Republic of South Sudan

South Sudan Social and Behavioural Strategy for HIV and AIDS Prevention, Care and Treatment 2018–2020

IOM • OIM

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Foreword

Reducing the burden of HIV and AIDS is a priority for the Government of South Sudan. This *National Social and Behaviour Change Strategy* is the product of teamwork across a variety of stakeholders, including the Ministry of Health, the South Sudan AIDS Commission, the Joint UN Team on AIDS, United Nations Development Programme (UNDP) as the principal recipient of the Global HIV grant, and the overall leadership of the International Organization for Migration (IOM) in overseeing this process. The development of this document is a strong example of country ownership in the HIV response.

We would like to call upon donors, international stakeholders and national institutions to support this plan both financially and technically to ensure efficient and timely implementation. Implementation of this strategy will result in strengthened community-based interventions around HIV and subsequently significant gains in HIV prevention.

Using this opportunity, we would like to express our appreciation to IOM and UNDP for the strong coordination of this exercise and to the Global Fund for financial support to undertake this exercise.

Many thanks and regards,

Dr Esterina Nyilok Novello
Chairperson, South Sudan HIV/AIDS Commission

Acknowledgements

The authors would like to extend thanks to the South Sudan AIDS Commission (SSAC), Ministry of Health (MoH), UNAIDS, World Health Organization, United Nations Population Fund and other members of the Joint United Nations Team on HIV/AIDS South Sudan, local partners including South Sudan Network for People Living with HIV/AIDS, National Empowerment of Positive Women United, Mubadiroon Organization for Future Generation, Charities Aid Foundation and international partners, including IntraHealth Limited and Adventist Development and Relief Agency South Sudan, for their support and encouragement to ensure its implementation.

Our special thanks go to the general population, key populations and vulnerable populations who participated in the consultative process including female sex workers (FSWs), men who have sex with men, clients of FSWs, internally displaced persons, as well as the South Sudan People's Defence Forces HIV Secretariat and Ministry of Interior. Their contributions and participation shaped this strategy and ensured that it represents their interests as key partners in the HIV and AIDS response. To all these and the rest of the general population that contributed to this document, including women, men, boys and girls from South Sudan, our hope is that the strategy will inform better focus and programming to reduce the prevalence and incidence of HIV in the country.

We would like to extend special thanks to the lead consultant, Bernad Mwijuka, for his dedication and commitment to this strategy and leadership of the HIV Technical Working Group; Dr Victoria Achut, Director of the HIV prevention Services (MoH); Dr Alex Nyiyal; Dr Kandyang Modi (MoH); Gabriel Atillio, Director for Prevention (SSAC), the Behaviour Change Communication Sub-Technical Working Group, particularly the chair, Gloria Chepkwony (MoH); all the MoH and SSAC State coordinators, IntraHealth and IOM field staff who

provided direct support either through technical input to the protocol and survey tools or through direct field support.

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Regards,

Mr Habib Daffalla Awongo
Director General for Programmes Coordination, SSAC

Table of contents

List of figures

List of tables

Abbreviations and acronyms

ADP	AIDS development partner
AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
ART	Antiretroviral therapy
ARV	Antiretroviral drug
BCC	Behaviour change communication
BSS	Behavioural Surveillance Survey
CBO	Community-based organization
CHS	Casual heterosexual sex
CMoH	County Ministry of Health
CSE	Comprehensive sexuality education
ECP	Emergency contraception
FBO	Faith-based organization
FSW	Female sex worker
GARPR	Global AIDS Response Progress Report
GBV	Gender-based violence
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
HIV	Human immunodeficiency virus
HTA	High transmission area
IDP	Internally displaced person
IEC	Information, education and communication
IGA	Income-generating activity

IGAD	Intergovernmental Authority on Development
ILO	International Labour Organization
IOM	International Organization for Migration
IPC	Interpersonal communication
KAP	Knowledge, attitudes, practices
MDA	Ministry, department and agency
MoH	Ministry of Health
MOT	Mode of transmission
MSM	Men who have sex with men
NEPWU	National Empowerment of Positive Women United
NGO	Non-governmental organization
NSP	National HIV and AIDS Strategic Plan
PEP	Post-exposure prophylaxis
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PoHC	Population of humanitarian concern
PREP	Pre-exposure prophylaxis
PwD	Person with disability
PWID	People who inject drugs
SBC	Social and behaviour change
SDD	Stigma, denial and discrimination
SGBV	Sexual and gender-based violence
SMoH	State Ministry of Health
SOP	Standard operating procedure
SPLM/A	Sudan People's Liberation Movement/Army

SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
SSAC	South Sudan HIV/AIDS Commission
SSDP	South Sudan National Development Plan
SSNeP+	South Sudan Network of People Living with HIV
STI	Sexually transmitted infection
TB	Tuberculosis
TWG	Technical working group
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Executive summary

A. Why a social and behaviour change strategy?

The *South Sudan Modes of Transmission Study* (SSAC, 2014) indicated that over 80 per cent of the new infections are due to sexual HIV transmission, central to which are low levels of comprehensive knowledge on HIV transmission and prevention and sociocultural norms and practices related to reproductive health.

Despite the critical effect of social and behaviour factors in determining the levels and patterns of the HIV epidemic, South Sudan currently has no specific guiding framework for effective SBC interventions supportive to HIV prevention, HIV and AIDS care and treatment. The National HIV/AIDS Communication Strategy (2008–2012) expired in 2012. To respond to this critical need, a national SBC strategy has been developed.

B. Structure and content of the Strategy

To be comprehensive and yet specific enough to the various elements and settings as a guiding framework, the Strategy has been structured into the following seven sections:

(a) Introduction and background to HIV epidemic, response, rationale and content;

(b) Audience segmentation and analysis, message concepts and content, communication channels and other enabling interventions;

(c) Principles, objectives, conceptual and results framework;

(d) Implementation framework and roll-out plan;

(e) Capacity-building objectives, scope, strategies and plan;

(f) Monitoring and evaluation strategies, indicators and data sources; and

(g) Glossary of related key concepts and terms and key references.

C. Strategy development process

The development of the SBC Strategy was undertaken through participatory approaches involving national-level HIV and AIDS response implementing partners, and priority target population groups for the national response at national, state, county and community levels. The process included the following:

(a) Formative assessment through desk/document review, key informant interviews, audience segmentation, focus group discussions, review, critical observation and analysis of information, education and communication/SBC materials, audience analysis, message concepts and content development;

(b) Identification of communication channels and capacity needs, needed enabling policy needs, institutional development/ orientation and interventions;

(c) Drafting of strategic objectives, intended results, strategies, key activities and roll-out plan, capacity development strategies, implementation plans, monitoring and evaluation framework; and

(d) Stakeholder validation.

D. Specially targeted populations and audience segmentation

For this strategy, the following audience segmentation in form of subpopulations and service providers has been undertaken based on the available literature on the epidemic in South Sudan and the rapid formative assessment undertaken in five different states. These subpopulations and service providers are to be specifically targeted as either primary or through the associated secondary and tertiary audiences under this SBC Strategy.

(a) Women of reproductive age (15–49)

(b) Young people 10–24 years (female and male, in and out of school)

(c) Internally displaced persons and refugees

(d) Uniformed services (military, police, prison workers, civil forces) populations

(e) Prison inmates population

(f) Long-distance truckers/transporters and mobile and immigrant traders

(g) Boda riders

(h) People living with HIV and serodiscordant couples

(i) Female sex workers

(j) Men having sex with men

(k) Service providers'/health workers in health facilities, institutions and communities

E. Audience segmentation and analysis

To provide guidance to the systematic planning and implementation of SBC interventions in the South Sudan National HIV and AIDS response, matrices with the following analytical presentation of the following information on each or a cluster of the prioritized subpopulations were generated:

(a) Social, behavioural and environmental related issues and risks;

(b) Target audiences segmentation for behaviour change interventions;

(c) Key benefiting behaviour change message concepts and content;

(d) Recommended communication approaches and channels; and

(e) Enabling framework: Policy, institutional development and programmes.

F. Strategic objectives

Based on the situation and response analysis undertaken during the rapid formative assessment, the envisaged scope and principles, the SBC strategy will strive to attain the following five interlinked strategic objectives:

Strategic objective 1:	To strengthen the national framework and enabling environment for SBC programming
Strategic objective 2:	To increase knowledge on HIV transmission and prevention and reduction of related risky sexual, social and cultural behaviours among the general and key populations
Strategic objective 3:	To promote health-seeking behaviour and uptake for high-impact interventions for prevention of HIV and related opportunistic infections; care and treatment and sexual and reproductive health services
Strategic objective 4:	To increase knowledge and promote positive behaviour among health service providers, the uniformed services and other auxiliary service providers on the HIV and opportunistic infection prevention, care and treatment, reproductive health needs of vulnerable and key populations
Strategic objective 5:	To reduce HIV-related stigma, denial and discrimination (SDD) at individual, interpersonal, community and institutional levels

G. Social and behaviour change results framework

A priority of social and behavioural changes that shall contribute and feed into the overall results frameworks of both the South Sudan National HIV and AIDS Strategic Plan (NSP 2013–2017) and the National Prevention HIV and AIDS Strategy 2015–2017 were generated and are logically presented below.

As indicated by the objectives and scope of the strategy, SBC interventions support nearly all elements of the HIV prevention and care and treatment thematic areas of the South Sudan National HIV and AIDS Strategic Plan (NSP 2013–2017).

Impact results *(Contributing to NSP impacts)*
▪ Reduction of new HIV infections ▪ Reduction of HIV-related mortality and morbidity among men, women and children living with HIV

Outcomes
(a) A strengthened framework and enabling environment for SBC programming
(b) SBC enabling interventions, principles and policies mainstreamed across HIV prevention, care and treatment interventions/services
(c) Increased knowledge on HIV prevention
(d) Reduction in multiple sexual partners
(e) Increased utilization of condoms in non-regular sexual partnerships
(f) Increased personal risk perceptions on multiple partnerships, condom use and age-disparate sex
(g) Reduction in the prevalence of harmful or risky social and cultural practices among the general and key populations
(h) Increased availability of mass media and interpersonal communication on HIV prevention, care and treatment among the general and key populations
(i) Increased demand and uptake of high-impact interventions for prevention of HIV and related opportunistic infections; care and treatment among the general and key populations
(j) Improved service delivery to key populations
(k) Increased human rights protection and rights-sensitive service delivery to access for both the general and key populations seeking services
(l) Reduced HIV-related SDD at individual, interpersonal, community and institutional levels

H. Implementation framework, roll-out and implementation plan

The Strategy also presents a guide to the framework within which the strategy shall be implemented with regard to planning, coordination and national and subnational levels down to the county level, as well as the role of the different partnerships and technical support structures. A roll-out and implementation plan is also presented in five matrices for the prioritized interventions under the five strategic objectives that indicate the programme level at which interventions will take place, the key targeted beneficiary populations, the timeline and the lead responsible actors.

I. Capacity-building plan and objectives

The strategy also outlines the following: (a) different capacity and competency needs; (b) objectives of a capacity development to effectively and sustainably meet needs; (c) different methods, approaches and strategies proposed to build this capacity and competencies; (d) direct beneficiaries; and (e) roll-out plan. The capacity-building component of the strategy highlights the following four capacity categories:

(a) Strategic;

(b) Human resource;

(c) Institutional and organizational; and

(d) Financial resource.

The capacity-building component of the SBC strategy prioritized the following objectives:

(a) To develop and strengthen the strategic resources for the development, implementation, monitoring and evaluation of contextually relevant and evidence-informed SBC interventions;

(b) To build and mobilize adequate human resource numbers, quality, competences and technical mix that is needed for the development and implementation of the prioritized SBC interventions;

(c) To strengthen the institutional and organizational landscape for effective planning, coordination, implementation, monitoring, quality assurance and evaluation of the SBC programmes and interventions; and

(d) To strengthen the systemic capacity to mobilize the needed financial and material resources for the SBC programmes.

J. Monitoring and evaluation of the Social and Behaviour Change Strategy

The sixth section presents the framework within which the SBC programmes shall be monitored and evaluated; the needed inputs, activities/processes, results at impact, outcome and output levels, indicators and routine and non-routine data sources.

The monitoring also includes the tracking of exposure to mass and interpersonal communication messages, regular and rigorous outcome evaluation focused on the sociobehavioural determinants (knowledge, risk perception, self-efficacy, norms, etc.) and prevention behaviours (sexual behaviour and service use) through bio-behavioural surveys shall be required.

Specifically, the strategy monitoring and evaluation framework aims at:

- Providing a framework for continuous tracking of SBC service delivery process (inputs, process, outputs and coverage) for routine programme management;
- Quality assuring of the SBC interventions;
- Providing a framework for regular and structured performance measurement/assessment of worth of SBC interventions and

programmes in regard to their effectiveness, efficiency, relevancy, coherency and alignment, exploration of possible alternative strategies of service delivery and sustainability of the interventions (process and outcome evaluation); and

- Providing a well-structured framework for generating and maintaining the vital records or key data on SBC.

Section 1: Introduction and background

1.1. Why a social and behaviour change strategy?

The South Sudan HIV and AIDS Strategic Plan (2013–2017) and the National HIV Prevention Strategy (2015–2017) have highly prioritized behavioural change communication as part of the strategic prevention interventions to reduce new HIV infections. The *South Sudan Modes of Transmission Study* (South Sudan AIDS Commission (SSAC), 2014), indicated that over 80 per cent of new infections are due to sexual HIV transmission, central to which are levels of correct and comprehensive knowledge; individual, interpersonal, community and institutional behaviours and sociocultural norms and practices related to reproductive health.

Despite the critical effect of social and behaviour factors in driving the epidemic, South Sudan currently has no specific guiding framework for effective SBC interventions supportive to HIV prevention and HIV and AIDS care and treatment. The National HIV/AIDS Communication Strategy (2008–2012) expired in 2012. To respond to this critical need, a national SBC strategy has been developed. Given the scope of issues to be addressed that go beyond behaviour and communication to include enabling interventions, the strategy shall be referred to as a Social and Behaviour Change Strategy and not just Behaviour Change Communication (BCC) Strategy or Communication Strategy as was its predecessor.

1.2. Structure and content of the Strategy

To be comprehensive and yet specific enough to the various elements and settings as a guiding framework, the Strategy has been structured into the following seven sections (refer to Figure 1).

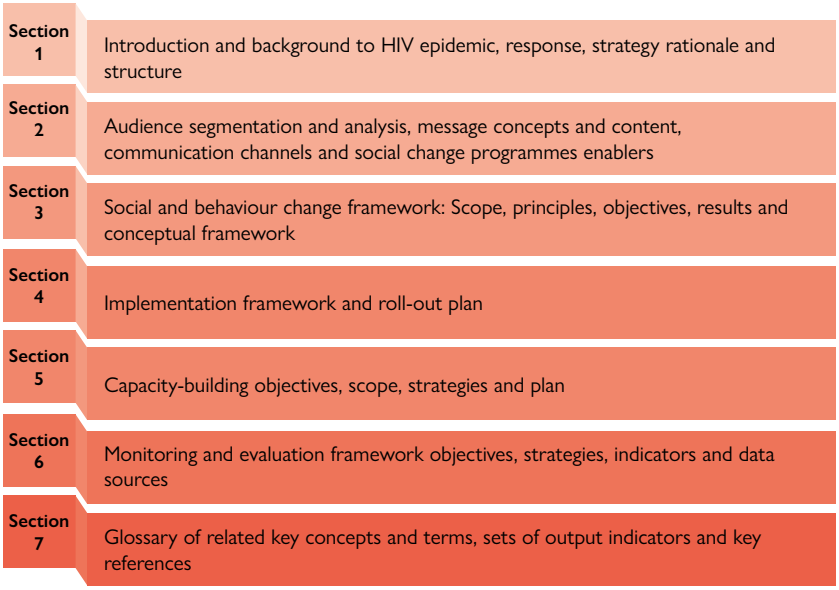
1.3. Strategy development process

The SSBC strategy development process was a thorough and inclusive process that entailed the following participatory process as indicated in Figure 1 below.

1.3.1. Participatory process

The development of the SBC Strategy was undertaken through participatory approaches involving national-level HIV and AIDS response implementing partners and priority target population groups for the national response at national, state, county and community levels. The process included different stakeholders, institutions and target populations of interest whose behaviours, institutional policies and programme orientation and actions the Strategy seeks to influence in order to positively impact HIV prevention care and support.

Figure 1: Structure of the Social and Behaviour Change Strategy



1.3.2. Strategy development leadership

The process was led by a BCC/Information, Education and Communication (IEC) Technical Working Group (TWG) as the steering committee. This TWG was coordinated by the SSAC with support of the Ministry of Health (MoH).

To ensure a wider input and appraisal by the other key stakeholders from technical organizations, the process also made use of the National HIV/AIDS TWG co-chaired by the MoH and SSAC to seek guidance on the process, scope, tools and deliverables. The draft formative assessment findings and the draft SBC Strategy were also shared and appraised by stakeholders at the Annual National HIV Joint Stakeholders Forum in February 2017.

Box 1: Strategy development process

- Participatory process
- National leadership and ownership
- Phased process
- Formative assessment
  - Desk/Document review
  - Key informant interviews
  - Audience segmentation
  - Focus group discussions
  - Review, critical observation and analysis of IEC/SBC materials
- Audience analysis, message concepts and content development
- Identification of communication channels and capacity needs, needed enabling policy needs, institutional development/ orientation and interventions
- Drafting of strategic objectives, intended key changes/results, strategies, activities and roll-out plan
- Drafting of capacity development strategies and implementation plans
- Drafting of monitoring and evaluation framework, indicators and data sources
- Stakeholder review/appraisal/validation meetings and workshops

These national multisectoral working groups brought together stakeholder leadership from the following:

- Government ministries, departments and agencies (MDAs);
- Non-governmental organizations (NGOs) (National and international);

- Faith-based organizations (FBOs);
- Networks of people living with HIV (PLHIV); and
- AIDS development partners (ADPs) and other categories of key stakeholders.

State and county leadership were also engaged as key informants during the field visits to at least four states and at the strategy validation stage.

1.3.3. Phased process

The development of the Strategy was spread over a two-month period from mid-November 2016 to early February 2017 and adopted a four-phased process: (a) preparatory and planning; (b) formative assessment; (c) formulation; and (d) validation phases.

1.3.4. Formative assessment

The development of the SBC Strategy was informed by a formative assessment, employing a mixed methods approach including the following:

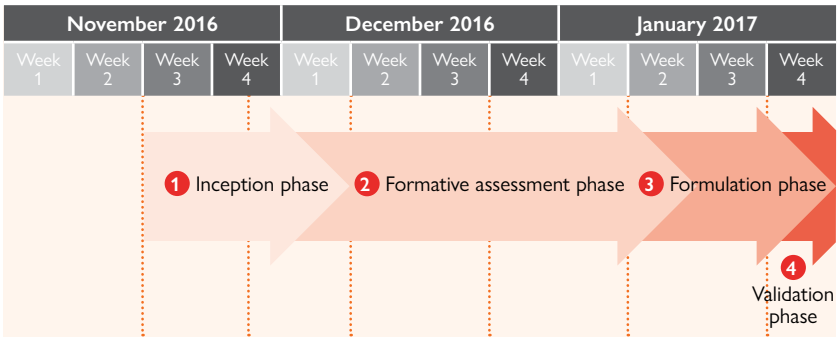
- **Key informant interviews** with a selected sample of 56 programme managers at national- and state-level government MDAs, NGOs, community-based organizations (CBOs), ADPs, service providers from health facilities and other facilities providing sexual and reproductive health (SRH) information and services, community-level health workers and peer educators;

- **Focus group discussions** were conducted with a range of the subpopulations prioritized in the South Sudan National HIV and AIDS Strategic Plan (2013–2017), the National HIV and AIDS Prevention Plan (2015–2017) and the *South Sudan Modes of Transmission Study* (MOT, 2014). A total of 293 respondents/ participants from the specially targeted populations across the seven states as indicated in segmented audiences in the second chapter were interacted with;

- **Review of SBC/IEC materials** and other documents available in service provision sites and communities; and
- **Critical observation and analysis** of the IEC/SBC materials currently in use and over recent years.

The data from the rapid formative assessment findings from consultations with the target populations was used to corroborate the limited secondary (most of which is not recent, collected before the war in 2014). The qualitative data further helped to generate the underlying factors that enriched the understanding of observed levels and patterns from the effectiveness and relevance of the national prevention, care and support interventions, as well as enabling environment.

Figure 2: Social and behaviour change development road map phases



1.3.5. Validation and consensus-building

The draft of the SBC Strategy was presented for review and discussion at a national workshop of the stakeholders in February 2017.

The Strategy's scope, principles and development process were appraised by multisectoral stakeholders in the TWGs and participatory meetings and workshops. These meetings and workshops also helped build consensus on the priority populations, the key and benefiting behaviours, the message concepts and content, communication channels, the needed interventions, capacity-building and monitoring and evaluation to build an enabling framework for effective and sustainable SBC.

1.4. HIV epidemic in South Sudan

The limited reliable information on the HIV and AIDS epidemic in South Sudan, notably the *Modes of Transmission Study* (2014) and the Antenatal Clinics Surveillance estimates the adult HIV prevalence to be at 2.5 per cent. This prevalence translates to about 150,000 PLHIVs in South Sudan, of which 130,000 are adults, whereas 20,000 are children below 15 years. Annually, an estimated 0.31 per cent of the total adult population becomes infected – approximately 13,200 new adult cases of HIV occurred in South Sudan in 2013 – translating to about 36 people newly infected each day.

However, indicative figures of the epidemic status have largely remained constant, owing to the low number of people newly initiated on treatment (averaging 800 annually). The epidemic is geographically differentiated, with the three equatorial states: Eastern, Central and Western, found along the country's south accounting for 60 per cent of new HIV infections. Communities close to urban centres, cross-border points and transport corridors tend to have higher prevalence than those in remote and inaccessible areas (SSAC and UNAIDS, 2014).

HIV prevalence is higher along the borders with the Democratic Republic of the Congo, Uganda and in Juba, the capital city. This may be a result of neighbouring countries having higher HIV prevalence than South Sudan. The country has a generalized HIV epidemic with pockets of high concentration among key populations. The female sex workers (FSWs), their clients – such as uniformed forces, truck drivers and boda boda riders – and perinatal transmission (mother-to-child transmission) account for 7 out of every 10 new HIV infections (SSAC, 2014a).

General awareness of HIV and AIDS remains low, and levels of both awareness and SBC efforts are yet to reach the desired levels. The HIV prevention response to date has been insufficiently prioritized to populations at higher risk, and interventions have lacked the intensity,

quality and focused coverage to turn back the epidemic, and interventions are not yet fully multisectoral (SSAC and UNAIDS, 2014).

1.5. Risk factors and vulnerability

The South Sudan National Strategic Plan for HIV and AIDS (2013–2017) identified some of the factors central to the epidemic and vulnerability. Central to these are the behavioural factors as presented in Table 1.

Table 1: HIV risk factors and vulnerability

Behavioural	Social	Biomedical	Structural
▪ Low knowledge of HIV and AIDS ▪ Low rates of condom use, including consistent and correct use ▪ High-risk behaviour (acceptance and low recognition of dangers of transactional sex) ▪ High rates of concurrent multiple sexual partners	▪ Increasing transactional sex ▪ Male-dominated gender norms ▪ Sexual and gender-based violence ▪ Poverty, conflict and humanitarian situation ▪ Peer pressure ▪ Age-disparate sex ▪ High rates of stigma, discrimination and denial ▪ Harmful social and cultural norms and practices, e.g. polygamy, widow inheritance and some tribal markings	▪ Early age of sexual debut for girls ▪ High rates of sexually transmitted infections (STIs) ▪ Lack of extensive male circumcision ▪ Levels of viral load	▪ Other human rights and policy barriers to service and commodity access and utilization (sex workers, men who have sex with men (MSM) and others) ▪ Gender inequality ▪ Population displacement and mobility due to political conflict and fragility ▪ Labour migration and high rates of internal movement ▪ Income disparities ▪ Very low general access to HIV prevention and treatment services

Source: National HIV and AIDS Strategic Plan 2013–2017.

The continued state of conflict has resulted in the following: (a) affected millions of people directly or indirectly through displacement, loss of services and general insecurity; (b) resulted in high numbers of refugees and cross-border migration; (c) high levels of poverty, illiteracy and poor overall health, education and social indicators; and (d) severely constrained government capacity to deliver on HIV prevention, care, treatment and impact mitigation (as well as all other areas of health and welfare).

1.6. Sources of new HIV infections

Table 2 below provides a snapshot of the national estimates of the risks facing the different groups as reflected by the respective proportions of new infections occurring. The national prevalence of 2.5 per cent in adults aged 15–49 years conceals widely differing prevalence levels around the country. This figure is significantly lower than the estimate from antenatal care (ANC) surveillance for 2007, which was 3.7 per cent.

The estimated decline in prevalence, however, may reflect rising deaths rather than lower incidence of new infections, and prevalence may rise again if the AIDS-related death rate goes down through improved treatment access.

Table 2: New infections by risk group (2013) in South Sudan

Adult risk behaviour (15–49 years)	Incidence	% incidence
FSW clients – Uniformed services	4,689	34.60
Casual heterosexual sex (CHS; multiple partners)	2,286	16.90
FSWs	1,766	13.00
Stable heterosexual – Polygamous	1,311	9.70
Other clients of FSWs	1,247	9.20
FSW clients – Boda boda riders	736	5.40
MSM	610	4.50
Partners of CHS	251	1.90
Stable heterosexual – Monogamous	234	1.70

Adult risk behaviour (15–49 years)	Incidence	% incidence
Partners of boda boda riders	50	0.40
Partners of MSM	32	0.20
Partners of truck drivers	31	0.20
Partners of uniformed services	25	0.20
FSW clients – Truck drivers	20	0.20
Partners of others	9	0.10
Blood transfusions	3	0.02
Medical injections	0	0.00
Total	13,540	100%

Source: South Sudan AIDS Commission (SSAC), *South Sudan HIV Modes of Transmission Study 2014.*

1.7. HIV and AIDS response framework and progress

The challenges notwithstanding, great strides have been made in policy and strategy development that set the framework for priority actions to develop a multisectoral response and enhance the scope and quality of service delivery.

South Sudan is now implementing the second successive National HIV and AIDS Framework since 2006. The current HIV and AIDS Strategic Plan 2013–2017, building on from the previous one – South Sudan HIV/AIDS Strategic Framework (2008–2012) – sets the framework for the HIV and AIDS response. A strategic information plan (SIP) for the HIV and AIDS response is in place to guide the crucial actions on generating, sharing and utilizing data effectively for evidence-informed programming.

The multisectoral response is led by the SSAC, while the wider MoH, through the department for HIV, leads on biomedical interventions. Coordination structures and mechanisms for the overall response are in place at national, state and county levels, although they are not all functional and face serious constraints in funding and human capacity. Of great importance, the focus of the response is increasingly targeting key affected populations and higher prevalence regions.

1.8. HIV prevention priorities in National Strategic Plan, 2013–2017

The South Sudan HIV and AIDS Strategic Plan (2013–2017) has set priorities in the form of key response pillars of prevention of new infections, HIV treatment, care and support, and socioeconomic mitigation, enabling environment and coordination and management.

Based on the NSP 2013–2017, a National HIV Prevention Strategy (2015–2017) was developed in 2015. One of the major priority strategies to optimize the impact of HIV prevention response is to combine key prevention strategies to generate the most impact, with biomedical approaches backed by strong awareness and sociobehavioural programmes to stimulate demand and adherence.

The first major outcome of the prevention pillar of the National HIV and AIDS Strategic Plan (2013–2017) and the National HIV and AIDS Prevention Strategy 2015–2017 is the reduction of sexual transmission of HIV, which is the biggest mode of transmission (MoT) of HIV in South Sudan. The major outputs and priorities towards attainment of this outcome are as follows:

- Reaching the general population with effective and evidence-informed HIV prevention and sexual and reproductive health communication initiatives to create a basic level of awareness throughout the country;
- SBC interventions are expanded and implemented with sufficient quality, intensity and coverage to have impact on HIV prevention and sexual reproductive health and rights (SRHR), particularly for those at higher risk;
- Effectively reaching the key and vulnerable populations;
- Targeting the geographical areas of high prevalence; and
- Sustaining effective reach with geographical areas where the prevalence is low to keep low or reduce it further.

1.9. Status of the HIV and AIDS knowledge and behaviour indicators

A review of the South Sudan Global AIDS Response Progress Report (GARPR) of 2014 (Table 3) (SSAC, 2014) indicates the status of the behavioural indicators is glaringly below the targets set in the performance framework of NSP 2013–2017. It is also noted that data is not available for most of the indicators.

Table 3: Behaviour indicators as of 2016

Indicator	2011	2012	2013	2014	2015
Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	7.30%	11%	No data	No data	No data
Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15	30.5% (F)	23.3% (F)	No data	No data	No data
	40.8% (M)	29% (M)			
Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	No data				
Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months and who report the use of a condom during their last intercourse	No data				
Percentage of women and men aged 15–49 who received an HIV test in the past 12 months and know their results	No data				
Percentage of sex workers reporting the use of a condom with their most recent client	No data				

Indicator	2011	2012	2013	2014	2015
Percentage of sex workers who have received an HIV test in the past 12 months and know their results	No data				
Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	No data				
Prevalence rate of recent intimate partner violence	No data				
Eliminating stigma and discrimination Discriminatory attitudes towards PLHIV (Stigma index 200)	▪ 30 per cent PLHIV reported to have ever been insulted or physically assaulted ▪ 23 per cent reported to have ever been excluded from family activities ▪ 20 per cent reported to have ever been excluded from social gatherings				
A Knowledge, Attitudes and Practices (KAP) Survey was conducted in Greater Bahr El Ghazal in 2015 (Northern, Western Bahr El Ghazal, Lakes and Warrap states). Results were available in 2016.					

Source: SSAC and UNAIDS, 2014.

In light of the limited recent data available on the current status of the relevant social and behaviour parameters and to corroborate the limited available data, a rapid formative assessment was undertaken on both the general and key populations.

1.10. Sociocultural practices

Like in most of sub-Saharan Africa, the sociocultural beliefs, values, norms, practices and behaviours across most of the population in South Sudan are deeply rooted. A number of these likely bear negatively on HIV transmission, HIV care and treatment, gender power relations and empowerment, self-efficacy of individuals to change and sustain desired behaviours, and general social normative that affects the enabling environment were reported during the assessment.

Given the rich sociocultural and ethnic diversity of South Sudan, these vary significantly across localities and are not yet well documented in respect to the HIV epidemic. These include the following:

(a) Cultural body scarification (tribal marks) usually on the face/forehead using shared instruments in non-sterile settings;

(b) Removal of fore teeth;

(c) Booking of brides at or even before birth;

(d) Intertribal/clan compensation by way of giving away brides;

(e) Wife inheritance by younger brother or in-laws upon death of a husband;

(f) Abated early sexual debut/activity and early marriages (such as *kasurabate* in Yambio);

(g) Socially suctioned elopement at marriage (convoy);

(h) Forced marriages;

(i) Arranged marriages;

(j) Taboo on open discussion on sexuality; and

(k) Polygamy.

In light of the limited recent data available on the relevant social, behavioural and environmental status indicators, a rapid formative assessment was undertaken, scoping beyond the secondary data to include primary data from the key target populations.

Section 2: Audience segmentation, analysis and targeted response

2.1. Introduction

To provide guidance to the systematic planning and implementation of SBC interventions in the South Sudan National HIV and AIDS response, this section presents matrices with analytical presentation of the following information on each or a cluster of similar prioritized subpopulations.

(a) Social, behavioural and environmental related issues and risks;

(b) Target audiences' segmentation for behaviour change interventions;

(c) Key benefiting behaviour change message concepts and content;

(d) Recommended communication approaches and channels; and

(e) Enabling framework: Policy, institutional development and programmes.

2.2. Specially targeted populations and audience segmentation

For this strategy, the following audience segmentation in form of subpopulations and service providers has been undertaken based on the available literature on the epidemic in South Sudan and the rapid formative assessment undertaken in five different states. These subpopulations and service providers are to be specifically targeted

as either primary or through the associated secondary and tertiary audiences under this SBC Strategy.

(a) Women of reproductive age (15–49)

(b) Young people, 10–24 years old (female and male, in and out of school)

(c) Internally displaced persons (IDPs) and refugees

(d) Uniformed services (military, police, prison workers, civil forces) populations

(e) Prison inmates' population

(f) Long-distance truckers/transporters and mobile and migrant traders

(g) Boda boda riders

(h) PLHIV and serodiscordant couples

(i) FSWs

(j) MSM

(k) Service providers'/health workers in health facilities, institutions and communities

(l) Other populations prioritized by the SBC TWG

2.3. Target populations and audience analysis; message concepts and content and social and behaviour change enablers

The analysis of data from the formative assessment yielded the levels/magnitudes, patterns and trends, affected populations, enabling and disabling factors for behavioural change at individual levels, interpersonal levels, community, institutional and entire society level. The analysis also generated the profiles of the target populations, the matching knowledge gaps, the behaviours that enhance and reduce risks, the desired positive change behaviours and messages, available and desired and relevant communication channels and media, and the status of the

enabling environment policy and programming structures, capacities, strengths and needs.

This data has been used for audience segmentation and analysis, message concepts and content development, identification of the communication channels and enabling policy needs, institutional orientation and development and key gap-filling interventions as presented in tabular form in this section.

2.3.1. Women of reproductive age (15–49)

Social, behavioural and environmental issues and risks	Target audiences	Key behaviour change message concepts and content	Communication approaches and channels	Enabling policies, institutions and programmes
▪ Limited comprehensive knowledge on HIV transmission and prevention, opportunistic infections, SRHR, emergency contraception (ECP) and post-exposure prophylaxis (PEP) and pre-exposure prophylaxis (PREP) ▪ Not able to start discussion on sex, to be assertive, negotiate safe sex and to get their partners test for HIV ▪ Stigma related to condom use in relationships and faced with male dominance ▪ At risk of sexual and gender-based violence (SGBV); fear of reporting SGBV ▪ No easily accessible providers of relationship management and marriage counselling	**Primary audience** ▪ Married women ▪ Non-married women **Secondary audience** ▪ Husbands, parents, ▪ Mothers and fathers in-law ▪ Family members ▪ Elders, traditional and religious leaders **Tertiary audience** ▪ Health service providers ▪ NGOs/CBOs, FBOs, women groups ▪ Government authorities	▪ Women should abstain or protect themselves and their partners from HIV and STIs by using condoms and by being faithful ▪ Women and their partners should seek SRH education and counselling from health workers and test for HIV before getting pregnant ▪ Every pregnant woman should attend all four recommended ANC visits before delivery ▪ Non-barrier methods of contraception (pill, injectable and others) do not protect from HIV	**Interpersonal communication** ▪ Face-to-face ▪ Peer counselling ▪ Group counselling ▪ Door-to-door **Community mobilization** ▪ Social marketing ▪ Community/ social events ▪ Edutainment community dialogue ▪ Mass media	▪ Equip women with entrepreneurship skills and microfinance ▪ Train health and social services workers in relationship counselling ▪ Promote women's groups, peer groups and mobilize membership ▪ Life skills training for all women ▪ Advocate for condoms and make condoms accessible

Social, behavioural and environmental issues and risks	Target audiences	Key behaviour change message concepts and content	Communication approaches and channels	Enabling policies, institutions and programmes
▪ Transactional sex largely due to poverty, attracted by mobile and migrant women in petty business and its link to sex work ▪ Sociocultural issues and risks associated to the following: early sex debut and marriages, arranged marriages, wife inheritance, reducing emphasis on virginity or no sex before marriage, increasingly away from parental guidance ▪ Limited access to services – transport cost, in some instances not free on their own and need family /husband/partner clearance, rude service providers in ANC, family planning with limited confidentiality ("Who brought you here"). ▪ Faced with unintended pregnancies		▪ If you do not know your HIV status or the status of your partner, use condoms (as well) until you and your partner are tested ▪ Address myths and misconceptions on condoms ▪ Facts on HIV and STIs. ▪ Assertiveness and insistence on safe sex/ Negotiation ▪ Every abused woman and girl should report and go for comprehensive care (testing, PEP, ECP), counselling, treatment, psychosocial and legal support, as well as social reintegration	**Advocacy** ▪ Mass media ▪ Social/community events ▪ Conferences, meetings	▪ Support adherence to consistent condom use ▪ Role modelling ▪ Dialogue on social norms to remove resistance and establish supportive environment

2.3.2. Young people, 10–24 years old (Female and male, in and out of school)

Social, behavioural and environmental issues and risks	Target audiences	Key behaviour change message concepts and content	Communication approaches and channels	Enabling policies, institutions and programmes
▪ Generally high levels of comprehensive knowledge on HIV transmission and prevention ▪ Limited knowledge on prevention of STI and other opportunistic infections, correct condom use, SRHR, ECP, PEP and treatment as prevention especially among young people who are not in school ▪ Generally, with more accepting attitudes towards PLHIV ▪ High demand for information and knowledge on SRH with ready and highly impressionable mindset ▪ Limited life skills needed for safe negotiation and relationships management among boys and girls; girls not assertive enough ▪ Misconceptions on condom use and safety	**Primary audience** Boys and girls ▪ 10–14 years old ▪ 15–19 years old ▪ 20–24 years old **Secondary audience** ▪ Parents ▪ Youth leaders ▪ Youth gatekeepers like teachers ▪ Elders, traditional religious leaders	▪ Facts on HIV, AIDS and STIs ▪ Parent–child communication ▪ Health benefits of abstinence in relation to HIV and AIDS and delayed sexual debut for those under 20 years old ▪ Benefits of consistent condom use in the prevention of HIV and STIs for those already sexually active, especially for the 19 to 24 years old ▪ Address myths and misconceptions on condom use	**Interpersonal communication** ▪ Face-to-face ▪ Peer and group counselling ▪ Youth clubs/ forum **Community mobilization** ▪ Edutainment/ social, musical and sports events ▪ Community, folk and traditional media ▪ Social dialogue	▪ Review and support teaching of the newly developed standardized Comprehensive Sexuality Education (CSE) for primary and secondary schools ▪ Train in-school group and individual counselling ▪ Teachers and peer groups training, exchanges ▪ Establish drop-in youth centres at tertiary institutions with edutainment materials

Social, behavioural and environmental issues and risks	Target audiences	Key behaviour change message concepts and content	Communication approaches and channels	Enabling policies, institutions and programmes
▪ Limited access to reproductive health services, especially condoms due to social barriers expectations as young people are not supposed to be having sex, limited economic means to buy condoms and associated stigma ▪ Early sexual debut, peer pressure to have sex, casual sex, transactional sex, multiple sexual partnerships, forced marriages, arranged marriages, wife inheritance, unsafe scarification, too much freedom at early ages with limited knowledge in some parts, society complacent to defilement in some cultural settings ▪ Limited and weak enforcement of anti-defilement laws (*kasurabate* in Yambio, "booked at birth", marriage convoy/escorting in Torit and Nimule) ▪ At risk of SGBV and fear of reporting SGBV	**Tertiary audience** ▪ Health service providers ▪ NGOs/ CBOs, FBOs ▪ Government authorities	▪ "Total protection for yourself and your loved one by correct and consistent condom use" ▪ "Real men protect their women" ▪ "Real cool girls protect themselves and their loved ones." ▪ "No babies for kids", too young to be a mother/father ▪ Assertiveness and insistence on safe sex/ negotiation; "Insist on condom use"	▪ Mass media (print and electronic); print materials, comics, leaflets, HIV Q&A, booklets, newsletters ▪ Electronic social media – SMS, WhatsApp and others ▪ Contests: Anti-AIDS cartoons/ short story/ musical and poems, debate competitions	▪ Equip young people (in and out of school) with entrepreneurship, life skills and microfinance support ▪ Support youth-to-youth programmes around youth centres, between youth groups and educational institutions ▪ Engage local CBOs, FBOs, school groups, drama groups and others to carry out interactive participatory youth-led activities ▪ Youth role modelling

Social, behavioural and environmental issues and risks	Target audiences	Key behaviour change message concepts and content	Communication approaches and channels	Enabling policies, institutions and programmes
▪ Limited access to youth centres and providers of relationship counselling and adolescent/youth-friendly/ reproductive rights/SRH services ▪ Few health facilities that offer youth-friendly reproductive health services ▪ Unintended pregnancies		▪ Report rape and go for comprehensive care (testing, PEP, ECP, counselling, treatment, psychosocial and legal support) ▪ If you are HIV positive, seek support from service providers so that you can: – Live a healthy, comfortable and productive life – Still enjoy sex – Get married – Have healthy HIV-free partner and children	▪ Concerts with integrated HIV and AIDS messages ▪ Wall painting of stigma-free community **Advocacy** ▪ Mass media ▪ Social/ community events ▪ Conferences, meetings	▪ Capacity-building for parents on HIV and AIDS and parent–child communication skills ▪ Disseminate guidelines for adolescent access to reproductive health services ▪ Have adolescent/ youth-friendly services in all places ▪ Guidelines for media houses on adolescent sexual and reproductive health

Social, behavioural and environmental issues and risks	Target audiences	Key behaviour change message concepts and content	Communication approaches and channels	Enabling policies, institutions and programmes
		▪ "Wearing a condom each time you have sex gives you peace of mind because you are protected from infections; it helps you to live longer and to realize your dreams" ▪ "Protecting young women from early sex helps them to stay safe, live longer and realize their dreams" ▪ "Advocating for protection of girls and women from coerced sex and rape helps to build a decent and HIV-free society"		

2.3.3. *Internally displaced persons and refugees*

Social, behavioural and environmental issues and risks	Target audiences	Key behaviour change message concepts and content	Communication approaches and channels	Enabling policies, institutions and programmes
▪ Limited knowledge on source of HIV prevention care and support information and services due to displacement, insecurity and language barriers ▪ Discontinuation of access to prevention and treatment/care services and low adherence, loss of medication personal refills/stocks, loss of referral documentation, confiscation of medication and violence against those carrying medication and condoms by border and security workers, hard to get resupply and other treatment support services and tests ▪ Stigma faced by refugees and IDPs as likely more infected with HIV; HIV is mainly looked at as an externally sourced disease	**Primary audience** ▪ IDP youth, women and men **Secondary audience** ▪ Service providers ▪ Camp and community leaders ▪ Host and surrounding population **Tertiary audience** ▪ Health and other essential services providers	▪ All behavioural change messages for general and key populations ▪ Being compassionate as host communities, service providers and security authorities towards IDPs and refugees as they are vulnerable and in need of access to life-saving information and services ▪ Healthy IDPs and refugees are good for host communities ▪ HIV is already in local communities and protected casual sex should be with both locals and IDPs or refugees' partners	**Interpersonal communication** ▪ Face-to-face ▪ Peer counselling ▪ Group counselling ▪ Support groups for the youth, women and men, as well as different ethnic groups **Community mobilization** ▪ Edutainment/ social, musical and events	▪ Establish drop-in information centres that provide counselling, referral, post-abuse reporting and comprehensive care and in guaranteed privacy ▪ Equip IDPs and refugees with entrepreneurship, life skills ▪ Engage local CBOs and FBOs to carry out interactive participatory IDP-led activities ▪ IDPs – Role modelling

Social, behavioural and environmental issues and risks	Target audiences	Key behaviour change message concepts and content	Communication approaches and channels	Enabling policies, institutions and programmes
▪ Limited economic means to be self-reliant and thus at risk of exploitative transactional sex ▪ Weak social protection systems for the youth, children and women and other groups since camps are underfacilitated/underresourced and overcrowded ▪ Disruption of social support groups for PLHIV ▪ Poor nutrition for those on treatment ▪ Peer pressure to have sex, casual sex, transactional sex or multiple sexual partnerships ▪ Dependent on caregivers/providers of essential services and at times at risk or extortion, including exchange of sexual favours ▪ Limited and weak social norms and practices adherence and enforcement due to uprooted, mixed multicultural mobile populations	▪ NGOs/CBOs, FBOs ▪ Government authorities ▪ Immigration and Security agencies	▪ Risky behaviours, though varying, are in all ethnic communities and among people of all migration statuses ▪ HIV services are free for all ▪ Good quality HIV services from MoH are locally available in private – continuous treatment ▪ Your private file is available with MoH all over the country, so you can continue accessing health services" ▪ "Fight HIV and not people with HIV, local or migrants"	▪ Mass media (print and electronic) – billboards and posters ▪ Social/ community events ▪ Conferences, meetings	▪ Support establishment of social support groups in the camps ▪ Establish referrals to prevention, treatment and care and food support for those in treatment and in need in the IDP camps ▪ Establish and sustain models for mobile HIV services delivery supported by an electronic medical record system with unique identifiers

Social, behavioural and environmental issues and risks	Target audiences	Key behaviour change message concepts and content	Communication approaches and channels	Enabling policies, institutions and programmes
▪ At increased risk of SGBV and fear of reporting sexual and gender violence due to insecurity and displacements ▪ Limited access to HIV prevention care and support and SRH/ reproductive rights information and services		▪ "People do not refuse but some fail to change behaviour – fight HIV and not people" ▪ Changing antiretroviral drug (ARV) type is not good and must only be under the guidance of qualified medical personnel		

2.3.4. Uniformed services (Military, police, prison workers, civil forces)

Social, behavioural and environmental issues and risks	Target audiences	Key behaviour change message concepts and content	Communication approaches and channels	Enabling policies, institutions and programmes
▪ Mobility leads to discontinuation of prevention and treatment/ care services and low adherence ▪ Leadership is supportive of the needs of PLHIV who open up and are given preferential duties and deployment where they can access services ▪ Active health units in the South Sudan People's Defence Forces garrisons and high interest in the leadership and welfare of the forces and eagerness to know more of what can be done ▪ High levels of stigma (HIV+ may be equated to people who inject drugs (PWID)	**Primary audience** ▪ Senior and mid-level uniformed men and women officers ▪ Uniformed men and women ▪ Residents and regular dwellers in establishments of the military, police and prisons **Secondary audience** ▪ Health and other service providers and caretakers	▪ Basic facts on HIV and AIDS ▪ The forces, your family and community need healthy and responsible men and women ▪ Protect yourself and care for others ▪ PLHIV in uniformed forces can serve, as well as those who tested negative or the unanimous ▪ Be supportive and accommodating to PLHIV to access life-saving information and services ▪ Using condoms during casual sex is key to continued good health for all	**Interpersonal communication** ▪ Face-to-face ▪ Peer counselling ▪ Group counselling ▪ Support groups **Community mobilization** ▪ Edutainment/ social, musical and events ▪ Role models for the sector ▪ Mass media (print and electronic) – billboards and sector-specific posters	▪ Sector HIV and AIDS workplace policies and mainstreaming ▪ Issue working guidelines or operational modalities on HIV and AIDS response in the sector ▪ Engage local CBOs and FBOs to carry out interactive SBC activities ▪ Support establishment of social support groups in the camps

Social, behavioural and environmental issues and risks	Target audiences	Key behaviour change message concepts and content	Communication approaches and channels	Enabling policies, institutions and programmes
▪ Some do actions and utter stigmatizing statements due to limited comprehensive knowledge on HIV and AIDS or denial or both ("isolate those infected" "lock out the foreigners bringing in HIV", "being with condoms and ARV is same as increasing HIV") ▪ Long periods of separation with families increases the risks associated with multiple concurrent partnerships and casual sex ▪ Rapid deployment in remote localities leads to loss of resupply and access to services, such as condoms and ARVs (for example, the case of Yambio police in December 2016) ▪ Information on HIV is regularly shared during parades, which enhances the knowledge of the staff	**Tertiary audience** ▪ Health and other services providers ▪ NGOs/CBOs, FBOs ▪ MoH ▪ SSAC ▪ Ministry of Internal Affairs ▪ Ministry of Defence ▪ Ministry of Justice ▪ Police and prison leadership ▪ Office of the President	▪ Condoms are strong and effective, if used consistently and correctly – use one every time ▪ Many South Sudanese use condoms. You too should use them when the need arises. Always use a condom ▪ HIV is already in our local communities and protected sex is needed, whether your casual partner is a local, refugee or foreigner ▪ "Fight HIV and not people with HIV, local or immigrants" ▪ Forced sex is criminal, unhealthy for all and not worthy of uniformed men: "Real men don't rape"	**Advocacy** ▪ Conferences, meetings	▪ Strengthen referrals for prevention, treatment and care and food support for those in treatment and in need ▪ Establish and sustain models for mobile HIV services delivery supported by an electronic medical record system with unique identifiers

Social, behavioural and environmental issues and risks	Target audiences	Key behaviour change message concepts and content	Communication approaches and channels	Enabling policies, institutions and programmes
▪ Misconceptions still permeate through, and the simple basic facts on HIV transmission and prevention are doubted by some men and women of the forces ("Coke soda can change one's sero-status") ▪ In many instances, senior members are not interested in awareness campaigns. They assume they know, and HIV programmes are not important ▪ In some localities, the uniformed forces are "reported to be responsible for rampant rape and coerced sex" ▪ Limited or no adequate resources for HIV prevention, care and treatment services to the population in uniformed services that operates in restricted access settings		▪ No sex without knowing your partner's HIV status ▪ A real man does not lower his power status to have sex with a young girl ▪ Positive African culture promotes protection of women and girls ▪ Forced sexual relationships are not acceptable and cannot be part of South Sudan culture ▪ If you are HIV positive, seek support from service providers so that you can: – Live a healthy, comfortable and productive life – Still enjoy sex – Get married and have healthy HIV-free partner and children		▪ Develop and produce specially targeted and protected IEC materials with a lot of pictorial illustrations given the high illiteracy levels and with plastic binding given their harsh settings where they operate

Social, behavioural and environmental issues and risks	Target audiences	Key behaviour change message concepts and content	Communication approaches and channels	Enabling policies, institutions and programmes
▪ Limited access to IEC materials; no HIV posters in establishments, camps or barracks		▪ "Wearing a condom helps you enjoy sex because you do not worry about the possibility of infection" ▪ "Protecting young women from early sex helps them to stay safe, live longer and realize their dreams" ▪ "Advocating for protection of girls and women from coerced sex and rape helps to build a decent and HIV-free society"		

2.3.5. *Prison inmates*

Social, behavioural and environmental issues and risks	Target audiences	Key behaviour change message concepts and content	Communication approaches and channels	Enabling policies, institutions and programmes
▪ Inmates in prisons, police and military cells have limited protection against HIV transmission owing to injuries due to sharing of sharp instruments, "shared, bloodied canes used to beat them", physical fights between inmates, unhealthy conditions good for opportunistic infections like TB and malaria ▪ High stigma ▪ Prison staff offer counselling and try to support treatment continuation on arrest and incarceration stage, but this is not adequate ▪ Inmates' access to treatment, not respectful to confidentiality, no regular access to health service providers due to limited means, limited adherence to treatment, ARV drugs are shared as painkillers and no food support to those on treatment	**Primary audience** ▪ Inmates in prisons, police and military cells **Secondary audience** ▪ Prison staff/workers ▪ Health service providers ▪ Human rights and health service providing national and international NGOs and development partners	▪ Basic facts on HIV and AIDS prevention, care and support for the prison and post-prison settings ▪ Compassion with PLHIV is good for us all ▪ Fight HIV and not people with HIV ▪ Inmates in prisons, police and military cells are more vulnerable and need protection against HIV ▪ Correctional services also extend to correcting social behaviours, which is key to HIV prevention	**Interpersonal communication** ▪ Face-to-face ▪ Peer counselling ▪ Group counselling ▪ Support groups **Advocacy** ▪ Conferences, workshops and meetings	▪ Establish local support supervision teams for the prison, police and military cells with central participation of health service providers and human rights defenders/ advocates ▪ Issue operational modalities or guidelines to all prisons and cells for HIV and AIDS prevention, care and support

Social, behavioural and environmental issues and risks	Target audiences	Key behaviour change message concepts and content	Communication approaches and channels	Enabling policies, institutions and programmes
▪ Poor access to treatment and care and high-transmission risks undermines the behavioural change process since changing behaviour may be of no benefit to an individual (a feeling of no need for knowing HIV status)	**Tertiary audience** ▪ MoH ▪ SSAC ▪ Ministry of Internal Affairs ▪ Ministry of Defence ▪ Ministry of Justice ▪ Police and prison leadership ▪ Parliament ▪ Immigrant associations ▪ Immigrant country embassies	▪ Lack of HIV prevention, discontinuation and lack of adherence to treatment in prison cells gravely impacts on the inmate's well-being and ultimately creates HIV and opportunistic infections and drug-resistance reservoirs for the general population ▪ Inmates' health is for the benefit of all of us ▪ A do-no-harm principle in prison setting is key to HIV prevention		

2.3.6. Long-distance truckers/transporters and mobile and migrant traders

Social, behavioural and environmental issues and risks	Target audiences	Key behaviour change message concepts and content	Communication approaches and channels	Enabling policies, institutions and programmes
▪ Long time and distance separation, extended stay at border and other transit points away from their regular sexual partners and families increase risks of casual sex and multiple concurrent partnerships ▪ Have the financial means and can therefore easily engage in casual and transactional sex ▪ Less constrained by prohibitive cultural practices against casual and transactional sex ▪ Limited knowledge on HIV and AIDS, on location and access modalities for HIV prevention, care and treatment services and language barriers	**Primary audience** ▪ Long-distance truckers/transporters (drivers, turn boys and managers) ▪ Mobile and migrant traders **Secondary audience** ▪ Immigration workers ▪ Police and other security staff ▪ Truckers and different trade association members ▪ City or town councils trade licensing and law enforcement workers	▪ Good quality and free HIV services from MoH are locally available in privacy for visitors and travellers ▪ Continuing to protect yourself from HIV and other STIs anywhere in South Sudan (even when away from home) is possible and in your interest ▪ No sex without knowing your partner's HIV status ▪ A real man does not use his power to have sex with a young girl ▪ Condoms are strong and effective if used consistently and correctly; use one every time	**Interpersonal communication** ▪ Face-to-face ▪ Peer counselling ▪ Group counselling ▪ Support groups for different immigrant or traveller groups ▪ Drop-in multipurpose travellers' centres **Community mobilization** ▪ Edutainment/ social, musical and events	▪ Establish HIV and AIDS prevention, care and support services directly targeting the cross-border, long-distance travellers and mobile traders ▪ Engage truckers' associations and networks and hospitality and leisure industry in HIV prevention, care and support

Social, behavioural and environmental issues and risks	Target audiences	Key behaviour change message concepts and content	Communication approaches and channels	Enabling policies, institutions and programmes
▪ Face HIV and AIDS stigma among themselves for fear of losing jobs and from local host populations ("You drivers have diseases"). This can increase discontinuation of treatment and encourage a hidden epidemic ▪ No visible information on the HIV and AIDS prevention, care and support services directly targeting the cross-border, long-distance travellers and mobile traders ▪ In some instances, not likely to travel with their ARV medication due to some unofficial prohibition or crackdown by border/immigration authorities	▪ Casual FSWs ▪ Hospitality industry workers, such as hotels, nightclubs and bars ▪ Immigrant associations **Tertiary audience** ▪ Health workers ▪ MoH, SSAC and development partners ▪ CBOs, NGOs providing health and HIV prevention, care and support officers ▪ Immigrant country embassies ▪ Travel insurance companies	▪ Always use a condom. ▪ Many South Sudanese use condoms. You too should use them when the need arises ▪ "Avoiding high-risk behaviours helps you to stay safe from HIV and other sexually transmitted infections. Also knowing your HIV status helps you to stay safe and avoid new infections" ▪ "Wearing a condom helps you enjoy sex because you do not worry about the possibility of infection"	▪ Mass media (print and electronic) – billboards, posters, brochures and flyers ▪ Social/community events ▪ Conferences, meetings **Advocacy** ▪ Association and embassy team's engagement meetings ▪ MoH, SSAC and cross-border population programmes, engagement meetings	▪ Establish and support networks with HIV and AIDS prevention and care and support NGOs, CBOs and the immigrant and transporters associations ▪ Support establishments and drop-in multipurpose travellers' centres with information on locally available services and entertainment

2.3.7. *Boda boda riders/drivers*

Social, behavioural and environmental issues and risks	Target audiences	Key behaviour change message concepts and content	Communication approaches and channels	Enabling policies, institutions and programmes
▪ Mainly young active men in the age range of 20–35, an age bracket that is very sexually active ▪ Highly mobile within same city and its environs and between towns ▪ Limited formal education but with generally high levels of comprehensive knowledge on HIV transmission and prevention ▪ Generally, with more accepting attitudes towards PLHIV and high demand for information and knowledge on SRH ▪ Misconceptions on condom use and safety	**Primary audience** ▪ Boys and girls ▪ Boda boda riders/drivers **Secondary audience** ▪ Parents ▪ Youth leaders ▪ Youth entrepreneurship groups ▪ Boda boda riders' associations	▪ Facts on HIV, AIDS and STIs ▪ Benefits of consistent condom use in prevention of HIV and STIs ▪ Address myths and misconceptions on condom use ▪ Good quality and free HIV services from MoH are locally available for all ▪ No sex without knowing your partner's HIV status ▪ A real man does not lower his power to have sex with a young girl ▪ Condoms are strong and effective if used consistently and correctly – use one every time ▪ Always use a condom	**Interpersonal communication** ▪ Face-to-face ▪ Peer counselling ▪ Group counselling **Community mobilization** ▪ Edutainment/ social, musical and sports events ▪ Folk and traditional media dialogue	▪ Train the members in group and individual counselling ▪ Link the riders to existing youth or drop-in centres and health facilities and services to enhance access and referral for HIV and AIDS prevention and care in the general and key populations ▪ Equip them with entrepreneurship, life skills and microfinance support

Social, behavioural and environmental issues and risks	Target audiences	Key behaviour change message concepts and content	Communication approaches and channels	Enabling policies, institutions and programmes
▪ Have some reasonable financial means, engaged with many people in different settings, a lot of free time and can therefore easily engage in casual and transactional sex with younger and older women and multiple concurrent partnerships ▪ Not well organized since the 2013 political upheavals; leaders of such groups where they exist before they were reported were targeted for security reasons ▪ Boda boda drivers not well linked to any existing youth centre programme and health facilities/services on HIV and AIDS prevention and care despite its immense reach in the general and key populations	**Tertiary audience** ▪ Health service providers ▪ NGOs/CBOs, FBOs ▪ City or town councils trade licensing and law enforcement workers	▪ Many South Sudanese use condoms. You too should use them when the need arises ▪ Positive African culture promotes protection of women and girls ▪ Forced sexual relationships are not acceptable and cannot be part of South Sudan culture ▪ "Wearing a condom each time you have sex gives you peace of mind because you are protected from infections; it helps you to live longer and to realize your dreams" ▪ "Protecting young women from early sex helps them to stay safe, live longer and realize their dreams" ▪ "Advocating for protection of girls and women from coerced sex and rape helps to build a decent and HIV-free society"	▪ Mass media (print and electronic) – print materials, comics, leaflets, HIV Q&A, booklets, newsletters ▪ Electronic social media – SMS, WhatsApp and others **Advocacy** ▪ Mass media ▪ Social/community events ▪ Conferences, meetings	▪ Engage the riders in SBC and IEC materials distribution as peer educators/ community workers

2.3.8. People living with HIV and serodiscordant couples

Social, behavioural and environmental issues and risks	Target audiences	Key behaviour change message concepts and content	Communication approaches and channels	Enabling policies, institutions and programmes
▪ Most with limited formal education but with generally highest levels of comprehensive knowledge on HIV transmission and prevention ▪ Not very knowledgeable on PEP, ECP and PREP ▪ Faced with a lot of non-accepting attitudes by the general population; "Isolated", abused and insulted as "moving coffins", "already dead" ▪ Highly appreciated by most health service providers ▪ Some health service providers and pharmacists still isolate and act with negative attitudes towards the PLHIVs (e.g. denied drugs (refills) and unfairly judged	**Primary audience** ▪ PLHIV **Secondary audience** ▪ Partners of PLHIV with same sero status or discordant ▪ Family members **Tertiary audience** ▪ FBO, leaders/ authorities at respective levels ▪ Health service providers ▪ Community elders and leaders	▪ Importance of HIV discordant couples using condoms for every sexual contact ▪ Importance of medical check-ups and frequent health-seeking behaviour and medical care independently and together to treat opportunistic infections like TB, persistent coughs and malaria, when symptoms of STIs appear and consistent adherence to treatment regimen ▪ To increase appreciation among the community that if well empowered, PLHIV can play a positive role in HIV and AIDS programmes at community levels ▪ Need for health workers to be more responsive to the needs of PLHIV	**Interpersonal communication** ▪ Face-to-face ▪ Peer counselling ▪ Group counselling **Community mobilization** ▪ Edutainment/ social, musical and sports events ▪ Folk and traditional media	▪ Strengthen the capacity of providers in pre- and post-test counselling, and the psychosocial and medical care and support of PLHIV; providing care and support tools ▪ Training of peer educators within the PLHIV community

Social, behavioural and environmental issues and risks	Target audiences	Key behaviour change message concepts and content	Communication approaches and channels	Enabling policies, institutions and programmes
▪ At times have no ready access to prevention services like condoms even when ready to use them to prevent transmission ▪ Very well-organized in terms of being supportive to each other and delivering services to the general population, including information, condoms, food distribution and counselling ▪ Faced with discontinuation of treatment due to stockouts of ARVs and other medication		▪ To increase employers' appreciation that PLHIV can be productive like any other workers ▪ PLHIV peers, family members and workmates appreciate and support PLHIV to adhere to treatment ▪ PLHIV can overcome and outlive self-denial and stigma through sustained positive living ▪ Community stigma appreciation towards people with HIV and AIDS is due to ignorance ▪ Importance of communication with partners, talking about one's status/getting involved in the fight against AIDS ▪ Benefits of joining together in associations/networking	▪ Information campaign targeting the general public to combat discrimination and stigmatization of PLHIV ▪ Community discussions ▪ Mass media (print and electronic) – print materials, comics, leaflets, HIV Q&A, booklets, newsletters ▪ Electronic social media – SMS, WhatsApp and others	▪ Support the establishment and functioning of PLHIV support groups in the community and workplaces

Social, behavioural and environmental issues and risks	Target audiences	Key behaviour change message concepts and content	Communication approaches and channels	Enabling policies, institutions and programmes
		▪ Importance of preventing unintended pregnancies as part of preventing mother-to-child transmission ▪ Reducing the number of sexual partners ▪ Understand actions that put one at risk (risk perception) ▪ Important to have self-esteem ▪ Increase knowledge that a healthy-looking person could still be HIV positive ▪ If you are HIV positive, seek support from service providers so that you can: – Live a healthy, comfortable and productive life – Still enjoy sex – Get married and have healthy HIV-free partner and children	**Advocacy** ▪ Mass media ▪ Social/community events ▪ Conferences, meetings ▪ "We need not be scared about talking about our HIV status" ▪ Join a post-test support group ▪ Every community needs a post-test support group ▪ Need HIV positive persons as advocates and experts for HIV prevention, care and treatment	

2.3.9. *Female sex workers*

Social, behavioural and environmental issues and risks	Target audiences	Key behaviour change message concepts and content	Communication approaches and channels	Enabling policies, institutions and programmes
▪ Mainly young to middle-age women with the primary aim of income generation ▪ Operate from given locations where they reside, in bars, restaurants, transit centres where truck drivers have stopovers ▪ Operate in networks, are highly supportive of each other and linked to/work with approval managers at places of entertainment ▪ The FSWs are nationals of both South Sudan and surrounding countries; a significant proportion are non-South Sudanese ▪ Have limited formal education but with generally high levels of comprehensive knowledge on HIV transmission and prevention	**Primary audience** ▪ FSWs **Secondary audience** ▪ Clients of FSWs ▪ Bar and restaurant owners, managers and other workers **Tertiary audience** ▪ Law enforcers ▪ Government authorities at respective levels	▪ Importance and the benefits of consistent and proper use of both male and female condoms; most need to be supported to access condoms easily and consistently ▪ Importance of medical check-ups/routine health-seeking behaviour/screening to treat STIs and opportunistic infections like TB, persistent coughs, malaria and symptoms of STIs and adherence to treatment regimen for those on treatment ▪ To increase appreciation among the law enforcement that sex work, though illegal, can play a positive role in HIV prevention if supported by NGOs, rather than forcing them underground	**Interpersonal communication** ▪ Face-to-face ▪ Peer counselling ▪ Group counselling **Community mobilization** ▪ Edutainment/ social, musical and sports events ▪ Folk and traditional media ▪ Group discussion ▪ Support groups	▪ Develop network of condom-friendly spots and bars (hotels, security checkpoints, filling stations) to ensure steady and reliable supply network of condoms and other services ▪ Create linkages with capacity-building and economic empowerment programmes ▪ Empower sex workers with alternative IGAs

Social, behavioural and environmental issues and risks	Target audiences	Key behaviour change message concepts and content	Communication approaches and channels	Enabling policies, institutions and programmes
▪ Have more accepting attitudes towards PLHIV ▪ Are eager to get information and knowledge on SRH and relationships management, both casual, transactional and with live-in boyfriends ▪ Not easily accepted by health service providers; some refuse them drugs on suspicion that they engage in transactional sex ▪ At times have no ready access to prevention services like condoms even when they are ready to use them to prevent transmission ▪ Encounter clients not willing to use condoms; this is more common with South Sudanese clients. ▪ The FSW are at times forced into unprotected sex by violent clients	▪ Health service providers	▪ Need for health workers to be more responsive to the knowledge and service needs of FSWs ▪ FSWs can overcome and outlive sex work and take on alternative, less stigmatized, less risky and more sustainable alternative or supplementary income-generating activities (IGAs) ▪ Benefits of joining associations/ networking and support groups for enhancing knowledge, accessing prevention and care services and IGA support ▪ Importance of preventing unintended pregnancies as part of preventing mother-to-child transmission through consistent condom use, other family planning methods, ECP, PEP and PREP	▪ Mass media (print and electronic, i.e. radio) – print materials, comics, leaflets, HIV Q&A, booklets, newsletters ▪ Electronic social media – SMS, WhatsApp and others ▪ Role modelling and use of reformed and successful sex workers/personal testimonies **Advocacy** ▪ Conferences, meetings	▪ Strengthen the capacity of providers in pre- and post-test counselling, and in psychosocial and medical care and support of FSWs; providing care and support ▪ Training of peer educators within the FSW community ▪ Support the establishment and functioning of FSW drop-in centres and support groups

Social, behavioural and environmental issues and risks	Target audiences	Key behaviour change message concepts and content	Communication approaches and channels	Enabling policies, institutions and programmes
▪ FSWs are more able to openly talk about sex than the young people and women of reproductive ages in the general population ▪ Not very knowledgeable on PEP, ECP and PREP		▪ Understanding the actions that put them at high risk of transmission (risk perception)		

2.3.10. *Service providers/health workers in health facilities and law enforcement agencies*

Social, behavioural and environmental issues and risks	Target audiences	Key behaviour change message concepts and content	Communication approaches and channels	Enabling policies, institutions and programmes
▪ Central to the provision of HIV prevention, care and support services to both the general and key populations ▪ Have high levels of comprehensive knowledge on HIV transmission and prevention, treatment. However, some are not trained and experienced in interpersonal communication (IPC) and counselling and other aspects of psychosocial support needed in interactions with key populations ▪ Most service providers have accepting attitudes towards PLHIV and other populations affected by the epidemic and in need of the SRH services	**Primary audience** ▪ Health educators ▪ In- and outpatient nurses, clinical officers and physicians ▪ ANC, voluntary counselling and testing, ART ▪ Laboratory health staff ▪ Pharmacists/ dispensers ▪ Records clerks ▪ Community health workers	▪ It is important that service provision does not pose obstacles to clients trying to access services. Once the obstacles are deemed insurmountable by the individuals concerned, they get frustrated and may even redefine and negate the nature of the threat. They may deny its existence, or they may come to see it as their fate, something about which they can do nothing ▪ Once the provision of a service is deemed an obstacle, it will affect behaviour change in the form of having medical check-ups/quick health-seeking behaviour	**Interpersonal communication** ▪ Mentoring ▪ Counselling supervision **Advocacy** ▪ Meetings and conferences	▪ SBC training for providers to empower service providers with the correct and appropriate information and effective communication skills, IPC, counselling and psychosocial support ▪ Equip service providers with SBC standard operating procedures (SOPs) and tools ▪ Support supervision ▪ Client exit surveys

Social, behavioural and environmental issues and risks	Target audiences	Key behaviour change message concepts and content	Communication approaches and channels	Enabling policies, institutions and programmes
▪ However, some sections of the providers have behavioural limitations due to lack of some knowledge like any other member of the population, due to lack of specific skills and affected by the challenging working environment in South Sudan.	**Secondary audience** ▪ Health facility administrators **Tertiary audience** ▪ Government authorities at respective levels	▪ It will affect clients' health-seeking behaviour including screening/testing, treatment of STIs and opportunistic infections like TB, persistent coughs, malaria and with symptoms of STIs and adhering to treatment regimens for those on treatment ▪ Importance of all service providers' appreciation of the behaviour change processes; that people do not refuse to change but may fail to change ▪ It is important that health workers are responsive to the knowledge, service needs and sensitivity of the needs of different clients ▪ Every community needs a post-test support group ▪ HIV positive persons as advocates and experts for HIV prevention, care and treatment		

2.3.11. *Men having sex with men*

Social, behavioural and environmental issues and risks	Target audiences	Key behaviour change message concepts and content	Communication approaches and channels	Enabling policies, institutions and programmes
▪ In South Sudan, MSM exist as a population whose sexual orientation is not legally and socioculturally recognized or acknowledged. ▪ Some MSM also operate as sex workers who are generally young to middle-age men. ▪ MSM operate in highly secretive ways since they are involved in an illegal activity that is also socially unexpected as a form of sexual orientation (in the context in South Sudan). ▪ Some studies estimate about 60 per cent of MSM are also in heterosexual relationships to defuse stigma. ▪ MSM operate in networks that are supportive of each other but also suspicious of new members. ▪ Like the FSWs, the MSM in sex work are linked to work with and/or have approval of managers and workers in places of entertainment/leisure activities. ▪ MSM in South Sudan are both nationals and non-nationals.	**Primary audience** ▪ MSM **Secondary audience** ▪ Friends and family members of MSM ▪ Clients of MSM ▪ Bar and restaurant owners, managers and other workers ▪ All community members and leaders	▪ Importance and the benefits of protection, such as consistent and proper use for their own protection, their partners and the heterosexual population ▪ Importance of regular medical check-ups/health-seeking behaviour, screening to treat STIs and opportunistic infections specific to anal sex	**Interpersonal communication** ▪ Face-to-face ▪ Peer counselling ▪ Group counselling **Community mobilization** ▪ Support groups ▪ Leaflets, HIV Q&A, booklets, newsletters ▪ Electronic Social Media – SMS, WhatsApp and others **Advocacy** ▪ Conferences, meetings	▪ Develop network of condom supply to ensure steady and reliable supply network of condoms and other services ▪ Create linkages with capacity-building and economic empowerment programmes for MSM and sex workers for alternative IGAs

Social, behavioural and environmental issues and risks	Target audiences	Key behaviour change message concepts and content	Communication approaches and channels	Enabling policies, institutions and programmes
▪ The MSM that are sex workers have generally high levels of comprehensive knowledge on HIV transmission and prevention ▪ The MSM have more accepting attitudes towards PLHIV compared to the general population ▪ MSM are eager to get information and relevant SRH services not readily available in MoH facilities ▪ MSM are generally accepted by health service providers and at times denied health services and drugs on suspicion of engaging in sex with men. The MSM sex workers and the non-sex workers therefore depend on more informal connections to access drugs and other SRH related supplies ▪ At times MSM have no access to prevention. ▪ Not very knowledgeable on PEP, ECP and PREP ▪ Some health service providers are not knowledgeable in undertaking diagnosis of STI and other services needed by MSM	**Tertiary audience** ▪ Law enforcers ▪ Government authorities at respective levels ▪ Health service providers	▪ To increase the appreciation among the law enforcement that though MSM is illegal, it is important to meet their SRH needs from a human rights perspective and general interest of public health ▪ Importance of preventing transmission through consistent condom use, PEP and PREP ▪ Understanding the actions that put them at high risk of transmission (personal risk perception)		▪ Strengthen the capacity of health service providers in undertaking diagnosis, treatment and provide other services needed by MSM and SOP support tools ▪ Support the establishment and functioning of MSM drop-in centres and support groups

Section 3: Social and behaviour change framework

3.1. Introduction

Section 3 presents the foundations of the strategy, the guiding principles and the conceptual framework within which the SBC Strategy will be operational and implemented. This section also presents the envisaged results framework of the SBC Strategy, highlighting the impacts, key outcomes and outputs of the strategy.

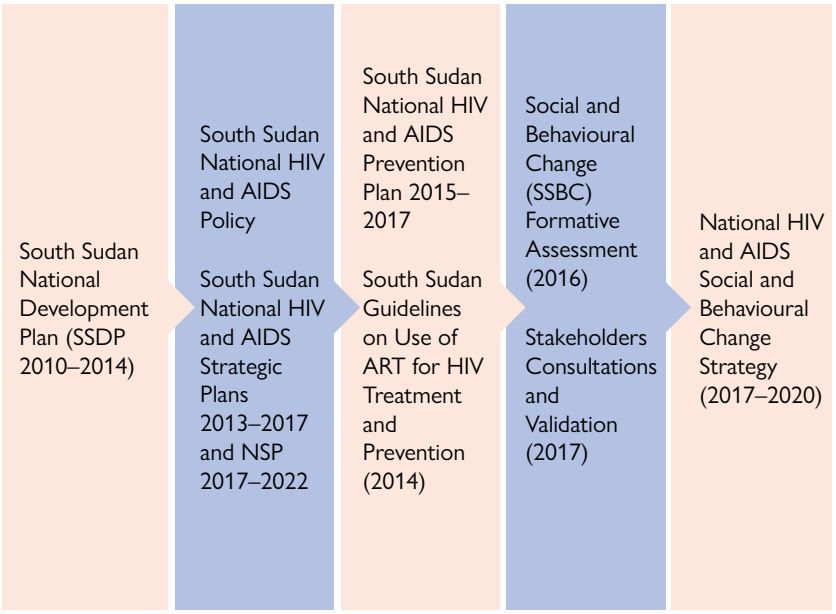
3.2. Foundations of the Social and Behaviour Change Strategy

The SBC Strategy is grounded within South Sudan's overall national development framework guided by the South Sudan National Development Plan (SSDP 2010–2014). The SSDP 2010–2014 pillar three on "Social and human development" has one of the objectives "to increase equitably the utilization of quality basic health and HIV and AIDS services".

In particular, the strategy is aligned to the South Sudan National HIV and AIDS Strategic Plan (2013–2017) and the National HIV and AIDS Prevention Plan (2015–2017). The strategy has also been informed by the review of available data on the national HIV epidemic and response from programme documents, key national surveys, assessments and reports on the national HIV situation and response in recent years. It must be noted that there is very limited national representative and reliable data for a deeper analysis of the status of the HIV epidemic and analysis of the performance of the response.

To collaborate the limited reliable national data on the HIV and AIDS response and behavioural change status of the different population groups, a rapid formative assessment was undertaken in Juba, Nimule, Torit, Wau and Yambio, covering a wide range of stakeholders and beneficiary populations. Figure 3 illustrates the foundations of the strategy within the national response framework.

Figure 3: Foundations of the National SSBC Strategy



3.3. Guiding principles

The SBC Strategy shall be guided by a number of principles including the following:

(a) Integration and foundation within national programme goals and strategic frameworks: SBC is an essential element of HIV prevention, care and support programmes that provides critical linkages between different programme components or thematic tracks and overarching policy initiatives. The

SBC Strategy is therefore anchored to the prevailing national policy, strategic, operational programming and service delivery frameworks.

These frameworks include the overall South Sudan Development Plan (2011–2014), the relevant social sector strategic development plans, the National HIV and AIDS Plan (NSP 2013–2017), the National Prevention HIV and AIDS Strategy 2015–2017 and other SBC and national HIV prevention, care and support policies and service delivery guidelines.

(b) Evidence-informed theory of change: The strategy is built on an evidence-informed theory of change outlining a clear results chain towards the adoption of safer sexual behaviours, the demand and uptake of HIV prevention, care and support services and the building of an enabling environment (strategic investment for results).

Consideration has been given to empirically established high impact or highly efficacious interventions and approaches as documented by lead technical agencies, such as UNAIDS, Family Health International, World Health Organization (WHO), United Nations Population Fund (UNFPA), UNICEF, United Nations Development Programme, the World Bank, Africa Medical Research Foundation and Johns Hopkins Program for International Education in Gynecology and Obstetrics.

(c) Formative assessment: The strategy development has been informed by consultations and engagement with persons and audiences whose behaviours and actions the strategy aims to influence. The assessment was highly participatory to improve understanding of the risks, issues, environment and obstacles/barriers facing the targeted populations and the support needed for effecting and sustaining behaviour change.

(d) All-through participation of stakeholders and target populations: Targeted populations participated in all phases

of SBC development and shall remain integral in the implementation of the strategy. Identified key stakeholders involved from the design stage have included local communities, networks of PLHIV, representatives of key populations and young people, political, religious, traditional, business and cultural leaders in changing social norms.

(e) Prioritization of the most affected geographical areas and hotspots. The SBC Strategy shall prioritize the coverage of the geographical areas most affected by HIV to reduce the negative effects of the epidemic while staying focused on the low HIV prevalence areas to keep low and/or further reduce the HIV prevalence.

(f) Linked communication channels: The strategy has also enshrined a variety of linked communication channels, an approach that is more effective in reinforcing the messages and sustaining behavioural changes than relying on stand-alone channels.

(g) Positive, target population benefiting and action-oriented strategies and messages.

(h) Respect for social justice, equity and human rights, particularly of PLHIV, key affected populations, women, young people, people with disabilities (PWDs) and forcible displaced populations. The strategy shall promote the right to HIV prevention, which keeps sexual rights grounded and formulated in local social, legal and cultural contexts.

(i) Gender equality and equity: The strategy seeks to promote gender awareness, support gender equity and reduce SGBV, including intimate partner violence.

(j) Capacity-building as an integral part of the design of any SBC Strategy and programmes.

(k) Results-based orientation with realistic and logically sequenced outputs and outcomes and corresponding indicators with

targets that can be effectively monitored/tracked and evaluated.

(l) Planning for monitoring and evaluation being an integral part of the design of any SBC Strategy and programmes.

(m) Flexibility and learning: The strategy is designed to be flexible and adaptive to taking on broad new knowledge and modalities/approaches from research and new evidence effective in triggering and sustaining behaviour change.

3.4. Scope of the Social and Behaviour Change Strategy

The strategy has been designed to include the following focus:

(a) Increasing knowledge by ensuring that people are given the basic facts about HIV and AIDS in a language or medium that they can understand and apply to themselves.

(b) Stimulating dialogue by encouraging community and national discussions on the basic facts of HIV and AIDS and the underlying factors that contribute to the epidemic, such as risk behaviours and risk settings, environments and cultural practices related to sex and sexuality. Promote acceptance among communities on some socially desired changes related to sexuality.

(c) Promoting essential attitude change by leading to self-reflection about such areas as perceived personal risk of HIV infection, the importance of compassionate and non-judgemental services, open-mindedness concerning gender roles, and the basic rights of those vulnerable to and affected by HIV and AIDS.

(d) Improving skills and sense of self-efficacy (perceptions about an individual's ability to perform a promoted behaviour effectively) by focusing on teaching or reinforcing new skills and behaviours, such as condom use and negotiating safer sex. This can contribute to a sense of confidence in making and acting on decisions.

(e) Reducing stigma and discrimination through compassionate behaviour towards PLHIV.

(f) Creating demand for information and services and increasing uptake of services for HIV prevention, care and support such as voluntary counselling and testing, prevention of mother-to-child transmission (PMTCT), STI and uptake and adherence to ART.

(g) Improving attitudes of the service providers in health care and other sectors who interact with clients from both the general adult population, young people and the PLHIV, FSWs and other marginalized and key population groups.

(h) Enhancing adherence by medical practitioners to service delivery guidelines.

(i) Strengthening the programme enablers through advocacy to interest policymakers and opinion leaders towards effective approaches and building of an environment conducive to effecting behavioural change and the overall fight against the epidemic through needed policy changes, legal and institutional reforms and development.

(j) Promoting and sustaining desired or positive behavioural changes: The ultimate results of the SBC Strategy shall be in the promotion and sustenance of the desired behaviours at the individual, interpersonal, community, institutional and wider society levels with respect to HIV prevention, HIV and AIDS care and support.

3.5. Strategy vision and goals

Vision: The strategy, as one of the documents to make the National HIV and AIDS Strategic Plan 2013–2017 operational, shall adopt the NSP Vision and Goals reproduced below:

Vision:

- Zero new HIV infections

- Zero HIV-related stigma and discrimination
- Zero AIDS-related deaths

Goals: The Strategy shall contribute to the goals or impact-level results set in the South Sudan National HIV and and AIDS Strategic Plan (NSP 2013–2017) for prevention and the treatment and care thematic interventions, which are:

Goal 1: To reduce new HIV infections

Goal 2: To reduce mortality among men, women and children living with HIV/AIDS

Note:
The targets of the NSP 2013–2017's impacts and outcomes can only be revised by the national HIV and AIDS estimates working group. The effects of the different thematic interventions on the population do overlap, and the SBC TWG on its own and in the absence of a recent national reliable bio-behavioural surveillance survey could not validly set these targets at the time of the SBC development. The revision shall also set the targets on the midterm of a new successor NSP or of the current NSP is rolled beyond 2017.

Box 2: Guiding principles

- Integration with national programme goals and strategies
- Evidence-informed theory of change (strategic investment for results)
- Prioritization and participation of the target populations
- Meaningful involvement of PLHIV and other key affected populations
- Linked communication channels
- Positive and action-oriented SBC strategy and messages
- Respect for social justice, equity and human rights
- Gender equality and equity
- Integral capacity-building
- Results-based monitoring and evaluation
- Flexible and evidence-informed learning processes

3.6. Strategic objectives

Based on the situation and response analysis undertaken during the rapid formative assessment and the envisaged scope and principles, the SBC Strategy will strive to attain the following strategic objectives:

Strategic objective 1:	To strengthen the national framework and enabling environment for SBC programming
Strategic objective 2:	To increase knowledge on HIV transmission and prevention and reduction of related risky sexual, social and cultural behaviours among the general and key populations
Strategic objective 3:	To promote health-seeking behaviour and uptake for high-impact interventions for prevention of HIV and related opportunistic infections, care and treatment, and SRH services
Strategic objective 4:	To increase knowledge and promote positive behaviour among health service providers, the uniformed services and other auxiliary service providers on HIV and opportunistic infection prevention, care and treatment and reproductive health needs of vulnerable and key populations
Strategic objective 5:	To reduce HIV-related stigma, denial and discrimination (SDD) at individual, interpersonal, community and institutional levels

3.7. Results framework

The results framework for the SBC Strategy as presented in Figure 4 shall contribute and feed into the overall results frameworks of both the

Box 3: Social and Behaviour Change Strategy scope

- Increasing knowledge
- Stimulating dialogue
- Essential attitude change
- Reducing stigma and discrimination
- Increasing uptake of services for HIV prevention, care and support
- Adherence by medical practitioners to service delivery guidelines
- Improving attitudes of the health-care, social service and other service delivery workers
- Strong programme enablers
- Building life skills and sense of self-efficacy
- Promoting and sustaining desired or positive behavioural changes

South Sudan National HIV and AIDS Plan (NSP 2013–2017) and the National Prevention HIV and AIDS Strategy 2015–2017. As indicated by the objectives and scope of this SBC Strategy, the strategy interventions support nearly all elements of the HIV prevention and care and treatment thematic areas of the South Sudan NSP 2013–2017.

Figure 4: Social and Behaviour Change results framework

Impact results (Contributing to NSP impacts)

- Reduction of new HIV infections
- Reduction of HIV-related mortality and morbidity among men, women and children living with HIV

Strategic objective 1	Strategic objective 2	Strategic objective 3	Strategic objective 4	Strategic objective 5
To strengthen the national framework and enabling environment for SBC programming	To increase knowledge on HIV transmission and prevention and reduction of related risky sexual, social and cultural behaviours among the general and key populations	To promote health-seeking behaviour and uptake for high-impact interventions	To increase knowledge and promote positive behaviour among health service providers, the uniformed services and other auxiliary service providers on the needs of vulnerable and key populations	To reduce HIV-related SDD at individual, interpersonal, community and institutional levels
Outcomes	**Outcomes**	**Outcomes**	**Outcomes**	**Outcomes**
(a) A strengthened framework and enabling environment for SBC communications programming	(b) Increased knowledge on HIV prevention (c) Reduction in multiple sexual partners	(h) Increased demand and uptake of high-impact interventions for prevention of HIV and related opportunistic infections; care and treatment among the general and key populations	(i) Improved service delivery to key populations	(k) Reduced HIV-related SDD at individual, interpersonal, community and institutional levels

	(d) Increased utilization of condoms in non-regular sexual partnerships (e) Increased personal risk perceptions on multiple partnerships, condom use and age-disparate sex (f) Reduction in the prevalence of harmful or risky social and cultural practices among the general and key populations (g) Increased availability of mass media and IPC on HIV prevention, care and treatment among the general and key populations		(j) Increased human rights protection and rights-sensitive service delivery and access for both the general and key populations seeking services	

3.7.2. Key outputs

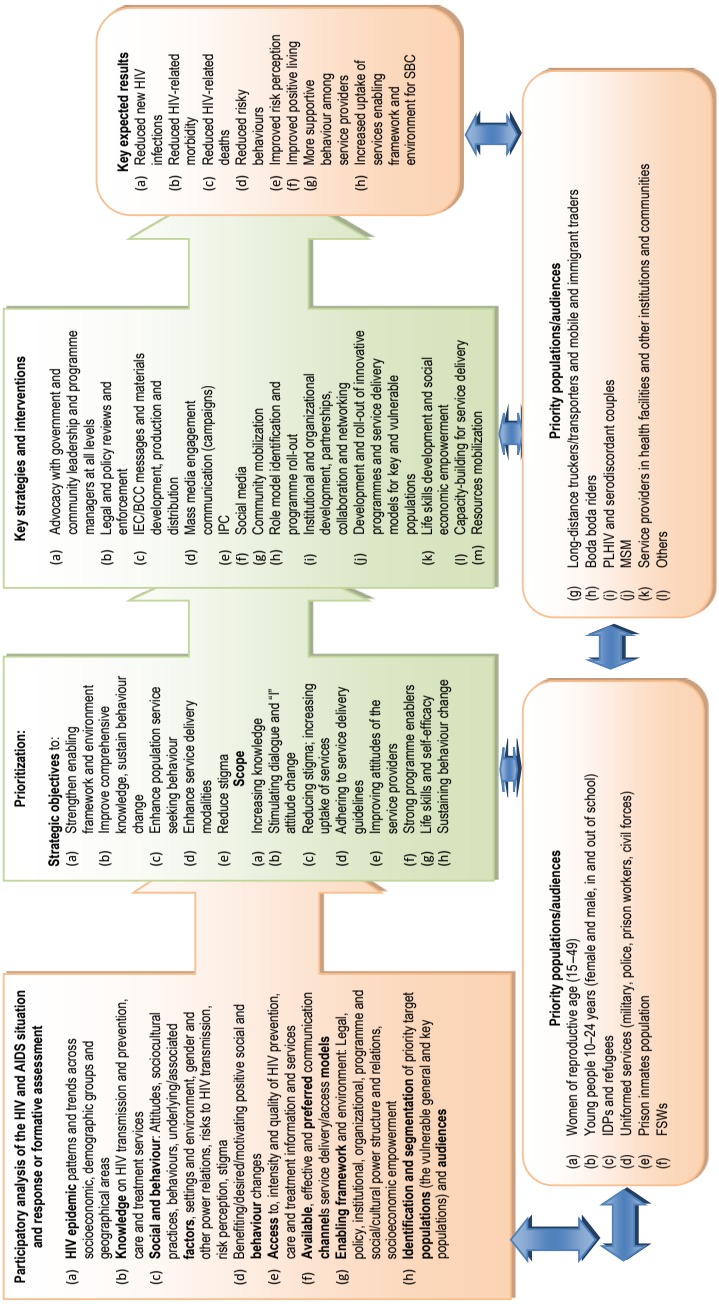
Output-level results per strategic objective are provided in the annex as reference achievements for implementation of the strategy.

3.7.3. Social and behaviour change conceptual framework

Figure 5 schematically presents the SBC conceptual framework for HIV response in South Sudan. The framework is evidence informed by the results of a situation and response analysis that serves as a formative assessment for the following: (a) development and continuous review of SBC; (b) development of the strategic objectives; (c) prioritization of the target populations and audiences for SBC messages and enabling interventions; (d) formulation of effective strategies and interventions; and (e) key expected results at the impact and outcome levels.

The framework enables those responsible for planning to review the SBC strategy from time to time and reprioritize the aims or objectives, strategies and SBC interventions to attain the desired results. The changes may, among other factors, depend on the changing context in as far as the following: (a) HIV epidemic patterns; (b) modes of transmission; (c) key and vulnerable populations; (d) social, cultural and economic factors; (e) prevailing knowledge levels and disparities; (f) institutional and administrative landscape; (g) stability and population mobility; (h) the strategic, human and financial/material resources; and (i) prevailing affordable prevention, care and treatment technologies that influences the service delivery and communication models.

Figure 5: South Sudan Framework for Social and Behaviour Change for HIV Response



Section 4: Implementation framework and roll-out plan

4.1. Introduction

The fourth section presents the framework for management, coordination, roll-out and implementation of the SBC Strategy over the next three years (2017/18–2019/20). The SBC implementation framework is aligned to South Sudan's overall institutional and administrative structures, HIV and AIDS coordination guidelines, planning, programming framework and fiscal cycles.

4.2. Overall national-level planning and coordination

The overall strategic and operational planning and coordination of the SBC programmes shall be facilitated by the South Sudan AIDS Commission (SSAC). SSAC shall ensure that the National SBC strategy is launched by the Government of South Sudan and widely disseminated at national, state and county levels. SSAC shall execute this responsibility in close collaboration with the central MoH, other sector MDAs, NGOs, ADPs, PLHIV networks and associations and other partners and beneficiary populations.

4.3. National Social and Behaviour Change Technical Working Group

A national social and behavioural change TWG shall be responsible for the stewardship of the strategy. The TWG membership shall comprise of technical or leadership representatives of the diversity of stakeholder organizations, including the following:

(a) Government MDAs;

(b) NGOs;

(c) Media and other private sector stakeholders;

(d) Representatives of beneficiary populations including PLHIV;

(e) ADPs;

(f) Training and research organizations; and

(g) Other relevant stakeholder organizations.

The TWG, with its multisectoral membership, shall work in close collaboration with other cluster working groups to provide the overall technical oversight and strategic direction to the roll-out and implementation of the SBC Strategy.

The TWG which shall, among other functions:

- Lead the strategic and operational planning for SBC needs of the response;
- Develop the strategic resources needed;
- Help integrate supporting SBC interventions with other thematic tracks of the NSP; and
- Mobilize support and resources for SBC programmes and monitor the compliance to the provisions of the strategy by different stakeholders.

The TWG shall operate as a forum guided by independent, objective and technical interpretation of the NSP and the SBC Strategy by the members. The TWG will also be expected to support the major national SBC data collection and research and the building of an enabling institutional and other enabling environment for effective SBC programmes.

SSAC and/or MoH or other selected TWG member institution shall provide the secretariat to the TWG.

4.4. State and county SBC programmes coordination

The coordination guidelines for the national HIV/AIDS response provide for the multisectoral HIV and AIDS committees at state and county levels and therefore there is no need to form new committees. The state AIDS committees (SACs) and county AIDS committees (CACS) shall select within their membership the SBC subcommittee or task force.

These two committees or their designated subcommittees or task forces shall replicate the functions of the national SBC TWG at the state and county levels. SSAC, with support of the national SBC TWG, shall specifically define the state and county committees' role to ensure effective decentralized planning, coordination and review of SBC programmes at their respective levels.

As part of the operational framework, the SACs and CACs shall develop state and county SBC action plans that shall draw priority SBC interventions, target groups and audiences, messages, communication channels and building of an enabling environment.

4.5. The roll-out and implementation plan

Strategic objective 1: To strengthen the national framework and enabling environment for SBC programming

Currently, South Sudan National HIV and AIDS Response has no SBC strategy since the expiry of the communications strategy expired in 2012. Under the current national response coordination arrangements, the framework to coordinate SBC interventions are through the SSAC coordinated Behavioural Change Communication (BCC) TWG. This working group is, however, not very active and not represented at state and county level. The national response therefore lacks the coherent guiding framework or strategy for SBC interventions.

At the state and county levels, the SACs and the CACs respectively are supposed to steer the SBC programming and interventions. This

is however nearly totally absent because the SACs and CACs are not very functional, and there are no written technical guidelines on how to do this. There is no systematic effort to enhance SBC, guide the development of by-laws to enable this, no sociocultural research to inform advocacy and development of model programmes and conduct to influence desired SBC. These are big programming gaps that the strategy shall address.

To enhance the enabling environment for SBC, the following strategies shall be pursued:

- Strengthened planning framework starting with the development of a national SBC Strategy;
- Sustained advocacy on social and behaviour issues to change the sociocultural normative status, build a conducive legal and policy environment;
- Legal review and policy development; and
- Evidence-informed sociocultural research.

Intended outcome:

- A strengthened framework and enabling environment for SBC communications programming.

Strategy and activities	Target audiences, stakeholders and institutions	Location	2018		2019		2020		Responsible lead institutions
			Quarters		Quarters		Quarters		
			1 and 2	3 and 4	1 and 2	3 and 4	1 and 2	3 and 4	
Strategy 1.1: Strengthening the planning framework for SBC									
1.1.1 Launch and disseminate the national HIV and AIDS Social and Behavioural Change Communication Strategy at national level	Government MDAs, NGOs, FBOs, PLHIV, ADPs, SACs, CACs	National	■						SSAC
1.1.2 Develop HIV and AIDS SBC/IEC materials and support/guiding tools	General and key populations	National							SSAC
1.1.3 Strengthen the national SBC resource centres at MoH and/or SSAC in which all best practice materials are available, appraised before printing and distribution	Programme managers and service providers at national, state and counties and other partners	National	■		■		■		SAC and MoH
1.1.4 Set up or strengthen state- and county-level SBC resource centres at the State Ministry of Health (SMoH) and/or SAC in which all best practice materials are available, appraised before printing and distribution		Counties	■		■		■		SAC and MoH
1.1.5 Develop user-friendly summary versions and disseminate the strategy at state and county levels		National	■						SSAC, sector MDAs and TWGs
1.1.6 Develop national annual operational SBC workplans		National	■		■		■		SSAC

Strategy and activities	Target audiences, stakeholders and institutions	Location	2018 Quarters 1 and 2	2018 Quarters 3 and 4	2019 Quarters 1 and 2	2019 Quarters 3 and 4	2020 Quarters 1 and 2	2020 Quarters 3 and 4	Responsible lead institutions
1.1.7 Develop guidelines on integration of supportive SBC across all the NSP thematic areas	Programme managers and service providers at national, state and counties and other partners	National	■				■		SSAC
1.1.8 Support states and counties to develop annual SBC change action plans		National	■						SSAC, SAC and MoH, SACs, SMoH, NGOs and CBOs, PLHIV associations, networks and coalitions
1.1.9 Widely disseminate SBC/IEC materials and tools to all counties, high transmission areas (HTAs), key populations and all populations of humanitarian concern (PoHC) and emergency setting		National, all states and counties	■		■		■		
1.1.10 Hold quarterly meetings of the SBC TWGs to provide oversight in effective implementation of systematic SBC programmes		National, all states and counties	■	■	■	■	■	■	SSAC, SBC TWG
1.1.11 Conduct and update the mapping of HTAs and locations of key populations to help target SBC programmes		National, all states and counties	■						SSAC, SBC TWG

Strategy and activities	Target audiences, stakeholders and institutions	Location	2018		2019		2020		Responsible lead institutions
			Quarters		Quarters		Quarters		
			1 and 2	3 and 4	1 and 2	3 and 4	1 and 2	3 and 4	
1.1.12 Conduct a national, state and county mapping of SBC programmes in response to HIV and AIDS	Programme managers and service providers at national, state and counties and other partners	National, all states and counties	■	■					SSAC, SBC TWG
1.1.13 Undertake support supervision focusing on SBC in the delivery of HIV and AIDS prevention, care and support to the general population, the PLHIV and other vulnerable key populations		National, all states and counties	■	■	■	■	■	■	SSAC, SBC TWG
1.1.14 Strengthen HIV focal unit in the ministry responsible for gender	Girls and women	National	■	■					SSAC, ministry for gender
1.1.15 Review HIV guidelines with regards to response within PWD	PWD	National	■	■					SSAC
1.1.16 Monitor teacher training and use of IEC materials in school clubs	In-school youth	National and counties	■	■	■	■	■	■	SSAC, Ministry of Education
Strategy 1.2: Sustained advocacy on social and behaviour issues to change the sociocultural normative status and build a conducive legal and policy environment									
1.2.1 Set up a national high-level multisectoral, multi-disciplinarian, multi-professional, multicultural, multi- or inter-religious, multi-political task force of HIV prevention and care advocates	Political, religious, cultural, military leaders, service providers	National	■	■					SSAC, SBC TWG

Strategy and activities	Target audiences, stakeholders and institutions	Location	2018 Quarters 1 and 2	2018 Quarters 3 and 4	2019 Quarters 1 and 2	2019 Quarters 3 and 4	2020 Quarters 1 and 2	2020 Quarters 3 and 4	Responsible lead institutions
1.2.2 Set up advocacy task forces on HIV prevention and care advocates in all states	Political, religious, cultural, military leaders, service providers	All states and counties	■	■					SSAC, SBC TWG, SAC, SMoH, CAC
1.2.3 Train the task forces and equip them with advocacy tools			■	■					SSAC, SBC TWG
1.2.4 Develop HIV and AIDS SBC advocacy action plan and tools, identify advocacy issues, publicize core advocacy messages and advocate to attain desired enabling environment and changes			■	■					SSAC, SBC TWG
1.2.5 Conduct advocacy campaign targeting national state and county, cultural, religious, military and other leaders and win them over as advocates and role models for behavioural change, to facilitate community dialogue and action to shift norms, including through use of participatory methods		All states		■	■	■	■	■	SSAC, SBC TWG
1.2.6 Engage traditional, religious, political, business and cultural leadership in HIV prevention at decentralized levels			■	■	■	■	■	■	SSAC, SBC TWG, MDAs, NGOs, SMoH, SAC

Strategy and activities	Target audiences, stakeholders and institutions	Location	2018		2019		2020		Responsible lead institutions
			Quarters		Quarters		Quarters		
			1 and 2	3 and 4	1 and 2	3 and 4	1 and 2	3 and 4	
1.2.7 Establish capacity-building and economic empowerment programmes/networks as alternative IGAs for young girls, MSM, PLHIVs and key populations to reduce transactional fuelled cross-generational/disparate sex	Young girls, MSM, PLHIVs and key populations	All states	■		■		■		SSAC, MDAs, SBC TWG, NGOs
Strategy 1.3: Legal and policy reviews and development									
1.3.1 Review the relevant HIV prevention care and support laws and policies to identify those not supportive of the desired SBC as per the SBC Strategy	Leaders, programme managers and service providers at national, state and counties		■						SSAC, SBC TWG
1.3.2 Develop alternative SBC supportive legal and policy briefs for the different enabling policy scenario and adopt those contextually relevant				■	■				
1.3.3 Develop policy guidelines to enhance the take-up of the new and existing laws and policies supportive of SBC while discouraging the prohibitive ones					■				
1.3.4 Carry out legal literacy sessions for policymakers and all relevant leaders, programme managers and service providers and the general public					■	■			

Strategy and activities	Target audiences, stakeholders and institutions	Location	2018 Quarters 1 and 2	2018 Quarters 3 and 4	2019 Quarters 1 and 2	2019 Quarters 3 and 4	2020 Quarters 1 and 2	2020 Quarters 3 and 4	Responsible lead institutions
1.3.5 Support all states and counties to develop and pass the necessary by-laws to implement the new legal and policy framework in their decentralized mandate					■	■			SSAC, SBC TWG
1.3.6 Monitor and enforce compliance of the programme managers and service providers to the new legal and policy framework					■	■	■	■	
Strategy 1.4: Evidence-informed sociocultural and behavioural research									
1.4.1 Establish an SBC change research task force and support it to document best practices in SBC, develop SBC component of the national HIV and AIDS research agenda and develop a resource mobilization plan		National, all states and counties		■		■			SSAC, SBC TWG
1.4.2 Support all states to undertake sociocultural and behavioural research to identify the social, cultural and behavioural norms and practices that have a bearing to HIV prevention care, treatment and support		All states		■		■			
1.4.3 Support the states and counties to develop action plan to strengthen the SBC environment with respect to the sociocultural and behavioural fabric documented by the research		All states	■	■					

Strategy and activities		Target audiences, stakeholders and institutions	Location	2018		2019		2020		Responsible lead institutions
				Quarters		Quarters		Quarters		
				1 and 2	3 and 4	1 and 2	3 and 4	1 and 2	3 and 4	
1.4.4	Undertake biannual client exit surveys at HIV prevention, care and treatment facilities to inform SBC programming		All states	■	■	■	■	■	■	MoH, SMoH
1.4.5	Undertake assessment on links and effects of new and emerging medical interventions and prevention technologies on sexual behaviours to inform planning		All states		■					MoH, SMoH
1.4.6	Conduct specific behavioural surveys/ KAP surveys (including focus on norms and practices; unintended consequences of messages, brands and products; basis of an evidence-informed behaviour change plan)		National, all states and counties	■			■			SSAC, SBC TWG
1.4.7	Conduct annual review/assessment on effectiveness of the NSP SBC		All states		■		■		■	SSAC, SBC TWG
1.4.8	Conduct regular national and subnational performance review meetings with key players				■		■		■	SSAC, SBC TWG

Strategic objective 2: To increase knowledge on HIV transmission, prevention and reduction of related risky sexual, social and cultural practices among the general and key populations

Knowledge is critical in affecting the desired SBC. By 2011, only one third (30%) of young women and men aged 15–24 in South Sudan could correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (SSAC, NSP 2013). The strategic plan also indicates that as high as one third of young women (30.5% of 15–24 years) and nearly one half of the youth (40.8% of 15–24 years) had had sexual intercourse by the age of 15. Data was also not available on most of the other key indicators on multiple sexual partnerships and use of condom in the previous 12 months.

A number of sociocultural practices are also likely to be increasing the risk to HIV transmission. These include the following: (a) cultural body scarification (tribal marks) usually on the face/forehead using shared instruments in non-sterile settings; (b) removal of fore teeth; (c) booking of brides at/or even before birth; (d) intertribal/clan compensation by way of giving away brides; (e) wife inheritance by younger brother or in-laws upon death of a husband; (f) abated early sexual debut/activity and early marriages (such as *kasurabate* in Yambio); (g) socially sanctioned elopement at marriage (convoy); (h) forced marriages; (i) arranged marriages; and (j) taboo on open discussion on sexuality and polygamy. In pursuit of an improved social normative, the SBC strategy may not have to change all the sociocultural practices but shall seek to make them safer or not risky.

The following shall be the intended outcomes:

- Increased knowledge on HIV prevention
- Reduction in multiple sexual partners
- Reduction in wide age-disparate sex
- Increased utilization of condoms in non-regular sexual partnerships

- Increased personal risk perceptions on multiple partnerships, condom use and age-disparate sex
- Reduction in the prevalence of harmful or risky social and cultural practices among the general and key populations
- Increased availability of mass media IPC on HIV prevention, care and treatment among the general and key population

To attain these outcomes, the following strategies shall be adopted:

- Mass media communication
- IPC
- Social media
- Community mobilization and dialogue
- Traditional and folk media, songs and drama
- Use of role models
- Edutainment, contests and concerts
- CSE
- Multipurpose one-stop drop-in information and service centres for key and vulnerable populations

Strategy and activities		Target audiences, stakeholders and institutions	Location	2018 Quarters 1 and 2	2018 Quarters 3 and 4	2019 Quarters 1 and 2	2019 Quarters 3 and 4	2020 Quarters 1 and 2	2020 Quarters 3 and 4	Responsible lead institutions
Strategy 2.1 Mass media communication										
2.1.1	Develop mass media campaign plans based on research and the overall SBC plans	Programme managers and service providers		■	■					SSAC, SBC TWG, National Media Council
2.1.2	Produce print materials and electronic media campaigns (including radio, television and Internet and/or mobile phone elements)	Programme managers and service providers		■	■					SSAC, MoH
2.1.3	Place media products through accessible outlets including radio, television and new media (as appropriate for the target populations)	Programme managers and service providers		■	■					SSAC, MoH
2.1.4	Train journalists and media producers on HIV prevention and establish a network of HIV prevention experts in the media sector	Journalists		■	■					SSAC, SBC TWG, National Media Council
2.1.5	Conduct a multimedia campaign focusing on risk perception, abstinence, faithfulness, condom use, cross-generational sex, transactional sex, partner reduction and knowing one's HIV status	General population, young people, younger women and older men	All states	■		■		■		SSAC, SBC TWG, National Media Council

Strategy and activities	Target audiences, stakeholders and institutions	Location	2018		2019		2020		Responsible lead institutions
			Quarters		Quarters		Quarters		
			1 and 2	3 and 4	1 and 2	3 and 4	1 and 2	3 and 4	
2.1.6 Conduct mass media campaign and dialogue at community level on PMTCT, including male involvement and male responsibility addressing the high risk of a newly infected man passing on HIV and AIDS to the mother and baby		All states	■		■		■		SSAC, SBC TWG, National Media Council
Strategy 2.2. Use of role models									
2.2.1 Develop an implementation role model SOPs and tools for IPC	General population	All states	■	■					SSAC, SBC TWG, National Media Council
2.2.2 Secure media coverage for popular opinion leaders who are prevention advocates and role models	Media houses and opinion leaders		■	■	■	■	■	■	SSAC, SBC TWG, National Media Council
2.2.3 Develop a media campaign with role models on faithfulness, television dramas and radio programmes; performing arts (role play, theatre, drama, music), focus on involvement of male role models (e.g. soccer stars)	Men 24–49 years old, women 15–49 years old	All states	■		■		■		SSAC, SBC TWG, National Media Council
2.2.4 Establish role model and dialogue programme in all states to support SBC and break stigma	General and key populations	All states							SSAC, MoH, SBC TWG, NGOs, SAC, SMoH, CAC, CMoH

Strategy and activities		Target audiences, stakeholders and institutions	Location	2018 Quarters 1 and 2	2018 Quarters 3 and 4	2019 Quarters 1 and 2	2019 Quarters 3 and 4	2020 Quarters 1 and 2	2020 Quarters 3 and 4	Responsible lead institutions
Strategy 2.3 CSE in and out of schools targeting young people										
2.3.1	Review and update national CSE curricula	Education managers, teachers, in-school children and youth		■	■					SSAC, MoH, MOE, NGOs
2.3.2	Production of communication and advocacy materials for in-school CSE				■					SSAC, MoH, MOE, NGOs
2.3.3	Train teachers and youth in life-skills based HIV and AIDS education		All primary and secondary schools and tertiary institutions	■		■		■		SSAC, MoH, MOE, NGOs
2.3.4	Roll out parent–child communication engagement and communication programmes through schools, community and youth centre discussion events	Parents, children and youth	All states	■	■	■	■	■	■	SSAC, MoH, SBC TWG, NGOs, SAC, SMoH, CAC, CMoH

Strategy and activities		Target audiences, stakeholders and institutions	Location	2018 Quarters 1 and 2	2018 Quarters 3 and 4	2019 Quarters 1 and 2	2019 Quarters 3 and 4	2020 Quarters 1 and 2	2020 Quarters 3 and 4	Responsible lead institutions
2.3.5	Support the establishment and functioning of regular meeting points for vulnerable young people at existing community structures (e.g. youth centres and youth-friendly afternoons at health facilities, churches, community centres), in-school anti-AIDS clubs and girls' education support clubs, provision of BC materials, skills-building, lay counselling and support	Youth		■		■		■		SSAC, MoH, SBC TWG, NGOs, SAC, SMoH, CAC, County Ministry of Health (CMoH)
2.3.6	Establish and support educational and entertaining social media platforms of SRH for young people			■		■		■		
2.3.7	Support in- and out-of-school youth contests and concerts with SRH messages through music, poems, drama, sports and music			■		■		■		
Strategy 2.4: Networks and multipurpose drop-in centres for key and vulnerable populations										
2.4.1	Establish multipurpose one-stop drop-in information and service centres along the main transit routes and hotspots for the cross-border and mobile populations	Cross-border and other mobile population	Transit routes and hubs	■		■		■		SSAC, MoH, NGOs, SAC, SMoH, CAC, CMoH

	Strategy and activities	Target audiences, stakeholders and institutions	Location	2018 Quarters 1 and 2	2018 Quarters 3 and 4	2019 Quarters 1 and 2	2019 Quarters 3 and 4	2020 Quarters 1 and 2	2020 Quarters 3 and 4	Responsible lead institutions
2.4.2	Establish networks of condom-friendly spots to reach the PLHIV, youth, sex workers and other key populations	Youth, PLHIV, Sex workers	Sex workers and other key populations	■		■				SSAC, MoH, NGOs, SAC, SMoH, CAC, CMoH
2.4.3	Develop SBC supporting networks between the transporters associations, MSM, leisure establishments industry and health service providers focusing on HIV prevention and care	Transporters associations, MSM, leisure industry providers	All states	■		■		■		SSAC, MoH, ministries responsible for trade and tourism, NGOs, SAC, SMoH, CAC, CMoH
2.4.4	Develop networks of boda boda riders and youth drop-in centres as focus for SBC interventions including SBC/IEC materials distribution to HTA, key and general populations	Boda boda riders and youth	All states	■		■				SSAC, MoH, SBC TWG, NGOs, SAC, SMoH, CAC, CMoH
2.4.5	Train youth, IDPs, uniformed forces, MSM and sex workers peer facilitators to provide support aimed at improving safe sex practices	Youth, IDPs, uniformed forces, MSM, sex workers, peer educators	All states	■		■		■		SSAC, MoH, SBC, TWG, NGOs, SAC, SMoH, CAC, CMoH

Strategy and activities		Target audiences, stakeholders and institutions	Location	2018 Quarters 1 and 2	2018 Quarters 3 and 4	2019 Quarters 1 and 2	2019 Quarters 3 and 4	2020 Quarters 1 and 2	2020 Quarters 3 and 4	Responsible lead institutions
Strategy 2.5: Community mobilization and dialogue										
2.5.1	Conduct community dialogue on the negative and risky sociocultural practices integrated in community-level dialogue and action planning processes	Community leaders	All states		■		■		■	SSAC, MoH, SBC TWG, NGOs, SAC, SMoH, CAC, CMoH
2.5.2	Hold advocacy meetings with employers to minimize spousal separation	Employers		■	■					SSAC, MoH, Ministry of Labour, Labour council/ federation/ association
2.5.3	Identify potential key behavioural change agents in each county and advocacy with county authorities and community leadership on behavioural change promotion	Leaders, married and young people in general population	All states		■	■				SSAC, MoH, NGOs, SAC, SMoH, CAC, CMoH, SSNEP+ and other PLHIV networks

	Strategy and activities	Target audiences, stakeholders and institutions	Location	2018 Quarters 1 and 2	2018 Quarters 3 and 4	2019 Quarters 1 and 2	2019 Quarters 3 and 4	2020 Quarters 1 and 2	2020 Quarters 3 and 4	Responsible lead institutions
2.5.4	Strengthen the capacity of states and county SAC and CAC members, support organizations through organizational development and training, and train FBOs, NGOs and other key stakeholders in promotion of behavioural change	Leaders, married and young people in general population	All states		■	■				SSAC, MoH, NGOs, SAC, SMoH, CAC, CMoH, SNEP+ and other PLHIV networks
2.5.5	Conduct community mobilization through trained behavioural change agents (supported state and county SBC support organizations) based on the state and county action plans, focus on risk reduction, GBV, PEP, ECP access to testing, counselling and treatment	Peer educators and all sexually active community members	All states	■		■		■		SSAC, MoH, NGOs, SAC, SMoH, CAC, CMoH, SNEP+ and other PLHIV networks
Strategy 2.6: Mainstreaming SBC in all prevention, care and support programmes										
2.6.1	Develop SOP for mainstreaming SBC into prevention, treatment and care service provision	Health facilities, NGOs, CBO distributors, peer educators	All states	■	■					SSAC, MoH, SSNEP+, National Empowerment of Positive Women United (NEPWU)
2.6.2	Mainstream SBC in all prevention, care and support programmes	Health facilities, NGOs, CBO distributors, peer educators	All states	■	■					SSAC, MoH, SSNEP+, NEPWU

Strategic objective 3: To promote health-seeking behaviour and uptake for high-impact interventions for prevention of HIV and related opportunistic infections; care and treatment; and SRH services

The formative assessment that follows indicates low levels of treatment literacy. This was largely due to stigma and very limited information and interaction between health providers and the general population. There was very limited literacy on the role that treatment can play in prevention, in efficacy of condoms, PEP and PREP. As a result, limited proportions of the population do actively seek services even where they exist free of charge, such as TB and STI diagnosis and treatment.

The SBC strategy seeks to attain increased demand and uptake of high-impact interventions for prevention of HIV and related opportunistic infections and care and treatment among the general and key populations. The following strategies shall be adopted:

- Prevention and treatment literacy outreach;
- Networks for service delivery and referral; and
- Quality monitoring and policy review.

Strategy and activities	Target audiences, stakeholders and institutions	Location	2018		2019		2020		Responsible lead institutions
			Quarters		Quarters		Quarters		
			1 and 2	3 and 4	1 and 2	3 and 4	1 and 2	3 and 4	
Strategy 3.1: Prevention and treatment literacy outreach									
3.1.1 Conduct health education outreach programme to communities and organized populations of interest, including the youth in schools, IDPs, uniformed services, male-dominated trades and workplaces, such as factories and sports arena	Youth in schools, IDPs, uniformed services, men	All states	■	■	■	■	■	■	SSAC, MoH, SBC TWG, NGOs, MOE, other MDAs, SAC, SMoH, CAC, CMoH, SNEP+ and other PLHIV networks
3.1.2 Support a campaign with mass media, edutainment, social media for young people, peer educators in general and key populations, male involvement to raise personal risk perception, benefits of early testing, treatment literacy focusing on availability and sources of free and yet high-impact/efficacious services, quick access, confidential access, non-judgemental including the testing, opportunistic infections treatment and ART among the general and key populations	General and key populations	All states	■		■		■		SSAC, MoH, SBC TWG, National Media Council

Strategy and activities		Target audiences, stakeholders and institutions	Location	2018		2019		2020		Responsible lead institutions
				Quarters		Quarters		Quarters		
				1 and 2	3 and 4	1 and 2	3 and 4	1 and 2	3 and 4	
Strategy 3.2: Networks for service delivery and referral										
3.2.1	Establish service access networks and referral systems between the health facilities and key population groups of interest, including sex workers, youth, MSM and IDPs	Sex workers, youth, MSM, IDPs	All states	■	■					SSAC, MoH, SBC TWG, NGOs, MOE, other MDAs, SAC, SMoH, CAC, CMoH, SNEP+ and other PLHIV networks
3.2.2	Establish linkages between service delivery facilities to enhance referral and service uptake	Sexually active population	All states	■		■		■		As above
3.2.3	Establish a country-wide electronic patient database or patient identification system with unique identifiers to minimize service dropouts and increase uptake in the current context of displaced populations	All HIV prevention, care and treatment clients		■	■					SSAC, MoH, SBC TWG, NGOs, SNEP+, NEPWU
3.2.4	Facilitate collaboration between health and non-health sectors in providing outreach and matching demand generation and supply at decentralized levels		All states							SSAC, MoH, SBC TWG, NGOs, SNEP+, NEPWU

Strategy and activities	Target audiences, stakeholders and institutions	Location	2018		2019		2020		Responsible lead institutions
			Quarters		Quarters		Quarters		
			1 and 2	3 and 4	1 and 2	3 and 4	1 and 2	3 and 4	
3.2.5 Establish public–private partnerships to increase the reach and frequency of prevention messages and access to products and services		All states							SSAC, MoH, SBC TWG, NGOs, SNEP+, NEPWU
Strategy 3.3: Quality monitoring and policy review									
3.3.1 Monitor and evaluate social and behaviour change and share the results across similar projects for learning and increased accountability		All states							SSAC, MoH, SBC TWG, NGOs
3.3.2 Conduct reviews of policy and legal barriers to the uptake of HIV prevention services and safer sexual practices (including among youth)		All states							SSAC, MoH, SBC TWG, NGOs

Strategic objective 4: To increase knowledge and promote positive behaviour among health service providers, uniformed services personnel and other auxiliary service providers on the HIV and opportunistic infection prevention, care and treatment and reproductive health needs of vulnerable and key populations

To a significant number of young people and key populations, some of the service providers are not caring enough. A number of young people, FSWs, MSM, IDPs and migrant workers expressed the feeling of not being welcome and guilty of their lifestyles and status based on how some service providers handle them. This institutionalized stigma and deliberate exclusion has kept them away from health-seeking behaviours and thus, more risk prone and more vulnerable.

The SBC strategy seeks to attain this result:

- Improved service delivery to key populations

The following shall be the key strategies:

- Advocacy with the leadership and programme management of health service providers and uniformed services personnel; and
- Training of service providers.

Strategy and activities		Target audiences, stakeholders and institutions	Location	2018		2019		2020		Responsible lead institutions
				Quarters		Quarters		Quarters		
				1 and 2	3 and 4	1 and 2	3 and 4	1 and 2	3 and 4	
Strategy 4.1: Advocacy with the leadership and programme management of health service providers and uniformed services personnel										
4.1.1	Hold advocacy meetings with the MoH and health facilities to establish modalities on how to best serve the needs of the key populations	Programme managers and service providers at national, state and counties, key populations	National	■	■					MoH, SSAC, SBC TWG, NGOs
4.1.2	Hold advocacy meetings with topmost leaders of uniformed services on how to manage the needs of the PLHIV, key populations and health facilities to establish modalities on how to best serve the needs of the key populations	Uniformed services, HIV and AIDS Secretariat	All states	■		■		■		MoH, SSAC, SBC TWG, NGOs
4.1.3	Support establishment of networks and joint service planning between service providers and networks of PLHIV	Programme managers and Service providers at national, state and counties, key populations and PLHIV		■	■	■	■	■	■	MoH, SSAC, SBC TWG, NGOs
4.1.4	Establish referral systems for key populations to enhance fast/less bureaucratic service access			■	■	■	■	■	■	

Strategy and activities		Target audiences, stakeholders and institutions	Location	2018		2019		2020		Responsible lead institutions
				Quarters		Quarters		Quarters		
				1 and 2	3 and 4	1 and 2	3 and 4	1 and 2	3 and 4	
Strategy 4.2: Training										
4.2.1	Train health service providers on the HIV prevention, care and support service needs packages of the key populations with specific focus on PLHIV, youth, sex workers and MSM	Programme managers and service providers at national, state and counties	All states	■		■		■		SSAC, MoH, SBC TWG, NGOs
4.2.2	Conduct refresher training health service providers in communication and counselling skills and handling of PLHIV, sex workers and MSM	PLHIV, sex workers and MSM	All states	■		■		■		MoH, SSAC, SBC TWG, NGOs
4.2.3	Establish adolescent- and youth-friendly sexual and reproductive health service provision	Adolescent and youth	All states							MoH, SSAC, SBC TWG, NGOs
4.2.4	Support functioning linkages between the standard health facilities, youth centres and drop-in centres for the young MSM and MSM	Youth MSM and MSM	All states	■		■		■		MoH, SSAC, SBC TWG, NGOs

Strategy and activities		Target audiences, stakeholders and institutions	Location	2018		2019		2020		Responsible lead institutions
				Quarters		Quarters		Quarters		
				1 and 2	3 and 4	1 and 2	3 and 4	1 and 2	3 and 4	
4.2.5	Train uniformed services: SPLA leadership, police leadership, immigration police/workers on the HIV prevention, care and support service needs packages of the key populations with specific focus on PLHIV, youth, sex workers, MSM; handling of PLHIV and general management of stigma, discrimination and denial; importance of supporting service access for key populations.	Uniformed services HIV and AIDS Secretariat	All states	■		■		■		MoH, SSAC, SBC TWG, NGOs

Strategic objective 5: To reduce HIV-related SDD at individual, interpersonal, community and institutional levels

Stigma, denial and discrimination are very prohibitive to prevention, care and support efforts. SDD happens at nearly all levels of society: personal (in form of denial), at family, community and institutional levels. All categories of priority populations met during the assessment have faced stigma related to HIV. The deeply rooted sociocultural norms and attitudes that make talking about sex a taboo, coupled with high levels of ignorance in a weak regulatory environment, have sustained SDD.

The SBC strategy seeks to cause the following results:

- Reduced HIV-related SDD at individual, interpersonal, community and institutional levels; and
- Increased human rights protection and rights sensitive service delivery to access for both the general and key populations seeking service.

The SBC strategy shall adopt the following strategies to fight stigma:

- Advocacy;
- Empowerment of PLHIV;
- Development and adoption of service delivery and workplace operational guidelines; and
- Greater involvement of PLHIV.

Strategy and activities	Target audiences, stakeholders and institutions	Location	2018		2019		2020		Responsible lead institutions
			Quarters		Quarters		Quarters		
			1 and 2	3 and 4	1 and 2	3 and 4	1 and 2	3 and 4	
Strategy 5.1: Advocacy									
5.1.1 Conduct advocacy meetings and workshops with all categories of leaders to support access to treatment and prevention services by PLHIV	General and key populations	All states	■	■		■		■	SSAC, MoH, SBC TWG, NGOs, PLHIV networks
5.1.2 Conduct advocacy meetings and workshops with employers to create enabling working environments in workplace, which allow for PLHIV to access services and even be open about their status			■	■	■	■	■	■	
5.1.3 Support the establishment of support groups in all the *bomas*									
Strategy 5.2: Greater involvement of persons living with HIV and empowerment									
5.2.1 Establish role model and dialogue programme in all states to support SBC and break stigma	General and key populations	All states	■	■			■	■	SSAC, MoH, SBC TWG, NGOs, PLHIV networks
5.2.2 Organize training-of-trainers (ToTs) for PLHIV in HIV prevention, stigma reduction and behaviour change and set up pools of trainers in each county	PLHIV	National	■	■		■	■		SSAC, MoH, SBC TWG, NGOs, PLHIV networks

Strategy and activities		Target audiences, stakeholders and institutions	Location	2018		2019		2020		Responsible lead institutions
				Quarters		Quarters		Quarters		
				1 and 2	3 and 4	1 and 2	3 and 4	1 and 2	3 and 4	
5.2.3	Develop and roll out campaigns on stigma reduction using the PLHIV ToT, with youth peer educators	PLHIV, youth	All states	■	■		■	■		SSAC, MoH, SBC TWG, NGOs, PLHIV networks
5.2.4	Involvement of PLHIV in HIV prevention and care programmes at all levels	PLHIV	All states	■	■	■	■	■	■	SSAC, MoH, SBC TWG, NGOs, PLHIV networks
5.2.5	Support IGAs for persons living with HIV			■	■	■	■	■	■	
Strategy 5.3: Development and enforcement of SOPs and guidelines										
5.3.1	Develop operational guidelines for uniformed services (in SPLA, all prisons and cells, border and urban law enforcement officers) for stigma reduction in provision of HIV and AIDS prevention, care and support to the PLHIV and other vulnerable key populations	Programme managers and service providers at national, state and counties	National	■	■					SSAC, MoH, SBC TWG, NGOs, PLHIV networks, uniformed forces
Strategy 5.4: Training of service providers and other caregivers										
5.4.1	Train uniformed services: SPLA leadership, police leadership, immigration police/workers on the needs of key populations with specific focus on PLHIV, youth, sex workers, MSM; handling of PLHIV and general management of stigma, discrimination and denial	Uniformed services HIV and AIDS Secretariat	National		■	■				SSAC, MoH, SBC TWG, NGOs, PLHIV networks, uniformed forces

Section 5: Social and behaviour change capacity-building plan

5.1. Introduction

The effective roll-out and implementation of the National Social and Behavioural Change Strategy for HIV prevention, AIDS treatment, care and support requires different categories for its resources.

Section five of the strategy outlines the following: (a) different capacity and competency needs; (b) objectives of a capacity development plan to effectively and sustainably meet needs; (c) different methods, approaches and strategies proposed to build this capacity and competencies; (d) direct beneficiaries; and (e) roll-out plan. It must be noted that the formative assessment for the development of the strategy was too rapid to assess in detail the different capacity gap analysis.

Nevertheless, the rapid formative assessment undertaken at the national, state and county programme levels involved consultations with a multitude of stakeholders, partners and HIV response beneficiaries; the key capacity gaps and needs have been identified and contextually analysed to inform the formulation of the needed capacity development plan.

5.2. Capacity needs

The capacity needs for the development and implementation of an SBC programme as part of the national HIV and AIDS response in South Sudan can be categorized under the following four capacity categories:

- Strategic;
- Human resource;
- Institutional and organizational; and
- Financial resource.

(a) Strategic capacity needs: The gaps or limitations in the approaches to bring about the desired behavioural changes needed for HIV prevention, care and support. The gaps in the strategic capacity include:

(i) Lack of a homegrown evidence-informed theory of change. This is due to inadequate sociocultural and market research to inform the theoretical framework behavioural theory of change.

(ii) Lack of strategies, plans and standardized tools for the advocacy, communication, organizational and institutional structuring, legal and policy frameworks.

(b) Human resource needs: The human resource capacity gaps include the following: (i) inadequate mobilization, building and deployment of the needed critical minimum numbers and technical mix to effectively undertake the sociocultural and market research; (ii) advocacy; (iii) mass and interpersonal communication; (iv) organizational and institutional development; (v) sustained political leadership and management governance (largely due to instability); and (vi) timely needed legal and policy reviews and enactment and formulation to create the enabling environment for SBC for the HIV response.

(c) Institutional and organizational capacity gaps: The national HIV and AIDS response has not built to the desired levels of functionality the much-needed multisectoral and decentralized institutional and organizational landscape for coherent evidence-informed planning, execution, implementation, coordination, monitoring and sustained quality assurance of SBC interventions.

(d) Financial capacity: The national HIV response is largely underfunded and the SBC programmes are no exceptions. Even when the institutional and organizational, human resource and strategic capacities have been in place, not enough financial and material resources have been available to have SBC interventions roll out and thus the coverage has been very inadequate.

5.3. Capacity-building objectives

The capacity-building component of the SBC strategy shall have the following objectives:

(a) Develop and strengthen the strategic resources for the development, implementation, monitoring and evaluation of contextually relevant and evidence-informed SBC interventions.

(b) Build and mobilize adequate human resource numbers, quality, competencies and technical mix that is needed for the development and implementation of the prioritized SBC interventions.

(c) To strengthen the institutional and organizational landscape for effective planning, coordination, implementation, monitoring, quality assurance and evaluation of the SBC programmes and interventions.

(d) To strengthen the systemic capacity to mobilize the needed financial and material resources for the SBC programmes.

5.4. Capacity-building strategies

The following capacity-building strategies shall be adopted:

Capacity category	Key capacity elements/areas	Strategies/Methods
Strategic	▪ Evidence-informed SBC theory of change framework ▪ Sociocultural and market research ▪ Advocacy models and tools ▪ Standardized tools for mass communication models and campaigns ▪ Models and standardized tools for IPC ▪ Enabling and legal and policy frameworks and environment	▪ Participatory development of the SBC strategy, tools, guidelines and frameworks ▪ Acquire the available SBC theoretical frameworks, guidelines, tools and SOP from credible sources – technical/development partners and other countries with similar settings and customize them to the South Sudan context
Human resource	▪ Sociocultural and market research ▪ Programme planning ▪ Advocacy ▪ Mass media communication experts ▪ IPC experts ▪ Community mobilization ▪ Leadership skills ▪ SBC/IEC materials development expertise	▪ Identification and using the already available and technically competent human resources in the localities and sectors of interest ▪ **Temporary outsourcing:** Structured and performance-based temporary sourcing from partner organizations from within and out of South Sudan; from other states in South Sudan; from other countries paired with under studying national/host institutional counterparts ▪ **Training workshops and courses:** Skills development through participatory training workshops and courses focused on the in-service participatory workshops

Capacity category	Key capacity elements/areas	Strategies/Methods
Human resource	▪ Counselling skills, relationship counselling ▪ Psychosocial support ▪ Organizational and institutional development ▪ Political leadership ▪ Policymaking and analysis ▪ Leadership and governance ▪ Programme management ▪ Monitoring, quality assurance, reviews and evaluation ▪ Life skills development ▪ Livelihood and entrepreneurship skills development ▪ Training and facilitation skills for young, adult and multidisciplinary/stakeholder training and facilitation skills	▪ **Mentorship:** Structured and performance-based mentorship. This could be linked online or shared work time or extended attachments. ▪ **Study tours:** Study tours and benchmarking studies (local or external) ▪ **Twining:** Structured and performance-based twinning between organizations (including government MDAs at national, state and county levels; NGOs, CBOs, PLHIV and other networks or associations, youth centres) networks) at different capacity and performance ▪ **Advocacy:** Intensive, highly engaging and sustained advocacy for the political, military and other civil persons, religious persons, other influential persons and policymakers who can influence the normative and enabling environment settings
Institutional and organizational	▪ Organizational and institutional model and templates ▪ Partnerships and network management models and tools	▪ Participatory Organizational Capacity Self-Assessment ▪ Partnership and network development ▪ Programme synergy development and management

Capacity category	Key capacity elements/areas	Strategies/Methods
Financial and material resources	Financial and material resources for: ▪ Enabling environment strengthening ▪ Programme management ▪ Capacity development: Strategic, human resource and institutional/ organizational development and functioning ▪ Service delivery for SBC: Community mobilization, SBC/IEC materials development, communication/message delivery/transmission, advocacy	▪ Fundraising ▪ Funding and resource management mechanisms ▪ Efficient utilization, enhancing allocative efficiency, value for money, resource recovery and other sustainable financing and resourcing models ▪ Equitable financing

5.5. Capacity-building roll-out plan

(a) To develop and strengthen the strategic resources for the development, implementation, monitoring and evaluation of contextually relevant and evidence-informed SBC interventions.

Strategy and activities	Beneficiaries/ Targets	Location	2018		2019		2020		Responsible lead institutions
			Quarters		Quarters		Quarters		
			1 and 2	3 and 4	1 and 2	3 and 4	1 and 2	3 and 4	
Undertake a rapid assessment of the available advocacy, mass communication, IPC models and tools	SSAC, MoH, MDAs, state and counties and partner NGOs and ADPs	National	■						SSAC, MoH, MDAs, media council, universities and research institutions, consultancy firms, NGOs
Develop advocacy models and tools			■						
Develop mass media engagement strategy and plan, standardized tools for mass communication models and campaigns			■						
Develop models and standardized tools for IPC			■						
Review the legal and policy frameworks and propose changes to create enabling environment			■						
Advocate and follow up the adoption of the needed legal and policy framework changes and execution guidelines to be operational			■	■	■	■			SSAC, MoH, MDAs, media council

Strategy and activities	Beneficiaries/ Targets	Location	2018		2019		2020		Responsible lead institutions
			Quarters		Quarters		Quarters		
			1 and 2	3 and 4	1 and 2	3 and 4	1 and 2	3 and 4	
Print the legal and policy framework changes and execution guidelines; advocacy models and tools; mass media engagement strategy and plan; standardized tools for mass communication models and campaigns; models and standardized tools for IPC	SSAC, MoH, MDAs, state and counties and partner NGOs and ADPs	National	■						SSAC, MoH, MDAs South Sudan Media Council
Hold a national ToT workshop for the selected service providers and programme managers from government MDAs and all states on the following: (i) legal and policy framework changes and execution guidelines; (ii) advocacy models and tools; (iii) mass media engagement strategy and plan; (iv) standardized tools for mass communication models and campaigns; and (v) models and standardized tools for IPC	SSAC, MoH, MDAs, national and state-based NGOs	National	■						SSAC, MoH, MDAs, media council
Conduct 10 training workshops (one in each of the previous 10 states) for selected service providers and programme managers from all states on legal and policy framework changes and execution guidelines; advocacy models and tools; mass media engagement strategy and plan; standardized tools for mass communication models and campaigns; models and standardized tools for IPC	SSAC, SMoH, state- and county-based NGOs and CBOs	State	■	■					SSAC, MoH, MDAs, media council, NGOs

Strategy and activities	Beneficiaries/ Targets	Location	2018		2019		2020		Responsible lead institutions
			Quarters		Quarters		Quarters		
			1 and 2	3 and 4	1 and 2	3 and 4	1 and 2	3 and 4	
Annually assess the legal and policy enabling environment and the uptake, user-friendliness, continued relevance of the standardized models and tools for advocacy, mass communication and IPC	SSAC, MoH, MDAs, NGOs and CBOs	National	■		■		■		SSAC, MoH, MDAs, media council
Hold an annual meeting to review the strategic coherence and roll-out of the SBC capacity-building plan		National	■	■	■	■	■	■	

(b) To build adequate numbers, quality, competencies and technical mix of the human resources needed for the development and implementation of the prioritized SBC interventions.

Strategy and activities	Beneficiaries/ Targets	Location	2018		2019		2020		Responsible lead institutions
			Quarters		Quarters		Quarters		
			1 and 2	3 and 4	1 and 2	3 and 4	1 and 2	3 and 4	
Develop a SBC human resource capacity-building training course based on the assessment and roll-out plan	SSAC, MoH, MDAs, NGOs, PLHIV, ADPs	National	■						SSAC, MoH, SBC TWG, MDAs, media council
Conduct a one-week (5 days) national ToT workshop on SBC programme planning and management (2 trainers from each state, one from the government and one from a local CBO/NGO, plus 10 more from the MDAs and national NGOs)	SSAC, MoH, MDAs, NGOs, PLHIV	National	■						SSAC, MoH, SBC TWG
Conduct 10 one-week (5 days) state workshops on SBC programme planning and management (2 trainers from each county, 1 from county administration and 1 from local CBO/NGO, plus 10 more from the MDAs and national NGOs)	SSAC, MoH, SAC, SMoH, SMDAs, PLHIV networks, state- and county-based NGOs and CBOs	10 states	■	■					SSAC, MoH, SBC TWG
Undertake annual refresher workshops			■		■		■		SSAC, MoH, SBC TWG

Strategy and activities	Beneficiaries/ Targets	Location	2018 Quarters 1 and 2	2018 Quarters 3 and 4	2019 Quarters 1 and 2	2019 Quarters 3 and 4	2020 Quarters 1 and 2	2020 Quarters 3 and 4	Responsible lead institutions
Maintain a register or database on the available SBC-related experts as informed by both the assessment and those trained	SSAC, MoH, MDAs	National	■	■	■	■	■	■	SSAC, MoH, SAC, SMoH, PLHIV networks
Develop and support a structured and performance-based mentorship scheme	SSAC, MoH, SAC, SMoH, SMDAs, PLHIV networks, state- and county-based NGOs and CBOs	National	■		■		■		SSAC, MoH, SBC TWG
Develop and support structured and performance-based study tours and benchmarking studies (local or external)		National	■	■					SSAC, MoH, SBC TWG
Develop and implement structured and performance-based twinning programme between organizations (including government MDAs at national, state and county levels; NGOs, CBOs, PLHIV and other networks or associations, youth centres and networks) at different capacity and performance		National and state	■	■	■	■	■	■	SSAC, MoH, SBC TWG, NGO network, PLHIV network
Develop and implement structured and performance-based advocacy with intensive, highly engaging and sustained advocacy for political, military and other civil persons, religious persons, other influential persons and policymakers who can influence the normative and enabling environment settings		National and state	■	■	■	■	■	■	SSAC, MoH, SBC TWG, NGO network, PLHIV network

(c) To strengthen the institutional and organizational landscape for effective planning, coordination, implementation, monitoring, quality assurance and evaluation of the SBC programmes and interventions.

Strategy and activities	Beneficiaries/ Targets	Location	2018		2019		2020		Responsible lead institutions
			Quarters		Quarters		Quarters		
			1 and 2	3 and 4	1 and 2	3 and 4	1 and 2	3 and 4	
Hold national review meetings to organizationally reorient SAC and CACs (committee) into effective and national aligned institutional and organizational structures and partnerships with clearly defined terms of references at national, state and county levels for steering the SBC programmes/interventions	SSAC, MoH, SMDAs, PLHIV networks, national NGOs		■						SSAC, MOH, SBC TWG, NGO network, PLHIV network
Support the states and counties to develop the SBC action plans	SSAC, SMoH, SMDAs, PLHIV networks, state-and county-based NGOs and CBOs		■	■	■	■	■	■	SSAC, MoH, SBC TWG, NGO network
Support the states and counties to coordinate the SBC action plans and the partnerships			■	■	■	■	■	■	SSAC, MoH, SBC TWG, NGO network

(d) To strengthen the systemic capacity to mobilize the needed financial and material resources for the SBC programmes.

Strategy and activities	Beneficiaries/ Targets	Location	2018		2019		2020		Responsible lead institutions
			Quarters		Quarters		Quarters		
			1 and 2	3 and 4	1 and 2	3 and 4	1 and 2	3 and 4	
Develop a SBC resource mobilization component of the national resource mobilization strategy to support the implementation of SBC programmes	SSAC, MoH, SAC, SMoH, SMDAs, PLHIV networks, state- and county-based NGOs and CBOs	National	■						SSAC, MoH, SBC TWG, NGO network
Mobilize resources for SBC programme			■	■	■	■	■	■	
Develop and adopt the funding and resource management mechanisms that will ensure allocative efficiency value for money, resource recovery, equitable and sustainable financing			■	■					SSAC, MoH, SBC TWG, NGO network

Section 6: Monitoring and evaluation

6.1. Introduction

The sixth section presents the framework within which the SBC programmes shall be monitored; their inputs, activities/processes and outputs quality assured, regularly assessed and evaluated to inform further planning and improvements in service delivery. The section also presents a roll-out plan and performance framework for the SBC strategy.

The monitoring shall include tracking of exposure to IPC and media through programme records. Regular and rigorous outcome evaluation of changes in sociobehavioural determinants (knowledge, risk perception, self-efficacy, norms and others) and prevention behaviours (sexual behaviour and service use) through bio-behavioural surveys shall be required.

6.2. Objectives

The objectives of the monitoring and evaluation plan shall be:

- To provide a framework for continuous tracking of SBC service delivery process (inputs, process, outputs and coverage) for routine programme management;
- To provide quality assurance for the SBC interventions;
- To provide a framework for regular and structured performance measurement/assessment of SBC interventions and programmes in regard to their effectiveness, efficiency, relevancy, coherency and alignment, exploration of possible alternative strategies of service delivery and sustainability of the interventions (outcome

and impact measurement); and

- To provide structured framework for generating and maintaining key data on SBC.

6.3. Monitoring and evaluation strategies

The monitoring and evaluation of SBC interventions shall be an integral part of the national HIV and AIDS monitoring and evaluation system made operational through the national HIV and AIDS Strategic Information Plan (SIP 2013–2017). The implementation of the SIP is coordinated by SSAC, SAC and CAC at national, state and county levels respectively.

The whole process shall be guided by the national SBC and Monitoring and Evaluation Technical Working Groups and the SAC and CAC at the state and county levels. The routine and non-routine data collection and reporting, data flow, flow, aggregation, analysis, storage, reporting, storage, retrieval, analysis, reporting and information products shall also align to national HIV and AIDS Strategic Information Plan (SIP 2013–2017).

To effectively monitor the delivery of the implementation of the SBC strategy and establish its outcomes at the population level, a number of routine and non-routine sources of data shall be made use of. These sources are listed in the table that follows.

6.4. Key data sources

6A: Data sources

Data source	Lead institutions	Frequency	Information products
Routine programme data			
1. Routine programme data from non-clinical services interventions	SSAC implementing partners	Quarterly	

Data source	Lead institutions	Frequency	Information products
2. Health sector programme data (from District Health Information System) mainly covering: HIV counselling and testing, ART, PMTCT, STI	MoH, WHO and implementing partners	Quarterly	Service coverage reports
3. Field monitoring and support supervision data	SSAC, all implementing partners	Quarterly	Field monitoring reports
4. ANC sentinel surveillance survey	MoH, WHO	1–2 years	Sentinel surveillance reports
Non-routine sources			
5. Population based bio and behavioural surveys, such as SSHHS, Demographic and Health Surveys and AIDS Indicators Survey	MoH, NSO	3–5 years	
6. Behavioural Surveillance Surveys (BSS) – usually population specific	MoH, SSAC, NBS	(2–3 years)	
• BSS for youth 15–24 years old	SSAC, NSO	(2–3 years)	
• BSS for FSWs and their clients	SSAC /MoH	(2–3 years)	
• BSS for truckers	SSAC/MoH	(2–3 years)	
7. Stigma Index/Survey	SSAC/MoH	2–3 years	
8. Quality of health services delivery and related HIV services assessments and facility surveys	SSAC	Biennially	
9. Programme/Project-specific reviews and evaluations	MoH, SSAC, Ministries	2–3 years	

Data source	Lead institutions	Frequency	Information products
10. HIV and AIDS Workplace Surveys	Respective projects	Every 2–3 years	
Other essential assessments/studies			
11. Sector-Wide Reviews/ Assessments, National Response Independent Assessment (including the Joint Annual Reviews, Mid NSP term and End of NSP term reviews)	SSAC	1–2 years, midterm and end of NSP	Assessment reports
12. Joint annual review Global AIDS Response Progress Reporting (GARPR) (now Global AIDS Monitoring) review	SSAC, UNAIDS	Annual	Annual report
13. Assets inventory, procurement and supply management and administrative records analysis	SSAC	Annually	Reports
14. Stakeholders and service mapping	SSAC	Biennial	Reports
15. HIV/AIDS operational research and special studies including orphans and vulnerable children situation reviews, sustainability analysis, condom surveys, situational analysis on children and mothers; situational analysis on male circumcision, MOTs; Know your epidemic/Know your response	SSAC, MoH, NSO	2–3 years, as applicable	Specific reports, publications

As indicated in both the South Sudan NSP 2018–2022 and the Operational plan 2018–2020, SSAC in collaboration with implementing and development partners shall develop community-based information/reporting system through which most SBC indicator shall be generated. The system shall have the tools, reporting templates, databases and the SOP or guiding handbook to strengthen the non-clinical sector HIV response reporting system.

Key of the partners in this drive shall include the ministries responsible for education, gender and sociocultural development, justice, communication and health. Other key partners shall include UNAIDS, UNICEF, UNESCO, UNFPA, USAID, IOM, IntraHealth, PLHIV networks, women networks, youth networks, coalitions against gender- and sexual-based violence, traditional and elders' councils and networks, research institutions and researchers.

6.5. Key social and behaviour change outcome indicators

The SBC results and indicators are already in the National Monitoring and Evaluation Plan and this SBC strategy Monitoring and Evaluation section. The National Monitoring and Evaluation TWG shall prioritize the indicators that can be feasibly reported on in a given/specific programme period and implementation levels. The outcome indicators shall include (though not limited to) the following:

Outcome	Indicators
Increased knowledge on HIV transmission and prevention	▪ Percentage of young women and men aged 15 ▪ Composite knowledge score (percentage of correct answers to questions on basic and new prevention knowledge based on country needs)

Outcome	Indicators
Increased personal risk perception	▪ 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 ▪ 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 who is 10 or more years older who believe they are at low or moderate risk of HIV (desired direction of change: reduction)
Positive change in attitudes/ social norms in regard to HIV prevention, care and support	▪ 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
Reduction of risky sexual behaviour among general, key and highly vulnerable populations	▪ HIV prevalence in young people aged 15–24 years old ▪ HIV incidence rate per 1,000 population ▪ Per cent of adults 15–49 with comprehensive HIV knowledge ▪ Percentage of PLHIV who know their HIV status ▪ Percentage of MSM who know their HIV status ▪ Percentage of FSWs who know their HIV status ▪ Percentage of uniformed personnel who know their HIV status ▪ Per cent of men and women who have more than one sexual partner who used a condom at last sexual intercourse ▪ Percentage of people key populations reporting use of a condom with their most recent partner (MSM, FSW)

Outcome	Indicators
(a) Reduction in multiple sexual partners by X per cent (b) Increased utilization of condoms in non-regular sexual partnerships by X per cent	▪ 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 demand for high-impact prevention services	▪ Percentage of men who intend to be circumcised (through voluntary medical male circumcision) 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 (especially for the IDPs, uniformed services and migrant, cross-border and mobile populations)	▪ 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 SBC 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 BCC through IPC

Outcome	Indicators
Reduced HIV and AIDS-related SDD among the service providers, general, key and vulnerable populations	▪ Percentage of women and men 15–49 years old who present discriminatory attitudes towards PLHIV ▪ Percentage of people expressing accepting attitudes towards people with HIV, of all people surveyed aged 15–49 ▪ Percentage of PLHIV at risk of and affected by HIV (disaggregated by sex, age group) who report no discrimination in community, health facility, education and workplace settings ▪ Percent of health facility staff who have observed unjust treatment of patients living with HIV in their facility ▪ Percent of health facility staff who report that their facility has written guidelines to protect patients living with HIV from discrimination
Increased health-seeking behaviour and uptake for high-impact interventions for prevention of HIV and related opportunistic infections, care and treatment and SRH services	▪ Per cent of general, PLHIV, key populations and other priority vulnerable groups including women, boys and girls timely accessing quality health and social services for HIV prevention, care and support
Increased positive behaviour among health service providers, the uniformed services and other auxiliary service providers on the HIV and opportunistic infection prevention, care and treatment, reproductive health needs of vulnerable and key populations	▪ Per cent of PLHIV, key populations and other priority vulnerable groups including women, boys and girls reporting discrimination at health facilities/ service delivery points

Outcome	Indicators
Strengthened national framework and enabling environment for SBC programming	▪ A current and operational national SBC strategy ▪ Research on sociocultural norms, empowerment of women, family and community structures and support systems, effective services and facilities; and formal and traditional legal systems ▪ Number and per cent of states and counties with functional inter-organizational multisectoral SGBV working groups with organizations focusing on health, psychosocial, security and legal services, NGOs and UN agencies ▪ A functional inter-organizational multisectoral SGBV working groups at national, state and county levels with organizations focusing on health, psychosocial, security and legal services NGOs and UN agencies ▪ Per cent of PLHIV, key populations and other priority vulnerable groups including women, boys and girls with access to human rights protection/ access to justice

6.6. Output indicators

A set of output indicators is provided in the annex as reference base for monitoring the implementation of the roll-out plan.

Section 7: Annex

7.1. Glossary of related terms and concepts

Adolescents: Males and females between 15 and 19 years old.

Adults: Males and females between 15 and 49 years old.

Advocacy: Any attempt to influence public opinion and attitudes that directly affect the lives of people. A person or an agency that can advocate for a particular cause or belief. The media may be used in advocacy to amplify an issue so that it is heard widely.

Age-disparate relationships: Refers to relationships in which the age gap between sexual partners is 5 years or more.

Antiretroviral drugs: Highly active medicines that suppress viral replication and reduce the amount of the virus in the blood to undetectable levels and slow the progress of the HIV disease.

Attitudes: An individual's predisposition towards an object, person or group that influences his or her response to be positive or negative, favourable or unfavourable.

Audience: The people to whom communications are directed. A distinction is made between target audience, primary audience and secondary audience.

Audience profile: A formal description of the characteristics of the people who make up a group.

Audience segment: A group of people who are enough alike on a set of characteristics of relevance for developing communication activities, such as a rural community and schooling status – in-school or out-of-school youth.

Audience segmentation: Division of a large group of people into smaller and more homogeneous groupings based on shared characteristics for the purpose of communication.

Barriers: Hindrances to desired behaviour change, either internal or external to the audience.

Baseline evaluation: An assessment or evaluation undertaken before an intervention is introduced or progresses.

Behaviour: The purposeful acts and actions of individuals or groups that can be observed, as opposed to reflexes.

Behaviour change: The adoption and maintenance of healthy behaviours (with respect to particular practices) that reduce the chances of acquiring HIV behaviour change and promote tailored messages of personal risk assessment, greater dialogue and an increased sense of ownership.

Behaviour change communication (BCC): Promotion of tailored messages, personal risk assessment, greater dialogue and an increased sense of ownership. Behaviour change communication is developed through an interactive process, with its messages and approaches using a mix of communication channels in order to encourage and sustain positive, healthy behaviours.

Bridging population: Population at higher risk of HIV exposure whose members may have unprotected sexual relations with individuals who are otherwise at low risk of HIV exposure.

Channel: The conduit or route for delivering/sending messages.

Combination HIV prevention: Combination HIV prevention seeks to achieve maximum impact on HIV prevention by combining human rights-based and evidence-informed behavioural, biomedical and structural strategies in the context of a well-researched and understood local epidemic. Combination HIV prevention also can be used to refer to

an individual's strategy for HIV prevention – combining different tools or approaches (either at the same time or in sequence), according to their current situation, risk and choices.

Commercial sex: The sale of sexual services.

Communication: The use of messages to transmit meanings within and across various contexts through different channels and media.

Comprehensive sexuality education (CSE): "An age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic and non-judgemental information". Sexuality education provides opportunities to explore one's own values and attitudes and build decision-making, communication and risk reduction skills about many aspects of sexuality. The term comprehensive indicates "that this approach to sexuality education encompasses the full range of information, skills and values to enable young people to exercise their sexual and reproductive rights and to make decisions about their health and sexuality. It is important to understand that comprehensive sexuality education offers the full range of possibilities for young people to practice safer sex and does not just promote messages about abstinence".

Comprehensive social protection: A range of measures for policy and programming, such as legal reforms to protect the rights of PLHIV, women and key populations. It also includes economic empowerment programmes, referrals and linkages to maximize the impact of investments in (and across) sectors.

Concurrent sexual partnerships: People with concurrent sexual partnerships are involved in overlapping sexual partnerships where intercourse with one partner occurs between two acts of intercourse with another partner. For surveillance purposes, this is defined specifically as those occurring within the past six months.

Counselling: An interpersonal, dynamic communication process between a client and a trained counsellor that tries to resolve personal,

social or psychological problems and difficulties. In the context of an HIV diagnosis, counselling aims to encourage the client to explore important personal issues, identify ways of coping with anxiety and stress and plan for the future (such as keeping healthy, adhering to treatment and preventing transmission). When counselling in the context of a negative HIV test result, the focus is exploring the client's motivation, options and skills to stay HIV negative.

Discrimination: When stigma is acted upon, the result is discrimination that may take the form of actions or omissions. Discrimination refers to any form of arbitrary distinction, exclusion or restriction affecting a person, usually but not only by virtue of an inherent personal characteristic or perceived belonging to a particular group – in the case of AIDS, a person's confirmed or suspected HIV-positive status – irrespective of whether or not there is any justification for these measures.

Enabling factors: These allow someone to perform a behaviour.

Formative research: The information-gathering activities conducted prior to developing health communication strategies and messages.

Gatekeepers: People who have the responsibility, or who are perceived to have the responsibility for upholding moral standards in a community. They can help support a behaviour change goal if they agree with it or prevent its adoption if they don't agree with it.

Gender-sensitive and gender-responsive: Policies, programmes or training modules recognize that both women and men are actors within a society, that they are constrained in different and often unequal ways and that consequently they may have differing and sometimes conflicting perceptions, needs, interests, and priorities

Impact: Long-term effect on the population as a result of the outcomes, i.e. HIV prevalence, mortality (death rates) and incidence of the HIV.

Indicator: An indicator is a variable that measures one aspect of a programme/project. An indicator can be a: rate, ratio, percentage, average, classification, number, index (composite of indicators).

Inputs: A set of resources that form the raw materials for the programme (finance, personnel, equipment).

Intergenerational relationships and cross-generation relationships: Those with a 10-year or greater age disparity between sexual partners.

Key populations: Those most likely to be exposed to HIV or to transmit it – their engagement is critical to a successful HIV response. In all countries, key populations include PLHIV. In most settings, men who have sex with men, transgender persons, PWID, sex workers and their clients, and seronegative partners in serodiscordant couples are at higher risk of exposure to HIV than other people.

Key populations at higher risk of HIV exposure: Refers to those most likely to be exposed to HIV or to transmit it; their engagement is critical to a successful HIV response, i.e. they are key to the epidemic and key to the response.

Message: The memorable, explanatory words or images that convey an idea – what you want people to know, feel or do.

Message concepts and creative briefs: Concepts are ideas that can be communicated to others. Creative brief is information needed to develop messages for specific audiences.

Midterm evaluation: Assessment undertaken midway in the implementation period (interim evaluation).

Migrant worker: A person who migrates from one country or area to another in pursuit of job opportunities.

Monitoring: "Day-to-day follow-up of the implementation of programme activities to find out if things are going on as planned" or simply as "routine tracking of priority information about a programme and its intended outcomes".

Outcomes: The short-term effects obtained in the population due to the outputs attained from the program (change in behaviour).

Outputs: The immediate results obtained at the programme level, as a result of the activities implemented using the resources (such as children vaccinated and counsellors trained).

Persons or people with disabilities: Impairments, activity limitations and participation restrictions. This accords with the definition given in the UN Convention on the Rights of Persons with Disabilities (2008), namely that PWDs include those who have long-term physical, mental, intellectual or sensory impairments that, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others.

Post-exposure prophylaxis (PEP): Antiretroviral medicines that are taken after exposure or possible exposure to HIV. The exposure may be occupational, as in getting stuck with an infected needle, or non-occupational, as in having unprotected sex with a person living with HIV.

Pre-exposure prophylaxis (PrEP): Antiretroviral medicines prescribed before exposure or possible exposure to HIV.

Primary audience: The group of people most affected by the problem and whose behaviour needs to be changed. The secondary audience, in turn, is the group of people that can help influence the intended audience; it is not considered part of the problem.

Prisons and other closed settings: Places of detention that hold people who are awaiting trial, who have been convicted or who are subject to other conditions of security. These settings may differ in some jurisdictions, and they can include jails, prisons, police detention,

juvenile detention, remand/pre-trial detention, forced labour camps and penitentiaries. There is a need to be inclusive in the language used to describe prisoners and other incarcerated people. Universal access to HIV prevention, treatment, care and support ideally should extend to these settings.

Reinforcing factors: It refers to a set of factors that encourage or discourage adopting a proposed behaviour, religious and political beliefs.

Risk: The likelihood that a person may become infected with HIV. Certain behaviours create, increase or perpetuate risk. Behaviours, not membership of a group, place individuals in situations in which they may be exposed to HIV.

Safer sexual behaviour: Behaviour adopted to reduce or minimize the risk of HIV acquisition and transmission.

Sexually transmitted infections (STIs): STIs are spread by the transfer of organisms from person to another person during sexual contact. In addition to the traditional STIs (syphilis and gonorrhoea), STIs also include HIV (which causes AIDS), chlamydia trachomatis, human papilloma virus (HPV) (which can cause cervical, penile or anal cancer), genital herpes and chancroid.

Stigma: A process of devaluation that significantly discredits an individual in the eyes of others. Within particular cultures or settings, certain attributes are seized upon and defined by others as discreditable or unworthy.

Target audience: The group that is intended to be the recipients of specific messages, and they often have common characteristic features, such as demographic factors, risk behaviour or roles to play in facilitating behaviour change by others.

Vulnerable populations: They are subject to societal pressures or social circumstances that may make them more likely to get exposed to infections (vulnerable to exposure), including HIV.

Women's empowerment: The action taken by women to overcome the obstacles of structural inequality that place them in a disadvantaged position. Social and economic empowerment of women is both a goal and a process mobilizing women to respond to gender discrimination, achieve equality of welfare and equal access to resources, and become involved in decision-making at domestic, local and national levels.

Young key populations: Young people aged 15 to 24 years who are members of key populations, such as young PLHIV, young gay men and other men who have sex with men, young transgender people, young PWID and young people (18 years and older) who sell sex. Young key populations often have needs that are unique, and their meaningful participation is critical to a successful HIV response.

Youth or young persons: Males and females between the ages of 15 and 24 years.

7.2. Reference output indicators for the SBC Implementation Plan

Strategic result 1:
Strengthened the national framework and enabling environment for SBC programming

(a) A national HIV and AIDS Social and Behavioural Change Strategy

(b) Strengthened national SBC resource centres at MoH and/or SSAC in which all best practice materials are available

(c) Number and per cent of states and counties with functional SBC resource centres

(d) Number and per cent of partners at national, state and county levels that have used or have access to the National SBC Strategy, current action plans and a full complement of SBC/IEC materials, mass and IPC and standardized support/guiding tools

(e) Number and per cent of quarterly meetings of the SBC TWGs to provide oversight in effective implementation of systematic SBC programmes that have been undertaken as scheduled (in the right quarter) –or per cent of quarterly meetings held

(f) A recently updated report of mapping of HTAs and locations of key populations to help target SBC programmes

(g) Per cent of states and counties with a recently updated report of mapping of HTAs and locations of key populations to help target SBC programmes

(h) A functional national high-level multisectoral, multidisciplinarian, multiprofessional, multicultural, multi- or inter-religious, multipolitical task force of HIV prevention and care advocates

(i) Number and per cent of states and counties with functional high-level multisectoral, multidisciplinarian, multiprofessional, multicultural, multi- or inter-religious, multipolitical task force of HIV prevention and care advocates

(j) Train the task forces and equip them with advocacy tools

(k) A functional HIV and AIDS SBC advocacy action plan with tools, identified advocacy issues, publicized core advocacy messages

(l) Number and per cent of states and counties that have been covered by advocacy campaign targeting cultural, religious, military and other leaders as role models for behavioural change to facilitate community dialogue

(m) Number and per cent of states and counties with capacity-building and economic empowerment programmes/networks as alternative IGAs for young girls, MSM, PLHIV and key populations to reduce transactional fuelled cross-generational/ disparate sex

(n) A functional SBC research agenda and task force

(o) Behavioural surveys/KAP surveys in the previous two to three years

(p) Number and per cent of states and counties (SAC and CAC), support organizations (FBOs, NGOs and other key stakeholders) whose capacity has been built in organizational development

(q) Number of states and counties that have had intra-programme sharing meetings and fora on SBC for learning and increased accountability

Strategic result 2:
Increased knowledge on HIV transmission and prevention and reduction of related risky sexual, social and cultural behaviours among the general and key populations

(a) Number and per cent of states, counties, HTA, key populations networks and PoHCs and emergency setting have access to a full complement of SBC/IEC materials, mass and IPC and standardized support/guiding tools

(b) Media campaigns undertaken in the previous year

(c) Per cent of the target population reached by media products through accessible outlets including radio, television and new media

(d) Number and per cent of media houses, freelance journalists and media producers that have benefited from the basic training on HIV prevention care and support

(e) Number and per cent of states and counties with popular opinion leaders who are prevention advocates and role models

(f) Number and per cent of states and counties that have had media campaigns with role models on faithfulness, television dramas and radio programmes; performing arts (role play, theatre, drama, music), focus on involvement of male role models (e.g. soccer stars) and on male involvement and male responsibility addressing the high risk of a newly infected man passing on HIV and AIDS to the mother and baby

(g) Number and per cent of state and counties that have been covered by multimedia campaigns focusing on risk perception, abstinence, faithfulness, condom use, cross-generational sex, transactional sex, partner reduction and knowing ones' HIV status

(h) Mass media campaigns and IPC implementation models, SOPs and tools

(i) Number and per cent of schools that taught life skills-based HIV education and/or updated national curricular of CSE

(j) Number and per cent of counties, HTAs and transit points with HIV and AIDS SBC communication and advocacy materials for out-of-school CSE programmes

(k) Number and per cent of states-trained teachers and youth in life skills-based HIV and AIDS education and CSE

(l) Number and per cent of counties, HTAs and transit points covered by publicly distributed and socially marketed condom promotion programmes emphasizing condom efficacy

(m) Number and per cent of counties with active parent–child communication engagement programmes through schools, community and youth centre discussion events

(n) Number and per cent of counties and payams with functioning regular meeting points for vulnerable young people at existing community structures (e.g. youth centres and youth-friendly afternoons at health facilities, churches, community centres), in-school anti-AIDS clubs and girls' education support clubs, provision of behaviour change materials, skills-building, lay counselling and support

(o) Number and per cent of youth groups, IDPs, uniformed forces, MSM and sex workers peer facilitators to train and provide support aimed at improving safe sex practices

(p) Number and per cent of counties, HTAs, transit points, IDP camps and other areas with PoHCs and potential key behavioural change agents

(q) Number and per cent of states, counties and *payams* and other populations of interest that have, in the previous year, benefited from a campaign with mass media, edutainment, social media for young people, peer educators in general

and key populations, male involvement to raise personal risk perception, benefits of early testing, treatment literacy focusing on availability and sources of free and yet high-impact/efficacious services, quick access, confidential access, non-judgemental including the testing, opportunistic infection treatment and ART

Strategic result 3:
Improved health-seeking behaviour and increased uptake for high-impact HIV interventions

(a) Number of thematic tracks of NSP with integrated SBC

(b) Number and per cent of states and counties with networks of boda boda riders and youth drop-in centres as focus for SBC interventions including SBC/IEC materials distribution to HTAs, key and general populations

(c) Number and per cent of states, HTAs and transit points with functional multipurpose one-stop drop-in information and service centres along the main transit routes and hotspots for the cross-border and mobile populations

(d) Number and per cent of states, HTAs and transit points with functional multipurpose SBC-supporting networks between the transporters associations', MSM, leisure establishments industry and health service providers focusing on HIV prevention and care

(e) Number and per cent of counties, HTAs, transit points, IDP camps and other areas with PoHCs with innovative, effective and friendly networks of condom distribution to reach PLHIV, youth, sex workers and other key populations

(f) Number and per cent of states, counties and *payams* and other populations of interest, including the youth in schools, IDPs, uniformed services, men-dominated trades and workplaces, such as factories and sports arenas that have had a health education outreach in the previous three months

(g) A functional countrywide (or even intercountry) electronic patient database or patient identification system with unique identifiers to minimize service dropouts and increase uptake in the current context of displaced populations

(h) Number of public–private partnerships established to increase the reach and frequency of prevention messages and access to products and services

(i) Reviews of policy and legal barriers to the uptake of HIV prevention services and safer sexual practices (including among youth) undertaken in the previous two years

(j) Number of counties with functioning linkages between the standard health facilities and the youth centres and drop-in centres for MSM

Strategic result 4:
Increased knowledge and positive behaviour among health service providers, the uniformed services and other auxiliary service providers on the needs of vulnerable and key populations

(a) A recent (within last one year) client exit survey at HIV prevention, care and treatment facilities to inform SBC programming

(b) A recent (within last two to three years) assessment on effectiveness of the NSP SBC and links and effects of new and emerging medical interventions and prevention technologies on sexual behaviours to inform planning

(c) Positive prevention mainstreamed into treatment and care, ART and home-based care service provision

(d) Number and per cent of states, counties and *payams* and other populations of interest that have established service access networks and referral systems between health facilities

and key population groups of interest including sex workers, youth, MSM and IDPs

(e) Number of advocacy meetings held with MoH to establish modalities on how best to serve needs of the key populations

(f) Number and per cent of health service providers trained on HIV prevention, care and support service needs packages and in communication and counselling skills and handling of key populations and with specific focus on PLHIV, youth, sex workers and MSM

(g) Number of states, counties, health facilities and youth or community centres with adolescent and youth-friendly sexual and reproductive health service provision

Strategic result 5:
Reduced HIV-related SDD at individual, interpersonal, community and institutional levels

(a) Number and per cent of counties, sectors and employers reached with advocacy messages and sessions to minimize spousal separation, stigma reduction and treatment literacy

(b) Number and per cent of states and counties with active community mobilization programmes through trained behavioural change agents focusing on risk reduction, GBV, PEP, ECP access to testing, counselling and treatment

(c) Number and per cent of top-level leadership of the uniformed services that have had at least two advocacy meetings and training on how to manage the needs of the PLHIV and key populations and health facilities to establish modalities on how best to serve the needs of the key populations

(d) Number and per cent of middle- and top-level leadership of the uniformed services: SPLA leadership, police leadership, immigration police/workers that have been sensitized on the

HIV prevention, care and support service needs packages of the key populations with specific focus on PLHIV, youth, sex workers, MSM; handling of PLHIV and general management of stigma, discrimination and denial; importance of supporting service access for key populations

(e) Number of states and counties with PLHIV ToTs pools of trainers for PLHIV in positive prevention, stigma reduction and behaviour change

(f) Number and per cent of states and counties with an active role model and dialogue programme to support SBC and break stigma

(g) Number of counties that have had campaigns on stigma reduction using the PLHIV and peer educators

(h) Number of employers sensitized on importance and modalities of developing a workplace HIV policy and programmes to create enabling working environment that allows for PLHIV to access treatment and even be open about their status

(i) Number and per cent of HIV prevention, care and treatment programmes at national, state and county levels that involve of PLHIV

(j) Number and per cent of camps or garrisons of barracks of uniformed service (in SPLA, all prisons and cells, border and urban law enforcement officers) following with functional operational guidelines for services for stigma reduction in provision of HIV and AIDS prevention, care and support to the PLHIV and other vulnerable key populations

(k) Number of personnel from the uniformed services (SPLA leadership, police leadership, immigration police/workers) trained on the HIV needs of key populations with specific focus on PLHIV, youth, sex workers, MSM; handling of PLHIV and general management of stigma, discrimination and denial

7.3. List of stakeholders consulted and part of strategy development

- Ministry of Health (MoH) (including police, prisons, fire brigade and wildlife)
- Ministry of Interior (MoI) (including police, prisons, fire brigade and wildlife)
- South Sudan People's Defence Forces (SSPDF) HIV Secretariat
- South Sudan AIDS Commission (SSAC)
- Joint United Nations Team on HIV/AIDS
- Members of the HIV/AIDS Technical Working Group
- Behaviour Change Communication (BCC) Working Group
- Key populations, including FSWs, boda bodas and truck drivers
- Vulnerable populations including IDPs
- Civil society organizations
- Local and international NGOs

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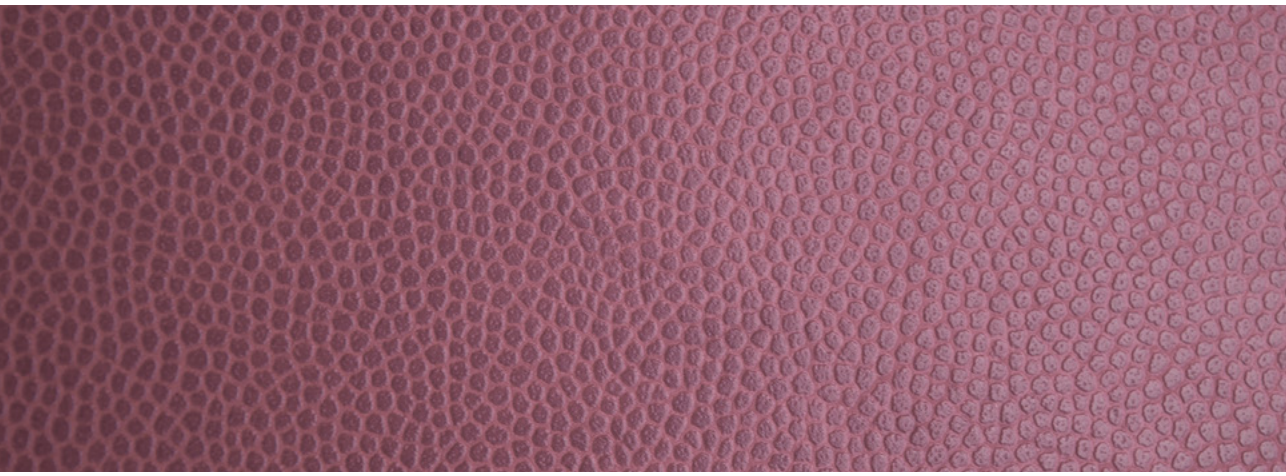

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