



Republic of Malawi

National Behaviour Change Interventions Strategy for HIV/AIDS and Sexual Reproductive Health

National AIDS Commission and Reproductive Health Unit

April 2003

ISBN: 99908-73-06-2



National AIDS Commission
P.O. Box 30622
Lilongwe 3
Malawi

Telephone: 265 1 770 022

Fax: 265 1 776 249

© April 2003 National AIDS Commission and Reproductive Health Unit

All rights reserved. The material in this publication is copyrighted. Copying and/or transmitting portions or all of this work without permission may be a violation of applicable law. The National AIDS Commission encourages dissemination of its work and will normally grant permission to reproduce portions of the work promptly.

For permission to photocopy or reprint any part of this work, please send a request to the Executive Director, National AIDS Commission.

ISBN: 99908-73-06-2

Table of Contents

Acronyms	v
Acknowledgements	vii
Foreword	viii
Executive Summary	ix
1.0 Introduction	1
1.1 Background	1
1.2 What is the global and local situation we are now facing?	1
1.2.1 Global HIV/AIDS/SRH Picture	1
1.2.2 Sub-Saharan Africa	2
1.2.3 Malawi	2
1.3 Why is a BCI strategy needed?	3
1.4 What and for who is the National BCI Strategy for HIV/AIDS/SRH?	4
1.5 How was the BCI Strategy developed and how will it be implemented?	4
1.6 What are the main differences between Behaviour Change Interventions and Information Education Communication (IEC)?	7
2.0 Components of the Strategy	9
2.1 Purpose of the BCI Strategy	9
2.2 Objectives of the National BCI Strategy	10
2.3 Guiding Principles	10
2.4 Key Social Groups	11
2.5 National BCI Planning Framework.....	11
2.5.1 Problem Behaviours	12
2.5.2 Barriers.....	12
2.5.3 Key Social Groups Segmented	14
2.5.4 Desired Behaviours	14
2.5.5 Strategic Objectives.....	14
2.5.6 Behaviour Change Interventions	16
2.5.7 Channels/Change Agents.....	17
2.6 Monitoring and Evaluation	18
2.6.1 Levels of monitoring and evaluation	18
2.6.2 Indicators.....	20
2.7 Supporting the Implementation of the Strategy	21
Appendices	23

Acronyms

AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Antenatal Care
BC	Behavior Change
BCC	Behaviour Change Communication
BCCU	Behaviour Change Communication Unit of the NAS
BCI	Behaviour Change Interventions
CBO	Community Based Organisation
CIDA	Canadian International Development Agencies
CSW	Commercial Sex Worker
DAC	District AIDS Coordinator
DHS	Department of Health Services
DFID	Department for International Development
DPS	Department of Population Services
FHI	Family Health International
FP	Family Planning
HBC	Home Based Care
HEU	Health Education Unit
HIV+	HIV Positive
HIV	Human Immuno-deficiency Virus
IEC	Information, Education, Communication
IMPACT	Implementing AIDS Prevention and Care Project
KSG	Key Social Group
KAP	Knowledge, Attitudes and Practices
LATH	Liverpool Associates in Tropical Health
M&E	Monitoring and Evaluation
MTCT	Mother to Child Transmission
MH	Maternal Health
MOGYCS	Ministry of Gender, Youth, and Community Services
MOHP	Ministry of Health and Population
NAC	National AIDS Commission
NACP	National AIDS Control Programme
NGO	Non-governmental Organisation
PLWA	People Living with HIV/AIDS
PLWSTIs	People Living with Sexually Transmitted Infections
PLWTB	People Living with Tuberculosis
PMTCT	Prevention of Mother-to-Child Transmission
RH	Reproductive Health
RHU	Reproductive Health Unit
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infections
SRH	Sexual and Reproductive Health
SRHP	Sexual and Reproductive Health Programme
TB	Tuberculosis
TBA	Traditional Birth Attendant

TC	Traditional Counselor (nankungwis, ngalibas, uncles, aunties, and grandparents)
TH	Traditional Healer
TWG	Technical Working Group
UN	United Nations
UNAIDS	United Nations AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nation Children Fund
USAID	United State Agencies for International Development
VCT	Voluntary Counseling and Testing

Acknowledgements

This document is prepared as a national guideline for planning behaviour change interventions and activities on HIV/AIDS and Sexual Reproductive Health [SRH] for the period 2001-2004. Overall leadership for the development process of this document was provided by Dr. Bizwik Mwale, Executive Director, National AIDS Commission, and Mrs. Jane Namasasu, Program Manager of the Reproductive Health in the Ministry of Health and Population.

A special mention is made of Dr. Owen Kaluwa, Director of Programmes, National AIDS Commission, and Ms. Francine Ducharme, BC Specialist, Family Health International (FHI) for their initiative and technical leadership in the development of the Behaviour Change Intervention Strategy.

The strategy development process was facilitated by a Joint Core Team comprising the Behaviour Change Interventions [BCI] Unit in the National AIDS Commission, the Reproductive Health Unit [RHU] and Health Education Unit (HEU) in the Ministry of Health and Population, as follows:

1. Mr. Roy Hauya, Head, BCI Unit, National AIDS Commission
2. Mr. Jonathan Nkhoma, Head, Health Education Services, Ministry of Health and Population
3. Mr. Hector Kamkwamba, IEC Officer, Health Education Unit, Ministry of Health and Population
4. Mr. Wise Chauluka, IEC Officer, National AIDS Commission
5. Mr. Robert Chizimba, Advocacy Officer, National AIDS Commission
6. Ms. Beth Deutsch, BCI Technical Officer, Sexual Reproductive Health Programme, Ministry of Health and Population
7. Ms. Karen Coyne, Reproductive Health Specialist, Reproductive Health Unit (RHU)
8. Susan Laver, Monitoring and Evaluation, Family Health International Consultant
9. Shalote Chipamaunga, BCI Training Consultant, Family Health International.

Special thanks and acknowledgement are also extended to all the members of the BCI Technical Working Group, donors and UN organizations for their guidance and invaluable comments made in the development of the BCI Strategy.

We would like also to acknowledge the contribution made by Dr. Yolande Coombes, who produced the BCI Literature Review and provided technical assistance in the preparation of the initial draft of the BCI Strategy.

The financial and technical assistance provided by Department For International Development (DFID), Family Health International FHI/IMPACT, Liverpool Associates in Tropical Health (LATH), United Nations Population Fund (UNFPA), United States Agency for International Development (USAID) in the preparation of the strategy is also gratefully acknowledged.

Foreword

Malawi has over the years continued to respond to the various challenges that the HIV/AIDS epidemic and Sexual Reproductive Health [SRH] has posed to its population. This is the first time that Malawi has developed a comprehensive strategy focusing on behavior change and integrating HIV/AIDS and SRH issues.

The publication of the Malawi National HIV/AIDS/SRH BCI Strategy is a culmination of one year of research analysis, consultations and participatory planning involving numerous stakeholders and development partners. It is recognition that with a comprehensive framework for behavior change interventions, Malawians will be able to translate generally high levels of awareness into sustainable behaviour change and adoption of positive sexual and health values.

This Strategy becomes the planning framework for all HIV/AIDS/SRH behavior change interventions. It will also form the base for increasing coordination of action and for mobilizing locally available resources and capacities to offer a stronger collective response. The strategy will further act as a tool for monitoring and evaluating the national responses in a sustainable manner.

We wish to urge all implementing agencies and cooperating partners to be forthcoming in putting this important framework into operation for increased behavior change among all Malawians, especially the young people of this country.



Dr. Richard B. Pendame
Secretary for Health and Population

Executive Summary

What is the strategy?

The National BCI Strategy is a planning tool, to guide ministries, district planners, NGOs, CBOs, DACCs, learning institutions, faith institutions and employers on effective HIV/AIDS and SRH behaviour change programs. The strategy is also intended to guide donors on areas of support and interventions that require national resources.

The strategy:

1. Provides background information to its development;
2. Describes what Behaviour Change Interventions are and how they differ from IEC approaches;
3. States the objectives of what needs to be achieved through the proposed interventions;
4. Outlines national behavioural priorities and strategies for HIV/AIDS and SRH that need to be addressed based on research evidence;
5. Defines coordination mechanisms to maximize limited human and financial resources; and
6. Sets up indicators for monitoring and evaluation of BCI.

Drawn from the goals of both the NAC and the SRHP, the purpose of the BCI Strategy “seeks to empower Malawians to develop and maintain safer sexual and reproductive health practices in a stigma-free and gender transformative environment.”

What will the BCI Strategy achieve?

A national literature review highlighted two main national problem behaviours, which need to be tackled in order to have an impact on high rates of STI/HIV infection and maternal death in Malawi. The problems are:

1. Unsafe sexual and reproductive health practices.
2. Inconsistent health seeking behaviours.

To address these two main problem behaviours, the national BCI Strategy seeks to achieve the following objectives:

- a) Promote safer sexual and reproductive health practices among Malawians
- b) Promote consistent health seeking behaviour among Malawians.

Safer sex practices include delaying first sexual intercourse, reducing the number of men, women and young people who have multiple sexual partners, and increasing the number of men, women and young people who use condoms correctly and consistently.

Consistent health-seeking behaviour includes increasing the number of men, women and young people accessing HIV/AIDS and SRH services in a timely manner, including early STI treatment, and increasing the number of women delivering with skilled personnel.

Behaviour change interventions focus on addressing the following barriers:

- a) Knowledge gaps on issues of HIV/AIDS/SRH
- b) Low self-risk perception
- c) Lack of community dialogue on issues of SRH and HIV/AIDS
- d) High stigma and stigmatisation related to HIV/AIDS/SRH.
- e) Gender inequalities at all levels of society that need to be addressed within HIV/AIDS and SRH issues.
- f) Harmful sexual and reproductive health practices in communities that increase STI/HIV transmission and maternal deaths.
- g) Little community involvement in HIV/AIDS/SRH activities
- h) Poor client and service provider relationships has led to dissatisfaction in the quality of services and low utilization of services.

Who are we targeting?

The BCI Strategy has identified 6 key social groups for BC interventions. These include young people aged 7-24, men and women engaging in high-risk behaviours, women of Childbearing age, opinion leaders, service providers, and policy makers.

For each of the 6 key social groups, a detailed matrix for development of implementation plans is provided.

What are the main indicators tracked at the national level?

Nationally, the BCI Strategy will track the following trends:

- a) HIV prevalence rates in sexually active population (females and males of all ages)
- b) STI incidence and prevalence rates in sexually active population (females and males of all ages)
- c) Maternal mortality rate

For each of the key social groups, specific behaviour-related indicators will address the following:

Sexual behaviour

- a) Age of first sexual intercourse for girls and boys
- b) % of reported condom use among men, women and young people with non cohabitating partners
- c) % of reported condom use among men and women with cohabitating partners
- a. Health seeking behavior
- d) % of men, women, and young people who go to health centers for STI treatment
- e) % of men, women, pregnant women and young people who are counseled and tested for HIV at all centers
- f) % of men and women using contraceptives of choice
- g) % of women who deliver with a skilled attendant (and present for post-natal checkups)

within the first week.

- h) % of women who receive emergency obstetric care
- i) % of women who report exclusive infant feeding with appropriate method of choice.

What are specific behavioural objectives to achieve for each key social group?

The objectives can be summarised as follows:

Objective: To promote safer sexual and reproductive health practices among men and women of all ages.

- a) Delay the age of first sexual intercourse
 - i. Girls first sexual intercourse from x to y
 - ii. Boys first sexual intercourse from x to y
 - iii. # of young women who delay their first pregnancy until 21
- b) Reduce the number of men, women and young people who have multiple sexual partners
 - i. # of youth having multiple sexual partners
 - ii. # of reported sexual partners by men
 - iii. # of men who paid for commercial sex in the last 12 months from x to y
 - iv. # of young women who report having alternative forms of income generation for low-income girls and women to prevent transactional sex.
- c) Increase the number of men, women and young people who use condoms correctly and consistently with both non-cohabiting and cohabiting partners
 - i. # of boy's reported condom use
 - ii. # of girl's reported condom use
 - iii. # of correct and consistent condom use with all non-cohabiting partners from x to y
 - iv. # of reported condom use for men with their cohabitating partners
 - v. # of reported condom use for women with their cohabitating partners
 - vi. # of women who report that they are successfully making decisions about condom use.

Objective: To promote consistent health seeking behaviour among men and women of all ages.

- a) Increase the number of men, women and young people accessing HIV/AIDS and SRH services in a timely manner.
 - i. # of young men and women utilising SRH/HIV/AIDS services
 - ii. # of young women reporting sexual violence including rape
 - iii. # of men and women's use of family planning methods to space or limit the number of desired children
 - iv. # of men and women who go for VCT and disclose their HIV status
 - v. # of women going to VCT before becoming pregnant and/or breastfeeding.

- vi. # of women who go to a qualified provider for safe abortion and post-abortion care.
- b) Increase the number of women delivering their babies with skilled personnel.
 - i. # of women who go for ANC during the first trimester (baseline?)
 - ii. # of women who deliver children with skilled personnel (baseline?)
 - iii. # of women who receive emergency obstetric care in case of danger signs during pregnancy.
- c) Increase the number of men, women and young people who seek early STI treatment.
 - i. # of men and women who go to health centres for early detection and treatment of STIs
 - ii. # of CSWs receiving regular STI screening and testing

How will implementation of the strategy be supported?

Coordination and support for the implementation of the BCI Strategy involves many different players at all levels of society. Within the national strategy, specific roles and responsibilities related to management, coordination, and technical support for the implementation of the strategy been outlined for the following key partners.

- a) National AIDS Commission
- b) Ministry of Health and Population's National Sexual and Reproductive Health Programme (Reproductive Health Unit and Health Education Unit)
- c) Department of Population Services
- d) BCI Core Team
- e) BCI Technical Working Group
- f) Key Lead Social Group Organisations
- g) Local Government/District Assemblies including the District AIDS Coordinating Committees and District Education Committees.

At the national level, specific objectives have also been developed to guide the coordination effort by these key players. Specifically, they shall:

- a) Coordinate implementation of a national BCI Strategy that defines priority behaviour objectives and strategic actions needed to address all SRH BCI activities.
- b) Determine existing activities and gaps that need to be addressed to develop effective BCI and establish baseline for specific priority areas.
- c) Establish mechanisms for coordination of research, dissemination and utilization of research results.
- d) Improve the quality of communication strategies and IEC materials.
- e) Develop district capacity to coordinate effective implementation of BCI at the district level.
- f) Increase participation of implementers in BCI at local levels.
- g) Mobilise resources for implementation of BCI at all levels.

1.0 Introduction

1.1 Background

From the 1980s, Malawi has responded through various programs and sectors to the challenges and problems posed by the HIV/AIDS epidemic and sexual and reproductive health issues. The public sector, the private sector, and the NGO community have all implemented programs utilizing various methodologies, mechanisms and resources. By the mid 1990s, it became clear that most of these interventions did not register the expected impact, consequently Malawi needed to re plan its own programs.

During the close of the 1990s, Government developed a number of key strategic documents to guide its responses to health and related population issues. Some of the documents include the Malawi National Health Plan [1999-2004], the National HIV/AIDS Strategic Framework, Agenda for Action 2000-2004, the National Reproductive Health Strategy [1999-2004] and the Sexual and Reproductive Health Policy.

This present Behavior Change Interventions Strategy reflects the national priorities underlined within these strategic and policy documents. It presents a summary of the major components of the Malawi National HIV/AIDS/SRH Behavior Change Interventions Strategy and serves as the main planning framework for behavior change programming during the period 2002-2004. The strategy is designed as a living document. It will be constantly updated to reflect changes in behaviour and developments in knowledge, evidence and progress made the implementation of the strategy.

The document starts by providing a general background of the HIV/AIDS/SRH situation globally and locally. It is given the rationale for the development of the BCI Strategy and a summary description of the processes that led to formulation of the strategy. The greater part of the document gives details on the elements of the strategy and how this has been applied to the key social groups in a planning matrix that summarizes the framework for the Malawi HIV/AIDS/SRH BCI Strategy.

1.2 What is the global and local situation we are now facing?

Meeting the sexual and reproductive health needs of men, women and young people is of critical importance. Through the International Conference of Population Development (1994) and the Fourth Annual Conference for Women in Beijing (1995), key areas were defined to reduce high rates of HIV/AIDS prevalence, particularly among young people, high maternal mortality rates and to promote reproductive health rights for all.

1.2.1 Global HIV/AIDS/SRH Picture

The devastating impact of the HIV/AIDS epidemic is rapidly increasing, claiming many lives and creating large numbers of orphans worldwide.

- a) Globally, HIV/AIDS has taken 22 million lives and created 13 million orphans
- b) 16,000 people worldwide are infected each day.

Young people represent a significant proportion of the total population and are at high risk for unwanted pregnancy, STIs, and HIV/AIDS.

- a) Around half a million young people are infected with STIs every day, representing more than two out of every three new cases
- b) There are currently 6 million young people infected with HIV worldwide.

Pregnancy and childbirth are still the greatest single cause of death and disability among women of reproductive age.

Women die because they lack proper management of complications arising during pregnancy and delivery. Other causes for maternal deaths can be attributed to anaemia, malaria and HIV/AIDS. Young women are at risk for early pregnancy and unsafe abortion.

- a) 600,000 women die *each year, worldwide* as a result of complications around pregnancy, childbirth, abortion and HIV/AIDS
- b) Direct causes for maternal death include: postpartum hemorrhage, sepsis, obstructed labour, eclampsia, and complications due to unsafe abortion
- c) It is estimated that 5 million teenage women undergo abortions each year, 2 million are performed under unsafe conditions.

1.2.2 Sub-Saharan Africa

Sub-Saharan Africa is most burdened by the impact of HIV/AIDS/SRH related problems. Girls, in particular are vulnerable.

- a) 70% of people living with HIV/AIDS (25 million) are in Sub-Saharan Africa.
- b) Over half of all new HIV infections are among 15-24 year olds.
- c) Maternal mortality rates are also high where one out of every 12 African women dies from pregnancy-related complications.
- d) 90% of the world's orphans are presently living in Sub-Saharan Africa
- e) Teenage girls are now five to six times more likely than boys to become infected with HIV, and on average women become infected with HIV five to ten years earlier than men.

There are a number of factors that have contributed to the magnitude of the problem in the region. These include increasing poverty and declining socio-economic conditions, widespread inequalities between men and women, and harmful cultural practices related to SRH.

1.2.3 Malawi

Malawi, situated in the heart of Sub-Saharan Africa, has an estimated population of 10 million, the majority live in rural areas. Malawi has also been greatly affected by both HIV/AIDS and high maternal mortality rates.

- a) 250 Malawians are infected with HIV each day, 1 in 3 live in an urban center*.
- b) An estimated 865,787 adults and children are living with HIV/AIDS. (NAC 1999).
- c) 60% of those infected with HIV/AIDS are young women. (NAC 1999)
- d) Young women are also at high risk for early and unwanted pregnancy.
- e) An estimated 70,000 children will be orphaned each year.

- f) The number of child-headed households is increasing.
- g) Maternal mortality rates have also doubled, from 620 to 1120 deaths per 100,000 live births.

The links between HIV/AIDS and wider SRH related problems are strong. For example while STIs, on their own pose a significant burden of disease and cause serious complications, they also facilitate the transmission and progression of HIV.

- h) The 2000 MDHS indicates that 11% of women and 8% of men had some type of STI during the previous 12 months.

Prevention of mother to child transmission of HIV has also become a priority because of risks to both the mother and the child.

- i) High maternal mortality rates are partly due to HIV/AIDS related complications. (DHS 2000)
- j) While 30% of urban pregnant women attending ANC tested positive for HIV, most women have never had an HIV test.
- k) Under five child mortality rates is 189 per 1,000 and infant mortality at 104 per 1,000. Deaths could partly be due to HIV/AIDS related complications.
- l) Approximately one-third of babies born to HIV infected mothers could also be infected.

Although the uptake of contraceptive methods is increasing among women, condom use for dual protection against STIs, HIV/AIDS and unplanned pregnancy remains low.

- m) Only 14% of men and 5% of women claim to have used condoms. (DHS 2000)

There are also social factors that impact on SRH and HIV/AIDS problems that need to be addressed (Coombes 2000). These include:

- n) Increased risk for women due to their powerlessness over issues of sexuality, low levels of education and low economic status.
- o) Harmful traditional practices and gender violence increases women's risk for HIV/AIDS infection, and maternal deaths.
- p) Stigma around sex, sexuality, and HIV/AIDS has led to a culture of silence, secrecy and denial,
- q) A conservative and slow-adapting culture prevents access to HIV/AIDS/SRH services and facilities, particularly for young people.

1.3 Why is a BCI strategy needed?

The BCI Strategy was developed to address key needs and gaps within current IEC programs. While IEC materials and activities in Malawi have made achievements in increasing high knowledge of HIV/AIDS and SRH related issues, there has been limited impact on behaviour change due to:

a) **High HIV prevalence and maternal mortality rates.**

It has become clear that high knowledge has not translated into adoption of safer behaviours. The changing social and economic situation in Malawi has led to increased risk behaviour, particularly for young people. This situation has required a change in strategy to focus more on the factors that influence an individual's ability to change their behaviour.

b) **Quality of IEC materials/activities.**

IEC development processes have not been carried out systematically with focus on behaviour, this has resulted into high levels of HIV/AIDS/SRH awareness. The IEC approach has not induced enough change of behaviour in the people as desired. Capacity for IEC has to be strengthened in the area of behaviour change as many people lack adequate training, life skills, and material support.

c) **Lack of adequate coordination.**

Existing IEC activities were often found to operate with minimal coordination and collaboration between and within institutions, programmes and other sectors. This led to duplication of efforts, overlap of activities, and inappropriate use of limited resources.

d) **Need for strategic focus.**

A strategic focus on key behaviours is needed to promote behaviour change more effectively. An integrated approach between SRH and HIV/AIDS programs will increase the measurable impact of interventions.

1.4 What and for who is the National BCI Strategy for HIV/AIDS/SRH?

This document is a planning tool, to guide ministries, district planners, NGOs, CBOs, DACCs, faith communities, learning institutions and employers seeking to come up with effective HIV/AIDS and SRH behaviour change programs. The strategy is also intended to guide donors on areas of support and interventions that require national resources. The strategy:

- a) Provides background information to its development.
- b) States the objectives of what needs to be achieved through the proposed interventions.
- c) Describes what Behaviour Change Interventions are and how they differ from IEC approaches,
- d) Outlines national behavioural priorities and strategies for HIV/AIDS and SRH that need to be addressed based on research evidence,
- e) Defines coordination mechanisms to maximize limited human and financial resources, and
- f) Sets up indicators for monitoring and evaluation of BCI.

1.5 How was the BCI Strategy developed and how will it be implemented?

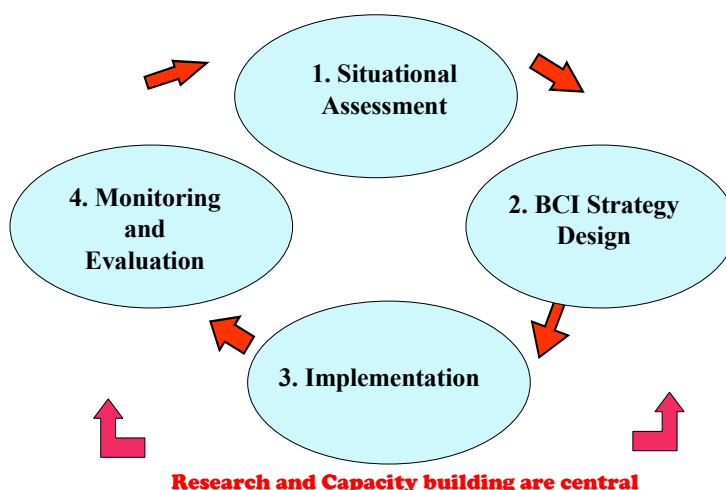
The National AIDS Commission and the National Sexual and Reproductive Health Program recognized the key role that Behavior Change Interventions have in improving HIV/AIDS /SRH outcomes and were determined to develop a coordinated response to the common behavioral issues that are critical to address.

Participation from a wide range of stakeholders guides both the development and implementation of the strategy. A representative BCI Technical Working Group (TWG) was formed in 2000 composed of relevant ministries, NGOs, media, private sector and NAC, which also included the involvement of young people and PLWHAs. This group had the mandate to provide guidance and facilitation support to the strategy formulation process. A national literature review was therefore commissioned, and it summarized the behavioral and programmatic issues.

Diagram 1 presents the process used and approved by the BCI TWG in developing this strategy. It is also an appropriate format for development of any specific BCI strategy at district and program levels. It followed the four main steps in the program development cycle based on international practice as shown in diagram 1.

- Situational Assessment
- Strategy Design
- Implementation
- Monitoring and Evaluation

Diagram 1: Phases of BCI Development and Implementation



Phase 1: Situational Assessment

The BCI TWG identified potential resources, partnerships, and related programs for the development of the BCI Strategy. As a first step, a National BCI Literature Review of more than 200 studies, mostly in Malawi, identified the major behavioural problems, program needs, gaps in research, and recommendations for action.

Phase 2: Strategy Design

The BCI Strategy was designed through a series of workshops and core group meetings. Drawing on the recommendations from the literature review, key components of a national strategy were

identified. The design of the strategy includes the main problems, key social groups, a national BCI planning framework for action and mechanisms for coordination and capacity building.

Phase 3: Implementation

This phase includes the following activities to support effective behaviour change interventions.

- a) Training to develop detailed implementation plans for each key social group identified in the strategy, support dissemination of this strategy and strengthen capacity building for effective implementation.
- b) Training in the districts to support effective behavior change implementation
- c) Other trainings to strengthen the capacity for production of materials, messages, and campaigns.
- d) National production of material prototypes

Phase 4: Monitoring and Evaluation

The BCI Strategy identifies indicators for monitoring and evaluation at the national level, and will support the development of indicators for programs at district and local level through further capacity building. Monitoring and evaluation is ongoing process, which occurs at all levels and throughout all the phases.

a) Research

In this strategy, research takes a central role in informing each of these four phases to develop and implement effective behavior change interventions. Research will guide implementers to refine the national strategy at the district level. Through, for example, focus group discussions and in-depth interviews, programs can refine their understanding of the main problem behaviours faced by their key social groups to determine feasible behaviours. Research, including pre and post-testing, is also needed in the development of specific messages, production and effective use of materials. As a tool for monitoring and evaluation, research is also needed to determine the effectiveness and efficiency of specific behaviour change interventions.

b) Capacity building

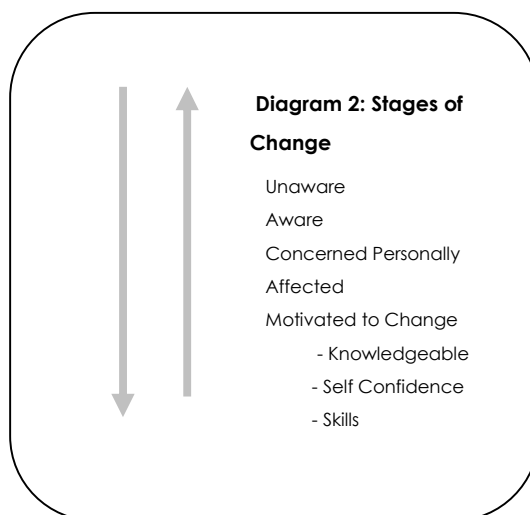
Capacity building for continuous effective program planning, implementation, monitoring and evaluation is an essential element at every phase. The main role of the national level players will be to strengthen the capacity of partner organizations through training, development of guidelines and material prototypes, provision of resources, and facilitation of linkages between organizations. This component is addressed in greater detail under 'Supporting the Implementation of the BCI Strategy' and in the appendices.

1.6 What are the main differences between Behaviour Change Interventions and Information Education Communication (IEC)?

IEC has primarily focused on disseminating messages and raising community awareness of important health behaviours through different media channels. While IEC has made an impact on increasing knowledge of HIV/AIDS and SRH, people rarely change their behaviour simply because their knowledge alone changes.

BCI is an approach that is used to support an individual's ability to adopt and maintain new behaviours. The approach recognizes that individual behaviour is influenced by many factors. Behavior change requires individual commitment to change and a supportive environment. Individuals need to recognise situations that put them at risk and develop analytical and communication skills to resist pressure.

Diagram 2 shows the main stages that individuals may go through when trying a new behavior and sustaining it. Behavior Change proceeds through a series of steps, sometimes moving forward, other times backwards. Even when an individual or group has adopted safe behaviors, going back into unsafe behaviors is common.



Nevertheless, because motivation to try and sustain new behaviours is dependent on individual feelings of personal power and the influence of others, there is need to analyse carefully the contextual factors that affect the individual.

Diagram 3, on the next page, presents the main factors influencing the individual that should be considered when designing BCI.

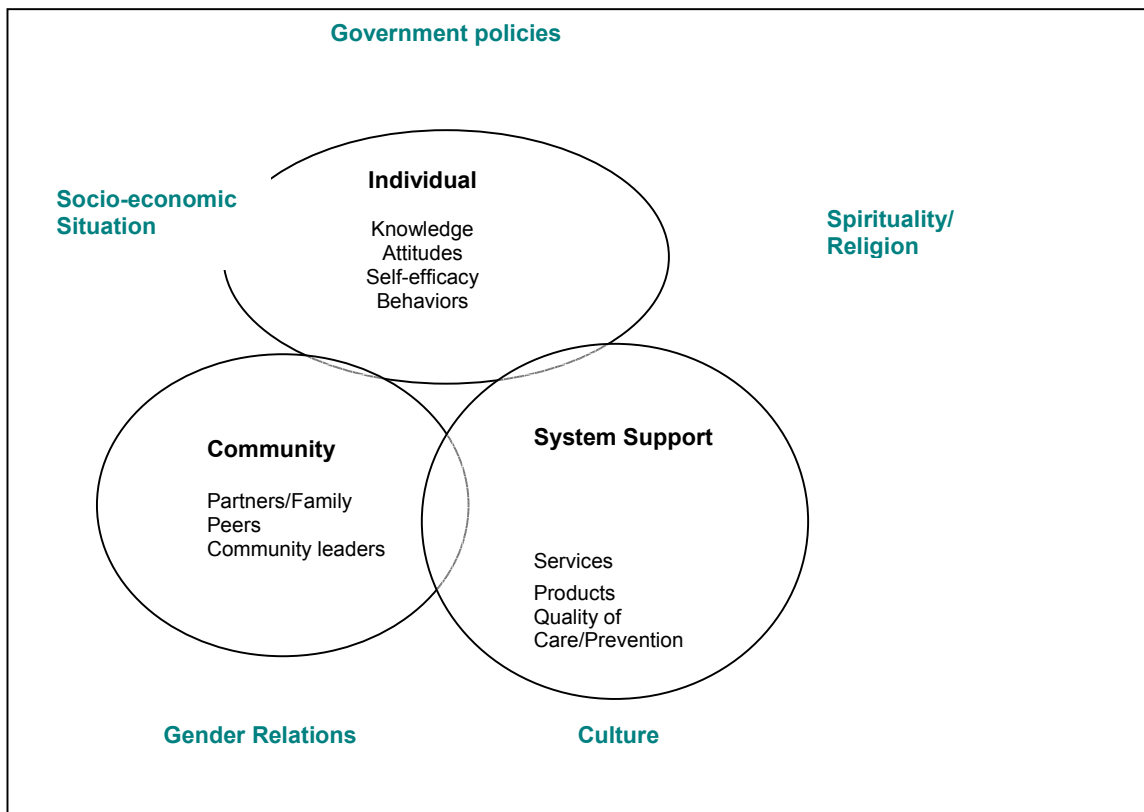
- At the individual level: one's knowledge, attitudes, self-confidence, skills and motivation to try new behaviors
- At the community level: how an individual is influenced and interacts with various people (i.e. partners, family members, peers, community and faith leaders, and traditional healers). For example, there are norms or practices in community that may encourage unsafe sexual behaviours.
- At the system level: the quality of services (health, education, recreation, etc). Are they accessible and friendly to everyone?

There are also wider influences that affect the individual, community and system supports available. These include:

- Government policy – the role of policy and law in supporting or hindering intervention efforts.
- Socio-economic situation– collective or individual income that may allow or prevent adequate intervention (e.g. Influence of poverty)

- c) Culture – positive, unique or negative characteristics that may promote or hinder prevention and care practices
- d) Gender relations – status of women in relation to men in society and community and the influence on sexual negotiation and decision-making.
- e) Spirituality/Religion – role of spiritual/religious values in promoting or hindering the translation of prevention messages into positive health actions

Diagram 3: Factors influencing Individual Behaviour



2.0 Components of the Strategy

The BCI Strategy consists of the following components: Purpose and objectives of the National BCI Strategy, guiding principles, key social groups, a National BCI Planning Framework, monitoring and evaluation, support structure to implement the strategy and plans for specific key social groups and districts. The components are illustrated in diagram 4.

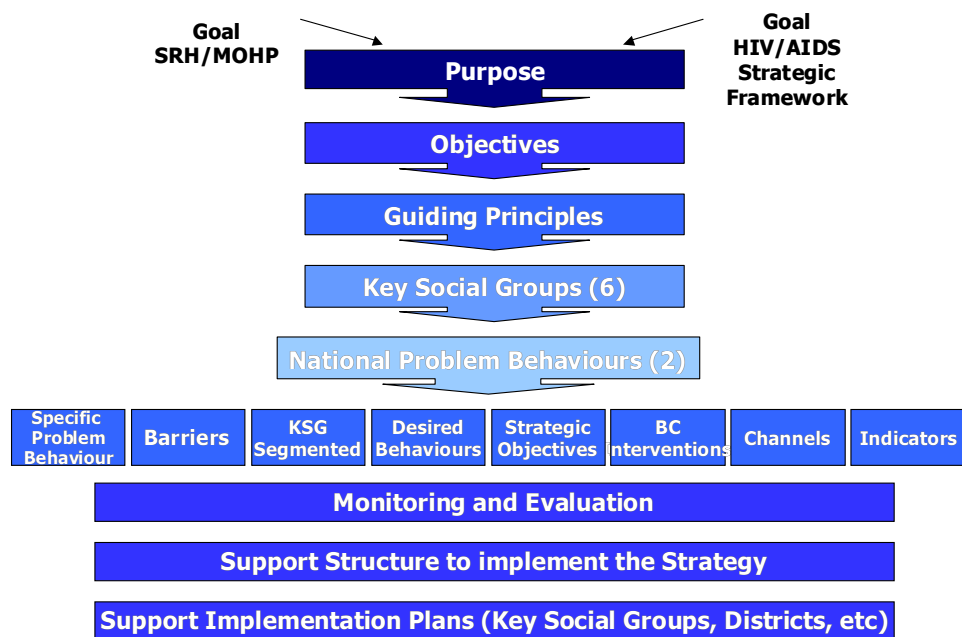


Diagram 4: Components of the BCI Strategy

2.1 Purpose of the BCI Strategy

The purpose of the strategy is drawn from the National AIDS Commission and the Sexual Reproductive Health Programme goals. The Sexual and Reproductive Health Programme goal is “to improve sexual and reproductive health for all men, women and young people in Malawi, especially the vulnerable and underserved”. HIV/AIDS Strategic Framework goal is “to reduce incidence of HIV/AIDS and other sexually transmitted infections and improve the quality of life of those infected and affected by HIV/AIDS”.

Purpose of the BCI Strategy

To empower Malawians to develop and maintain safer sexual and reproductive health practices in a stigma-free and gender transformative environment.

In order to understand the purpose of the strategy, the following terms have been defined as:

- a) *Empower*: means enabling people to make informed choices about their behavior. This includes the development of knowledge, skills and confidence.
- b) *Stigma-free*: creating an environment, which promotes open dialogue and acceptance about sensitive SRH/HIV/AIDS issues (stigma is a sense of shame, discrimination and isolation).
- c) *Gender transformative*: creating an environment in which both men and women respect each other's basic rights and relate to each other as equals.

2.2 Objectives of the National BCI Strategy

The national BCI Strategy seeks to achieve the following objectives:

- a) **Promote safer sexual and reproductive health practices among Malawians**
- b) **Promote consistent health seeking behavior among Malawians.**

Safer sex practices includes delaying first sexual intercourse, reducing the number of men, women and young people who have multiple sexual partners, and increasing the number of men, women and young people who use condoms correctly and consistently with both non-cohabiting partners.

Consistent health-seeking behaviour includes increasing the number of men, women and young people accessing HIV/AIDS and SRH services in a timely manner, including early STI treatment, and increasing the number of women delivering with skilled personnel.

2.3 Guiding Principles

The guiding principles for the BCI Strategy are defined to assist and direct planners and implementers on key areas of concentration/focus. The BCI Strategy is based on:

- a) A balanced focus on both HIV/AIDS and Sexual Reproductive Health issues
- b) Local, national and international evidence of best practices
- c) Participation and coordination between sectors and between government and civil society, including faith-based organizations
- d) Malawian culture and innovation, utilising positive language and images to overcome the culture of silence on sexuality issues and HIV/AIDS.
- e) Elimination of gender inequalities in order to achieve optimal impact on the HIV/AIDS epidemic and issues surrounding sexual and reproductive health.
- f) Existing systems and structures - formal and informal- and promotes linkages and referral networks
- g) Respect for equity, human rights and the rights and perspectives of patients and people living with HIV in program design and implementation.
- h) The needs of the individual and the community in the context of a national program, putting human face on programming.
- i) Flexibility to evolve with time as the needs of the individuals and communities change in relation to the AIDS epidemic and SRH problem.

2.4 Key Social Groups

The BCI Strategy has identified six key social groups for BC interventions. These include Young People Aged 7-24, Men and Women engaging in high-risk Behaviours, Women of Childbearing Age, Opinion Leaders, Service Providers, and Policy Makers.

The first three were identified as most vulnerable and have been prioritised for action.

- a) Young People 7- 24 (in-school, out of school) to ensure their health and safe transition into adulthood
- b) Men and Women engaging in High Risk Behaviours to avoid risk practices and situations
- c) Women of Child Bearing Age to be able to choose how many children they want to have, and ensure that each birth is safe.

The last three were identified as specific social groups that play an important role in determining whether the environment is supportive or blocks change.

- d) **Opinion Leaders** (including faith leaders, traditional leaders, traditional initiators, healers) play a critical role in mobilizing communities around issues of community dialogue, and involvement and in challenging damaging beliefs and practices related to stigma and gender inequality.
- e) **Service providers** (including health center staff, TBAs, HBC providers, and teachers) provide individuals with important health related information and services and can assist in strengthening both the quality of service provision, and referral. They are key partners in communications, improving provider-client relations, and strengthening links between communities and health services.
- f) **Policymakers** (within relevant ministries, lawmakers,) determine national priorities and laws to prevent stigma and gender inequalities and set guidelines for service improvements and access to needed products.

2.5 National BCI Planning Framework

The National BCI Planning Framework is a planning tool that was used to analyse problem behaviours and barriers for each of the key social groups, and develop behaviour change interventions in a systematic manner. It can also be used to guide the process of implementation at all levels such as districts, line ministries and institutions.

The planning framework broadly outlines and defines the national problem behaviours, barriers that need to be addressed for each key social group, segmented key social groups, desired behaviours, strategic objectives, BC Interventions, channels, and indicators.

For each of the six key social groups, a detailed guide for development of implementation plans is provided in the appendices.

2.5.1 Problem Behaviours

Problem behaviours are practices that increase individual risk of unwanted pregnancy, unsafe pregnancy and delivery; and transmission of STIs and HIV,

The literature review highlighted two main national problem behaviours, which need to be tackled in order to have an impact on high rates of STI/HIV infection and maternal death in Malawi. The problems are:

- a. Unsafe sexual and reproductive health practices
- b. Inconsistent health-seeking behavior

The following are examples of practices related to problem behaviours:

a. Unsafe sexual and reproductive health practices Examples:

- i. First sexual intercourse often occurs in adolescence
- ii. Many Malawians report having multiple sexual partners
- iii. There is a lack of consistent and correct condom use

b. Inconsistent health-seeking behavior

Examples:

- i. Many people do not go for voluntary counseling and testing (VCT), reproductive health services, and STI treatment
- ii. Many Malawians delay going to health services

2.5.2 Barriers

Barriers are the underlying factors that influence individual decision-making and practices. The barriers may be related to the community, the support systems, government policies, socio-economic status, culture, gender relations and spirituality/religion. (Refer to Diagram 3).

The following eight barriers were identified and are described in detail:

a) There are still important knowledge gaps on issues of HIV/AIDS/SRH

- Misconceptions, myths and rumors

b) There is still low self-risk perception among many Malawians.

- i. 50% of Malawian population do not feel personally affected or at risk.
- ii. Low condom use
- iii. Having multiple sexual partners

c) There is a lack of community dialogue on issues of SRH and HIV/AIDS, which make it difficult for individuals to get information or support.

- i. Lack of discussion about sex, sexuality and SRH between men and women
- ii. Open discussion about sex in communities is a taboo
- iii. Some religious leaders discuss sex and sexuality in the context of sin
- iv. There are contradictions regarding accepted sexual behaviour. Although sex outside marriage

is socially unacceptable, many married people are engaged in sex with different partners.

- v. Youth are unable to ask questions regarding their body changes and know little about their own anatomy
- vi. There is secrecy around pregnancy, childbearing and abortion, especially for young women
- vii. Women, in particular, are not aware of their right to sexual pleasure and are ashamed to ask questions.

d) High stigma and stigmatization related to HIV/AIDS/SRH makes it difficult for Malawians to access information, seek health services, or support within their communities.

- i. There is stigmatization around STIs and HIV/AIDS
- ii. Low willingness to access services such as STI treatment, VCT, family planning services, etc.
- iii. Low willingness to receive HIV results if tested
- iv. Low willingness to disclose HIV status if tested positive
- v. Condoms are not promoted as a method of family planning in conjunction with other contraceptive methods because they are linked to promiscuity and HIV/AIDS.
- vi. Reluctance to seek support on HIV/AIDS/SRH problems

e) There are gender inequalities at all levels of society that need to be addressed within HIV/AIDS and SRH issues.

- i. Women are not key decision makers in choosing family planning methods, condom use and negotiating sex
- ii. Women are subjected to harmful practices, including rape and violence
- iii. Women's limited access to education, employment, loan facilities, increases their economic dependence on men, and risk for transactional sex.
- iv. Women's low status in society has led to low self-esteem and feelings of disempowerment.
- v. Ideas of masculinity have placed men at risk of having multiple partners at an early age.
- vi. Men are not involved in reproductive health at home or included in RH services.
- vii. There is male dominance in decision-making and financial control in the family and communities.

f) There are harmful sexual cultural practices in communities that increase STI/HIV transmission and maternal deaths.

- i) Practices that increase HIV/STI infection include:
 - Wife inheritance
 - Dry sex
 - Widow and adolescent sexual cleansing rituals
 - Fisi
 - Genital mutilation, including use of herbs to dry out the vagina
 - Traditional treatment of vulval/vaginal warts and hemorrhoids (e.g., by cutting)
- ii) Practices that increase maternal death include
 - The use of herbs to induce abortion
 - Community rituals that delay pregnant women's access to emergency health services leading to maternal death

- g) Lack or inadequate community involvement in HIV/AIDS/SRH activities
 - i. Lack of ownership about HIV/AIDS/SRH activities at all levels of planning and implementation
 - ii. There are few links for quality health services between communities and health centers.
- h) Poor client and service provider relationships have led to dissatisfaction in the quality of services and low utilization of services.
 - i. Poor attitude from the service providers towards clients, especially young women and men
 - ii. Lack of confidentiality and privacy in health centers including VCT and STI treatment
 - iii. Lack of essential drugs and medical equipment
 - iv. Long waiting time for health services

2.5.3 Key Social Groups Segmented

Key social groups segmented are groups of individuals who share specific common characteristics. These characteristics can be based on their identification with a specific cultural group, language, or religion, their age, gender, economic status, or level of literacy. It can also be based on places where they can be found (in school, or out of school, workplaces) and or specific roles and responsibilities they hold within their family or community.

Example: For young people, these include in-school, out of school, sexually active, before first sexual intercourse. For service providers these may include nurses, health surveillance assistants, teachers and other extension workers.

2.5.4 Desired Behaviours

Desired Behaviours are ideal practices, which need to be promoted and sustained in order to develop and maintain safer sexual and reproductive health. Desired behaviours should be practices that people are willing and able to do.

The desired behaviours may be identified for the individual, family, community leaders and service providers.

Examples of desired behaviours are:

- a) Young people delay first sexual intercourse
- b) Young people use a condom at first sexual intercourse, and correctly and consistently after.
- c) Parents support their children to get SRH information and health services.
- d) Health providers give young people needed information and services.

2.5.5 Strategic Objectives

The BCI Strategy has identified eight main strategic objectives that provide a common direction for behaviour change interventions at all levels. They are based on the literature review, and seek to address the main barriers presented in the previous section (2.5.2) and support the two national objectives of the strategy (2.2).

Strategic objectives are intended outcomes, which are articulated to guide program interventions in order to achieve the desired behaviours.

At the programmatic level:

- a) *Increase knowledge on HIV/AIDS/SRH among men, women and young people.* For example by:
 - i. Increasing knowledge of MTCT and VCT services

- b) *Increase the number of men, women and young people who are aware of their own personal risk factors for HIV/AIDS transmission and SRH problems,* for example by:
 - i. Increasing men who state personal benefits for using condoms consistently
 - ii. Increase men, women and young people reporting personal benefits for accessing VCT and disclosing results to others.

- c) *Increase opportunities for open discussion on SRH/HIV/AIDS issues in communities,* for example by:
 - i. Increase community meetings/discussions on SRH/HIV/AIDS
 - ii. Increase *parent-child communication*

- d) *Promote gender equality,* for example by increasing:
 - i. male and female involvement in HIV/AIDS/SRH activities
 - ii. women's decision making capacity in choosing suitable contraceptive methods, negotiating condom use, and safe maternal practices.
 - iii. men and women who are aware of human rights law pertaining to gender violence.
 - iv. women who report physical/sexual violence and advocating for greater legal support.

- e) *Reduce stigma and stigmatisation related to HIV/AIDS and SRH,* for example by:
 - i. Decreasing the number of people reporting negative perceptions and attitudes towards sexuality, contraceptives, especially the condom, and VCT.
 - ii. Increasing emotional and social support to PLWHAs within communities and in the workplace
 - iii. Increasing the number of PLWHAs making public testimonies
 - iv. Decreasing the number of PLWHAs reporting discrimination and stigma

- f) *Eliminate harmful sexual and maternal health practices that put men, women and young people at risk,* for example by:
 - i. Raising community awareness of harmful sexual and maternal health practices that contribute to HIV/AIDS and STI transmission, unwanted pregnancies and delay women's access to emergency health services.

- g) *Increase community involvement in the planning and implementation of HIV/AIDS/SRH activities,* for example by:
 - i. Increasing young people and PLWHAs initiating meetings, establishment of clubs and support groups.

- ii. Increasing community-based support/health related activities established and managed by communities.
- iii. Increasing referrals made from the community to the formal health centres and visa versa for home based care

h) Improve client and service provider relationship, for example by:

- i. Increasing the communication and provision of information by health care providers
- ii. Increasing clients reporting satisfaction with services

2.5.6 Behaviour Change Interventions

BCI is an approach that is used to support an individual's ability to adopt and maintain new behaviours. Behaviour change interventions are implemented through a set of activities identified to realise the different strategic objectives. Behaviour change interventions operate through: Communication, Community Mobilization and Advocacy to address behaviours needed at the individual, community and system levels.

Communication seeks to change knowledge, attitudes and practices. Communication is a process to share ideas for common understanding. Communication can be two way or one way and uses different channels and methodologies. Communication strategies should be based on local needs, and priorities and planned with community partners. It is crucial to understand the existing knowledge, attitudes and practices of specific social groups in order to develop feasible behaviours that have an impact on strategic objectives. Effective communication emphasises problem-solving based on real situations communities face and develop skills and confidence for individual action.

Example of communication activities are:

- i. Conduct media campaign using popular singers or football players who emphasise the benefits of condom use
- ii. Establish peer education programs to help young people develop their communication skills with parents
- iii. Develop and air radio drama series using enter-educate approach highlighting role models that people can identify with in different stages of behaviour change.

Community mobilisation seeks to promote wider participation and ownership by members of community based activities. It refers to the use of community networks (leadership and groups of people) to encourage community support and action. This can include dissemination of messages, establishment of community support groups, and strengthening links and referrals between the community and health centres for quality services and care. It also involves enlisting the participation of institutions, communities, social and religious groups, in identifying, raising, and managing human and material resources needed for BCI.

Example of communication activities are:

- i. Initiate and establish community based distribution services i.e. CBDAs, TBAs
- ii. Promote food security for HIV-affected households through community gardens, communal granary

- iii. Facilitate community dialogue and information sharing on SRH, ANC and PMTCT.

Advocacy seeks to raise political commitment, social will, and resources for BCI. This includes providing needed resources, developing policies, and laws as well as raising public awareness of BCI related activities.

This occurs at all levels of society: at the personal level with partners, family and friends; at the community level with neighbours, influentials in media, and in public events; and institutional level through organisations to reach policy-makers and other media influentials.

Example of communication activities are:

- i. Lobby Parliamentarians to enact a law against harmful sexual practices
- ii. Brief the media on the importance of emphasising hope and living positively with HIV/AIDS
- iii. Sensitize traditional/faith leaders on gender based violence

2.5.7 Channels/Change Agents

Communication channels are means by which messages and interventions are disseminated and received. Channels cover interpersonal communication, traditional and popular media, and mass media.

Each channel has its own strengths and weaknesses, depending on the role it will take in the behavior change processes. In other words, channels must fit the messages selected and be relevant to the specific social groups and their environment.

Interventions should combine multiple channels in order to have the most impact in changing people's behaviours.

Examples of channels are interpersonal, traditional and mass media as described below:

- i. Interpersonal is used with individuals or small groups, and includes meetings, counseling, training sessions, events, role play and interactive drama, home and site visits.
- ii. *Traditional and popular media*, such as local theatre, song, festivals and puppets, can help bring messages to more remote areas or when messages from "the outside" are not credible.
- iii. *Mass media*, involves wide spread diffusion to a large number of people through radio, TV, newspapers, mass media advertisements, billboards, banners, posters, stickers and calendars. In Malawi, the use of radio is one of the most popular and widely used channels for disseminating communication messages, reaching a large number of people quickly and frequently. Print media are broad reaching to literate audiences and can carry more complex messages than broadcast media. However, for greater effectiveness, they should be used in combination with interpersonal communication to reinforce messages.

Change agents are groups, institutions, organizations who could influence changes towards desired behaviors. For example, youth clubs, village development committees, villages AIDS committees, support groups, media personnel, schools, and churches.

2.6 Monitoring and Evaluation

Monitoring and evaluation provides information to help programs determine whether BCI implementation efforts and resources, are making progress in achieving the objectives of the national strategy.

Monitoring and Evaluation takes place at different levels. At each level, different information is collected and synthesized to demonstrate how a specific programme or a combination of programmes, have been conducted and what has occurred as a result.

At the national level, the BCI Strategy will measure progress towards achieving the national objectives based on the outcome indicators presented on page 22. These statistics will be collected from existing sources of information such as the DHS, National BSS and National KAPS. At the district level, districts, with their partners, will identify specific priority objectives and indicators for behaviour change as outlined in the BCI strategy. At the program level, implementing agencies will also identify objectives and indicators for behaviour change to support BCI district plan.

2.6.1 Levels of monitoring and evaluation

Formative research

Formative research is conducted during the planning phase of the programme. This is the first step when designing an effective monitoring and evaluation plan. It helps program planners to determine specific objectives and priorities for behaviour change interventions. It also assist the planners to make decisions about feasible interventions.

Process evaluation

Process evaluation includes monitoring.

For **Monitoring**, once interventions are under implementation, there is a need to examine whether they are being carried out correctly, on time and within budget. The following constitute the key elements:

- i. **Inputs:** people, money, equipment, policies, time, etc. For example, the amount of money and human resources allocated to do BC interventions for PLWHA, availability of relevant policies addressing HIV/AIDS in workplace.
- ii. **Process/Activities:** training, logistics, management, IEC, behavior Change communication etc. For example, research, meetings and trainings were conducted by PLWHA to develop a policy of stigma for the workplace. How were the activities conducted (effective and efficient)?

- iii. **Outputs:** services, service use, knowledge, attitudes, etc. For example, a policy of stigma was developed in a workplace, the output could be an increase in the % of employees with better knowledge and positive attitude toward PLWA. The increase in the % of PLWA sharing experiences at workplace.

At program level, NGOs and CBOs are encouraged to monitor program activities and collect information relevant to inputs, processes and outputs. The data should be used for programme improvement and modification.

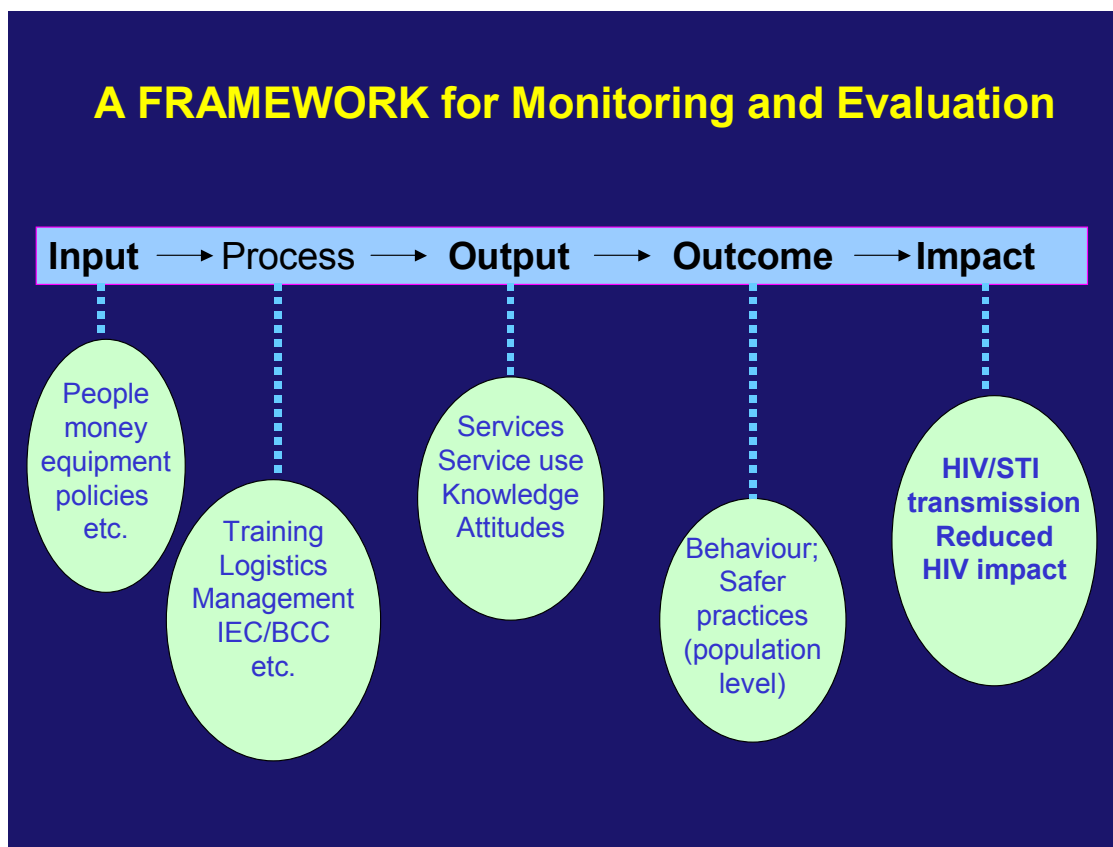
For **Evaluation**, outcome and impact data are the two main elements. They are usually collected through demographic and Health surveys (DHS), Behavioural Surveillance Survey (BSS) or through population-based surveys such as antenatal or young adult sentinel surveillance surveys. These are reflective of the overall effect of all programmes going on at the national level.

- i. **Programme outcomes** or short-term and intermediate programme effects: behaviour, safer practices (population level). Outcome data is sometimes collected by small explanatory surveys that aim to explain something that is situation-specific. For example at a workplace, we can increase the number of PLWHA who report discrimination against fellow employees, and we can also increase the number of PLWA using condoms with all partners.
- ii. **Programme impact** or long term effects: HIV/AIDS transmission reduced HIV Impact. An example is the decrease in % of People infected by HIV/AIDS and STD. Another one could be the % in maternal death of women of child-bearing age.

Districts are becoming increasingly responsible for the sentinel surveillance or population-based surveys and as capacity for monitoring and evaluation increases, a more accurate picture of SRH and HIV/AIDS and behavior change should emerge.

Diagram 5 presents a framework for Monitoring and Evaluation, which describes and links each of the elements. **Inputs** of people, training, resources and equipment lead to activities/ processes such as training which in turn generate **outputs** such as improved quality of services, improved knowledge and increased access to services. Outputs should facilitate the achievement of short term intermediate effects - or **outcomes**, such as changed attitudes, adoption of safer sexual behavior, increased skills or increased ability to cope with AIDS. Outcomes should lead to long term effects (**impacts**) such as reduction of risk, reduction in infections, reduction in STI/AIDS transmission.

Diagram 5: Framework for Monitoring and Evaluation



² Source: Measure *Evaluation Project*

2.6.2 Indicators

An indicator is a marker. Good indicators should be directly linked to BCI purpose and strategic objectives. Often one indicator alone is insufficient to reach a conclusion. For example, measuring self reported use of condoms is greatly strengthened if it is presented together with data showing condom distribution and a reduction in STI's. Similarly this is true of other indicators that rely on self-reported data such as extra-marital sex.

Implementers are encouraged to collect indicators that are relevant to the measurement of their specific BC interventions. It is important that indicators are defined and measured in a standardized way based on the objectives of the BCI strategy.

Tracking change using standard indicators that can be compared over time, is therefore more likely to give feedback and information that will guide program managers and decision makers to replan interventions in order to improve the national response to HIV/AIDS/SRH.

The National BCI Indicators (*Those indicators need to be revised for final approval*)

Disease Trends

- a) HIV prevalence rates in sexually active population (females and males of all ages)
- b) STI incidence and prevalence rates in sexually active population (females and males of all ages)
- c) Maternal mortality rate

Sexual behavior

- a) Age of first sexual intercourse for girls and boys
- b) % of reported condom use among men, women and young people with non cohabitating partners
- c) % of reported condom use among men and women with cohabitating partners

Health seeking behaviour

- a) % of men, women, and young people who go to health centers for STI treatment
- b) % of men, women, pregnant women and young people who are counseled and tested for HIV at all centers
- c) % of men and women using contraceptives of choice
- d) % of women who delivery with a skilled attendant (and present for post-natal checkups within the first week.
- e) % of women who receive emergency obstetric care
- f) % of women who report exclusive infant feeding with *appropriate* method of choice up to six months.

Cross-cutting behaviour

- a) % of health care workers with accepting attitudes towards people living with HIV/AIDS
- b) % of women reporting rape and sexual violence.

Examples of Indicators for districts and BCI Programme:

- a) Number of sites providing PMTCT services
- b) Number of HIV/AIDS communities activities initiated by the districts
- c) Number and % of antenatal clients receiving post-test HIV counseling and test result
- d) Number of community initiatives/organizations receiving support to care for orphans
- e) Number of youth people train on peer education/life skills program
- f) Number of income generating and micro-finance programs for PLWA and their families
- g) Number of staff trained in VCT

2.7 Supporting the Implementation of the Strategy

This document marks the first step to developing a national coordinated BC response to the HIV/AIDS/SRH needs facing Malawi. The BCI strategy will be disseminated to all donor and implementing partners in order to promote a shared vision and facilitate strategic planning for BCI at

all level. In collaboration with key partners, the core BCI team have also initiated a process of training, capacity building and information sharing with partner organisations to guide the development of refined implementation plans for specific social groups. Mechanisms for long-term coordination will also be established to support joint planning, sharing of new research, resources, effective practices, and capacity building.

All partners have a coordination role to ensure that BCI activities are implemented in an effective manner. At the National level, the National BCI Technical Working Group is at the centre of coordination among stakeholders and should guide the implementation of the BCI Strategy. The TWG will advise the NAC and SRHP, through the BCI core group, on how best to coordinate and facilitate the implementation of the BCI Strategy through ongoing technical assistance, facilitation of meetings, establishing mechanisms for sharing resources, and supporting monitoring and evaluation. Key Lead Social Group Organisations will provide the main mechanism for coordination, technical assistance and resource sharing in relation to specific social groups. At the district level, district assemblies will coordinate district BCI planning and prioritisation based on specific district needs, and implement activities in partnership with local organisations.

At the national level, specific objectives have been developed to guide coordination efforts which include:

- a) Coordinate implementation of a national BCI Strategy that defines priority behavioural objectives and strategic actions needed to address all SRH BCI activities.
- b) Improve quality of communication strategies and IEC materials
- c) Determine existing activities and gaps that need to be addressed to develop effective BCI interventions and establish baseline for specific priority areas
- d) Establish mechanisms for coordination of research, dissemination and utilization of research results
- e) Develop district capacity to coordinate effective coordination and implementation of BCI interventions at districts level.
- f) Increase participation of implementers in BC Interventions at local levels.
- g) Mobilize resources for implementation of BCI at all level.

The specific roles and responsibilities for all the partners are described in detail in the appendices.

Appendices

Appendix I: BCI Strategy for Working with Young People aged 7-24 years

Key Lead Organisation:	National Youth Council of Malawi/Youth Technical Working Group
Partners:	All organizations that are leading BC interventions
Lead Training Institution:	Mzuzu University

Segmented Social Groups

- Strategies will need to be age specific focusing on young people before first sexual intercourse, and those who may be sexually active: 7-12, 13-15, 16-19, 20-24.
 - Different strategies may be needed for youth in urban vs. rural areas.
 - Strategies will focus within schools at primary, secondary and tertiary level.
 - Strategies will focus on young people found out of school through entertainment places, youth clubs, working children, and children living in institutions.
 - Strategies will focus on vulnerable children including the girl child, orphans, adopted children, street vendors, the very poor, delinquents, and children with mental or physical disabilities.
 - Strategies should highlight positive messages of sex and sexual pleasure, which are safe for both men and women and critically analyse Malawian values and beliefs that can both strengthen individuals and communities or put them at risk.
-
-

Young people represent a sizable population in Malawi and are at high risk for unwanted pregnancy, STIs and HIV/AIDS. Girls, in particular, are more at risk due to adult denial of their needs.

Youth needs are distinct from those of adults and of children. They are exposed to many physical and psychological changes and have questions, particularly about their emerging sexuality. It is a time of experimentation with adulthood, and a time when the influence of peers and adult role models can be very strong. It is also a time when young people will likely have their first sexual relations. These relations can take place under different circumstances such as intimate/romantic love, within marriage or before, or as a rite of passage through initiation rituals or with commercial sex workers.

In Malawi, young people are difficult to generalise about. The age range of 7-24 includes a diverse group representing different lifestyles, occupations and social roles. While many of them are in school, many are not. Even young people in primary school can be found in different grades with

only a small percentage completing secondary school. They can be from urban or rural areas with very different experiences and exposures to an emerging popular youth culture and access to information.

Young people can be students, agricultural labourers, fishermen, home care providers, market sellers, factory workers and commercial sex workers. This makes it difficult to develop comprehensive programs that address their needs and sometimes difficult to find, especially once they have left school.

Because of significant changes during the “adolescence/transitional” period, it is important to examine youth needs in the context of changes they experience as they get older, and plan programs that help them with their transition into adulthood. Effective programs should address the needs of youth long before first sexual intercourse, and up to the age of marriage or stable partnership. Preventive education before the onset of sexual activity delays it, and protects those who are sexually active.

Youth driven approaches are critical to develop effective interventions. Youth need to be involved in all stages of program development and implementation. Adult led interventions are not meaningful to a youth culture with its distinct language and conduct. Youth must lead adults through their world for messages to be appropriate and relevant. Youth worlds are different and needs cannot be generalised. The needs of in school and out of school youth are different. Youth in urban settings, such as Lilongwe and Blantyre have different opportunities and risks than their rural partners. It is also certain that girls experience different risks and barriers than boys.

Behavioural strategies need to take into be age and context specific to be effective. No single approach can be effective among such a diverse population with varying degrees of access to information and services and levels of trust with outsiders. Approaches must be singular and specific, **designed and implemented in partnership with people in that target group.** They also need to address and transform gender inequalities/stereotypes/power dynamics.

Parents, teachers, traditional leaders, initiators and faith communities play an important role in supporting youth access to information and services. They should also speak of sex and sexual pleasure as something positive and the importance of making sex safe and fun for both men and women within stable relationships.

A. Problem Behaviours:

1 Unsafe sexual and reproductive health practices

- a) First sexual intercourse occurs around age 15 and perhaps as early as 12-13.
- b) Most girls become pregnant and have children between the age of 15 and 19. When these girls and young women begin families at such an early age, the education and employment opportunities available to them are very limited.
- c) Up to 69% of youth reported to have more than one partner at the same time.
- d) Some young women use herbs to induce unsafe abortion and to dry out their vaginas.

2 Inconsistent health seeking behaviour

- a) Young people do not access health services.

B. Barriers to Address:

The following eight barriers are addressed separately within the matrix. However, behaviour change interventions need to be interlinked.

1. Knowledge gaps on HIV/SRH issues, low risk perception
2. Lack of life skills
3. Lack of community dialogue or parental guidance and support (& stigma)
4. Gender related risks/Inequalities
5. Harmful cultural SRH practices
6. Poor client/provider relationship and lack of community involvement
7. Lack/inadequate youth involvement in SRH/HIV/AIDS issues
8. Lack of collaboration among organisations working with young people

C. National Behavioural Objectives for Young People

- i) Sexual and Reproductive Health Behaviour
 - a) Delay first sexual intercourse from 13 to 16 years (for girls X to Y, for boys x to y*)
*district specific data needed
 - b) Increase the number of sexually active youth 15-19 who report using a condom always with all sexual partners
 - c) Reduce the number of young men and women who report having multiple sexual partners
- ii) Health-seeking Behaviour
 - a) Increase number of young men and women utilizing SRH services
 - b) Increase the number of young men and women who are counselled and tested for HIV at all centres.
 - c) Increase the number of young women who receive post abortion care and select a family planning method.
 - d) Increase the number of young people reporting sexual violence including rape.
 - e) Increase female participation in community and youth activities.

Barrier	Desired Behaviours	Key Interventions
<p>Knowledge gaps and low perception of risk for STIs including HIV, unwanted pregnancy, exchanging sex for money or gifts, risks of alcohol or drugs on their sexuality/sexual behaviour.</p> <p>Myths and misconceptions about adolescent physical and emotional changes including sexuality, sexual intercourse, menstruation, masturbation, how pregnancy occurs.</p> <p>Beliefs about semen</p> <p>Condoms and condom use</p> <p>Signs and symptoms of STI</p>	<p>Young people avoid risk situations that lead to early or unsafe sex, including alcohol and drugs.</p> <p>Sexually active young people (7-16) adopt safer sex practices including masturbation instead of penetrative sex.</p> <p>Sexually active young people reduce the number of sexual partners</p> <p>Young people ask for advice from parents, teachers and health providers</p> <p>Young people refer friends to get needed help and support</p>	<p>Carry out research to determine youth risk perception and assess feasible safer sex options.</p> <p>Involve young people in the planning and implementation of HIV/AIDS/SRH activities.</p> <p>Use positive role models for boys and girls to strengthen youth radio and TV programs and in community interventions.</p> <p>Correct myths and misconceptions through materials distributed through health providers, YCBDAs, schools and peer educators</p>
<p>Lack of gender specific life skills to deal with peer and adult pressure to have early sex, multiple partners, drug and alcohol abuse.</p>	<p>Use condoms correctly and consistently</p> <p>Young people support and influence peers positively on HIV/AIDS/SRH issues</p> <p>Teachers discuss SRH with students in a positive, open manner</p> <p>Students resist unwanted sexual advances from adults (including teachers)</p> <p>Teachers stop blackmailing students to have sex with them.</p> <p>Parents and adults discourage children from having early sex intercourse.</p>	<p>Train peer educators and leaders of youth clubs/organizations on life skills approach</p> <p>Integrate strong SRH gender sensitive life skills education into formal education curricula and teacher training starting early within primary schools.</p> <p>'No means No' campaign for girls and boys</p> <p>Lobby for condom demonstrations in schools</p>
<p>Lack of community dialogue, parental</p>	<p>Parents and /or guardians initiate open</p>	<p>Train parents in adolescent sexuality to increase their</p>

<p>guidance & support (stigma)</p> <p>Parents do not talk to their children about adolescence due to embarrassment and stigma related to sex and sexuality.</p> <p>Lack of open community discussion due to stigma and secrecy about SRH and condom use, secrecy about pregnancy, childbearing and abortion</p> <p>Faith leaders condemn discussion about youth sexuality and condom use.</p>	<p>discussion about adolescent changes with children</p> <p>Young people ask their parents and/or guardians about body changes or sex feelings</p> <p>Traditional leaders /elders facilitate open dialogue about SRH issues in community.</p> <p>Faith leaders encourage parent-child dialogue and support youth access to condoms for safer sex.</p> <p>PLWHAs disclose status to community with the support of the community.</p>	<p>confidence in discussing with their children</p> <p>Advocacy and training with traditional and faith leaders to support open dialogue on SRH with young people highlighting the importance of sexual pleasure, which is safe for both men and women in the context of regular/steady partners.</p>
<p>High risk cultural SRH practices</p> <p>Initiation which encourage early sex among youth, multiple partners.</p> <p>Circumcision which increase HIV transmission through blood</p> <p>Use of herbs to induce labour/abortion or dry out the vagina for sex.</p> <p>Rituals that delay young women's to emergency health services</p>	<p>Traditional leaders/initiators eliminate high risk cultural practices and strengthen positive traditional/cultural values and rituals.</p> <p>Initiation counselors provide accurate information on SRH/HIV/AIDS to delay first sexual intercourse, benefits of condom use, and refer clients to health services</p> <p>Initiation counselors use one razor blade/knife for each boy during circumcision</p> <p>TBAs do not give girls herbs for unsafe abortion and refer to health services for emergency contraception or PAC.</p>	<p>Carry out research with traditional leaders to determine high risk cultural practices and how to modify them.</p> <p>Conduct sensitization meetings with traditional leaders and initiation counselors to adopt safer initiation practices for boys and girls.</p> <p>Conduct campaign on the benefits of condom use with leaders and with the community at large</p>
<p>Poor client-provider relationship</p> <p>Negative attitudes to youth access to SRH information and services</p> <p>Lack of access to condoms, and</p>	<p>Sexually active young people access all SRH health services (FP, STI treatment, emergency contraceptives, PAC, HIV testing, ANC and safe delivery)</p> <p>Young women and men report sexual</p>	<p>Carry out research to determine alternative service delivery outlets for condoms, contraceptives, and other RH services</p> <p>Integrate youth friendly health service approaches into</p>

<p>contraceptives.</p> <p>User fees that exclude youth</p>	<p>violence/rape and receive needed legal, health and counseling support.</p> <p>Peers refer their friends to health and social services.</p> <p>Parents help children get needed SRH services</p> <p>Service providers provide youth friendly services</p>	<p>existing health services and youth centres.</p> <p>Train service providers on youth-friendly health and social services, guided by youth.</p> <p>Involve youth in the delivery of youth friendly RH services through youth corners in health centres and stand alone youth centres.</p> <p>Promote youth friendly services and providers through branding campaigns.</p> <p>Increase condoms availability through a variety of outlets.</p> <p>Facilitate establishment of support groups for youth PLWHAs.</p>
--	---	--

Appendix II: BCI Strategy for Working with Women of Child Bearing Age 13-49

Key Lead Organisation:	Ministry of Health and Population
Partners:	White Ribbon Alliance, All organizations that are leading interventions
Lead Training Institution:	Mzuzu University
Partners:	Kamuzu College of Nursing CHAM and Training Institutions College of Medicine Malawi College of Health Sciences

Segmented Social Groups

- ▶ Strategies will need to consider the needs of unmarried vs. married women and their partners
 - ▶ Young women's needs (age 13-20) will be different from older women
 - ▶ Strategies will need to be different to address the needs of men and women who have not completed their desired family size vs. those who have completed their desired family size (multiparity, high risk pregnancies)
 - ▶ Rural and low income women found in more remote areas are at higher risk.
 - ▶ Strategies will be needed for women who are mobile, including migrant workers, commercial sex workers, and uniformed women.
 - ▶ Men, and men's involvement in women's SRH risk, are critical to address in all strategies focusing on women's health.
-

Maternal mortality rates are unacceptably high. Women begin having children while still in their teens and many continue to have closely spaced pregnancies throughout their childbearing years. Every pregnancy, whether planned or unplanned, is a high-risk activity for women, which can lead to death. Factors leading to early death may include couple's lack of awareness of danger signs in pregnancy, delayed referral for emergency obstetric care, unsafe deliveries, and unsafe abortions.

Women are also a population most affected by HIV/AIDS. While unprotected sex can lead to pregnancy, it also places high risk for transmission of HIV and other STIs both for herself and her unborn child (Mother to Child Transmission). It also increases for pregnancy/delivery related complications. Young women are currently most affected by HIV/AIDS.

Women, as traditional caregivers, also take the greatest burden in caring for the sick and the

increasing number of orphans needing care. Thus, there is a need to support women's informed choice around when to get pregnant, safe pregnancy, delivery and newborn/infant care as well as promote her access to key PMTCT services.

There is also a need to address widely held beliefs about women and men's roles, which place them at risk, and affect their access to information, services, and supports differently.

Men's involvement in women's sexual and reproductive health are critical to address. Although men are key decision-makers regarding women's SRH, they have been traditionally excluded in reproductive health messages and services. Women are often put at risk for HIV, STIs, and unwanted pregnancy because of their male partner's sexual behaviour..

Strategies should emphasise the positive aspects of sex and sexual pleasure and the importance of making sex safe and fun for both men and women within stable relationships.

A. Behavioral Problems:

I Unsafe sexual and reproductive health practices

- a) Women and men engage in unprotected sex with multiple partners or women engage in unprotected sex with men who may have multiple partners.
- b) Many women (and men) will not use condoms as a dual form of protection against unplanned pregnancy/STI and HIV transmission
- c) Women (and men) may use herbs and other objects to dry their vaginas which increases their risk for HIV transmission
- d) Women use herbs/take 'medicines' to induce early labour and abortion
- e) Sexual violence increases women's risk for STIs, HIV, and unsafe abortion

II Inconsistent health seeking behaviour

- a) Many women, who have stated that they would like to use family planning methods, do not use modern contraceptives to space or limit their children.
- b) Pregnant women with complications often delay access to emergency obstetric services too late and die as a result
- c) Many women do not deliver their children with a skilled attendant
- d) Many women die from complications after child-birth because they do not come to the health center for postnatal checkups during the first week
- e) Women do not access VCT services before getting pregnant, or during pregnancy
- f) Many women do not go for early STI detection and treatment
- g) Many women who are HIV+ do not seek advice/support to protect their newborn from HIV transmission (utilise proper infant feeding procedures).

B. Barriers to Address:

The following eight barriers are addressed separately within the matrix. However, behaviour change interventions need to be interlinked.

1. Knowledge gaps on HIV/SRH issues
2. Low risk perception and assessment
3. Gender Inequalities/Related Risks
4. Stigma
5. Poor community dialogue
6. High risk cultural practices at community level
7. Poor access to SRH services including poor client/service provider relationship and lack of male friendly services
8. Lack/inadequate community involvement in SRH/HIV/AIDS issues

C. National Behavioural Objectives for Women of Child-bearing Age

Sexual and Reproductive Health Behaviour

- a) Increase the number of rural young women who delay their first pregnancy until 18 years of age.
- b) Increase reported condom use for men with their cohabitating partners
- c) Establish a baseline for the number of women who report that they are successfully making decisions about FP, place of delivery, or condom use.

Health-seeking Behaviour

- a) Reduce men and women's unmet demand for family planning methods to space or limit the number of desired children
- b) Increase the number of women age (15-24) utilizing post-abortion care (PAC) who select a family planning method.
- c) Increase the number of men and women who go to health centres for detection and treatment of STIs.
- d) Increase the number of men and women being counselled and tested for HIV at available centres.
- e) Increase the number of women who deliver with a skilled attendant.
- f) Increase the number of women who receive emergency obstetric care in case of danger signs during pregnancy.
- g) Increase the number of women who attend post-natal checkups within the first week.
- h) Increase the number of women who exclusively feed their infant with appropriate method of choice up to six months.
- i) Increase the number of district hospitals who have access to safe blood.
- j) Increase the number of women reporting sexual violence including rape (using baseline from MoGYCS based on Gender Action Committees)

Barriers	Desired Behaviours	Interventions
<p>Low risk perception regarding dry sex, unsafe abortion, death related to pregnancy related complications, mother to child transmission.</p> <p>Most women abort unwanted pregnancies, some men force/encourage their partners to abort, some women who abort use harmful herbs/chemicals or instruments</p> <p>Most women and men do not see too frequent, too late, too many births as a risk</p> <p>Most women do know the benefit of HIV testing before the next pregnancy</p> <p>Many women do not know the danger signs in pregnancy (or realise the importance of immediate referral to hospital once they occur)</p>	<p>Women of all ages stop inducing abortion</p> <p>Men and women use contraceptives to prevent unwanted pregnancy</p> <p>Couples use condoms as a dual method of protection (STI/HIV and FP method)</p> <p>Service providers support women's access to emergency contraception and safe post abortion care</p> <p>Women who go for post abortion care, choose a family planning method.</p> <p>Women go for VCT before becoming pregnant or during pregnancy to reduce risk.</p> <p>Pregnant women and families have birth plan, emergency transport in case of complications.</p> <p>Women go to health centre within first week post delivery.</p>	<p>Conduct awareness campaigns on benefits of VCT , for the prevention of mother to child transmission</p> <p>Media campaign highlighting priority safe motherhood themes each year (birth preparedness, early postnatal care, strengthening community response, benefits of ANC</p> <p>Promote PMTCT services through all media channels once services are available.</p> <p>Posters/counselling materials within health centres which link FP services through VCT, ANC, PAC, and Post delivery.</p> <p>Media campaign highlighting role models who use condoms as couples.</p> <p>Sensitisation meetings to mobilise communities to organise emergency transport</p> <p>Develop and promote birth preparedness card for low literate families to distribute through ANC.</p>
<p>Pressure by family members on married couples to have more children</p>	<p>Married women in liaison with their husbands make decisions about the number of children they want to have</p>	<p>Carry out campaign on choosing the most suitable FP method for couples.</p> <p>Promote male role models who support FP for</p>

<p>In most communities high number of children one has is regarded as a status symbol</p> <p>There are myths and misconceptions that when a woman uses contraceptives becomes barren</p> <p>There is lack of couple communication on family planning methods</p> <p>There is lack of knowledge on reproductive health rights especially for women</p> <p>Lack of decision making among women</p> <p>Men do not support women to realise their reproductive rights (not involved in RH issues)</p>	<p>Women stop having children after age of 35 years</p> <p>Men protect women's health by supporting women's decisions about when to have sex, using condoms, supporting timely access to RH services (FP, VCT, SM)</p> <p>Men become more involved in RH services with wives.</p> <p>Families and marriage counsellors support couples to use family planning methods</p> <p>Traditional and religious institutions teach/discuss correct sexual reproductive health issues</p> <p>Women are supported by partners, family and community to exercise their sexual and reproductive health rights</p>	<p>themselves and their partners</p> <p>Conduct national campaign to promote gender balanced relationships and empowerment of women</p> <p>Train more teachers, traditional healers, agriculture extension workers and health workers in FP issues for information and referral</p> <p>Identify ways to make RH services more male friendly.</p> <p>Conduct sensitisation meetings with traditional and religious leaders to support FP and PMTCT.</p>
<p>Lack of adequate knowledge on the available RH services</p> <p>Failure to recognise emergency SRH issues among men and women</p> <p>Stigma surrounding sexual related issues for example STIs, abortion</p>	<p>Men and women seek emergency care on RH issues</p> <p>Community members stop practices that delay women's access to emergency health care</p> <p>Women deliver under skilled care</p> <p>Members of the community seek appropriate</p>	<p>Campaigns on SRH issues based on research.</p> <p>Train service providers on SRH issues and update trends</p> <p>Train providers in inter-personal relationship and counselling</p> <p>Train providers in life saving skills</p>

<p>and use of contraceptives</p> <p>Lack of community dialogue (sharing of information)</p> <p>Lack of community involvement on issues related to SRH</p>	<p>information on HIV/AIDS/SRH and share it with peers</p> <p>Peers refer their friends to health and social services.</p> <p>TBAs and HSAs refer clients to the health centres</p> <p>Faith leaders support all community members access to info, products and needed services.</p>	<p>Promote quality counselling on PMTCT issues to ensure utilisation</p> <p>Conduct open days on SRH services for example VCT and PMTCT</p> <p>Lobby for integration of SRH services at all levels</p> <p>Organise community support groups and TBAs to support and monitor women's access to safe delivery and new born care practices in community.</p>
<p>High risk cultural practices increase women's risk for STIs / HIV, unwanted pregnancy, and delays to emergency health services</p> <p>Rituals that encourage multiple sexual partners (death cleansing, fisi, wife inheritance)</p> <p>Use of herbs to induce labour, abortion or to dry out the vagina for sexual excitement</p> <p>Rituals that delay young women's to appropriate and emergency health services</p>	<p>Traditional leaders/initiators eliminate high risk cultural practices and strengthen positive traditional/cultural values and rituals.</p> <p>Traditional counsellors provide accurate information on SRH/HIV/AIDS to men and women in the communities (benefits of condom use, and refer clients to health services)</p> <p>TBAs discourage use of herbs to induce abortion labour or dry out vaginas</p> <p>Community members organize emergency transport, support hospitals by mobilizing voluntary blood drives in communities to ensure that women have access to safe blood for emergency obstetric care.</p>	<p>Carry out research with traditional leaders to determine high risk cultural practices and ways to modify them.</p> <p>Campaign on the dangers of high risk cultural practices, highlighting communities and traditional leaders who have found safe alternatives.</p> <p>Conduct campaign on the benefits of condom use with opinion leaders, and community at large (use national role models/media figures as spokespeople)</p> <p>Campaigns and mobilization activities for community action for emergency transport and blood donations for safe delivery.</p>
<p>Poor access to SRH services/ service provider-client relationship</p>	<p>Men and women access all SRH health services (FP, STI treatment, emergency contraceptives, PAC, HIV testing, ANC and safe delivery)</p>	<p>Carry out research to determine alternative service delivery outlets for condoms, contraceptives, and other RH services</p>

<p>Negative attitudes by service providers to men and women who seek services especially STIs, contraceptives and post abortal care</p> <p>User fees that exclude those who cannot afford them</p>	<p>TBAs, CBDAs and other community-based service providers refer their clients to appropriate services</p> <p>Service providers show kindness, demonstrate caring through active listening skills, allow time for clients to ask questions</p> <ul style="list-style-type: none"> - counsel on breastfeeding during ANC - use infection prevention methods during delivery - Perform procedures according to standards - Encourage referral to other SRH services - Refer clients to community based providers for support and home-based care. - Educate all clients on benefits of condoms use, its dual function, demonstrate how to use. <p>TBAs and health providers share positive experiences in interpersonal communication and counselling</p>	<p>Review effectiveness of TBAs and identify new roles and responsibilities in information/communication as partners in SRH delivery.</p> <p>Try innovative strategies to bring TBAs and midwives together as partners in protecting women's health (ie. Incentives for referrals, follow-up care for women in communities).</p> <p>Train service providers on friendly health and social services for youth and males.</p> <p>Increase condoms availability through a variety of outlets.</p> <p>Facilitate establishment of support groups for youth PLWHAs.</p> <p>Lobby for increased financial allocation for training of health personnel; and procurement of drugs and other essential equipment for safe delivery and PMTCT services.</p> <p>Identify alternatives for those who can't pay user fees.</p>
--	---	---

Appendix III: BCI Strategy for Working with Men and Women Engaging in High Risk Behaviours

Key Lead Organization: Ministry of Gender, Youth and Community Services (Dept. defined by Ministry), Ministry of Labour, Chamber of Commerce

Partners: All organizations that are leading BC interventions
Lead companies

Lead Training Institution: Mzuzu University

Partners: Kamuzu College of Nursing

Segmented Social Groups

- Strategies will need to be target specific in terms of sex, age, socio-economic status and most importantly, places where risk practices occur
 - Strategies will focus mainly on people who often leave their spouses and work far away from their homes, including low-income women, commercial sex workers, men and women who engage in petty trade.
 - Men and women who frequent drinking establishments
 - Interventions will also focus on hotel managers, bar and bottle store owners, and senior civil servants in order to solicit their support for successful implementation of planned activities.
 - Interventions will focus on developing workplace policies and programs, particularly within companies and ministries that involve extensive travel and within entertainment places where people meet to ensure education, access to contraceptives and referral to RH services.
-

Anyone who doesn't know his or her HIV/AIDS status and has unprotected sex is involved in high-risk behaviour.

Men and women who travel or live away from their homes for periods of time are more vulnerable to engaging in risk behaviours because they are separated from their spouses and partners. Men, who travel, for example, seasonal workers, truck drivers, petty traders or uniformed men, may seek out sexual comfort from women in bars, bottle stores hotels because they feel greater stress or loneliness. **They are also putting their spouses at risk.**

Low-income women of all ages may enter into sexual relationships with men in exchange for money or gifts. While some of these women can be found in the commercial sex industry, within bars or brothels, other women may engage in transactional sex through informal networks.

Women who give birth too frequent, too many and too late (after age 35) are considered to be at risk of pregnancy and child-birth related complications. Young girls who become pregnant too early (below age 18) are also at risk.

Strategies should emphasise positive aspects of sex and sexual pleasure and the importance of making sex safe and fun for both men and women within stable relationships. They should encourage open discussion of Malawi values and rituals that place men and women at risk while emphasising positive ones that strengthen Malawi culture.

A. Problem Behaviors:

1 Unsafe sex practices

- a) Men who travel a lot or are based in other places for work, often have more sexual partners
- b) Most commercial sex workers do not use condoms consistently. Some commercial sex workers as well as mobile men do not use condoms with their 'boy friends/girl friends' and often accept not to use condoms if the agreed payment is higher
- c) Commercial sex workers use herbs and other drugs to dry their vaginas

2 Inconsistent health seeking behavior

- a) Most high risk men and women are unwilling to access STI services and other support services
- b) High risk men and women who contract STIs delay in seeking treatment
- c) When they have contracted an STD most high risk men and women often go to a traditional healer first before to health centre/clinic
- d) High risk men and women do not access VCT services

B. Barriers to Address:

1. Knowledge gaps on issues of HIV/AIDS/SRH including condoms and condom use
2. **Harmful sexual cultural practices in communities that increase HIV/AIDS transmission and unwanted pregnancies**
3. Lack of dialogue on HIV/AIDS/SRH in the communities

4. Gender inequalities and sexual violence
5. High stigma and stigmatization related to HIV/AIDS/SRH and condom acceptance and use
6. Unavailability and inadequate SRH/HIV/AIDS services
7. Negative attitudes of health providers towards clients seeking STI services.
8. Low risk perception about HIV/AIDS/SRH

C. National Behavioural Objectives for Men and Women Engaging in High Risk Behaviours

1 Sexual and Reproductive Health Behaviour

- a) Increase correct and consistent condom use with all non-cohabiting partners
- b) Decrease number of reported sexual partners
- c) Decrease number of men who paid for commercial sex in the last 12 months
- d) Increase the number of young women who report having alternative forms of income generation for low-income girls and women to prevent transactional sex

2 Health-seeking Behaviour

- a) Increase number of men and women who are counseled and tested for HIV at available centres
- b) Increase number of men and women in high risk areas accessing STI treatment
- c) Increase the number of women reporting sexual violence and rape

Barrier	Desired Behaviours	Key Interventions
<p>Knowledge gaps and low risk perception</p> <p>Related to multiple partners and benefits of condom use</p> <p>Dangers of alcohol abuse and high risk sex.</p> <p>Links between STIs and HIV</p> <p>Masculinity</p>	<p>Men and women who work at high risk places use condoms consistently and correctly with all partners</p> <p>Go for VCT before entering new relationships and before getting pregnant.</p> <p>Seek regular STI screening and early treatment.</p> <p>Women (particularly those over 35 or under 18, working in high risk places) use contraceptives to avoid unwanted pregnancy and related complications</p> <p>Owners of entertainment places (bars, bottle stores, rest houses, truck stopping points, hotels) promote 100% condoms use among clients and arrange regular STI screening for CSWs.</p> <p>Government and companies provide their workers with accurate information on sex, gender, HIV/AIDS and STIs, and condom access</p>	<p>Campaign to promote benefits of VCT, by highlighting positive testimonies of those who have been tested.</p> <p>Man to man peer education and support in high risk settings to address knowledge gaps, risk analysis to challenge damaging norms of masculinity, and links to condoms and services</p>
<p>Stigma and stigmatisation</p> <p>HIV and PLWHA makes VCT and disclosure difficult.</p> <p>Stigma that links condoms to</p>	<p>Traditional and religious leaders, workplace managers, speak on silence, stigma and risk; encourage people to go for VCT and use condoms.</p> <p>Society recognises and respects rights of</p>	<p>Conduct meetings on rights of PLWAs</p> <p>Lobby to government on possibility of legalizing CS industry and setting health standards.</p>

<p>promiscuity</p> <p>Certain professions stigmatised making it difficult for them to take new action</p>	<p>PLWHA and CSWs</p>	
<p>Gender inequalities and sexual violence</p> <p>Low economic status, low educational level, increases dependence on men.</p> <p>Pressure to engage in transactional sex.</p> <p>Pressure for men to have multiple partners</p> <p>Communities promote idea that 'real man' have frequent sex.</p> <p>Sexual harassment in prisons, offices, police, defense facilitates spread of disease</p> <p>Lack of laws to protect CSWs</p>	<p>Policy makers promote gender balance at all levels</p> <p>More economic opportunities for women, including income generation loans</p> <p>Peers support each other to avoid starting transactional sex and seek out alt. income</p> <p>Families discourage sex for gifts and money</p>	<p>Awareness campaigns on gender inequalities and violence against women</p> <p>Promote role models for both men and women</p> <p>Life skills and income generation...</p> <p>Access to loans,</p> <p>Laws and regulations</p>
<p>Unavailability and inadequate SRH services</p> <p>Lack of condom access</p> <p>Poor attitudes of service</p>	<p>Promote condom use and access in entertainment places and workplaces.</p> <p>Service providers promote condoms as both a FP and STI/HIV prevention</p>	<p>Train providers in friendly and gender sensitive services</p> <p>Develop community based man to man peer education programs linked to condom supply and distribution</p>

providers towards clients seeking STI services Men feel RH services are for women	Service providers strengthen links with community providers to promote condoms and referrals	Advocate for mobile health clinics from private and public sector. Lobby for establishment of VCT and STI screening centres close to entertainment places.
--	--	---

Appendix IV: BCI Strategy National Planning Framework for Opinion Leaders

Key Lead Organization: Ministry of Sports Youth and Culture, Malawi Multi-religious Task Force or HIV/AIDS State Religion Task Force as lead coordinating body

Partners: All faith-based organizations and all that are leading Interventions on HIV/AIDS/SRH
National Council of Chiefs

Lead Training Institution: Mzuzu University

Partners: Kamuzu College of Nursing

Segmented Social Groups

- Strategies will need to be specific in terms of working with religious leaders, traditional leaders, traditional healers, local politicians and celebrities who also command the majority of followers and supporters
 - Different strategies may be needed for literate and illiterate opinion leaders. In Malawi, most traditional leaders are illiterate and appropriate interventions have to seriously take this into consideration in order to make use of such leaders
 - Strategies will focus on how to make use of power and authority of religious and traditional leaders in order to influence or bring about changes in high risk cultural practices; and misleading norms, values and beliefs
 - Strategies should focus on critical analysis of understanding behaviours within an African context (gender- related values, beliefs and the role of community and rituals). Positive aspects of cultural values, and rituals should be emphasised, and acceptable alternatives within tradition/culture found to practices which are high risk.
 - Strategies will also aim at promoting role models especially among celebrities such as footballers, musicians, Miss Malawi, drama artists, radio and television personalities in order to promote positive behaviours
-
-

For purposes of BCI Strategy in Malawi, opinion leader has been defined as anyone who wields significant authority and influence, particularly at the community level.

Opinion leaders are the most significant audience in creating an enabling environment for behaviour change because it is their action or inaction that determines the outcome of desired behaviours of community members.

Traditional leaders (chiefs, village headmen, counsellors) are custodians of traditional norms, practices and values. Any HIV/AIDS/SRH activity requires their support to eliminate cultural practices that facilitate STI/HIV transmission, unwanted pregnancy or delays access to health services. They have to promote community dialogue on HIV/AIDS/SRH issues that are still considered as a taboo and strengthen positive aspects of culture and tradition.

Most religious leaders talk about HIV/AIDS and sexuality issues in the context of sin. This promotes stigma and discrimination to those people with or suspected of having HIV. The religious leaders should bring about hope faith and a spirit of acceptance of the reality of the HIV/AIDS epidemic among all Malawians in order to facilitate prevention and mitigation of its impact. They should also speak of sex and sexual pleasure as something positive, and the importance of making sex safe and fun for both men and women within stable relationships. They should encourage open discussion of Malawi values and rituals that place men and women at risk while emphasising positive ones that strengthen Malawi culture.

Famous people such as musicians, footballers, Miss Malawi, drama artists, radio and television personalities are considered influential people because ordinary people tend to associate with them and what they do. If famous people behave irresponsibly, chances are high that their followers may do the same. The celebrities need to be exemplary and behave in a manner that will induce positive behaviours.

A. Problem Behaviours

i Unsafe sexual and reproductive health practices

- a) Some traditional leaders still encourage first sexual intercourse around age 15 and perhaps as early as 12 to 13 during initiation.
- b) Traditional and religious leaders do not support condom use. They associate condoms and condom use with promiscuity.
- c) In some societies polygamy is accepted and even promoted and encouraged
- d) Many men, women, and young people have multiple sexual partners
- e) Some traditional healers demand sex from their clients as a healing methods
- f) Some famous artists and celebrities have multiple sexual partners because of their fame and money which they can afford to spend

ii Inconsistent health seeking behaviour

- a) Religious leaders discuss issues of HIV/AIDS/SRH in the context of sin
- b) Traditional leaders strongly hold secrecy around issues of sex, pregnancy, abortion and child bearing.
- c) Some religious institutions do not or cannot support modern family planning methods
- d) Some people when infected with STIs visit traditional healers first before health centre

B. Barriers to Address:

1. Lack of dialogue on sex, sexuality and HIV/AIDS
2. Harmful cultural practices in communities that predispose people especially youth and women to HIV infection
3. High stigma and discrimination
4. Lack of role models
5. Inadequate involvement of traditional and religious leaders in the planning and implementation of HIV/AIDS/SRH projects

C. *National Behavioural Objectives for Opinion Leaders*

1. Promote dialogue in the communities on HIV/AIDS/SRH issues and positive gender relations.
2. Increase number of role models who will take the lead in the fight against HIV/AIDS and promote positive SRH practices and health seeking behaviours.
3. Strengthen support for the planning and implementation of family planning, safe motherhood and HIV/AIDS programmes within communities
4. Increase the support mechanisms for information sharing and service provision within communities.

Barrier	Desired behaviours	Key Interventions
<p>Lack of dialogue on sex, sexuality and HIV/AIDS</p>	<p>Traditional leaders initiate open discussion about sex, sexuality and HIV/AIDS</p> <p>Religious leaders discuss sex, sexuality and HIV/AIDS issues in the context of their spirituality and faith</p> <p>Leaders (traditional, religious, celebrities) sensitise their people on the impact of HIV/AIDS on food security and other socio-economic development</p> <p>Musicians, drama artists, radio and TV personalities disseminate messages on dangers of indulging in promiscuity especially unprotected sex</p>	<p>Train faith leaders to understand the scientific nature of HIV/AIDS and the social, cultural and economic factors that predispose people to HIV infection</p> <p>Train musicians, artists and personalities on HIV/AIDS/SRH especially on message development and dissemination</p> <p>Conduct series of sensitisation meetings with leaders on HIV/AIDS/SRH issues</p> <p>Engage leaders in open discussions on HIV/AIDS/SRH</p>
<p>High risk cultural practices for SRH</p> <p>Traditional practices that promote early sex, beliefs and rites that encourage multiple sexual partners</p>	<p>Traditional leaders advocate for elimination of high risk cultural practices that contribute to the spread of HIV/AIDS, STIs, unwanted pregnancy, and unequal gender relations.</p> <p>Traditional counsellors utilize initiation ceremonies to promote the delay early sex</p>	<p>Map out high risk cultural practices with traditional leaders and identify ways to modify them.</p> <p>Train chiefs, village headmen, counsellors on HIV/AIDS especially on the nature and modes of transmission of HIV/AIDS/STIs and identify positive aspects of culture to strengthen.</p> <p>Promote awareness among parents and community members of the importance of strengthening positive aspects of culture and tradition.</p>

	Traditional leaders, healers and counsellors provide accurate information on sex, sexuality and HIV/AIDS	
<p>Stigma and Discrimination</p> <p>Stigma around HIV/AIDS that makes VCT and disclosure of status difficult</p> <p>Some religious leaders condemn PLWHAs as sinners</p> <p>Traditional leaders associate condoms and condom use with promiscuity</p> <p>Some churches are not allowed to talk about condom use.</p>	<p>Leaders show compassion to PLWHAs and those affected by the epidemic</p> <p>Faith-based communities promote the rights of PLWHAs</p> <p>Communities, Churches and Mosques encourage their subjects to go for VCT and disclose their HIV status</p> <p>Traditional leaders support condom promotion</p> <p>Leaders establish support groups for PLWHAs</p>	<p>Campaign for the rights of PLWHAs and the affected individuals</p> <p>Train traditional and religious leaders on the rights of PLWHAs and people infected with STIs</p> <p>Mobilize communities and faith-based institutions to establish support groups for PLWHAs</p> <p>Lobby for stiff penalties for those who discriminate against PLWHAs</p> <p>Lobby churches and mosques to develop a culture of tolerance to those infected with HIV/AIDS</p> <p>Identify national spokespeople as role models.</p>
<p>Lack of role models among religious and traditional leaders</p> <p>There is inadequate individual commitment and willingness to take lead in advocating for HIV/AIDS.SRH issues</p> <p>Most leaders do not display</p>	<p>Celebrities, religious and traditional leaders take lead in educating the general public on HIV/AIDS/SRH issues</p> <p>More celebrities use condom correctly and consistently</p> <p>Leaders practice mutual</p>	<p>Produce printed materials, radio and TV programmes on the role of religious and traditional leaders on HIV/AIDS/SRH activities</p> <p>Train drama artists, radio and TV personalities on life skills</p> <p>Mobilize celebrities to take lead in advocating HIV/AIDS/SRH activities through their shows and activities</p>

<p>exemplary behaviours</p> <p>Some faith-based institutions discriminate against PLWAs by condemning them as 'sinners deserving the fate</p>	<p>faithfulness to their partners</p> <p>Religious leaders show love, compassion and support to PLWAs and those affected by HIV/AIDS</p>	
<p>Most projects are planned and implemented without full involvement of the beneficiaries</p>	<p>Local leaders fully participate in the formulation and development of HIV/AIDS/.SRH projects</p> <p>Leaders take the lead in the fight against HIV/AIDS</p> <p>Faith-based institutions (churches, Mosques) establish support groups for people infected and affected by HIV/AIDS</p>	<p>Mobilize communities to identify major HIV/AIDS/SRH issues to address in their communities</p> <p>Mobilize financial resources for implementation of HIV/AIDS/SRH activities</p> <p>Organize exchange visits for leaders in areas of best practices on HIV/AIDS/SRH</p> <p>Conduct media tour in communities implementing best practices in HIV/AIDS/SRH for replication to other communities</p>

Appendix V: BCI Strategy National Planning Framework For the Service Providers

KEY LEAD ORGANIZATION: Ministry of Health and Population
Partners: MOEST
Ministry of Information
MOGYCS Youth Department

LEAD TRAINING INSTITUTION: Mzuzu University
Partners: Kamuzu College of Nursing
MCHS
College of Medicine
Bunda College of Agriculture
CHAM
Natural Resources College of Malawi
Chancellor College of Malawi

Segmented Social Groups

- Strategies will need to address a multi sector approach to reach different service providers
 - Health providers include health centre staff, nurses, doctors, clinical officers, radiographers, medical assistants, midwives, and clerks. They also include health extension workers, such as community health nurses, HSAs, and health assistants.
 - The community based health workers such as trained TBAs, traditional healers, CBDAs, the growth monitoring volunteers and home based care providers.
 - Strategies also need to reach social service providers such as teachers, agriculture extension workers, traditional initiators, priests, media personnel, NGOs, and business people, etc.
-

Service providers (health and non-health providers) are those responsible for providing information, counseling and services on HIV/AIDS/SRH. **They should assist in strengthening both the quality of services and referrals.** Their attitude and relationship towards clients, community members, and students is crucial to bringing desired behaviours among targeted social groups.

Service providers often work in difficult situations. They may lack an efficient and supportive working environment, financial resources, education and training, medical resources, supportive supervision and management, tools and materials, and economic empowerment. There is an urgent need to take action to assist them to improve management and coordination between health, education and social sectors, and also the capacity and performance of all service providers.

A. Problem Behaviours:

i Unsafe sexual and reproductive health practices

- a) Service providers do not promote safe SRH practices, including condoms to prevent STIs, including HIV/AIDs or unwanted pregnancy or warn of the dangers of having multiple partners
- b) Service providers continue to promote high risk cultural practices and some TBAs and traditional healers administer herbs to pregnant women (pitocin) or cut warts out, which increases maternal risk or transmission of HIV/AIDs.
- c) Some TBAs promote risky alternatives to DNC for women who want to terminate pregnancy.
- d) Service providers do not set examples within their own workplaces
- e) Some service providers are engaging in unsafe sexual practices as well
- f) Some service providers use their position of power to engage in risky sexual behaviours.

ii. Inconsistent health seeking behaviour

- a) Service providers do not refer community members to appropriate health services
- b) Service providers are not providing adequate information, kindness, respect, to clients who use their services
- c) Some service providers lack technical skills and competency to provide SRH services and counseling
- d) TBAs delay referral of pregnant women with complications to emergency obstetric services

B. Barriers to Address:

The following seven barriers are addressed separately within the matrix. However behavior changes interventions need to be interlinked.

1. Knowledge and skills gaps in HIV/AIDs/SRH
2. Poor client-provider relationship
3. Harmful SRH practices

4. Poor community involvement and community dialogue in SRH issues
5. Gender Inequalities and lack of promotion of human rights
6. Poverty-lack of economic empowerment
7. Increase in unsafe abortions

C. National Behavioural Objectives for Service Providers

- Increase the number of referrals made from the community to the formal health centres and vice versa for home based care.
- Increase supportive supervision by health centres to informal health providers.
- Increase the communication and provision of information by all service providers
- Replace cultural practices that put men, women and young people at risk of HIV/AIDS transmission and unwanted pregnancies with safer practices.
- Increase support mechanisms for open discussion at the community level
- Increase the number of care and support groups within the community

Barrier	Desired Behaviour	Key Interventions
<p>Poor client-service provider relationship</p> <p>Many service providers are not friendly to clients, especially to youth</p> <p>Inadequate staff in health centres resulting in pressure of work</p> <p>Long waiting time at health centres before clients are attended to</p> <p>Low motivation or commitment of health centre staff</p> <p>Lack of training in interpersonal relationships</p>	<p>Service providers treat all clients and patients, young and old with respect</p> <p>Service providers dispense all types of contraceptives, provide STI and abortion services to young people, married and unmarried women and men without prejudice</p> <p>Providers refer clients to other needed SRH services and community based providers for support and home based care.</p> <p>Health centre service providers demonstrate kindness, active listening skills, allow time for clients to ask questions (exhibit high motivation and commitment to their work)</p> <p>Professional peers role model positive provider-client behaviour and report negative behaviour.</p> <p>Clients express appreciation for positive relationship and take advise</p>	<p>Highlight best experiences with service providers (role models) through media, with popular figures who speak of their own experience</p> <p>Recognise star provider teams with incentives</p> <p>Involve the youth in the design/planning and implementation of youth friendly services</p> <p>Train service providers in interpersonal relationships and youth friendly services</p> <p>Campaign to promote the trained/quality service provider (provides service with a smile) through branding.</p> <p>Radio spots role modeling positive client-provider interactions, incorporate good vs. bad role model provider in soap operas.</p> <p>“Thank your provider today” promotion</p> <p>Lobby for review and improvement of the conditions of service providers</p> <p>Conduct client flow analysis and time and motion studies in health centres to determine causes of long waiting time</p>

	<p>SRH service delivery is youth and male friendly.</p> <p>Hospital staff facilitate information exchange to all levels of service delivery.</p> <p>Policymakers put into place supportive policies to improve quality of care.</p> <p>TBAs and health providers share positive experiences interpersonal communication and counseling.</p>	
--	---	--

<p>Skills and knowledge gaps in SRH/HIV/AIDS</p> <p>Service providers give incomplete and inaccurate information to clients on SRH/HIV/AIDS, MTCT and VCT services</p> <p>Some service providers are not aware of risks associated with use of herbs or cutting of the skin</p> <p>Do not recognize the benefits of condom use (including dual protection), have negative perceptions, or have little experience using condoms themselves.</p> <p>Do not educate on risky behaviours that lead to contracting STIs and HIV</p>	<p>All service providers give clients/community members complete and accurate information on HIV/AIDS/SRH including benefits of PMTCT and VCT services.</p> <p>Health/non health service providers (incl. HSAs) educate TBAs on the dangers of administering herbs and cutting under septic conditions - traditional initiators and healers on - importance of using one razor/knife per person for circumcision</p> <p>All service providers educate clients/community members on - the anatomy and physiology of the reproductive system - dual benefits of condom use - demonstrate correct condom instructions</p> <p>All service providers refer clients/patients timely for further care</p>	<p>Develop professional IEC materials that address gaps and support attitude change and boost their morale.</p> <p>Strengthen quality assurance committees</p> <p>Re-enforce infection prevention guidelines for both facility and community based health service providers</p> <p>Strengthen/develop guidelines and standards for the performance of procedures by both facility based and community based service providers</p> <p>Conduct regular sensitization meetings with built-in mechanisms for M&E.</p> <p>Raise community awareness on the magnitude and dangers of unsafe abortions (based on survey to find out causes, where and how they are performed)</p> <p>Sensitise all service providers on alternative safer cultural practices</p> <p>Support extension work of CBDAs, HSAs and others by creating awareness of services, IEC materials distribution, and monitoring and evaluation.</p>
<p>Gender inequalities and lack of promotion of human rights</p> <p>Some health services are not male friendly</p>	<p>Service providers view men and women as equal in SRH, HIV/AIDS issues</p> <p>Both men and women, boys and girls access SRH services</p>	<p>Carry out research to find out what people view as gender equality and how it can be promoted</p> <p>Disseminate information on the importance of gender equality, elimination of gender-based violence.</p>

<p>Lack of knowledge on human rights</p> <p>Cultural roles do not support gender equality</p> <p>Negative attitudes that view women as inferior to men</p>	<p>equally</p> <p>Service providers interpret human rights correctly</p>	<p>Lobby for review of policies and implementation of equal rights between men and women</p> <p>Conduct civic education on human rights (highlighting those people at risk in communities)</p> <p>Conduct sensitization meetings with traditional and faith leaders on gender inequality and violations of human rights in the spread of HIV and increase in SRH problems.</p>
--	--	--

<p>Poor community involvement and dialogue in HIV/AIDS/SRH issues</p> <p>There is very little dialogue of SRH, HIV/AIDS issues by service providers at community level</p> <p>Poor links between health and education institutions and community based providers</p> <p>Lack of coordination between different sectors at the community level to support SRH, HIV/AIDS services</p> <p>Service providers find it difficult to discuss SRH, HIV/AIDS issues in the community</p> <p>Poor communication infrastructure in the community</p>	<p>Health and non health service providers share information on SRH, HIV/AIDS issues with leaders, community-based committees, community members.</p> <p>Involve CHC in delivery of services</p> <p>Community members involved in the design and delivery of both facility and community based health services</p> <p>All service providers dialogue with the community and the media on SRH, HIV/AIDS issues</p> <p>HSAs, TBAs and traditional healers refer clients to health centres and vice versa.</p> <p>HSAs, TBAs and traditional healers have access to follow their clients up in health centres and vice versa</p>	<p>Carry out research to determine factors that hinder community involvement and dialogue on HIV/AIDS issues with formal health sector.</p> <p>Sensitisation meetings with health and community-based service providers in interpersonal communication</p> <p>Conduct workshops for health centre based and community based health and non health service providers to share information and promote dialogue on the importance of working together</p> <p>Campaign on the role of communities and service providers in HIV/AIDS issues, highlighting community rights regarding the provision of health services</p> <p>Mobilize communities to provide emergency transport and communication facilities to health centres</p>
--	---	---

Appendix VI: BCI Strategy for Working with Policy Makers

Key Lead Organisation: Office of President and Cabinet/Business and Commerce
Partners: All that are leading Interventions on HIV/AIDS/SRH

Lead Training Institution: Mzuzu University
Partners: Kamuzu College of Nursing

Segmented Social Groups

- Strategies will need to be specific in terms of working with cabinet ministers, members of parliament, ward councilors, and local party leaders as they command majority of followers and supporters. Their influence will therefore make an impact on HIV/AIDS and SRH interventions
- Different strategies may be needed for senior civil servants, programme managers and lawyers so that they interpret policies and give direction for implementation.
- Strategies will focus on strengthening cooperation between the executive and legislature branches in order to promote establishment of support groups, CBOs and committees at local level for effective implementation of HIV/AIDS/SRH activities.
- Strategies will also aim at promoting role models among policy makers in order to promote positive behaviours.

For purposes of BCI Strategy in Malawi, policy makers have been defined as those vested with power and authority to take action to effect the desired changes in policies, laws, programmes and practices. In HIV/AIDS/SRH interventions, policy makers are the most significant audience because it is their action or inaction that determines the outcome of any intervention, for example creating supportive environment to people to adopt and sustain positive behaviours.

These policy makers include parliamentarians, lawyers, cabinet ministers, senior civil servants and programme managers.

In the face of dwindling external resources and competing priorities, policy makers have to be used to lobby financial, material and human resources. There is need to raise political and social leadership commitment so that services are accessible to those who them.

Policy makers such as cabinet ministers, parliamentarians and business leaders should be actively involved in enforcing all the international and regional conventions and charters and the respective laws that aim at promoting rights and improving the living conditions of those infected and affected by HIV/AIDS.

Policy makers have power and authority to influence. If they behave irresponsibly, chances are high that their followers may do the same or not take them seriously on any HIV/AIDS/SRH issues. Policy makers need to be exemplary therefore and behave in a manner that will induce positive behaviours.

A. Problem Behaviours

i Unsafe sex practices

- a) Policy makers do not speak against first sexual intercourse that occurs around age 15 and perhaps as early as 12 to 13. They do not also campaign on the dangers of having multiple sexual partners
- b) Some policy makers do not support condom use. They associate condoms and condom use with promiscuity.
- c) Policy maker do not enforce laws that discriminate against PLWAs and those affected by HIV/AIDS.
- d) In some societies having multiple sexual partners (wife inheritance, polygamy) is accepted and even promoted and encouraged
- e) Policy makers have low risk perception regarding their own sexual behaviour.
- f) Some policy makers have multiple sexual partners
- g) Harmful cultural practices such as fisi, wife inheritance are practiced without any enforcement against them.

ii Inconsistent health seeking behaviour

- a) Some policy makers discuss issues of HIV/AIDS/SRH in the context of sin
- b) Because of lack of policy direction and guidelines issues of VCT, positive living, sex, pregnancy, abortion and child bearing are discussed in secrecy.
- c) Some policy makers do not support modern family planning methods
- d) Some people when infected with STIs visit traditional healers first before health centre

B. Barriers to Address:

6. Lack of National HIV/AIDS Policy
7. Lack of role models among policy makers
8. Stigma/secrecy and discrimination of those infected and affected by HIV/AIDS including STIs
9. Lack of resources to increase access to HIV/AIDS/SRH services
10. Preference by most Malawians to go to traditional healers first for HIV/AIDS/SRH related illnesses or implications

C. National Behavioural Objectives for Policy Makers

1. Strengthen support for the planning and implementation of HIV/AIDS/SRH programmes within communities
2. Promote dialogue in the communities on HIV/AIDS/SRH issues

3. Increase number of role models who will take the lead in the fight against HIV/AIDS
4. Increase the support mechanisms for information sharing and service provision within communities.

Barrier	Desired Behaviour	Key Interventions
<p>Lack of National HIV/AIDS Policy</p> <p>Lack of guidance on key interventions/planning/coordination on how best to implement HIV/AIDS/SRH activities</p> <p>There are no specific programmes aimed at modifying or eliminating harmful cultural practices</p> <p>There are no laws against harmful cultural practices</p>	<p>Government through National AIDS Commission initiate development process for National HIV/AIDS Policy</p> <p>Government, private sector and NGOs adopt and implement the National HIV/AIDS Policy</p> <p>Government Departments, NGOs, private sector develop and implement HIV/AIDS policies based on the National HIV/AIDS Policy</p> <p>Policy makers promote HIV/AIDS policies within their organizations and ministries</p>	<p>Sensitize communities on the importance of having National HIV/AIDS Policy</p> <p>Conduct wider consultations for consensus building across all sectors on National HIV/AIDS policy development and adoption</p> <p>Network with media and civil societies to advocate for the adoption of the policy</p> <p>Lobby government, private sector and donor community for financial support for the development, dissemination and implementation of the policy</p>
<p>Stigma/secretcy and discrimination of people infected and affected by HIV/AIDS</p> <p>Lack of knowledge on the rights of PLWAs among policy makers and the general public</p> <p>Lack of enforcement of laws against discrimination of PLWAs and those affected by HIV/AIDS</p> <p>Stigma and discrimination make people not to go for HVI testing</p> <p>Stigma and discrimination make those who go for HIV test not to disclose their sero status especially when found positive</p>	<p>More policy makers promoting the rights of PLWAs through meeting, rallies and media</p> <p>Policy makers formulate and pass laws that do not discriminate against PLWAs</p> <p>Policy makers ensure enforcement of laws against individuals and employers that discriminate PLWAs</p> <p>More policy makers go for HIV test</p>	<p>Carry out research to determine factors, issues, and environment that perpetuate stigma and discrimination</p> <p>Develop IEC materials addressing issues of stigma and discrimination</p> <p>Conduct civic education on the rights of PLWAs, orphans, widows and widowers</p> <p>Train policy makers on human rights as they relate to HIV/AIDS especially positive living</p>

	<p>and disclose their status</p> <p>Traditional leaders observe customary laws that are supportive to the infected and affected people</p>	<p>Engage stigmatized social groups as advocates on HIV/AIDS/SRH issues own their right</p> <p>Advocate for the enforcement of laws against any form of discrimination</p> <p>Lobby for material, financial and moral support for PLWAs</p>
<p>Lack of role models among policy makers</p> <p>Lack of individual commitment and willingness to take a leading role in advocating for HIV/AIDS/SRH issues</p> <p>Some policy makers do not adequately promote SRH/HIV/AIDS services (condom use, VCT, PMTCT and contraceptives)</p>	<p>Policy makers take lead in initiating HIV/AIDS/SRH programme activities in their ministries, organizations or areas</p> <p>Policy makers lobby for financial and material resources for implementation of HIV/AIDS/SRH activities</p> <p>More policy makers go for HIV test and disclose their status</p> <p>More policy makers especially those of reproductive age group go for family planning</p>	<p>Carry out a research to determine factors hinder policy makers to be role models</p> <p>Produce radio and television programmes on role modelling</p> <p>Train policy makers on their role in HIV/AIDS/SRH education</p> <p>Develop HIV/AIDS/SRH information kits for policy makers for use during meetings and rallies</p> <p>Conducts debates engaging policy makers and the civil society on HIV/AIDS/ SRH issues</p>
<p>Lack of resources to increase access to HIV/AIDS/SRH services</p> <p>Inadequate health facilities providing STI treatment and HIV testing in most communities</p> <p>Shortage/lack of drugs and other essential supplies in most hospitals, health centres and clinics (e.g. reagents for HIV testing, ARVs, drugs to treat opportunistic infections and contraceptives for family planning)</p>	<p>More people satisfied with HIV/AIDS/SRH services offered in health centres</p> <p>Policy makers advocating for provision of HIV/AIDS/SRH services within easy reach</p>	<p>Mobilize communities to establish community-based service delivery points and change agents</p> <p>Train more community-based agents in service provision (youth club leaders, TBAs, CBDAs, HSAs)</p> <p>Lobby financial resources for recruitment and training of health personnel</p>

<p>Shortage of highly trained health personnel</p> <p>There is poor communication infrastructure at health centres(most health centres have no telephones, wireless message equipment)</p>	<p>Policy makers ensure constant supply of drugs at health centres including ARVs, reagents, contraceptives and drugs used to treat opportunistic infections</p> <p>Policy makers mobilize resources for recruitment and training of more health personnel</p>	<p>Lobby financial resources for procurement of drugs and equipment</p> <p>Lobby for free distribution of ARVs to PLWAs especially those who cannot afford to buy</p>
<p>Preference by most Malawians to go to traditional healers first for HVI/AIDS/SRH related illnesses or implications</p> <p>There are misconceptions and myths that traditional medicines are more powerful than modern ones</p> <p>Popular belief that some traditional headers can cure AIDS</p> <p>Treatment is done without proper diagnosis</p> <p>In most referrals to formal health centres are not made (sometimes they are made too late)</p>	<p>People access treatment and others HIV/AIDS/SRH services from formal health centers</p> <p>Policy makers ensure constant supply of contraceptives and drugs such ARVs, reagents and those used to for treat opportunistic infection</p> <p>Medical personnel offer health friendly services</p> <p>To all clients</p> <p>Traditional healers make referrals</p>	<p>Carry out research to determine factors that make people to visit traditional healers first before formal health centers and hospitals</p> <p>Train traditional healers on HIV/AIDS/SRH issues</p> <p>Train (or conduct refresher courses for) nurses, health assistants, and traditional healers on HVI/AIDS/SRH service provision</p> <p>Lobby to government, NGOs and private sector for financial resources for training of traditional healers and formal service providers</p> <p>Mobilize financial resources for procurement of drugs for example ARVs</p>

**Appendix VII:
Supporting the implementation of the BCI strategy**

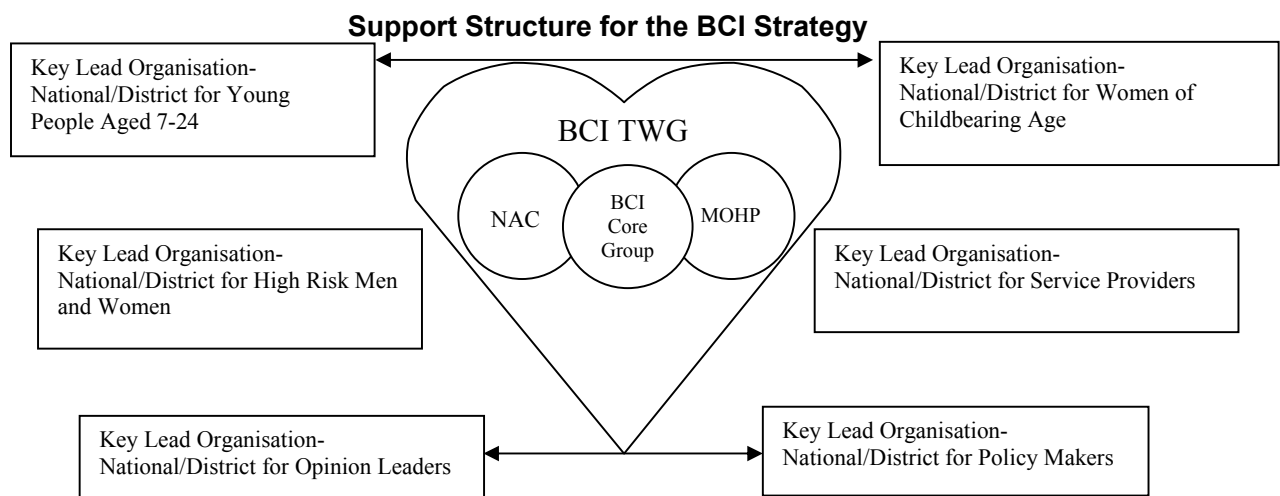
The management and the coordination of the BCI strategy is a complex undertaking which will involve many different entities at all levels of the society? The head of the BCI support is guided by BCI TWG which oversees the work of the BCI group comprised of National Aids and Ministry of Health and population.

In the following document the key roles and responsibilities have been described to detail so that all partners and stakeholders can be assisted in the area of concern during the implementation of the BCI strategy. The key players are:

- National Aids commission (NAC)
- Ministry of Health and Population (MOHP) involving the Reproductive Health Unit, the Health Education Unit, and the department of Population Services.
- BCI team comprised of NAC and MOHP
- District AIDS Coordinating Committee
- Key Social Groups Lead Organizations
- Behavior Change Interventions Technical Working Group

The BCI management has various players such as Ministries, District Health Officers (DHO), District Assemblies (Das), District Aids Coordinating Committee (DACCs), NGOs and CBOs, Capacity building should support each player at all levels for effective BCI implementation.

At all levels, during the implementation of the strategy, the National Aids Commission in conjunction with Reproductive Health Unit-MOHP will train staff of participating institutions and organization to conduct BCI sessions and come up with work plans for implementation. The lead key organization will assist in coordinating and managing the implementation of the BCI strategy both at National and District levels. The illustration below is the graphic conceptualization of the BCI strategy support structure followed by a description for each of the key players.



National AIDS Commission's Behavior Change Interventions Unit

Key Roles and Responsibilities

- Coordinate the development of the national BCI Strategy in collaboration with Reproductive Health Unit, Health Education Unit and the Department of Population Services by ensuring and facilitating linkages/networking and communication between those instances.
- Facilitate the adoption and effective implementation of the BCI strategy nation-wide through the RHU, HEU, and DPS to other partners.
- Establish mechanisms to monitor the implementation of the BCI Strategy through the works of Districts and Key Social Groups (KSG) lead organizations.
- Establish national BCI evaluation systems
- Facilitate with the M & E Unit the coordination of research and dissemination of findings
- Establish mechanism for communication, information sharing, and distribution of essential materials
- Facilitate technical and program management capacity development for Districts and lead KSG organizations and other BCI implementation partners
- Develop and maintain an inventory of BCI capacity and BCI implementing organizations nation wide
- Mobilize resources through the grants management unit of the NAC for implementing of BCI activities at all levels

Meeting/Contact Schedule with Partners

- Quarterly meetings with the BCI TWG
- Meetings with key stakeholders
- Other scheduled coordinating meetings
- Core team planning/coordinating meetings

Main Activities

- Coordinate the BCI TWG quarterly meetings
- Review operations and implementation progress with the KSG and lead organizations
- Facilitate and give technical support to the planning of BCI programs and activities
- Establish an information resource and resource centre
- Establish an effective communication system (like database of BCI organization, key individuals, etc.)
- Collect and disseminate information to the BCI TWG especially that related to KSG lead organizations
- Prepare and disseminate quarterly progress report to the Government, key stakeholders, partners and donors
- Review proposals submitted to the NAC related to the implementation of BCI strategy
- Prepare terms of reference for tendering work to private agencies or NGOs in collaboration with RHU, HEU and DPS
- Participate in collaboration meetings, BCI activities and other technical service provision with stakeholders
- Facilitate participatory workshops to develop implementation plan for

- each of the Key Social Groups identified in the BCI strategy
- Organize meetings with the M & E Unit for BCI M & E system
- Raise BCI research and survey issues and facilitate special studies on ongoing basis in collaboration with the M & E Unit
- Build BCI capacity

Key Partners

Ministry of Health and Population, Reproductive Health Unit

Key role and Responsibilities

- Advocate for the integration of HIV/AIDS within RH
- Advise on effective incorporation of sexual and reproductive health issues, including PMTCT, in the BCI Strategy
- Coordinate activities for prevention of PMTCT of HIV in the framework of the BCI Strategy
- Advise on and disseminate emerging public policy issues and direction in sexual and reproduction health, including PMCTC
- Collaborate with the BCI Unit, HEU, DPS, Districts and KSG Lead Organizations in the coordinating of BCI Strategy's development and implementation
- Provide technical and management support to Districts, the (KSG) and Lead Organizations
- Facilitate the coordination of formative research

Key Partners

- National AIDS Commission/BCI Unit
- Health Education Unit
- Key Social Group Lead Organizations

- National AIDS Commission Management and Commissioners
- NAC Units: care and support; planning monitoring and evaluation; grants management
- MOHP: RHU; HEU; DPS
- Key Social Group Lead organizations
- BCI Technical Working Group
- HIV/AIDS Technical Working Group
- BCI stakeholders

- Department of Population Services
- BCI Technical working group
- BCI stakeholders

Meetings/Contact Schedule with Partners

- Quarterly meetings with the BCI TWG
- Committee quarterly meetings (for policy issues)
- Core team planning/coordination meetings
- Monthly meetings with key stakeholders (NSRH Program Management Group)
- Other scheduled coordination meetings (Reproductive Health Coordinating meetings)

Main Activities

- Organize and planning review meetings with stakeholders implementing sexual and reproductive Health programs (National Sexual and Reproductive Health Programs Addresses: STIs, PMTC, Safe Motherhood, Family Planning, Adolescent Reproductive Health, Gender related harmful practices)
- Collect, compile and disseminate information on the implementation of

- sexual reproductive health programs, including STIs, PMTC, Safe Motherhood, Family Planning, Adolescent Reproductive Health, Gender related harmful practices
- Participate in quarterly BCI TWG meetings and preparation necessary documentation
- Participate in planning and coordination meetings of the core team for the development and implementation of the BCI strategy

- Prepare and disseminate program progress reports to Government, key stakeholders, partners and donors
- Establish mechanism to monitor the implementation of the BCI Strategy through the work of the Districts and Key Social Groups (KSG) Lead Organizations
- Participate in the budget review

Ministry of Health and Population / Health Education Unit

Key roles and Responsibility

- Develop and maintain an inventory of organizations producing communication materials and BCI training Nation wide
- Coordinate materials production processes with the districts, the KSG lead Organizations and the NAC/BCI Unit
- Establish the mechanisms/guidelines to monitor the quality of communication materials
- Monitor the distribution and utilization at community levels, working in close collaboration with department of Population Services
- Support capacity development in the preparation and production of communication materials in collaboration with stakeholders

Key partners

- National AIDS Commission/BCI Unit
- Reproductive Health Unit
- Department of Population Services Organizations
- Communication Materials producing organizations
- Mass media organizations

Meetings/Contact Schedule with partners

- Quarterly meetings with BCI TWG
- Monthly meetings with stakeholders
- Other scheduled coordination meetings
- Core team planning/coordination meeting

Main Activities

- Prepare a work plan for implementation of the communication components of the BCI strategy at national and district/community levels
- Conduct baseline/needs surveys at districts/community levels to guide development of communication interventions and activities
- Develop various types of communication and advocacy materials for various aspects for BCI Strategy
- Support the development of communication materials for agencies implementing behavior change interventions
- Monitor quality of implementation of communication activities at national and district/community levels

- Supervise on regular basis the work of IEC officers at national, districts and community levels
- Support the IEC capacity development to implementing agencies in collaboration with BCI Unit, BCI Technical Working Group and stakeholders
- Participate in quarterly BCI TWG meetings and regular team planning and coordination meetings
- Prepare and disseminate program progress reports to key stakeholders, partners and donors

BCI Core Team

Key roles and Responsibility

- Play a joint management role by organizing consultative meetings between NAC and MOHP
- Organize planning and program review meetings with TWG and stakeholders
- Prepare broad strategies for follow up activities on quarterly basis
- Develop necessary budgets for the BC coordination interventions
- Advocate for funding and implementation of the BCI strategy at all levels
- Facilitate networking to support BCI at all levels

Key partners

- National AIDS Commission and ministry of Health and Population: RHU, HEU, DPS
- NAC Executive Director and RHU Program Manager
- NAC Units: care and support, planning monitoring and evaluation, Grants management

- National Safe Motherhood Coordinator
- Technical Officers
- Family Planning Officers
- STI/HIV Program Officer
- STI Technical Officer
- Key Social Group Lead Organizations
- BCI technical working Group
- BCI stakeholders

Meetings/Contact schedule

- Weekly meetings, or when need arises
- Quarterly meetings with BCI TWG
- Monthly meetings with key stakeholders
- Other scheduled meetings

Main Activities

- Planning, preparation and facilitation of meetings
- Prepare and disseminate reports

Ministry of Health and Population, Department of Population Service

Key roles and Responsibility

- Support with technical guidelines on the development of IEC and advocacy materials in collaboration with National AIDS Commission
- Develop an inventory of all population IEC and advocacy

- programs and activities according to category
- Provide technical guidelines on IEC and advocacy related to health and population

- Develop tools for monitoring and evaluation of IEC and advocacy programs and materials
- Develop and disseminate policy related to IEC advocacy and oversee its implementation at grassroots levels
- Collaborate with HEU in plans and activities for IEC and BCC\

Key partners

- Reproductive Health Unit
- Health Education Unit
- National AIDS Commission/BCI Unit
- Safe Motherhood Program
- Key Social Group Lead Organizations

Meetings/Contact Schedule

- Quarterly meetings with BCI TWG
- Monthly meeting with stakeholders
- Other scheduled coordination meetings

- Support training in IEC advocacy development and implementation
- Develop and design national and community communication campaigns
- Support design and conduct of IEC advocacy and behavioral research and surveys
- Monitor implementations of the BCI strategy at district and community levels
- Participate in quarterly BCI Technical Working Group coordinating meetings
- Advise on matters of national IEC advocacy policy
- Support development of an inventory of organizations engaged in BCI activities at all levels

Main Activities

Local Government, Districts Assemblies

Key Roles and Responsibilities

- Coordinating the integration of BCI in the district plans
- Manage and monitor the implementation of BCI strategy
- Source financial and material resources from NAC/RHU and other discrete funds for implementation of activities
- Manage financial and material resources allocated to BCI
- Identify other key partners for implementation of activities
- Interpret guidelines and policies to partners regarding implementation of BCI strategy
- Advocate for HIV/AIDS/SRH behavior change interventions

Key partners

- Reproductive Health Unit
- Health Education Unit
- Key Social Group Lead Organizations
- Local NGOs/CBOs
- Private sector representatives
- National AIDS Commission/BCI Unit

Main Activities

- Quarterly meetings with DEC and DACC
- Other scheduled coordination meetings
- Conduct participatory workshops to develop plans for each priority areas
- Coordinate and manage production of IEC/Advocacy materials

- Prepare and disseminate progress reports to NAC/RHU other key partners

Key Lead Social Groups Lead/Lead Organisations/Consortia

Key Roles and Responsibilities

- Coordinate the implementation of communication, advocacy and social mobilization activities for the particular social Group at field/community levels
- Coordinate communication and information sharing with the NAC/BCI Unit, BCI Technical Working Group and agencies implementing activities within the social group
- Supervise and monitor implementation of activities within the social group
- Supervise and monitor implementation and activities for the particular social group
- Support capacity development for field-level partners to implement the BCI strategy
- Advocate for an increased number of resources and agencies to take part in the implementation of the BCI strategy at field/community levels

Key Partners

- National AIDS Commission/BCI Unit
- Reproductive Health Unit
- Health Education Unit
- District Health Officer
- District Assemblies
- BCI stakeholders/agencies
- Department of Population Services
- Media organization
- Representatives of Faith-based institutions

Main Activities

- Manage and coordinate implementation of the BCI strategy for the particular social group through field-level partners
- Advocate for adoption and effective implementation of the national BCI

Meetings/Contact Schedule

- Quarterly meetings with the BCI TWG
- Quarterly meetings with BCI stakeholders at field level
- Schedule program review meetings
- Other scheduled coordination meetings at field level strategy, especially among KSG implementation agencies
- Collect and disseminate essential information and materials to support planning and implementation of the strategy at field/community levels
- Facilitate establishment of a communication system with BCI agencies and field partners
- Prepare quarterly program progress reports for dissemination to key stakeholders, partners and donors
- Identify and fill gaps in the extent and depth of implementation of the strategy at field/community levels
- Supervise and monitor the implementation of the strategy among BCI agencies in the particular social group
- Advocate for more agencies to take part in behavior change interventions and activities

- Participate in quarterly BCI Technical Working Group meeting and other scheduled or ad hoc coordination meetings
- Organize quarterly program review meetings with agencies implementing activities in the particular social group

Criteria for selection of the Key Lead Social Group Organization

- Malawian organization who has the capacity to coordinate at the national, community and districts levels
- High degree of involvement in HIV/AIDS/SRH and experience in the area
- Strong capacity in networking and established partnerships with other organizations
- Willingness and commitment
- Financial management experience
- Well established with well developed structures up to the grassroots level or show potential to penetrate to the grassroots level through existing structures

Behavior Change Interventions Technical Working Group

Key Roles and Responsibilities

- Provide guidance in technical issues of planning, implementation and quality control for the national BCI strategy
- Provide a representative forum for consensus building and support for decisions relating to behavior change interventions in the country
- Assist the National AIDS Commission/BCI Unit and RHU to monitor the implementation of the BCI strategy nation wide: national, districts, BACCs, etc.
- Advocate for adoption and integration for effective implementation of the BCI strategy by stakeholders and at all levels of the nation
- Facilitate collaboration among BCI stakeholders and the Key Social Group for practical and strong linkages of implementing agencies
- Facilitate sharing/exchange of information and experiences among agencies implementing behavior change programs
- Link and inform the others such as National HIV/AIDS, the IEC Committee

Key Partners/Membership [maximum 40 People]

- Head of behavior change interventions Unit-Chairperson
- BCI core Team Members
- Reproductive Health Unit Program Manager
- Department of Population Services Coordinator
- Representatives of Key Social Group Lead Organizations[6]
- Representative of the AIDS Commission Board[2]
- Representatives of public key sector institutions[3]
- Representatives of private sector institutions[3]
- Representatives of faith-based institutions[3]
- Representatives of donor/partner organizations[3]
- Ministry of Education
- Ministry of Gender
- Ministry of Agriculture and Irrigation
- Legal institutions like women and law
- Ministry of Labour