SOCIAL AND BEHAVIOUR CHANGE COMMUNICATION STRATEGY FOR SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS AND HIV IN LESOTHO 2020-21 TO 2022-23

Ministry of Health
Government of Lesotho

LIST OF ABBREVIATIONS

AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immuno Deficiency Syndrome ANC
ANC	Ante Natal Care
ARVs	Anti Retro Virals
ART	Anti Retroviral Therapy
CSE	Comprehensive Sexuality Education
CSOs	Civil Society Organisations
DHMT	District Health Management Team
DSTV	Digital Satellite Television
FB	Facebook
FBOs	Faith Based Organisations
FGDs	Focus Group Discussions
FSW	Female Sex Worker
GBV	Gender based Violence
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counseling
ICTs	Information Communication Technologies
IPC	Inter Personal Communication
IUDs	Intra Uterine Devices
KAPN	Knowledge, Attitudes, Practices and Norms
KIIs	Key Informant Interviews
LDHS	Lesotho Demographic and Health Survey
LePHIA	Lesotho Population based HIV Impact Assessment
MCP	Multiple Concurrent Partnerships
MoE	Ministry of Education
MoH	Ministry of Health
MoSD	Ministry of Social ??

MoY and Girls	Ministry of Youth and Girls
MSC	Most Significant Change Method of Participatory Monitoring
MSM	Men who have Sex with Men
NAC	National AIDS Commission
NSP	National Strategic Plan
PC FM	People's Choice FM
PLHIV	People Living with HIV
PrEP	Pre Exposure Prophylaxis
RMNCAH	Reproductive, Maternal, Newborn, Child, Adolescent, Health
SBCC	Social and Behaviour Change Communication
SMART	Specific, Measurable, Achievable, Relevant, Timebound
SRHR	Sexual Reproductive Health and Rights
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TVET	Technical and Vocational, Education and Training
TWG	Technical Working Group

TABLE OF CONTENTS

1. Executive Summary

HIV prevalence and incidence: Despite a reduction in new infections by 20 per cent, Lesotho continues to have one of the highest rates of HIV prevalence in the world, at 25.6 per cent for adults 15 to 59 years of age (30.4 per cent for females and 20.8 per cent for males)[1]. Prevalence among key affected populations, such as Female Sex Workers (FSWs) was estimated at 71.9 per cent, and 32 per cent among Men who have Sex with Men (MSM)[2]. Lesotho also has the highest incidence rate of HIV in the world at 1.55 per cent.[3] An analysis of the distribution of new infections showed that most new infections in 2017 were among women compared to men, and outside of stable relationships[4].

HIV-Tuberculosis (TB) co-infection: TB co-infection is also high, although many people living with HIV have not been to a TB clinic for testing. Among self-reported HIV-positive adults, 51.9 per cent reported ever visiting a TB clinic (60.9 per cent of HIV-positive men compared to 46.6 per cent of HIV-positive women). Among those who ever visited a TB clinic, 46.6 per cent were diagnosed with TB (57.6 per cent of HIV-positive men compared to 38.1 per cent of HIV-positive women). Among those diagnosed with TB, 97.9 per cent reported receiving TB treatment (99.0 per cent of men and 96.7 per cent of women).[5]

Comprehensive knowledge about HIV: Despite over 18 years of HIV programming, in Lesotho, comprehensive knowledge of HIV among men and women 15-49 years remains low – 26 per cent among men and 30.7 per cent among women[6]. There are common misconceptions that if a wife tests negative for HIV, the husband is also negative. Some people also believe that HIV can be transmitted through mosquito bites or by sharing the same utensils.

Drivers of the HIV epidemic: According to the National Strategic Plan (NSP), the drivers of the epidemic include early sexual debut, particularly in girls, multiple concurrent partnerships, sex work, anal sex, low uptake of Voluntary Medical Male Circumcision (VMMC), age disparate sex, stable discordant couples, inadequate condom use, low comprehensive knowledge and high prevalence among women of child bearing age (27 per cent of all antenatal care attendees).

Structural and socio-economic drivers of the epidemic include poverty, unemployment, urban migration, high levels of sexual and gender based violence and gender inequality, and harmful cultural norms and practices related to gender, such as child marriage. Stigma, particularly towards FSWs and MSMs, as well as legal and policy barriers, which do not create an enabling environment, are also among the barriers. Most new infections in 2017 were among women compared to men, and outside of stable relationships.

The need for an SBCC strategy: The National Strategic Plan (NSP) for HIV 2018/19-2022/23 of Lesotho identifies Social and Behaviour Change Communication (SBCC) as one of the core programme areas. The present social and behavior change communication strategy has been developed in response to this.

Methodology: The development of the SBCC strategy followed a systematic process. The methodology included a desk review, Key Informant Interviews (KIIs) with partners at national and district level (Leribe)

---

[1] Lesotho Population Based HIV Impact Assessment (LePHIA), 2018
[2] LePHIA, 2017
[3] LePHIA, 2018
[4] DHS, 2014, BSS 2012 compared to LePHIA 2017
[5] LePHIA, 2018
[6] Lesotho Demographic and Health Survey (DHS), 2014

and Focus Group Discussions (FGDs) with young people and their influencers in two districts -Thaba Tseka (highlands) and Mohale's Hoek (lowlands).

Communication objectives: Communication objectives have been developed for the strategy. Communication objectives differ from programme objectives, as they focus on what can be achieved through communication. Most of the objectives are SMART (Specific, Measurable, Achievable, Relevant and Time bound). However, in some cases baseline data is not available and therefore it is not possible to make those objectives SMART. The objectives include those related to comprehensive knowledge, delaying sexual debut, reducing multiple concurrent partnerships, increasing condom use at last sex, increasing the self efficacy/agency of girls/women to negotiate condom use, male perceptions about condoms, increasing demand for services, reducing gender based violence as well as stigma and discrimination. LePHIA has been used as the baseline for most of the objectives, and the Knowledge, Attitudes, Practices and Norms (KAPN) study conducted in 2019, for a few of them.

Socio-ecological model: The socio-ecological model has been used as a conceptual framework for developing the SBCC strategy. The socio-ecological model facilitates careful consideration of how social and environmental dynamics influence development outcomes at the individual, household, community, institutional and societal level. SBCC programming is thus able to address variables at the level of the individual and group knowledge, and in relation to attitudes, beliefs, individual and collective efficacy, motivations, behaviours, social and cultural norms, community and institutional infrastructure and in relation to policy advocacy and governance. Issues and participants to be addressed at each level of the socio-ecological model, that is the individual, interpersonal, community, organizational and policy levels, have been identified. While it may not be able to address all the levels at the same time, in order for individual behaviour change to take place barriers at other levels need to be removed and supportive factors identified to create an enabling environment.

Participant groups: Based on the analysis of the socio-ecological model, primary, secondary and tertiary participant groups have been identified. As the focus of the strategy is on adolescents and young people and some key populations, the primary target group comprises adolescents and young people, both boys and girls, 15-24 years old, those who are in as well as out of school, including those who have disabilities. It also includes female sex workers (FSWs) and men who have sex with men (MSMs), as the prevalence of HIV is very high in these key populations. The secondary participant groups are those who influence the primary group, such as parents, peers, teachers and health workers, and the tertiary group are those who influence the secondary group and have the ability to create an enabling environment for behaviour and social change, such as policy makers.

Participant analysis: A participant analysis has been carried out of the primary participant group, comprising adolescents and young people. Issues specific to girls and boys, have been identified, as they need to be addressed through a segmented approach. The primary need is to engage adolescents and young people in a dialogue, which gives them information they need to make informed decisions about their own risk behaviours, but also gives them an opportunity to express their views through a dialogic process. As mentioned earlier, poverty, unemployment and gender issues, are some of the reasons for low risk perception. Unless the reasons for the risk behaviours they practice are understood and addressed, change is unlikely to take place.

Key messages: Key messages have been developed for each of the primary and the main secondary participant groups, based on the issues identified at each level in the analysis of the socio-ecological model. As the roles each of them play, as well as the barriers to behaviour and social change, differ by participant group, key messages need to be segmented for each group, although some may be common. These 'messages' are not the words/tag lines that will be used to develop communication materials, but the content of what we need to communicate to each of the participant groups. When the creative strategy is developed, these messages will be used to develop the communication materials and content using language, style and tonality that appeals to each participant group, that is memorable and appropriate to the particular channel of communication. The messages should contain a benefit for the participant group to whom it is addressed. That is, it should give them a reason why they should change their behaviours, as they see it.

It will not be possible to communicate all the messages at the same time, so only the most important ones need to be selected at one time. It is important not to clutter communication, particularly communicational materials and content, with too many messages at the same time, as they will then be lost. Therefore, it is suggested that 3-4 messages be selected at a time for a particular participant group and repeated for one year. Then the next group of 3-4 can be selected for the second year and so on. Messages require repetition through various media, so that the participant group is exposed to them at different intersections, and they reinforce each other, while keeping the creative execution fresh so that "message fatigue" does not develop. Messages for the participant groups should be finalized with the participation of members of those groups for whom they are developed, such as adolescents and key populations, so that the most important issues for each of these are identified, benefit/s from the participant's perspective is included and the tonality is appropriate.

Communication channels: As part of channel analysis, mass media, as well as community based communication channels, have been analysed for their effectiveness and appropriateness in reaching various participant groups. Mass media channels are limited in Lesotho and include the state broadcaster on TV, Lesotho TV, radio, both state owned and private, a few weekly newspapers, mobile phones (SMS) and social media, mostly Facebook and whatsapp. Community based channels in Lesotho include community meetings/*pitsos* called by traditional Chiefs and facilitated by peer educators, which would be an effective channel for parents and other community members, roadshows for new services and visibility, community theatre, community radio, community film screenings, local festivals and events.

Considerations while developing communication for young people: Young people have mostly not been engaged in a dialogue in which they are equal participants, in a way which they find interesting and relevant to their needs. Many years of 'informational campaigns' have not significantly impacted knowledge or behaviours. One the one hand there is "message fatigue", on the other hand, the low levels of comprehensive knowledge indicate that there is a need to provide this information in a medium and language young people can relate to. Like all young people, they do not want to be told what to do. They need to be engaged and provided information on knowledge and risks, so that they are in a position to evaluate their own risk and take responsible decisions.

Entertainment education: Therefore, entertainment education methods are recommended, to engage young people through a storyline and characters, to evaluate their own situation and risks. People get engaged in stories and characters, which also act as a projective technique, which engages them in

evaluating their own risk through the situations that the character find themselves in, and do not feel judged. The tone of communication should be non-judgemental. Entertainment education also has the potential for role modelling appropriate behaviours through characters and situations. *MTV Shuga* presents such a possibility. The organization has already been contracted to undertake training of peer educators in Lesotho and dubbing of the episodes which have been broadcast in South Africa into Sesotho. Other possibilities should also be explored.

The radio episodes could also be dubbed and broadcast on *Ultimate* and *MoAfrika* channels, which seem to be popular with young people, although there is no listenership data available. Listener groups could be developed to listen to the programme in groups, followed by a facilitated discussion by a trained peer educator. The strength of *MTV Shuga* is that it is a 360 degree intervention, combining mass media with community based interventions, which has been proven to be successful in many countries. The episodes can be screened in the community, where possible, followed by a discussion facilitated by trained peer educators. The dubbed episodes can also be uploaded on *youtube* and young people encouraged to watch them through social media posts.

Mass media channels for adolescents and young people: Radio, social media and other ICTs seem to be the most effective mass media channels to reach young people. Social media, such as Facebook and whatsapp, should be widely used to engage young people in a two-way interaction and encourage then to share their stories and contribute content, such as photographs, videos and stories. U-Report will also soon be introduced in Lesotho and would be an appropriate channel to engage young people in a two-way interaction. All ICTs/apps should be used to reach adolescents and young people, but their use should be coordinated across partners, so that it is not duplicated. TV and newspapers could have some efficacy in reaching older people. If the content on TV is engaging for young people, such as *MTV Shuga*, it may be channel to reach them as well.

Peer education: Peer education will remain the cornerstone of the SRHR/HIV communication strategy with young people, as they are most likely to be responsive to their peers rather than older people, and this has proven to be an effective strategy in many countries. However, this needs to be supported through other entertainment education and social media interventions to draw more young people in and make it interesting and engaging for them. Peer educators need to be equipped with communication materials to show/give to their peers when they meet them and talk to them about SRHR/HIV related issues.

Comprehensive sexuality education (CSE): Schools remain the institutional structure which provides easy access to adolescents in a learning environment. However, the capacity and comfort level/efficacy of teachers to deliver the comprehensive sexuality education curriculum needs to be improved. The efficacy of the programme in increasing comprehensive knowledge levels among adolescents should also be evaluated. The out of school programme is being mostly delivered by peer educators and the quality of this also needs to be monitored and its results evaluated.

Community based channels/activities for young people: Community theatre should be used to engage the entire community in dialogue on SRHR/HIV issues in an entertaining manner. Sports activities like football would be an effective way to engage young people, both boys and girls, in games that are good for them physically, emotionally and socially through clubs, and use opportunities to engage them on SRHR/HIV issues. Vocational/skilling programmes, being implemented by the government of other organisations, would also equip adolescents, particularly those out of school, for employment/starting

their own businesses and an opportunity to engage with them on SRHR/HIV. As already mentioned, community radio this could be an effective way of building skills of young people and providing them with an opportunity to express their views on issues that concern them.

Monitoring and evaluation: A monitoring and evaluation framework for the social and behavior change communication strategy has been developed. It has been proposed that implementation monitoring would be carried out through field visits by Ministry of Health (MoH) staff and partners, using a simple format. Behavioural monitoring which tries to detect early signs of behavior change would be carried out using participatory methods involving young people and peer educators, such as Most Significant Change. This is a participatory monitoring method which entails the collection of stories of the most significant changes in people's lives in defined domains within a specified time period, followed by selection by peers and community members of those stories considered to represent the most significant changes in people's lives. Participatory photography/video of the implementation of communication activities by young people using their mobile phones, could also be considered, which could additionally be used for documentation, social media and human interest stories.

Evaluation would be carried out by using the communication objectives phrased in results language as indicators, and comparing the baseline data from the 2020 LePHIA survey with another survey three years later, as well as comparing the KAPN conducted in 2019 with another follow up study conducted after three years. The indicators have been identified.

Implementation: The next steps for implementation have also been outlined.

2. Situation Analysis

Despite a reduction in new infections by 20 per cent Lesotho continues to have one of the highest rates of HIV prevalence in the world, at 25.6 per cent for adults 15 to 59 years of age, (30.4 per cent for females and 20.8 per cent for males)[7]. The highest HIV prevalence across all ages and both sexes is 49.9 per cent in females aged 35 to 39, compared to 46.9 per cent in males aged 40-44 years)[8]. Variances in prevalence between males and females are most marked between 20 to 24-year olds, over four times as high in females (16.7 per cent) than in males (4.0 per cent)[9]. Prevalence among key affected populations, such as Female Sex Workers (FSWs) was estimated at 71.9 per cent, and 32 per cent among Men who have Sex with Men (MSM)[10]. Lesotho also has the highest incidence rate of HIV in the world at 1.55 per cent.[11]

All 10 districts of Lesotho have high HIV prevalence, ranging from 17.8 per cent to 29.3 per cent adult prevalence, with the five lower lying districts with a higher population density and stronger economic activities, accounting for an estimated 75 per cent of all people living with HIV (PLHIV)[12]. As a result, Lesotho has more than 330,000 people living with HIV. The population of Lesotho is 2,007,201 with 38 per cent between the ages of 15 and 34[13], with high level of youth unemployment, which is one of the drivers of the epidemic. 57.8 per cent of Lesotho's population lives below the poverty line[14].

Urbanization and labour migration are significant drivers of the HIV epidemic. Behavioural risk factors, such as Multiple Concurrent Partnerships (MCP), increase vulnerability to infection. According to the Knowledge, Attitudes, Practices and Norms (KAPN) Research on HIV, 2019, three-quarters of the respondents had vaginal sex without a condom, one-half did not know the HIV-status of their last sexual partner, and one-quarter would knowingly sleep with an HIV-positive person – all risky and avoidable behaviours.

Incidence of HIV

As mentioned, the HIV incidence in Lesotho is the highest in the world at 1.55 per cent.[15] An analysis of the distribution of new infections showed that most new infections in 2017 were among women compared to men, and outside of stable relationships[16]. However, uncircumcised men, never married females and sero-discordant couples (where the male partner was HIV positive) constituted a sizeable proportion of new infections. Nearly half of all women and girls who get infected are single (49 per cent), while 22 per cent are in discordant relationships with a HIV positive partner. An additional 9 per cent of infections among women and girls occur from sex work. These three groups contribute 80 per cent of new infections among females.

HIV-TB Co-infection

---

[7] Lesotho Population Based HIV Impact Assessment (LePHIA), 2018
[8] LePHIA, 2018
[9] LePHIA, 2018
[10] LePHIA, 2017
[11] LePHIA, 2018
[12] LePHIA, 2018
[13] 2016 Household Census
[14] World Bank 2016
[15] LePHIA, 2018
[16] DHS, 2014, BSS 2012 compared to LePHIA 2017

Tuberculosis (TB) con-infection related to HIV affects many people living with HIV in Lesotho. However, many people living with HIV are either not aware that they could have TB or have reservations about going to clinics and being tested. Among self-reported HIV-positive adults, 51.9 per cent reported ever visiting a TB clinic (60.9 per cent of HIV-positive men compared to 46.6 per cent of HIV-positive women). Among those who ever visited a TB clinic, 46.6 per cent were diagnosed with TB (57.6 per cent of HIV-positive men compared to 38.1 per cent of HIV-positive women). Among those diagnosed with TB, 97.9 per cent reported receiving TB treatment (99.0 per cent of men and 96.7 per cent of women).[17] The National Strategic Plan (NSP) also mentions the need to create demand for TB services and myths and misconceptions that act as a barrier to this.

Low levels of comprehensive knowledge

Despite over 18 years of HIV programming, in Lesotho comprehensive knowledge of HIV among men and women 15-49 years remains low – 26 per cent among men and 30.7 per cent among women[18]. The KAPN study also found that knowledge of HIV transmission methods is quite low, particularly surrounding sex-related methods. Almost a third of respondents in the KAPN study aged 15-19 years, and almost a quarter of those aged 20-24 years said that HIV is not transmitted through anal sex. Almost a quarter of those aged 15-19 years as well as those aged 20-24 years felt that early sexual debut is not associated with higher risk of HIV infection. The study concluded that it is imperative to close these information gaps, so Basotho understand the importance of using condoms and practicing safe sex, including within marriages.

There are common misconceptions that if a wife tests negative for HIV, the husband is also negative. Some people also believe that HIV can be transmitted through mosquito bites or by sharing the same utensils. The study concluded that with infidelity and unprotected sex outside the marriage high among men, it is imperative for all Basotho to understand exactly how HIV transmission occurs, what prevents it, and how frequently to test for it. Only increased education, not advancing age, close these information gaps, so these issues will persist without an informational intervention.

Drivers of the HIV epidemic

According to the National Strategic Plan (NSP), the drivers of the HIV epidemic include the following:

- **Early sexual debut in girls and boys.** The percentage of young women and men aged 15-24 who had sexual intercourse before the age of 15 was 20.6 per cent for boys and 4.7 per cent for girls. About 67 per cent of girls had their sexual debut before they attained the age of 18 years.[19] According to the KAPN study on HIV, 2019, men in Lesotho report first having vaginal sex much earlier than women - one-half of women (50 per cent) first had sex when they were 18 years or older, while nearly the same amount of men (49 per cent) report first having sex at 15 or younger. Additionally, those with higher educational achievement waited slightly longer to engage in sex than those with lower levels of education.
- **Multiple Concurrent sexual partnerships:** According to the KAPN study, nearly nine in ten Basotho (87 per cent) believe it is wrong to have multiple sex partners and three-quarters (75 per cent) do not

---

[17] LePHIA, 2018
[18] Lesotho Demographic and Health Survey (DHS), 2014
[19] LePHIA, 2017

believe it is in their nature to have more than one sexual partner, although this varies between women (81 per cent) and men (64 per cent). There appears to be an equal amount of stigma around women having more than one sexual partner as men, as roughly similar percentages of respondents reported that they do not have respect for women who have more than one sexual partner (70 per cent) and men who have more than one sexual partner (68 per cent). This indicates that there could be some attitudinal changes towards having multiple concurrent partners taking place, or that respondents were not very open in their responses, as the practice continues to be prevalent.

- **Sex work** (full or part time) drives the epidemic among sex workers and their clients and stable partners of both Female Sex Workers (FSWs) and their clients. Poverty fuels various forms of transactional sex among Adolescent Girls and Young Women, (AGYW) orphans and some male migrants.
- **Anal sex** drives the epidemic among gay men and other MSM such as male prisoners, herd boys and some sex workers.
- **Low uptake of voluntary medical male circumcision (VMMC)**: While there are no prevailing myths about male circumcision, there are still significant segments of the population with limited awareness.[20]A communication campaign is currently being implemented by Jhpiego to increase awareness and willingness to undergo the procedure. Fortunately, it also appears that medical male circumcision is increasingly common among the younger generations, and even considered stylish, suggesting that existing informational campaigns have already laid important groundwork on the benefits of medical male circumcisions.
- **Age-disparate sex** affecting adolescent and young women, older men and young male partners of AGYW. However, the KAPN study on HIV, 2019, found that Basotho as a whole do not appear to be accepting of significant age differences between partners, with four in five (80 per cent) expressing disapproval toward a man being in a relationship with a woman ten years his junior, although it should be noted that acceptance of the practice increases with age. However, as mentioned earlier, it is possible that respondents in the KAPN study were not very open in their responses, as this and other forms of transactional sex fueled by poverty, seem quite common in Lesotho.
- **Stable discordant couples** place the HIV negative partner at significant risk unless the HIV positive partner is virally suppressed.
- **Inadequate condom use** across all ages and groupings. The KAPN study on HIV and AIDS, 2019, found that nine in ten (92 per cent) Basotho know using a condom can lower a person's chance of getting HIV, know where to get them (89 per cent), and are in favor of using them (84 per cent). There do not appear to be any significant barriers to use; seven in ten (71 per cent) do not fear rejection if they suggest using a condom to a partner, two-thirds (66 per cent) are not embarrassed to put a condom on themselves or their partner, and a majority (52 per cent) say that they do not believe condoms reduce sexual pleasure. However, this contradicts anecdotal evidence which strongly suggests that married and unmarried men are not fully committed to using condoms for sexual encounters both within and outside of marriage
- **Low comprehensive knowledge of HIV**
- There is also high prevalence among **women of child bearing age,** with a 27 per cent prevalence among all women attending ANC Clinics.

---

[20] KAPN Study on HIV, 2019

Structural and Socio-cultural barriers

- Several structural and sociocultural drivers of the epidemic are mentioned in the National Strategic Plan, including ***poverty, unemployment, urban migration, as well as high levels of sexual and gender based violence and gender inequality***, and harmful cultural norms and practices related to gender, such as ***child marriage***.

- ***Child marriage:*** According to the Violence Against Children Survey carried out in Lesotho in 2019, 2.3 per cent of girls were married, or living with a partner as if married, before the age of 16, and 11 per cent before the age of 18. The same study indicated that 14.5 per cent of the girls had experienced sexual violence in childhood, compared to 5 per cent for the boys. The most common perpetrator of the first incident of sexual violence in childhood was the intimate partners for 54.8 per cent of the girls/women. 18.3 per cent of the girls experienced the first sexual intercourse as pressured or forced among those whose first sexual intercourse was before the age of 18 years. This constitutes a violation of human rights and a high risk factor for HIV.

  According to the KAPN study on HIV, 2019, one-quarter (26 per cent) of Basotho ages 15-29 say child marriage is common in their community and seven in ten (70 per cent) say it is not. Four in five (80 per cent) do not believe child marriage is an acceptable practice, particularly younger Basotho (86 per cent) aged 15-17. Even though almost two in five (38 per cent) do not know why parents allow their children to marry at a young age, nearly as many (36 per cent) think reasons could be monetary in nature. Teenage pregnancies are also an area of concern with 17.8 per cent of girls 15-19 years old having either given birth or who were pregnant at the time of the survey. 26 per cent of those who were 15-19 years old had already given birth.[21]

- ***Stigma:*** Nine in ten Basotho have a basic understanding of HIV and its effects, and the stigma surrounding getting tested for HIV appears to have largely dissipated[22]. As a result, nearly all Basotho know where to get tested and do not believing getting tested implies they engaged in some "bad behaviour." However, stigma still exists around having an HIV-positive status. While many factors contribute to the spread of HIV, reluctance to disclose a positive status to loved ones and sexual partners and hesitation to seek treatment out of fear of others finding out, may be two important reasons the infection rate is not on the decline.

  Socio-cultural gender norms and beliefs regarding masculinity and femininity fuel stigma, discrimination and violence, compelling FSW and MSM to conceal their sexual behaviours and identities and dissuading them from accessing HIV prevention and treatment services.

- ***Legal and policy barriers***: While the environment for key populations is gradually improving because of advocacy efforts at multiple levels, including by local CSOs, customary laws (Leruthuli laws) continue to contradict statutory laws – key among them are laws addressing gender-based violence, protecting individual rights and the strategy to combat child marriage – that are not adequately understood by community leaders, women and girls. The Criminal Procedures Act, criminalising sodomy between men (though not between men and women), is contradicted by the more recent

---

[21]

[22] KAPN Study on HIV, 2019

Sexual Offences Act of 2003, that endorses sexual activity between consenting adults. Access to legal services for key populations remains insufficient.

Need for a social and behaviour change communication (SBCC) strategy

According to the National Strategic Plan 2018/19-2022/23, communication for social and behaviour change, demand creation for services, and transforming harmful socio-cultural norms, values, beliefs and practices will support the attainment of all program results. It identifies behavioural, socio-cultural and structural factors as critical determinants of HIV risk in the different population groups, which requires responses tailored to diverse needs. The NSP observes that this has not been sufficiently operationalised in the HIV response to date.

It mentions that apart from comprehensive knowledge about HIV transmission, many other aspects of knowledge and behavioural determinants also need to be communicated, such as where to access services, risk perception, including for reinfection, and agency to take action. Social issues such as gender norms, sexual and gender-based violence and power imbalances, will also need to be addressed. All interventions need to take into account what is relevant to different age cohorts, and in different settings and populations.

Other strategies related to SBCC included in the NSP, are building capacities of implementing stakeholders in SBCC at national, district and community level, identification of community-specific champions for HIV prevention to engage in communication for awareness and advocacy and developing a campaign for male involvement.

Further, according to the National Strategic Plan, "Mutually reinforcing multi-media channels will be used appropriately for different populations, including innovative use of social media, radio and television, community dialogue, interpersonal communication and other community approaches. The action plan will make logical links between expected outcomes and key messages, intended audience, channel of communication, tool and responsible actor, with a clearly defined monitoring and evaluation framework. SBCC and advocacy should also be synchronised with community service delivery. In particular, the engagement of men is important to promote gender equitable attitudes and to enhance their health seeking behaviour".

3. Methodology

The development of a Social and Behaviour Change Communication Strategy is a systematic process. The diagram below indicates the systematic process followed to develop an SBCC strategy:

Development of an SBCC Strategy: A systematic process
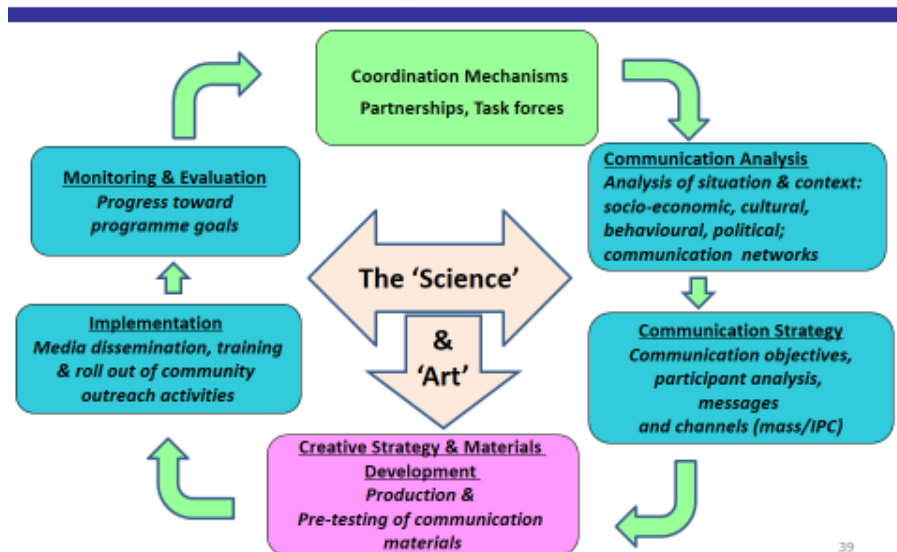
In order for the SBCC strategy to be evidence based, the methodology included the following:

1. **Desk Review:** All relevant documents were reviewed. These included the HIV SBCC Strategy 2014-17, the SBCC Strategy for RMNCAH, the National Strategic Plan, 2018/19-2022/23, the Knowledge, Attitudes, Practices and Norms (KAPN) Study, among others. The complete list is given in Annex 1.
2. **Key Informant Interviews (KIIs):** KIIs were conducted with key national level partners in Maseru. KIIs were also conducted with district level partners in Leribe, during a workshop being held there. The complete list is included in Annex 2.
3. **Field visits:** FGDs and KIIs were conducted during field visits to Thaba Tseka (highlands) and Mohale's Hoek (lowlands). These included the District Health Management Team (DHMT), adolescents and young people (boys/men and girls/women), young mothers and teenage pregnant women, village health workers, peer educators, mothers and grandmothers of adolescents. Discussion/Interview Guides were developed or each group.
4. **Consultation workshop with stakeholders:** A consultation workshop with stakeholders was held on 20 March 2020. The list of participants is given in Annex 3. A draft SBCC strategy was presented at the workshop.
5. **Finalisation and validation of the SBCC strategy:** Based on the feedback and inputs received during the stakeholder workshop the SBCC strategy has been finalized.

Findings

Observations from KIIs with partners

- ***Implementation of previous SBCC strategy****:* The previous SBCC strategy did not appear to have been implemented and the reason for this was not clear. It was mentioned that it did not have a focus on adolescents and was more of a general strategy. However, it also appeared that it was not clear who was to lead the implementation.

- ***Low visibility of HIV and communication activities:*** Considering the high prevalence of HIV in Lesotho, the issue is not very visible, in terms of media or materials that can be seen. The reason for this could be lack of funds. There is also anecdotal evidence that some years ago there was quite a lot done on communication for HIV, on radio as well as print materials and outdoor media. Some partners commented that there was "message fatigue". It is possible that no direct results were discernible from the investment, and it was discontinued. This effort may not have been intensive enough or strategic enough or sustained enough to bring about the desired behaviour and social change.

- ***Comprehensive sexuality education (CSE):*** Comprehensive sexuality education is being implemented in schools as well with out of school children through peer educators. While there is a manual for the comprehensive sexuality education, and teachers have been trained to teach it, some of them are apparently not comfortable delivering it, and therefore the quality of the delivery varies. As principals were not engaged in the beginning, some of them did not provide the space in the timetable for CSE. These issues are being addressed.

- ***Stigma and discrimination in schools:*** Stigma still exists in schools, mostly from the teachers themselves, and this needs to be addressed through teacher training. Although there is no obligation for children who are living with HIV to reveal their status to their teachers, it becomes known as they have to take leave from school to go for their checkups and medication. Partners are now trying to see whether this can be done on Saturdays so that children do not need to miss school. Some teachers start excluding children who are living with HIV from activities and make their status apparent to the other children. Teacher's attitudes towards children living with HIV need to be addressed through teacher training. This should also include children with disabilities.

- ***Peer educators:*** Peer educators are trained, although they may require more intensive/refresher training. However, they have no materials with them, such as flip charts, posters or leaflets which they can give or show to young people when they talk to them, to engage them in the subject and reinforce what they communicate to them. While global experience indicates that peer education can be an effective way to communicate with young people, it needs to engage them in a two-way interaction and be supplemented by other materials and activities. Most partners in Maseru are paying peer educators LSL 1400 per month, while those in districts may be paying less. There is high turnover among peer educators as many of them move on to other jobs. This creates a burden of constantly training new peer educators.

- ***VMMC, PrEP:*** There are some communication activities being implemented by partners, such as Jhpiego, on specific issues such as VMMC and PrEP, through roadshows with music, collaterals such as lanyards and caps to be given away at road shows, open days at schools, going office to office, radio phone-in programmes, posters and social media, including testimonies of young men who have undergone VMMC, as well as one-minute videos produced and posted on the Facebook page. PrEP is being promoted mostly to key populations.

- **Parenting skills:** The capacity of parents to engage with their children on issues of sex and sexuality is low, and they do not feel comfortable talking to their children about these issues. While some interventions are trying to address this issue by sensitizing the parents and providing a platform for parents and young people to dialogue, these are currently not being implemented at scale.
- **Youth friendly services:** Although adolescent corners have been set up in many health centres, they do not provide all services. Adolescents still have to queue up with everyone else to get medicines, and they do not feel comfortable doing that. Health care workers also sometimes stigmatise young people, those living with HIV and key populations and this need to be addressed as part of their training.
- **Social accountability***: In a new social accountability initiative to engage young people in evaluating whether health services are youth friendly, some of them have been asked to rate their experience in the health facilities on various parameters, using a community score card. This engages the young people in trying to improve the quality of service delivery and make it more responsive to young people's needs, as well as gives them a reason to visit the health facility, which they may not otherwise do, so that they can rate their experience. This initiative has been piloted in Berea and is now being implemented in Berea and Mafeteng, and should be scaled up.
- **Sports:** Some partners are also trying to engage young people through activities which they enjoy, such as sports, and this has great potential for getting young people interested and engaged in issues relating to SRHR and HIV. However, so far these activities are simulated sports activities, such as football, which incorporates SRHR/HIV knowledge. A manual is followed for implementing this activity.
- **Skilling adolescents:** Some programmes are enhancing skills of young people through training in computers, helping adolescent girls and young women set up thrift groups or starting vegetable gardens etc.
- **Coordination:** Even though there is a Technical Working Group for (TWG) SRHR/HIV communication, there does not seem to be much coordination of activities, including those related to communication, among partners. As mentioned by several partners, each partner is implementing programmes according to their own mandate.
- **Monitoring and evaluation:** There seems to be little monitoring or evaluation of programmes or of communication activities. Therefore, there is not much evidence available on what has been working and what has not. Where training is conducted or a manual is delivered, sometimes pre and post tests are conducted. Numbers trained or reached by various interventions are tracked, but not whether or how they increased knowledge or changed behaviours.

Observations from field visits: Knowledge and risk behaviours

The interactions with young people and peer educators during the field visits confirmed what had already been learnt from the desk review and KIIs with partners. Some of the observations are as follows:

- **Comprehensive knowledge:** Myths and misconceptions continue to prevail around the methods of transmission of HIV and how to prevent it, as indicated by the KAPN study. Some of these are that HIV is transmitted through mosquito bites and sharing utensils. However, once young people are engaged in discussion they have many questions and want to know more.
- **Gender:** In Lesotho men have the power and decision making role on sexual matters. Most of the young people have seen gender based violence in their families or neighbours. In some cases, this is

because the husband is co-habiting with a younger girl. They feel that the women suffer as a result of this, but they are too scared of the retaliation from the men if they complain and do not know who to complain to either. Some say police, some say health centre. Marriage and motherhood before the age of 18 is also common.

- **Condoms:** Also related to gender is that boys/men do not want to use condoms as they feel that it reduces sexual pleasure. Apparently they say that using condoms leads to kidney problems. Even if the girls would like their partners to use condoms their partners refuse and they do not have the skills or agency to negotiate condom use with their partners. However, young girls are more concerned about getting pregnant, which would have financial implications, rather than getting infected with HIV. The risk perception related to HIV is low.
- **Contraceptives:** Some of the girls/women were using other methods of contraception, such as oral contraceptives, IUDs and injectibles. Some were using "natural methods". However, the fact that the number of teenage pregnancies is very high also indicates that contraceptive use is low. Most of the girls drop out of school when their pregnancy starts showing, and their mothers look after the children. Some of them work to earn money.
- **Intergenerational sex:** It seems to be a common practice for young girls to engage in transactional sex with older men, in return for gifts, food and looking after their families. Older women also felt that while this was placing the girls at risk, it was justified due to their poverty and at least the family had food to eat. Again, the perception of risk to the girl is low.
- **Social protection:** The government of Lesotho has a number of social protection schemes for those who are disadvantaged, including a child grant, and it is not clear why these benefits are not reaching those in need, or possibly not adequately. Lack of food is also a reason for poor adherence to ARVs in some cases, particularly in child headed households.
- **Multiple concurrent partners:** Both girls and boys seem to have multiple concurrent partners, although it seemed to be more among the boys, with some even saying that had lost count of how many partners they had had. Most of them are aware that this puts them at higher risk of HIV, but it does not seem to affect their behaviour.
- **School drop out:** Many of the young people had dropped out of school after completing the primary level, due to financial reasons. Secondary schools are fewer and farther away and access and lack of transport may also be challenges. Some of these young people are now just sitting at home, another underlying factor for risky behaviours.
- **VMMC:** While there is some awareness of VMMC, levels of knowledge, particularly regarding the difference between VMMC and traditional initiation is low overall. Most of the boys had not undergone VMMC. There is resistance from some parents to VMMC as they want their sons to go through traditional initiation.
- **PrEP:** While some of the girls were aware that there are some medicines you can take to reduce the risk of HIV infection, they did not know much about it and were not taking it. Both VMMC and PrEP are new services and still need promotion.
- **Testing**: Levels of testing are high, as also corroborated by data and the stigma around testing as being an indication of having done something "bad" seems to have dissipated, as alos indicated by the KAPN study.
- **Stigma and discrimination:** While there are indications that stigma and discrimination towards people living with HIV has reduced, it is still present. As now those who are adhering to ARVs appear to be in good health, sometimes others in the community do not know that they are living with HIV.

However, disclosure of a positive status to partners and family members, is still an issue. Adolescents and young people appeared to be more affected by stigma and discrimination in schools and health centres, rather than in communities.

- *Channels of communication:* While radio is listened to in Lesotho, the preferred channel of communication for young people, through mass media is social media, primarily Facebook and Whatsapp. As far as face to face communication is concerned, information on SRHR/HIV issues is received mostly in schools, or from health care workers and peer educators.

There did not appear to be much difference in knowledge attitudes and behaviours between Thaba Tseka and Mohale's Hoek.

4. Communication Objectives

Communication objectives have been developed for the strategy. Most of them are SMART (Specific, Measurable, Achievable, Relevant and Time bound). However, in some cases baseline data is not available, and therefore it is not possible to make those objectives SMART. It should be noted that communication objectives are different from programme objectives (although in some cases they could be the same), and should be limited to what communication can achieve. Based on the situation analysis, the following communication objectives are proposed:

1. *Comprehensive knowledge:* Increase comprehensive knowledge of HIV among young girls/women aged 15-24 from 30.7 per cent to 50 per cent and among boys/men aged 15-24 from 26 per cent to 45 per cent (LePHIA).
2. *Sexual debut:* Decrease percentage of males 15-24 years who had sex before the age of 15 from 20.6 per cent to 10 per cent and of females from 4.7 per cent to 1 per cent (LePHIA)
3. *Multiple Concurrent Partnerships:* Decrease percentage of males aged 15-29 years having multiple concurrent partnerships from 54 per cent to 30 per cent and females from 26 per cent to 10 per cent (KAPN).

   OR

   Decrease the percentage of sexually active men who report having sex with a non-marital non-cohabiting partner in the last 12 months from 59.8 per cent to 30 per cent and amongst sexually active women from 38.9 per cent to 20 per cent. (LePHIA)

4. *Condom use at last sex:* Increase percentage of males 15-24 years who report using a condom the last time they had sex with a non-marital, non-cohabiting partner, from 79.9 per cent to 95 per cent and for women from 71.9 per cent to 90 per cent. (LePHIA) and by FSWs and MSMs with most recent partners to 90 per cent (IBBSS 2[23], NSP. Baselines are available of each of the 4 study districts. However, since it was not a nationally representative survey they cannot be aggregated. The target figure is from the NSP).
5. *Negotiating condom use:* Increase capacity of girls/women and FSWs to negotiate condom use with partners and clients (no baseline data available).
6. *Male perceptions about condoms:* Decrease the percentage of males 15-29 years old who sstate that condoms reduce sexual pleasure, from 54 per cent to 30 per cent (KAPN).

---

[23] Integrated Bio Behavioural Surveillance Survey (IBBSS 2) for Key Population in Lesotho, 2019

7. ***Demand for services:*** Numbers of people using a few services, such as HIV testing, VMMC and TB services are available from LePHIA and can be used as a baseline. Numbers for the other services may be available elsewhere. Otherwise numbers coming to health facilities for each service and aggregated at district/national level can be used. It should be noted, however, that increase in demand for any service could be due to factors other than communication, such as improved access to or quality of services.

    i. HIV Testing: Increase the percentage of adults 15-59 years old who reported having HIV testing and receiving results in the 12 months preceding the survey from 61.7 per cent of women to 80 per cent and from 50.5 percent of men to 70 per cent (LePHIA).

    ii. HIV Treatment: Increase percentage of those who tested HIV positive regularly coming for treatment from X per cent to Y per cent

    iii. VMMC: Percentage of young boys/men 15-24 years old who are medically circumcised increased from 50.7 per cent to 75 per cent (LePHIA)

    iv. PrEP: Increase numbers of those regularly taking PrEP from X per cent to Y per cent

    v. Contraceptives: Increase numbers of those using contraceptives from X per cent to Y per cent

    vi. STI treatment: Increase numbers coming to clinics for STI treatment from X per cent to Y per cent

    vii. ANC: Increase percentage of pregnant women registering for ANC in the first trimester from X per cent to Y per cent

    viii. TB services: Increase percentage of HIV positive adult men ever visiting a TB clinic from 60.9 per cent to 80 per cent and HIV positive adult women from 46.6 per cent to 60 per cent (LePHIA).

8. ***Gender based violence:*** Decrease percentage of women 15-24 years old who were pressured to have sex from 1.6 per cent to 0 per cent (LePHIA).

9. ***Stigma/discrimination:*** Decrease percentage of adults 15-59 years old who disagree that children living with HIV should be allowed to attend school with children who are HIV negative from 11.3 per cent to 5 per cent (LePHIA).

5. Conceptual framework: Socio-Ecological Model

The socio-ecological model is a conceptual framework which facilitates careful consideration of how social and environmental dynamics influence development outcomes at the individual, household, community, institutional and societal level. SBCC programming is thus able to address variables at the level of the individual and group knowledge, and in relation to attitudes, beliefs, individual and collective efficacy, motivations, behaviours, social and cultural norms, community and institutional infrastructure and in relation to policy advocacy and governance.

All levels may not be relevant to all issues and in all situations, nor may it be possible to address all of them at the same time due to resource constraints. However, global experience indicates that the more levels that are addressed, unless they are not relevant, the greater the probability of removing barriers to behaviour change at each level, and of creating an enabling environment for behavior change.

The Socio-Ecological Model and appropriate SBCC approaches
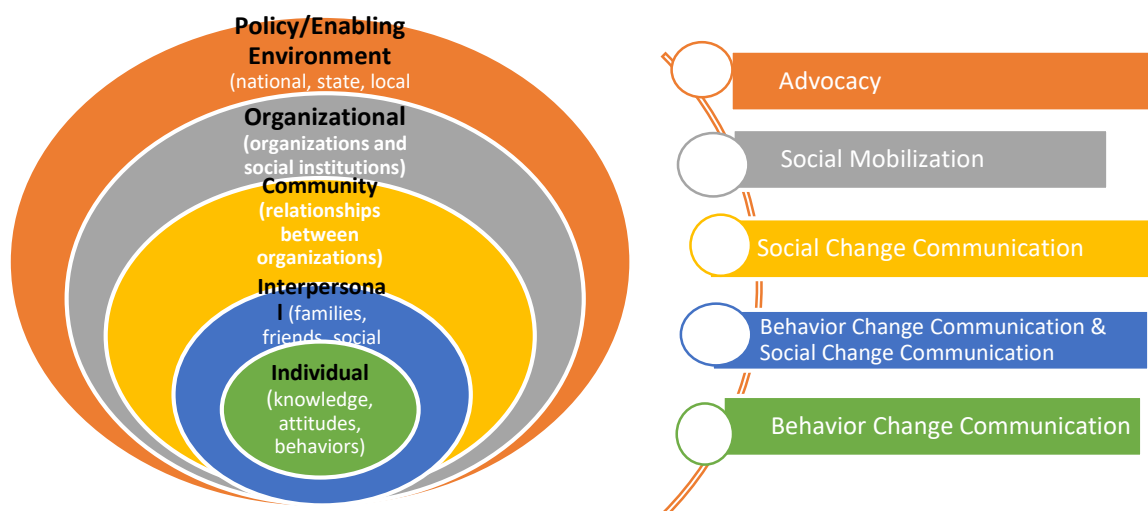
Individual level

At the individual level, of the socio-ecological model are knowledge, attitudes and behaviours. In the case of this SBCC strategy, this will focus primarily on adolescents and young people, both girls/women and boys/men 15-24 years old, both in and out of school, including those have disabilities. Evidence indicates that the girls are more vulnerable, both biologically and because of gender related issues, but this needs to be addressed by actively engaging with boys/men who are the partners of the girls, and also trying to change their attitudes and behaviours. The individual level will also include some key populations, such as female sex workers (FSWs) and men who have sex with men (MSMs), due to the high HIV prevalence in these groups. The following knowledge, attitudes and behaviours will be addressed through the SBCC strategy:

- Comprehensive knowledge about HIV, particularly among young people. The KAPN study shows that the knowledge levels in the 15-19 age group are lower on most parameters than those in 20-24 and 20-29 age groups, and this is the group that is particularly vulnerable.
- Increasing knowledge of and demand for services – HTC, VMMC, PrEP, contraceptives, STI treatment, ANC, TB testing and treatment.
- Knowledge of complaint mechanisms and support services for gender based violence
- Attitudes and behaviour towards risk of early sexual debut
- Attitudes towards condom use and risk of not using condoms, particularly for MSMs
- Attitudes and behaviour towards risk of multiple concurrent partnerships
- Attitudes and behaviour towards intergenerational and transactional sex
- Attitudes towards people living with HIV and those with disabilities
- Increasing self efficacy of girls/women and FSWs to negotiate condom use with partners and clients and to access services for gender based violence

At the individual level behaviour change communication through interpersonal communication /counseling is one of the most effective ways of promoting individual behavior change. A multi-country review of interpersonal communication interventions in Sub Saharan Africa found that those that rely on individual and group counseling, both within and beyond clinical settings can enhance the uptake of services and continued engagement in care. Interpersonal communication can also effectively promote adherence to anti-retroviral therapy (ART), which can limit the spread of HIV.

Peer education has been shown to be effective when combined with other interventions in promoting individual behavior change, such as condom use, and service uptake, including HIV testing and counselling and VMMC. Quality evidence shows that in-school interventions can positively impact HIV related outcomes, such as self reported sexual risk behaviours. A review of school based sex education, that included 15 Sub-Saharan Africa countries, found that students who received school based sex education were better informed with HIV knowledge, had greater self efficacy for refusing sex or using condoms, had fewer sexual partners, or were better able to delay initiation of first sex.

Interpersonal level

The interpersonal Level: includes families, friends and social networks. For this SBCC strategy it will include the following groups:
- Parents and caregivers of adolescents, including those in orphanages
- Peers of adolescents
- Clubs
- Peer educators
- Clients and partners of FSWs
- Networks of FSWs and MSMs

Appropriate strategies at the interpersonal level are behaviour change communication, individually or in groups, and social change communication.

By engaging with these groups the following communication issues will be addressed through the SBCC strategy:
- Improving parenting skills of parents and encouraging parent-adolescent dialogue on sex, sexuality SRHR and HIV, using trained teachers as facilitators
- Ensuring comprehensive knowledge of HIV, PrEP, VMMC, STIs, among parents and peers, adapting the comprehensive sexuality education manual
- Supporting young people to resist peer pressure from friends and networks on early sexual debut, having multiple concurrent partners and not using a condom
- Increasing collective self efficacy of young people to delay sexual debut, not have concurrent multiple partners and use/negotiate correct and consistent use of condoms
- Stigma and discrimination towards young people living with HIV, teenage pregnant girls and those who have disabilities.
- Support adolescents to stay in school till they complete secondary education, including teenage pregnant girls
- Prevention of gender based violence (GBV)and response

Community level

Engaging the community through social change can be very effective in creating an enabling environment for individual behaviour change and for changing social norms or creating new ones. When the whole community is engaged, it becomes possible to include community influencers, leaders of faith based organisations, traditional chiefs, community and lay counselors, community health workers, people living with disabilities and HIV and older men and women, who can be powerful leaders of social change.

The communication issues that would be addressed through the SBCC strategy at this level would be as follows:
- Gender based violence
- Child marriage
- Access to quality services, particularly adolescent friendly health services
- Acceptability and risk of intergenerational and transactional sex
- Acceptability and risk of multiple concurrent partnerships
- Stigma and discrimination towards people living with HIV, children with disabilities and teenage pregnant girls
- Preventing school drop outs

At the community level the appropriate strategy is social change communication through community engagement. In the area of HIV prevention, community mobilisation interventions have demonstrated success in increasing condom use, improving service access and quality, increasing social capital or social cohesion and in promoting uptake of HTC services among men and women 18 to 35 years of age in South Africa. Social norms can be changed/created by identifying early adopters of safe behaviours and making role models of them by amplifying their experiences to the rest of the community, through mass media and community based media, as well as at community events and gatherings, and offering non-financial incentives such as pride and recognition.

Communities need to be stimulated and motivated to take collective action to prevent unhealthy/unsafe behaviours, such as those mentioned above. They need to be informed about complaint mechanisms with the justice and police departments so that they can take appropriate action and ensure accountability of these law enforcing duty bearers, to the rights holders they serve. They also need to be made aware of referral pathways for services for sexual gender based violence, so that they can access these services. The community score card has been found to increase access to adolescent friendly youth services and to improve their quality. Similar systems can be used to improve the quality of comprehensive sexuality education.

The reasons for school drop out, primarily after primary school as mentioned earlier, are mostly financial and the distance to secondary schools, or girls getting married or pregnant. While the community may not be able to address all these issues, they can try to find solutions, such as accessing social protection schemes for those not financially able to send their children to school or community transport.

Organisational level

At the organizational level key institutions would be the school, including the principal and teachers, faith based organisations through their national and district level networks, as well as health workers, counselors of the Ministry of Health. It would also include initiation schools, which are influencers of behaviours, particularly related to gender socialization and VMMC, as well as the workplace, including private sector organisations. The appropriate strategy at this level is social mobilisation of these organisations and groups.

The communication issues that would be addressed through the SBCC strategy at this level would be as follows:

- Improving skills and self efficacy of teachers to deliver the comprehensive sexuality education curriculum in schools
- Addressing attitudes of teachers towards sexuality education as well as stigma and discrimination against children living with HIV and disabilities
- Enlisting support of faith based groups to use their influence to reduce multiple concurrent partners and intergenerational and transactional sex, gender based violence and child marriage
- Promoting condom use, linking with existing programmes in the community for adolescents and young people around SRHR/HIV.
- Supporting adolescents to stay in school till they complete the secondary level, including girls who are pregnant.
- increasing demand for services - HTC, VMMC, PrEP, contraceptives, STI treatment, ANC, TB etc.
- Improving interpersonal communication skills and attitudes of health care workers and teachers towards young people, particularly those living with HIV and disabilities, teenage pregnant girls, and rights of FSWs and MSMs
- Improving knowledge and interpersonal communication skills of peer educators
- Building capacity of MoH and other line ministries delivering social services (MoG, MoY, MoSD), to coordinate implementation and monitoring and evaluation of SBCC activities.
- Increase awareness of implementing partners on the school health programme and school health and nutrition days to include them in their programmes.
- Ensure implementation of adolescent friendly health services standards.
- Ensuring linkages with ongoing programmes for TVET and other skilling programmes for young people, particularly those who are out of school.
- Ensure that all communication activities and materials are developed with the engagement of young people and other participant groups for whom they are intended.

Policy level/Enabling environment

The policy level would include the Ministry of Health, National AIDS Commission, Ministry of Education, Ministry of Gender and Youth, Social Justice and other relevant ministries, Parliamentarians, District Councils, donors and partners, as well as the media - Lesotho Broadcast Authority, TV, Radio station owners/managers and telecom companies, who would be addressed through advocacy. A primary role of government is to address the structural issues underlying the HIV epidemic – gender, poverty, unemployment etc., and to ensure that the human rights based approach is implemented for all Basotho. At the policy level the following communication issues would be addressed through the SBCC strategy:

- Enactment of appropriate laws and development and implementation of policies to end child marriage and gender based violence
- Ensuring complaint mechanisms for gender based violence and child marriage as well as appropriate linkages at the community level and encouraging girls/women to use them
- Ensuring access to services for all adolescents and young people, as well as FSWs and MSMs and adequate stocks of medicines and commodities
- Ensuring quality pre-service and in-service training of teachers, peer educators, health workers and counselors, including addressing stigmatizing attitudes and improvement of interpersonal communication skills

- Providing vocational training/skilling programmes for young people and creation of employment opportunities at scale
- Improved targeting of social protection schemes, such as the child grant, to ensure it reaches those in need
- Ensuring coordination of SBCC activities across partners and ensuring quality, monitoring and evaluation and documentation and dissemination of best practices and lessons learnt
- Ensuring free education for all
- Ensuring implementation of the School Health and Nutrition Policy, including School Health and Nutrition Days
- Ensuring schools and health facilities are disabled friendly
- Ensuring funding for sustained communication activities to bring about behaviour and social change
- Ensure media policy includes media space and special programmes by and for adolescents and young people.

The relevant participant groups at each level of the Socio-ecological Model and the Communication Issues to be addressed at each level are summarized in the table below:

Socio-Ecological Model: Participant Groups and Communication Issues at each level

SEM Level	Participant Groups	Communication Issues
Individual Level	Adolescents and young people, female and male, 15-24 years old, including those with disabilities	• Comprehensive knowledge about HIV, particularly among young people.
		• Increasing knowledge of and demand for services – HTC, VMMC, PrEP, contraceptives, STI treatment, ANC, TB testing and treatment.
	FSWs	• Knowledge of complaint mechanisms and support services for gender based violence
	MSMs	• Attitudes and behaviour towards risk of early sexual debut
		• ttitudes towards condom use and risk of not using condoms, particularly for MSMs
		• Attitudes and behaviour towards risk of multiple concurrent partnerships
		• Attitudes and behaviour towards intergenerational and transactional sex
		• Attitudes towards people living with HIV and people with disabilities
		• Increasing self efficacy of girls/women and FSWs to negotiate condom use with partners and clients and to access services for gender based violence

Interpersonal Level	Parents and caregivers of adolescents, including those in orphanages	• Improving parenting skills of parents and encouraging parent-adolescent dialogue on sex, sexuality SRHR and HIV, using trained teachers as facilitators • Ensuring comprehensive knowledge of HIV, PrEP, VMMC, STIs, among parents and peers, adapting the comprehensive sexuality education manual • Supporting young people to resist peer pressure from friends and networks on early sexual debut, having multiple concurrent partners and not using a condom • Increasing collective self efficacy of young people to delay sexual debut, not have concurrent multiple partners and use/negotiate correct and consistent use of condoms • Stigma and discrimination towards young people living with HIV, teenage pregnant girls and those who have disabilities • Support adolescents to stay in school till they complete secondary education, including teenage pregnant girls • Prevention of gender based violence (GBV)and response
	Peers of adolescents	
	Peer educators	
	Clients and partners of FSWs	
	Networks of FSWs and MSMs	
Community Level	Traditional chiefs	• Gender based violence • Child marriage • Access to quality services, particularly adolescent friendly health services • Acceptability and risk of intergenerational and transactional sex • Acceptability and risk of multiple concurrent partnerships • Stigma and discrimination towards people living with HIV, children and adults with disabilities and teenage pregnant girls • Preventing school drop outs
	Community counselors, lay counselors	
	People living with HIV (PLHIV)	
	People with disabilities	
	Older men and women 25-55 years old	
Organisational Level	School principal and teachers	• Improving skills and self efficacy of teachers to deliver the comprehensive sexuality education curriculum in schools • Addressing attitudes of teachers towards sexuality education as well as stigma and discrimination against those living with HIV and children with disabilities • Enlisting support of faith based groups to use their influence to reduce multiple concurrent
	Faith based organisations through their national and district level networks	
	MoH, health care workers, counselors	
	Initiation schools (VMMC)	

	Workplace, including private sector organisations,	partners and intergenerational and transactional sex, gender based violence and child marriage
	Law enforcers (police)	• Promoting condom use, linking with existing programmes in the community for adolescents and young people around SRHR/HIV.
		• Supporting adolescents to stay in school till they complete the secondary level, including girls who are pregnant.
		• increasing demand for services - HTC, VMMC, PrEP, STI treatment, ANC, TB etc.
		• Improving interpersonal communication skills and attitudes of health care workers and teachers towards young people, particularly those living with HIV and disabilities, teenage pregnant girls, and FSWs and MSMs
		• Improving knowledge and interpersonal communication skills of peer educators
		• Building capacity of MoH and other line ministries delivering social services (MoG, MoY, MoSD), to coordinate implementation and monitoring and evaluation of SBCC activities.
		• Increasing awareness of implementing partners on the school health programme and school health and nutrition days, to include them in their programmes.
		• Ensuring implementation of adolescent friendly health services standards.
		• Ensuring linkages with ongoing programmes for TVET and other skilling programmes for young people, particularly those who are out of school.
		• Ensuring that all communication activities and materials are developed with the engagement of young people and othe rpartcipant groups for whom they are intended.
Policy Level	Ministry of Health, National AIDS Commission, Ministry of Education, Ministry of Youth and Gender and other relevant Ministries in the government	• Enactment of appropriate laws and development and implementation of policies to end child marriage and gender based violence
		• Ensuring complaint mechanisms for gender based violence and child marriage, as well as

	Parliamentarians	appropriate linkages at the community level and encouraging girls/women to use them
	District Councils	• Ensuring access to services for all adolescents and young people, as well as FSWs and MSMs, and adequate stocks of medicines and commodities
	Donors and partners	
	Media: Lesotho Broadcast Authority, TV, Radio station owners/managers, telecom companies	• Ensuring quality pre-service and in-service training of teachers, peer educators, health workers and counselors, including addressing stigmatizing attitudes and improvement of interpersonal communication skills • Providing vocational training/skilling programmes for young people and creation of employment opportunities at scale • Improved targeting of social protection schemes, such as the child grant, to ensure it reaches those in need • Ensuring coordination of SBCC activities across partners and ensuring quality, monitoring and evaluation and documentation and dissemination of best practices and lessons learnt • Ensuring free education for all • Ensuring implementation of the School Health and Nutrition Policy, including School Health and Nutrition Days • Ensuring schools and health facilities are disabled friendly • Ensuring funding for sustained communication activities to bring about behaviour and social change • Ensuring media policy includes media space and special programmes by and for adolescents and young people

6. Participant/Target Groups

Based on the communication objectives and the above application of the socio-ecological model, primary, secondary and tertiary participant/target groups have been proposed. The primary groups are the ones whose behaviours we want to change, the secondary groups are the ones who will influence the primary groups to change their behaviours and the tertiary groups are the ones who will influence the secondary groups. This does not imply a scale of importance/relevance.

Primary participant/Target group

- Adolescent girls and young women 15-24 years old, in and out of school, including those with disabilities (includes migrants and female prisoners)

- Adolescent boys and young men 15-24 years old, in and out of school, including those with disabilities (includes herd boys and migrants)
- FSWs
- MSMs (includes male prisoners)

Secondary participant/Target group

- Parents, mothers and fathers, and caregivers of young people 15-24 years old, caregivers in orphanages and other institutions
- School principals and teachers
- Peer educators
- Health care workers, including village health workers, village health coordinators, counselors, lay counselors, community counselors
- People living with HIV (PLHIV)
- Older men and women 25-55 years old
- Leaders of faith based organisations
- Traditional leaders/Chiefs
- Clients and partners of FSWs
- Law enforcers (police)
- Media: Lesotho Broadcast Authority, TV, Radio station owners/managers, telecom companies

Tertiary Participant/Target Groups

- Ministry of Health, National AIDS Commission, Ministry of Education, Ministry of Youth and Gender and other relevant Ministries in the government
- Parliamentarians
- District Councils
- Donors and partners
- Private sector/workplace

7. Participant Analysis

Adolescent girls and young women

They are the most vulnerable group, biologically as well as due to prevailing gender norms in Lesotho. They do not have the self efficacy/agency to negotiate condom use with their partners. They are often victims of gender based violence, including forced sex, which is a high risk factor for HIV. Child marriage is also common in Lesotho, as well as intimate partner sexual violence. Yet their attitude and risk perception towards getting HIV is low. Young girls/women are more concerned about getting pregnant, which would have economic consequences, rather than getting HIV, for which they know treatment is available free. They often end up getting pregnant while they are still children themselves, a pregnancy that is fraught with risk for both the mother and the baby. Most of the pregnant girls drop out of school, ending opportunities that education could have brought them. Most of them are also not in a position to bring up the children themselves, and leave the children with their mothers, and try to find work to support themselves and their families. This is also one of the reasons for intergenerational and transactional sex, which poor families seem to actually support even though they know it's a risk for the girls, as at least it brings them food to eat.

Adolescent boys and young men

These boys and young men have grown up in an environment of gender socialization, where they have been brought up to believe that men should dominate girls/women, including taking the lead in initiating sex as well as perpetrating physical, emotional and sexual gender based violence. Many of them have grown up seeing this violence in their own homes and communities and believe it is their right. They are subject to peer pressure from their peers to demonstrate that they are true 'men', which includes sexual conquests and probably having multiple concurrent partners. They believe that it is alright and even macho to not use condoms, as they think they reduce sexual pleasure, and mostly do not listen even if their partners try to tell them to use one.

Common to both adolescent boys and girls

Poverty and the lack of employment opportunities, and the prospect of a bleak future, are also some of the reasons for the uncaring attitude of young people that leads to low risk perception. The minds of these young people are preoccupied with concerns other than SRHR/HIV and that is one of the reasons communication efforts have not so far been able to make a significant impact. There has also so far not been a sustained attempt to engage these young people in a dialogue on risk behaviours in a way that they find interesting and engaging, which speaks to them in their own language and not in the preachy, judgemental language of adults, and gives them an opportunity to also express their views and be heard.

Like all young people, they also want to have some fun listening to music, playing sports, dancing, communicating on social media. There are limited opportunities for entertainment of young people in Lesotho, particularly for those who are disadvantaged. A lot of the communication that has been done so far, has told them what to do and what not to do, without adequately trying to understand their thoughts, feelings, perceptions, frustrations, hopes and dreams, which have led to low risk perception and "message fatigue", so that they tune off as soon as they hear the word 'HIV'. At the same time, once they are engaged, they do want to know many things about SRHR/HIV. They need to be equipped with the right knowledge and stimulated to think about and evaluate their own risks, rather than have someone else do it for them. As mentioned before, the levels of comprehensive knowledge levels about SRHR/HIV of adolescents are low, although higher for girls than boys. Unless the reasons for risk behaviors are understood and addressed, behaviour change is unlikely to take place.

8. Key Messages

Key messages have been developed for each of the primary and the main secondary participant groups, based on the issues identified at each level in the analysis of the socio-ecological model. As the roles that each of them play, as well as the barriers to behaviour and social change, differ by participant group, key messages need to be segmented for each group. These messages are not the words that will be used to develop communication materials, but the content of what we need to communicate to each of the participant groups. When the creative strategy is developed, these messages will be used to develop the communication materials and content using language, style and tonality that appeals to each participant group, as well as appropriate to the particular channel of communication. The messages should contain a benefit for the participant group to whom it is addressed. That is, it should give them a reason why they should change their behaviours, as they see it.

It will not be possible to communicate all the messages at the same time, so only the most important ones need to be selected at one time. It is important not to clutter communication, particularly communicational materials and content, with too many messages at the same time, as they will then be lost. Therefore, it is suggested that 3-4 messages be selected at a time for a particular participant group and repeated for one year. Then the next group of 3-4 can be selected for the second year and so on. Messages require repetition through various media, so that the participant group is exposed to them through various media, and they reinforce each other, while keeping the creative execution fresh so that "message fatigue" does not develop. Messages for the primary participant groups should be finalized with the participation of members of those groups for whom they are developed, such as adolescents, so that the most important issues for each of these are identified, benefit/s from the participant's perspective is included and the tonality is appropriate.

Primary Participant Groups

Adolescent girls and young women 15-24 years old, in and out of school, including those with disabilities

- **Comprehensive knowledge:** Complete and correct knowledge of HIV can protect you because knowledge is power that enables you to take your own decisions with confidence! HIV does not spread through mosquito bites or by using the same utensils. If one person tests negative, it does not mean that the partner is negative too.
- **Sexual debut:** Although you may want to try sex, and your friends may already have done so, remember that at a younger age you can more easily get infected with sexually transmitted infections, including HIV, which could affect the rest of your life. You could also get pregnant and may have to leave school. Is it worth the risk?
- **Multiple Concurrent Partners:** Having sex with multiple partners in the same time period will increase your risk of getting infected with HIV, particularly as it is possible that your partner/s also has/have several partners in the same time period or earlier. Think about it and be safe.
- **Negotiating condom use:** You and your partner should be equal partners in the relationship. If you are sexually active, have the self confidence to negotiate with your partner to use a condom every time you have sex. He may not want to at first but you must try to discuss this with him for your safety and his. It will also prevent you from getting pregnant and from other sexually transmitted diseases.
- **Intergenerational/transactional sex:** Having sex with a man 10 years or more older than you, increases your risk of getting infected with HIV, as he would have had several other partners, from whom he may have got HIV or other sexually transmitted infections. The gifts or money you may get are tempting, particularly if you can't afford them yourself, but getting infected with HIV would change your whole life. Is it worth taking the risk?
- **Testing:** Getting tested regularly for HIV will give you peace of mind, as you will know your status and can then decide what to do. It doesn't mean that you have done anything wrong. The result will be kept confidential. There are adolescent corners in the health centres where you will find people of your own age and feel comfortable.
- **VMMC:** If your partner has not undergone VMMC, talk to him about doing it. It feels clean, fresh and stylish and will also reduce the risk of him and you getting infected with HIV. It is available free of cost at the health facility.

- **Treatment:** If you have tested positive for HIV ensure that you go to the health centre for treatment and counselling and take your medication regularly. That is the only way to control the spread of HIV and stay healthy. If your partner if not HIV positive, there are medicines called PreP that you can take which will reduce the risk of passing on the infection to your partner. But remember to still use a condom as your partner could get infected or you could get reinfected.
- **ANC:** If you are pregnant, ensure you go to the clinic for antenatal care soon and an HIV test so that you and your baby stay healthy. If you are pregnant/have children and you need money to support your child/children there are schemes the government has, like child grant, which can help you support your child.
- **Gender based violence:** If you have been a victim of physical, emotional or sexual abuse and violence there are people who can help you. Be strong and report it to   . If you keep accepting it, it won't stop.
- **Child marriage:** If you get married before the age of 18 you could place yourself in a situation where you may be subject to violence from your partner or his family and not be able to do anything about it. If you get pregnant, your body will not be ready to have a baby and you and your baby could be at risk.
- **Stigma & discrimination:** If you know someone in your school or community who is HIV positive or has a disability, remember that it is their right to be treated like anyone else*.* Think of how you would feel if you were in that girl/boy's place.

Adolescent boys and young men 15-24 years old, in and out of school, including those with disabilities

- **Comprehensive knowledge:** Complete and correct knowledge of HIV can protect you because knowledge is power that enables you to take your own decisions with confidence! HIV does not spread through mosquito bites or by using the same utensils. If one person tests negative, it does not mean that the partner is negative too.
- **Peer pressure:** Your friends and peers might encourage you to start having sex at an early age or follow their example, and also to have several partners at the same time, but you must use your own judgement. Starting to have sex at an early age and having several partners in the same time period places you and your partner at greater risk of getting HIV as your partners could be infected, which could affect the rest of your life. Think about it and take the right decision.
- **Condom use:** You may feel that using a condom reduces sexual pleasure but by not using a condom you are putting yourself and your partner at risk of being infected with HIV and other sexually transmitted infections. Is it worth taking the risk?
- **Testing:** Getting tested regularly for HIV will give you peace of mind as you will know your status and what to do. It doesn't mean that you have done anything wrong. The result will be kept confidential. There are adolescent corners in the health centres where you will find people of your own age and feel comfortable.
- **Treatment:** If you have tested positive for HIV ensure that you go to the health centre for treatment and counselling and take your medication regularly. That is the only way to control the spread of HIV and stay healthy. If your partner if not HIV positive, there are medicines called PreP that you can take which will reduce the risk of passing on the infection to your partner But remember to still use a condom as your partner could get infected or you could get reinfected.

- **VMMC:** VMMC makes you feel clean, fresh and stylish and also reduces the risk of getting infected with HIV and other STIs. If you have not undergone the procedure do it now and tell your friends to get it done as well. Traditional initiation does not remove the entire foreskin and cannot protect you from these diseases. It is available free at health centres.
- **Gender based violence:** Your partner deserves the same respect as you. Being violent with her is not manly behaviour and will have a negative impact on her physically as well as emotionally. You don't want that to happen do you?
- **Stigma & discrimination:** If you know someone in your school or community who is HIV positive or has a disability, remember that it is their right to be treated like anyone else*.* Think of how you would feel if you were in that girl/boy's place.

Female sex workers

- **Collective self efficacy:** If all sex workers in your community/network get together and unite, and with the help of your networks, you will be able to help each other to develop the skills to negotiate condom use with your clients, get access to services that are your right, and cope with the way others in your community might sometimes treat you. This will protect you and your partner from STIs, including HIV.
- **STis:** You should go to the health centre for regular check ups to ensure any sexually transmitted diseases you may have, including HIV, are treated. This will keep you and your partner healthy. Remember it is your right to get the services that you need and to be treated like everyone else.
- **Testing:** Regular testing for HIV will ensure that you know your status and can get treatment in case you are HIV positive. Some of the networks for sex workers are providing testing services, in addition to health centres.
- **Treatment:** If you have tested positive for HIV you should ensure that you go to the health centre and start treatment and take your medicines, which are free, regularly so that you stay well. You need to be sure that you are virally suppressed before having sex again, otherwise you could get reinfected and infect others as well.
- **PrEP:** There are medicines available called PrEP which can help to reduce your and your partner's risk of getting infected with HIV. You can get them from health centres, or networks and organisations that are working with sex workers.
- **Social protection:** If you have children, there are schemes the government has, like child grant, which can help you support your child.

Men who have sex with Men (MSMs)

- **Anal sex:** The risk of getting infected with HIV is much higher when you have anal sex than when you have vaginal sex. That's why you must make sure you use a condom every time.
- **Multiple Concurrent Partners:** Having multiple partners in the same time period, whether male or female, increases your risk of your getting HIV, as they may also have had other partners who could be infected. So protect yourself from HIV and only have one partner in one time period.
- **HTC:** Get yourself regularly tested so that you know your status and take the right decisions about your life. If you test positive go to the clinic and start the treatment, which is free, and take it regularly. This will let you live a healthy life so that you can do the things you want to do.
- **Stigma & discrimination:** When you go the health centre, remember that it is your right to be able to get the services you need, and to be treated like everyone else.

- **PrEP:** There are medicines called PrEP that you can take which reduce your risk of getting infected with HIV. They are available free of cost in the health centre and from some civil society organisations. You should take them to reduce your risk of getting HIV, partcilarly if you your partner is HIV positive.
- **VMMC:** VMMC makes you feel clean, fresh and stylish and reduces your risk of getting HIV. It can be done at health centres free of cost. Get it done today!
- **Collective self efficacy:** Get together with other MSMs and networks so that you can collectively ensure that you get the services you need, practice safe behaviours and deal with the way that some people in the community may sometimes treat you.

Secondary participant groups

Parents of adolescents 15-24 years old

- **Parenting:** You may feel embarrassed to talk to your adolescent children about sex and sexuality but it's important as a parent that you do, so that they understand the risks and are able to protect themselves from HIV, other sexually transmitted diseases and pregnancy by practicing safe behaviours. If you need help to do this, please talk to the health centre staff or the school.
- **Early sexual debut:** Talk to both your son/s and daughter/s about not starting to have sex before they are 18 years old, as they could otherwise get infected with sexually transmitted diseases, including HIV. This is particularly true for girls, who could also get pregnant at a very young age when their bodies are not ready to have the child and both she and the baby could be at risk.
- **Condom use:** Boys often refuse to use a condom when they have sex, even if the girls ask them to. If you have son/s, please explain to them the risk they are exposing themselves as well as their partners to, by not using a condom.
- **VMMC:** If you have sons, encourage them to have VMMC done, so that they can reduce their risk of getting HIV and other sexually transmitted diseases. Traditional initiation does not remove the entire foreskin and therefore does not reduce the risk of getting sexually transmitted diseases, including HIV.
- **Intergenerational and transactional sex**: If you have a daughter, talk to her about the risks of a relationship with a man at least 10 years or more older than her. He may give her gifts and look after the family, but she is putting herself at great risk of contracting HIV and other sexually transmitted infections, as the man would have had many sexual partners.
- **Gender based violence:** Bring up your sons and daughters as equals, so that the boys learn to treat girls with respect and are not violent with them. It is not the right of boys/men to be violent with their partners. It does not mean that they are true men, but rather that they are taking advantage of a vulnerable person.
- **Child marriage:** If girls get married before the age of 18, it could interfere with their education and life opportunities. They are likely to get pregnant before their bodies are ready for it, putting themselves and their baby at risk. Talk to your daughters about this and don't pressure them into getting married too early. If your daughter gets pregnant, support her to go to the health centre soon, so that she and the baby stay healthy.
- **Children with disabilities:** If you have a child, boy or girl, who has a disability, ensure that they go to school and complete a secondary education. This is their right and important for their future. If they

are discriminated against in school, either by other children or by the teacher, speak to the teacher/principal about it.

- **Stigma and discrimination:** If there are people in your community who are HIV positive, treat them like you would treat anyone else. They have done nothing wrong and need your and the community's support to live with this.
- **AYPs living with HIV:** If you have a son/daughter who is HIV positive, encourage and support them to take their ARVs regularly so that they do not transmit the infection to others. Till then they still need to use condoms when they have sex.

Teachers and Principals of schools

- **Comprehensive knowledge:** You have a very important role in ensuring that the children you teach/who are in your school are equipped with the right knowledge about sex and sexuality and safe behaviours, which will enable them to make the right decisions in their lives and not expose themselves to unnecessary risks, which could have lifelong consequences for them.
- **Comfort level:** You may not feel entirely comfortable talking to your students about sex and sexuality, as you may not be used to it, but it's important that you really make the effort, as it is critical for the children to have complete and correct knowledge about sexual and reproductive health and rights and HIV.
- **Stigma & discrimination:** All children have the right to be treated equally, even if they are HIV positive, have disabilities or are teenage pregnant girls. If you are aware of their status, you must protect them from stigma by other students and not reveal his/her status. Include them in all activities in the school, so that they feel they are a part of it. They have not done anything wrong and are deserving of the same love and care as others.
- **Gender based violence/child marriage:** Talk to the children in your class about the need to respect girls/women and not be violent with them. Explain to the boys that this is not 'macho' behaviour to dominate girls/women, even if that is what they may have seen at home. Encourage them to talk about it and share their experiences. Explain to the girls how getting married at a young age can place them in a vulnerable position to violence from their partners and pregnancy, for which their bodies would not be ready.
- **Vocational/skilling programmes:** Link the young people in your class to vocational/skilling programmes being run by government or other organisations, so that they can improve their skills and find employment opportunities.

Health care workers

- **Recognition:** You are doing a great job under difficult circumstances and the country recognizes and thanks you for your service.
- **Stigma & discrimination:** Everyone who comes to the health centre has an equal right to receive quality services, even if they are young people who may be HIV positive or FSWs or MSMs. They all deserve the same treatment as any other person. They may be worried that they are HIV positive or have other sexually transmitted infections. Even if you are busy, try to explain to them what their risks are and what actions they can take to protect themselves.

- **Stigma & discrimination towards FSWs**: FSWs are doing another kind of job which puts them at greater risk of getting STIs, including HIV. We should not judge them for what they do, as sometimes they have to make hard choices.
- **Stigma & discrimination towards MSMs:** MSMs are differently oriented from heterosexual people. This does not make them bad people. It does place them at greater risk of getting HIV and they deserve to be treated like anyone else when they come for services.
- **Comprehensive knowledge:** You have a key role to play in your community, as someone who is respected and who can communicate the correct information to everyone, particularly adolescent boys and girls on SRHR and HIV issues, including how it is transmitted, how they can protect themselves and correcting myths and misconceptions. This is important for them to be able to evaluate their own risks and take appropriate decisions.
- **Vocational/skilling programmes:** Link the young people in your community to vocational/skilling programmes of the government or those being run by other organisations, so that they can improve their skills and find employment opportunities.

Leaders of faith based organisations/Traditional Chiefs/community counselors

- **Key role:** As a leader of your community you have a key role to play in ensuring that the young people in your community are well informed on issues related to SRHR and HIV so that they can evaluate their own risk and make the right decisions about their lives.
- **Stigma and discrimination:** Your faith tells you to treat everyone as equals and with compassion, whether they are HIV positive, have disabilities, are teenage pregnant girls or FSWs or MSMs. You have a powerful role in communicating this message to your followers/community, to ensure that people support each other and work together and do not discriminate against them.
- **Encourage parent-adolescent dialogue:** At *pitsos* and other occasions, when the community gathers/at faith gatherings, encourage the parents of adolescent children in your community to talk openly to their children about SRHR and HIV, so that they can take the right decisions which could affect the rest of their lives. Try to get parents and young people together so that they can do this.
- **Safe behaviours:** Encourage young boys and girls in your community to adopt safe behaviours, like delaying first sex, not having multiple partners and using condoms. This could protect them from HIV and other sexually transmitted diseases.
- **Access to information and materials:** If you don't have the right information or materials to talk to young people and their parents, get in touch with your nearest health centre/CSO/peer educator.
- **Gender based violence/child marriage:** Talk to the people in your community class about the need to respect girls/women and not be violent with them. Explain to the boys that this is not 'macho' behaviour. Explain to the girls how getting married at a young age could place them in a vulnerable position to violence from their partners and pregnancy, for which their bodies would not be ready.
- **Vocational/skilling programmes:** Link the young people in your community to vocational/skilling programmes, run by the government or other organisations, so that they can improve their skills and find employment opportunities.

Peer educators

- **Key role/recognition:** You have a very important role in ensuring that your peers in the community adopt safe behaviours and protect themselves from HIV and other sexually transmitted infections. As you are also young, they would rather talk to you than older people in the community who may

judge them. Ensure that they have the right information and can assess their own risk, so that they adopt safe behaviours.

- **Encouragement:** Behaviours take time to change. Do not be disheartened and continue this important work that you are doing.
- **Comprehensive knowledge:** Young people have a great need for information on SRHR and HIV related issues and they have many myths and misconceptions about them. You have a key role to play in changing this, because your peers will listen to you more than older people.
- **Dialogue with young people:** Engage your peers in dialogue so that they too get an opportunity to ask questions and put across their point of view to you.
- **Gender based violence/child marriage:** Talk to the young boys about the need to respect girls/women and not be violent with them. Explain to the boys that this is not 'macho' behaviour. Link the girls to complaint and support mechanisms in the community. Explain to the girls how getting married at a young age can place them in a vulnerable position to violence and pregnancy, for which their bodies would not be ready, placing them and their baby at risk.
- **Vocational/skilling programmes:** Link the young people in your group to vocational/skilling programmes run by the government or other organisations, so that they can improve their skills find employment opportunities.

Concept

Increased comprehensive knowledge about HIV will help young people and key populations to make informed decisions about their sexual behaviours. Engaging young people in a dialogue on risk behaviours, in a way that that they find interesting, will help them to evaluate their own risk behaviours and take decisions about their sexual behaviors. This dialogue has to be sustained so that young people also have an opportunity to express themselves and share their perspectives. Entertainment education approaches which that are non-judgemental will engage young people in characters and storyline and ultimately to reflect on their own behaviours. Such approaches can be very transformative and also have possibilities for modelling safe and appropriate behaviours through role modelling of characters.

9. Communication Channels and materials

Channel analysis

Mass media

In Lesotho mass media channels are limited. The major channels available are analysed below for their reach in our participant groups and their appropriateness for the purpose:

Television: The only local TV channel is Lesotho TV, which is the state broadcasting channel. It broadcasts for limited hours in the day and does not have many entertainment programmes. Those who have access to TV, mostly prefer to watch South African channels, which are accessible through satellite (DSTV). However, Lesotho TV is still watched by the older generation in Maseru and other towns. Therefore, the content can be tailored for influencers (secondary groups), such as talk shows on SRHR issues with experts and others, particularly on supporting their adolescent children to avoid risk behaviours and on supporting them to take ART regularly if they are HIV positive.. If the content is engaging/interesting for adolescents, such as an entertainment show like MTV Shuga, it could be a channel to reach adolescents and young people as well, if broadcast is free or at extremely reduced rates to make it feasible.

Radio: Radio signals cover about 87 per cent of Lesotho, although the signal strength varies across the country. There are two state owned channels – Radio Lesotho and Ultimate. Ultimate seems to be a popular channel with young people. The most popular private radio stations are MoAfrika FM, Harvest FM and PC FM. There is no listenership data available in Lesotho. Although radio is considered a medium for older people by some young people, it is nevertheless recommended as many people, young and older, do still, listen to it and it has news as well as entertainment programmes, particularly music which a lot of people listen to. Adolescent issues can be included in programming and programmes specific to adolescents developed. These should be broadcast at appropriate times when adolescents tune in.

Newspapers: There are no daily newspapers in Lesotho. There are some weekly newspapers, but their circulation and readership are limited to a few urban areas. However, they are read by the older generation and can be used to reach the influencers, or the secondary participant group, through appropriate editorial content tailored for them. This would be done through having orientation workshops with journalists, editors and owners of publications, which could also include other media, such as radio and TV. Editorial coverage would not be paid for.

Billboards: There are billboards in Maseru and a few other bigger cities in Lesotho. International experience suggests that they are not a medium for behaviour change, but serve mostly as a reminder medium and to publicise events, and are often expensive to sustain over a period of time. Therefore, they are recommended only for short periods, to publicise events in Maseru and other cities, such as around World AIDS Day.

Mobile phones: Research studies conducted by Research Africa show that by the end of 2016 Lesotho had a mobile penetration rate of 78.7 per cent (Lesotho residents owning a mobile phone). This would have substantially increased by now. Most young people have mobile phones. Although data to access the internet, is expensive in Lesotho, young people try to connect through Wifi services where they are available, and buying data. Social media seems to be the way to reach young people in a medium and language that they can relate to. Facebook and Whatsapp seem to be the social media that young people mostly use.

U-Report: U-Report will be introduced in Lesotho soon and represents a convenient and confidential way of communicating with young people via SMS on issues of concern to them. U-Report is an anonymous messaging service developed by UNICEF, that allows young people to speak out on issues that matter to them. Young people over 13 years of age sign up to receive regular information and questions via Facebook or SMS. When they respond, their answers appear instantly on U-Report's Lesotho website, which collates and showcases the views of young people across the country. Agreements are currently being worked out with telecom service providers to start this initiative.

All ICTs/apps should be used to reach adolescents and young people, but their use should be coordinated so that it is not duplicated.

Community engagement channels

There are a number of channels/activities that can be used for community engagement. It would be important to use some of these in conjunction with mass media, to ensure that those who have limited access to mass media channels are reached, and to reinforce messages through mass media, in a way that allows community dialogue. Some of them are described below:

Road shows: The same group of people moves from place to place, or different groups go to different places, and hold events to talk to people who gather about a particular issue, as is being done by Jhpiego for VMMC. Local singers/celebrities can be invited to come and perform at these events, to attract people, particularly young people. They a can then be given information about services and motivated to access them. Road shows offer opportunities for two-way interaction through questions and answers and fun through quizzes and contests, with collateral materials, such as caps and lanyards, as prizes/giveaways. However, they are usually used to create awareness when there is a new service/product available to motivate people to use it.

Community meetings/pitsos: Meetings at the community level called by the Chief and facilitated by a trained facilitator, such as a peer educator. This would be an effective channel for the secondary participant group, such as parents. Ideally such meetings should use some materials to interest community members and facilitate discussion, such as a film, if it is possible to screen it, or a flip chart or even some posters that will attract people. These can be used to illustrate various points being made by the facilitator.

Meetings with young people: Separate meetings would have to be organized for young people, facilitated by peer educators, perhaps separately for girls and boys, as they may feel inhibited to freely express themselves in front of older people. Such meetings need to be oragnised with specific topics and following a specific guideline, otherwise they will just be general discussions and not lead to any action/change. They should also be supported with communication materials, such as flip charts, posters and leaflets, specially designed for young people, so that they appeal to them.

Film screenings on SRHR/HIV in the community, where possible, followed by facilitated discussion on what was shown in the film. Ideally the film/s should be in an entertainment education format, to engage young people and others in assessing their own situation, roles and risks through characters and storylines. Episodes of *MTV Shuga* from South Africa dubbed in Sesotho, or other entertainment education based films, present an opportunity to do this, where community screenings are possible, using content that will engage young people. This can be an extremely powerful and transformative method of communication, which would enable discussion around the situation and dilemmas faced by characters in the drama. Facilitators would need to be trained to facilitate the discussions after the screening.

Community theatre: Theatre performances in the community, either by a local group, young people who are trained, or by a travelling troupe. This channel has possibilities for engagement and involvement of the audience in the characters and story. Forum theatre is a form of participatory theatre in which, aided by a facilitator, at a certain point in the performance members of the audience are encouraged to take on the roles of the actors and change the direction of the plot and the outcome in a way they think appropriate. This can also be an extremely powerful and transformative process, as it enables people to challenge what they see, to relate it to their own specific circumstances, and to rehearse real-life solutions. The theatre groups would need to be trained, through co-creation workshops, on development of appropriate scripts.

Community radio: Local radio stations with low power transmitters run by communities/CSOs/FBOs. There are four community radio stations in Lesotho, in Quthing, Butha Buthe, Thaba Tseka and Mafeteng. While their reach is only within the town where they are located, there are possibilities of engaging young people in the production of programmes by training them, as part of skill development

programmes. This would enable them to develop programmes on issues which they think are important, using language and style which they think appeals to other young people like them. This has been successfully done in several countries. Some commercial radio stations, like MoAfrika, also hire young people to develop programmes for young people, so that the content and tonality are appropriate for young people.

Sports for development: Sports represent a powerful way of engaging young people in an activity that they enjoy and which is healthy for them, and using it as a channel of communication on SRHR/HIV issues. This could be done though having a short interactive discussion before/after the sports activity, supported by appropriate communication materials as mentioned above, or a short film of around 10-15 minutes in an entertainment education format, which could be shown, followed by a facilitated discussion on the content of the film.

Local events/festivals: Information stalls can be set up at local festivals and events, with appropriate, colourful and interesting materials on SRHR/HIV issues. Music could be played to attract people. A film could be shown and other entertainment programmes organized in addition to an interactive discussion on SRHR/HIV.

A ***theme song*** could be developed to highlight key issues and reinforce branding. This could be played at community events to attract people and reinforce branding of the SRHR/HIV programme.

Gatherings of faith based organisations: These are opportunities for leaders of faith based organisationsto speak to the community about SRHR/HIV issues. However, they will have to be trained to do this and equipped with appropriate communication materials.

To pilot the community engagement approach, a group of facilitators could be trained and go from place to place and train other people, and then this approach assessed for scaling up across the country.

Communication channels: Young people

Entertainment Education

As has been mentioned, young people have mostly not been engaged in a dialogue in which they are equal participants, in a way which they find interesting and relevant to their needs. Many years of 'informational campaigns' have not significantly impacted knowledge or behaviours. One the one hand there is "message fatigue", on the other hand, the low levels of comprehensive knowledge indicate that there is a need to provide this information in a medium and language young people can relate to. Field visits indicated that once young people are engaged, there is a great desire for information, testimony to an unmet need. Like all young people, they do not want to be told what to do. They need to be engaged and provided information on knowledge and risks, so that they are in a position to evaluate their own risk and take responsible decisions. Some of these decisions may not be the ones that reduce their risk, but experience in other countries indicate that such approaches do show adoption of safer behaviours over time.

Therefore, entertainment education methods are recommended, to engage young people through a storyline and characters, to evaluate their own situation and risks. People get engaged in stories and characters, which also act as a projective technique, so that they do not feel judged, and get them to indirectly evaluate their own risk through the situations of the characters. As mentioned earlier,

entertainment education also has the potential for role modelling of appropriate behaviours through characters. The tone of communication should be non-judgemental.

MTV Shuga presents such a possibility. Although currently their contract seems limited to training some peer educators and dubbing episodes from South Africa into Sesotho, this should be explored in greater detail. The radio episodes could also be dubbed and broadcast on Ultimate and MoAfrika channels. Listener groups could be developed to listen to the programme in groups followed by a facilitated discussion by a trained peer educator. The strength of *MTV Shuga* is that it is a 360 degree intervention, which combines mass media with community based interventions, which has been proven to be successful in many countries. The episodes can be screened in the community, where possible, followed by a discussion facilitated by trained peer educators. The dubbed episodes can also be uploaded on *youtube* and young people encouraged to watch them through social media posts.

Mass media

- **TV:** Once the *MTV Shuga* episodes are dubbed into Sesotho they should be aired on Lesotho TV at appropriate times for young people, if possible within the broadcast hours of Lesotho TV. This should be publicized and popularized through social media. Interactive discussions can also be held on SRHR/HIV issues with experts or young people as participants. This would also serve to highlight the issues faced by young people to the older generation.
- **Radio** as a channel should be used to engage young people through entertainment education programmes, such as *MTV Shuga* or other locally produced radio entertainment education programmes, as well as education programmes – music, chat shows, phone-in programmes etc. Listener groups could also be formed to listen to the programme, either live or recorded, in groups, followed by a facilitated discussion by a trained peer educator.
- **Social media** (primarily Facebook and Whatsapp) is the medium that young people relate to the most, and therefore it should be used widely. A special Facebook (FB) page could be created and young people urged to go to it through social media. Agreements could be worked out with telecom companies for this purpose. This would also provide opportunities for contests/quizzes on SRHR/HIV knowledge, risk behaviours with small prizes, which would engage young people and sustain their interest. Young people should be engaged in developing content for social media, as well as other media, so that it in the language they relate to.
- **U-report** should also be used to engage young people and have a two-way interaction with them to increase knowledge as well as evaluate risk in a manner that is confidential.

  As mentioned earlier, the use of ICT platforms should be coordinated across partners to prevent duplication.

Community based approaches

- **Peer education** will remain the cornerstone of the SRHR/HIV communication strategy with young people, as they are most likely to be responsive to their peers rather than older people, and this has proven to be an effective strategy in many countries. However, this needs to be supported through other entertainment education and social media interventions to draw more young people in, and make it interesting and engaging for them.

Peer educators need to be equipped with materials to show/give to their peers – flip chart, short film, pamphlets, posters etc. A unique branding should be developed for programmes/materials for young people, which is fun and increases identification. All material should have the same branding and be colourful and appealing, and should be developed with the engagement of young people.

- **Comprehensive sexuality education in schools and out of school:** Schools remain the institutional structure which provides easy access to adolescents in schools in a learning environment. However, the capacity and comfort level/efficacy of teachers to deliver the curriculum needs to be improved. The efficacy of the programme in increasing comprehensive knowledge levels among adolescents should also be evaluated. The out of school programme is being mostly delivered by peer educators and the quality of this also needs to be monitored and its results evaluated.
- **Community theatre** should be used to engage the entire community in dialogue on SRHR/HIV issues in an entertaining manner. A local theatre group could be trained to this through co-creation workshops for script development. If it is possible to do forum theatre, it could be a powerful tool to facilitate social change on gender/SRHR and HIV.
- **Sports for development:** Sports activities like football to engage young people (boys and girls) in games that are good for them physically, emotionally and socially through clubs, and use opportunities to engage them on SRHR/HIV issues.
- **Vocational/skilling programmes:** TVET programmes being implemented by the government or other organisations, are an effective way of equipping adolescents, particularly those out of school, for employment/starting their own businesses and an opportunity to engage with them on SRHR/HIV.
- **Community radio:** As already mentioned, this could be an effective way of building skills of young people and providing them with an opportunity to express their views on issues that concern them.

Channels: Other Participant Groups

- FSWs and MSMs will be reached primarily through their networks. However, some materials could be developed for their special needs, to be used by the peer educators.
- Parents of adolescents should be engaged through churches and by the traditional Chiefs in *pitsos*, through editorial content in newspapers, appropriate radio channels, content on lasotho TV, and local events/festivals. Parenting programmes that engage parents and adolescents together would be helpful in encouraging discussion on SRHR/HIV issues and breaking down barriers and giving them an opportunity to practice these behaviours.
- Messages for teachers on stigma and discrimination and building their capacity and efficacy to teach the CSE curriculum should be incorporated into their pre-service and in-service training.
- Stigma by health workers should be addressed through pre-service and in-service training to improve their interpersonal communication skills and attitudes, towards, PLHIV, FSWs and MSMs.
- Policy makers and partners would be addressed through focused advocacy meetings supported by appropriate communication materials and presentations, websites, human interest stories etc. The development of an advocacy kit, could be considered.

Communication materials

As the above indicates, appropriate communication materials need to be developed for different participant groups. As the focus of this strategy is on young people, the materials for young people

should be prioritsised. These need to be developed with the participation of young people so that the content, tonality and style are appropriate.

The materials will include audio visual materials, such as *MTV Shuga* or other short film/s/programmes in an entertainment education format, audio programmes, either dubbed episodes of *MTV Shuga* on radio or a locally produced programme, as well as a package of print materials such as a flip chart, a set of posters, leaflets to give away and banners for events, to support the primary communication effort. On their own these materials may not be very meaningful, but they should be regarded as materials to support and reinforce communication through entertainment education, peer education, or other methods. As has been mentioned, a unique branding should be developed for the materials for young people, so that they can identify with them, and all materials should follow this branding in their style, so that they look like part of a package and appeal to young people.

10. Monitoring and Evaluation
Monitoring and Supervision

- **Implementation monitoring** would be carried out by MoH and implementing partners. A monitoring format/checklist should be developed to do this through field visits, and responsibilities must be clearly defined and included in the implementation plan. Indicators for implementation would include
    - Numbers of different kinds of activities implemented vs those planned in each geographic area within a specified time period, and reasons for shortfall if any
    - Quality of implementation of activities
    - Number of participants (men. Women, adolescents, children) in group activities
    - Suggestions for improvement

  The monitoring format should be simple, so that it is easy for those visiting the field for supportive supervision to complete. A sample format is given in Annex 4.

- **Behavioural monitoring:** Behavioural monitoring looks for early signs of behavior or social change and focuses on the process of change , not merely on the outcome. This is an important factot in communication as behavior change communication is a process. It is suggested that young people and community members be engaged in monitoring behavioural change through participatory methods, such as Most Significant Change*, participatory photography/video etc.* Before actual behaviour change takes place there are signs that can be observed, of changes in attitudes and mind sets, such as discussing the issues with peers or others, seeking more information or services, or statement of intention to change behavior, which is considered the best predictor of change.

  Most Significant Change (MSC) involves collection and selection by community members of stories of the most significant changes in their lives within defined domains, within a particular time period. These stories could be collected by peer educators who could be trained for this. A standars format could be used to record the stories, which could be written, on audio or video. It could also be piloted in areas where there are community radio stations, through training community reporters as part of their skills training, and could form the content of the stories they produce for community radio. The domains could be gaps in knowledge and various risk behaviours identified earlier. A group of people, could be young people in this case, would the select together and review the

stories in each domain and select stories that they feel reflect the most significant changes in people's lives. This process must be done in an open and transparent manner. Wherever possible the stories are verified to ensure their authenticity. These stories would then be passed upward to a higher level for further selection, such as from village to district.

The final step is sharing the stories and discussion of values with stakeholders and contributors so that learning happens, about what is valued. MSC is not just about collecting and reporting stories, but about having processes to learn from these stories – in particular, to learn about the similarities and differences in what different groups and individuals value. It provides some information about impact and unintended impact but is primarily about clarifying the values held by different stakeholders. More information on the Most Significant Change Method is available at https://www.intrac.org/wpcms/wp-content/uploads/2017/01/Most-significant-change.pdf It is important in using this method to not only focus on the ultimate behavioural change but also on the small steps towards it, as behaviours take time to change and a person goes through many phases before that as indicated in the stages of change model (Annex 5).

Participatory photography/participatory video would engage young people in monitoring changes in their own lives and those of their friends, families and peers, and is based on the principles of participatory problem solving of Paolo Friere, similar to forum theatre. It involves training a group of young people as co-researchers, rather than objects of research, to take photographs/video on the subject of interest. In this case it could be on the process of changes in risk behaviours or implementation of be communication activities. This can be done on smart phones and would not need much training as young people are adept with their phones.

Photographs/video on the subject of interest are then shot followed by a participatory group process of selection of illustrative images/video and appropriate captions. This would include explanations by individuals of why they shot a particular photograph/video and what it represents to them. This would be followed by a group discussion of the themes in the photographs/videos. An exhibition aimed at decision makers would then be organized or a video screening in the case of videos. Some users of these methods feel that videos are more versatile and compelling. The photographs/video could also be used for documentation, social media and human interest stories. Participatory photography/video would also enable feedback from young people on whether the communication activities are appropriate or need modification.

Evaluation

Evaluation would be carried out by comparing the baselines in the objectives to new data on the same indicators from LePHIA, using results language. A new LePHIA is currently being carried out in 2020 and this will form the baseline for evaluation of the SBCC strategy after three years, assuming that implementation is rolled out quickly in 2020. A follow up KAPN should also be conducted after three years and the results compared with the baseline KAPN carried out in 2019. The new study should use the same methodology as the earlier one, so that the results are comparable. While the instruments for the study would remain essentially the same, additional questions can be added on the implementation of the SBCC strategy, particularly in the qualitative component. It would not be advisable to conduct an evaluation less than 3 years after implementation, as behaviours and norms take time to change

Indicators

Based on the communication objectives of the SBCC strategy, the following indicators are proposed for evaluation its results:

1. **Comprehensive knowledge:** Comprehensive knowledge of HIV among young girls/women aged 15-24 years increased from 30.7 per cent among women to 50 per cent, and among men aged 15-24 years from 26 per cent to 45 per cent (LePHIA).
2. **Sexual debut:** Percentage of males 15-24 years who had sex before the age of 15 reduced from 20.6 per cent to 10 per cent and of females from 4.7 per cent to 1 per cent (LePHIA).
3. **Condom use at last sex:** Percentage of males 15-24 years old who reported using a condom the last time they had sex with a non-marital, non-cohabiting partner, increased from 79.9 per cent to 95 per cent and for women from 71.9 per cent to 90 per cent. (LePHIA) and by FSWs and MSMs with most recent partners to 90 per cent (IBBSS 2[24], NSP).
4. **Multiple Concurrent Partnerships:** Percentage of males aged 15-29 years having multiple concurrent partnerships decreased from 54 per cent to 30 per cent and females from 26 per cent to 10 per cent (KAPN).

   OR

   Percentage of sexually active men who report having sex with a non-marital non-cohabiting partner in the last 12 months decreased from 59.8 per cent to 30 per cent and amongst sexually active women from 38.9 per cent to 20 per cent. (LePHIA)

5. **Negotiating condom use:**
   i. Percentage of girls/women 15-24 years old who state that they feel confident to negotiate condom use with partners (no baseline data available. Include in follow up KAPN).
   ii. Percentage of FSWs who state that they feel confident to negotiate condom use with partners and clients
6. **Male perceptions about condoms:** Percentage of males 15-29 years old who agree that condoms reduce sexual pleasure decreased from 54 per cent to 30 per cent (KAPN).
7. **Demand for services:** Numbers of people using a few services, such as HIV testing, VMMC and TB services are available from LePHIA and can be used as a baseline. Numbers for the other services may be available elsewhere. Otherwise numbers coming to health facilities for each service and aggregated at district/national level can be used. However, it should be noted that increase in demand may not be due only to communication factors, but other variables such as improvement in access and quality of services.
   i. HIV Testing: The percentage of adults 15-59 years old who reported having HIV testing and receiving results in the 12 months preceding the survey, increased from 61.7 per cent of women to 80 per cent and from 50.5 percent of men to 70 per cent (LePHIA).
   ii. HIV Treatment: Percentage of those who tested HIV positive regularly coming for treatment increased from X per cent to Y per cent
   iii. VMMC: Percentage of young boys/men 15-24 years old who are medically circumcised increased from 50.7 per cent to 75 per cent (LePHIA)
   iv. PrEP: Numbers of those regularly taking PrEP increased from X per cent to Y per cent

---

[24] Integrated Bio Behavioural Surveillance (IBBSS 2) for Key Populations in Lesotho, 2019

      v.   Contraceptives: Numbers of those using contraceptives increased from X per cent to Y per cent

      vi.   STI treatment: Numbers coming to clinics for STI treatment increased from X per cent to Y per cent

      vii.   ANC: Percentage of pregnant women registering for ANC in the first trimester increased from X per cent to Y per cent

      viii.   TB services: Percentage of HIV positive adult men ever visiting a TB clinic, increased from 60.9 per cent to 80 per cent and HIV positive adult women from 46.6 per cent to 60 per cent (LePHIA).

8. ***Gender based violence:*** Percentage of women 15-24 years old, who were pressured to have sex decreased from 1.6 per cent to 0 per cent (LePHIA).

9. ***Stigma/discrimination:*** Percentage of adults 15-59 years old, who disagree that children living with HIV should be allowed to attend school with children who are HIV negative decreased from 11.3 per cent to 5 per cent (LePHIA).

11.Implementation: Next steps

- Develop branding for SRHR/HIV prevention among young people
- Develop social media content for Facebook by engaging young people. Whatsapp can be used for young people to ask for further information/advice or to form support groups.
- Explore possibilities of *MTV Shuga* and finalise. If not possible, consider developing a locally produced entertainment education programme for radio by doing co-creation workshops with producers of select local radio stations.
- Train selected peer educators on facilitating discussions on *MTV Shuga* episodes/other entertainment education programme on radio/TV. Peer educators may require some additional incentive to do this.
- Set up listener groups through clubs for young people, to listen to *MTV Shuga*/local produced radio programme followed by a discussion on the content facilitated by a trained peer educator
- After *MTV Shuga* episodes are dubbed in Sesotho, upload on *youtube* and screen in communities wherever possible, followed by a discussion on the issue facilitated by a trained peer educator. Use social media to publicise screening of *MTV Shuga* on Lesotho TV.
- Explore and finalise partnerships with Kick4Life/other partners for sports programmes with young girls and boys that include opportunities for SRHR/HIV interactive dialogue.
- Develop print materials to support peer education/counseling/interpersonal counselling – short film (10-15 minutes) featuring young people in an entertainment education format, flip chart, leaflets, posters and banners. Young people should be involved in the development of all materials being developed for them, so the messages are appropriate and the materials appeal to them.
- Identify community theatre groups and discuss partnership possibilities for community theatre. Train in script development through co-creation workshops.
- Integrate SRHR/HIV content into ongoing vocational training/skilling programmes for young people of Ministry of Education and Training (MoET), non formal education (NFE), technical and vocational, education and training (TVET). Activities for young people, such as sports and music, which young people enjoy, could be blended with the skills course content as well as SRHR/HIV related content. There are many examples of such successful programmes that have been implemented in South Africa, such as OneLove.

- Once agreements are finalized with internet service providers for U-Report, increase the number of U-Reporters through social media and events and engage in two-way communication on issues related to SRHR/HIV that they would like to talk about. All available ICT platforms should be used to engage young people, but their use coordinated among partners, to ensure they are not duplicated.
- In consultation with other relevant ministries and partners develop and implement a plan to address structural issues, such as poverty, unemployment and gender
- Develop detailed activity plan with partners, identifying timelines and responsibilities for activity implementation.
- Ensure sufficient and sustained funding for SBCC activities
- Institutionalise regular monitoring, supervision and evaluation of communication activities

12. Conclusions and Recommendations

Conclusions

- Communication efforts so far have relied mostly on CSE and peer education without supportive Comprehensive knowledge is low, particularly in the area of myths and misconceptions
- materials/content to engage young people and the community.
- Risk perception of young people continues to be low even though they mostly know they are engaging in risky behaviours
- Without addressing structural issues like poverty, unemployment and gender, SBCC efforts are unlikely to be successful on their own, as these are major drivers of risk behaviours.
- Lack of coordination of activities across partners and leadership and ownership of SBCC for SRHR/HIV at the national and district levels.
- Few entertainment opportunities available for young people
- Low visibility of communication on SRHR/HIV. Lack of sustained communication effort.
- "Message fatigue" among young people and SRHR/HIV partners on messages related to HIV, which have mostly been about 'dos and don'ts' and have not attempted to engage young people in dialogue.
- Inadequate funding for sustained SBCC campaign.
- Lack of monitoring and evaluation of programme and communication

Recommendations

- Support CSE and peer education with entertainment education on mass media and social media and other ICTs, such as U-Report in a coordinated manner across partners to avoid duplication, and a set of print materials with branding that appeals to young people
- Engage young people and other groups in development of messages, materials and content directed to them, so that they have ownership and messages and materials are appropriate for them.
- Engage young people, parents and community members in dialogue on SRHR/HIV issues at different levels
- Improve quality of CSE and peer education through training of teachers and health workers, which includes addressing issues of stigma and comfort level and attitude to discuss SRHR/HIV with young people and key populations
- Initiate sports for development programme with interwoven SRHR/HIV content to engage young people

- Address structural issues and ensure linkages with other programmes, such as complaint and redressal mechanism for gender based violence, social protection and TVET and skilling programmes for young people
- Institutionalise regular monitoring and evaluation, with clearly allocated responsibilities and periodicities as per a plan.
- Ensure that males of all ages are engaged to address gender issues, around gender based violence and condom use.

- Advocacy is required with Ministry of Health and other relevant Ministries to enact and implement appropriate laws and policies with regard to gender based violence, child marriage, ensuring linkages with other programmes, such as TVET, child protection, social protection etc., leadership and ownership of the SBCC strategy and its implementation, including ensuring sufficient and sustained funding for SBCC activities for at least five years, and operationalizing an effective coordination of communication activities across partners.

Annex 1

Desk Review: List of Documents Reviewed

1. Social and Behaviour Change Communication Strategy for HIV and AIDS in Lesotho, 2014-17

2. National Strategic Plan (NSP) 2019/20-2022/23
3. Lesotho Population Based HIV Impact Assessment (LePHIA), 2018
4. Lesotho Demographic and Health Survey (LDHS), 2014
5. Comprehensive HIV Epidemiological Analysis for Lesotho (CHEAL), 2018
6. Lesotho National Assessment Knowledge, Attitudes, Practices and Norms (KAPN) Study on HIV, 2019
7. National Reproductive, Maternal, Newborn, Child, Adolescent Health (RMNACH+N) and Nutrition Social and Behaviour Change Communication (SBCC) Strategy for Lesotho 2019-2023, 2018
8. Knowledge, Attitudes, Practices and Norms Survey (KAPS) on Comprehensive Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition (RMNCAH+N) in Three Districts in Lesotho, 2017
9. Integrated Bio Behavioural Surveillance Survey (IBBSS 2) for Key Populations in Lesotho, 2019
10. Lesotho Violence Against Children Survey (VACS), 2019
11. Modes of Transmission Study in Lesotho, 2017
12. Multiple Concurrent Partnerships Report
13. Multiple Indicator Cluster Survey (MICS), 2018
14. Available communication materials

Annex 2

List of KIIs with Partners

1. Nkuatsana, Mathato, Matselitso Leboka, Motsoanko, Ministry of Health

2. National AIDS Commissio
3. Moeraoetsi Rakuoana, PACT
4. Lekhetho Ntsukunyane, MISA
5. John Taineomwangire, Skillshare
6. Ntoli Moletsane, Sentebale
7. Tampose Mothopeng, Matrix
8. Mamofuta Kale, SAFAIDS
9. Polo Motsoari, JHPIEGO
10. Thabiso Lekhotsa, PEPFAR
11. Mafisa Lethola, UNESCO
12. Ratia Maseretse UNFPA
13. Jamila Jarrakhova, UNAIDS
14. Makhauta Mokhethi, WFP

Annex 3

List of Participants in Stakeholder Consultation Workshop held on 20 March 2020

Serial No.	Name	Designation	Organisation

1	Bakoane Phenethi	HIV/AIDS Communication Expert	Ministry of Health
2	Matsitso Mohoanyane	Adolescent Officer	Ministry of Health
3	Mokerac Mathaha	Senior Research Officer	Ministry of Health
4	Limpho Kabi	Officer	Ministry of health
5	Malume Panyane	Communication Officer	Ministry of Health
6	Makelolo Mosabikoa	Public Relations Officer	Ministry of Health
7	Mathaba Moroka		Ministry of Health
8	Motsentsi M		EPI, Ministry of Health
9	Boreng P		Ministry of Health
10	Marethabile Nei	Community TA	Ministry of Health
11	Makhabe Khanalishao	TB/HIV	Ministry of Health
12	Rosian Cesilia	CPO	Ministry of Health
13	M. Mokhelele	Dietician	Ministry of Health
14	No. 27 (Illegible)	EPI DO	Ministry of Health
15	M. Motehelapi	EPI	Ministry of Health
16	P. Mokoroane	JH Programme	Ministry of Health
17	Makhotso Lecheko	HIV & AIDS Counselor	Ministry of Education and Training (MoET)
18	Lineo Molapo	CSE	Ministry of Education and Training (MoET
19	Patricui Aliganzira	Programme Manager, Maternal and Newborn Health	Clinton Health Access Initiative (CHAI)
20	Hlalele Hlalele	Programme Director	Clinton Health Access Initiative (CHAI)
21	Lipolelo Khoeli	Programme Coordinator	Sentebale
22	Bonang Sejana	HTC Advisor	ECPAF
23	Moraoetsi Rakuoana	Programme Manager	PACT
24	Jill Sanders	Pediatrician	Pamoja Consulting
25	Jsepo Myuthela	Peer educator	KB Baylor
26	Motlatsi Letsitia	Prevention Specialist	KB Baylor
27	Matusi Bcopel	District Coordinator	KB Baylor
28	Thithiu Malacsi	Programme Director, Adolescents	KB Baylor
29	? BL	Programme Manager	LENASO
30	Peter Rauito	Programme Manager	LENASO
31	Thabiso Lekhotsa	DREAMS Specialist	PEPFAR (USAID)
32	Thabo Lebaka	Programme Analyst, HIV	UNFPA
33	Maseretse Ratia	NPA Adolescent ?	UNFPA
34	Lothola Mafisa	Advisor	UNAIDS
35	Maria Vivas	HIV Specialist	UNICEF

Annex 4

Sample Monitoring Format

Date of visit: Site visited: Village, district

Activity	Description of Activity	No. planned	No. Implemented	Reason for shortfall if any	Quality of activities implemented Good/average/not good	Communication materials available	Approx. no. of participants in activities Men/women/adolescents/children				Suggestions for improvement
							M	W	A	C	
Community meetings											
Community theatre shows											
Sports activities											
Community radio											

Name: Designation, Organisation:

The Transtheoretical Model (Stages of Change)

The Transtheoretical Model (also called the Stages of Change Model), developed by Prochaska and DiClemente in the late 1970s, evolved through studies examining the experiences of smokers who quit on their own with those requiring further treatment to understand why some people were capable of quitting on their own. It was determined that people quit smoking if they were ready to do so. Thus, the Transtheoretical Model (TTM) focuses on the decision-making of the individual and is a model of intentional change. The TTM operates on the assumption that people do not change behaviors quickly and decisively. Rather, change in behavior, especially habitual behavior, occurs continuously through a cyclical process. The TTM is not a theory but a model; different behavioral theories and constructs can be applied to various stages of the model where they may be most effective.

The TTM posits that individuals move through five stages of change: precontemplation, contemplation, preparation, action, maintenance, and termination. Termination was not part of the original model and is less often used in application of stages of change for health-related behaviors. For each stage of change, different intervention strategies are most effective at moving the person to the next stage of change and subsequently through the model to maintenance, the ideal stage of behavior.

1. ***Precontemplation*** - In this stage, people do not intend to take action in the foreseeable future (defined as within the next 6 months). People are often unaware that their behavior is problematic or produces negative consequences. People in this stage often underestimate the pros of changing behavior and place too much emphasis on the cons of changing behavior.
2. ***Contemplation*** - In this stage, people are intending to start the healthy behavior in the foreseeable future (defined as within the next 6 months). People recognize that their behavior may be problematic, and a more thoughtful and practical consideration of the pros and cons of changing the behavior takes place, with equal emphasis placed on both. Even with this recognition, people may still feel ambivalent toward changing their behavior.
3. ***Preparation (Determination)*** - In this stage, people are ready to take action within the next 30 days. People start to take small steps toward the behavior change, and they believe changing their behavior can lead to a healthier life.
4. ***Action*** - In this stage, people have recently changed their behavior (defined as within the last 6 months) and intend to keep moving forward with that behavior change. People may exhibit this by modifying their problem behavior or acquiring new healthy behaviors.
5. ***Maintenance*** - In this stage, people have sustained their behavior change for a while (defined as more than 6 months) and intend to maintain the behavior change going forward. People in this stage work to prevent relapse to earlier stages.

The Stages of Change Model
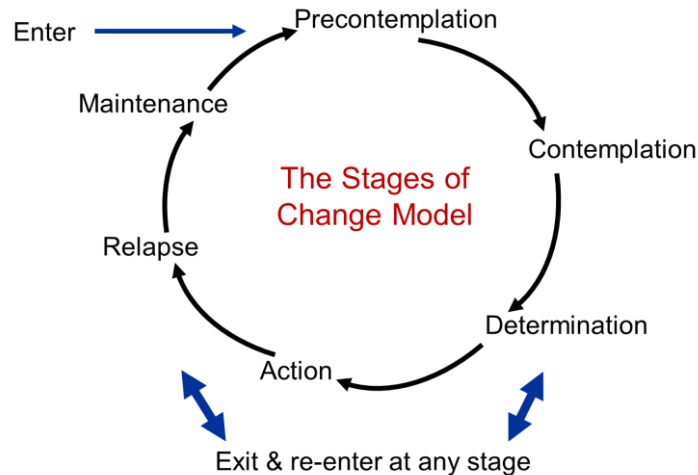
To progress through the stages of change, people apply cognitive, affective, and evaluative processes. Ten processes of change have been identified with some processes being more relevant to a specific stage of change than other processes. These processes result in strategies that help people make and maintain change.

1. **Consciousness Raising** - Increasing awareness about the healthy behavior.
2. **Dramatic Relief** - Emotional arousal about the health behavior, whether positive or negative arousal.
3. **Self-Reevaluation** - Self reappraisal to realize the healthy behavior is part of who they want to be.
4. **Environmental Reevaluation** - Social reappraisal to realize how their unhealthy behavior affects others.
5. **Social Liberation** - Environmental opportunities that exist to show society is supportive of the healthy behavior.
6. **Self-Liberation** - Commitment to change behavior based on the belief that achievement of the healthy behavior is possible.
7. **Helping Relationships** - Finding supportive relationships that encourage the desired change.
8. **Counter-Conditioning** - Substituting healthy behaviors and thoughts for unhealthy behaviors and thoughts.
9. **Reinforcement Management** - Rewarding the positive behavior and reducing the rewards that come from negative behavior.
10. **Stimulus Control** - Re-engineering the environment to have reminders and cues that support and encourage the healthy behavior and remove those that encourage the unhealthy behavior.