Core Package for HIV Prevention
GUIDELINES FOR IMPLEMENTERS
FOREWORD

The extended Multisectoral National Strategic Framework for HIV and AIDS (eNSF, 2014-2018) provides the basis for the Core Package for HIV Prevention: Guidelines for Implementers. The HIV Prevention Technical Working Group provided an oversight role in developing the Guidelines. The process was collaborative and iterative, involving a series of working sessions and review meetings where a diverse range of stakeholders participated.

The Guidelines were inspired by a combination prevention approach whereby all prevention efforts rely on the concurrent use of complementary behavioural, social, biomedical and structural prevention strategies targeting individuals, couples, communities and the wider society. To maximise impact, implementers need to use the available evidence to identify demographic groups or sub-populations that face the greatest risk of HIV acquisition and/or transmission. The technical working group has made this work easy by reviewing the evidence and recommending a core set of interventions for specific demographic groups. This document is intended to be a living document and will incorporate new data as and when it is made available.

The result is this core package of guidelines intended for use by all implementing partners in HIV prevention programmes. Implementing partners will have the responsibility to ensure that all new and existing programmes include the core package specific to the priority population that is the primary target of their programme. This will ensure that delivery of interventions is standardised. It will also help to improve the quality and intensity of programming. Ultimately, the programmes will be capable of making a positive contribution to reducing new HIV infections.

As a nation, we want to eliminate new HIV infections, so that we realise an HIV-free generation. However, achieving this will not be easy if we are stuck in “business as usual.” Therefore, availability of this instrument will be the basis for the design, implementation, monitoring and evaluation of the country’s HIV prevention efforts as we harmonise across all HIV programmes. All concerned stakeholders are implored to use the recommended core package for HIV prevention and to be proactive in sharing the lessons they are learning. This will help us to improve our collective effectiveness.

As a member of the Global HIV Prevention Coalition, we commit to put more momentum to reduce new HIV infections through equity, dignity and ensuring that no one is left behind.

Khanyisa Mabuza
National Executive Director NERCHA
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The Guidelines were written by a team comprised of representatives from NERCHA, the Ministry of Health (MOH), the U.S. Agency for International Development (USAID), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Population Fund (UNFPA), the Health Communication Capacity Collaborative (HC3), ICAP and Population Services International, with technical assistance and synthesis from the Johns Hopkins Center for Communication Programs (CCP).

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ACRONYMS

**ABYM**  Adolescent Boys and Young Men

**AG**  Adolescent Girls

**AIDS**  Acquired Immune Deficiency Syndrome

**ANC**  Antenatal Care

**ART**  Antiretroviral Therapy

**CCP**  Johns Hopkins Center for Communication Programs

**CSOs**  Civil Society Organisations

**EGPAF**  Elizabeth Glaser Paediatric AIDS Foundation

**eNSF**  Extended Multisectoral National Strategic Framework for HIV and AIDS

**FP**  Family Planning

**FSW**  Female Sex Worker

**GBV**  Gender-Based Violence

**HC3**  Health Communication Capacity Collaborative

**HIV**  Human Immunodeficiency Virus

**HTC**  HIV Testing and Counselling

**HTS**  HIV Testing Services

**LLAPLa**  Life-long ART to Pregnant and Lactating Women

**M&E**  Monitoring and Evaluation

**MOH**  Ministry of Health

**MSM**  Men Who Have Sex with Men

**NERCHA**  National Emergency Response Council on HIV and AIDS

**OVC**  Orphans and Vulnerable Children

**PEPFAR**  President’s Emergency Plan for AIDS Relief

**PLHIV**  People Living with HIV

**PMTCT**  Prevention of Mother-to-Child Transmission

**PEP**  Post-Exposure Prophylaxis

**PrEP**  Pre-Exposure Prophylaxis

**PY**  Person Years

**SBC**  Social and Behaviour Change

**SBCC**  Social and Behaviour Change Communication

**SDHS**  Swaziland Demographic and Health Survey

**SHAPMOS**  The Swaziland HIV and AIDS Program Monitoring System

**SHIMS**  Swaziland HIV Incidence Measurement Survey

**SRH**  Sexual and Reproductive Health

**STI**  Sexually Transmitted Infection

**SW**  Sex Worker

**TB**  Tuberculosis

**TWG**  Technical Working Group

**UNAIDS**  Joint United Nations Programme on HIV/AIDS

**UNFPA**  United Nations Population Fund

**USAID**  United States Agency for International Development

**VMMC**  Voluntary Medical Male Circumcision

**YW**  Young Women
EXECUTIVE SUMMARY

Swaziland has a generalised HIV epidemic, with prevalence estimated at 31 percent among adults 18-49 (1). According to the eNSF (2014-2018), Swaziland’s goal is to “halt the spread of HIV and reverse its impact on the Swazi society.” In pursuit of this goal, the first priority is to “prevent new HIV infections and reduce mortality among people living with HIV (PLHIV)” (2). One of the strategic gaps in the multi-sectoral HIV and AIDS response identified in the eNSF is “inadequate targeting and lack of intensity of HIV prevention programmes” (2).

The Core Package for HIV Prevention: Guidelines for Implementers (referred to in this document as the Guidelines) aims to provide guidance to implementers on how to address this critical gap. The Guidelines recommend prioritising sub-populations at increased risk of HIV infection and/or transmission, targeting them with a core set of proven effective HIV prevention strategies and aiming to increase the uptake of high-impact services, such as condoms, HIV testing and counselling (HTC), prevention of mother-to-child transmission (PMTCT), antiretroviral therapy (ART) and voluntary medical male circumcision (VMMC), according to the unique risks and vulnerabilities within each priority population.

Accordingly, the vision inspiring the Guidelines is to realise a situation where all HIV prevention programmes reach priority populations with a core package of standardised interventions tailored to their unique circumstances that will achieve a reduction in HIV incidence. The goal is to provide standardised guidelines for the design, implementation, and monitoring and evaluation (M&E) of high-quality HIV prevention interventions.

The specific objectives are to:
1. Improve uptake of core services
2. Achieve standardisation in HIV prevention approaches
3. Attain scale and coverage
4. Provide guidance on monitoring HIV prevention interventions

Taking into account the epidemiology and socio-behavioural context of HIV specific to each sub-population, the Guidelines identify the following as priority populations:

Priority Populations
- Adolescent girls (AG) (15-19 years)
- Young women (YW) (20-24 years)
- Adult men (25-39 years)
- Adolescent boys and young men (ABYM) (15-24 years)

Key Populations
- Female sex workers (FSWs)
- Men who have sex with men (MSM)

Guided by the social ecological model (5) and existing evidence on best practises, the core package for each population includes an overview of the evidence, key biological, behavioral and structural determinants; desired program outcomes; program-level indicators for interventions; the recommended evidence-based interventions for each population; and suggested approaches based on documented evidence and best practise.
USING THE GUIDELINES

The Guidelines are intended for use by implementing partners of HIV prevention programmes who should use them to ensure existing or new programmes include all elements of the core package for each priority population which the programme is addressing. They are meant to serve as a reference for the development of programmes, activities, materials and tools for use with priority populations.

It is expected each organisation will provide all components of the core package over the course of their intervention for their designated priority population(s). Organisations are not, however, limited to the content contained in the Guidelines, nor are they limited to the priority populations specified in this document. However, it is strongly recommended that the bulk of the efforts focus on these populations, whose size, HIV incidence and prevalence, prevention behaviours and uptake of services can have a significant impact on the epidemic.
**BACKGROUND**

Swaziland has a persistent HIV and AIDS epidemic with the highest HIV prevalence rate in the world, at 31 percent among adults 15-49 (1). This epidemic continues to present the Government of the Kingdom of Swaziland (GKoS) with great public health and socio-economic development challenges. The Government is most committed to overcoming this challenge, and has made substantial progress in addressing the epidemic through development and implementation of various strategic plans. Most recently the HIV response was guided by the Swaziland Multi-sectoral National Strategic Framework (2009-2014), which was reviewed at mid-term in 2012. Outcomes of the review demonstrated that the strategies were still relevant to the epidemic context and control, and resulted in an extension of the NSF (eNSF) from 2014 to 2018 (2).

With the goal of halting the spread of HIV and reversing its impact on Swazi society, the eNSF prioritizes the following impact-level results:

- Fifty percent and 90 percent reduction of new HIV infections among adults and paediatrics, respectively, by 2015.
- Avert 15 percent of deaths among people living with HIV (PLHIV) and in particular, those with TB/HIV co-infection.
- Alleviate socio-economic impacts of HIV and AIDS among vulnerable groups.
- Improve efficiency and effectiveness of the national response.

The eNSF guides the GKoS response with a sharp focus on the complex interrelated factors that influence the transmission of HIV, a clear priority on the populations most vulnerable to HIV acquisition, and an emphasis on the high-impact interventions that prevent and reduce transmission and acquisition of the virus among the population.

The eNSF response recognizes that “individual and social factors are both a cause and potential solution of the epidemic, “ which is seen as a “reflection of the pattern of behavior in …society, the complexities of our sexuality, our relationships, our beliefs and attitudes that influence the transmission of HIV.” (2) One of the strategic gaps in the multi-sectoral HIV and AIDS response identified in the eNSF is the “inadequate targeting and lack of intensity of HIV prevention programmes” as well as the weak and fragmented coordination of prevention interventions, “with a myriad of approaches, lack of intensity and scale and little standardization” (emphasis added).

**Swaziland’s Response**

Swaziland’s National Emergency Response Council on HIV and AIDS (NERCHA) is leading the implementation of the eNSF and coordinating the multi-sectoral, multifaceted and community-driven response in addressing this strategic gap. NERCHA began working with partners to create approaches and tools that will contribute to the greater standardization of the prevention response. For instance, the HIV Prevention Toolkit (3) was developed to standardize the work of field facilitators and provide them with concrete tools, approaches and messages they can use in their work directly with beneficiaries.

In a similar fashion, NERCHA and its partners now aim to support program managers and address the strategic gap identified in the eNSF with *The Core Package for HIV Prevention*, a standardized approach for the design, development and management of targeted HIV prevention programs. It provides a set of guidelines intended to help program managers focus interventions on the priority populations and subpopulations driving the epidemic, as per the eNSF and other key documents.

*The Core Package for HIV Prevention* was developed through a collaborative and iterative process between NERCHA, the core task team and the HIV Prevention Technical Working Group (TWG). It involved a series of consultations, working sessions and review meetings with a diverse range of stakeholders.

Swaziland has a youthful population, with 50 percent under the age of 20 (4). With an estimated 31 percent HIV prevalence, Swaziland has a generalized epidemic (1). As the pyramid on the following page demonstrates, the effect of the epidemic is not uniform and some population segments are more acutely affected than others. A quick glance shows that HIV prevalence is higher among women.
at 38 percent than among men (23 percent) (1). Additionally, women between the ages of 25-34 are at highest risk, compared to men whose risk increases in the 30-39 age group (1). Prioritizing these populations for intensive prevention measures can have a strong effect in reducing the spread of the epidemic. Demographics and HIV epidemiology are essential to begin to identify populations which need to be prioritized in a prevention response. When residence, socio-cultural practices and structural relationships are considered as well, the identification of priority populations can become more precise for a better targeted prevention response that makes the most of available resources.

As the delineation of priority populations takes into consideration a variety of epidemiological, demographic, social and cultural variables, it is helpful to organize the thinking around an explanatory model, such as the Socio-Ecological model which considers that behavior results from the intersection of variables at different levels from individual to social and structural (5). The conceptual framework below is a guide to help understand the variables at each of these levels that can increase the risk of exposure to HIV, and the subsequent vulnerability to the risk of acquisition and transmission among populations. Priority populations for an effective prevention response are thus the ones that are most vulnerable to acquiring or transmitting the virus, as a result of the intersection of a set of physiological, behavioral and structural factors, as per the conceptual framework on the following page.
CONCEPTUAL FRAMEWORK FOR A COMBINATION PREVENTION RESPONSE

The Core Package is based on a conceptual framework that identifies the determinants of HIV exposure, acquisition and transmission among the priority populations which drive the epidemic, according to the eNSF. Importantly, the conceptual framework lays out the logic that underlies and justifies a national response based on a combination prevention approach. It also lays the foundation for a standardized core package of combination prevention interventions that are tailored to specific priority populations.

The framework considers the factors that increase the risk of exposure to HIV; the epidemiological, structural, socio-cultural and behavioral factors that affect the potential for transmission and acquisition of HIV among specific populations; and clarifies the ways in which they interact and are interrelated. Because these determinants are physiological, social and/or structural in nature, it follows that the national prevention response must combine interventions
that can address each category of determinant. By focusing on the priority populations that drive HIV infection in the country, and the determinants of HIV exposure associated with each, the conceptual framework establishes the parameters for each core package of prevention interventions. With a priority population at its heart, each core package of prevention interventions highlights the biological, behavioral normative and structural factors that increase the risk of HIV transmission and acquisition among that priority population. Each package also proposes approaches and tools that have been shown to work in reducing risk among the specific priority population and can be adapted for use in the country.

In that vein, the following section clarifies a number of the core principles that should support programming across all core packages to do the right things in the right places for the right populations, at the right scale, as called for by the eNSF, PEPFAR, UNAIDS and others. Underlying these guiding principles is the recognition that a prevention response is complex and must go beyond the health system. It must thus be planned and implemented by engaging with the existing community structures at multiple levels and across multiple sectors. This will greatly help to identify and reach the right populations, in the right locations and at the right scale.

**Engaging communities effectively** therefore becomes a core activity, no matter who the population or population segment, because the transmission of HIV results primarily from social and cultural factors, and only secondarily from biomedical ones. In particular, intimate behaviors, such as sexual relationships and practices, are shaped and affected more by community norms than clinical factors. This basic understanding naturally leads to the conclusion that “the success of any health intervention requires engagement well beyond the traditional health sector” (7) and must extend into the community.

**Community engagement** is a key approach and an objective that is prioritized in several national documents, including the eNSF where it is identified as a “critical enabler” to identify high-risk groups, create demand for and use of services, and critically to help reduce vulnerabilities. Additionally, in its 2013-2018 Strategic Plan, the Ministry of Tinkhundla Administration and Development (MTAD) emphasizes the role of community mobilization and action in key development pillars, including HIV and AIDS (8). In its Strategic Plan, MTAD identifies people-focused **service delivery** as a central strategic objective. In collaboration with MTAD, MOH and partners, NERCHA created the Community Engagement Guidelines (9) designed to complement the eNSF. The guidelines describe a systematic approach to effective community engagement through multiple layers from chieftom to Inkhundla, region and nation and bringing together multiple sectors to catalyze a community-led response that can address social and behavioral barriers to uptake of and retention in health services.

### Factors that Determine Increased Exposure to HIV

**PHYSIOLOGICAL**
- e.g.
  - Age
  - Sex status
  - Circumcision status
  - Type of sexual activity (vaginal/anal/oral)
  - Pregnancy
  - Genital secretions and inflammations
  - Viral suppression

**BEHAVIORAL**
- e.g.
  - Sexual debut
  - Sexual activity and partnership type & number
  - Condom use
  - Forced sex
  - Use of services: HIV testing, PMTCT, MC
  - Alcohol, drug intake

**STRUCTURAL**
- e.g.
  - Cultural and traditional practices
  - Gender norms
  - Social practices
  - Economic conditions
  - Commodity availability
  - Service accessibility
  - Social support systems

### GUIDING PRINCIPLES

Programming across all the core packages should be driven by the fundamental principle that “the HIV epidemic is about locations and populations” (6) and should therefore follow the virus by focusing on areas and populations with high transmission and acquisition rates.

In addition, even though each core package is constructed around a priority population and its unique epidemiological and behavioral profile, all packages share a common set of guiding principles. These are considerations that, when applied, will enhance programming and increase its reach and effectiveness.

**Across all Core Packages, Make Sure to**

1. Engage communities effectively
2. Refine our understanding of priority populations
3. Focus SBC on refined population segments
4. Deepen understanding of HIV transmission among them
5. Program for Scale
Refining our understanding of each population through sensible segmentation reflects the reality that populations are not homogeneous and risk is not evenly distributed through any priority population. Segmentation contributes to improved targeting by delineating subpopulations, including such information as high-risk behaviors and venues frequented by those subpopulations. This in turn allows program designers to identify, describe and appropriately address more discrete behaviors and challenges that need to be overcome for each population segment. Segmentation is necessary because within any broad population group – for instance, men over 24 years old – the risk of acquiring or transmitting HIV is not always equal. It could depend on schooling, occupation, residence or marital status, as all influence the chances of transmitting or acquiring the virus. It is important to note that HIV prevalence peaks among women in the 30-34 year-old age group (1). It is, however, insufficient for programming an effective prevention intervention which needs to answer the questions “what more do we know about the prevalence in this age and sex group? Is it different by residence, educational level, marital status, pregnancy status, number of children? or other?” Developing a more granular understanding of a vulnerable population is vital to the design of strategies and approaches that can truly motivate and engage each identified segment/sub-population because they speak to their realities and risk profile.

Focusing social behaviour change (SBC) interventions to draw in the refined population segments. Generic SBC interventions are both ineffective and wasteful. They must be tailored to the understanding gained by segmenting priority populations. Nevertheless a generic and systematic process for developing strategic SBC interventions must always be followed, regardless of which priority population is being addressed. Only the content will be tailored. The process should start with taking stock of what exists and how it was received by the focus population, to developing a strategic model that explains how the desired behavior changes, through to materials development and always ensuring constant monitoring to guarantee quality. Several guidelines exist for developing high-quality and effective SBC programmes. These should be followed to ensure quality while ensuring that the content is tailored or adapted to the factors and behaviors that characterize a specific population segment (see Annex B for further guidance on developing high-quality SBCC interventions and messages).

Deepening the knowledge and understanding of HIV transmission and acquisition dynamics continues to be of critical importance across all populations. SBC programming needs to remain relevant by reflecting scientific knowledge and programmatic emphases to increase people’s knowledge and expand their understanding. Among the critical pieces of information that must be disseminated when educating people about the virus are a focus on the differential impact of various sexual practices (anal, oral, vaginal sex) on transmission efficiency; the concept of viral load and its role in transmission; and the role of treatment in reducing the overall probability of transmission as well as its contribution to prevention – especially today. Educating the intended audience, rather than just providing information, is a better guarantee that they will increasingly understand the how and why of treatment, and link it to adherence and prevention. SBC interventions today also need to focus on ensuring a deeper understanding of correct and consistent behaviours across the HIV spectrum of prevention care and treatment. This includes the appropriate use of services such as HIV testing, which remains the gateway to care and treatment, and ART services. SBC for priority populations with known risky behaviors must go beyond what has become traditional HIV SBC to focusing more on our new knowledge and understanding.

Achieving scale and coverage of core package interventions among specific populations (80 percent) is key. It is helpful to establish the extent to which the Core Package interventions have reached and covered the population segments at each level of implementation whether inkhundla, region or national. This coverage needs to be assessed against the target set by each implementer.

The Swaziland HIV and AIDS program monitoring system (SHAPMOS) is NERCHA’s monitoring and reporting system of all prevention activities implemented at the community level. As more and
more partners report on the uses of the Core Package among priority populations in the SHAPMOS, NERCHA will have an improved understanding of the scale of prevention programming and the extent of coverage achieved.

COMPONENTS OF THE CORE PACKAGES

The components of the Guidelines were identified by taking into consideration the core programmes outlined in the eNSF, along with other agencies’ guidance around and definitions of what constitutes core HIV prevention programmes. Doing this ensures that the components align with and operationalise the combination prevention approach articulated in the eNSF. It also ensures that implementing partners are able to design, implement and report on interventions that meet the requirements of both government and donors.

In addition, each Core Package includes successful and evidence-informed approaches for combination prevention, tailored for the different priority and key populations which are covered by these Guidelines. To illustrate,

• Targeted risk assessment and provision of risk-reduction information, education and counselling is meant to support the correct identification of HIV prevention methods, rejection of misconceptions about HIV transmission, accurate gauging of personal risk for HIV acquisition and/or transmission.

• Condom promotion, condom skills training, including negotiation skills, and facilitated access to condoms includes direct provision, linkages to social marketing outlets and other means of accessing condoms and skills strengthening.

• Small group, community mobilisation and health communication activities are intended to strengthen behaviors related to timely health-seeking, correct and consistent use of prevention and life-saving products by increasing awareness, acceptability, demand for and uptake of relevant clinical services (HTS, VMMC, ART and reproductive health).

• Activities which promote gender equity and address harmful norms related to sex, gender and sexual orientation seek to change gender norms that perpetuate harmful sexual practices, impede uptake of services, result in stigma and discrimination, and allow gender-based and homophobic violence.

• The core packages for youth additionally include curriculum-based, age-appropriate HIV prevention skills and sexuality education that will increase their knowledge and understanding of risky sexual practices and HIV transmission dynamics, and encourage safer sex strategies for sexually active youth.

• Community programmes targeting adults to raise awareness of HIV risks for young people are intended to promote positive parenting and mentoring practices, and effective adult-child communication about sexuality and sexual risk reduction.

PRIORITY POPULATIONS

The priority populations for the Core Packages are those at high risk of acquiring or transmitting HIV as evidenced by the data on HIV incidence and prevalence in Swaziland, and associated behaviours. Priority populations experience significant HIV burden and they influence the dynamics of HIV epidemic.

Priority Populations

• Adolescent girls (AG) (15-19 years)
• Young Women (YW) (20-24 years)
• Adult men (25-39 years)
• Adolescent boys and young men (ABYM) (15-24 years)

As previously stated, the country has a generalised HIV epidemic and these Guidelines serve to provide direction on the delivery of HIV prevention interventions to the priority populations listed above. However, key populations are also included in these Guidelines as they are at particularly high risk of HIV infection due to the behaviours and key determinants...
associated with them. Although they constitute a small proportion of the Swazi population, they face a high burden of HIV infection and have therefore been included.

**Key Populations**

- Female sex workers (FSWs)
- Men who have sex with men (MSM)

The Guidelines acknowledge that there are overlaps among the priority populations. While the epidemiological data demonstrates that some priority populations are at greater risk than others, interventions should aim to deliver the components of all relevant core packages to the overlapping individual or group, including referrals to the appropriate services.

**HOW THE CORE PACKAGES ARE ORGANIZED**

Each core package is organized along the same lines. The priority population in clearly identified, available statistics and other pertinent data are summarized and briefly analyzed in a narrative that highlights the epidemiology related to the particular population.

The next section summarizes the key physiological, behavioral and structural determinants of specific relevance to the particular priority population. These determinants may not necessarily be unique to the particular priority population only, however taken together they describe the types of combination prevention interventions that can address the particularities of the priority population. The program-level outcomes measure the objectives of the various interventions.
CORE PACKAGE FOR PRIORITY POPULATIONS

Adolescent Girls (15–19 years old)

- Swaziland has the world’s highest HIV prevalence: 31% (18-49). Women carry the greatest HIV burden at 38%, compared with men at 23% (1)
- Women are infected at a younger age than men. 11% of adolescent girls 15-19 were infected, compared to 2% of adolescent boys of the same age (1)
- 7% of girls have had sex by the time they are 15 years old and 48% are sexually active by age 18 (10)
- 82% of sexually active 15-19 year old girls engaged in high-risk sex in the past 12 months (10)
- 14% of girls reported having sex with men who are 10 or more years older than them (10)
- Adolescent girls had 10% HIV prevalence (5) which increases to 15% among those 18-19
- The rate of new HIV infections is 3.8 per 100 person years (PY) among 18-19 years old girls (1)
- 57% of the 15-18 year olds are classified as orphans and vulnerable children (OVC) (11)
- 40% of school dropouts among girls were a result of pregnancy (11)
- 28% of girls aged 13-17 had experienced sexual violence (12)

Adolescent girls (AG) are biologically more vulnerable to HIV than adult women, which means fewer sex acts can result in an HIV infection among adolescent girls than among adult women. This is of concern in the country, where sexual activity starts early among girls, when their bodies are developing and their knowledge and skills about their sexual and reproductive health (SRH) rights are not well developed. Societal-level gender and social norms worsen their vulnerability to HIV. The first sexual experience for many young women is often coerced and the perpetrator is often a male known to the young woman, such as a relative or partner.

One in three girls experience sexual violence before the age of 18 and one in four experience some form of physical violence during childhood (12). Further, about 14 percent of sexually active girls are involved in sexual relationships with men at least 10 years older and do not see these relationships as risky (10). Two in every five girls that drop out of school do so as a result of pregnancy (11), another consequence of early sexual debut. Pregnancy is also one of several factors that increases vulnerability for HIV acquisition. While these factors increase adolescent girls’ vulnerability to acquiring HIV, actual HIV transmission depends on the sero-status of the sexual partners. The prevalence of HIV among men is therefore a critical risk factor for adolescent girls. Reducing HIV prevalence among men is a strategic objective that supports HIV prevention efforts among adolescent girls. Given that a multiplicity of factors contribute to increasing the vulnerability of adolescent girls to HIV through direct and less direct exposure to the virus, it follows that no single high-impact intervention will be effective alone. Rather, a variety of tailored approaches are needed to reach this highly vulnerable population.
### Adolescent Girls (15-19)

<table>
<thead>
<tr>
<th>Key Biological determinants</th>
<th>Key Behavioral determinants</th>
<th>Key Structural determinants</th>
<th>Desired Program Outcomes</th>
<th>Program-level Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young age, immature genitalia, genital secretions are typical, STIs penetrate cells easily</td>
<td>Early sexual debut, mostly unprotected</td>
<td>Limited adolescent-friendly SRH service availability and accessibility (education, contraceptives, condoms)</td>
<td>Reduce AG pregnancy by 75% by 2018</td>
<td>Percent AG who correctly identifies ways of preventing sexual transmission of HIV (MICS, program data)</td>
</tr>
<tr>
<td>Being female is a risk factor, the vagina is a mucous membrane and allows penetration, unlike skin which is a barrier</td>
<td>Immaturity, undeveloped decision-making and negotiation skills</td>
<td>Community norms that strongly disapprove of early sexual debut</td>
<td>Decrease AG fertility rate from 87 per 1,000 AG to 71 per 1,000 AG by 2018</td>
<td>Percent AG who can cite 3 biological and/or behavioral factors that increase risk of HIV acquisition/transmission</td>
</tr>
<tr>
<td>Differential efficiency of HIV transmission depending on type of sexual activity (especially anal, dry sex, vaginal).</td>
<td>Preferred sexual practices, danger of which poorly understood (dry sex, anal sex, use of harmful products)</td>
<td>Socialization norms that promote male superiority</td>
<td>Increase % of AG who are using modern contraception</td>
<td>Percent AG who remain in school/complete secondary school (EIS, program data)</td>
</tr>
<tr>
<td>Sexual practices, forced sex with AG predispose to tears and increased risk of infection</td>
<td>Non-disclosure of pregnancy status</td>
<td>Strong community expectations for men to marry girls much younger than themselves</td>
<td>Improve access to SRH education across all Tinkhundla reaching 80% of AG by 2018</td>
<td>Percent AG who were married or in a union before age 18 (population surveys, chiefdom information)</td>
</tr>
<tr>
<td>Pregnant and lactating adolescents are at higher risk of seroconversion due to pregnancy itself</td>
<td>Transactional sex with older men, who are more likely to be HIV+</td>
<td>Gender norms that support male superiority and violent behaviors, and female submissiveness</td>
<td>Improve access to SRH products across all Tinkhundla for 80% of AG by 2018</td>
<td>Percent AG who were pregnant/ had a live birth before age 18 (MICS, program data)</td>
</tr>
<tr>
<td>The brain is under development in adolescence, which affects decision-making skills</td>
<td>Exchange of sex and money especially with older men</td>
<td>Stigmatisation of condoms</td>
<td>Increase % of AG who complete secondary school</td>
<td>Percent AG who are using a modern contraceptive method (MICS, program data)</td>
</tr>
<tr>
<td>Forced sex</td>
<td>Forced sex</td>
<td>Poor availability of accurate information and education about sexual activity at school and community settings</td>
<td>Increase % of AG with comprehensive HIV knowledge from 44.5% to 80% by 2018</td>
<td>Percent AG who have tested for HIV in the last 12 months and know their results (MICS, program data)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Poverty and economic conditions that promote selling and exchanging sex</td>
<td>Increase the % of AG with accurate knowledge of the risk associated with different kinds of sex and sex partners</td>
<td>Percent AG who were linked to ART after testing HIV positive (program data)</td>
</tr>
<tr>
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<td>Exposure to and use of various media, including social media, which can influence perceptions and actions</td>
<td>Reduce % of YW who had sex with a man 10 or more years older than them in the last 12 months by 2018</td>
<td>Percent AG living with HIV on ART (program data)</td>
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<td>Increase % of AG who were linked to ART at last risky sex</td>
<td>Percent AG on ART who are virally suppressed (program data)</td>
</tr>
<tr>
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<td></td>
<td>Increase % of AG who report using a condom at first sex from 74% to 85% in 2018</td>
<td>Percent AG reporting the use of a condom at first sex</td>
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<td>Decrease % of AG who report having sexual intercourse before the age of 15 from 3.8% to 1% in 2018</td>
<td>Percent AG reporting the use of a condom during last sexual intercourse with a non-marital, non-cohabiting partner in the last 12 months (MICS, BSS, SHIMS)</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Increase % of AG who have tested for HIV and received their results from 47% to 65% by 2018</td>
<td>Percent AG who know of at least one source they can access for each of the following: HIV/SRH information; Condoms; SRH services; Post-violence care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Increase % of HIV+ AG on ART from 70% to 80% by 2018</td>
<td>Percent AG who had sexual intercourse with a partner 10 years or older (MICS)</td>
</tr>
</tbody>
</table>
### Core Package for Adolescent Girls (15–19 Years)

#### Minimum/Key Information Needs
- Targeted HIV risk assessment, education and/or counseling
  - Information and education on HIV transmission dynamics and risks of different sexual practices (anal vs. oral vs. vaginal sex)
  - Information and skills building on delayed sexual debut and intergenerational sex
  - Information and education on unprotected sex, consistent and correct condom use and contraceptive methods
- Informational sessions on HIV testing services (HTS) with active referrals to lifelong ART for HIV-positive AG
- Demand creation to increase awareness, uptake and acceptability of relevant services:
  - Pre-Exposure Prophylaxis (PrEP)
  - Post-violence care
  - Family Planning (FP)
  - HIV testing
  - Lifelong ART
  - PMTCT for pregnant and lactating adolescent girls
- Information and education on condom use, effectiveness and where and how to access condoms
- Information and education on gender equity, preventing gender-based violence (GBV), and reducing stigma, discrimination and school-based violence
- Information and education on economic empowerment skills and opportunities
- Information and skills building to improve AG’s social capital

#### Key Services
- **All AG**
  - Counselling and risk assessment
  - HTS
  - Condom distribution
  - FP options
  - GBV prevention, screening and referral to services
- **HIV-positive AG**
  - Linkage to care
  - Referral, enrollment in lifelong ART
  - Adherence counseling and support
  - Social support groups
  - PMTCT for pregnant and lactating adolescent girls
Examples of Evidence-Informed Approaches

- Comprehensive youth sexuality education
  - Both in- and out-of-school life skills and health education can decrease risk behaviour and increase knowledge of key HIV transmission and prevention (13-17)
- Pre-Exposure Prophylaxis (PrEP) for sexually active adolescent girls (18)
- GBV prevention and treatment
  - Community-based interventions, such as SASA! (19)
  - Trauma-focused counselling (20)
  - Linking adolescent girls to services where they can receive case and clinical management and post-exposure prophylaxis (PEP) (21-23)
- Entertainment education
  - TV shows, dramas, radio programmes and use of celebrities can all help to influence HIV outcomes (24-29)
- Social capital building (30-32)
  - Hold regular meetings in small groups in safe public spaces where participants receive social support, information and services (and/or links to services, such as health care)
  - Focus on building sustainable individual protective assets, such as self-esteem, problem-solving abilities, confidence and social networks that support increased education and economic participation
  - Link socially isolated girls to higher-status adult female mentors who can serve as advocates on their behalf and to community institutions and services
- Parenting/caregiver programmes (33)
  - Skills-building programmes involving parents and caregivers benefit the child, parent/caregiver and child-parent/caregiver relationship
- Cash transfer programmes (unconditional or with schooling conditions) (34-40)
  - Demonstrated impact on behavioural and biological outcomes in some settings
- Community mobilisation programmes (30,31,41)
  - Engaging boys, men and the larger community in HIV prevention, as well as GBV prevention
- Combination socio-economic approaches (42-49)
  - Combining social empowerment interventions with economic strengthening platforms increases the positive effects on behavioural and violence outcomes

Curriculum and Resources

- SASA! (http://raisingvoices.org/sasa/)
- Stepping Stones (http://www.steppingstonesfeedback.org/)
- Go Girls! (https://www.k4health.org/toolkits/go-girls)
- The Girl Effect (www.girleffect.org)
- Entre Nous Jeunes (http://www.advocatesforyouth.org/publications/1162-entre-nous-jeunes-peer-education- Cameroon)
Young Women (20-24)

- Swaziland has the world’s highest HIV prevalence: 31% (18-49). Women carry the greatest HIV burden at 38%, compared with men at 23% (1)
- The trend is also present among the 20-24 year olds, with prevalence among young women at 49.2% compared with 27.8% among men (5)
- New HIV infections are highest among young women 20-24 years old, with 4.2% per year (1)
- Among young women, incidence was higher in those not married, nor living with a partner, those with two or more partners and those who reported pregnancy (1)
- Results of a GBV survey highlight that 38% of respondents aged 18-24 experienced sexual violence before age 18 (12)
- Young women often know their sero-status and tend to test early (1)

Both HIV incidence and prevalence are highest among the young women in this age group (1), making them a key focus for prevention strategies. Results of the SHIMS survey of 2012 highlights that in this age group, higher incidence was associated with not being married or not living with a partner (4.1/100 PY), those with two or more sexual partners (9.6/100 PY) as well as among those reporting being pregnant at the time of the survey (4.4/100 PY). While all these characteristics come down to exposure through sexual activity, they also demonstrate that vulnerability to HIV infection is multifaceted and caused by interlinked factors some physiological (e.g., pregnancy) and others behavioral (e.g., multiple sexual partners) and that sexual activity takes place in a context: for instance consensual, forced and/or casual sex. The first sexual experience for many young women is often coerced and the perpetrator often a male known to the young woman such as a relative or spouse. (12)

Pregnancy, whether unplanned or wanted, is also one of several factors that increases vulnerability for HIV acquisition, and particularly among younger women, when compared with adult women. While these factors increase young women's vulnerability to acquiring HIV, whether or not there is actual HIV transmission depends on the sero-status of the sexual partners. The prevalence of HIV among men is therefore a critical risk factor for young women. Reducing viral load and HIV prevalence among men is a strategic objective that accelerates HIV prevention efforts for young women.

Given this complexity of factors, it follows that no single high-impact intervention will be effective alone. Rather, a variety of tailored approaches are needed to reach this highly vulnerable population and their sexual partners.
### Key Biological determinants

- High physiological vulnerability in this age group compared to older women
- Bacterial infections common and often asymptomatic, but are more conducive to HIV acquisition
- Differential efficiency of HIV transmission depending on type of sexual activity (especially anal, dry sex, vaginal)
- Sexual practices, forced sex increase risk of STIs and HIV infection
- Co-infection with other STIs (chlamydia, HPV, etc.)
- Pregnant and lactating young women have higher risk of seroconversion due to pregnancy itself (especially 3rd trimester)

### Key Behavioral determinants

- Unplanned and unprotected sex, poor or no condom use
- Low contraceptive use
- Preferred sexual practices, risk of which poorly understood (dry sex, anal sex, use of harmful products)
- Use of ANC and HIV testing services
- Poor or no knowledge of partner HIV status
- Peer influence
- Alcohol and drug intake

### Key Structural determinants

- Limited youth-friendly SRH service availability and accessibility (education, contraceptives and condoms)
- Stigmatisation of condoms
- Community norms that promote non-disclosure of pregnancy, or sero-status
- Couple communication not a social norm
- Gender norms that support male supremacy and violent behavior and unequal relations between men and women
- Poor availability of accurate information and education regarding sexual activity at health centers and community settings
- Stock outs of commodities

### Desired Program Outcomes

- Reduce unmet need for contraception from 17.4% to 10% by 2018
- Reduce % of YW who had a live birth before age 18 from 16.7% to 10% by 2018
- Increase % of YW who are using modern contraceptives
- Improve access to SRH education across all Tinkhundla reaching 80% of YW by 2018
- Improve access to SRH products across all Tinkhundla for 80% of YW by 2018
- Reduce % of YW who had sex with a man 10 or more years older than them in the last 12 months from 14.8% to 10% by 2018
- Increase % of YW reporting the use of a condom during last sexual intercourse with a non-marital, non-cohabitating partner in the last 12 months from 73.8% to 80% by 2018
- Increase % of YW who have tested for HIV and received their results from 47% to 65% by 2018
- Increase % of HIV+ YW on ART from 83% to 95% by 2018
- Increase % of YW on ART who are virally suppressed from 50% to

### Program level Indicators

- Percent YW who correctly identify ways of preventing sexual transmission of HIV (MICS, program data)
- Percent YW who can cite 3 biological and/or behavioral factors that increase risk of acquisition/transmission
- Percent YW who have managed financial skills (program data)
- Percent YW who are married or in a union and know their partner’s status (surveys, program data)
- Percent YW who were pregnant/had a live birth before 18 (MICS, program data)
- Percent YW who have tested for HIV in the last 12 months and know their results (MICS, program data)
- Percent YW who were linked to ART after testing positive (program data)
- Percent YW who know at least one source they can access for each of the following: HIV/SRH information; Condoms; SRH services; Post violence care
- Percent YW who have accessed PrEP (program data)
- Percent YW who know at least one source they can access for each of the following: HIV/SRH information; Condoms; SRH services; Post violence care
- Percent YW who had sexual intercourse with a partner 10 years or older (MICS, survey)
## Core Package of Interventions: Young Women (20-24)

### Minimum/Key Information Needs

- Targeted HIV risk assessment, education and/or counselling
  - Information and education on HIV transmission dynamics and risk of different sexual practices
  - Information and education on unprotected sex, consistent and correct condom use, and contraceptive methods
- Demand creation to increase awareness, uptake and acceptability of relevant services
  - HIV testing services (HTS) and antenatal care (ANC) for pregnant YW
  - FP and pregnancy planning
  - PMTCT for pregnant and lactating YW
  - Lifelong ART
  - Post violence care
- Information and education on condom use, effectiveness and where and how to access condoms
- Information and education on gender equity, preventing GBV, and reducing stigma, discrimination and school-based violence
- Information and education on economic empowerment skills and opportunities
- Information and skills building to improve YW's social capital
- Advocate for enabling polices for supporting young women

### Key Services

- **All YW**
  - HIV Counselling and risk assessment
  - HTS
  - Condom promotion and distribution
  - FP options and counselling
  - GBV prevention, screening and referral to services
- **HIV-positive YW**
  - Linkage to care
  - Referral, enrollment in lifelong ART
  - Adherence counseling and support
  - PMTCT for YW pregnant or lactating
  - Support services, support groups
Examples of Evidence-Informed Approaches for Prevention Programming Benefiting YW

- Lowering viral load in communities with high prevalence and HIV-related morbidity especially among men (50)
- PrEP for sexually active women (18)
- Interpersonal communication
  - Encouraging couples to discuss testing and health decisions together can lead to better uptake and outcomes (51,52)
- HTC
  - Community-based HTC involving community mobilisation activities, mobile HTC and community-based post-test support services (53)
- Couples counselling
  - Testing together can lead to better PMTCT outcomes for women (54)
- Entertainment education (24-29)
  - TV shows, dramas, radio programmes and use of celebrities can all help to influence HIV outcomes when well targeted and designed according to well-established process
- Comprehensive youth sexuality education (13-17)
  - Health education can decrease risk behaviour and increase knowledge about HIV transmission dynamics and understanding of risky behaviors
- GBV prevention and treatment including PEP
  - Community-based interventions, such as SASA! (19)
  - Trauma-focused counselling (20)
  - Linking young women to services where they can receive case and clinical management (21-23)
- Social capital building (30-32)
  - Hold regular meetings in small groups in safe public spaces where participants receive social support, information and services (and/or links to services, such as health care)
  - Focus on building sustainable individual protective assets, such as self-esteem, problem-solving abilities, confidence and social networks that support increased education and economic participation
  - Link socially isolated girls to higher-status adult female mentors who can serve as advocates on their behalf and to community institutions and services
- Cash transfer programmes (unconditional or with schooling conditions) (34-40)
  - Demonstrated impact on behavioural and biological outcomes in some studies
- Community mobilisation programmes (30,31,41)
  - Engaging boys, men and the larger community in HIV prevention, as well as GBV prevention
- Combination socio-economic approaches (42-49)
  - Combining social empowerment interventions with economic strengthening platforms increases the positive effects on behavioural and violence outcomes

Curriculum and Resources

- SASA! (http://raisingvoices.org/sasa/)
- Stepping Stones (http://www.steppingstonesfeedback.org/)
- Go Girls! (https://www.k4health.org/toolkits/go-girls)
- The Girl Effect (www.girleffect.org)
- Entre Nous Jeunes (http://www.advocatesforyouth.org/publications/1162-entre-nous-jeunes-peer-education- cameroon)
- Mothers2mothers (www.m2m.org)
- Addressing the Social and Behavioral Barriers to Prevention of Mother-to-Child Transmission of HIV Through Community Dialogue - An Implementer’s Guide Based on the Elizabeth Glaser Pediatric AIDS Foundation’s Swaziland Experience (http://b3cdn.net/glaser/c4438f41cbe6a76286_fem6bc8gi.pdf)
Adolescent Boys and Young Men (15–24 Years)

- HIV incidence among 18-19 year-old boys 0.84% and 1.8% among the 20-24 year olds (1)
- HIV prevalence is 2% among the 15-19 year old boys, and 7% among the 20-24 year olds (1)
- Delayed sexual debut with 2.5% of boys having had sex by age 15 (10) and increasing slightly to 2.8% in 2014 (55)
- Among young men 20-24, 36.7% report having had sex by age 18 (10)
- Among young men 15-24, 18.2% have been circumcised (10)

The incidence of HIV among ABYM is low; however, their risk of HIV infection does increase with age. From a low of 0.84 percent incidence at age 18-19, the rate doubles to 1.66 percent by the time boys reach 24-25 years of age (1). To a large extent, low HIV incidence is due to delayed onset of sexual activity among boys. By age 15, only 2.5 percent of all boys reported having had sex in 2010 (10) and the trend toward delaying sexual debut among boys seems to be increasing slightly to 2.8 percent in 2014 (55). By the age of 18, over one in three ABYM have had sex (10). This should be considered a window of opportunity toward an HIV-free generation. Currently, less than 25 percent of ABYM are circumcised (55). There is however growing demand for this procedure, which is increasingly considered a healthy practice.

The percentage of all men 15-59 years who are circumcised has increased from 19 in 2010 (10) to 24.3 in 2014 (55). The national VMMC program shows a continued higher demand for VMMC among the 10-14 year age group. Comprehensive knowledge of HIV among adolescent boys and young men is weak, with only 51 percent reporting correct understanding of HIV transmission and prevention (55). Young men in general have not received the attention that young women have with respect to health information and education, as well as access to services, as they are a generally healthy population. This represents a missed opportunity to educate this priority population early on with the intention of keeping them healthy, but also educating them about their bodies, sexuality, dynamics of HIV transmission, as well matters of gender equity.

This is a foundational population that must be reached through in and out of school programming, with a package of male-centered prevention approaches that can increase their uptake of testing and circumcision services, correct and consistent condom use, gender sensitivity and equitable attitudes.
### Adolescent Boys and Young Men (15 -24 Years)

#### Key Physiological Determinants
An uncircumcised penis increases the risk of HIV acquisition among adult men

Existing STIs increase vulnerability and susceptibility to HIV acquisition

The brain is under development in adolescence, which affects decision making skills

#### Key Behavioral Determinants
Late sexual debut

Adolescent boys and young men have limited comprehensive knowledge of HIV dynamics and prevention

Low condom use due to negative and stigmatized attitudes and perceptions about condoms

Myths and misconceptions about sexual activity

Behavior is very susceptible to peer influences and pressure

Rare treatment seeking behavior for STIs

Poorly developed life skills for decision making and negotiation

Experimenting with alcohol intake

#### Key Structural Determinants
Community norms promote delayed sexual debut

Socialization norms that promote male superiority

Gender norms around masculinity and virility shape sexual perceptions and activity

Community norms shape perceptions of condoms and sexual prowess

Exposure to and use of various media, including social media, which can influence perceptions and actions

Access to male friendly health services and condom outlets is limited

#### Desired Program Outcomes
Increase % of ABYM who are circumcised to 70% by 2018

Increase % of ABYM using condom consistently and correctly to 70% by 2018

Increase % of ABYM who have been tested for HIV in the last 12 months and know their result from 45.9% to 60% by 2018

Increase % of ABYM with comprehensive HIV knowledge to 70% by 2018

Increase % of HIV+ ABYM who are on ART to 80% by 2018

Increase % of ABYM on ART who are virally suppressed to 80% by 2018

#### Program-level Indicators
Percent ABYM who correctly identify ways of preventing sexual transmission of HIV

(MICS, program data)

Percent ABYM who can cite 3 biological and/or behavioral factors that increase risk of acquisition/transmission

(survey, program data)

Percent ABYM who have been circumcised (MICS, program data)

Percent ABYM who reporting the correct use of a condom at first sex (MICS)

Percent ABYM who reporting the correct use of a condom during last sexual intercourse with a non-marital, non-cohabitating partner in the last 12 months (MICS)

Percent ABYM who have been tested for HIV in the last 12 months and know their results

Percent ABYM who were linked to ART after testing HIV positive (program data)

Percent ABYM living with HIV how are currently on ART (program data)

Percent ABYM on ART who are virally suppressed (program data)

Percent ABYM who know at least one source they can access for each of the following: HIV/SRH information; Condoms; SRH services; Post violence care

Percent ABYM who can define consensual sex

Percent ABYM who had sexual intercourse with more than one partner in the last 12 months
### Core Package for Adolescent Boys and Young Men (15-24 Years)

#### Minimum/Key Information Needs
- Targeted HIV risk assessment, education and/or counselling
  - Information and education on HIV transmission dynamics and risks of different sexual practices
  - Information and skills building on delayed sexual debut
  - Information and education on unprotected sex, and consistent and correct condom use
- Male-centered demand creation to increase awareness, uptake and acceptability of relevant clinical services
  - Informational sessions on HTS with active referrals
  - VMMC
  - Lifelong ART
- Information and education on condom use, effectiveness and where and how to access condoms
- Information and education on gender equity, preventing GBV, and reducing stigma, discrimination and school-based violence
- Information and education on economic empowerment skills and opportunities
- Information and skills building to improve ABYM’s social capital
- Promotion of positive masculinity norms

#### Key Services
- All ABYM
  - Counselling and risk assessment
  - HIV Testing Services (HTS)
  - Condom distribution and facilitated access
  - STI screening and treatment
  - Gender awareness and GBV prevention
  - VMMC
- HIV-positive ABYM
  - Linkage to care
  - Referral and enrollment in lifelong ART
  - Adherence counseling and support
  - Support services, support groups
- HIV-negative ABYM
  - VMMC

#### Examples of Evidence-Informed Approaches
- HIV Testing Services (HTS)
  - Follow guidance for quality and ensure 5 Cs (consent, confidentiality, counselling, correct test results, connection/linkage to prevention, and care and treatment) (56)
  - Community-based HTS involving community mobilisation activities, mobile HTS and community-based post-test support services (53)
- Life skills/education sessions (13-17)
  - Both in- and out-of-school life skills and health education can decrease risk behaviour and increase knowledge
  - Peer education: contact with trained peers can decrease risk behaviours (24, 25, 57)
- GBV awareness and shifting gender norms toward more positive and less violent masculinities (19, 58, 59)
  - Engage men and boys in community conversations about HIV and violence-related issues, such as gender norms, sexuality, relationships, joint decision-making and alcohol use
  - Edutainment (24-28, 60)
  - TV shows, dramas, radio programmes and use of celebrities can all help to influence HIV outcomes
• Shifting gender norms and GBV awareness
  • Engage men and boys in community conversations about HIV and violence-related issues, such as gender norms, sexuality, relationships, joint decision-making and alcohol use in an effort to promote more positive masculinities. (61-63)

Curriculum and Resources

• Brothers 4 Life (http://www.brothersforlife.org/)
• Coaching boys into men (http://www.futureswithoutviolence.org/engaging-men/coaching-boys-into-men)
• Stepping Stones (http://www.steppingstonesfeedback.org/)
• Entre Nous Jeunes (http://www.advocatesforyouth.org/publications/1162-entre-nous-jeunes-peer-education-cameroon)
• Promundo (http://promundoglobal.org/)
Adult Men (25-39 years)

- HIV incident rates among adult males rise dramatically to peak at 3.12% among 30-34 year olds before tapering off to 0% among 45-49 year olds (1).
- HIV prevalence is highest among men aged 30-39, at 37% among those aged 30-34 and 47% among those 35 to 39 (1).
- One-third (32.2%) of all men have been tested for HIV and know their status. Comparative results show a significant increase between the 2011 (32%) and 2014 (55%) (10, 55).
- Condom use is the lowest reported among men 30-39, 60% of whom said they had used a condom at last sex (10).
- Among men reporting being sexually active in the past six months, about 20% reported consistent condom use (1).
- Adult men have low male circumcision (MC) rates. Generally speaking, however, MC rates are increasing among men 15-59, from 19% (10) to 24% (55).
- Adult men engage in multiple sexual relationships often reporting 2+ partners. The trend may be on the increase with 20.6% men 15-59 reporting more than one partner in 2014 MICS (55), compared to 15.4% in 2011 MICS (10).

Incidence was also higher among men who were not married nor living with a partner, with those who reported low condom use and among those men not circumcised (1). Adult men often report multiple sexual partnerships (2+) over a six-month period (1). Half (50 percent) of the men who tested HIV positive in the SHIMS survey were unaware of their HIV status. Also, the risk of HIV positive status is nearly four times greater among men who do not know their partner’s status (1). HIV prevalence is also significantly higher in uncircumcised adult men, at 29.3 percent among those circumcised in the 25-34 age group, compared to 18.4 percent among the uncircumcised in the same age group (1). According to the SHIMS, 18.4 percent of men 25-34 have been circumcised. According to the comparative report between MICS 2011 and 2014, the trend for MC uptake among men 15-59 is on the increase, although it is not clear whether the increase is higher within an age subgroup (63). The SHIMS survey (1) and the recently released national data from the Swaziland HIV Estimates and Projections Report (2015) (64) indicate that men are more commonly on ART regimens than are women, which may reflect that men test late when they would already be eligible for ARVs. The recent data also show higher HIV-related mortality among men than among women (64), a trend also observed in several other sub-Saharan African countries. A recently published article summarized this phenomenon: “AIDS prevalence may have the face of a woman, but AIDS mortality has the face of a man” (65).

The prevalence of HIV among men is a critical determinant of HIV acquisition, and most importantly of HIV transmission. Reducing incidence and viral load among men is therefore a strategic objective that accelerates HIV prevention efforts in Swaziland. However with adult men engaging in multiple sexual encounters, and not using health services generally and HIV testing ones even less, it is a critical priority to reach this key population early enough with men-centered services, approaches and messages that will help to improve their access to services and ARVs and lower their viral load.

Here again, no single high-impact intervention will be effective alone. Rather, a variety of tailored approaches are needed to reach this highly vulnerable population and their sexual partners.
## Adult Men (25-39 Years)

<table>
<thead>
<tr>
<th>Key Physiological Determinants</th>
<th>Key Behavioral Determinants</th>
<th>Key Structural Determinants</th>
<th>Desired Program Outcomes</th>
<th>Program-level Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>An uncircumcised penis increases the risk of HIV acquisition among adult men.</td>
<td>Fear of knowing HIV status.</td>
<td>Gender norms that define masculinity and virility affect health behaviors and attitudes.</td>
<td>Increase % of men who have been tested for HIV in the last 12 months and know their result from 57.5% to 70% in 2018.</td>
<td>Percent men who correctly identify ways of preventing sexual transmission of HIV (MICS, program data).</td>
</tr>
<tr>
<td>Existing STIs increase vulnerability and susceptibility to HIV acquisition.</td>
<td>Poor health-seeking behaviour for themselves.</td>
<td>Cultural and social norms and expectations that men will marry women much younger than themselves.</td>
<td>Inter-spousal and inter-partner communication strengthened with 80% of men knowing both their own and their partner’s sero-status by 2018.</td>
<td>Percent men who can cite 3 biological and/or behavioral factors that increase risk of acquisition/transmission (survey, program data).</td>
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<tr>
<td></td>
<td>Low HIV risk perception and therefore low uptake of HIV testing.</td>
<td>Health structures and services are primarily geared for childbearing women which may deter timely health seeking among men.</td>
<td>Heightened risk perception of HIV transmission dynamics and different sexual practices among 80% of men by 2018.</td>
<td>Percent men who have been circumcised (MICS, program data).</td>
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<tr>
<td></td>
<td>Potential reliance on partner’s HIV status as their own.</td>
<td>This also results in late diagnoses among men and increased HIV morbidity and mortality among them.</td>
<td>Increase % of men who are circumcised from 28.3% to 70% by 2018.</td>
<td>Percent men who reporting the correct use of a condom during last sexual intercourse with a non-marital, non-cohabitating partner in the last 12 months (MICS).</td>
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<td>Fear of pain related to VMMC.</td>
<td>Economic conditions that encourage employment mobility in various industries (e.g., construction, mining, uniformed services, etc.) and long periods away from the family.</td>
<td>Increase % of HIV+ men who are on ART from 70% to 80% by 2018.</td>
<td>Percent men who have been tested for HIV in the last 12 months and know their results.</td>
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<tr>
<td></td>
<td>Inconsistent condom use in casual sexual encounters, and low condom use in long-term/committed relationships.</td>
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<td>Increase % of men on ART who are virally suppressed to 80% by 2018.</td>
<td>Percent men who were linked to ART after testing HIV positive (program data).</td>
</tr>
<tr>
<td></td>
<td>Adult men are highly mobile and have multiple relationships, potentially as a result of this mobility.</td>
<td></td>
<td>Increase % of men who use condoms correctly and consistently at last risky sex to 85% by 2018.</td>
<td>Percent men living with HIV who are currently on ART (program data).</td>
</tr>
<tr>
<td></td>
<td>Alcohol and drug abuse.</td>
<td></td>
<td>Increase % of men with comprehensive HIV knowledge to 80% by 2018.</td>
<td>Percent men on ART who are virally suppressed (program data).</td>
</tr>
</tbody>
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25
Core Package for Adult Men (25-39 Years)

<table>
<thead>
<tr>
<th>Minimum/Key Information Needs</th>
<th>Key Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Targeted HIV risk assessment, education and/or counselling</td>
<td>• All men 25-39 years old</td>
</tr>
<tr>
<td>• Information and education on HIV transmission dynamics and risks of different sexual practices</td>
<td>• Counselling and risk assessment</td>
</tr>
<tr>
<td>• Information and skills building on delayed sexual debut</td>
<td>• HIV Testing Services (HTS)</td>
</tr>
<tr>
<td>• Information and education on unprotected sex, and consistent and correct condom use</td>
<td>• Condom promotion and distribution</td>
</tr>
<tr>
<td>• Male-centered demand creation to increase awareness, uptake and acceptability of relevant clinical services, i.e.,</td>
<td>• STI screening and treatment</td>
</tr>
<tr>
<td>• Informational sessions on HTS, including self testing, and active referrals to HTS</td>
<td>• HIV-positive men</td>
</tr>
<tr>
<td>• Lifelong ART</td>
<td>• Linkage to care</td>
</tr>
<tr>
<td>• VMMC</td>
<td>• Referral and enrollment in lifelong ART</td>
</tr>
<tr>
<td>• STI screening and treatment</td>
<td>• Adherence counseling and support</td>
</tr>
<tr>
<td>• Creation of male-centered health services</td>
<td>• Support services, support groups</td>
</tr>
<tr>
<td>• Information and education on condom use, effectiveness and where and how to access condoms</td>
<td>• HIV-negative men</td>
</tr>
<tr>
<td>• Information and education on gender equity, preventing GBV, and reducing stigmatization of health service use</td>
<td>• VMMC</td>
</tr>
<tr>
<td>• Information and education on economic empowerment skills and opportunities</td>
<td></td>
</tr>
<tr>
<td>• Information and education on responsible alcohol intake</td>
<td></td>
</tr>
</tbody>
</table>
Examples of Evidence-Informed Approaches

- Uptake of HTS
  - Community-based HTS involving community mobilisation activities, mobile HTS and community-based post-test support services (53)
  - Mobile and outreach testing (e.g., workplaces, sports/faith/music/holiday events, bars/clubs, schools) (63)
  - Home-based HTS, including self-testing for HIV (66, 67)
- Linkages to HIV care and ART initiation (68)
  - Telephone follow-up systems
  - Paper-based referral and tracking
  - Community support structures and cadres
  - Provision of ART clinic appointments at diagnosis
- Uptake of HIV care and ART initiation
  - Home-based initiation of HIV care (69)
  - Home visits by community support agents for continued counselling for newly diagnosed PLHIV (70)
- Entertainment education (63)
- Peer (adult men to adult men) approaches (63)
- Condom use interventions
  - HIV risk reduction intervention based on Information-Motivation-Behavioural skills model (71, 72)
  - HIV/STD risk-reduction addressing self-efficacy (73)
  - Involvement of educators and community in development of tools/curriculum (74)

Curriculum and Resources

- Brothers 4 Life (http://www.brothersforlife.org/)
- Stepping Stones (http://www.steppingstonesfeedback.org/)
- Promundo (http://promundoglobal.org/)
Female Sex Workers

A bio-behavioral study was conducted among female sex workers (75) and is the main source of qualitative and quantitative information about this key population. Results indicated:

- 70.3% HIV prevalence nationally
- 33% reported an average of six or more clients/week
- 92% also had a regular partner in the last 12 months
- 89% reported condom use with a new client, and 82% reported condom use with their regular clients
- 50% reported condom use with their non-paying romantic partners
- 68.7% reported having sex without a condom in the last six months
- 81.5% are not using lubricants
- 10% identified anal sex as the riskiest form of sex
- 74% had tested for HIV
- 41% of those who tested positive reported to be on treatment
- 82% reported daily alcohol use

In Swaziland, female sex workers have very high HIV prevalence, and multiple clients. One in every three FSWs reported having more than five clients a week and 14.7 percent reported over 11 clients/week. Although high condom use was reported with new as well as with regular clients, it remains that nine of every 10 FSWs reported also having a regular romantic partner with whom condom use is much less consistent. Only one in every two reported using a condom with a non-paying romantic partner. In addition, the study revealed that in the last six months preceding the survey, about 69 percent of FSWs reported not using a condom, and 54 percent reported that condom had slipped off or broken at least once in the last 30 days before the survey.

Furthermore, the majority of FSWs are not using lubricants which are likely not very accessible. Very few FSWs were able to identify anal sex as the riskiest form of sexual practice. A quarter of FSWs have not been tested for HIV. Among those who were tested, seven of every 10 received a positive result.

Even though health services in Swaziland are free of charge to everyone, uptake of services among this key population remains low due to the illegality of sex work and high levels of stigma and discrimination toward FSWs by health care workers. Rape and violent sex are hazards of the sex trade and FSWs do not have legal recourse in such cases, given the illegality of the trade.
### Female Sex Workers

#### Key Physiological Determinants
Repeated frequent sexual practices, of many types increase exposure to HIV infection, including forced sex and rape.

Vaginal dryness is common and predisposes to abrasions and lesions that increase the potential of sexually transmitted infections, including HIV.

#### Key Behavioral Determinants
- Low health-seeking behaviors due to provider stigma, self stigma and clinic hours
- Inability to negotiate 100% condom use with all clients
- Low perception of HIV risk with romantic partners
- Poor knowledge of risky sexual practices
- Regular alcohol intake

#### Key Structural Determinants
- Stigmatizing health provider attitudes
- Clinic hours are not accessible or adapted for this population
- Economics of the trade whereby clients pay more for condomless sex
- Poverty
- Illegality of sex work resulting in no legal recourse in cases of rape by clients

#### Desired Program Outcomes
- Increase % of FSW who consistently and correctly use condoms and lubricant with all clients, new as well as returning to 100% by 2018
- PrEP available for FSW by 2018
- Increase % of FSW with comprehensive HIV knowledge to 70% by 2018
- Increase % of FSW who have tested for HIV and received their results to 100% by 2018
- Increase % of HIV+ FSW on ART to 80% by 2018
- Increase the percent of FSW on ART who are virally suppressed to 80% by 2018
- Reduce % of unwanted pregnancies

#### Program-level Indicators
- Percent FSW who correctly identify ways of preventing sexual transmission of HIV (*BSS, program data*)
- Percent FSW who can cite 3 biological and/or behavioral factors that increase risk of acquisition/transmission
- Percent FSW who have financial management skills (*program data*)
- Percent FSW who consistently use condoms and lubricants (*BSS, program data*)
- Percent FSW who are using a contraceptive method (*BSS, program data*)
- Percent FSW who have tested for HIV and know their results (*BSS, program data*)
- Percent FSW who were linked to ART after testing positive (*program data*)
- Percent FSW living with HIV who are currently on ART (*program data*)
- Percent FSW on ART who are virally suppressed (*program data*)
- Percent FSW who have accessed PrEP (*program data*)
- Percent FSW who know at least one source they can access for each of the following: HIV/SRH information; Condoms and lubricants; SRH services; Post violence care; psychosocial support; legal services; safe spaces; other services
### Core Package for Female Sex Workers

#### Minimum/Key Information Needs

- Targeted HIV risk assessment, education and/or counselling
  - Information and education on HIV transmission dynamics and risks of different sexual practices
  - Information and skills building on delayed sexual debut
  - Information and education on unprotected sex, and consistent and correct condom use
  - Information on alcohol and substance use/abuse
- Informational sessions on HTS with active referrals
- Demand creation to increase awareness, uptake and acceptability of relevant clinical services
  - Pre-Exposure prophylaxis (PrEP)
  - Lifelong ART
  - STI screening and treatment
  - Post-violence care (PEP)
- Information and skills building on condom use, effectiveness and where and how to access condoms
  - Emphasis on use with all partners including romantic partners
  - Information and promotion of lubricant use
- Information and education on gender equity, how to reduce GBV, and stigma and discrimination
- Information and skills building on self-efficacy and community building
- Activities to promote social cohesion/capital

#### Key Services

- **All FSWs**
  - Counselling and risk assessment
  - STI screening and treatment
  - HIV Testing Services (HTS)
  - Pre-Exposure Prophylaxis (PrEP)
  - Condom and lubricant distribution
  - Condom negotiation skills
  - FP
  - GBV screening, reporting and referral
- **HIV-positive FSWs**
  - Linkage to care
  - Referral and enrollment in lifelong ART
  - Adherence counseling and support
  - Social support services, support groups
**Examples of Evidence-Informed Approaches** (76, 77)

- Provision of Pre-exposure prophylaxis (PrEP) and counseling
- Community/peer-led outreach
  - Outreach and peer education that works to empower and increase self-esteem has been found to be associated with lowering HIV risk behaviours (78, 79)
- Outreach/extended hours screening, testing, treatment and referral services that are specific to sex workers (SWs), such as HTC, TB, STI, SRH, FP, cervical cancer (80)
  - Providing a safe, welcoming health care environment for SWs can lead to better outcomes
- Condom and lubricant distribution and negotiation skills building
- Promotion of safe spaces (81)
- Sensitization of police and monitoring of human rights abuses (81)
- Community empowerment and capacity strengthening of FSW communities (82)

**Curriculum and Resources**

Men Who have Sex with Men (MSM)

In Swaziland, a bio-behavioral study was conducted among men who have sex with men (75) and is the main source of qualitative and quantitative information about this key population. Results indicated:

- 17.7% HIV prevalence
- 25.5% have both male and female regular sexual partners
- 23.8% had sex with two or more male partners in the last 12 months
- 69.5% reported condom use at last sex with main male partner and 46% with casual male partner
- 63.7% reported condom use with main female partner and 62.7% with casual female partner
- 54.2% reported having sex without a condom in the last six months
- 60.7% reported using petroleum jelly as a lubricant
- 18.3% knew that anal sex is the most risky type of sex
- 51% tested for HIV in the last 12 months
- 30% already knew they were HIV positive

Same sex relations are frowned upon and highly stigmatized. More than one in every four MSM have both a male and female sexual partner, and over half of MSM reported having sex without a condom in the past six months. Close to one in every five MSM knew that unprotected anal sex carried high risks of HIV infection. HIV prevalence among MSM is 17 percent and nearly one in every three MSM know their HIV status, of whom a further 33 percent are already on ART.
### Men Who have Sex with Men (MSM)

<table>
<thead>
<tr>
<th>Key Physiological Determinants</th>
<th>Key Behavioral Determinants</th>
<th>Key Structural Determinants</th>
<th>Desired Program Outcomes</th>
<th>Program-level Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anal sex is the riskiest form of sexual practice for HIV transmission and acquisition</td>
<td>Limited knowledge of the risk of anal sex</td>
<td>Social norms that are unsupportive of homosexuality</td>
<td>Increase % of MSM with comprehensive HIV knowledge to 80% by 2018</td>
<td>Percent MSM who correctly identify ways of preventing sexual transmission of HIV (BSS, program data)</td>
</tr>
<tr>
<td>Sexual relations with both men and women increases risk for HIV transmission</td>
<td>Social norms are strongly discriminatory against homosexuality</td>
<td>Increase % of MSM who have tested for HIV and received their results to 70% by 2018</td>
<td>Percent MSM who can cite 3 biological and/or behavioral factors that increase risk of acquisition/transmission</td>
<td></td>
</tr>
<tr>
<td>Limited knowledge of the correct types of lubricants to use for anal sex</td>
<td>Health services are discriminatory and not therefore accessible to this population</td>
<td>Increase % of HIV+ MSM on ART 80% by 2018</td>
<td>Percent MSM who consistently use condoms and lubricants (BSS, program data)</td>
<td></td>
</tr>
<tr>
<td>Self-stigma</td>
<td></td>
<td>Increase the percent of MSM on ART who are virally suppressed to 80% by 2018</td>
<td>Percent MSM who have tested for HIV and know their results (BSS, program data)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increase % of MSM who correctly and consistently use condoms and lubricant to 80% by 2018</td>
<td>Percent MSM who were linked to ART after testing positive (program data)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increase uptake of STI screening and treatment to 70% of MSM by 2018</td>
<td>Percent MSM living with HIV who are currently on ART (program data)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Percent MSM on ART who are virally suppressed (program data)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Percent MSM who have accessed PrEP (program data)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Percent MSM who know at least one source they can access for each of the following: HIV/SRH information; Condoms and lubricants; SRH services; post violence care; psychosocial support; legal services; safe spaces; other services</td>
<td></td>
</tr>
</tbody>
</table>
### Core Package for Men Who Have Sex with Men (MSM)

#### Minimum/Key Information Needs
- Targeted HIV risk assessment, education and counseling
  - Information and skills building on delayed sexual debut
  - Information and education on unprotected sex, and consistent and correct condom use
  - Information and education on HIV transmission dynamics and risk of different sexual practices
  - Informational sessions on HTS with active referrals
- Demand creation to increase awareness, uptake and acceptability of relevant clinical services
  - HTS
  - Lifelong ART
  - STI screening and treatment
- Information and skills building on condom use, effectiveness and where and how to access condoms
  - Information and promotion of lubricant use
- Information and education on gender equity, how to reduce GBV, and stigma and discrimination
- Information and skills building on self-efficacy and community building
- Activities to promote social cohesion/capital

#### Key Services
- All MSM
  - Counseling and risk assessment
  - HTS
  - STI screening and treatment
  - Condom and lubricant distribution
- HIV-positive MSM
  - Linkage to care
  - Referral and enrollment in lifelong ART
  - Support services, support groups
- HIV-negative MSM
  - VMMC
  - Pre-Exposure Prophylaxis (PrEP)

#### Examples of Evidence-Informed Approaches (77)
- Peer outreach services/men’s health days for screening, testing, treatment and referral services, such as HTC, TB, STIs, ART (83, 84)
  - Providing medical services and increasing self-efficacy through outreach is important for reducing risk behaviours
- Condom and lubricant distribution and negotiation skills building (85)
- Training of health care providers in key populations – friends service delivery (85)
- Community empowerment/capacity strengthening of MSM communities (81)
- Safe spaces for MSM to gather (81)
Curriculum and Resources

- WHO Consolidated Guidelines on HIV prevention, diagnosis, treatment and care for key populations (http://www.who.int/hiv/pub/guidelines/keypopulations/en/)
REFERENCES

3. XXXX


56. PEPFAR. Preventing HIV in adolescent girls and young women: Guidance for PEPFAR country teams on the DREAMS partnership. 2014.


61. XXX


ANNEX A: DEVELOPING HIGH-QUALITY, EFFECTIVE SBCC INTERVENTIONS AND MESSAGES

To be effective, social and behaviour change communication (SBCC) programmes must follow a systematic, strategic process, starting even before the programme is designed, through to evaluation and re-programming. Regardless of whether one is developing an entire comprehensive SBCC programme, an SBCC toolkit to fit into an existing programme or SBCC messages that will be communicated as part of ongoing outreach and other activities, being strategic is essential to achieving high quality and impact.

In brief, being strategic includes:

- Having a strategic model and theory that guides decisions.
- Knowing your audience and including their input in the design.
- Designing SBCC programmes/materials/messages (referred to as “SBCC”) that are based on evidence and best practices.
- Pre-testing SBCC materials to ensure they are communicating what you intend them to, will inspire people to take action and are not having unintended effects.
- Doing ongoing monitoring.
- Evaluating the SBCC materials to determine what worked best and how they can be strengthened.
- Re-programming based on the evaluation.

Several guidelines providing information on the steps for developing effective SBCC programmes and messages exist. The section below draws upon one often used and proven method, the P Process© (8).

Gathering the Evidence

Before designing any SBCC programme, it is important to understand the audience, including the context they live in, the barriers and facilitators they face to changing behaviours, the communication channels to which they have access, as well as what other SBCC programmes they are exposed to, so there can be harmonisation and synergy.

At minimum, a literature review (of published and gray literature) should be conducted to learn about research undertaken with the audience, as well as evaluated approaches to change their behaviour. Formative research provides:

- Essential information about current knowledge, attitudes and beliefs
- Current behaviours
- Media usage and access
- Trusted sources of health information
- Barriers and facilitators to uptake of the behaviour
- The audience’s level of efficacy to perform the behaviours.

Formative research can take various forms, including focus groups and key informant interviews, among other qualitative techniques. Quantitative surveys help provide understanding of the prevalence of specific knowledge, attitudes and practises, and can be used as baseline to measure impact (see Monitoring and Evaluation Section below). The amount of research undertaken is generally dictated by the resources (financial and human) available. If organisations cannot conduct their own research, they may be able to add areas of inquiry or questions on to planned research by other agencies.

Strategic Design

The design process should be based on the evidence, in line with government and other national documents, theory-based, and harmonise and add value to existing SBCC programmes. If possible, it should be a participatory process that includes the target audience’s feedback. Using theory to design SBCC programmes helps ensure the audience will be moved to change its behaviour and uptake services. The Extended Parallel Process Model (EPPM) (9) is a behaviour change theory that is commonly used to examine HIV-related behaviour and as a foundation for HIV-related SBCC. It proposes that in order to adopt a behaviour, an individual must feel that they are at risk, the risk is severe, they are capable of preventing the risk, and their strategy for preventing the risk is effective (9). For example, individuals who feel they are at high risk for HIV, but do not feel they are capable of negotiating condom use with their partner(s) may not respond to messages that emphasise the effectiveness of condoms in
Best Practises for SBCC Materials/Message Design (10)

1. Command the attention of the priority population.
2. Appeal to emotions (11-13).
3. Communicate clear HIV prevention care and treatment messages that are understandable, relevant to the priority population and delivered in a language that is familiar and appropriate. **Focus the messages** as much as possible, and **prioritise** what is most important to communicate.
4. Communicate a benefit. People are more likely to change their behaviour if they know what is in it for them.
5. Provide a clear call to action. The priority population should understand what it is supposed to do in order to achieve the desired result. Many times this will include promotion to uptake a service.
6. Create trust. Deliver messages through trusted sources, such as community members, leaders, peers, popular media personalities and others. Use local slang and colloquial language. Make sure that the messages take into account the cultural and social worldview of the priority population, are framed in the context of its day-to-day and overall priorities, and that they are not offensive.
7. Be consistent and ensure the messages are harmonised with what other partners are saying and, above all, are not contradictory.
8. Make sure the medium and the messages fit. For example, a poster should not promote a complex behaviour with in-depth information, while a flip chart should not promote only one key message or slogan without any additional information.