current review, specific modalities of mass media were considered. Radio was identified as the most accessible mass communication tool for large-scale interventions, able to support outreach in both rural and urban settings. A number of partners using radio had integrated listenership clubs based on learning to improve outcomes on knowledge, skills and service linkages. Mobile and online technology were seen as more appropriate in urban or peri-urban settings, but informants highlighted the need to evaluate the target populations' ownership or access to devices and internet. One stakeholder highlighted that younger girls were far less likely to have regular access to a mobile phone, and if they did, it was unlikely to be a smart phone. Thus, simple SMS services were considered to be an important feature of continued interaction between clients and services, to reinforce treatment adherence and testing by key informants, and would represent an important area to build further evidence.

All key informants stressed that mass media on its own is unlikely to be sufficient and need to be part of multi-level SBCC interventions. Some key informants suggested that the high costs of mass media campaigns was a constraint, contributing to short-term campaigns, such as promoting uptake of HCT, rather than generating dialogue towards longer term social change issues.

Community mobilisation

Both the literature and key informant interviews identified community mobilisation as a critical component of SBCC. A review of 39 community-based interventions (CBI) which targeted HIV knowledge, attitudes and transmission, found that CBIs increase HIV awareness, risk reduction, and improve knowledge, attitudes, and practice outcomes.³⁰ One example was the SASA! RCT in Kampala, Uganda, which provided a community mobilisation program on HIV and intimate partner violence (IPV) prevention. It showed significant reductions—by over 40%—in concurrent partnerships reported by men and changed norms through lower social acceptance amongst women and men in the trial.³¹ This model is now being adapted to target adolescent girls and young women and their partners on IPV as part of the PEPFAR DREAMS intervention in Tanzania. A retrospective cohort study of Soul Buddyz Clubs in South Africa found that “ex_buddies” were nearly three times more likely to be HIV negative than the control group – ten years after their participation in the programme³².

Comprehensive sexuality education (CSE)

Schools have been identified by UNAIDS as an important pathway to take HIV prevention to scale as they offer an opportunity to engage with large numbers of adolescents and young people. CSE is also recognised as a protective factor in girls' lives, and there is evidence that interventions that focus on school-based prevention see improved educational outcomes in terms of results and retention, as well as reduction in other SRHR risk factors.^{33 34} In addition to HIV/AIDS CSE tends to include broader issues related to SRHR, including gender based violence, gender norms, relationships, citizenship, amongst other topics. Comprehensive sexuality education (CSE) has been reinvigorated in the region through the ESA Commitment of 2013 (see 4.2 below).

Implementation has expanded significantly beyond simply supporting classroom-based teaching, with the development of pilot TV and radio packages in the focus countries. A community-based resource kit is currently being developed with support from SaFAIDS to target and engage gatekeepers in the community. Teacher curriculums have been reviewed and re-developed around the topics of CSE. This package addresses a range of issues relevant to adolescents and young people beyond HIV/AIDS, positioning knowledge and learning within a broader range of rights, risk and responsibilities, and specific issues seen as urgent in many communities such as teen pregnancies.

30 Salam, R et al, Impact of community based interventions on HIV knowledge, attitudes, and transmission. *Infectious Diseases of Poverty*, 2014, 3: 26.

31 Abramsky, T, et al, Findings from the SASA! Study: a cluster randomized controlled trial to assess the impact of a community mobilisation intervention to prevent violence against women and reduce HIV risk in Kampala, Uganda, 2012, *BMC medicine*, 12(1),122.

32 Findings presented at SA AIDS Conference, 2017

33 Haberland, N, The case for addressing gender and power in sexuality and HIV education: A comprehensive review of evaluation studies, *International Perspectives on Sexual and Reproductive Health* 41(1): 31-42, March 2015

34 Fonner, V. A., Armstrong et al. School based sex education and HIV prevention in low and middle-income countries: A systematic review and meta-analysis. *PLoS ONE*, 2014 9(3).

3.5 Integrated, large-scale combination prevention programmes

The review looked at three key tailored programmes as well as a range of small-scale implementation research programmes, which fall under the umbrella of combination prevention for adolescents and young people. These programmes were all designed to integrate the three pillars of combination prevention and to deliver interventions at scale (or as a pilot for at scale) in an integrated package.

The three programmes are:

- **DREAMS:** This is a PEPFAR- funded programme DREAMS focusing on 10-24-year-olds in 10 sub-Saharan African countries. DREAMS provides a menu of proven interventions that go beyond the health sector to address the structural drivers that increase girls' HIV risk, including poverty, gender inequality, sexual violence, and lack of education.
- **Sauti:** This is a multi-partner programme in Tanzania that promotes state of the art high quality biomedical, behavioural and structural interventions for key and vulnerable populations including female sex workers, men who have sex with men, and adolescent girls and young women aged 15-24. The project works at the community level to improve access to HIV prevention, treatment and care, and family planning (FP) services and to address gender norms and prevent gender-based violence (GBV).
- **She Conquers:** This is a three-year South African government-led national combination prevention initiative for adolescents aged 15-24 years. It is intended to operate in 53 priority sub-districts with high HIV transmission. Alongside biomedical interventions it supports a range of evidence-based behavioural and structural interventions including risk reduction programmes, community mobilisation, economic empowerment (cash transfers), GBV programmes as well as adolescent and youth-friendly services. It builds on existing programmes by coordinating a range of partners already working in the areas. The coordination is done by provincial, district and ward AIDS Councils. She Conquers was launched in 2016 and there are indications that it is having a positive impact on HIV testing rates, condom distribution, VMMC uptake and rates of sexual crimes³⁵.

A number of features are common across these new generation programmes:

- They are data- and evidence-driven – targeting priority groups/subgroups and geographical areas;
- They incorporate SBCC as an intervention component across programme pillars;
- They use optimized SBCC packages to reduce cost and improve scalability;
- They provide a combination of interventions from a wide menu as appropriate for particular contexts; and
- They employ multi-layered communication channels to reach audiences.

These new generation combination prevention programmes are aligned with the UNAIDS 2014 Fast-track strategy and seem to create potential for more effective adolescent HIV prevention than previous generation, more limited biomedical and SBCC interventions.

3.6 Implementation research

There are currently a number of implementation research programmes and pilots on combination prevention programmes for adolescents.

Three EHPA-funded implementation research projects explore different combinations of interventions for adolescents that may increase uptake and adherence to services. These include:

- **P-ART-Y** – An adolescent study nested within the large PopART trial HPTN 071 in Zambia and South Africa, which evaluates the acceptability and uptake of a community-level combination prevention intervention, including universal HIV testing and treatment. This study includes numerous school-based and out-of-school SBCC interventions.
- **GIRL POWER** – A study in Malawi and South Africa that assesses the impact on sexual and care-seeking behaviour of four packages – standard of care, standard of care plus youth-friendly health services, standard of care plus empowerment interventions and standard of care plus empowerment and cash transfers.

³⁵ Satellite session at 8th SA AIDS Conference, Durban 2017

- EMPOWER - A study in South Africa and Tanzania that pilots simple scaleable interventions to enable effective integration of PrEP into existing HIV prevention activities for women experiencing GBV and stigma. This study tests the impact of empowerment interventions.
- Mzantsi Wakho – A study to review the impact of various combinations of structural drivers of risk, and possible interventions that assist HIV-positive adolescents to prevent onward transmission of HIV.

All of these studies are ongoing and it is too soon to assess impact, however their findings have the potential to influence large-scale combination prevention programmes that are already underway.

4. Policy and investment for SBCC in Combination Prevention

This section provides a snapshot of key policies and guidelines relevant to the region which guide implementation of SBCC in HIV prevention. It also identifies available information regarding investments in the SBCC sector linked to these policy frameworks.

4.1 Global Policy

Key informant interviews with a number of different actors highlighted concerns that the commitment to SBCC at the global level is waning. This is difficult to determine definitively through government and donor policy. However, there is a notable lack of availability of specific, in-depth and up-to-date policies in this area.

Recent developments in global policy frameworks that are affecting the direction and delivery of HIV/AIDS interventions include:

- Sustainable development goals: HIV/AIDS is mentioned in limited detail and falls under SDG 3 where HIV/AIDS is defined as a threat to healthy lives and well-being. There is no specific mention of SBCC. However, indicator 3.7 focuses on information and education to facilitate universal access to SRHR.
- UNAIDS Fast Track strategy, launched in 2014 to accelerate response in low and middle-income countries. This was affirmed through the 2016 UNGAS Political Declaration on Ending Aids and defined via the UNAIDS Strategy 2016-2021 which provides detail on targets, implementation and accountability. Both include some information on SBCC (education, counselling, demand creation campaigns etc) as a requirement to support effective combination prevention. However, they provided limited information regarding effective approaches.
- The ALL-IN agenda: This was launched by UNAIDS, UNICEF, governments and other partners, and aims to catalyse HIV prevention for adolescents. It focuses on four key action areas: engaging, mobilising and empowering adolescents as leaders and actors of social change; improving data collection to better inform programming; encouraging innovative approaches to reach adolescents with essential HIV services adapted to their needs; and placing adolescent HIV firmly on political agendas to spur concrete action and mobilise resources.
- Start free, stay free AIDS free: This fast-track framework for ending AIDS among children, adolescents and young women by 2020, was launched by UNAIDS and PEPFAR in 2016. It aims, inter alia, to reduce new infections among adolescents and young women (ages 15-24) to less than 100,000. Policy actions include strengthening HIV education for young women and implementing combination prevention. However, it does not refer specifically to SBCC.
- Global Prevention Coalition: Chaired by UNAIDS and UNFPA in 2017, the Coalition is a multi-partner initiative to accelerate HIV prevention. It launched a roadmap for prevention by 2020 which includes elements of SBCC - including comprehensive sexuality education (CSE) and addressing harmful gender norms.
- Policies of donors such as PEPFAR and Global Fund, play an important role in setting priorities in HIV prevention. For example, DREAMS funded through PEPFAR and other investors, represents a combination prevention approach for young women and adolescent girls. It recognises no one tool or approach will be effective in HIV prevention and places a high emphasis on biomedical and structural approaches to prevention, with a limited range of SBCC approaches such as community mobilisation, and social change activities identified.

Other important developments include changes in leadership of UK Aid and the US government, and apparent limitations on funding for the Global Fund. These have introduced significant uncertainty about international HIV support going forward.

4.2 Regional Policy

At a regional level, several different institutions and instruments offer political support and leadership on HIV and AIDS including: the African Union's technical body 'New Partnership for Africa's Development'; the East African Community; the Southern African Development Community; Champions for an AIDS Free Generation in Africa; the Organization of African First Ladies against HIV/AIDS.

A key policy commitment in relation to adolescents and young people and SBCC is the Eastern and Southern Africa (ESA) Commitment for Comprehensive Sexuality education (CSE) and youth-friendly sexual and reproductive health service. This was signed in 2013 by twenty countries, which defined CSE as "an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgemental information". The accountability framework for the commitment monitors 20 indicators with targets for 2015, 2017 and 2020 against the following areas:

- Development of an enabling environment;
- Scale-up of CSE;
- Improvement in access to youth-friendly SRH services;
- Increase in comprehensive HIV knowledge levels; and
- Reduction of new HIV infections, early and unintended pregnancies, and GBV; and
- Elimination of child marriage.

The signing of the commitment obtained an unprecedented level of political support within the region. It further highlighted a shift in approach in which HIV and SBCC is being integrated into a broader suite of interventions addressing young people's sexual and reproductive health and rights. This was highly evident as standard practice in real world programmes seen during the in-depth review phase, and was regarded as a priority amongst programmers

A ministerial progress report presented at the International AIDS Conference in Durban, 2016 showed that all 21 countries in ESA reported having comprehensive sexuality education training programmes for teachers, and 15 out of 21 countries in the region reported providing comprehensive sexuality education in at least 40 per cent of primary schools and secondary schools. Seventeen of the countries are providing training to health and social workers to help young people receive non-judgmental sexual and reproductive health care³⁶.

4.3 National Policies and strategies

The majority of National HIV frameworks in the region include SBCC and an adolescent and youth programmes, however the extent of focus is variable as Annexure 2 shows.

Whilst SBCC is included as a component of all HIV/AIDS frameworks across this regional sample, it's role and specificity is mixed. Most frameworks identified a role for SBCC in youth and adolescent HIV education, but only four frameworks articulated linkages between SBCC and biomedical prevention and treatment methods in relation to adolescents and youth.

Kenya and South Africa have the most developed and detailed breakdown on SBCC. Kenya's framework is clearly delineated according to the three combination prevention pillars. The main recent example of a detailed plan is Kenya, although SA has also developed a higher level, umbrella approach in the form of She Conquers.

Kenya

Kenya has some of the latest adolescent-focused guidance in relation to the role of SBCC in HIV combination prevention. Kenya's Adolescent Fast-Track Plan (2015) provides a disaggregated analysis of adolescents

³⁶ UNICEF. 2016. Fulfilling our promise to young people today. <http://youngpeopletoday.net/wp-content/uploads/2016/07/ESA-Commitment-Report-Digital.pdf>

aged 10-24 years and identifies specific strategies to promote acceleration of HIV prevention and treatment against the three CP pillars. It identifies young people as agents of change, taking their role beyond that of beneficiaries or clients. It reinforces the need to focus on CSE, and identifies mass media and social marketing campaigns, alongside inter-personal communication, as critical enablers for the future. This plan establishes objectives and targets for CSE, targets for vulnerable populations including young key populations and young survivors of sexual violence. It also identifies specific packages, which are described as evidence-based models for SBCC. These include Shuga, Stepping Stones, Sasa, and Healthy Choices.

South Africa

The recently-launched South African adolescent and youth health policy³⁷ has one of six objectives devoted to HIV prevention for adolescents. However, the document is strongly focused on adolescent and youth friendly health services and does not spell out any particular SBCC activities. In the foreword of the document, however, the Minister of Health specifically mentions the need to focus social and behaviour change interventions on geographical areas where they are most needed.

4.4 SBCC investments

The limited information available in this area is summarised in Annexure 2. It is evident that from this information and key informant inputs that data on SBCC investment is both limited and presented in different ways in each country. The data available on SBCC investment for adolescents and young people from HIV/AIDS frameworks accounted for less than 1% of framework budgets, indicating substantial constraints in the area, although it is uncertain what an appropriate level would be in various contexts.

In 2012, UNAIDS developed the 'Investing in People. Investing in Results' guidance. This has informed recent efforts to strengthen well-prioritised HIV investment frameworks, and to produce HIV and TB Investment Cases in countries of the region. The original guidance specified SBCC as a core intervention, but investment cases have placed varying, and often quite limited, priority on investments in SBCC given the difficulties of quantifying their direct and indirect impact.

5. Conclusions

5.1 Key informant perceptions on SBCC and CP

Overall, the review found general agreement that SBCC plays a necessary and important role in HIV prevention, even though it may be difficult to demonstrate a direct influence of SBCC on HIV infection rates and it may not be adequate as a stand-alone strategy for prevention. However, some stakeholders see it primarily as a component of biomedical interventions, while others see SBCC as a specific and important general intervention to ensure adequate levels of critical knowledge, and to change behaviours and general norms. A range of approaches to SBCC in CP were considered to have merit, particularly the new generation scaleable CP programmes, such as DREAMS, discussed in 3.5 above.

Some informants expressed concern that SBCC, as a social process to reduce HIV risk, is becoming secondary to more linear SBCC packages in support of supporting biomedical outcomes. Extensive evidence was cited to show that SBCC has, over time, proved capable of facilitating changes such as much wider use of condoms and greater uptake of HCT in many contexts. However, some questioned whether SBCC had, in reality, ever been implemented and evaluated adequately or for long enough to assess its potential at population or target group level.

In summary, key informants widely supported views that included the following:

- SBCC plays a vital role in enhancing prevention when it is part of an integrated combination prevention strategy.
- SBCC has an important place in supporting the new biomedical prevention tools.

³⁷ South African National Adolescent and Youth Health Policy, 2017. <https://www.idealclinic.org.za/docs/policies/National%20Adolescent%20and%20Youth%20Health%20Policy%202017.pdf>

- SBCC packages that have been designed to support biomedical interventions may not always be based on best evidence or have the necessary evaluation tools in place.
- SBCC programmes are critical for addressing HIV risk behaviours of adolescents and should not be restricted to demand creation and support for biomedical interventions. Programmes aimed at reducing the age of sexual debut, multiple partners and age-disparate partnerships; and increasing consistent and correct condom use, are essential and should be part of any national combination prevention strategy.
- Changing approaches and guidance around SBCC and combination prevention have left many stakeholders confused and as a result there are a wide range of different approaches being implemented.
- Donors have withdrawn support from SBCC as a stand-alone intervention, even in countries that urgently require expanded programming for youth HIV prevention, and where even basic knowledge about HIV and prevention is too limited for adolescents to protect themselves.
- A new generation of integrated and targeted HIV combination prevention programmes are now being developed and tested for adolescents and other vulnerable groups and key populations. These programmes are designed to be large scale and implemented nationally and are seen by many to hold much promise for turning the tide of HIV among youth in eastern and southern Africa.

5.2 Gaps

The review also identified a number of gaps in the field of SBCC and combination prevention. While a significant research agenda may be needed to fill these gaps, much can be made of unpublished data from existing programmes such as formative research and evaluations.

Evidence

Critical evidence gaps remain around SBCC. These include evidence on:

- Successful approaches to SBCC within biomedical and structural interventions.
- The perceptions, risks, and life-style preferences of adolescents and youth that can inform the design of SBCC combination packages.
- Sub-groups, including young and adolescent key populations, early adolescents (under 15 years), adolescent boys and adolescents living with HIV.

Frameworks and packages

- There is a need for broader frameworks and packages that bring together integrated approaches to HIV, SRHR and other priority challenges across the life cycle, such as livelihoods.
- There are few packages for adolescents and youth that take a life cycle approach to mitigating risk at key junctures, partly as a result of this missing evidence.
- SBCC is seldom identified as an integrated approach in national HIV and AIDS frameworks, but seen as a programme or project.
- SBCC is often not strongly supported in global and national policy and programming and is frequently characterised as difficult to measure and “expensive” – often with limited data to substantiate this for various specific SBCC interventions.
- Though investment into the area is unclear, it appears constrained and not adequate for a comprehensive approach to national programming.

Youth agency

- The role of youth agency in combination prevention has not been rigorously developed or tested. This appears to be a missed opportunity for generating greater involvement, accountability, and demand from adolescents and young people in HIV prevention.

5.3 The way forward

This review identified a number of priority actions for strengthening SBCC and therefore HIV prevention for adolescents. These are:

- Ensure that SBCC interventions are not designed as stand-alone efforts, but as part of a multi-faceted prevention approach.
- Undertake systematic and rigorous assessment of SBCC components in biomedical pillars of combination prevention to identify what works best.

- Develop and disseminate good practice standards and guidance to support evidence-based SBCC programme design and implementation. This will need to include drawing on appropriate unpublished information and practical experience.
- Expand the use of evidence-based SBCC packages which incorporate effective measurement techniques across the combination prevention framework, including biomedical, behavioural and structural interventions.
- Invest in packages which facilitate youth-centred design, participation and leadership, and build evidence to better understand the value of this approach in improving programme effectiveness.
- Strengthen data on adolescent risk behaviours and practices, particularly for sub-groups of adolescents such as early adolescents (under 15s), adolescent boys and young men, adolescent key populations and adolescents at key life transition stages.
- Significantly increase country-level investment for HIV combination prevention that has potential to shift social norms and behaviours at the required scale in the medium to longer term.

5.4 Summary

Adolescent risk is multi-layered and occurs at different moments during an individual’s transition from childhood to adulthood. Today, the world is at ‘peak youth’³⁸ meaning that the generation under 30 years of age is the largest (as a percentage/proportion) it has been for at least a generation. In order to bring about impact in averting AIDS deaths and HIV incidence amongst adolescents and youth, HIV prevention frameworks need to be longer term, and generate impact across the life cycle in order to mitigate risk throughout this transition.

The review identified a number of important findings, including a mix of barriers and opportunities surrounding the role, application, and evaluation of SBCC in HIV prevention programming with adolescents and young people. Through addressing these, stakeholders could support more effective SBCC packages that will lead to improved prevention outcomes.

Key findings and recommendations are further summarised in the table below.

This review concluded that SBCC has an ongoing and important role in changing behaviours and norms. Furthermore, it is relevant to supporting biomedical and other interventions, and may be a critical determinant of whether current levels of uptake and adherence can be enhanced to achieve targets, particularly the ambitious 90-90-90 targets.

Summary of findings and key recommendations

Summary of Findings	Related Recommendations
Role of SBCC in HIV Prevention	
1. SBCC does not have a direct relationship to HIV incidence that can be measured. SBCC mainly produces intermediate outcomes that support achievement of HIV endpoints. These range from short-term and immediate changes in individual behaviours, to long-term and more complex social and structural changes.	1.1 SBCC interventions should form part of a combination prevention approach, which includes other proven interventions, and should not be stand-alone programmes. 1.2 Investments in SBCC should consider medium and longer-term impact not just the short term.
Role of SBCC in Combination Prevention Pillars	

³⁸ Perry Maddox and Restless Development. The world’s population has reached ‘peak youth’. This should be a wake-up call to world leaders. *The Independent*, 30 July 2015,

(<http://www.independent.co.uk/voices/comment/the-worlds-population-has-reached-peak-youth-this-should-be-a-wake-up-call-to-world-leaders-10426179.html>)

<p>2. It is too early to draw conclusions about the effects of SBCC in the current generation of adolescent and youth focused combination prevention programmes as they are still emerging.</p>	<p>2. Further research is needed to investigate the effects of SBCC in adolescent and youth focussed programmes.</p>
<p>3. SBCC in biomedical interventions 3.1 SBCC packages are frequently used to support biomedical interventions but these do not seem to be systematically informed by previous learning and evidence around SBCC. 3.2 Within VMMC prevention programmes, SBCC packages are vital to the achievement of results, specifically in addressing perception barriers to improve uptake of VMMC, and particularly amongst older young men. 3.3 PrEP trials focussing on adolescents and young people are currently still at demonstration stage. However, early findings indicate a strong role for structural and behavioural prevention strategies, including SBCC. 3.4 Current biomedical trials and demonstrations do include SBCC packages. Carefully selected SBCC tools and methodologies will be critical to demonstrating the role that SBCC can play in combination prevention strategies.</p>	<p>3.1 Develop and disseminate good practice standards and guidance to strengthen SBCC interventions that support biomedical interventions. These include PrEP, VMMC, TasP and condomisation. 3.2 The potential to use SBCC to improve uptake of VMMC amongst adolescent boys could be further explored, including addressing VMMC in sexuality education and integrating VMMC within broader community, adolescent and youth SRHR programmes. 3.3 A review of SBCC and structural interventions to support PrEP would help to ensure good evidence is built at trial stage. 3.4 Scale-up of biomedical prevention to meet targets will require rigorous evaluation of complementary SBCC tools.</p>
<p>4. SBCC interventions to reduce risk behaviour 4.1 SBCC interventions to reduce HIV risk behaviour among adolescents are essential to HIV prevention. 4.2 Broader SBCC may be important to ensure that knowledge and norms in youth and communities support biomedical and structural interventions.</p>	<p>4.1 Strengthen good practice standards and guidance for SBCC interventions to reduce HIV risk among adolescents 4.2 Strengthen good practice standards and guidance around SBCC interventions that support biomedical and structural interventions.</p>
<p>The SBCC Evidence Base</p>	
<p>5. Adolescent and youth focused SBCC programmes offer significant insights through a wealth of predominantly unpublished formative research studies.</p>	<p>5. Draw appropriately on unpublished programme studies, research and resources to assist in generating evidence to support effective programming and programme innovation.</p>
<p>6. Multi-level and combination interventions often have an over-arching theory of change, but not one specific to the SBCC components. This creates challenges for subsequent measurement and evaluations.</p>	<p>6. Develop a logical theory of change for each intervention component to strengthen the over-arching theory of change and ability to evaluate for HIV prevention programmes</p>
<p>7. A lack of accurate data on adolescent behaviours and practices is limiting effective planning and design of interventions.</p>	<p>7. Produce better data on the 'unknown factors' related to adolescent risks, behaviours and practices.</p>
<p>8. There is very limited programming and data on certain sub-groups such as early adolescents (under 15 year), school leavers, adolescent boys and young men and adolescent key populations.</p>	<p>8. Expand the evidence base for more targeted programming for adolescent sub-groups.</p>

Measurement of SBCC	
<p>9. Causal pathways from inputs to endpoint outcomes are indirect and complex.</p> <ul style="list-style-type: none"> • SBCC interventions are not always suited to measurement within randomised control trials and require sophisticated and well-designed methodologies to monitor and measure their effects. • Promising evaluations have used diverse methods to triangulate data including from randomised control trials, quasi-experimental studies, qualitative studies, and retrospective studies • Many stakeholders call for further use of social science methodologies and use of combinations of different types of data to better understand the role and effects of SBCC in their interventions. 	<p>9. Address the clear need for complementary studies to better understand the role and effects of SBCC within the current research and evidence- into-action programmes.</p>
<p>10. More tools are now available to support the effective measurement of SBCC in HIV prevention programmes. These tools need to be promoted and applied more frequently. They include but are not limited to: step-wedge design; propensity score matching, dose response; and drug and STI biomarkers.</p>	<p>10. Regional experts could develop and use improved guidance on SBCC. This should include information on effective measurement of SBCC interventions and provide links to specific tools to support this.</p>
Engagement of adolescents and youth in combination prevention	
<p>11. Adolescents and youth are engaged in programmes primarily as beneficiaries, not as active partners who could tackle some of the significant gaps in our understanding of adolescents and youth.</p>	<p>11. Develop ways of working with young people as partners in combination prevention to enable them to contribute to effective design, implementation, and monitoring of CP programmes.</p>
<p>12. SBCC approaches are driven by user design and involvement, and therefore, can play a critical role in supporting improved youth centred design and participation across the combination prevention pillars.</p>	<p>12. Strengthen adolescent SBCC by using methodologies that facilitate youth centred design, participation and leadership, and build evidence to better understand the value of this approach in improving program effectiveness.</p> <p>Adolescent engagement in SBCC can be strengthened by:</p> <ul style="list-style-type: none"> • Sharing formative research conducted in the design of SBCC programmes • Sharing research findings • Refinement of targeting and messaging for more nuanced age disaggregation

Annexures

Annexure 1 - Role of SBCC within UNAIDS Fast Track Combination Prevention Targets

Selected Target	Context and Role for SBCC
90% of key populations have access to HIV combination prevention	<ul style="list-style-type: none"> • Supporting biomedical prevention through support for demand, linkages, counselling, knowledge and skills across the continuum • Community mobilisation to reduce stigma and discrimination • Advocacy for policy and social change
90% of young women and girls have access to HIV CP and SRHR services, and live free from violence	<ul style="list-style-type: none"> • Changing attitudes and skills of service providers, educators. • Influencing social and cultural norms, beliefs and perceptions amongst the key stakeholders • Created demand for, and adherence to, new prevention technologies e.g. PrEP or TasP among youth and older partners living with HIV • Knowledge, skills, and risk-reduction counselling to complement structural interventions such as cash transfer programmes • Interpersonal communication with influencers e.g. parents. • Community mobilisation on GBV and gender norms • Advocacy for policy and legal change
Expand VMMC to 25 million additional young men in high HIV incidence areas	<ul style="list-style-type: none"> • Integration of correct knowledge into national CSE packages • Demand creation and promotion of VMMC for new generations • Community mobilisation to reduce perception barriers and promote incentives
3 million people on PrEP annually, focusing on key populations and people at higher risk in high prevalence settings	<ul style="list-style-type: none"> • Promoting correct knowledge and public awareness of PrEP including the importance of dual prevention • Reducing perception barriers to demand and uptake • Supporting service navigation e.g. referral, counselling etc. • Skills and knowledge for risk reduction and safe behaviours • Support to manage side effects and treatment adherence
90% of young people are empowered with skills, knowledge and capability to protect themselves from HIV	<ul style="list-style-type: none"> • Basic as well as comprehensive sexuality education • Social marketing to promote commodities, treatment and services • Community mobilisation and advocacy to reduce barriers • Promote youth agency and leadership across packages

Source: Adapted from UNAIDS, Fast-tracking combination prevention. 2015

Annexure 2 – Summary of the status of SBCC in national HIV frameworks in the region, 2016

Policy Type	Kenya	Tanzania	Uganda	Malawi	Mozambique	SA	Zambia	Zimbabwe
National HIV and AIDS Frameworks								
<i>Sub-topic focus</i>								
<i>Adolescent and youth focus</i>	Extensive	Modest	Modest	Modest	Unable to source	Modest	Extensive	Modest
<i>SBCC focus (and in relation to adolescents and youth where specified)</i>	Extensive	Modest	Modest	Modest	N/A	Minimal	Modest	Minimal
<i>SBCC investment (based on figures available in strategy document)</i>	Minimal	Figures not available	SBCC figures not given	Minimal	N/A	Minimal	Minimal	Figures not available

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EVIDENCE FOR HIV PREVENTION IN SOUTHERN AFRICA

