Social and behaviour change programming

Resource kit for high-impact programming

This Guidance Note is part of the resource kit for high-impact programming that provides simple, concise and practical guidance on key areas of the AIDS response. The resource kit is jointly developed by the joint United Nations Programme on HIV/AIDS. The resource kit can be accessed at http://www.unaids.org/en/ourwork/programmebranch/countryimpactsustainabilitydepartment/globalfinancingpartnercoordinationdivision/.

For more information, please contact highimpact@unaids.org.

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The development of this Guidance Note was led by the UNAIDS Secretariat in collaboration with United Nations Population Fund (UNFPA) with input from experts in social and behavioural programming. This Guidance Note provides simple, concise and practical guidance on social and behaviour change programming. References and links to full guidance are provided in the last section of the guidance note.

WHAT IS NEW?

- There is new high quality evidence for the effect of intensive inter-personal communication for preventing HIV and Intimate Partner Violence (IPV). The SHARE (Safe Homes and Respect for Everyone) randomized control trial (RCT) in Rakai, Uganda found reductions in HIV incidence by around a third, reductions in intimate partner violence (IPV) and increased disclosure of HIV status. http://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X(14)70344-4.pdf

- The SASA! RCT in Kampala, Uganda provided a community mobilization program on HIV and IPV prevention, which significantly reduced sexual concurrency reported by men by over 40 % and changed norms around IPV. http://www.biomedcentral.com/content/pdf/s12916-014-0122-5.pdf

- A comprehensive review summarizes HIV prevention for adolescents. See: Ending HIV and AIDS in Adolescents: Programmatic and Implementation Science Priorities; 2014 (http://journals.lww.com/jaids/toc/2014/07011)

- A 2014 systematic review established that social support reduces HIV risk behavior among female sex workers, people living with HIV and heterosexual adults, while findings were inconsistent for men who have sex with men, people who inject drugs and adolescents. http://link.springer.com/article/10.1007/s10461-013-0561-6

- A 2014 systematic review suggests that students who received school-based sex education had significantly increased knowledge and higher self-efficacy, while reporting fewer sexual partners and higher condom use. http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0089692

- E-Health programs and new media provide new channels for social and behaviour change programs. A comprehensive overview on new medial tools is available from: https://www.aids.gov/using-new-media/tools/

Introduction

Social and behaviour change (SBC) programmes are essential components of HIV prevention and represent one of the six basic programmes highlighted under the UNAIDS investment approach.[1] Social and behaviour change efforts aim to reinforce protective sexual behaviours by addressing knowledge, attitudes, skills and social norms using a combination of strategic approaches and methods. Although social and behaviour change is difficult to evaluate through randomized controlled trials (RCT), a range of evidence suggests that they can be effective if designed and implemented well. Early declines in HIV incidence in sub-Saharan Africa were associated with changes in behaviour. A meta-analysis[2] demonstrated the effectiveness of social and behaviour change programmes in increasing condom use and reducing HIV incidence.

It is essential that social and behaviour change programmes are planned and designed considering local practices and methods of community participation, including the participation of affected populations, people living with HIV, women and young people. Social and behavioural programming is an inclusive way of addressing the cultural contexts within which behaviours occur. This is important as often these contextual factors, such as gender ineqality, stigma and punitive laws, influence the epidemic.

This Guidance Note is primarily targeted at addressing sexual behaviours iin high HIV prevalence epidemics which are most commonly found in eastern and southern Africa and some specific subnational areas within mixed epidemics contexts of West and Central Africa and a few settings in the Caribbean. Social and behaviour change programmes are also aimed at and essential to increasing the uptake of HIV prevention tools including condoms, voluntary medical male circumcision (VMMC), HIV testing and counselling (HTC) for early treatment and antiretroviral drugs–based approaches to prevention. Social and behaviour change programme components in concentrated epidemics should be a part of targeted and comprehensive programmes for key populations. These programmes are covered in separate guidance notes for key populations. For more information on condom programming, see the Guidance Note on condom programming.

1 Smart investments. Geneva: Joint United Nations Programme on HIV/AIDS; 2013 (Available from http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2013/20131130_smart-investments_en.pdf, accessed 22 June 2014).

2 Scott-Sheldon LA, Huedo-Medina TB, Warren MR, Johnson BT, Carey MP. Efficacy of behavioral interventions to increase condom use and reduce sexually transmitted infections. A meta-analysis, 1991 to 2010. J Acquir Immune Defic Syndr. 2011;58(5):489–498. doi:10.1097/QAI.0b013e31823554d7.

1. Key elements

Social and behaviour change programmes go beyond information dissemination, individual awareness, knowledge and skills. Social and behaviour change programmes:

- Design all communications and overall activities based on an evidence-informed theory of change outlining a clear results chain towards the adoption of safer sexual behaviours and the uptake of HIV prevention services.
- Involve local communities, networks of people living with HIV, representatives of key populations and young people, political, religious, traditional, business and cultural leaders in changing social norms.
- Advocate for policy changes and legal reform on structural factors associated with HIV transmission (such as discriminatory laws, inheritance, access to housing and land rights as well as rights in the context of marriage and divorce, keeping girls in school or reducing spousal separation in employment policies).
- Promote the right to HIV prevention, which keeps sexual rights grounded and formulated in local social, legal and cultural contexts.
- Ensure understanding and engagement of the person whose bahaviour you aim to influence through market/consumer/formative research.

Given that the range of factors that may affect HIV-related behaviours and norms are highly contextual, it is critical that social and behaviour change programmes are based on a detailed understanding of local needs and reviews of evidence. The purpose of such evidence-based reviews is not to address all possibly relevant factors, but to identify the most important behaviours and norms which increase the risk of acquiring or transmitting HIV within that context. Such reviews provide opportunities for working with communities and policy-makers to alter the social and cultural constraints that undermine safer sexual practices.

The choice of behaviour change programme models will also depend on the specific context. The following are some of lessons learned:[3] [4]

- Targeted communication approaches addressing specific risks can reduce high-risk sexual behaviours for specific groups (such as multiple partners and unprotected transactional sex among men, and age-disparate sexual relationships).
- Active behaviour change approaches, which involve participants into actual prevention skills development (such as personal risk assessment, practicing condom use and role playing prevention communication), have been shown to be more effective than passive approaches.
- Approaches that strengthen self-efficacy have been shown to be more effective than those limited to appeals for responsible behaviour.

3 Scott-Sheldon LA, Huedo-Medina TB, Warren MR, Johnson BT, Carey MP. Efficacy of behavioural interventions to increase condom use and reduce sexually transmitted infections. A meta-analysis, 1991 to 2010. J Acquir Immune Defic Syndr. 2011;58(5):489–498. doi:10.1097/QAI.0b013e31823554d7.

4 Albarracin D, Gillette JC, Earl AN, Glasman LR, Durantini MR, Ho MH. A test of major assumptions about behaviour change: A comprehensive look at the effects of passive and active HIV-prevention interventions since the beginning of the epidemic. Psychol Bull. 2005;131(6):856–897.

- At the same time, broad self-management approaches have not been associated with increased condom use or reduced HIV incidence, while the removal of social and legal barriers to condom uses have shown positive results.

Essential components of social and behaviour change programmes

Social and behaviour change programming is an umbrella term involving strategic use of advocacy, media, interpersonal and dialogue based communication, and social mobilization to systematically accelerate change in the underlying drivers of HIV risk, vulnerability and impact. It also requires an appraisal of the existing national communication strategy and the range of communication opportunities to maximize ways to communicate and strengthen existing communication channels and capacities. All social and behaviour change activities for HIV prevention should be branded with one unifying communication strategy and theme that addresses individual knowledge and behaviour, collective attitudes or norms, societal level policies, and regulations. In order to design appropriate activities, social and behaviour change programmes require an assessment of the social, legal and cultural contexts where people live and work and an understanding of the prevailing norms that shape local epidemics and people's responses to risk. They also require explicit attention to gender norms, including norms related to both femininity and masculinity. Social and behaviour approaches have shown demonstrable impact in behaviour change, raising awareness and influencing social norms. Social and behaviour change programming can be used to change deeply rooted harmful practices, such as domestic violence and police complicity in violence against men who have sex with men. Behaviour change programmes aimed at increasing healthy behaviours, but which lack a social change communication component to create more supportive environments, often fail to achieve sustained behaviour change.

Essential components of social and behaviour chance programmes include the following:

- *Sociocultural and market research.* Investments in social and behaviour change programmes need to be based on a clear understanding of the social, legal and cultural contexts that shape sexual behaviours as well as the demand for and uptake of HIV services. Therefore, the first essential element of social and behaviour change programmes is to assess these contexts. Basic information from Demographic and Health Surveys (DHS) reports is not sufficient; more precise qualitative and quantitative research and/or analysis of knowledge, risk perceptions, norms and perceived HIV service quality and access should be carried out. Such research should always be undertaken in a manner that respects the human rights and dignity of key populations and people living with and affected by HIV. Only through such research and analysis can social and behaviour change programmes realize their potential in addressing sexual risk practices and tackling the specific barriers and enablers for increasing demand for prevention. The data is best obtained through secondary analysis of or AIDS impact surveys (AIS), special surveys[5] using more anonymous interview techniques,[6] as well as community-led evidence and complementary qualitative research.

5 In many countries, such surveys are being carried out by individual organizations, but are not consistently used for national programming.

6 These include automated computer-assisted self-interviews (ACASIs) or confidential voting interview techniques, which have been shown to reduce desirability bias.

- *Advocacy for social change.* After the key drivers of HIV transmission, the goals of prevention efforts and the determinants of behaviours and service use are clearly defined, a systematic advocacy process at the national and subnational levels is necessary. Advocacy needs to set the norms for HIV prevention through opinion leaders who set the standards for good practice and safe behaviour. It is important that national and local political, traditional, religious and cultural leaders lead by example and serve as role models in HIV prevention practices. Leaders need to be engaged through advocacy, and should be trained and provided with simple advocacy tools to inspire and implement normative changes within their communities. HIV prevention advocacy must go beyond appeals for individual behaviour change. Advocacy for social change through community leaders has been effective in changing social norms around multiple sexual partners, gender-based and sexual violence, increasing openness about HIV and involving men in HIV prevention (see section 2).[7] Advocacy efforts aimed at social change may help raise awareness about HIV risks associated with multiple concurrent sexual partners and the risk of intergenerational relationships, the importance of engaging men for change and as champions of change and to challenge cultural constraints that undermine the possibilities for safer sex.
- *Interpersonal communication (IPC).* This entails different forms of one-on-one, small group and community interactions. Because it is the most labour- and cost-intensive form of communication, it needs to be well targeted to priority groups (see section 2) with a high HIV incidence. Interpersonal communication has been effective in personalizing risk perception in the context of sero-discordant couples, in building skills around condom use, resolving ambiguities about risk and safety, enhancing individual motivation towards the use of HIV services and in changing norms around HIV prevention.[8] During HIV testing and counselling, interpersonal communication has been more effective among people living with HIV and serodiscordant couples.[9] It is critical that credible facilitators of interpersonal communication who are (or have the potential to be) popular opinion leaders and who may serve as role models be chosen. These may include community workers, peer counsellors (in particular from the communities of key populations), teachers or dedicated outreach staff who need to be trained to apply standard operating procedures (SOPs) for interpersonal communication so that the focus around the core themes of the social and behaviour change programme is maintained.
- *Mass communication.* Mass communication programmes use a range of media and various approaches to communicate larger messages related to advocacy, education and information. Such messages can be conveyed through print media, radio, television, internet and mobile devices (including smartphones and tablets). However, such activities are less efficient in generating skills, self-efficacy and changes in social norms since they lack the opportunity for exchanges, feedback and consensus building. Computer-based approaches mobile phone—and internet-based technologies provide for new and potentially more interactive communication tools. Mass media on its own, however, is likely insufficient for effecting sustainable change.

7 Green EC, Halperin DT, Nantulya V, Hogle JA. Uganda's HIV prevention success: The role of sexual behaviour change and the national response. AIDS Behav. 2006;10(4):335–346. doi:10.1007/s10461-006-9073-y.

8 Albarracin D, Gillette JC, Earl AN, Glasman LR, Durantini MR, Ho MH. A test of major assumptions about behaviour change: A comprehensive look at the effects of passive and active HIV-prevention interventions since the beginning of the epidemic. Psychol Bull. 2005;131(6):856–897.

9 Fonner VA, Denison J, Kennedy CE, O'Reilly K, Sweat M. Voluntary counselling and testing (VCT) for changing HIV-related risk behaviour in developing countries. Cochrane Database Syst Rev. 2012;9:CD001224. doi:10.1002/14651858.CD001224.pub4.

Programme enablers and development synergies relating to social and behavioural change programmes

Programme enablers include the necessary managerial, programmatic and policy conditions for the smooth functioning of programmes. Development synergies include wider national priorities, which are important in their own right, with specific indirect benefits to HIV prevention, treatment, care and support outcomes as well to issues beyond HIV. These include the following:

- *National, decentralized and non-discriminatory response management.* Unlike treatment and other health-related services, social and behaviour change programmes do not have a specific institutional home in many countries. One of the key roles of national AIDS coordinating authorities is to manage HIV prevention programmes and activities and to strengthen their decentralized structures to play the same managerial role at the district and community levels. At the local level, this role entails ensuring that advocacy takes place such that interpersonal communication is delivered at an adequate quality in order to meet social and behavioural chance targets and ensure that demand is matched with the availability of prevention services. Social and behaviour change programmes require routine monitoring and evaluation for quality and coverage, while market and sociocultural research needs to be repeated periodically to track progress on knowledge, attitudes, norms, demand and practices. Moreover, social and behaviour chance programmes at the community level should be closely linked to rights and treatment literacy programmes by and for specific communities, in particular, key populations.
- *Policy analysis.* Policy analysis and activities to reduce the legal and policy barriers are important in addressing societal level causes of HIV transmission. In particular, there is a need to assess the broader social policies relevant to HIV prevention.
- *Financial incentives and conditional cash transfers.* Recent studies[10] [11] have shown that financial incentives have the potential to reduce HIV incidence through influencing partner choice among young women. They have also been successful in keeping girls in school through conditional cash transfers tied to school attendance. Financial incentives and other investments in keeping girls in school have wider health and development benefits including reducing teenage pregnancies and child marriage as well as increasing the participation of women in the economy. National AIDS coordinating bodies can advocate for the scale-up of such transfers and for making existing social transfers HIV-sensitive by ensuring that low-income young women benefit from them. (For further details, refer to the Guidance Note on HIV and social protection).
- *Comprehensive sexuality education (CSE).* As a long-term investment, comprehensive sexuality education can lay the foundation for comprehensive knowledge on HIV prevention, including the promotion of correct and consistent condom use, delaying sexual debut, limiting the number of sexual partners, the risks associated with age-disparate sexual relationships and the disclosure of one's HIV status to sexual partners.

10 Baird SJ, Garfein RS, McIntosh CT, Özler B. Effect of a cash transfer programme for schooling on prevalence of HIV and herpes simplex type 2 in Malawi: A cluster randomised trial. Lancet. 2012;379(9823):1320–1329. doi:10.1016/S0140-6736(11)61709-1 .

11 de Walque D, et al. Incentivising safe sex: A randomised trial of conditional cash transfers for HIV and sexually transmitted infection prevention in rural Tanzania. BMJ Open. 2012;2(1):e000747. doi:10.1136/bmjopen-2011-000747.

2. Focus populations

Social and behaviour change programmes should target those age and social groups with the highest levels of HIV incidence and the largest numbers of new HIV infections, while also being tailored to the sociocultural context in which they will be implemented. This will, in many cases, match the groups reporting high levels of risk behaviour or individuals living in high prevalence settings.[12] Targeting needs to be based on country-specific age and gender-disaggregated data, an understanding of the modes of transmission, the coverage of services (e.g. treatment and prevention) and other socio-demographic factors (see section 3 on data requirements). Target populations should be involved in designing, pretesting, validating, implementing and monitoring the programme. With many of these focus populations experiencing stigma, discrimination, injustice and even physical violence, the following target groups will require particular attention (to be customized based on country information):

- *Young adult women aged 15-29 years:*[13] In all generalized all high HIV prevalence epidemics, HIV incidence is very high in women aged 18 to 29 and, in some epidemics, among slightly younger women. Due to the demographic profile of countries with high HIV prevalence epidemics, women aged 15-29 years also represent the majority of sexually active women. Therefore, it is recommended that decision-makers primarily target and design social and behaviour chance programmes to respond to the needs of women in this age group. While social and behaviour chance programme content would be primarily designed to meet the needs of younger women (15 to 29 years old), older women should remain involved since there is a continued risk of HIV infection in the group aged 30 to 49 years and older women tend to have greater social influence. In some settings, a second peak of HIV incidence has been observed among women in their late 30s. Promoting safer sex, creating space for dialogues on the complexity of power dynamics that can accompany age-disparate relationships and supporting women to develop skills around correct and consistent condom use are also critical alongside information related to gender-based violence and gender negative norms. These need to be accompanied by advocacy for young women's full access to HIV prevention and contraception and around keeping girls in school, including through targeted cash transfers. Given the imbalance in gender relationships, programmes are more likely to be effective with targeted elements of empowerment,[14] for example, towards strengthened self-efficacy in condom use, strengthening women's understanding of the risks involved with older sexual partners, negotiating mutually monogamous relationships and involving their partners in HIV prevention including through couples' HTC.

12 However, it is important to note that some groups with a high HIV incidence—for example, young women—may substantially underreport risk behaviours or be at high risk because of the behaviour of their sexual partners.

13 The United Nations definitions of age groups are as follows: the age group 10–19 years is referred to as adolescents, 15–24 years is defined as young people and 15–49 years refers to adults. Although it is useful to apply these terms consistently, targeting should not be restricted by these definitions and should focus on the groups at highest risk of HIV infection.

14 The economic empowerment of women is a critical development priority in itself; but, there is no clear evidence for the effectiveness of approaches such as microfinance or income generation for HIV prevention. Since these programmes are very resource-intensive, it is proposed that these approaches be considered as development synergies rather than implementing them through HIV prevention programmes and making use of HIV prevention funding. The same applies to generic programmes on gender equality, which are a development synergy for HIV prevention and should be implemented through the relevant government departments rather than through HIV prevention programmes or funding. HIV prevention programmes should focus on gender norms directly related to behaviours relevant to HIV transmission or the uptake of HIV services.

- *Adult men aged 18–39.* Among men, HIV incidence tends to be highest in the age group 20-39 years in high HIV prevalence epidemics, due to the demographic profile of the affected countries, these men also represent the majority of sexually active men. Younger and older men should not be excluded as focus populations, but social and behaviour change programmes should be primarily targeted to 18 to 39-year olds. Due to the lower uptake of health services, men need to be reached at places commonly frequented by men, such as workplaces and sports venues, as well as through the involvement of political, religious and community leaders and public role models. Priority themes include the risk of multiple sexual partners, consistent condom use, motivation for voluntary male medical circumcision, HIV testing and counselling and antiretroviral treatment. In areas in which sex work is common, the high risk of unprotected commercial and transactional sex and consistent condom use need to be particularly emphasized. Advocacy for normative change is likely to be more effective than individual appeals. Advocacy can be designed around concepts already established in the sociocultural context, such as responsible fatherhood which can be used as a springboard to promote health-seeking behaviours, reducing the number of multiple sexual partners, participating in antenatal care, HIV testing and counselling and the elimination of mother-to-child HIV transmission or taking care of their children's educational needs.
- *Serodiscordant couples and people living with HIV.* Between 10% and 38% of new adult HIV infections in high HIV prevalence epidemics are estimated to occur within serodiscordant couples.[15] Couples can be reached efficiently through encouraging couples' HIV testing and counselling in the context of antenatal care and family planning programmes. This can serve as an entry point for communication on the risk of multiple sexual partners, couples' communication, consistent condom use, voluntary male medical circumcision, treatment as prevention and provide information on safe conception and breastfeeding. Messages on the positive health, dignity and prevention[16] approach to HIV prevention and risk-reduction counselling can be provided through HIV testing and counselling and antiretroviral treatment services. Evidence suggests that behavioural interventions are effective in promoting condom use among people living with HIV and sero-discordant couples.[17] In addition, there is a need to communicate the benefits of early antiretroviral treatment as a prevention strategy and encouraging consistent condom use while providing information on reinfection, co-infection and sexually transmitted infections.
- *Sex workers and their clients.* Up to 15% of HIV infections in generalized epidemics in southern Africa may occur among sex workers, their partners and clients, while in eastern Africa up to 20% and in West Africa one third or more of new infections occur among sex workers, their partners and clients.[18] HIV prevalence within the sex work community is often much higher than that among the general population. Specific guidance on social

15 Chemaitelly H, Shelton JD, Hallett TB, Abu-Raddad LJ. Only a fraction of new HIV infections occur within identifiable stable discordant couples in sub-Saharan Africa. AIDS. 2013;27(2):251–260. doi:10.1097/QAD.0b013e32835ad459.

16 Global Network of People Living with HIV, Joint United Nations Programme on HIV/AIDS. Positive health, dignity and prevention: Operational guidelines. Amsterdam: Global Network of People Living with HIV; 2013 (Available from http://www.gnpplus.net/resources/positive-health-dignity-and-prevention-operational-guidelines/, accessed 22 June 2014).

17 Kennedy CE, Medley AM, Sweat MD, O'Reilly KR. Behavioural interventions for HIV positive prevention in developing countries: A systematic review and meta-analysis. Bull World Health Organ. 2010;88(8):615–623. doi:10.2471/BLT.09.068213.

18 Gouws E, Cuchi P, International Collaboration on Estimating HIV Incidence by Modes of Transmission. Focusing the HIV response through estimating the major modes of HIV transmission: A multi-country analysis. Sex Transm Infect. 2012;88(S2):i76–i85. doi:10.1136/sextrans-2012-050719.

and behaviour change for sex workers is addressed within specialized United Nations guidance materials.[19] Social and behaviour change programmes for men in geographic locations where sex work is common should address the specific risks associated with commercial sex and required prevention actions (see guidance note on services for sex workers).

- *Men who have sex with men, transgender people, people in prisons and people who inject drugs.* See the relevant guidance notes for these specific key populations.
- *Adolescent girls and boys aged 10-19 years.* HIV incidence in this group is relatively low in men and younger girls up to the age of 16 years (with the exception of some areas). However, many norms around sexuality are shaped during this period of life and adolescents are easy to reach as long as they are in school. Keeping girls in school and reducing teenage pregnancies are goals which complement the HIV prevention goals among this age group. Integrating comprehensive sexuality education into national education curricula can be a cost-efficient approach towards scaled up HIV and health education. There is evidence that increasing risk awareness regarding age-disparate sex among adolescent women can be effective in reducing sexual risk-taking and teenage pregnancy.[20] While cash transfers to keep girls in school and comprehensive sexuality education should be advocated for, it is important to keep in mind that they are social development priorities in their own right and should, therefore, not primarily or exclusively depend upon HIV prevention funding.
- *Key locations.* HIV prevalence and incidence can vary greatly between different subnational areas within a single country. In some countries, social and behaviour change programmes will focus exclusively on specific districts. In countries with hyper-endemic HIV epidemics, some minimum components will be delivered to high-priority populations (e.g. women aged 15 to 29 years, sex workers, men who have sex with men and men aged 18 to 39 years) nationwide, while specific attention will be given to high-incidence areas or among communities where HIV prevalence is high. Depending on the modes of transmission and population size estimations, as well as the geographic service coverage (disaggregated by key population, gender, etc.) within a country, the different settings for reaching priority groups need to be identified and targeted. Reaching those engaged in transactional sex will require targeting through bars, small towns, transit routes and hubs and alongside other business centres according to the local epidemic. Couples can be reached through existing health services (e.g. family planning and antenatal care services) or religious and other community gatherings. Based on country-specific data, specific professional groups (e.g. miners, farmers or bar staff), income groups (e.g. low-income and peri-urban women), social groups (e.g. orphaned young women) will need to be prioritized.

Apart from focus populations, it is important also to include "significant others" as a secondary audience who influence the focus populations. Depending on the context, these key influentials may include family members, peers, policy makers, community and religious leaders, teachers,

19 World Health Organization, United Nations Population Fund, Joint United Nations Programme on HIV/AIDS, Network of Sex Work Projects. Prevention and treatment of HIV and other sexually transmitted infections for sex workers in low- and middle-income countries. Recommendations for a public health approach. Geneva: World Health Organization; 2012 Available from: (http://apps.who.int/iris/bitstream/10665/77745/1/9789241504744_eng.pdf?ua=1, accessed 22 June 2014).

20 Dupas P. Do teenagers respond to HIV risk information? Evidence from a field experiment in Kenya. Am Econ J Appl Econ. 2011; 3(1):1–34.

and health care providers. It is important to be realistic about what the country can achieve for as wide of a range of possible target groups and in different settings. In many contexts, it will be more realistic to scale up through a specific national social and behaviour change programme which addresses as many different target audiences as necessary, while ensuring that key social and behaviour change messages are also delivered through individuals in leadership positions, health services, workplaces and other community-based programmes.

3. Data requirements

HIV prevention efforts are most effective when targeted to where the majority of new infections occur. Knowing your epidemic refers to understanding the size and nature of the epidemic, the populations most affected (population size estimations) and the main modes of transmission. An in-depth understanding of the social, cultural and behavioural contexts is also central to understanding the economic context and sociocultural norms that enable and limit risk, and facilitating responses to address these cultural factors which may contribute to risk behaviours or act as barriers to reducing risk.

The data requirements related to social and behavioural change programmes, therefore, include the following elements.

Situation analysis (know your epidemic)

The following data is related to the situation analysis:

- HIV prevalence;
- HIV incidence if available;
- Population size estimates;
- Analysis of the modes of transmission;
- Treatment access and patterns and levels of service utilization;
- Determinants of sexual behaviour and service uptake including social and ethnographic data on sexual practices and broader sociocultural mechanisms that shape perceptions of risk and safety, including:
  - knowledge (including newer knowledge on risk factors and services);
  - attitudes,
  - norms,
  - demand;
  - social, cultural and religious practices; and
  - individual motivators and social and logistical barriers to service use.

Data should be disaggregated along the following dimensions wherever possible:

- age;
- sex;
- geographical area (province/ district);
- key population;
- wealth quintile;
- education status;
- marital status; and
- other sociodemographic variables.

Biological understanding of fluctuating HIV infectivity, combined with accumulating data on concurrency and sexual networking, provides a new angle on the risks of multiple sexual partners where HIV is prevalent; an issue that needs to be further researched and applied in HIV prevention programmes.

Response analysis (know your response)

The following data is relevant to understanding the national context in relation to the response to the HIV epidemic:

- national results frameworks for prevention;
- baseline information, including the current status and targets;
- numbers and types of service providers and locations of service provision in relation to locations of high HIV incidence settings;
- numbers and types of community cadres;
- numbers and types of popular opinion leaders;
- coverage of different communications channels (access to media and mobile phone technologies, health system, education system and outreach community workers);
- cost of interventions based on the national strategy; and
- available funding and sources.

Social and behaviour change programme components targeting the demand for services need to consider collecting detailed information on the coverage and map the types of services available.

4. Implementation challenges

Social and behaviour change is a challenge that involves knowledge, motivation and available choices. These are, in turn, influenced by social and cultural norms, as well as by self-assessment in relation to immediate benefits and future consequences. It involves both rational decision making and impulsive emotion-driven behaviour. Gender-focused, rights-based, age-appropriate comprehensive sexuality education may increase knowledge and contribute to more responsible sexual behaviour. However, if introduced as a stand-alone intervention, it may leave significant gaps in even basic knowledge, and without an enabling environment recipients may not be able to effect changes in behaviour. In contrast to biomedical approaches that are easy to measure, understand and respond to, social and behaviour change is complex and highly context-specific. It requires an understanding of how individuals understand and relate to risk, including HIV risk and their ability to protect themselves from contracting HIV, including knowledge of the choices available to people at risk. Individual risk behaviours are embedded in larger social and cultural norms and practices. Without addressing the social and cultural norms that shape and underpin health-seeking behaviours, opportunities for individual-level behaviour change are limited. Social practices that perpetuate risk behaviours have been identified, including gender expectations with which boys and girls are raised and

gender-based violence. Specific challenges to implementing social and behavioural chance programmes include:

- *Limited evidence.* Although population-level behaviour change has been shown to reduce the incidence of HIV in several countries with generalized epidemics, linking behaviour change programming to specific HIV outcomes remains challenging. The limited evidence to demonstrate the specific effectiveness of social and behavioural chance programmes has sometimes erroneously been interpreted as ineffectiveness. The consistent association between social and behavioural chance and reduced incidence provides plausible support related to the impact of behaviour change programming in general, but more specific evidence showing which programme elements cause which effects is urgently needed to help guide informed investment. A good proxy for assessing such effects are multi-method evaluations involving HIV incidence modelling, surveys on behavioural and service utilization trends, programme performance reviews and qualitative research.
- *Policy, legal and cultural barriers* may create resistance to social and behavioural chance initiatives. An assessment to identify external barriers to implementing social and behaviour chance programmes should be carried out in order to understand if there is opposition to specific messages and to determine how to overcome these barriers. Social and behaviour change programmes should have a high coverage and systematic approaches to avoid the fragmentation of efforts and messages. Continuous monitoring and evaluation should be implemented.
- *Political barriers.* The gap between implementation and effectiveness in social and behaviour change programmes is largely due to political rather than technical barriers. Engaging and building leadership and a clear constituency for HIV prevention are critical.
- *Weak results chains.* Social and behaviour change programmes commonly have weaknesses in defining their results clearly, which may include the following:
  - Too many behavioural outcomes rather than focusing on outcomes that are key in the context of the epidemic.
  - Non-targeted social and behaviour chance programmes or an inappropriate choice for the communication medium for a targeted population or for the specific change in behaviour.
  - Under- or overambitious outcome targets creating unrealistic expectations.
  - Lack of market-style research on behavioural determinants, such as knowledge, attitudes, norms and perceived service quality, which may lead to an inadequate focus for specific strategies and messages.
  - A mismatch between the social and behaviour chance objective and activities (e.g. exclusive use of mass media appeals for changes that would actually entail shifts in social norms, which may require the involvement of national and local popular opinion leaders; the use of male adolescent peer educators where the majority of HIV transmission occurs between young women and older adult men).
- *Project-style approaches with low coverage.* Social and behaviour change programmes commonly lack an agreed plan for scale up. In many countries, a variety of localized projects with different foci, different target groups and different delivery modalities exist, which fail to achieve sufficient coverage.

5. Main activities

Effective prevention involves reducing risk, vulnerability and impact. Behaviour change messages and models that focus on individual knowledge, skills and choices are not enough, particularly in high HIV prevalence contexts. Projects need to move from an intervention or service paradigm to one of engagement grounded in the right to HIV prevention. Behaviour change programmes need to support and empower individuals to understand and minimize their infection risks through adoption of prevention behaviours.

Various components should be deployed unison. The total sum of all outputs should reflect a conprehensive and unified strategy for social and behavioural change in support of HIV prevention. Tables 1a and 1b summarize the main activities under each of the key elements of social and behaviour chance programmes outlined in section 1 above.

Table 1a

Main activities: Essential components of social and behaviour change programmes

Component	Main activities under the essential components of social and behaviour chance programmes	Thematic focus
Sociocultural and market research	▪ Conduct special biobehaviour knowledge, attitudes and practices (KAP) surveys using anonymous interview techniques. ▪ Conduct qualitative research on norms and practices (including longitudinal panel designs for tracking progress over time including any unintended consequences of messages). ▪ Conduct formative research on messages, brands and products. ▪ Based on research and taking into account community perspectives, develop a theory of change and concise evidence-informed social and behaviour change plan.	▪ Epidemiology of HIV transmission. ▪ Status of knowledge, attitudes, risk perceptions, demand, norms, access and perceived service quality. ▪ social and behaviour change content, brands and design. ▪ National social and behaviour change theory of change, results framework and operational plans.
Advocacy for normative change	▪ Set up a small, multisectoral taskforce of HIV prevention advocates (including a full-time senior-level manager). ▪ Identify national public role models and advocates for core prevention themes. ▪ Develop advocacy tools and standards for the national and local levels to facilitate community dialogue and action to shift norms, including through use of participatory methods. ▪ Training of traditional, religious, political, business and other leaders as role models and advocates. ▪ Implement an advocacy plan building on major existing events in order to publicize core advocacy messages.	▪ Define standards and norms of HIV prevention (e.g. no multiple partners / partner change without protection; (couples) HTC with contraception and before marriage, etc.). ▪ Role models and advocacy around multiple partners, condom access for all, HTC, openness about HIV, reduced stigma and male involvement.

Component	Main activities under the essential components of social and behaviour chance programmes	Thematic focus
Interpersonal communication	▪ Develop an implementation model for interpersonal communication with adequate thematic focus and targeting. ▪ Develop standard operating procedures and tools for interpersonal communication. ▪ Identify interpersonal communication providers (organizations) and develop their capacity in managing evidence-informed, quality interpersonal communication. ▪ Identify and train credible community-level facilitators of IPC with the potential to be opinion leaders (staff or community-based workers). ▪ Establish a referral mechanism to HIV prevention services including tracking tools (e.g. referral slips). ▪ Conduct interpersonal communication (such as group talks, short community courses, dramatized information sessions, road shows and home visits) in line with standard operating procedures. ▪ Systematic and regular quality assurance of interpersonal communication through support in sessions, progress monitoring and qualitative research.	▪ Personalized risk perception of multiple sexual partnerships (in particular, age-disparate, concurrent, transactional and casual sex). ▪ Benefit statements on safer sexual practices and enhanced motivation to adopt prevention behaviours by making people feel how HIV affects them personally. ▪ Core social and gender norms for HIV prevention (including barriers). ▪ Self-efficacy and key prevention skills (e.g. communication and consistent condom use). ▪ Referral to HIV prevention, testing and treatment services.
Mass media	▪ Identify social and behaviour chance programme elements for mass media campaigns. ▪ Develop media campaign plans based on research (see above) and the overall social and behaviour change plan. ▪ Produce print materials and electronic media campaigns (including radio, television, internet and/or mobile phone elements). ▪ Place media products through accessible outlets including radio, television and new media (as appropriate for the target populations). ▪ Train journalists and media producers on HIV prevention and establish a network of HIV prevention experts in the media sector. ▪ Secure media coverage for popular opinion leaders who are prevention advocates and role models.	▪ New knowledge on HIV prevention ▪ Risk perception of multiple sexual partnerships. ▪ Marketing of innovation in HIV prevention services (e.g. condom brands). ▪ Protective lifestyles and norms (consistent condom use and male responsibility). ▪ Core prevention messages delivered by role models.

Table 1b

Main activities: Programme enablers and development synergies

Component	Main activities: Programme enablers and development synergies	Thematic focus
National and decentralized response management	▪ Set up a decentralized mechanism for planning, implementation and monitoring of social and behaviour change programme. ▪ Conduct regular national and subnational performance review meetings with key players. ▪ Ensure continued engagement of traditional, religious, political, business and cultural leadership in HIV prevention at decentralized levels. ▪ Facilitate collaboration between health and nonhealth sectors in providing outreach and matching demand generation and supply at decentralized levels. ▪ Establish public-–private partnerships to increase the reach and frequency of prevention messages and access to products and services.	▪ Coverage targets of the different IPC components. ▪ Accountability of leaders on advocacy targets and normative changes. ▪ Local referral mechanisms in place for joint health and nonhealth outreach activities. ▪ Major businesses at the national and local levels are engaged in social and behavioural chance.
Quality assurance of social and behavioural change programmes	▪ Monitoring and evaluation of social and behaviour change and sharing the results across similar projects for learning and increased accountability ▪ Appraisal of the existing national HIV communication and behaviour change strategy and the range of communication opportunities to maximize strengthening of existing channels and capacities ▪ Capacity building of community-based organizetions	▪ Quality of implementation of social and behavioural change programmes
Policy analysis and review	▪ Conduct reviews of policy and legal barriers to the uptake of HIV prevention services and safer sexual practices (including among youth). ▪ Conduct assessments of the impact of employment practices and policies on spousal separation and HIV risk including in key locations. ▪ Develop alternative policy scenarios for major public and private sector employers towards reducing spousal separation. ▪ Conduct a review of data on young women's access to education.	▪ Barriers to the adoption of safer sexual behaviours (including condom use) and services. ▪ Effect of employment practices and labour system on families and HIV. ▪ Policy changes allowing for spouses and families to live together. ▪ Barriers in access to girls' education.

Component	Main activities: Programme enablers and development synergies	Thematic focus
Financial incentives / conditional cash transfers	▪ Conduct analysis of the role of socioeconomic factors in HIV transmission among young women in the country-specific context. ▪ Develop alternative policy scenarios for enhanced social transfers for young women, which are HIV-sensitive. ▪ Advocate for financial transfers including cash transfers to keep girls in school and ensure that young women at highest risk of HIV are reached through such transfers. ▪ Explore the use of targeted financial incentives for staying HIV-negative among young women at highest risk of HIV infection (including cost-efficient options through lottery tickets rather than full incentives).	▪ Perceived and actual economic factors affecting young women's HIV risk. ▪ Policy changes towards the introduction of social transfers, in particular, conditional cash transfers.
Comprehensive sexuality education (CSE)	▪ Review and update national comprehensive sexuality education curricula. ▪ Training of teachers on HIV prevention and sexuality education. ▪ Advocacy and technical assistance to include HIV in comprehensive sexuality education curriculum. ▪ Production of communication and advocacy materials for in-school comprehensive sexuality education.	▪ Sexual and reproductive health, HIV prevention (including a focus on the risk of multiple sexual partners, age-disparate sex, condoms, HIV testing and counselling and antiretroviral treatment, the elimination of mother-to-child HIV transmission and voluntary male medical circumcision) and familiarization with health service options broader life skills, gender roles, stigmatisation.

6. Key indicators, monitoring and evaluation

Due to the complex nature of social and behaviour change, it is important to measure progress regularly. Therefore, it will be important to conduct specific behavioural surveillance surveys which cover a range of questions including knowledge, attitudes, norms, behaviours, demand for services, HIV service use patterns and others.

A balanced monitoring and evaluation approach requires the **precise monitoring** of activities and output coverage. This involves the standardized tracking of exposure to interpersonal communication and media through programme records. Regular and rigorous **outcome evaluation** of changes in socio-behavioural determinants (knowledge, risk perception, self-efficacy, norms, etc.) and prevention behaviours (sexual behaviour and service use) through bio-behavioural surveys is required. While this type of evaluation comes at a cost, the costs may be reduced by improving synergies between surveys carried out by different actors. Rather than conducting various social and behaviour chance project evaluations, a single national bio-behavioural survey, which also includes HIV and herpes simplex 2 virus biomarkers, can be conducted every two

years. Such surveys are not only useful for tracking the performance of social and behaviour chance programme indicators, but can inform the demand side of the broader HIV prevention and treatment responses.

The table below includes indicators related to specific results.

Table 2
Possible indicators for social and behaviour chance programmes[21]

Results	Indicator
Reduce new HIV infections by 75% by 2020	▪ Number of new HIV infections in the population aged 15 years and older (by sex, age group and gender). ▪ HIV prevalence among young women aged 15-24 years (as a proxy for HIV incidence). ▪ Percentage of young people aged 15-24 years who are living with HIV.
Reduction in multiple sexual partners by X% Increased utilization of condoms in non-regular sexual partnerships by X% *(for indicators on other services promoted by social and behaviour change programmes, see other guidance notes)*	▪ Percentage of men and women reporting two or more sexual partners in the past 12 months (disaggregated by age, marital status and for men paying for sex). ▪ Percentage of young women reporting transactional sex. ▪ Percentage of young women reporting sex with a partner who is 10 or more years older. ▪ Percentage of men and women with a casual partner in the past 12 months who used a condom during last sexual encounter. ▪ Percentage of men and women with more than one sexual partner in the past 12 months who used a condom during last sexual encounter.
Increased knowledge on HIV prevention	▪ Percentage of people who identify having more than one partner as a risk factor for HIV. ▪ Percentage of young women who identify having an older, sexually experienced partner as a risk factor for HIV. ▪ Composite knowledge score (percentage of correct answers to questions on basic and new prevention knowledge based on country needs). ▪ Percentage of young women and men aged 15-24 years who identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.
Increased personal risk perception of multiple partnerships and age-disparate sex	▪ Percentage of people with two or more partners in the past month who believe they are at low or moderate risk of HIV (desired direction of change: reduction). ▪ Percentage of young women with a partner 10 or more years older who believe they are at low or moderate risk of HIV (desired direction of change: reduction).

21 Similar indicators at all levels are required for HIV prevention and treatment services, including condoms, VMMC, HTC, antiretroviral therapy and the elimination of mother-to-child HIV transmission. These should be collected through the same national surveys and can be found in the Guidance Notes on the specific service delivery areas.

Results	Indicator
Change in attitudes / social norms around multiple sexual partners	▪ Percentage of people who believe that a woman should be able to refuse sex with a husband who has sex with an extramarital partner. ▪ Percentage of people who heard a leader speak out against married men having multiple sexual partners. ▪ Percentage of people who believe that their friends and their community do not approve of married people having multiple sexual partners.
Increased demand for high-impact prevention services	▪ Percentage of men who intend to be circumcised (through VMMC) in the coming 12 months. ▪ Percentage of women and men who say that they will consistently use condoms with partners with an unknown HIV status. ▪ Percentage of women and men who intend to get tested for HIV in the coming 12 months.
Reduced spousal separation among couples	▪ Percentage of people in a relationship who slept away from home more than half of the time in the past 12 months to this indicator.
Increased availability of mass media communication on multiple sexual partners and high-impact services	▪ Percentage of population 15–49 years old who received social and behaviour change messages through mass media (disaggregated by gender, age and source).
Increased availability of IPC on multiple concurrent sexual partners and high-impact services	▪ Percentage of population 15–49-years old who received behaviour change communication through IPC. ▪ Number of people reached (or persons exposed) through IPC (disaggregated by gender, age and source).
Increased number of leaders involved as advocates and role models	▪ Number of key public figures speaking out as advocates and role models in the past 12 months.
Improved deployment policies for spouses for employees of major public- and private-sector firms	▪ Number of major employers implementing revised employment policies in the past 12 months.

WHO target setting guide for HIV programmes for key populations (2015) provides in-depth methods for evaluating these programmes.

Quantitative methods should be combined with **repeated qualitative research**. Designs such as panel studies allow for the following of communities over time to track changes in norms and practices.

In addition, indicators from existing frameworks,[22] monitoring and evaluation approaches[23] may be useful in defining indicators for social and behaviour change communication.

22 See, for example, Who measures change? An introduction to participatory monitoring and evaluation of communication for social change. South Orange, NJ: Communication for Social Change Consortium; 2005. Available from: (http://www.communicationforsocialchange.org/pdf/who_measures_change.pdf, accessed 23 June 2014).

23 For an inventory of existing tools and frameworks, visit Available from: http://www.communicationforsocialchange.org/publications-resources.php?id=283.

7. Approaches to costing

Costs of social and behaviour chance programmes depend on a number of factors, local or international, that require standardization even if it might be labor-intensive to collect accurate figures to estimate the unit costs. The costs per person reached vary greatly between countries and between programmes.[24,25] This is largely due to the differences in approaches, programme models, production functions and different economies or diseconomies of scale and scope.

WHO has developed a work planning and budgeting tool to assist countries in developing Global Fund concept notes. The tool facilitates development of well-structured and accurately costed budgets. Costing of social and behaviour change programmes is complex with spending requirements on HIV-related information, education and communications, community mobilization, risk reduction for vulnerable populations, social marketing of condoms, preventing sexually transmitted infections, behaviour change communication, prevention activities among young people and others.

For purposes of delivering social and behaviour chance programmes at scale, it is therefore more useful to estimate the cost for implementing national social and behavioural chance efforts. Table 3 gives a brief overview on indicative costs per person reached for scaling up social and behaviour chance programmes in contexts of generalized and mixed epidemics; adaptations due to purchasing power parity need to be taken into account for final country-specific costs as appropriate.

24 See Futures Group Unit cost repository (http://policytools.futuresinstitute.org/UC/). Costs per person reached for various social and behaviour change, youth and community mobilization programmes implemented in sub-Saharan Africa ranged from 0.27 to 50.28 USD.

25 The average unit cost is the estimate of the expenditure associated to a specific output (quantity) resulting from a particular combination of factors, called production function, along successive possible levels of output.

26 The costs in the table were established based on a detailed costing spreadsheet, which estimated cost of implementing selected social and behaviour change programmes at scale in high priority countries in Eastern and Southern Africa. The range in the table indicates the range of costs arising out of different input costs in low and middle income countries, in particular for human resources, which is a significant cost component of social and behaviour change programmes. Input costs were derived from nation-wide implementation of social and behaviour change programmes in Zimbabwe 2007-2011 and budgets for grants from Global Fund and other sources. Also see: Health Partners International (2012) Impact Assessment of the Expanded Support Program. Available from: https://www.gov.uk/government/publications/impact-assessment-of-the-expanded-support-programme-zimbabwe.

Table 3

Programme activity	Cost per person reached /year (in US$)[33]	Comments
HIV prevention community course (e.g. condensed version of Stepping Stones)	9-17	For a community member attending a course with 8 sessions
HIV prevention community meetings	2-4	Per community member reached (on average in 4 different community meetings/interactions)
Leadership campaigns	126-251	Per leader trained and supported as role model and advocate
School-based campaign	1.5-3	Per adolescent girl reached in 2 repeat sessions
Radio campaign	0.3-0.6	Per person reached (on average 4 times)
TV campaign	0.8-1.6	Per person reached (on average 4 times)
New media campaign (SMS/ internet)	0.6-1.3	Per person reached (on average 4 times)
Sociobehavioral survey	50-80	Per survey respondent in a bio-behavioral evaluation survey

Social and behaviour change programmes can reach large numbers of people at low unit cost if well implemented, but this requires that scalability is considered at the programme design stage. Considering that social and behaviour change is only one dimension of HIV combination prevention, social and behaviour change programmes — even if delivered at scale — are not expected to account for more than 10% of the total resources invested in the national HIV responses (in many case this is substantially less).[27]

8. Addressing gender, human rights and equity issues

Social and behaviour change programming should be grounded in human rights principles, gender equality and the sociocultural context. All social and behaviour change programmes need to be mindful to not reinforce gender stereotypes, HIV-related stigma and denial and to determine and use the appropriate language and build on images that demonstrate the benefits of gender equality and respect for sexual rights and responsibilities. A variety of social factors may influence HIV prevention outcomes positively or negatively. These include gender norms, including stereotypes of male and female roles in relationships, gender-based violence, stigma, socioeconomic disparities, spousal separation in the context of migrant labour, coinfection and other issues in varying legal, political and human rights contexts. Such drivers of the epidemic require structural interventions.

27 The UNAIDS Report on the Global AIDS Epidemic 2012 indicated that among the 26 countries with high HIV prevalence epidemics that submitted expenditure data for the most recent year, an average of 5% of HIV expenditure was allocated to social and behaviour change programming (including condom promotion), representing 36% of overall combination prevention spending.

Social and behaviour change programming enables communities and national AIDS programmes to tackle structural barriers to an effective AIDS response. It should be grounded in human rights principles, gender equality, sensitivity to work in different cultural settings, and HIV related stigma and denial. Linking broader gender- based violence programmes with HIV prevention programmes is of paramount importance as the goals of both programmes are mutually reinforcing. All social and behaviour change programmes need to be cautious not to reinforce gender stereotypes and to find the appropriate language and local images that demontrate the benefits of gender equality and respect of human rights.

The gap between implementation and effectiveness in behaviour change programmes is largely due to political rather than technical barriers. Having strong, local and up-to-date epidemiological data is invaluable for policy dialogue. There is a need to conduct and disseminate policy research, to inform diagnosis of political barriers and Policy options and document and share such examples.

9. Additional information

Useful information ncluding:

Health COMpass collection of resources, tools and programme examples;
Field Guide to Designing a Health communication Strategy;
The Health COMpass How-To guides; and
Spotlights on successful social and behaviour change campaigns.
This information is available in: http:// healthcomspringboard. org

http://healthcomspringboard.org/groups/social-marketing-materials-and-health-communication-campaigns

http://healthcomspringboard.org/groups/monitoring-and-evaluation-of-health-communication-programs/

There are a number of other useful resources on social and behaviour change programmes, including:

C-Modules: A learning package for social and behaviour change communication. Washington, DC: C-Change, Family Health International. 2012 (Available from: http://www.fhi360.org/sites/default/files/media/documents/Cover.pdf, accessed 22 June 2012).

Global HIV Prevention Working Group. Behaviour change and HIV prevention: Considerations for the 21st century. Menlo Park: Henry J Kaiser Foundation. 2008 (Available from: http://www.globalhivprevention.org/pdfs/PWG_behavior%20report_FINAL.pdf, accessed 22 June 2014).

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