USAID

Tulonge Afya

Youth Social and Behavior Change Communication (SBCC) Strategy | HIV and Contraception – July 2018

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Acronyms

ADDED	Audience-driven Demand, Design, and Delivery
AHDS	Adolescent Health and Development Strategy
ART	Antiretroviral Therapy
CBO	Community-based Organization
CHW	Community Health Worker
DHS	Demographic and Health Survey
FP	Family Planning
GOT	Government of Tanzania
HIV	Human Immunodeficiency Virus
HPS	Health Promotion Section
HSSP	Health Sector Strategic Plan
HTC	HIV Testing and Counseling
IPs	Implementing Partners
IPC	Interpersonal Communication
LTFU	Loss to Follow Up
M&E	Monitoring and Evaluation
MCM	Modern Contraceptive Method
MIS	Malaria Indicator Survey
MOHCDGEC	Ministry of Health, Community Development, Gender, Elderly, and Children
NAAIA	National Accelerated Action and Investment Agenda
NACP	National AIDS Control Programme
SBC	Social and Behavior Change
SBCC	Social and Behavior Change Communication
SMS	Short Message Service
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TACAIDS	Tanzania Commission for AIDS
TDHS	Tanzania Demographic and Health Survey
THIS	Tanzania HIV Impact Survey
USAID	United States Agency for International Development
VMMC	Voluntary Medical Male Circumcision

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Other organizations and stakeholders

- Bill and Melinda Gates Foundation
- Chama cha Uzazi na Malezi Bora Tanzania (UMATI)
- Engender Health
- Femina Hip
- Girl Effect
- Marie Stopes Tanzania
- National Council of People Living with HIV and AIDS in Tanzania (NACOPHA)
- Population Services International (PSI)
- Restless Development
- Tanzania Bora
- Tanzanian Commission for AIDS (TACAIDS)
- Tanzania Health Promotion Support (THPS)
- Tanzania Youth and Adolescent Reproductive Health (TAYARH)
- Tanzania Youth Vision (TYV)
- T-MARC Tanzania
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- USAID Kizazi Kipya – PACT
- USAID Tulonge Afya – FHI 360
- Youth Action Movement

Contents

Background

The USAID Tulonge Afya project, implemented by FHI 360 with funding from the U.S. Agency for International Development (USAID), supports the Government of Tanzania to catalyse opportunities for Tanzanians to improve their health status by transforming socio-cultural norms and supporting the adoption of healthier behaviours. By addressing key social and cultural norms and social and behaviour change (SBC) system needs, USAID Tulonge Afya identifies the drivers of behaviours directly tied to health and leverage social and behaviour change communication (SBCC), among other approaches, and works in partnership with the Government of Tanzania to achieve the following results:

- Result 1: Improved ability of individuals to practice healthy behaviours
- Result 2: Strengthened community support for health behaviours
- Result 3: Improved systems for coordination and implementation of SBCC interventions

USAID Tulonge Afya uses a participatory, evidence-based, and theory-informed approach to: 1) address norms and inequities that drive poor health and related behaviours; 2) advance health while promoting rights; 3) use data better to support regional and district needs; 4) harmonize messages and media; 5) strengthen institutional capacity to manage and deliver high-quality SBC; and, 6) facilitate coordination to maximize SBCC impact and efficiencies.

The purpose of this strategy is to inform the development of a comprehensive SBCC program—spanning interpersonal communication to mass media—to promote positive social norms and motivate youth to adopt healthier behaviours. This strategy document is the result of a workshop conducted in May 2018 by USAID Tulonge Afya in collaboration with partners from the Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC). Participants in this workshop included peer educators and youth ambassadors associated with the organization Youth Action Movement as well as technical staff from the MOHCDGEC, USAID Tulonge Afya partners, Boresha Afya partners, and wider stakeholder organisations. The strategy was reviewed, updated, and validated by these and other stakeholders in July 2018 during a meeting organized by USAID Tulonge Afya. All aspects of the youth SBCC program informed by this strategy will be developed in collaboration with the MOHCDGEC to ensure sustainability and their alignment with emerging national strategies and priorities.

Linkage to National Strategies and Priorities

The USAID Tulonge Afya youth SBCC strategy is intended to contribute directly to the achievement of the strategic objectives of the MOHCDGEC, as outlined in the National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child & Adolescent Health (2016-2020) (One Plan II), the draft 2018 Adolescent Health and Development Strategy (AHDS), Health Sector Strategic Plan 2015-2020 (HSSP IV), and draft National Accelerated Action and Investment Agenda for Adolescent Health and Well Being (NAAIA). Table 1 outlines the objectives to which the youth SBCC strategy will contribute and how it will make those contributions. The strategy is currently focused on HIV and modern contraceptive methods for youth but may be expanded to cover additional behaviors and health areas, as required.

Table 1: Linkages to national priorities

Source	Objective	Youth SBCC Strategy's Expected Contribution
AHDS 2018	Strategic Objective #1: Engage adolescents to better understand their issues and develop effective and sustainable solutions while also strengthening schools and working with	• Develop a youth brand to promote credible sexual and reproductive health (SRH) information to empower young people with the knowledge, support, and motivation they need to adopt healthier behaviors

	communities and adolescent gatekeepers to address negative socio-cultural norms and promote adolescent health and well-being.	• Interventions reaching young people with positive messages that empower them to improve their sexual health and prevent unintended pregnancies and HIV/STI • Interventions to promote positive socio-cultural norms in communities and in families by engaging providers, parents, school administers through community-based organizations and faith-based organizations
AHDS 2018	Strategic Objective #2: Ensure availability of holistic, appropriate and cost-effective adolescent friendly health services with a well-trained workforce and promote public-private partnerships to address the gap in public health service delivery.	• Collaboration with service delivery partners to improve the quality of services offered to young people
AHDS 2018	Strategic Objective #6: Strengthen intersectoral coordination and cooperation among adolescent stakeholders and enhance their role in promoting adolescent health and well-being.	• Support to service delivery partners to improve utilization of SRH services by young people • Collaboration with district health authorities to supervise implementation of community-based activities
HSSP IV	Specific Objective #1: The health and social services sector will achieve objectively measurable quality improvement of primary health care services, delivering a package of essential services in communities and health facilities.	• Collaboration with service delivery partners to improve the quality of services offered to young people
HSSP IV	Specific Objective #2: The health and social welfare sector will improve equitable access to services in the country by focusing on geographic areas with higher disease burdens and by focusing on vulnerable groups in the population with higher risks.	• Interventions to address socio-cultural norms that prevent young people from accessing health services • Interventions to promote SRH services among adolescent girls and young women • Active referrals to link at-risk adolescent girls and young women with SRH services
One Plan II	Adolescent Health Key Result Area (KRA) 1: Adolescent and Youth Friendly Sexual and Reproductive Health (AYFSRH) including HIV service coverage and FP increased by 2020.	• Collaboration with service delivery partners to improve the quality of services offered to young people
	Adolescent Health KRA 2: Comprehensive knowledge, skills and positive behaviors on sexuality and reproductive health improved among adolescents by 2020.	• Interventions reaching young people with positive messages that empower them to improve their sexual health and prevent unintended pregnancies and HIV/STI
	Adolescent Health KRA 3: Linkage and capabilities among various stakeholders in the government, private sector and CSOs dealing with adolescent SRH strengthened by 2020.	• Support to service delivery partners to improve utilization of SRH services by young people
	Adolescent Health KRA 4: Institutionalize policies and supportive laws to improve access to information, education and services for adolescents by 2020.	• Collaboration with service delivery partners to improve the quality of services offered to young people • Interventions to promote positive socio-cultural norms in communities and in families

		by engaging providers, parents, school administers through community-based organizations and faith-based organizations
	Adolescent Health KRA 5: Knowledge, understanding and healthy practice for sexual and reproductive health and rights (SRHR) as well as socio-economic situation of adolescents and youth improved by 2020.	• Interventions reaching young people with positive messages that empower them to improve their sexual health and prevent unintended pregnancies and HIV/STI
NAAIA	Pillar #1: Preventing HIV Pillar #2: Preventing teenage pregnancy Pillar #3: Preventing physical, sexual and emotional violence	• Interventions reaching young people with positive messages that empower them to improve their sexual health, prevent unintended pregnancies and HIV/STI, and address harmful gender norms

Behavioral Objectives

The behavioral objectives of the youth SBCC strategy are to significantly increase the proportion of young people age 10-24 who:

- Delay first sex;
- Use a modern contraceptive method to
  - Delay first birth;
  - Delay future pregnancies;
- Use condoms correctly and consistently;
- Get an HIV test (if at risk);
- Adhere to HIV treatment (if living with HIV); and,
- Go for voluntary medical male circumcision (VMMC).

Each of these behavioral objectives are intended for specific youth audiences, which have been segmented and further described in subsequent sections of this document.

Audience Segments and Promoted Behaviors

Demographic, behavioral, and attitudinal data were used to inform audience segmentation for both contraceptive and HIV behaviors. The result is several primary and secondary audiences for each promoted behavior, which are outlined in table 2. Detailed primary audience profiles can be found in annex A.

Table 2: Primary audiences and promoted behaviors[1]

Primary audience	Promoted behavior(s)	Secondary audience(s)
Early adolescent girls (10-14), not yet sexually active (Pamela)	• Delay first sex	• Parents (Mr. and Mrs. Alex) • School teachers, administrators (Margaret)
Early adolescent boys (10-14), not yet sexually active (Khamar)	• Delay first sex • Go for VMMC	• Parents (Mr. and Mrs. Alex) • School teachers, administrators (Margaret)
Unmarried, sexually active older adolescent girls (15-19) (Subira)	• Use a modern contraceptive to delay first birth • Use condoms correctly and consistently to avoid HIV/STI • Get an HIV test (if at risk) • Adhere to HIV treatment (if living with HIV)	• Parents (Mr. and Mrs. Alex) • Health care providers (Cynthia) • Unmarried, sexually active young men (15-24) • Adult male partners (to be engaged through Adult Platform)

[1] Primary and secondary audience names are pseudonyms used for internal purposes only.

Unmarried, sexually active emerging adult women (20-24) (Edna)	• Use a modern contraceptive to delay first birth • Use condoms correctly and consistently to avoid HIV/STI • Get an HIV test (if at risk) • Adhere to HIV treatment (if living with HIV)	• Health care providers (Cynthia) • Adult male partners (to be engaged through Adult Platform)
Older adolescent girls who have begun childbearing (15-19) (Maua)	• Use a modern contraceptive to delay future pregnancies	• Parents (Mr. and Mrs. Alex) • Health care providers (Cynthia)
	• • Note: This segment is comprised only of unmarried/unpartnered older adolescent girls. Data from audience consultations suggest that married/partnered older adolescent girls (15-19) and emerging adult women (20-24) identify more strongly as mothers and wives/partners than as young women. Therefore, reaching married women through a young platform that promotes contraceptive use to maintain one's independence will be less engaging than the Adult Platform, which promotes behaviors to ensure child and family health.	
Unmarried, sexually active young men (15-24) (Juma)	• Use condoms correctly and consistently to avoid HIV/STI • Go for VMMC • Get an HIV test (if at risk) • Adhere to HIV treatment (if living with HIV)	• Parents (Mr. and Mrs. Alex)

Supportive behaviors were identified for each secondary audience and are outlined in table 3.

Table 3: Secondary audiences and supportive behaviors

Secondary audience	Supportive behavior(s)
Parents (Mr. and Mrs. Alex)	• Support daughter/son to access SRH information and services; keep children enrolled in school through secondary; support children living with HIV to adhere to treatment.
Female sexual partners (Subira and Edna)	• Support male sexual partner to seek out VMMC services.
School teachers and administrators (Margaret)	• Advocate for adolescents and young people to receive comprehensive SRH information.
Health care providers (Cynthia)	• Provide quality, unbiased, non-judgmental services to young women and men.
Adult male partners	*Link to Adult Platform packages

Situation Analysis

Data from key sources, including the Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS-MIS) 2015-16, were reviewed to understand current behaviors and identify characteristics of potential audience segments within the larger youth population. Data available for contributing factors of each promoted behavior were examined to inform the development of communication objectives and are outlined in the Communication Objectives section of this document.

Sexual debut

The median age of sexual debut is 17.3 years among young women age 20-24 and 18.1 years among young men 20-24 (MoHCDGEC 2016). Approximately 45% of young women age 15-19 and 37% of young men age 15-19 report having been sexually active in the past twelve months (MoHCDGEC

2016). The median age of marriage is 19.6 for women and 24.4 for men (MoHCDGEC 2016). Open communication about SRH with unmarried young people is often limited by cultural norms that discourage discussions about sex (Kitula 2016, Sommer 2014).

These data suggest that the youth SBCC strategy may need to:

- Reach adolescents early with information about puberty and SRH; and,
- Engage parents to generate support for discussing SRH issues with young people.

Modern contraceptive method use

By age 19, 50% of young women in Tanzania have begun childbearing. Although awareness of contraception among all categories of young women is high (over 90%), current contraceptive use among unmarried, sexually active young women remains low, ranging from 33.1% among young women age 15-19 to 53.9% among those age 20-24 (MoHCDGEC 2016). Current contraceptive use is 13.3% among married young women age 15-19 and 29.9% for those age 20-24 (MoHCDGEC 2016). Lower rates among married young women may reflect strong social norms encouraging young couples to produce many children soon after marriage (FHI360 2018(1), PSI 2017). Among unmarried, sexually active young women age 15-19 have a higher unmet need than those age 20-24 (42.4% vs 21.6%) (MoHCDGEC 2016). Among married young women unmet need is nearly identical for those age 15-19 and those age 20-24 (23% vs 22.7%) (MoHCDGEC 2016). Underlying factors for this behavior were also explored and are documented in the Communication Objectives section of this strategy.

These data suggest that the youth SBCC strategy may need to:

- Build on awareness to motivate young women to use a modern contraceptive method
- Prioritize unmarried, sexually active young women age 15-19, especially in rural areas
- Generate demand among young women who have already started childbearing by promoting contraceptives to delay future pregnancies

HIV

Although the rate of new HIV infections has dropped significantly since 1996, HIV/AIDS and TB related complications still account for over one third of deaths among 10 – 24-year old men and women (IHME 2016). Less than half of young people aged 15 – 24 (43.4%) have complete knowledge about HIV prevention (UNAIDS 2017) and reported condom use at last premarital sex remains low, 41.4% among young men and 36.5% among young women (MoHCDGEC 2016). Among young men aged 15 – 24 uptake of VMMC services remains high across most regions but drops off dramatically for men after age 25 (OGAC 2018). In 2017 it was estimated that 40% of new infections occurred among young people under age 24 years and of these, 70% occurred among adolescent girls and young women (UNAIDS 2017). As a result, young women aged 15-24 are significantly more likely to be HIV infected than their male counterparts (ICAP/THIS 2017). Viral suppression data suggest that adherence among HIV-positive young people continues to lag, contributing to lower than average rates of viral suppression, especially among both young men and women aged 10 – 19 (OGAC 2018). Underlying factors for this behavior were also explored and are documented in the Communication Objectives section of this strategy.

These data suggest that the youth SBCC strategy may need to:

- Prioritize condom use among young women age 15-19, especially those at-risk, and young men 15-24;
- Promote HIV testing among at-risk young women age 20-24 and establish linkages to services;
- Support service providers to promote treatment adherence; and,
- Create demand for VMMC among young men age 15-24 in key regions where circumcision rates remain below the national average (Iringa, Njombe, Tabora, Morogoro, and Singida).

Social and gender norms

Social and gender norms have a significant influence on the decisions that young people make, especially with regards to sexual health decision-making. Several studies suggest that current norms may encourage young men to demonstrate their sexual prowess from a young age, which contributes to early sexual debut and hinders young women's ability to negotiate safer sexual practices (Sommer 2014, FHI360 2018(2)). Norms around what is considered acceptable behavior also affect young people's motivation and ability to access contraceptive and other SRH services, especially young women (PSI 2017, FHI 2018(2)). Some research also suggests that community norms also affect how providers feel about providing SRH services to young people, especially unmarried young people (PSI 2017).

These data suggest that the youth SBCC strategy may need to:

- Address social and gender norms that affect young people's motivation to access SRH services;
- Address social norms that discourage providers from providing non-judgmental services to all young people; and,
- Challenge harmful concepts of masculinity held by community members and adolescent boys and young men.

Overarching Priorities

Based on the data reviewed, the following overarching priorities were identified to guide the development of the objectives and activities outlined in this strategy:

- Tackle entrenched beliefs regarding the safety of contraceptives, especially among young women and providers;
- Improve health care providers skills and attitudes to deliver services to young people;
- Challenge social norms, especially among parents and providers, that discourage young people from accessing SRH services; and,
- Address gender norms, especially concepts of masculinity and virility among men, that discourage women from proposing condom or contraceptive use with their sexual partners.

Strategic Approach

The youth SBCC strategy will implement a multi-channel, branded program to create a "360-surround sound" effect reinforcing key messages across all channels. Community- and individual-level activities will be designed to encourage discussion and to enable individual and collective decision-making to adopt promoted behaviors. Community-level activities will also address social and gender norms that prevent young people from adopting promoted behaviors. Mid-media and mass media activities will be designed as campaigns to reinforce key messages disseminated during community- and individual-level activities. Figure 2 provides an example of how a multi-channel program is expected to reach primary audiences to create this effect.

Figure 1: Creating a 360-surround sound effect

Master Brand and Positioning

All activities will be implemented under a Master Brand that will be developed to unify youth program communication activities and give youth a sense of belonging to a movement of other young people. This new Master Brand will:

- Link promoted behaviors with outcomes young people care about (i.e. success, achievement, financial independence);
- Use stories and experiences from young people to motivate other young people to act;
- Give young people options, not directives;
- Create a safe space for dialogue and exchange; and,
- Address social norms that discourage young people from adopting promoted behaviors.

To inform the positioning of this Master Brand for youth, several formative research studies were reviewed. Findings of these studies suggest that:

- Young people care about achievement and want to be successful (i.e. having a good job, providing for their family, being admired by others in their community) (WTS 2017).
- Traditions that have guided young girls through the transition from adolescent to adulthood are less common, while they never existed for young boys; which leaves young people feeling confused as they grow up (PSI 2017; Sommer 2014).
- Schools remain an important source of information about sex, but they usually promote abstinence as the only way to avoid pregnancy and HIV/STIs (DKT 2015; MOHCDGEC 2018; Sommer 2014).
- Older adolescent girls feel they do not have anyone they can rely on for accurate information about sex and contraception (FHI 360 2018 (1)).
- Friends are the preferred source of information for young people (FHI 360 2018; DKT 2016; WTS 2016), but the accuracy of the information they give is questionable (WTS 2016).

Based on these findings, the positioning statement for the youth SBCC program's Master Brand is:

> [MASTER BRAND NAME] is the most trusted and accessible source of SRH/HIV information, giving me the support and motivation I need to stay on track to achieve my dreams.

A brand blueprint (annex B) will be used to guide the design and testing of a new Master Brand for the youth SBCC program.

Communication Objectives

Audience consultation research applied USAID Tulonge Afya's Audience-driven Demand, Design, and Delivery (ADDED) theoretical approach (Figure 1) to identify barriers and facilitators to adoption of the promoted behaviors. Other resources and lessons from previous projects were used to further review barriers to determine their *importance* and *changeability* in the Tanzanian context. For the purposes of this strategy, *importance* was defined as the degree to which the barrier prevents adoption of the behavior. *Changeability* was defined as the practicality of addressing the barrier within the time and budgetary constraints of the project. Results of this review are represented by (+) or (-) symbols, indicating either "more" or "less" important or changeable. Communication objectives for each audience and promoted behavior are based on results of this review and are presented in tables 4 to 9.

Figure 2: USAID Tulonge Afya theoretical approach

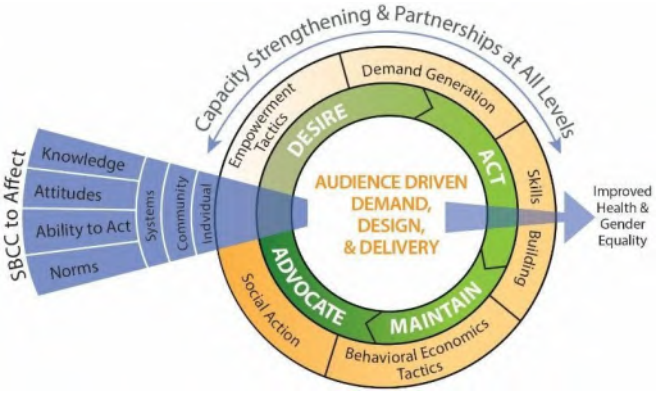

Table 4: Communication objectives for delayed first sex[2]

Audience	Factors	Communication objectives
Primary #1: Early adolescent girls (10-14), not yet sexually active (Pamela)	• Need more information	**Knowledge**: Need more information
		Attitudes: Need more information
		Ability to Act: Need more information
		Norms: Need more information
Primary #2: Early adolescent boys (10-14), not yet sexually active (Khamar)	• Need more information	**Knowledge**: Need more information
		Attitudes: Need more information
		Ability to Act: Need more information
		Norms: Need more information
Secondary: Parents (Mr and Mrs Alex)	• Need more information	**Knowledge**: Need more information
		Attitudes: Need more information
		Ability to Act: Need more information
		Norms: Need more information
Secondary: Teachers, School Administrators (Margaret)	• Need more information	**Knowledge**: Need more information
		Attitudes: Need more information
		Ability to Act: Need more information
		Norms: Need more information

Table 5: Communication objectives for modern contraceptive use to delay first birth or future pregnancies

Audience	Factors	Communication objectives
Primary #1: Unmarried, sexually active older adolescent girls (15-19) (Subira)	Barriers • Believe that contraceptives are for older women, not young people like her (FHI360 2018(1), PSI 2017) (+/+)	**Knowledge**: ↑ proportion who state that modern contraceptive methods are safe.
		Knowledge: ↑ proportion who have comprehensive knowledge of puberty, menstruation, and SRH (including HIV).

[2] The design of activities to reach Pamela and Khamar will include consultations with younger adolescents, their parents, and teachers/school administrators to identify barriers and facilitators to the adoption of promoted behaviors. These data will be used to inform communication objectives, key messages, and channels for this promoted behavior. These consultations are planned for the first half of FY2019.

	• Have limited knowledge about SRH, including puberty and menstruation (PSI 2017) (-/+) • Believe that modern contraceptives can cause long-term problems (FHI360 2018(1), PSI 2017) (+/+) • Feel she cannot ask male partners to use condoms (FHI360 2018(1)) (-/+) • Are afraid providers will interrogate or judge her if she tries to access services (FHI360 2018(1), Hokororo 2015) (+/-) Facilitators • Have high awareness of modern contraceptive methods (FHI360 2018(1), TDHS-MIS 2015-16) • Fear pregnancy would lead to parental/guardian rejection (FHI360 2018(1)) • Want others in the community to look up to her as a successful person (FHI360 2018(1), PSI 2017) • Want to be perceived as a "good girl" (FHI360 2018(1))	**Attitudes:** ↑ proportion who believe modern contraceptives are for young women like them. **Ability to Act**: ↑ proportion who feel providers will support them to use a modern contraceptive method. **Norms**: ↑ proportion who state that their parents support their decision to use a modern contraceptive method.
Primary #2: Unmarried, sexually active emerging adult women (20-24) (Edna)	Barriers • Fear side effects of modern contraceptives (FHI360 2018(1)) (+/+) • Feel providers are not friendly and criticize young people (FHI360 2018(1), Hokororo 2015) (+/-) • Believe that contraceptives are for married mothers (PSI 2017) (+/+) • Feel if she were to have an unintended pregnancy is not an insurmountable problem (FHI360 2018(1)) (+/+) Facilitators • Have started to establish her independence from her parents (FHI360 2018(1)) • Have high awareness of modern contraceptive methods (FHI360 2018(1), TDHS-MIS 2015-16) • Feel that family planning can lead to a healthy, harmonious family (FHI360 2018(1)) • Feel it is appropriate to talk about contraceptive with a regular partner (FHI360 2018(1)) • Want to feel secure and in control (FHI360 2018(1))	**Knowledge**: ↑ proportion who state that modern contraceptive methods are safe. **Attitudes**: ↑ proportion who believe modern contraceptives are for young women like them. **Ability to Act**: ↑ proportion who feel providers will support them to use a modern contraceptive method. **Norms**: ↑ proportion who state that most of their peers support modern contraceptive use.

	• Want others in the community to view her successful (FHI360 2018(1), PSI 2017) • Are interested in using modern methods (FHI360 2018(1))	
Primary #3: Older adolescent girls who have begun childbearing (15-19) (Maua)	Barriers • Have limited knowledge about SRH, including puberty and menstruation (PSI 2017) (-/+) • Believe that modern contraceptives can cause long-term problems (FHI360 2018(1), PSI 2017) (+/+) • Feel she cannot ask male partners to use condoms (FHI360 2018(1)) (-/+) • Are afraid providers will interrogate or judge her if she tries to access services (FHI360 2018(1), Hokororo 2015) (+/-) Facilitators • Have high awareness of modern contraceptive methods (FHI360 2018(1), DHS 2015-16) • Are concerned community will judge her for not spacing births (urban only) (FHI360 2018(1)) • Want others in community to view her as a good mother (FHI360 2018(1)) • Feel confident in ability to access services at health facilities (FHI360 2018(1))	**Knowledge**: ↑ proportion who state that modern contraceptive methods are safe. **Ability to Act**: ↑ proportion who feel providers will support them to use a modern contraceptive method. **Norms**: ↑ proportion who state that their parents support their decision to use a modern contraceptive method.
Secondary: Parents (Mr and Mrs Alex)	Barriers • Feel it is not appropriate to speak with their children about sex (PSI 2017, Sommer 2014, Kitula 2014) (+/+) • Worry that talking about sex and contraception will encourage children to have sex (PSI 2017, WTS 2017, Mubyazi 2016) (+/+) Facilitators • Want their children to be successful and healthy (PSI 2017) • Recognize that young people are sexually active and need to be protected (Mubyazi 2016)	**Attitudes**: ↑ proportion who feel it is important for young people to have access to SRH information and services. **Ability to Act**: ↑ proportion who feel confident in their ability to speak to young people about SRH. **Norms**: ↑ proportion who state that most parents encourage their children to access SRH information and services.
Secondary: Health care providers (Cynthia)	Barriers • Have received limited training on how to work with young people (FHI360 2018(1), PSI 2017) (-/+) • Believe modern contraceptives give unmarried young women	**Knowledge**: ↑ proportion who state that modern contraceptive methods are safe for young women. **Attitudes**: ↑ proportion who believe unmarried, young women have a right to access SRH and contraceptive services.

	permission to be promiscuous (FHI360 2018(1), PSI 2017) (+/+) • Believe modern contraceptives are not safe for young women (FHI360 2018(1), PSI 2017) (+/+) • Worry how parents will react if they provide young women with contraceptives (FHI360 2018(1), PSI 2017) (+/-) • Feel they have limited time to provide adequate counselling to every client (FHI360 2018(1)) (+/-) Facilitators • Want to help young women avoid (or respond to) a "crisis" (FHI360 2018(1), PSI 2017) • Want to be recognized as a respected "healer" in her community (FHI360 2018(1))	**Ability to Act**: ↑ proportion who feel confident in their ability to provide quality, confidential services to young people. **Norms**: ↑ proportion who state that their community supports providing SRH and contraceptive services to young people.

Table 6: Communication objectives for correct and consistent condom use

Audience	Factors	Communication objectives
Primary: Unmarried, sexually active young women (15-24) (Subira & Edna)	Barriers • Do not think condoms prevent HIV/STI infection (Kalolo 2015, Hokororo 2015) (+/+) • Feel condoms are difficult to find or access (Njau 2013, Kalolo 2015) (-/+) • Believe women are not allowed to propose condom use to partners (Kitula 2014, FHI360 2018(1)) (+/+) • Fear violence from sexual partner (Kitula 2014) (+/-) Facilitators • Are aware of condoms (DHS 2015-16) • Are aware of how HIV is transmitted and prevented (FHI/Maraxis 2018)	**Knowledge**: ↑ proportion who state that condoms are effective at preventing HIV/STI. **Attitudes**: ↑ proportion who believe young women have a right to ask their male sexual partners to use a condom. **Ability to Act**: ↑ proportion who feel confident in their ability to propose condom use to their male sexual partners. **Norms**: ↑ proportion who state that their male partners support using a condom during sex.
Primary: Unmarried, sexually active young men (15-24) (Juma)	Barriers • Feel condoms are difficult to find or access (FHI360 2018(1), Njau 2013, Kalolo 2015) (-/+) • Do not believe peers are using condoms (Hill 2018) (+/+) • Believe peers do not support condom use (Hill 2018) (-/+) • Believe condoms reduce sexual pleasure (FHI360 2018(1)) (+/-) • Believe men cannot control their sex drive (FHI360 2018(1)) (+/+) Facilitators • Are aware of condoms (DHS 2015-16, FHI360 2018(1))	**Knowledge**: ↑ proportion who state that men can control their sexual desires. **Attitudes**: ↑ proportion who state that men do not need to prove their masculinity through virility. **Attitudes**: ↑ proportion who believe that their female sexual partners have a right to refuse sex without a condom. **Ability to Act**: ↑ proportion who feel that condoms are easy to find and access. **Norms**: ↑ proportion who state that most of their peers are using condoms.

	• Are aware of how HIV is transmitted and prevented (FHI/Maraxis 2018) • Fear an unintended pregnancy might affect their community standing and future (FHI360 2018(1))	

Table 7: Communication objectives for HIV testing

Audience	Factors	Communication objectives
Primary: Unmarried, sexually active young women (15-24) (Subira & Edna)	Barriers • Are afraid of HIV results (Sanga 2015) (+/+) • Are afraid that providers will interrogate or judge her if she tries to access services (FHI360 2018(1), Hokororo 2015) (+/-) Facilitators • Are aware of how HIV is transmitted and prevented (FHI/Maraxis 2018) • Feel that HIV testing is important (FHI/Maraxis 2018, Sanga 2015) • Is aware of HIV testing and where it is available (FHI/Maraxis 2018, Sanga 2015)	**Attitudes**: ↑ proportion who believe that HIV treatment can keep someone healthy and productive if they are HIV-positive. **Ability to Act**: ↑ proportion who know where to access youth-friendly HIV testing services. **Norms**: ↑ proportion who feel providers will provide supportive, confidential HIV testing services.
Secondary: Health care providers (Cynthia)	Barriers • Believe that unmarried young people should not be sexually active (PSI 2017) (-/+) • Have limited training on new HIV counselling methods (Cawley 2016) (-/+) • Have received limited training on how to work with young people (FHI360 2018(1), PSI 2017) (+/+) • Feel they have limited time to provide adequate counselling to every client (FHI360 2018(1)) (+/-) Facilitators • Want to be recognized as a respected "healer" in their communities (FHI360 2018(1))	**Attitudes**: ↑ proportion who believe unmarried, young women have a right to access HIV testing services. **Ability to Act**: ↑ proportion who feel confident in their ability to provide confidential HIV testing services to unmarried, young women. **Norms**: ↑ proportion who state that their community supports providing HIV testing services to unmarried, young women.

Table 8: Communication objectives for adherence to HIV treatment[3]

Audience	Factors	Communication objectives
Primary: Unmarried, sexually active young women (15-24) (Subira & Edna)	• Need more information	**Knowledge**: Need more information **Attitudes**: Need more information **Ability to Act**: Need more information **Norms**: Need more information

[3] A loss to follow-up survey is planned for 2019 to identify barriers and facilitators to adherence to HIV treatment and use this evidence to develop communication objectives and activities.

Unmarried, sexually active young men (15-24) (Juma)		
Secondary: Parents (Mr and Mrs Alex)	• Need more information	**Knowledge**: Need more information **Attitudes**: Need more information **Ability to Act**: Need more information **Norms**: Need more information

Table 9: Communication objectives for VMMC

Audience	Factors	Communication objectives
Primary: Early adolescent boys (10-14), not yet sexually active (Khamar)	Barriers • Worry about pain from the injection or procedure (Patel 2018) (+/+) Facilitators • Are aware that VMMC offers many health benefits (Patel 2018) • Believe that most of their peers are circumcised (Patel 2018) • Believe that most of their peers think circumcision is a good thing (Patel 2018) • Believe they will be stigmatized if they are not circumcised (Patel 2018)	**Knowledge**: ↑ proportion who state that VMMC is a minor procedure. **Knowledge**: ↑ proportion who state that medicines are used during the procedure to make VMMC less painful. **Ability to Act**: ↑ proportion who feel confident in their ability to go for VMMC. **Norms**: ↑ proportion who state that most of their peers are circumcised.
Primary: Unmarried, sexually active young men (15-24) (Juma)	Barriers • Worry about pain from the injection or procedure (Patel 2018) (+/+) Facilitators • Are aware that VMMC offers many health benefits (Patel 2018) • Believe that most of their peers are circumcised (Patel 2018) • Believe that most of their peers think circumcision is a good thing (Patel 2018) • Believe they will be stigmatized if they are not circumcised (Patel 2018) • Are influenced by the preferences of their female sexual partners (Kaufman 2018; Osaki 2015)	**Knowledge**: ↑ proportion who state that VMMC is a minor procedure. **Knowledge**: ↑ proportion who state that medicines are used during the procedure to make VMMC less painful. **Ability to Act**: ↑ proportion who feel confident in their ability to go for VMMC. **Norms**: ↑ proportion who state that women prefer sexual partners who have been circumcised.
Secondary: Juma's female sexual partners (Subira and Edna)	Barriers • Believe that VMMC encourages men to be promiscuous (Kaufman 2018; Osaki 2015) (+/+) Facilitators • Believe that a circumcised penis is cleaner (Osaki 2015; Potkin 2013) • Believe that a circumcised penis is more pleasurable during sexual intercourse (Kaufman 2018; Potkin 2013)	**Knowledge**: ↑ proportion who state that VMMC reduces a male sexual partner's risk of HIV infection. **Knowledge**: ↑ proportion who state that VMMC improves penile hygiene. **Attitudes**: ↑ proportion who state that VMMC does not encourage men to be promiscuous.

	• Believe that VMMC reduces their partner's risk of HIV infection (Kaufman 2018; Potkin 2013)	
Secondary: Khamar's parents (Mr and Mrs Alex)	• Need more information[4]	**Attitudes**: Need more information
		Ability to Act: Need more information
		Norms: Need more information
		Norms: Need more information

Key Messages and Channels

Audience insights informed the development of key messages for each communication objective. Each key message was matched to a channel based on that channel's (1) ability to reach the intended audience; (2) ability to effectively communicate the content of the message; (3) acceptability to the intended audience; and, (4) cost. Key messages and suggested channels are outlined in Table 10 for primary audiences and Table 11 for secondary audiences.

Table 10: Key messages and suggested channels for dissemination with primary audiences

Audience	Promoted behavior/key promise	Insight	Key message	Channel
Early adolescent girls (10-14), not yet sexually active (Pamela)	Behavior: Adhere to HIV treatment. Key promise: Need more information	Need more information	Need more information	Need more information
Early adolescent boys (10-14), not yet sexually active (Khamar)	Behavior: Adhere to HIV treatment. Key promise: Need more information	Need more information	Need more information	Need more information
Unmarried, sexually active older adolescent girls (15-19) (Subira)	Behavior: Use a modern contraceptive method to delay first pregnancy. Key promise: Using a modern contraceptive method is the best way to prevent an unintended pregnancy that might derail your goals and cause	She thinks that modern contraceptives have side effects that cause problems and could affect future fertility. (*Knowledge*)	There are many modern contraceptive methods available and they are safe; providers will help you decide on the best one for you and your needs.	Reality radio programs, interactive digital platform, small group discussions, referral invitations, print materials
		She does not understand her body or reproduction, so does not understand how a	Understanding your body and reproduction is an important part of growing up.	Small group discussions, print materials

[4] Audience consultations planned to inform the design of activities to reach younger adolescents (Pamela and Khamar) will include questions on VMMC.

	problems in your life.	modern contraceptive would help her. (*Knowledge*)		
		She feels that modern contraceptives are for older women or women who have already had children. (*Attitudes*)	Young women just like you are using modern contraceptives to prevent unintended pregnancies.	Reality radio programs, interactive digital platform, community magnet theatre, artistic competitions, small group discussions, print materials
		She is afraid that she will be judged and lectured by providers when she tries to access modern contraceptive services. (*Ability to Act*)	Many health centers and clinics have providers who have been trained to work with young people.	Reality radio programs, community magnet theatre, young women's events, small group discussions, referral invitations
		She wants her parents to view her as a "good girl" and is afraid that if they find her using contraceptives that she will be shamed. (*Norms*)	Your parents care about you and want you to be successful in life, using a modern contraceptive method is one way to protect your success.	Reality radio programs, community magnet theatre, small group discussions
Unmarried, sexually active emerging adult women (20-24) (Edna)	Behavior: Use a modern contraceptive method to delay first pregnancy. Key promise: Using a modern contraceptive method helps you avoid unintended pregnancies that will cause you to lose control over your own future.	She is afraid of side effects and does not know which options are best for her. (*Knowledge*)	There are many modern contraceptive methods available and they are safe; providers will help you decide on the best one for you and your needs.	Reality radio programs, interactive digital platform, community magnet theatre, small group discussions, referral invitations, print materials
		She feels that modern contraceptives are for older women or women who have already had children. (*Attitudes*)	Young women just like you are using modern contraceptives to prevent unintended pregnancies.	Reality radio programs, interactive digital platform, community magnet theatre, small group discussions, print materials
		She is afraid that she will be judged and lectured by providers when she tries to access contraceptive services. (*Ability to Act*)	Many health centers and clinics have providers who have been trained to work with young people.	Reality radio programs, community magnet theatre, young women's events, small group discussions, referral invitations

		She does not believe her peers are using modern contraceptives. (*Norms*)	Your peers are using contraceptives to avoid unintended pregnancies that could cause them to lose control of their futures.	Reality radio programs, community magnet theatre, small group discussions
Older adolescent girls who have begun childbearing (15-19) (Maua)	Behavior: Use a modern contraceptive method to delay future pregnancies. Key promise: Using a modern contraceptive method to delay future pregnancies will allow you to get your life back on track.	She is afraid of side effects and the impact modern contraceptives might have on her future fertility. (*Knowledge*)	Modern contraceptive methods are safe for young women and have no impact on future fertility.	Small group discussions, in-home visits, printed materials
		She is afraid that she will be judged and lectured by providers when she tries to access modern contraceptive services. (*Ability to Act*)	Many health centers and clinics have providers who have been trained to work with young people.	Young women's events, small group discussions, in-home visits, referral invitations
		She wants to show her parents that she is making up for her past mistakes and taking control of her life. (*Norms*)	Your parents care about you and want you to be successful in life, using a modern contraceptive method is one way to show them that you're taking control of your future.	Small group discussions, in-home visits
Unmarried, sexually active young women (15-24) (Subira & Edna)	Behavior: Use a condom correctly and consistently. Key promise: Encouraging your sexual partner to use a condom can protect your health and future by avoiding both HIV/STI and an unintended pregnancy.	She doubts that condoms are effective at preventing HIV/STI infections. (*Knowledge*)	When used correctly and consistently condoms are very effective at protecting you against HIV/STI or an unintended pregnancy during sex.	Reality radio programs, community magnet theatre, targeted interpersonal outreach, small group discussions, print materials
		She does not believe it is appropriate for women to ask their partner to use a condom. (*Attitudes*)	Women have a right to protect their own health, so you have a right to ask your partner to wear a condom.	Reality radio programs, community magnet theatre, targeted interpersonal outreach, small group discussions, print materials
		She is not sure how to ask her male sexual partners to use a condom. (*Ability to Act*)	With a little practice, you will see that it is easy to talk to your partner	Reality radio programs, community magnet theatre, targeted interpersonal outreach, small group

			about using a condom.	discussions, print materials
		She does not think her male sexual partner would be supportive of using a condom. (*Norms*)	Like you, your male partner does not want an unintended pregnancy; he will happy to know that you're trying to avoid an unintended pregnancy.	Reality radio programs, community magnet theatre, targeted interpersonal outreach, small group discussions, print materials
Unmarried, sexually active young men (15-24) (Juma)	Behavior: Use a condom correctly and consistently. Key promise: Using a condom to avoid an unintended pregnancy or HIV/STI can ensure your future independence.	He thinks that men cannot control their sexual desires. (*Knowledge*)	Strong men can control their sexual desires.	Reality radio programs, community magnet theatre, sponsored mobilizations, small group discussions, printed materials
		He believes that a man must prove his masculinity by dominating many sexual partners. (*Attitudes*)	Virility does not define a man, his actions to protect his health do.	Reality radio programs, community magnet theatre, sponsored mobilizations, small group discussions, printed materials
		He does not believe that his female sexual partners have a right to refuse sex without a condom. (*Attitudes*)	Your female sexual partners have a right to refuse sex without a condom; she has a right to protect her health and future, just like you.	Reality radio programs, community magnet theatre, sponsored mobilizations, small group discussions, printed materials
		He does not feel that condoms are easy to find and access. (*Ability to Act*)	Free and low-cost condoms are available everywhere, including youth-friendly outlets.	Reality radio programs, community magnet theatre, sponsored mobilizations, small group discussions, print materials
		He does not think his peers are using condoms. (*Norms*)	Your peers are using condoms to protect their futures too.	Reality radio programs, community magnet theatre, sponsored mobilizations, small group discussions, print materials
Unmarried, sexually active young women (15-24) (Subira & Edna)	Behavior: Get an HIV test. Key promise: Knowing your HIV status helps keep you healthy; if you're HIV-positive, there is treatment available.	She believes that an HIV-positive test would destroy her future plans. (*Attitudes*)	HIV treatment is available to keep you healthy and productive if they are HIV-positive.	Reality radio programs, community magnet theatre, targeted interpersonal outreach, sponsored mobilizations, print materials
		She is afraid that if she tests HIV-positive the provider will not protect her	Providers are trained to protect your confidentiality.	Reality radio programs, community magnet theatre, targeted interpersonal outreach, sponsored mobilizations

		confidentiality. (*Ability to Act*)		
		She is afraid that providers will judge her if she tries to access HIV testing services. (*Norms*)	Youth-friendly services are available and can be found at [reference to local facility with providers trained to work with young women].	Targeted interpersonal outreach, referral invitations
Unmarried, sexually active young women (15-24) (Subira & Edna) **Unmarried, sexually active young men (15-24) (Juma)**	Behavior: Adhere to HIV treatment. Key promise: Need more information	Need more information	Need more information	• Need more information
Early adolescent boys (10-14), not yet sexually active (Khamar)	Behavior: Go for VMMC. Key promise: By going for VMMC, you are taking an important step to guard your future success.	He thinks VMMC is a major procedure that can be very painful. (*Knowledge*)	VMMC is a minor procedure that takes only a few minutes to complete.	School- and club-based instructional program, print materials
		He believes that VMMC is not worth the pain suffered. (*Attitudes*)	VMMC uses medicines during the procedure that make it less painful.	School- and club-based instructional program, print materials
		He is not confident in his ability to go for VMMC. (*Ability to Act*)	Many young men like you have undergone VMMC, you can too. Providers are there to support you throughout the process.	School- and club-based instructional program, print materials
		He is influenced by his peers and wants to do what his peers are doing. (*Norms*)	Most of your peers are circumcised and think you should do it too.	School- and club-based instructional program, print materials
Unmarried, sexually active young men (15-24) (Juma)	Behavior: Go for VMMC. Key promise: By going for VMMC, you are taking an important step to guard your future success.	He thinks VMMC is a major procedure that can be very painful. (*Knowledge*)	VMMC is a minor procedure that takes only a few minutes to complete.	Outdoor media, radio spots, reality radio programs, community magnet theatre, sponsored mobilizations, small group discussions, print materials
		He believes that VMMC is not worth the pain suffered. (*Knowledge*)	VMMC uses medicines during the procedure that make it less painful.	Outdoor media, radio spots, reality radio programs, community magnet theatre, sponsored mobilizations, small group discussions, print materials

	He is not confident in his ability to go for VMMC. (*Ability to Act*)	Many young men like you have undergone VMMC, you can too. Providers are there to support you throughout the process.	Outdoor media, radio spots, reality radio programs, community magnet theatre, sponsored mobilizations, small group discussions, print materials
	He is influenced by what he believes his future sexual partners want. (*Norms*)	Your future sexual partners prefer men who have undergone VMMC.	Outdoor media, radio spots, reality radio programs, community magnet theatre, small group discussions, print materials

Table 11: Key messages and suggested channels for dissemination with secondary audiences

Audience	Promoted supportive behavior/key promise	Insight	Key message	Channel
Parents (Mr and Mrs Alex)	Supportive behavior: Support daughter/son to access SRH information and services; keep children enrolled in school through secondary. Key promise: Supporting your daughter/son to access SRH information and services is one of the best ways to protect her/his future.	They do not feel that it is appropriate to talk to young people about SRH. (*Attitudes*)	If you want to protect the future success of your children, you need to be open with them about SRH and how they can protect themselves from unintended pregnancies.	Reality radio programs, community dialogues
		They are not sure how to support to their children about SRH. (*Ability to Act*)	You can talk to children about your hopes for their future and encourage them to stay safe by knowing their bodies and taking steps to protect their health.	Reality radio programs, community dialogues
		They do not want people in their community to think they are bad parents encouraging their children to have sex. (*Norms*)	Other parents are talking about SRH with their children and encouraging them to take steps to protect their health and future success.	Reality radio programs, community dialogues

Juma's female sexual partners (Subira and Edna)	Supportive behavior: Encourage male sexual partner to undergo VMMC. Key promise: Supporting your male sexual partner to undergo VMMC is one way to show him that you care.	They are open to promoting VMMC if they know it can reduce the risk of HIV acquisition. (*Knowledge*)	VMMC has many benefits, including a reduced risk of acquiring HIV.	Radio spots, reality radio programs, community magnet theatre, small group discussions
		They would like their sexual partner to maintain good penile hygiene. (*Knowledge*)	VMMC has many benefits, including improving penile hygiene since it is easier to keep clean.	Radio spots, reality radio programs, community magnet theatre, small group discussions
		They fear that if their male partner undergoes VMMC he will become promiscuous. (*Attitudes*)	There is no evidence showing that men who are circumcised are more likely to have multiple sexual partners.	Radio spots, reality radio programs, community magnet theatre, small group discussions
Teachers, School Administrators (Margaret)	Supportive behavior: Advocate for adolescents and young people to receive comprehensive SRH information. Key promise: Ensuring your students have complete and correct information about SRH is one of the best ways to protect their futures.	Need more information	Need more information	Need more information
Health care providers (Cynthia)	Supportive behavior: Provide quality, unbiased, non-judgmental services to young women and men. Key promise: Supporting young women to access modern contraceptives could help prevent an unintended pregnancy that might be the ruin of her and her family.	She feels unmarried, young women should not be having sex. (*Attitudes*)	Young people are sexually active, denying them services will not change that; it is better to prevent than treat the problems that may come with unprotected sex.	Provider coaching & training, recognition program, printed provider tools
		She is not confident in her ability to provide services to young people. (*Ability to Act*)	With training and practice, you will become more comfortable providing SRH	Provider coaching & training, recognition program, printed provider tools

		services to young people.	
	She does not think her colleagues and community want her to give SRH services to young people. (*Norms*)	Your community wants you to help young people stay healthy; they know it is better to prevent than treat SRH problems.	Recognition program, provider coaching & training, printed provider tools

Addressing Key Social and Gender Norms

As indicated in the tables above, addressing key social and gender norms will be a priority to enable adoption of most of the behaviors promoted by the youth program. Table 12 summarizes the key social and gender norms to be addressed.

Table 12: Summary of social and gender norms to be addressed

Social and gender norm	Effect on individual behavior	How this will be addressed
Social expectations dictate that unmarried young people, especially young women, should not be sexually active	• Discourages unmarried young people, especially young women, from accessing SRH services or seeking out information about SRH from parents or other adults • Discourages providers from facilitating access to SRH services and information	• Radio programs and community dialogues that explore gender norms and provide actions parents and other community members can adopt to support young people • Coaching, training, and equipping providers to offer non-judgmental, quality SRH services and information to young people
Widespread belief that contraceptives are primarily for married women with children	• Discourages unmarried young people, especially young women, from accessing SRH services • Discourages providers from facilitating access to contraceptive services and information	• Radio programs, interactive digital platform, community magnet theatre, artistic competitions, small group discussions, and print materials that promote use of contraceptives among unmarried young women • Coaching, training, and equipping providers to offer contraceptive services to unmarried young women
Most people, including young women, believe that fertility is the most important asset a young woman possesses	• Discourages young women from taking actions they believe could affect future fertility • Encourages unmarried women to view an unintended pregnancy as a potentially positive • Discourages providers from offering young women all contraceptive options	• Radio programs, interactive digital platform, small group discussions, and print materials that promote the variety and safety of contraceptive options • Coaching and training providers to understand the variety and safety of contraceptive options

Men are perceived by the community as needing to dominate in relationships and be the primary decision-makers in their households	• Encourages men, including young men, to exert violence and dominance over women • Discourages young women from insisting on condom use with their sexual partners	• Radio programs, community magnet theatre, sponsored mobilizations, small group discussions, and printed materials that promote discussion around concepts of gender equity and masculinity
Widespread belief that talking about sex with young people will encourages them to engage in premarital sexual activity	• Discourages parents from talking to their children about SRH issues • Discourages young people from seeking out SRH information from their parents and other adults • Discourages providers from facilitating access to SRH services and information	• Radio programs and community dialogues that explore gender norms and provide actions parents and other community members can adopt to support young people • Coaching, training, and equipping providers to offer non-judgmental, quality SRH services and information to young people

Coordination with Service Delivery Partners

To achieve the behavioral objectives outlined above, the youth SBCC program will enhance coordination with service delivery partners to address supply-side barriers—such as provider skills and attitudes, accessibility of HIV and contraceptive services, and availability of needed products—to ensure that young people receive high quality services. Specific activities that must be developed, implemented, and monitored in collaboration with service delivery partners include:

- Equipping, inspiring and supervising providers to deliver high-quality, non-judgmental services to young people, including screening young contraceptive clients for HIV risk and young HIV clients for contraceptive need;
- Organizing youth day events at local health facilities;
- Implementing a provider recognition program;
- Collecting and tracking referral tickets distributed by the youth SBCC program community partners; and,
- Conducting HIV testing outreach to reach at-risk AGYW.

Each of these activities will be co-created with the appropriate service delivery partner and work planning linkages will be established.

Monitoring and Evaluation

To monitor implementation of this strategy, several activity indicators will be collected through standardized activity report forms and analyzed on a regular basis. Activity indicators are outlined in table 13.

Table 13: Proposed activity indicators

Indicator	Disaggregation	Data Source	Reporting frequency
Mass media activities			
Number of outdoor media elements flighted	Theme, format, district	Agency reports	Quarterly
Number of radio spots flighted	Theme, district	Agency reports	Quarterly
Number of reality radio episodes flighted	Theme, district	Agency report	Quarterly
Mid-media activities			
Number of mid-media events organized	Theme, format, district	Activity reports	End of event

Number of participants in mid-media events	Theme, format, district	Activity reports	End of event
Facility-based activities			
Number of printer provider tools disseminated	District	Dissemination reports	Quarterly
Number of referrals from community activities redeemed	Gender, service type, age category, district	Referral tracking reports	Quarterly
Number of client takeaway materials distributed	Theme, district	Dissemination reports	Quarterly
Community dialogue activities			
Number of community dialogue sessions organized	Theme, district	Activity reports	End of event
Number of participants in community dialogue sessions	Theme, district, age category	Activity reports	End of event
IPC activities			
Number of individuals trained to conduct IPC activities	Gender, age category, district	Training reports	Quarterly
Number of individuals who participate in at least 4 IPC activities	Gender, theme, age category, district	Participant register; end of group contact reports	Quarterly
Number of young couples that participate in in-home counseling sessions	Gender, theme, age category, district	Monthly counseling reports	Quarterly
Number of client takeaway materials distributed through IPC channels	Theme, district	End of group contact reports	Quarterly
Number of referrals made during IPC activities	Gender, service type, age category, district	End of group contact reports	Quarterly
Number of supervision visits completed	District	Supervision reports	Quarterly

The reach and impact of activities described in this strategy will be evaluated using discrete omnibus and sentinel surveillance surveys. Reach of some mass media activities will also be monitored using commercially available tools.

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Annex A: Detailed Primary Audience Profiles

Pamela & Khamar

Early adolescent boys and girls (10-14), not yet sexually active

Behaviors to Promote

- Delay first sex
- Go for VMMC (Khamar only)

Summary

Pamela and Khamar are primary school students in their early teenage years. They both spend most of their day at school. They live in a peri-urban area with their families, which include two parents and some siblings. Neither has heard much about puberty or sex, although they have learned about animal reproduction in school. Their parents have never spoken with them about puberty or sex, but they have heard people talk about unintended pregnancy and how it is bad for the girl and her family.

Demographics

- Age: 12 years old (10-14)
- Education: Currently enrolled in primary school
- Marital status: unmarried
- Living situation: Lives in a peri-urban area with their families
- Comes from lowest or second lowest wealth quintile

Current behaviors

(Sexual debut): Not yet sexually active

Psychological developmental stages

Independence	Pamela and Khamar are starting to feel older and want more privacy and independence from their parents.
Cognitive development	Pamela and Khamar are not able to process abstract thoughts so consequences of their actions are not always clear.
Peer group	Pamela and Khamar are mostly interested in friendships with people of the same sex.
Body image	Pamela and Khamar have started to notice changes in their bodies, but they do not understand them.
Sexuality	Pamela and Khamar are starting to become attracted to others. Khamar feels pressure to show he is a real man by showing interest in girls.

Psychographics

- Likes to: need more information
- Wants: need more information
- Thinks that: need more information
- Believes that: need more information

Media Habits

- Need more information

Pamela and Khamar's typical day

Time of day	Where is they	What is they doing	Which channel are they exposed to
Early morning	At home	Preparing for school, eating breakfast	Radio
Mid-morning	In the community	Walking to school	Billboards
Mid-day	At school	Listening to lessons	In-school posters, dialogues, print materials
Early afternoon	At home	Break time	Dialogues, posters
Late afternoon	At school	Listening to lessons	In-school posters, dialogues
Early evening	At home	Preparing food, doing chores	Radio
Dinner	At home	Eating with family, talking with family	Radio
Night	At home	Talking with family	Radio
Special events	At church At mosque	Visiting with family, listening to speeches	Drama, dancing, dialogues, preacher remarks
Seasonal events	At family home	Visiting with family, doing chores	Radio, dialogues

Subira

Unmarried, sexually active older adolescent girls (15-19)

Behaviors to Promote

- Use a modern contraceptive method to delay first pregnancy
- Use condoms correctly and consistently to prevent HIV/STI infection
- Get an HIV test (if at risk)

Summary

Subira is in her late teens, does piece work to make some money; she is lower income and unmarried, and has a primary education. She lives in a peri-urban area with her family. She dreams of having a better life so is enrolled in DOTS training to develop some job skills, but also wants to get married one day to a man who cares for her and their family. She wants people in her community to view her as a success. She feels she has no one to talk to about sex and contraceptives, but will get information from her female friends since they don't judge her. She is very dependent on her family so she wants to keep them happy and be perceived as a "good girl." She fears getting pregnant early since her family would reject her, and even if the father were to marry her, she doubts he could adequately support her and their child. She is sexually active but doesn't use a modern contraceptive method, except the occasional male condom, which she relies on her partner(s) to propose. She's heard lots of bad things about modern contraceptives, mostly from her friends who talk about the side effects and bad treatment they received from health care providers.

Demographics

- Age: 17 years old (representing ages 15-19)
- Education: Dropped out of secondary school, but may be taking vocational classes
- Marital status: Not married (approx. 75% in this age group are not married)
- Living situation: Lives in a peri-urban area with her family
- Does piece work to contribute to household and cover personal some personal expenses
- Comes from lowest or second lowest wealth quintile

Current behaviors

(For contraceptive use): Sexually active since a young age, has never used a modern contraceptive, besides the male condom. Relies on her sexual partner(s) to decide if he will use a male condom.

(For HIV): Has sex with older men in exchange for money or gifts, such as car rides and airtime. Has never had an HIV test.

Psychological developmental stages

Independence	Subira is starting to develop her own value system; she still relies on her family for support, but her job gives her some financial independence.
Cognitive development	Subira understands the consequences of her behavior; wants to act to be more responsible.
Peer group	Subira relies heavily on her relationships with friends, they have an important influence on her decisions.
Body image	Subira is comfortable with her body, and has figured out how to handle her monthly periods; she likes to look good.
Sexuality	She has already initiated sex, but hasn't yet formed a strong emotional attachment to one person.

Psychographics

- Likes to: spend time with her friends
- Wants: to achieve success in life
- Thinks that: you cannot always trust the advice of other young women
- Believes that: an unintended pregnancy would ruin her "good girl" image with her family

Media Habits

- Watches some TV (at least 45% once per week) (FHI/Maraxis 2018)
- Listens to radio (at least 60% once per week) (FHI/Maraxis 2018)
- Does not own a mobile phone (FHI/Maraxis 2018)

Subira's typical day

Time of day	Where is she	What is she doing	Which channel is she exposed to
Early morning	At home	Getting ready for work	Radio
Mid-morning	On public transport	Traveling to work, listening to the radio	Radio, outdoor media
Mid-day	At work	Working, interacting with customers	Radio, posters, outdoor media
Early afternoon	At work	Working, interacting with customers	Radio, posters, outdoor media
Late afternoon	At work	Having lunch with friends/co-workers	Radio, posters
Early evening	In public transport	Traveling home, listening to the radio	Radio, outdoor media
Dinner	At home	Preparing dinner, eating	Radio
Night	At home	Visiting with friends	TV
Special events	Around town	Visiting with friends and family members	Drama, dancing, dialogues, preacher remarks
Seasonal events	At family home	Visiting with family, eating with family	Radio, dialogues

Edna

Unmarried, sexually active emerging adult women (20-24)

Behaviors to Promote

- Use a modern contraceptive method to delay first pregnancy
- Use condoms correctly and consistently to prevent HIV/STI infection
- Get an HIV test (if at risk)

Summary

Edna is in her early twenties, employed part-time at a restaurant; she is lower income, unmarried, and has a primary education. She lives in a peri-urban area with her family, but dreams of having a better life with a good family and meaningful relationship with her husband. She struggles now with feelings of financial insecurity. She wants to succeed in life and have the people around her view her as a success. She spends any free-time she has socializing with her female friends, who she trusts the most for information about health and contraception. She is sexually active and although she knows about modern contraceptives, she has never used one, except the male condoms. She wants to avoid an unintended pregnancy, but if it did happen, she feels she could adjust and handle it. She's heard lots of bad things about modern contraceptives, mostly from her friends who talk about the side effects and bad treatment they received from health care providers.

Demographics

- Age: 22 years old (representing ages 20-24)
- Education: Primary level only
- Marital status: Not married (approx. 60% in this age group are not married)
- Living situation: Lives in a peri-urban area with her family
- Works at a restaurant
- Comes from lowest or second lowest wealth quintile

Current behaviors

(For contraceptive use): Sexually active since age 17, but has never used a modern contraceptive, besides the male condom, which she uses only occasionally when her partner wants to use one.

(For HIV): Has sex with older men in exchange for money or gifts, such as car rides and airtime; she has never had an HIV test.

Psychological developmental stages

Independence	Edna is starting to develop her own value system; her job gives her some independence.
Cognitive development	Edna understands the consequences of her behavior; wants to act to be more responsible
Peer group	Edna relies heavily on her relationship with her friends
Body image	Edna is comfortable with her body, and has figured out how to handle her monthly periods; she likes to look good.
Sexuality	Edna has already initiated sex, but hasn't yet formed a strong emotional attachment to one person.

Psychographics

- Likes to: spend time with her friends
- Wants: to become financially independent so she can get married and have children on her own terms

- Thinks that: men cannot be trusted so she needs to make it on her own
- Believes that: a strong woman can handle an unintended pregnancy

Media Habits

- Watching bongo movies
- Owns a mobile phone with basic services (60% use at least once per week) (FHI/Maraxis 2018)

Edna's typical day

Time of day	Where is she	What is she doing	Which channel is she exposed to
Early morning	At home	Getting ready for work	Radio, SMS
Mid-morning	On public transport	Traveling to work, texting friends, listening to the radio	Radio, outdoor media, SMS
Mid-day	At work	Working, interacting with customers, texting friends	Radio, posters, outdoor media, SMS, social networks
Early afternoon	At work	Working, interacting with customers, texting friends	Radio, posters, outdoor media, SMS, social networks
Late afternoon	At work	Having lunch with friends/co-workers	Radio, posters
Early evening	In public transport	Traveling home, texting friends, listening to the radio	Radio, outdoor media, SMS
Dinner	At home	Preparing dinner, eating	Radio
Night	At home	Visiting with friends	TV
Special events	Around town	Visiting with friends and family members	Drama, dancing, dialogues, preacher remarks
Seasonal events	At family home	Visiting with family, eating with family	Radio, dialogues, TV

Maua

Has already begun childbearing (15-19)

Behaviors to Promote

- Use a modern contraceptive method to delay future pregnancies

Summary

Maua is in her late teens with a primary school education. She lives in a peri-urban area with her family, who she relies on to support her and her child. She will sometimes do small jobs or sell things to make some extra money. When she became pregnant, her parents were very angry and she was ostracized by some people in her community. Having a child out-of-wedlock has made her feel isolated from other people her age. Even though she is still young, she wants to be a good mother and give her child a healthy start in life. She often feels that now that she has a child of her own, it's impossible for her to dream about a bettering her situation in life. She sometimes wonders if her best option is to find a good husband who will take care of her and her child. More than anything, she wants to get her life back on-track, so she can provide for her child and show her family that she will be a success.

Demographics

- Age: 18 years old (representing older adolescent girls aged 15-19 who have already started childbearing)
- Education: Primary level only
- Marital status: Unmarried
- Living situation: Lives in a peri-urban area with her family
- Will do small jobs or sell things to make extra money
- Comes from lowest or second lowest wealth quintile

Current behaviors

(For contraceptive use): Has never used a modern method to prevent unintended pregnancies

Psychological developmental stages

Independence	Maua is close to her family and relies on them for support and guidance.
Cognitive development	Maua understands the consequences of her behavior.
Peer group	Maua relies less on peers, her family plays a more important role in her decision-making processes.
Body image	Maua is comfortable with her body.
Sexuality	Maua does not yet have an emotional attachment to a specific person.

Psychographics

- Likes to: spend time with her family and friends
- Wants: to achieve financial stability for her family
- Thinks that: being a mother is her most important role
- Believes that: finding a good husband is her best realistic option

Media Habits

- Listens to the radio (Approximately 60% listen at least once per week; FHI/Maraxis 2018)

Maua's typical day

Time of day	Where is she	What is she doing	Which channel is she exposed to
Early morning	At home	Doing house work, preparing food, caring for her child	Radio
Mid-morning	At home	Talking to neighbours, doing house work, selling things/working	Radio
Mid-day	At the market	Buying house items and food	Radio, posters, dialogues
Early afternoon	At home	Preparing food	Radio, outdoor media
Late afternoon	At home	Doing house work, talking with neighbours, selling things/working	Radio, dialogues
Early evening	At home	Preparing food	Radio
Dinner	At home	Eating with family, talking with family	Radio
Night	At home	Talking with family, visiting with friends	Radio
Special events	At church	Visiting with friends, listening to speeches	Drama, dancing, dialogues, preacher remarks
Seasonal events	At family home	Visiting with family, helping to prepare food	Radio, dialogues

Juma

Unmarried, sexually active young men (15-24)

Behaviors to Promote

- Use condoms correctly and consistently
- Go for VMMC

Summary

Juma is in his late teens, depends on hustling to make small money; he is lower income and unmarried, and has a primary education. He lives in a peri-urban area with his family. Once Juma started to go through puberty, his parents didn't track his activities as closely so he feels more independent. He has high expectations for himself and wants to become financially independent and in control of his own life. He feels pressure from his peers to prove he is a "real" man by having sex with girls. Juma hasn't ever received a lot of information about sex or puberty, but has heard things from his friends. Although he wants to avoid an unintended pregnancy, he believes that men have such a strong sex drive that you cannot easily stop to put on a condom. Also, he feels he would be embarrassed to go into a shop to purchase condoms. (For VMMC): He had heard of VMMC and feels that most young men his age are interested in VMMC. However, he is afraid of the pain and doesn't think he could make it through the recovery period without having sex.

Demographics

- Age: 19 years old (representing ages 15-24)
- Education: Primary level only
- Marital status: Not married (approx. 98% of 15-19 and 67% of 20-24 are not married)
- Living situation: Lives in a peri-urban area with his family
- Depends on hustling to earn income he contributes to household
- (For VMMC only) Lives in Kagera, Kigoma, Njombe, Shinyanga, Simiyu, or Tabora

Current behaviors

(For HIV): Sexually active since age 17, has had sex with a few girls in his community, rarely uses a male condom

Psychological developmental stages

Independence	Juma feels independent of his family.
Cognitive development	Juma understands the consequences of this behavior.
Peer group	Juma is still influenced by his peers.
Body image	Juma's body has finished developing, he is comfortable with his body and wants to look attractive to girls.
Sexuality	Juma has not developed an emotional attachment with one person.

Psychographics

- Likes to: spend time with his friends
- Wants: to become a successful person who is admired by his community
- Thinks that: men cannot control their sexual desires
- Believes that: a man must prove his sexual prowess early

Media Habits

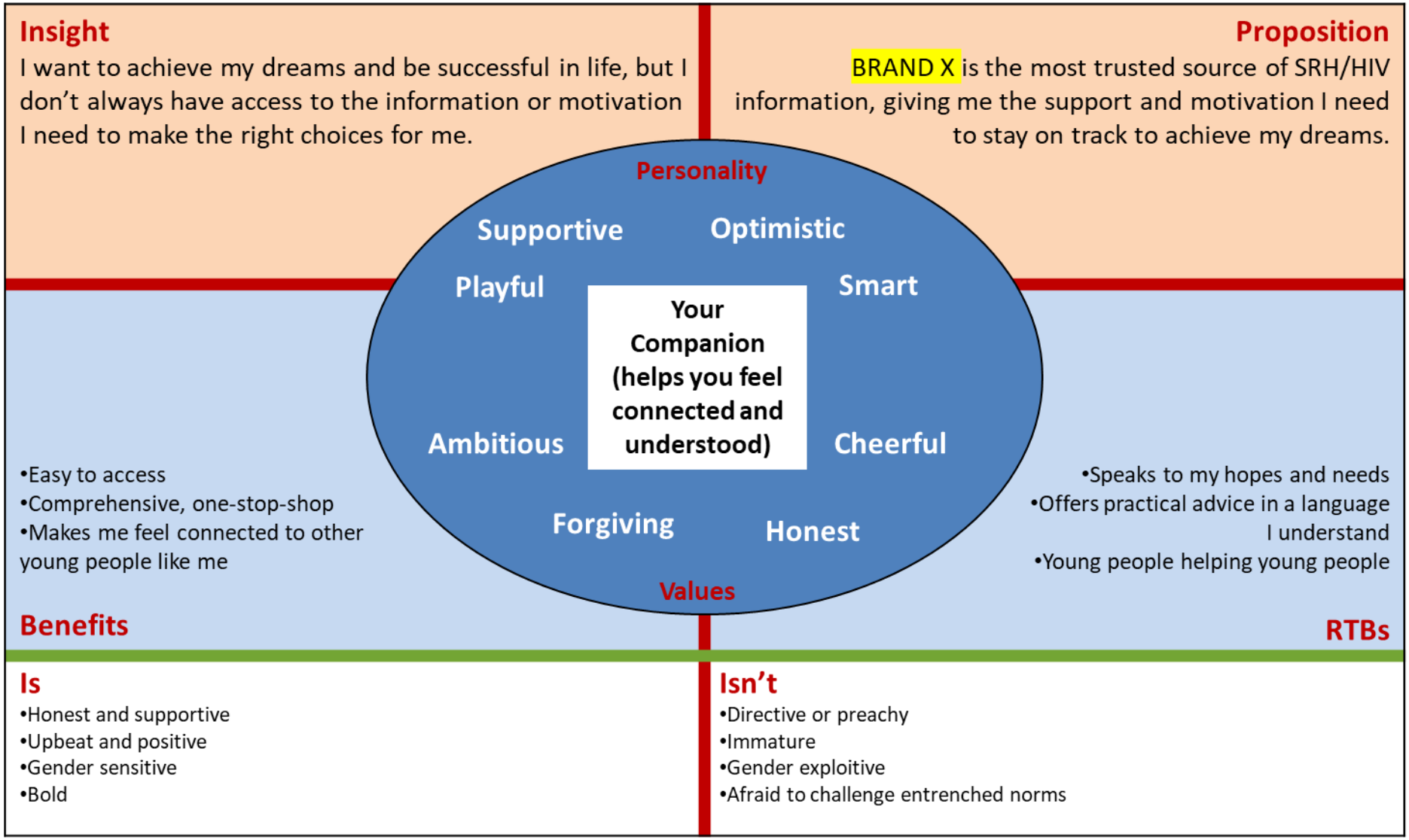
- Listens to the radio (60% at least once per week; TDHS-MIS 2015-16)

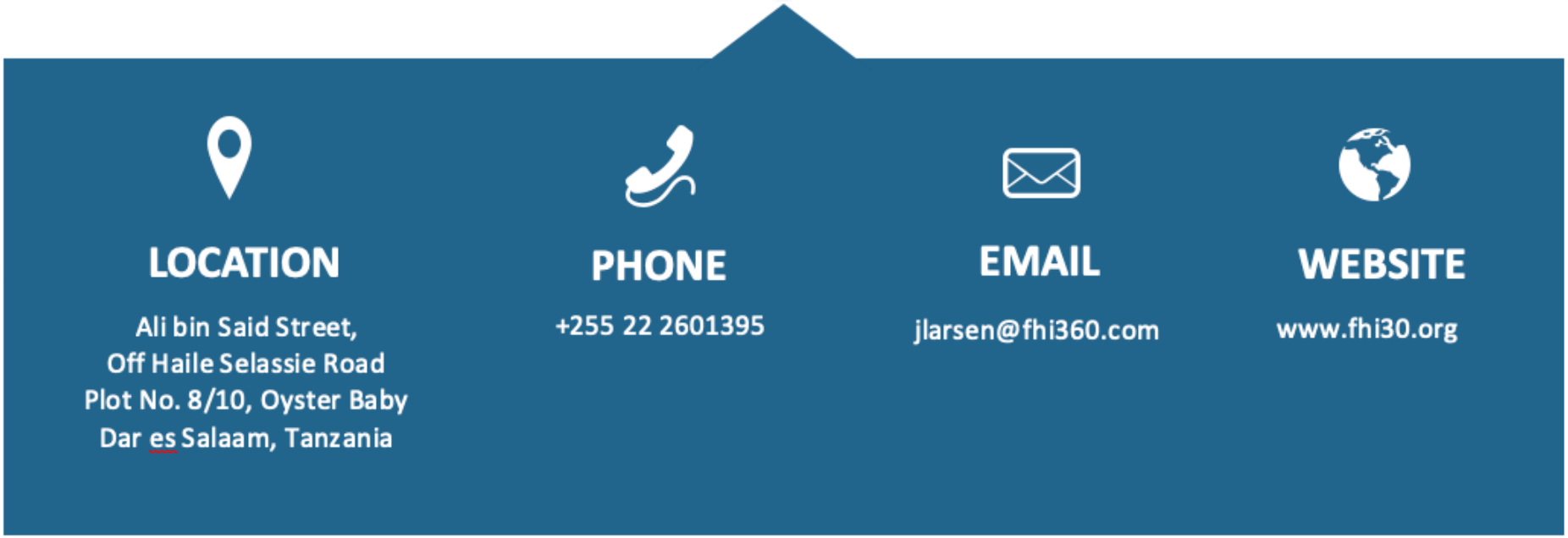
- Owns a mobile phone
- Uses basic SMS almost daily (51.8%; FHI/Maxaris 2018)

Juma's typical day

Time of day	Where is he	What is he doing	Which channel is he exposed to
Early morning	At home	Eating breakfast, getting ready to leave the house, doing small chores	Radio
Mid-morning	Around town	Talking to friends, trying to make business	SMS, posters, billboards, dialogues
Mid-day	Around street or workplace	Having lunch	Radio, SMS
Early afternoon	Around town	Talking to friends, trying to make business	SMS, posters, billboards, dialogues
Late afternoon	Around town	Talking to friends, trying to make business	SMS, posters, billboards, dialogues
Early evening	Sports grounds	Watching or playing football with friends	SMS, posters, billboards, dialogues
Dinner	At home	Eating with family, talking with family	Radio
Night	Around neighbourhood	Hanging out with friends, club video or kijiweni	Radio, SMS, dialogue
Special events	Around town	Visiting with friends and family members	Drama, dancing, dialogues, preacher remarks
Seasonal events	Around town	Visiting with family, eating with family	Radio, posters, SMS, dialogues

Annex B: Master Brand Blueprint

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