Republic of Malawi

SOCIAL MOBILIZATION IMPLEMENTATION PLAN FOR WORKING WITH SIX KEY SOCIAL GROUPS IN MALAWI ON BEHAVIOUR CHANGE

- Young People aged 7-24 years
- Women of Child-bearing age 13-49
- Men and Women Engaging in High Risk Behaviours
- Service Providers
- Opinion Leaders
- Policy Makers

National AIDS Commission

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Acknowledgement

The Social Mobilization Implementation Plan for working with various key social groups was consolidated from the main Behaviour Change Interventions Strategy document. The Behaviour Change Intervention Strategy was produced during a series of workshops, which the National AIDS Commission (NAC) in collaboration with the Reproductive Health Unit (RHU) and the Health Education Unit in the Ministry of Health and Population conducted.

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Forward

Any behaviour change communication programme that regards people in the communities as mere recipients rather than engaging them in the planning and actual implementation of such interventions usually fails. Consulting the people in the communities and actively engaging them in the identification of factors that shape their behaviours, how they would like to behave, and how they would like to achieve such desired behaviours ensures the programme's success.

Information, Education and Communication can only help people in the communities to gain new knowledge and ideas about HIV/AIDS and SRH. However, there is need to employ **Social mobilization** interventions in the communities so that Community leaders can mobilize communities and initiate dialogue on sensitive but critical issues . The sharing of such information and exchanging of ideas would lead people to adopt and sustain positive behaviours.

This is why apart from IEC Implementation Plan and the Advocacy Plan presented in the BCI Strategy document, the Social Mobilization plan has also been produced to guide stakeholders on how to actively engage communities in behaviour change interventions.

Social mobilization interventions presented in the plan will enrich dialogue in the communities on how HIV/AIDS/SRH issues affect them, discovering what others think in their communities, and see what other communities have achieved, for example, in eliminating harmful cultural practices, promoting family planning, in dealing with gender inequalities, and about breaking the culture of silence especially on positive living. Social mobilization is an effective strategy to help people to reach a consensus and find out common grounds for action, based on their needs and capabilities.

Much as I appreciate that communication campaign on HIV/AIDS and SRH has intensified on radio, television and the newspapers, I still feel that most communities in remote and difficult to reach areas have not been effectively reached. They lack the infrastructures and communication systems such as newspapers, radios, television screens and telephones to keep abreast of behaviour change messages on HIV/AIDS and SRH. The Social Mobilization intervention will, therefore, increase the quantity and accessibility of information to the remotest parts of our society. It will engage people who live in such areas in interpersonal communication through meetings, trainings, seminars and conferences. It is through this process that barriers to positive behaviours will be elicited even more and guide planners and project implementers to design effective interventions that would lead to the adoption and sustenance of positive behaviours among Malawians.

I strongly feel that any interventions aimed at changing people's behaviour cannot realize their full potential if information about HIV/AIDS and SRH is not shared effectively. Such interventions would not achieve their goals and objectives if the intended audiences are not motivated and committed to change. This social mobilization plan, therefore, seeks to guide implementers to take into account the active community participation of intended audiences at every stage so that positive behaviours are adopted and sustained.

Dr. Richard Pendame
Secretary for Health and Population

List of Abbreviations

ADRA	Adventist Development Relief Agency
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARVs	Anti-retrovirals (drug therapies)
BCI	Behaviour Change Interventions
BLM	Banja La Mtsogolo
CBDA	Community-based contraceptive Distribution Agent
CBO	Community-based Organization
CHAM	Christian Hospital Association of Malawi
CHRR	Centre for Human Rights and Rehabilitation
CIDA	Canadian International Development Agency
CILIC	Civil Liberties Committee
CPEP	Community-based Population Education Programme
CSW	Commercial Sex Worker
DACC	District AIDS Coordination Committee
DFID	British Department for International Development
DPS	Department of Population Services
ECM	Episcopal Conference of Malawi
FHI	Family Health International
FP	Family Planning
FPAM	Family Planning Association of Malawi
GTZ	German Development Agency
HEU	Health Education Unit
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
KCN	Kamuzu College of Nursing
KSG	Key Social Group
MACRO	Malawi AIDS Counselling and Resource Organization
MAM	Muslim Association of Malawi
MANASO	Malawi Network of AIDS Service Organization
MANET	Malawi Network of People Living with HIV/AIDS
MASO	Media and AIDS Society
MCC	Malawi Council of Churches
MIE	Malawi Institute of Education
MOAI	Ministry of Agriculture and Irrigation
MOEST	Ministry of Science and Technology
MOHP	Ministry of Health and Population
MOGCS	Ministry of Gender and Community Services
MSF	Medicines Sans Frontieres
MP	Member of Parliament
MW	Malawi
NABW	National Business Women of Malawi
NAC	National AIDS Commission
NAPHAM	National Association of People Living with HIV/AIDS
NEC	National Economic Council
NGO	Non-Governmental Organization
NORAD	Norwegian Agency for International Development
NYCOM	National Youth Council of Malawi
PLWAs	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission of HIV

PSI	Population Services International
RH	Reproductive Health
RHU	Reproductive Health Unit
SRH	Sexual and Reproductive Health
SCF	Save Children Federation
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TBA	Traditional Birth Attendant
TV	Television
TVM	Television Malawi
UK	United Kingdom
UNAIDS	Joint United Nations Programme on HIV/AIDS
USA	United States of America
VCT	Voluntary Counselling and Testing of HIV/AIDS
USAID	United States Agency for International Development
WVI	World Vision International

INTRODUCTION

What is this Consolidated Social Mobilization Implementation Plan?

The plan is an extract of key social mobilization related strategic objectives, activities and a set of indicators from the main BCI strategy document which NAC and the Ministry of Health and Population in collaboration with partners produced to address unsafe sex practices and inconsistent health seeking behaviours among Malawians. The social mobilization plan was developed in full realization that no positive behaviour change can take place without informed and active participation of the intended beneficiaries.

The plan, therefore, guides implementers on what they should do to induce informed participation of intended audiences, how to mobilize people's capacities and energies and on how to increase their skills so that they are able to change their behaviours.

Who is this Social Mobilization Implementation Plan for?

The plan is for planners, project coordinators, social workers and managers in the ministries, government departments, NGOs, CBOs, DACCs, learning institutions and faith communities seeking to carry out interventions aimed at mobilizing communities and engage them in the fight against HIV/AIDS. It is for those whose interventions are aimed at calling for conscious and active participation of the intended beneficiaries in the promotion of SRH programmes including family planning.

Organization of the Social Mobilization Implementation Plan

Firstly, the plan presents key organizations and training institutions that could lead social mobilization related interventions on HIV/AIDS and SRH. This is to direct implementing partners on some of the existing organizations that have comparative advantage in their mandate and capacity in community mobilization.

The lead organizations are followed by a presentation of segmented social groups and the prevailing conditions that should be addressed. The social groups are the intended audiences who should be mobilized or be used to mobilize other people in the communities.

Secondly, the plan broadly presents two national behaviour problems, a list of barriers that hinder the adoption and sustenance of positive behaviours, and behaviour objectives, which implementers should use to frame key messages that would mobilize people for change of targeted behaviours in the communities.

Lastly, the plan presents a detailed matrix. The matrix outlines in detail the national behaviour problems and sub-sets to each problem; barriers which are factors that contribute to further spread of HIV/AIDS and sexual and reproductive ill-health; segmented social groups which are intended audiences to reach; desired behaviours which we would like sub-populations to adopt; strategic objectives; key activities (interventions) for mobilizing the communities; suggested channels of communication for the messages; and indictors for monitoring at implementation level to track progress for the planned activities and assess impact for the interventions.

How to use this Social Mobilization Implementation Plan?

Since there are a lot of factors and determinants contributing to unsafe sex and inconsistent health seeking behaviours in Malawi, the temptation among most project implementers has been to initiate and start carrying out planned activities without properly taking into account the perceptions and capacities of the intended beneficiaries.
For example, a lot of radio and TV programmes are aired on HIV/AIDS and SRH issues without necessarily realizing the perception of the audiences. A lot of mass campaigns are conducted in the communities with minimal involvement of the people themselves. This kind of approach yields minimal behaviour change.

With the plan the coordinators or planners are, in the first place, advised to identify major behaviour problems, barriers and the affected populations in their local impact area(s) or the project area.

Secondly, they should establish desired behaviours of the communities, strategic objectives and key activities, which the community members should be fully engaged in. This exercise should be done while closely referring to those presented in the matrix. Thirdly, after establishing the problems, objectives and the interventions the next step is to identify and agree on the channels of communication presented in the matrix. The selected medium of communication should be those, the intended audience would easily access and enjoy most. Lastly, together with the communities set indicators that would assist in monitoring your activities. Present the indicators clearly in the logical framework and use them at all times when reporting the progress and impact of the planned activities.

Chapter 1 BCI Strategy for Young People aged 7-24 years

Key Lead Organization: National Youth Council of Malawi
Partners: All organizations that are leading interventions

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

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 for example those aged between 7-12, 13-15, 16-19, 20-24.

- Different strategies may be needed for youth in urban and 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, delinquents, and children with mental or physical disabilities.

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.

Youth needs are distinct from thos e 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 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 generalize 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 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 and power dynamics.

Parents, teachers, traditional leaders, initiators and faith communities play an important role in supporting youth access to information and services.

A. Problem Behaviours:

- **Unsafe sexual and reproductive health practices**
  - First sexual intercourse occurs around age 15 and perhaps as early as 12-13.
  - 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.
  - Up to 69% of youth reported to have more than one partner at the same time.
  - Some young women use herbs to induce unsafe abortion.

- **Inconsistent health seeking behaviour**
  - Young people do not access health services.
  - Young women and men do not report sexual violence or rape.
  - Use of condom among youth is often inconsistent. They often clarify which partner to use a condom with.
  - Most young people do not visit a health centre when infected with STIs or when they become pregnant.

B. Barriers to Address

1. Knowledge Gaps and low risk perception about issues of SRH and HIV/AIDS
2. Lack of life skills.
3. Lack of Community dialogue, parental guidance and support.
4. Gender inequalities and related risks.
5. Harmful cultural SRH practices.
6. Poor client-provider relationship and community involvement in planning and implementation.
7. Lack of youth involvement.
8. Lack of collaboration among organizations working with young people.

Barrier 1: Knowledge gaps & low risk perception about issues of SRH/HIV/AIDS

Problem Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Response
1. Unsafe Sex Practices Early first sexual intercourse Early first pregnancy Multiple partners Low and incorrect condom use Use herbs to dry vaginas for sex Use herbs for unsafe abortion. **2. Inconsistent health seeking behaviours** Young people do not access health services timely and consistently Namely: Contraceptives STI treatment Emergency Contraceptives/ PAC HIV Testing ANC Safe Delivery Young women and men do not report sexual violence or rape	Myths/misconceptions about physical and emotional changes that occur in their bodies during adolescence Lack of knowledge about sexuality, sexual intercourse, menstruation, masturbation and how pregnancy occurs. Misconceptions that semen provides girls with needed vitamins for disease prevention Misconceptions around condoms and condom use and other family planning methods Iinadequate knowledge on the signs and symptoms and consequences of STI Iinadequate knowledge on the benefits of VCT and where to access the services Some young people are unable to read information related to HIV/AIDS/SRH or instructions for condom use **Low risk perception** about their own risk for STIs including HIV, unwanted pregnancy, exchanging sex for money or gifts Young people do not recognize the risks of alcohol or drugs on their sexuality/sexual behavior	Age specific strategies to address the needs of young people before first sexual intercourse, and those who may be sexually active: 7-12 13-15 16-19 20-24 **In urban and rural area** **In-school:** ■ Primary ■ Secondary ■ Tertiary **Out of school:** ■ Entertainment places ■ Youth clubs ■ Youth centres ■ Children in Institutions ■ Working Children in estates **Vulnerable Children:** ■ Girl child ■ Orphans ■ Adopted children ■ Children with mental or physical disabilities ■ Street vendors ■ Very poor ■ Children of CSWs ■ Delinquents	Young people avoid risk situations that lead to early or unsafe sex, including use of alcohol and drugs. Sexually active young people (7-16) stop having penetrative sex**. A**dopt safer sex practices Sexually active young people reduce the number of sexual partners Sexually active young people use condoms correctly and consistently Girls do not dry out their vaginas for dry sex. Young people ask for SRH information/ advice from parents, teachers and health providers Young people support and influence peers positively on HIV/AIDS/SRH issues Young people refer friends to get needed help and support Young people treat each other as equals, irrespective of gender Young people, including girls, frequent youth clubs to share information on HIV/AIDS/SRH	Increase young people and peers who report correct SRH & HIV/AIDS information Increase the number of young men and women who report personal self risk Increase dialogue on sexuality, HIV/AIDS, SRH and gender between boys and girls and peers, family, community & teachers Increase the number of young people who disclose their HIV status Increase number of condom demonstrations and discussions	Involve young people in planning and implementing HIV/AIDS/SRH activities Raise community awareness for the need for open discussion on matters of SRH/HIV/AIDS Establish youth clubs and multipurpose youth centers Establish support groups for young people living with HIV/AI DS	Media (Electronic and Print) Schools Youth Clubs (AIDS Toto Clubs, Anti-AIDS Clubs) Youth Organisation Religious organisations Trainings Group discussions Drama Workshops MOE NYCOM Youth festivals MOGYCS Tertiary institutions MIE MoHP	High median age of first sexual intercourse for girls and boys Reduced number of reported sexual partners Increased number of young men and women reporting correct condom use Increased number of reported girls and boys involved in the implementation of peer education programs Increased visible role models at all levels who promote gender equality and safer sex practices Reduced % of reported alcohol and drug use among young people Increased number of girls who report confidence with negotiation skills	**Lead Org.** MOGYCS **Partners:** NYCOM Reg. Youth Networks MOHP – DHO & Youth Tech Com FPAM MOEST Youth NGOs MIE Min of Education St John of Gods SOS

Barrier 2: Lack of life skills

Problem Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
1. Unsafe Sex Practices Early first sexual intercourse Early first pregnancy Multiple partners Low and incorrect condom use Use herbs to dry vaginas for sex Use herbs for unsafe abortion. **2. Inconsistent health seeking behaviours** Young people do not access health services timely and consistently including: Contraceptives STI treatment Emergency Contraceptives/ PAC HIV Testing ANC Safe Delivery Young women and men do not report sexual violence or rape	Lack of life skills to deal with peer pressure to have early sex, multiple partners, drug and alcohol abuse Inability to make independent decisions by young people Lack of condom negotiation skills by girls, and low self-esteem Girls and boys alike are taught that when girls say no they mean yes. Young people who can't read are more likely to have less self-esteem and confidence. Parents do not support young people's right to access to SRH information and sometimes provide young people with incorrect information. Initiators may provide incorrect information about SRH Traditional healers may provide incorrect information about STIs Faith leaders block youth access to SRH information Teachers are not trained to offer gender sensitive sex education and life skills in schools Teachers coerce students to have sexual relations in exchange for pass marks	Age specific strategies to address the needs of young people before first sexual intercourse, and those who may be sexually active: 7-12 13-15 16-19 20-24 **In urban and rural area** **In-school:** ■ Primary ■ Secondary ■ Tertiary **Out of school:** ■ Entertainment places ■ Youth clubs ■ Youth Centres ■ Children in Institutions ■ Working Children in estates **Vulnerable Children:** ■ Girl child ■ Orphans ■ Adopted children ■ Children with mental or physical disabilities ■ Street vendors ■ Very poor ■ Children of CSWs ■ Delinquents	Parents respect SRH rights of youth and communicate about SRH issues. Traditional leaders respect SRH rights of youth and facilitate dialogue on SRH issues in community. Faith leaders support youth access to information Service providers offer accurate information and positive attitudes to youth RH issues and services Teachers discuss SRH with students in a positive, open manner Students resist unwanted sexual advances from adults (including teachers) Teachers stop blackmailing students to having sex with them	Increase the number of visible young role models that discourage early sex and multiple partners Reduce the number of young men engaging in early sexual intercourse Reduce the number of young men abusing drug and alcohol Promote establishment of youth clubs and entrepreneurial opportunities Increase youth access to information and support Increase youth access to friendly health and social services Empower teachers to discuss SRH confidently with students Promote respect of SRH for young people by teachers	Train teachers to enable them teach life skills education Train peer educators and leaders of youth clubs/organizations on life skills approach Train parents on SRH/HIV/AIDS related issues including the importance of self-esteem and confidence	**Channels** Media (Electronic and Print) Schools Youth Clubs (AIDS Toto Clubs, Anti-AIDS Clubs) Youth Organisation Religious organisations Trainings Group discussions Drama Workshops MOE NYCOM Youth festivals MOGYCS Tertiary institutions MIE MOHP	Reduced number of reported cases of sexual abuse of students by teachers Increased number of young people who are gainfully employed Increased number of teachers trained on HIV/AIDS & SRH Life skills and SRH incorporated into exams Increased number of gender positive curriculum developed and used Increased number of schools integrating HIV/AIDS and SRH in their curriculum Increased number of youth who access IGAs/ credit and loan schemes	**Lead org.** NYOC **Partners** Manaso MOHP Media (TV and Radio) MOEST Youth Arm AYISE CEYCA YOUDAO Regional Youth networks

Barrier 3: Lack of community dialogue, parental guidance and support

Problem Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
1. Unsafe Sex Practices Early first sexual intercourse Early first pregnancy Multiple partners Low and incorrect condom use Use herbs to dry vaginas for sex Use herbs for unsafe abortion. **2. Inconsistent health seeking behaviours** Young people do not access health services timely and consistently Including: Contraceptives STI treatment Emergency Contraceptives/ PAC HIV Testing ANC Safe Delivery Young women and men do not report sexual violence or rape	Youth cannot ask questions about their sexuality due to cultural & religious beliefs about sex and young people's roles Parents do not talk to children about adolescence due to embarrassment & stigma related to sex and sexuality Parents are unclear about when the transition into adulthood should occur. Lack of open discussion in the community due to (a) stigma & secrecy around SRH, HIV/AIDS, & condom use (b) secrecy about pregnancy, childbearing and abortion Faith leaders condemn discussion on youth sexuality or condom use. Some religious leaders discuss sex and sexuality in the context of sin	■ Parents ■ Guardians ■ Elders ■ Traditional leaders ■ Faith leaders	Parents and/or guardians initiate open discussions about adolescent changes with their children Young people ask their parents and/or guardians issues related to their body changes and sexuality feelings Traditional leaders/elders facilitate dialogue on SRH issues in community. Traditional leaders actively support the establishment of youth clubs and support groups for PLWHAs Faith leaders encourage parents to speak with their children about life changes. Faith leaders support youth access to condoms for safer sex. PLWHAs disclose their status with the support of community	Increase parent communication with their children about HIV /AIDS SRH issues before they are sexually active. Increase the number of young people who report they have asked their parents and guardians for guidance on sexuality matters	Conduct peer edaction on adolescent sexuality in different forums in the communities	NGOs working with young people Ministry of Education Media Parent committees	Increased number of parents/ guardians who discuss sexuality issues with their children Increased number of young people who report discussing sexuality freely with their parents/guardians Increased number of parents/guardians trained on SRH issues	**Lead org.** Ministry of Education **Partners** NYCOM Reg. Youth Networks -MOHP –DHO & Youth Tech Com FPAM - MIE St John of Gods SOS

Barrier 4: Gender inequalities and related risks

Problem Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
1. Unsafe Sex Practices Early first sexual intercourse Early first pregnancy Multiple partners Low and incorrect condom use Use herbs to dry vaginas for sex Use herbs for unsafe abortion. **2. Inconsistent health seeking behaviours** Young people do not access health services timely and consistently Including: Contraceptives STI treatment Emergency Contraceptives/PAC HIV Testing ANC Safe Delivery Young women and men do not report sexual violence or rape	Girls are more likely to drop out of school to take care of siblings, sick relatives, or work Girls face unequal power dynamics Girls who drop out marry young, have children or engage in transactional sex Boys who drop out are more likely to be exposed to adult world of sex. Boys/girls who drop out have less employment opportunities/ economically gainful occupations Parents and community do not promote gender equality. Young men and women are exposed to sexual abuse by adults ■ Prisons ■ Teachers ■ Police in holding cells ■ Relatives	**Age specific strategies to address the needs of young people before first sexual intercourse, and those who may be sexually active:** **7-12** **13-15** **16-19** **20-24** **In urban and rural area** **Out of school:** ■ Entertainment places ■ Youth clubs ■ Youth centres ■ Children in Institutions ■ Working Children in estates **Vulnerable Children:** ■ Girl child ■ Orphans ■ Adopted children ■ Children w/ mental or physical disabilities ■ Street vendors ■ Very poor ■ Children of CSWs ■ Delinquents	Young girls delay early pregnancy and marriage. Young people report sexual abuse More young men and women complete primary, secondary and tertiary education Schools and NGOs integrate HIV/AIDS/SRH in their curriculum. Young people engage in safe income generation activities Prison authorities provide sufficient protection of young people from abuse by other prisoners Adults stop abusing young prisoners Teachers stop coercing students to have sexual relations in exchange for pass marks Social workers protect young people in institutions and homes Judges take legal action on reports of sexual abuse of young people	Increase enrolment rates of boys and girls at primary school Increase retention rate of boys and girls at primary and secondary school (Reduce repetition rates of both boys and girls) Increase budgetary allocation to HIV/AIDS education within education (formal and informal sector) Enforce laws that protect young people from abuse Reduce contact between young and adult prisoners Increase income generating activities for young people Promote policies that protect youth from early sex Provide youth with positive role models that discourage early sex and harmful sexual treatment of girls.	Involve the communities in planning for protection of young people Mobilize for income generating activities to prevent young people from being abused for monetary gains Train NGOs/CBOs (who work with out of school children) on the integration of sexuality, HIV/AIDS, RH in the literacy classes	**Change agents** NGOs working with young people Ministry of Justice Media Ministry of Home Affairs Faith based organizations National Youth Council Meetings Training Media	Increased number of young people (juveniles) reporting abuse by other prisoners and by prison officials Increased number of young people reporting abuse by adults Increased number of adults reporting abuse of young people by adult relatives Reduced HIV/AIDS/SRH infection rate amongst young prisoners Increased number of laws revised to protect young people Increased number of students who report sexual abused by their teachers Reduced number of young commercial sex workers Increased enrolment of boys and girls in primary schools Reduced % of repeaters Increased enrolment of girls in secondary schools Reduced % of boys and girls who drop out of school	**Lead org.** MOEST **Partners** MEDIA (Ministry of Information) MOGYCS NYCOM Schools CBOs/NGOs MPs Ministry of Justice

Barrier 5: Harmful cultural SRH practices

Problem Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
1. Unsafe Sex Practices Early first sexual intercourse Early first pregnancy Multiple partners Low and incorrect condom use Use herbs to dry vaginas for dry sex Use herbs for unsafe abortion. **2. Inconsistent health seeking behaviours** Young people do not access health services timely and consistently Including: Contraceptives STI treatment Emergency Contraceptives/ PAC HIV Testing ANC Safe Delivery Young women, and men do not report sexual violence or rape	Some initiation rites encourage young people to engage in early sex Sharing razor blade/knife during circumcision increase boys risks for HIV Female genital mutilation is still practised in some areas Adolescent sexual cleansing rituals increase risk for STI/HIV and unwanted pregnancy Fisi is still practised Use of herbs to dry out the vagina increases risk for HIV The use of herbs to induce abortion Rituals which delay pregnant women's access to emergency health services Traditional treatment of vulva/vaginal warts and haemorrhoids (e.g., by cutting) increases risks and delays access to services	Age specific strategies to address the needs of young people before first sexual intercourse, and those who may be sexually active: 7-12 13-15 16-19 20-24 **In urban and rural area** **In-school:** ■ Primary ■ Secondary ■ Tertiary **Out of school:** ■ Entertainment places ■ Youth clubs ■ Children in Institutions ■ Working Children in estates **Vulnerable Children:** ■ Girl child ■ Orphans ■ Adopted children ■ Children with mental or physical disabilities ■ Street vendors ■ Very poor ■ Children of CSWs ■ Delinquents	Traditional leaders/healers eliminate harmful cultural practices that contribute to the transmission of HIV/STI and SRH problems and strengthen positive traditional/cultural values and rituals. Traditional leaders/healers/ counselors provide accurate information about HIV/AIDS/SRH and refer clients to health services Traditional leaders and counselors utilize initiation ceremonies to promote the delay of age of first sexual intercourse Traditional leaders promote condom use Traditional counselors use one razor blade/knife for each boy during circumcision TBAs refer young women to health services and not give them herbs for unsafe abortion	Increase the number of communities who report positive cultural practices & rites that encourage abstinence among young people Increase the number of communities who report adoption of safer cultural practices during male circumcision, during initiation ceremonies Increase knowledge of traditional leaders, healers, TBAs on HIV/AIDS and SRH knowledge and available services. Increase the number of traditional leaders, TBAs, healers who promote condoms for first sexual intercourse.	Train TBAs, healers, traditional and faith-based leaders on SRH/HIV/AIDS affecting young men Train traditional leaders and counselors on the negative effects of harmful cultural practices	Peer education groups Media AIDS prevention groups Training	Reported number of harmful cultural practices modified Reported number of harmful cultural practices eliminated Reported number of boys who were circumcised with an individual knife / razor blade Increased number of traditional leaders promoting condoms in their communities Increased number of girls and women who report rape and other forms of sexual violence	**Lead org.** Min. of Sports & Culture **Partners** Training institutions MOHP / DPS ADDRA National Health Council Umoyo Regional Youth Office DACC

Barrier 6: Poor client-provider relationship and community involvement in planning and implementation

Problem Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BC I	Channels	Indicators	Responsibility
1. Unsafe Sex Practices Early first sexual intercourse Early first pregnancy Multiple partners Low and incorrect condom use Use herbs to dry vaginas for sex Use herbs for unsafe abortion. **2. Inconsistent health seeking behaviours** Young people do not access health services quickly and consistently Including: Contraceptives STI treatment Emergency Contraceptives/ PAC HIV Testing ANC Safe Delivery Young women and men do not report sexual violence or rape	Lack of youth friendly services Health provider attitudes towards young people are negative Private health facilities that charge fees exclude young people Inadequate health facilities providing STI and VCT services Limited access to condoms Limited access to contraceptives Lack of privacy and confidentiality at health centres Lack of information on VCT and STI services	Age specific strategies to address the needs of young people who are sexually active: 7-12 13-15 16-19 20-24 **In urban and rural area** **In-school:** ■ Primary ■ Secondary ■ Tertiary **Out of school:** ■ Entertainment places ■ Youth clubs and centres ■ Children in Institutions ■ Working Children in estates **Vulnerable Children:** ■ Girl child ■ Orphans ■ Adopted children ■ Children with mental or physical disabilities ■ Street vendors ■ Very poor ■ Children of CSWs ■ Delinquents	Sexually active young people use condoms every time they have sex. Sexually active young people also use other family planning methods, to prevent unwanted pregnancy Sexually active young people go to health centres for STI treatment Sexually active young people are counseled and tested for HIV Sexually active women receive emergency contraceptives when they need them Young women and men report sexual violence/rape and receive needed health care and counseling support Young women with incomplete abortions receive PAC and select a contraceptive method Pregnant young women receive ANC, deliver with skilled attendant, and receive postnatal care within the first week. Peers refer their friends to available health and social services Parents help their children receive needed health and social services Health providers provide youth friendly services	Improve the quality of health services: Increase young people's access to friendly health and social services for information and support, and treatment Strengthen links between youth/peer providers and health providers for youth friendly services and support within all health facilities Increase young people's access to condoms through a variety of outlets Increase the number of young people accessing VCT and STI services Reduce distance that young people have to go to access condoms, VCT, and health centre services.	Train health providers in youth friendly RH services Involve young people in the delivery of reproductive health services through health center youth corners and stand alone youth centres	Mass media Health training institutions YCBDAs HSAs TBAs Condoms dispensaries	Increased number of health centers offering youth friendly corners Increased number of service providers trained in youth friendly services Increased number of youth involved in the delivery of reproductive health services and information to young people Increased number of young people who report satisfaction with services Reduced distance to access condoms, contraceptives, VCT and STI by young people (health facilities available within walking distance) Increased number of young people accessing VCT services Increased number of young people accessing STI services timely Increased number of young people who openly disclose their HIV status Increased number of young PLWAs reporting stigma and stigmatization Increased % of young people reporting STIs	**Lead org.** NYOC **Partners** Manaso MOHP Media (TV and Radio) MOEST Youth Arm AYISE CEYCA YOUDAO Regional Youth networks

Barrier 7: Lack of youth involvement

Problem Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsible Agencies
1. Unsafe Sex Practices Early first sexual intercourse Early first pregnancy Multiple partners Low and incorrect condom use Use herbs to dry vaginas for sex Use herbs for unsafe abortion. **2. Inconsistent health seeking behaviours** Young people do not access health services timely and consistently including: Young women and men do not report sexual violence or rape	Lack of or inadequate involvement of young people in HIV/AIDS/SRH program/policy formulation and development Adults often plan HIV/AIDS/SRH programmes without involving young people During implementation, young people do not take a leading role	Age specific strategies to address the needs of young people before first sexual intercourse, and those who may be sexually active: 7-12 13-15 16-19 20-24 **In urban and rural area** **In-school:** ■ Primary ■ Secondary ■ Tertiary **Out of school:** ■ Entertainment places ■ Youth clubs and centres ■ Children in Institutions ■ Working Children (Estates, **Vulnerable Children:** ■ Girl child ■ Orphans ■ Adopted children ■ Street vendors ■ Very poor ■ Children of CSWs ■ Delinquents	Young women and men fully participate in the formulation and development of program/policies benefiting them Young people take a leading role in HIV/AIDS/SRH program design, implementation and monitoring and evaluation Policymakers, NGOs, DACS involve youth at all levels of program/policy development	Increase young men and women's involvement in the development of policies which affect them Increase youth involvement in many areas in the society such as the workplace, schools committees Increase youth involvement in the design and development of youth friendly services in health and non-health HIV/AIDS/SRH service delivery outlets	Train youth in leadership skills	Meetings Conferences Media Trainings Service providers Opinion leaders Policy makers Human rights groups Children's Parliament YTWG	Increased number of forums/meetings where youth voice their concerns Increased number of programs developed and managed with/by young people Increased % of young people in leadership positions, especially young women	**Lead org.** MANASO **Partners** NYCOM Regional Youth Networks (RYN) Youth NGOs Matindi Youth Organisation Youth Arm Youth Alive Support AYISE CEYCA YOUDAO HEU Umoyo networks DPS Media

Barrier 8: Lack of Collaboration among Organizations Working with Young People

Problem Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
1. Unsafe Sex Practices Early first sexual intercourse Early first pregnancy Multiple partners Low and incorrect condom use Use herbs to dry vaginas for sex Use herbs for unsafe abortion. **2. Inconsistent health seeking behaviours** Young people do not access health services timely and consistently Including: Contraceptives STI treatment HIV Testing ANC Safe Delivery Young women and men do not report sexual violence or rape	Lack of collaboration and networking among organizations implementing youth program Inadequate sharing of information, research findings on key issues No sharing of expertise, financial and material resources In some cases, duplication in coverage of HIV/AIDS/SRH issues Duplication in geographical coverage when programming	Age specific strategies to address the needs of young people before first sexual intercourse, and those who may be sexually active: 7-12 13-15 16-19 20-24 **In urban and rural area** **In-school:** ■ Primary ■ Secondary ■ Tertiary **Out of school:** ■ Entertainment places ■ Youth clubs and centres ■ Children in Institutions ■ Working Children (Estates, **Vulnerable Children:** ■ Girl child ■ Orphans ■ Adopted children ■ Children w/ mental or physical disabilities ■ Street vendors ■ Very poor	Organizations collaborate and network with existing organizations working with the young people in their districts and at the national level.	Increase collaboration and networking among organizations working with young people	Conduct coordination meetings to explore possibilities of sharing expertise and resources Train youth on advocacy	YTWG NYCOM Youth organizations	Increased networking among organizations (sharing experiences, expertise, IEC materials, research findings etc) Increased number of exchange visits conducted within and between districts and organizations	**Lead org.** NYOC **Partners** Manaso MOHP Media (TV and Radio) MOEST Youth Arm AYISE CEYCA YOUDAO Regional Youth networks

Chapter 2 BCI Strategy for Men and Women Engaging in High Risk Behaviours

Key Lead Organization: Ministry of Gender and Community Services
Partners: All organizations that are leading interventions

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 more importantly places where risk practices occur.

- Strategies will also focus mainly on low-income women, commercial sex workers, men and women who engage themselves in petty trade and those people who often leave their spouses and work far away from their homes.

- Apart from addressing men and women who engage in high risk behaviours, interventions will also focus on hotel managers, bar and bottle store owners, senior civil servants in order to solicit their support for successful implementation of planned activities.

Anyone who does not know his or her HIV 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.

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.

A. Problem Behaviors:

Two behavioural problems have been identified in Malawi, namely: Unsafe sexual and reproductive health practices; and inconsistent health seeking behaviour. Presented below are some of the examples under each behavioural problem for High risk men and Men and Women engaging in high risk behaviours.

- **Unsafe sex practices**
  - Men who travel a lot or are based in other places for work, often have more Sexual partners.
  - 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 friend' a nd often accept not to use condoms if the agreed payment is higher.
  - Commercial sex workers use herbs and other drugs to dry their vaginas.

- **Inconsistent health seeking behaviour**
  - Most high risk men and women are unwilling to access STI services and other support services.
  - High risk men and women who contract STIs delay in seeking treatment.
  - When they have contracted an STD most high risk men and women often go to a traditional healer first before to health center or clinic.
  - Most High-risk men and women do not access VCT services

B. Barriers to Address:

1. Knowledge gaps on issues of HIV/AIDS and SRH including condoms and condom use
2. Low risk perception about HIV/AIDS and SRH
3. High stigma and stigmatisation related to HIV/AIDS/SRH and condoms
4. Harmful sexual cultural practices in communities that increase HIV/AIDS transmission and unwanted pregnancies
5. Unavailability and inadequate SRH and HIV/AIDS services
6. Lack of dialogue on HIV/AIDS and RH in the communities
7. Gender inequalities and sexual violence

Barrier : 1. . Knowledge gaps on issues of HIV/AIDS/SRH including condoms and condom use

Problem Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
1. Unsafe sex practices Men who travel a lot have more sexual partners 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 Commercial sex workers use herbs to dry their vaginas **2. Inconsistent Seeking Behaviours** High risk men and women who contract STIs delay in seeking treatment Most men and women are unwilling to access STI services	There are still rumours, myths and misconceptions that surround condoms and their use (beliefs that sex is not sweet when one uses a condom, condom is porous, condoms easily burst and are not safe to use) There are still misconceptions about TB and HIV/AIDS (those diagnosed with TB are believed to be HIV positive) Limited access to accurate information on HIV/AIDS and SRH Inadequate IEC materials on HIV/AIDS/SRH for low literate people Inappropriate selection of persons to disseminate information on HIV/AIDS and SRH Inadequate education on sex, sexuality, gender, HIV/AIDS and STIs by service providers in formal and informal health systems, schools, communities, and workplaces Lack of knowledge of STI signs, symptoms and consequences	Women and men who work at high risk places (hotels, rest houses, boarder posts, bars, restaurants) Commercial sex workers Mobile workers (uniformed men, truck drivers, seasonal workers, sales vendors, civil servants) Low income girls and women in urban and rural areas who exchange sex for gifts or money Women job seekers House maids Widows Orphaned young girls Girl students	Men and women who work at high risk places use condoms correctly and consistently with all partners Owners of entertainment places (bars, bottle stores, rest houses, truck stopping points, hotels) distribute condoms to clients Employers provide their workers with accurate information on sex, sexuality, gender, HIV/AIDS and STI Service providers and communication experts leaders intensify education on HIV/AIDS/SRH in schools, communities, workplaces, border posts and entertainment places STI infected men and women seek regular STI screening and early treatment High risk men and women seek VCT services TB patients accessing HIV test early Men and women go for VCT before entering into new relationships	Increase access to accurate information on HIV/AIDS/SRH issues Increase condom use among high risk men and women at all levels by promoting benefits for HIV/AIDS and STI prevention Increase women's and men's understanding about HIV/AIDS/ STI and risk of multiple partners Promote sex education and communication in families, workplaces communities and schools Increase the number of service provider/educators intensifying condom use and sex education Promote benefits of VCT Promote early diagnosis of TB/STI early and treatment	Conduct peer education among high risk groups to address knowledge gaps, risk analysis and links to condoms and other services Train more service providers including teachers (in-service training & refresher courses) on HIV/AIDS/SRH Train more communication experts on audience analysis, IEC materials development and use/dissemination	Media (print, electronic) Mass IEC campaigns (folk and popular) Owners/managers of hotels, rest houses, bars, bottle stores truck stopping points and boarder posts Peer groups Traditional/community leaders Community/village AIDS committees Churches/Mosques Women's groups Men's groups Trainings	Increased % of high risk men and women reporting correct and consistent condom use with all partners Decreased % of men and women having multiple sexual partners Increased number of people going for VCT and disclose their HIV status Increased number of high risk men and women getting early STI screening and treatment Increased % of places for commercial sex reporting regular screening for STIs for their sex workers Reduced % of men who paid for commercial sex in the last 12 months	**Lead Org.** Min. of Information **PARTNERS** FPAM WVI Project Hope BLM PSI Min. of Defence Min. of Transport Immigration Department Nurses & Midwives Council Malawi College for Health Sciences

Barrier: 2. Low risk perception about HIV/AIDS/SRH

Problem Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
1. Unsafe sex practices Men who travel a lot have more sexual partners 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 Commercial sex workers use herbs to dry their vaginas **2. Inconsistent Seeking Behaviours** High risk men and women who contract STIs delay in seeking treatment Most men and women are unwilling to access STI services	Most young men and women wanting to enter into new relationships or become pregnant do not go for VCT first In some societies men are allowed to have more than one wife (polygamy is still acceptable in many communities) Risk awareness of having more than one partner/spouse is very low in some societies There is pressure among men, women and especially young people to indulge in alcohol and drug abuse Some STI infected men, women and young people still have sex without using a condom	Men and women who have not tested for HIV Women and men who work at high risk Low income girls and women in urban and rural areas who exchange sex for gifts or money CSWs Mobile workers (uniformed men, truck drivers, seasonal workers, sales vendors, civil servants)	Young workers delay onset of first sexual intercourse Men and women use condoms correctly and consistently with all partners Women (especially those below age 18 and above age 35) use contraceptives to avoid unwanted pregnancy and related complications Young people reduce alcohol and drug abuse CSWs go for regular STI screening and treatment Traditional and religious leaders promote faithful monogamous relationships within their communities Traditional and religious leaders sensitize their subjects on the dangers of multiple sexual partners More men and women who go for VCT disclose their HIV status	Increase HIV/STI Personal risk assessment Increase correct and consistent condom use to prevent unwanted pregnancies and STIs/HIV infection Increase man to man peer support to challenge damaging norms of masculinity that put men and women at risk of HIV/STI infection Reduce the number of people abusing alcohol and drugs Replaced harmful cultural practices and values with positive ones Promote role models Promote benefits of VCT and STI early diagnosis Increase number of people who disclose their status	Conduct peer education using interactive events within entertainment zones/places Train peer educators on risk perception	Media (print, electronic) Mass IEC campaigns (folk and popular) Owners/managers of hotels, rest houses, bars, bottle stores truck stopping points and boarder posts Peer groups Traditional/community leaders Community and village AIDS committees Churches and Mosques Trainings Anti-AIDS clubs Schools	Reduced % of men, women and young people reporting having sexual partners Increased % of men, women and young people reporting condom use correctly and consistently Increased % of people going for VCT and disclose HIV status Increased number of people getting early STI screening and treatment Decreased number of young people and women abusing drug and alcohol Number of armful traditional values and beliefs eliminated	**Lead Org.** Family Planning Association of Malawi **PARTNERS** MOGYCS-CPEP BLM WVI Ministry. of sport & Culture MOAI Ministry of Home Affairs CHRR Armed Forces Ministry .of Labour Securicor Youth groups and NGOs Mental Health Dept.

Barrier: 3. High stigma and stigmatisation related to HIV/AIDS/SRH and condoms

Problem Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
1.Unsafe sex practices Men who travel a lot have more sexual partners 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 Commercial sex workers use herbs to dry their vaginas **2. Inconsistent Seeking Behaviours** High risk men and women who contract STIs delay in seeking treatment Most men and women are unwilling to access STI services	Stigma around HIV and PLWAs makes VCT and disclosure of HIV status difficult. Stigma around STIs and people infected with STIs makes those infected with the diseases not to seek appropriate treatment early Stigma that links condoms to promiscuity makes it difficult to buy/procure condoms when one wants to use them Men and women in certain profession (army, police) are believed to be HIV/STI infected. A misconception that encourages them to continue indulging in unsafe practices Society associates commercial sex workers as PLWAs and STI infected group a stigma that encourages CSWs not to use condoms when having sex as they believe that they are already infected	Men and women who have not tested for HIV Women and men who work at high risk places (hotels, rest houses, boarder post, bars, restaurants) Men and women in polygamous relations Low income girls and women who exchange sex for gifts or money Mobile workers (uniformed men, truck drivers, seasonal workers, sales vendors, civil servants, CSW) Women and men with sexual multiple partners Women prisoners Juveniles Traditional and religious leaders	Community leaders accept and show compassion to PLWAs and those affected by the epidemic More men and women go for VCT, willing to disclose their HIV status and share experiences More men and women seek appropriate STI treatment once infected without any shyness or fear Service providers treat PLWAs, TB and STI patients equally regardless of their health problem Policymakers legalise prostitution to easily set and monitor health standards at high risk places Peer sex workers organize a support system to encourage regular condom use and STI screening Communities support promotion of condoms as a means of preventing Society recognize and respect CSWs human rights	Increase support and acceptance for PLWAs at the work place and communities Increase number of people giving testimonies on HIV/AIDS positive living in the communities Increase knowledge in the communities on the rights of PLWAs and CSWs Promote human rights for CSWs and set standards for commercial sex Increase number of people using condoms correctly and consistently condom use Increase positive community dialogue on sex and sexuality and condom use Increase number of people accessing STI services Promote benefits of VCT and importance of disclosing one's HIV status	Establish peer educators in communities and work places to engage dialogue on VCT, PLWAs, STIs, condoms and condom use Train peer educators on HIV/AIDS/SRH issues and human rights especially for PLWAs Conduct TOTs in community dialogue on sex and sexuality	Media (print, electronic) Owners/managers of hotels, rest houses, bars, bottle stores truck stopping points and boarder posts Peer groups Traditional/community leaders Community and village AIDS committees Churches and Mosques Women's groups Men's groups Trainings Seminars, conferences	Increased number of communities establishing support mechanisms for PLWAs Increased % of clients accessing STI services at health centres Increased % of HIV/AIDS work place policies Reduced number of PLWAs reporting discrimination Increased number of peer educators trained on Increased budgetary allocation by companies and government on HIV/AIDS/SRH programmes Constant availability of essential drugs and supplies (reagents & ARVs in government and private health centres) Existence of an Act of parliament legalizing commercial sex	**Lead Org.** MANET **<u>Partners</u>** Malawi Law Commission NAPHAM MANASO MASO CADECOM Malawi Council of Churches Clinical & Nurses Council CILIC CHRR Malawi Carer Dept. of Environmental Health Min. of Labour Wilsa Malawi

Barrier: 4. Harmful sexual cultural practices in communities that increase HIV/AIDS transmission and unwanted pregnancies

Problem Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
1. Unsafe sex practices Men who travel a lot have more sexual partners 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 Commercial sex workers use herbs to dry their vaginas **2. Inconsistent Seeking Behaviours** High risk men and women who contract STIs delay in seeking treatment Most men and women are unwilling to access STI services	Practices that increase STI/HIV transmission included initiation, wife inheritance, fisi, ritual cleansing, genital mutilation Beliefs that traditional medication are more powerful than modern medicine	Men and women who have not tested for HIV Women and men who work at high risk places (hotels, rest houses, boarder post, bars, restaurants) Low income girls and women in urban and rural areas who exchange sex for gifts or money Mobile workers (uniformed men, truck drivers, seasonal workers, sales vendors, civil servants) Wives and husbands of field workers. Women and men with sexual multiple partners Aged women Commercial sex workers Traditional and religious leaders	Traditional leaders and counsellors abolish harmful cultural practices that promote HIV/AIDS/STI infection (fisi, wife inheritance, ritual cleansing genital mutilation) Policy makers pass laws eliminating harmful cultural practices and cleansing rituals Traditional leaders in collaboration with traditional healers regulate traditional health practices that delay early treatment of STIs/TB /pregnancy related complication and HIV/AIDS opportunistic infections Traditional healers and TBAs promote condom use Traditional leaders and healers refer clients to formal health centres for early and appropriate treatment of STIs Traditional leaders promote discussions on sex and sexuality, the risks associated with the 'real man' image	Create awareness on the dangers of harmful cultural practices in communities Eliminate harmful cultural practices that facilitate spread of HIV/AIDS/STI infection (fisi, wife inheritance, ritual cleansing genital mutilation) Strengthen linkages between traditional counselors with community based service providers (TBAs & CBDAs) on referral systems Strengthen linkages between traditional healers and services providers on the management of STIs and HIV/AIDS opportunistic infections	Train traditional counsellors on HIV/AIDS/SRH Train traditional practitioners and chiefs in proper management and referral protocols of clients Mobilize men, women and young people as role models against harmful cultural practices Form/strengthen community/village AIDS committees	Media (print, electronic) Traditional/community leaders Traditional counselors Service providers Owners/managers of hotels, rest houses, bars, bottle stores truck stopping points and boarder posts Peer groups Parliamentary committee on Health and Population Community and village AIDS/health committees Churches/Mosques Women's groups Men's groups Trainings Seminars, conferences	Increased number of campaigns conducted against harmful cultural practices Increased number of harmful cultural practices modified or eliminated Increased % of STI/Antenatal clients referred to health facilities by traditional practitioners Increased number of traditional practitioners procuring and stocking condoms Increased % of functioning community and village AIDS/health committees Increased number of traditional counsellors trained on HIV/AIDS and SRH	**Lead Org.** Family Planning Association of Malawi **PARTNERS** Min. of sport & Culture Ministry .of Justice CPEP Ministry of Agriculture CRECOM WILSA NEC MEDICA Ministry of Finance

Barrier: 5. Unavailability and inadequate HIV/AIDS/ SRH services

Problem Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
1. Unsafe sex practices Men who travel a lot have more sexual partners 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 Commercial sex workers use herbs to dry their vaginas **2. Inconsistent Seeking Behaviours** High risk men and women who contract STIs delay in seeking treatment Most men and women are unwilling to access STI services	Most of the STI and antenatal clinics are far from clients Lack of essential drugs and appropriate care in most health centres Poor attitudes by services providers to clients that discourage them to seek further services/treatment Lack of provision of condoms in the entertainment places (bars, bottle stores, hotels) in a free and friendly manner Lack of social workers working on HIV/AIDS/SRH education at the entertainment places (bars, bottle stores hotels) Lack of quality services on SRH/ HIV/AIDS. Lack of privacy and confidentiality at health centres Men often feel that RH services are for women only and unfriendly to them User fees being charged in some health centres prohibit men and women to access appropriate care and treatment	Women and men who work at high risk places (hotels, rest houses, boarder posts, bars, restaurants) Commercial sex workers Mobile workers (uniformed men, truck drivers, seasonal workers, sales vendors, civil servants) Low income girls and women in urban and rural areas who exchange sex for gifts or money Women job seekers House maids/ Widows Orphaned young girls Girl students Women and men who work at high risk places (hotels, rest houses, boarder posts, bars, restaurant	Government, CHAM, NGOs provide quality SRH/HIV/AIDS services within easy reach Private and government offer affordable SRH/HIV /AIDS services Owners of entertainment places provide condoms and promote use to their clients Service providers giving adequate and friendly services Health providers offer male friendly RH services Private sector and government ensure availability of essential drugs and other supplies to clients Service providers exercising their skills in serving clients Service providers strengthen their links and support with traditional healers, TBAs to promote condoms and referrals	Increase number of public and private health sectors offering HIV/AIDS/SRH services within easy reach Increase provision of free condoms at entertainment places Increase access to male-friendly health services, information, treatment and support Increase provision of essential drugs and supplies on HIV/AIDS/SRH to the communities Strengthen skills for the service providers on SRH/HIV/AIDS education and treatment Advocate for affordable user fees for SRH services Increase health services delivery points including mobile clinics Increase number of traditional healers who could be able to refer SRH/ HIV/AIDS clients to service providers	Train service providers and counsellors in HIV/AIDS/SRH service provision including VCT Train service providers in provision of friendly and gender sensitive services (in-service and in-schools) Develop community based man to man peer education programs linked to condom supply and distribution (develop positive attitudes, and gender sensitive skills) Design and implement community-based programs engaging men as providers	Media (print, electronic) Traditional/community leaders Traditional counselors Service providers Owners and managers of hotels, rest houses, bars, bottle stores truck stopping points and boarder posts Peer groups Parliamentary committee on Health and Population Community and village AIDS/health committees Churches/Mosques Women's groups Men's groups Trainings Seminars, conferences Media (print, electronic)	Increased number of service providers trained in high quality and friendly services Increased number of SRH/HIV/AIDS services within easy reach Increased **%** of workers associations involved in integration of HIV/AIDS, SRH services into their routine systems Increased % of treatment compliance statistics captured during exit interviews with clients Increased % of women reporting satisfaction with services Increased % of budgetary allocation to Ministries and private sector for HIV/AIDS/SRH activities	**Lead Org.** MOHP-RHU **Partners** BLM Save US MACRO MSF-France CHAM Nurses & Midwives Council Central Medical Stores KCN NAM Malawi College for Health Sciences

Barrier : 6. Lack of dialogue on HIV/AIDS/SRH in the communities

Problem Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
1. **Unsafe sex practices** Men who travel a lot have more sexual partners 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 Commercial sex workers use herbs to dry their vaginas **2. Inconsistent Seeking Behaviours** High risk men and women who contract STIs delay in seeking treatment Most men and women are unwilling to access STI services	Lack of openness to talk about issues of sex and sexuality Commercial sex workers do not come out in the open There is secrecy around pregnancy (youth are not educated by their parents and relatives on how a pregnancy occurs) Those infected with STIs rarely discuss their status with their partners and often do not seek appropriate treatment together with their partners Some PLWAs feel shy and offended to discuss issues of HIV/AIDS including their status with their partners and relatives Some religious leaders do not discuss issues of HIV/AIDS/SRH and they consider high risk people especially CSW as sinners deserving to be infected with HIV/STI Some traditional and religious leaders do not talk about benefits of condoms and condom use as they associate them with promiscuity	Women and men who work at high risk places (hotels, rest houses, boarder posts, bars, restaurants) Commercial sex workers Mobile workers (uniformed men, truck drivers, seasonal workers, sales vendors, civil servants) Low income girls and women in urban and rural areas who exchange sex for gifts or money Women job seekers House maids Widows Orphaned young girls Girl students	Men, women and young people discuss issues of sex and sexuality, HIV/AIDS and STIs openly CSWs being open about their social status and be able negotiate condom use with all partners Communities accept CSWs and respect their rights Communities accept and fully support PLWAs PLWAs take a lead role in HIV/AIDS advocacy and awareness creation activities in their communities STI infected people discuss their status with partners Traditional leaders encourage community discussions on sex, sexuality and the risks associated with the 'real man' image Peers support each other to avoid risk situations, have one sexual partner, and use condoms correctly and consistently	Promote community discussion on HVI/AIDS/SRH issues including STIs Create awareness in the communities on the rights of PLWAs and CSWs Increase community acceptance and support for PLWAs Increase public testimonies on positive living Promote role models in the fight against SRH/HIV/AIDS Increase couple communication within families	Develop/ strengthen community based man to man peer education programs aimed at promoting dialogue on HIV/AIDS/SRH Train peer educators on interpersonal communication Conduct demonstration of correct condom use Train PLWAs on interpersonal communication (including counselling) Conduct orientation sessions on signs and symptoms of STIs and benefits of early treatment of STIs	Media (print, electronic) Traditional leaders Traditional counselors Service providers Peer groups Community and village AIDS/health committees Churches/ Mosques Women's groups Men's groups Trainings Seminars, conferences	Increased number of communities discussing issues of HIV/AIDS and issues Increased number of peers educators trained on interpersonal communication and counseling Increased number of community based programmes developed on community dialogue Increased % of PLWAs engaged in community dialogue on HIV/AIDS including positive living Increase % of partners reporting open dialogue on matters of HIV/AIDS/SRH Increased % of people getting early STI screening and treatment Increased % of people using condoms consistently	**Lead Org.** MBC (DBU) **Partners** MOI MIE Action Aid PSI NAPHAM MANASO MASO CADECOM Malawi Council of Churches Bowler Beverages State Faith Task Force WVI ECM MAM MCC Evangelical Association of Malawi

Barrier: 7. Gender inequalities and sexual violence

Problem Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
1. Unsafe sex practices Men who travel a lot have more sexual partners 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 Commercial sex workers use herbs to dry their vaginas **2. Inconsistent Seeking Behaviours** **High risk** men and women who contract STIs delay in seeking treatment Most men and women are unwilling to access STI services	For Women: Low economic status (women have low access to education, employment, loan facilities that increases their economic dependence on men and risk commercial or transactional sex) Women's low socio-economic status in society has led to low self-esteem and feeling of disempowerment as a result most women are unable to negotiate condoms use with all sexual partners Lack of laws to protect women and CSWs Pressure by family on young females to engage in transitional sex Peer pressure among men to have multiple sexual partners Communities promote the idea that being a 'real man' imply having frequent sex Sexual harassment in prisons, offices, Police and the Defence Force facilitates the spread of HIV/AIDS	Women and men who work at high risk places (hotels, rest houses, boarder posts, bars, restaurants) Commercial sex workers Mobile workers (uniformed men, truck drivers, seasonal workers, sales vendors, civil servants) Low income girls and women in urban and rural areas who exchange sex for gifts or money Women job seekers Traditional and religious leaders House maids Widows Orphaned young girls Girl students	Policy makers, politicians, and opinion leaders promote gender balance at all levels Lending institutions and companies provide loans to more women Government, NGOs and private sector create more employment opportunities for women Communities support women's access to income generating activities within their societies Policy makers enact laws to protect women and commercial sex workers (CSW) Families discourage young women from exchanging sex for gifts or money Communities and workplaces observe and respect individual human and reproductive health rights	Increase women and peers self-esteem, sense of power and skills to negotiate condom use with all partners when having sex Increase women's access to economic resources Promote policies that protect women, Reinforce legal protection against rape and sexual exploitation Increase the number of politicians, policy makers, and opinion leaders promoting gender balance relations at all level Increase parent child communication (especially girl child) to discourage transactional sex and multiple sexual partners Increase employers responsibility to protect staff from sexual harassment and violence	Introduce and expand life skills education programs Train women in basic business management skills Mobilize women to access loans and form income generating activities Design and implement community based mobilization engaging low-income women using local NGOs, CBOs and religious organization in community	Media (print, electronic) Traditional/community leaders Traditional counselors Service providers Owners/managers of hotels, rest houses, bars, bottle stores truck stopping points and boarder posts Peer groups Parliamentary committee on Health and Population Community and village AIDS/health committees Churches/ Mosques Women's groups Men's groups Trainings Seminars, conferences	Proportion of women in decision making positions Increased number of income generating activities sustained by women and girls Reduced % of reported cases of sexual abuse among women and girls Increased number of lending institutions providing leans to women Increased % of men, women and youth trained in life and basic business management skills Increased number of programmes addressing gender issues Increased % of women reporting condom negotiation with partner	**Lead org.** MOGYCS **Partners** Wilsa-Malawi NABW CILIC Malawi Carer Ministry of Justice

Chapter 3 BCI Strategy for Women of Child-bearing Age 13-49 Years

Key Lead Organisation: Ministry of Health and Population
Partners: All organizations that are leading interventions

Lead Training Institution: Mzuzu University
Partners: Kamuzu College of Nursing
College of Medicine
Malawi College for Health Sciences
Christian Health Association of Malawi Health Institutions

Segmented Social Groups

- Strategies will need to consider the needs of unmarried and married women and their partners
- Strategies have to toke into consideration the needs of young women aged 13-20 years, which are 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 and those who have completed their desired family size
- Strategies will have to focus much more on rural and low income women found in more remote areas who are at higher risk
- Strategies will be needed to women who are mobile, including migrant workers, commercial sex workers, and uniformed women.

Maternal mortality rates are unacceptably high in Malawi (620 per 100, 000 live births). 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.

Women, as traditional caregivers, also take the greatest burden in caring for the sick, and the increasing number of orphans needing care. There is a need to support women's informed choice around PMTCT and when to get pregnant including the issues of safe pregnancy and delivery. There is also a need to address widely held beliefs about women and men's roles, which place them at risk, and a ffect their access to information, services and support.

A. Behavioural Problems:

Two behavioural problems have been identified in Malawi, namely: Unsafe sexual and reproductive health practices; and inconsistent health seeking behaviour. Presented below are some of the examples under each behavioural problem for Women of Child-bearing age.

❖ **Unsafe sexual and reproductive health practices**

- Many women do not use condoms as a dual form of protection against unplanned pregnancy, STI and HIV transmission.
- Women engage in unprotected sex with men who may have multiple partners.
- Women use herbs or take 'medicines' to induce abortion or early labour.
- There is sexual violence that increases women's risk for STIs and HIV.

❖ **Inconsistent health seeking behaviour**

- Women do not access VCT services before getting pregnant, or during pregnancy.
- Many women do not go for early STI detection and treatment
- Many women who are HIV positive do not seek advice or support to protect their newborn babies from HIV transmission. They do not utilise proper infant feeding procedures.
- Some do not use contraceptives and those with complications often delay access to emergency obstetric services too late and die as a result

B. Barriers to Address:

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

1. Unavailability and inaccessibility of condoms
2. Misconceptions that dry sex (tightened vagina) brings maximum sexual excitement between partners
3. Pressure by family members on married couples to have more children

4. Lack of Knowledge about the Dangers of having Multiple Sexual Partners e.g. transmission of STIs/HIV
5. Personal risk of unsafe abortion and death from pregnancy related complications is still low
6. Ignorance among men and women on the benefits of family planning, VCT, antenatal postnatal care.
7. Inadequate knowledge on the available SRH services

Barrier: 1Unavailability and inaccessibility of condoms

Problem Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
1.Unsafe sexual and reproductive health practices Low condom use for HIV/AIDS/STI protection as well as a family planning method	In some health centres there is perpetual condom stock out (medical personnel do not order condoms from MOHP (RHU), Central Medical Stores) Some people do not have money to buy condoms Some people complain about condom sizes (some are too small and users fell pain when suing them) Religious teachings restrain followers from accessing and using condoms Peer pressure that unprotected sexual intercourse is a sign of true love (trust) make people not to buy or get condoms and use them Beliefs that condoms promote promiscuity make some people unable to access and use condoms as a family planning method In certain areas health centres where people can get condoms are very far apart In certain areas condoms are not sold in shops/groceries as proprietors (owners) do not order them for sale	Unmarried young people aged between 13-20 years Women who have not completed their family size Men and female teachers	Women and men of child bearing age use condoms correctly and consistently as both family planning method and STI/HIV prevention Shop owners ensure condom availability for sale Managers/medical personnel distribute condoms to all clinics/health centres Young people use condoms at first sexual intercourse	Increase number of men and women who use condoms correctly and consistently at first sexual intercourse and afterwards Increase the number of people who can identify benefits of condom use (HIV/STI prevention and controlling family size) Increase the number of service delivery points (clinics/health centres/shops) where people can easily get or buy condoms Promote acceptance of condoms among traditional and religious leaders Increase good communication skills and provision of information by health care providers	Train CBDAs, adult CBAs and Youth CBDAs, on condom use and demonstration Train shop owners and pharmacists of health centres on condom storage procedures	Drama Traditional songs Village meetings Media (newspapers, radio, TV) Meetings Conferences Traditional and religious leaders Policy makers	Increased number of men and women using condoms correctly and consistently Increased % of people citing dual purposes of condoms and their benefits Reduced % of HIV/AIDS /STI infection and unwanted pregnancy Increased number of policy makers, traditional, opinion and religious leaders taking in condom promotion activities Number of women accepting/utilising condoms as a method of contraceptive Number of condoms issued at: i) STI clinics ii) FP clinic iii) VCT centres	**Lead Org.** MOHP (RHU) **Partners** BLM PSI CHAM Project Hope GTZ SCF (UK, US)

Barrier: 2. Misconceptions that dry sex (tightened vagina) brings maximum sexual excitement between partners

Problem Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
1.Dry sex	There is low risk perception of contracting STI/HIV/AIDS People are not a ware of advantages of wet sex (vagina with natural body fluids/secretions) Belief that when condom is used there will be no sexual satisfaction between partners Lack of pelvic floor muscle exercises taught at antenatal and postnatal clinics	Unmarried /married males and females aged between 13-49 years	Women stop drying out their vaginas with herbs or crystals Men stop asking/encouraging their partners to dry out vaginas for sexual excitement Sexually active young men delay first sexual intercourse Men and women use condoms correctly and consistently People discuss openly sexual and reproductive health issues Government bar importation of modern medicines that are used to dry out vaginas Community leaders and traditional counsellors bar use of herbs that are used to dry out vaginas	Increase number of women who stop using herbs and crystals to dry vaginas Increase number of men who discourage their female partners from using herbs or crystals to dry their vaginas Increase the number of young people who delay first sexual intercourse Increase the number of young people who do not follow harmful cultural practices Promote dialogue within families and communities on sexual and reproductive health issues Increase individuals' low risk perception of STI/HIV/AIDS Empower women to start income generating (low scale) activities	Conduct counselling sessions on the advantages of wet sex Conduct/revive life skills curriculum to address physiology of sex activities Train married couples skills to reach sexual satisfaction with a partner	Traditional counsellor/ initiators Teachers Schools Peer educators Religious/traditional leaders Trainings Media	Reduced number of reported women using herbs/crystals to dry vaginas Reduced % of reported genital infections among women due to use of herbs Number of public statements made banning/against use of herbs/crystal to dry vaginas Increased number of men and women who practice safe sex	**Lead Org.** MOHP (RHU0 **Partners** BLM PSI CHAM Project Hope GTZ SCF (UK, US)

Barrier: 3. Pressure by family members on married couples to have more children

Problem Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BC Interventions	Channels	Indicators	Responsibility
1.Low use of family planning methods	In most communities high number of children one has is regarded as a status symbol There are myths and misconceptions that when a woman uses contraceptives becomes barren There is lack of couple communication on family planning methods There is lack of knowledge on reproductive health rights especially for women Lack of decision making among women There is a belief that when using family methods husband/partner "samva kukoma" Family planning services are inadequate (they are far apart, shortage of contraceptives) and in some areas they are not available Poor provider/client relationship discourage men and women to seek family planning methods and information	Men and women aged between 13-49 years Traditional counsellors/initiators Traditional and religious leaders	Families practice family planning Traditional and Religious institutions teach/discuss correct sexual reproductive health issues Married women in liaison with their husbands make decisions about the number of children they want to have Women exercise their sexual and reproductive health rights Women should not conceive more than four times Women stop having children after age of 35 years	Increase number of couples/individuals who use family planning methods Increase number of young people who delay first pregnancy until at 20 years Increase number of couples/individuals who stop child bearing at age of 35 years. Increase number of husbands who support their wives in decision making about family planning and SRH issues Increase number of couples that report partner communication on SRH issues. Strengthen policies that promote increased age of consent for first sexual intercourse Strengthen the existing policies that support men and women and young people access to quality SRH services Reduce number of people reporting negative perceptions and attitudes towards education on sex and sexuality	Integrate FP into VCT services Incorporate FP education into school curriculum and Agriculture extension training Train more teachers, traditional healers, agriculture extension workers and health workers in FP issues	Training Conferences Home visits Meetings Media Traditional and religious leaders	Increased % of men, women and young people who use modern FP methods (those who have undergone vasectomy, tubal ligation, Norplant, LUCD etc) Increased number of service providers (teachers, agriculture extension workers, traditional healers, health workers) trained on FP and SRH Reduced drop out rate of FP clients Increased number of unmarried men and women who go for VCT before marriage Increased number of married couples who go for VCT before next pregnancy Increased number of pregnancies reported at ANC	**Lead Org.** RHU **Partners** BLM FPAM CHAM Project Hope SCF (UK, US) GTZ

Barrier: 4. Lack of Knowledge about the Dangers of having Multiple Sexual Partners e.g. transmission of STIs/HIV

Problem Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
1.Most men and women have multiple sexual partners	Poor social-economic status of women make some of them become dependant on men who demand sex in return Some men who have more money buy sex or tend to have more sexual partners Some people have many Sexual partners in order to seek sexual satisfaction Lack of knowledge on how to have sexual satisfaction within a family	Unmarried and married males and females aged between 13-49 years Low Income women Industrial and migrant workers Women and men in uniform (army prisons, police, immigration Health Workers etc) Men/women involved in religion/general conferences Business men and women Commercial sex workers Widows and widowers	Men and women stick to one sexual partner Men and women discuss openly sexual and reproductive health issues Community members refer couples and young people to SRH issues Policymakers formulate policies that support women's socio-economic base Women start income generating activities Service providers teach married couples issues of sex and sexuality	Reduce number of men and women having multiple sexual partners Increase the number of policies that support women's social economic base Increase community dialogue on SRH including dangers of multiple sexual partners Increase number of income generating activities especially for women Eliminate cultural practices that encourage sex intercourse with multiple partners Increase number of service providers offering sex and sexuality education in the communities	Together with traditional leaders identify harmful cultural practices that encourage people to have multiple sexual partners Train service providers in SRH and interpersonal communication and counselling Train peer educators on sex and sexuality	Meetings Workshops Traditional and religious leaders Media Lending institutions	Decreased number of men and women reporting having multiple partners Increased number of peer educators trained Increased number of harmful cultural practices that encourage people to have multiple sexual partners identified and eliminated Increased % of traditional leaders speaking against harmful cultural practices that promote multiple sexual relationships Increased number of NGOs providing loans to women Increased number income generating activities initiated by women Increased number of role models promoting mutual faithfulness between couples Increased number of people trained in interpersonal communication and counselling	**Lead Org.** RHU **Partners** BLM FPAM Lending institutions/NGOs CHAM Project Hope SCF (UK, US) GTZ

Barrier: 5 Personal risk of unsafe abortion and death from pregnancy related complications is still low

Problem Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility (by Whom)
1.There are high cases of abortions	Most women abort unwanted pregnancies (those that occur from another partner other than the husband or those that occur too early, too late etc) Some men force or encourage their partners to abort Most women who abort use harmful herbs/chemicals or instruments	Women aged between 15-24 Men of reproductive age	Women of all ages stop inducing abortion Men encouraging their partners to go FP services and use contraceptives Service providers support women's access to safe abortion Women go for post abortal care Women and men recognise danger signs in pregnancy Women access antenatal care	Create awareness on availability of emergency contraceptives and post abortal care Increase number of women who attend post abortal care Increase number of men and women who recognise danger signs in pregnancy Increase the number of women who go for early antenatal care (first trimester)	Train service providers on obstetric care Conduct counselling sessions with couples on the dangers of abortion	Campaigns Media Training Meetings Refresher courses Workshops and seminars	Reduced number of abortion cases Increased number of women accessing antenatal and postnatal care Increased number of men who report encouraging their spouses to use family planning methods always Increased number of health workers equipped with knowledge and skills on post-abortal care	**Lead Org.** MOHP (RHU) **Partners** BLM PSI CHAM Project Hope GTZ SCF (UK, US)

Barrier: 6. Ignorance among men and women on the benefits of family planning, VCT, antenatal and postnatal care

Problem Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
1.Non compliance to SRH Services	Low risk perception among pregnant women on PMTCT In availability of VCT services and antiretroviral drugs (some people do not see any need for HIV testing when they cannot access ARVs) Long waiting time at certain health centres/clinics discourage clients to go for HIV/AIDS/SRH services again	Men and women aged between 13-49 years Pregnant mothers PLWAs STI infected persons Lactating mothers Young parents	Men and women go for family planning, VCT Pregnant women go for antenatal care Those who have given birth access postnatal care Men and women come for check ups for STIs Care services Clients spend short time at RH service delivery points	Promote use of contraceptives Increase number of women who access antenatal and postnatal care Reduce STI among men and women Develop/strengthen efficient and accessible HIV/AIDS/SRH services	Establish male/partner discussion groups to discuss SRH issues Mobilise couples and individuals to go for VCT Initiate Community debates on SRH issues on danger signs, HIV/AIDS, PMTCT, VCT and gender Strengthen supervision of community based providers: TBAs, CBDAs Strengthen communication links between community based providers and health facilities for referral Mobilising couples to identify voluntary blood donors in preparation for delivery	Service Providers TBAs Workshops Districts Health Management Teams Village Health Committee Health Advisory Committee Meetings Open days Clubs Faith communities Opinion Leaders Testimonies Schools	Increased number of men and women who report benefits of FP, VCT, STI treatment and PMTCT Increased % of couples and individuals utilising VCT services Increased number of policies supporting VCT, family planning, PMTCT developed and enforced Increased number of roles models giving testimonies on use of FP and VCT	**Lead Org.** RHU **Partners** MACRO NAPHAM Light House CHAM BLM Hope Humana MSF SCF (UK, US) Media Project Hope

Barriers: 7. Inadequate knowledge on the available SRH services

Problem Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
Inconsistent health-seeking behaviour Delay in seeking family planning methods, STI and cervical cancer treatment, antenatal and postnatal care Most women do not deliver children with skilled attendants (most of them deliver at home) There is traditional norm in certain societies for married women to seek a concert from elderly relatives before accessing RH services Most men and women do not go for early detection of STIs and treatment if infected Belief in seeking traditional medicine before going to hospital	Failure to recognise emergency SRH issues among men and women Poor communication facilities to access RH services that make people ignorant about available services Lack of community dialogue Lack of community involvement on issues related to SRH Transport problems to access HIV/AIDS and SRH facilities Poor referral mechanism between communities and health centres In availability of reproductive health services In availability of VCT services There is poor service provider /client relationship (poor attitudes of some providers	Lactating mothers Young parents Business women/men Working men/women Women/men soldiers Emergency obstetric complication mothers House wives Women falling pregnant for the first time Single parents HIV Positive spouses/marriages Men and women in unstable marriage	Men and women practicing family planning methods Community members stop practices that delay women's access to emergency health care Women deliver under skilled care Men and women report early danger signals for pregnancy Men and women go for VCT before marriage and any pregnancy Couples plan their families (when to have a child, number of children they want to have etc) Service providers offer friendly SRH services	Increase knowledge on STI/HIV/AIDS and other RH services Increase number of women delivering under skilled care Increase number of **men** and women utilising modern family planning methods Reduce the number of harmful sexual practices that delay appropriate care and treatment Increasing male involvement in HIV/AIDS/SRH activities Increase knowledge of PMTCT and VCT services Reduce clients waiting for services at delivery points Strengthen links between health system and community based service providers Increase awareness on emergency RH issues e.g. danger signs in pregnancy	Train service providers on SRH issues and update trends Train providers in inter-personal relationship and counselling Train providers in life saving skills Conduct supervisory visits to TBAs in SRH services and encourage referral of early danger signs of pregnancy Promote quality counselling on PMTCT Issues to ensure utilisation Conduct open days on SRH services e.g. VCT and PMTCT	Mass campaigns Trainings Service Providers TBAs Workshops Districts Health Management Teams Village Health Committee Health Advisory Committee Meetings Open days Clubs Faith communities Opinion Leaders Testimonies Schools	Increased knowledge on HVI/AIDS /SRH issues Increase number of women delivering under skilled care Increased number of communities abolishing rituals that delay access to emergency health care Increased number of partners utilising VCT before getting married and first pregnancy Increased number of sites providing PMTCT Increased number of community groups formed and operational	Lead Org MOHP Partners CHAM (PHAM) BLM KCN Medical Council of Mw. Traditional Healers Association Poisons and Pharmacy Board

Chapter 4 BCI Strategy for working with Service Providers

Key Lead Organization: Ministry of Health and Population
Partners: MOEST
Ministry of Information
MOGYCS

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

- The Health providers cover the health centre staff, the nurses, the doctors, the clinical officers, the radiographers, the medical assistant, the midwifes, the clerks, and it is also covering the health extension workers, such as the community health nurses, the HSAs, the health assistants.

- The community based health workers include trained TBAs, the traditional healers, the CBDAs, the growth monitoring volunteers and the home based care providers

- Strategies need also to reach social service providers such as the teachers, the agriculture extension workers, the traditional initiators, religious leaders and counselors, the media personnel, the NGOs, and the business people.

Service providers work in a very difficult situation including lack of efficient and supportive working environment. Some of them lack financial resources, lack of education and training, lack of medical resources, lack of supervision and management, lack of tools and materials and lack of economic empowerment. There is an urgent need to take action to assist them to improve the management and the coordination between the health, the education and the social sectors. There is need to develop their capacity and improve their performance.

Service providers are those responsible for providing information, counselling and services on HIV/AIDS and SRH. They should assist in strengthening both the quality of services and referrals. Their attitude and relationship towards clients is crucial in bringing desired behaviours among targeted social groups.

A. Problem Behaviours:

- **Unsafe sexual and reproductive health practices**
  - Some service providers do not promote safe SRH practices, including condoms to prevent STIs and unwanted pregnancies.
  - In certain cases service providers do not set examples towards their clients within their own workplaces.

- Some service providers are engaging in unsafe sexual practices as well.
- Some service providers use their position of power to engage in risky sexual behaviours.

❖ **Inconsistent health seeking behaviour**

- Some service providers do not refer community members to appropriate health services.
- Some service providers do not provide adequate information, kindness and respect to clients who use their services.
- Some service providers lack technical skills and competency to SRH services and counselling.
- In certain cases TBAs delay referrals of pregnant women with complications to emergency obstetric services.

B. Barriers to Address:

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

1. Knowledge and skills gaps in HIV/AIDS and 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

Barrier: 1. Knowledge and skills gaps in HIV/AIDS/SRH

Problems Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
1. Unsafe SRH practices Do not adequately promote SRH/HIV/AIDS services -Condom use -Contraception -PMTCT -VCT Increase in unsafe abortion cases Promote harmful cultural practices Youth rarely visit RH services **2.Inconsistent health seeking behaviour** Do not timely refer community members to appropriate SRH services Do not provide adequate information to clients Do not treat clients with respect Delay referral of pregnant women with complications to emergency obstetric services	Limited information and skills on SRH, HIV/AIDS Service providers give incomplete and inaccurate information to clients on SRH/HIV/AIDS, MTCT and VCT services Some service providers are not aware of risks associated with use of herbs or cutting of the skin. Low condom promotion for dual use Myths and misconceptions around contraceptives and condoms Do not educate on risky behaviours that lead to contracting STIs and HIV Do not have adequate information on the available health services	**1. Health service providers** **Health centre personnel:** Radiographers, clerks, administration, dentists, Doctors, nurses/midwives, clinical officers, medical assistants, pharmacy assistants **Extension workers:** Community health nurses, HSAs, environmental health officers, health assistants **Community based health workers:** Trained TBAs, traditional healers, CBDAs, growth monitoring volunteers, home based care providers **2. Non Health Service Providers** Community development assistants Traditional initiators Teachers Commercial sex workers Truck drivers Media personnel Agricultural extension workers NGOs Business people Lending agencies Vendors	All service providers: Give clients complete and accurate information on HIV/AIDS/SRH including MTCT and VCT Inform people of the dangers of having multiple sexual partners Educate the TBAs on the dangers of administering herbs and cutting under septic conditions Educate clients on the anatomy and physiology of the reproductive system Give information on the dual benefits of condom use Demonstrate correct condom instructions Perform procedures according to standard Refer clients/patients timely for further care	Increase knowledge and skills among all service providers on HIV/AIDS/SRH issues and available services Increase supportive supervision of health service providers Reduce harmful STI treatment practices Increase number of clients using SRH/HIV/AIDS services Increase teacher capacity to teach youth on HIV/AIDS and SRH.	Integrate SRH, HIV/AIDS in mainstream educational curriculum Strengthen quality assurance committees Re-enforce infection prevention guidelines for both facility and community based health service providers Strengthen/develop guidelines and standards for the performance of procedures by both facility based and community based service providers Train all key social groups on basic health issues that impact SRH, HIV/AIDS	Training institutions Mass media Schools Posters Leaflets Meetings Workshops Traditional leaders Policy makers	Increased number of service providers trained or updated in SRH, HIV/AIDS Increased number of institutions and schools providing SRH, HIV/AIDS education Increased % of service providers reached with SRH, HIV/AIDS education Increased % of clients going for VCT % of service providers giving correct and accurate information to clients Increased number of condoms distributed	**Lead Org.** MOHP **Partners** PSI, BLM, Media, CHAM, FPAM, MOEST, MOGYCS -Dept of Youth

Barrier: 2. Poor client-service provider relationship

Problems Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
1.Unsafe SRH practices Do not adequately promote SRH/HIV/AIDS services Increase in unsafe abortion cases Promote harmful cultural practices Youth rarely visit RH services **2.Inconsistent health seeking behaviour** Do not timely refer community members to appropriate SRH services Do not provide adequate information to clients Do not treat clients with respect Delay referral of pregnant women with complications to emergency obstetric services Do not promote economic empowerment	Many service providers are not youth friendly There is stigma around contraceptives, abortion and youth access to RH information and services Inadequate staff in health centres resulting in pressure of work Long waiting time at health centres before clients are attended to Low motivation or commitment of health centre staff Lack of training in interpersonal relationships Service providers are not recognized for their services Poor supervision of service providers	**1.Health service providers** **Health centre personnel:** Radiographers, clerks, administration, dentists, Doctors, nurses/midwives, clinical officers, medical assistants, pharmacy assistants **Extension workers:** Community health nurses, HSAs, environmental health officers, health assistants **Community based health workers:** Trained TBAs, traditional healers, CBDAs, growth monitoring volunteers, home based care providers **2. Non Health Service Providers** Community development assistants Traditional initiators Teachers Commercial sex workers Truck drivers Media personnel Agricultural extension workers NGOs Business people Lending agencies Vendors	Service providers treat all clients and patients, young and old with respect Service providers dispense all types of contraceptives to young people, married and unmarried women and men without prejudice People seek abortion services without being stigmatized Health centre service providers exhibit high motivation and commitment to their work	Increase clients reporting satisfaction with services Increase youth access to SRH, HIV/AIDS health services Develop a policy to legalize abortions Introduce/strengthen youth corners in health centres or stand alone youth centres Reduce client-waiting time to a maximum of 30min. Strengthen effective coordination between management and other health personnel Increase incentives for recognition of good work	Train service providers in interpersonal communication and in youth friendly service provision Involve the youth in the design/planning and implementation of youth friendly services Develop effective supervisory mechanisms	Training Workshops Meetings Opinion leaders	Increased number of clients reporting satisfaction with services Increased % of health centres with youth friendly services Types of incentives introduced Increased number of youth centers established Increased % of youth visiting youth centres Reduction in client waiting time at the health centres	**Lead Org** MOHP **Partners** PSI, BLM, Media, CHAM, FPAM, MOEST, MOGYCS - Dept of Youth OPC NGOs

Barrier: 3. Harmful SRH practices

Problems Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
1. Unsafe SRH practices Do not adequately promote SRH/HIV/AIDS services Increase in unsafe abortion cases Promote harmful cultural practices Youth rarely visit RH services **2. Inconsistent health seeking behaviour** Do not timely refer community members to appropriate SRH services Do not provide adequate information to clients Do not treat clients with respect Delay referral of pregnant women with complications to emergency obstetric services Do not promote gender equality	Culture of silence on harmful cultural practices Lack of standards or guidelines for initiation ceremonies Lack of coordination between health and non health providers on cultural practices Service providers do not discourage women from drying their vaginas for dry sex Some service providers, themselves change agents, engage in or encourage harmful cultural practices Low literacy levels prevent rational thinking	**1. Health service providers** **Health centre personnel:** Radiographers, clerks, administration, dentists, Doctors, nurses/midwives, clinical officers, medical assistants, pharmacy assistants **Extension workers:** Community health nurses, HSAs, environmental health officers, health assistants **Community based health workers:** Trained TBAs, traditional healers, CBDAs, growth monitoring volunteers, home based care providers **2. Non Health Service Providers** Community development assistants Traditional initiators Teachers Commercial sex workers Truck drivers Media personnel Agricultural extension workers NGOs Business people Lending agencies Vendors	Service providers educate people on the spread of HIV and SRH problems through harmful cultural practices Service providers present role models in the community Men and women despise cultural practices that are harmful Opinion leaders in the community eliminate harmful cultural practices that contribute to the transmission of HIV/AIDS and SRH problems Initiators adopt safer cultural practices Initiators utilize initiation ceremonies to promote SRH, HIV/AIDS messages	Increase knowledge levels of service providers on the prevailing harmful cultural practices Develop role models among service providers Raise the levels of literacy of men and women Increase the number of initiators who integrate SRH and HIV/AIDS messages during traditional initiation ceremonies Increase the number of communities that eliminate harmful cultural practices	In collaboration with community leaders identify all harmful cultural practices in the area Educate community leaders and initiators on SRH, HIV/AIDS problems Strengthen adult literacy classes Enforce free and compulsory education	Media Workshops AIDS prevention groups Women's groups Politicians Churches	Increase number of initiators reporting using the modified cultural practices Number of cultural practices modified Increased % initiators giving SRH, HIV/AIDS messages during initiation ceremonies	**Lead Org.** MOHP **Partners** PSI, BLM, Media, CHAM, FPAM, MOEST, MOGYCS -Dept of Youth OPC NGOs

Barrier: 4. Poor community involvement and community dialogue in SRH issues

Problems Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
1.Unsafe SRH practices Do not adequately promote SRH/HIV/AIDS services Increase in unsafe abortion cases Promote harmful cultural practices Youth rarely visit RH services **2.Inconsistent health seeking behaviour** Do not timely refer community members to appropriate SRH services Do not provide adequate information to clients Do not treat clients with respect Delay referral of pregnant women with complications to emergency obstetric services Poor quality of services Do not promote economic empowerment	Poor links between health institutions and community based providers Lack of coordination between different sectors at the community level to support SRH, HIV/AIDS services High stigma and stigmatization of PLWHAs There is very little dialogue of SRH, HIV/AIDS issues by service providers at community level Service providers find it difficult to discuss SRH, HIV/AIDS issues in the community Lack of emergency transport at community level Poor communication infrastructure in the community	**1.Health service providers** **Health centre personnel:** Radiographers, clerks, administration, dentists, Doctors, nurses/midwives, clinical officers, medical assistants, pharmacy assistants **Extension workers:** Community health nurses, HSAs, environmental health officers, health assistants **Community based health workers:** Trained TBAs, traditional healers, CBDAs, growth monitoring volunteers, home based care providers **2. Non Health Service Providers** Community development assistants Traditional initiators Teachers Commercial sex workers Truck drivers Media personnel Agricultural extension workers NGOs Business people Lending agencies Vendors	Health and non health service providers share information on SRH, HIV/AIDS issues Community members involved in the design and delivery of both facility and community based health services Health service providers feel free to dialogue with the community and the media on SRH, HIV/AIDS issues PLWHAs freely disclose their HIV status to other community members HSAs, TBAs and traditional healers refer clients to health centres and vice versa. HSAs, TBAs and traditional healers have access to follow their clients up in health centres and vice versa	Increase referrals between the community and formal health service providers Increase number of community members that are involved in health centre activities Strengthen community dialogue on issues of HIV/AIDS and SRH Increase the number of people who disclose their HIV status Increase knowledge of HIV/AIDS/SRH among men and women in the communities Increase information exchange between health and non health service providers Strengthen community capacity to refer clients to needed SRH, HIV/AIDS services	Conduct community meetings with leaders and health service providers to share information and promote dialogue on the importance of working together Conduct training sessions for community leaders on their role in mobilizing their subjects and the provision of health services	Media DACC VACC CACC Traditional leaders Policy makers	Increased number of referrals made from the communities to health centres and vice versa Increased number of social activities that integrate SRH and HIV/AIDS Increased number of PLWHAs who disclose their status Increased number of sessions of dialogue involving service providers and community leaders on HIV/AIDS/SRH	**Lead Org.** MOHP **Partners** PSI, BLM, Media, CHAM, FPAM, MOEST, MOGYCS -Dept of Youth OPC NGOs

Barrier: 5. Gender inequalities and lack of promotion of human rights

Problems Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
1. Unsafe SRH practices Do not adequately promote SRH/HIV/AIDS services Increase in unsafe abortion cases Youth rarely visit RH services **2. Inconsistent health seeking behaviour** Do not timely refer community members to appropriate SRH services Do not provide adequate information to clients Do not treat clients with respect Delay referral of pregnant women with complications to emergency obstetric services Poor quality of services Do not promote gender equality Do not promote economic empowerment	Some health services are not male friendly Cultural roles do not support gender equality Negative attitudes that view men as inferior to men Lack of knowledge on human rights	**1. Health service providers** **Health centre personnel:** Radiographers, clerks, administration, dentists, Doctors, nurses/midwives, clinical officers, medical assistants, pharmacy assistants **Extension workers:** Community health nurses, HSAs, environmental health officers, health assistants **Community based health workers:** Trained TBAs, traditional healers, CBDAs, growth monitoring volunteers, home based care providers **2. Non Health Service Providers** Community development assistants Traditional initiators Teachers Commercial sex workers Truck drivers Media personnel Agricultural extension workers NGOs Business people Lending agencies Vendors	Service providers view men and women as equal in SRH, HIV/AIDS issues Both men and women, boys and girls access SRH services equally Religious leaders refrain from using the Bible to promote gender inequality NGOs adopt rights based approach in implementing projects in the communities Service providers interpret human rights correctly	Increase equal access to SRH, HIV/AIDS services for both men and women Increase the knowledge levels on human rights Strengthen implementation of human rights and gender equality policies	Train traditional and faith leaders on the concept gender and gender roles Train traditional and faith leaders on their role in the promotion of gender equality and equity Conduct training sessions within communities on the human rights especially reproductive health rights and the rights of PLWAs	Extension workers Traditional and Faith leaders Mass media NGOs Schools Youth clubs CHCs	Increased number of service providers trained in gender issues and human rights Increased number of civic educators trained in human rights Increased number of civic education sessions held in the community Increased % of organizations implementing programmes in the communities using rights based approach	**Lead Org.** Human Rights NGOs **Partners** Media, MPs, Chief's Council, Faith organizations

Barrier: 6. Poverty – Lack of economic empowerment

Problems Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
1. Unsafe SRH practices Do not adequately promote SRH/HIV/AIDS services Increase in unsafe abortion cases Promote harmful cultural practices Youth rarely visit RH services **2. Inconsistent health seeking behaviour** Do not timely refer community members to appropriate SRH services Do not provide adequate information to clients Do not treat clients with respect Delay referral of pregnant women with complications to emergency obstetric services Do not promote gender equality Do not promote economic empowerment	Lack of entrepreneurial skills make service providers unable to address the relationship between poverty and HIV/AIDS/SRH Tough conditions attached to loans Lack of funds for income generating activities	**1.Health service providers** **Health centre personnel:** Radiographers, clerks, administration, dentists, Doctors, nurses/midwives, clinical officers, medical assistants, pharmacy assistants **Extension workers:** Community health nurses, HSAs, environmental health officers, health assistants **Community based health workers:** Trained TBAs, traditional healers, CBDAs, growth monitoring volunteers, home based care providers **2.Non Health Service Providers** Community development assistants Traditional initiators Teachers Commercial sex workers Truck drivers Media personnel Agricultural extension workers NGOs Business people Lending agencies Vendors	Business people and lending agencies provide loans to the poor Service providers refer clients to social services for financial assistance Service providers issue drugs and services to all patients/clients who cannot afford to pay	Increase the number of people who are economically viable Reduce poverty levels Increase the number of people who access loans and social services Increase supervision of small scale business management	Train service providers in business management skills	Business people Government Lending institutions Media	Increased number of advocacy sessions held with lending institutions Increased number of people accessing loans Increased number of people owning and sustaining small scale business successfully	**Lead Org.** MOHP **Partners** PSI, BLM, Media, CHAM, FPAM, MOEST, MOGYCS - Dept of Youth OPC **NGOs**

Barrier: 7. Increase in unsafe abortions

Problems Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
1. Unsafe SRH practices Do not adequately promote SRH/HIV/AIDS services Increase in unsafe abortion cases Promote harmful cultural practices Youth rarely visit RH services **2. Inconsistent health seeking behaviour** Do not timely refer community members to appropriate SRH services Do not provide adequate information to clients Do not treat clients with respect Delay referral of pregnant women with complications to emergency obstetric services Poor quality of services Do not promote gender equality Do not promote economic empowerment	Stigma around contraceptives, abortion, and youth access to RH information and services Lack of supportive policies -Anti-abortion policy promotes unsafe abortion Lack of legal abortion services	**1. Health service providers** **Health centre personnel:** Radiographers, clerks, administration, dentists, Doctors, nurses/midwives, clinical officers, medical assistants, pharmacy assistants **Extension workers:** Community health nurses, HSAs, environmental health officers, health assistants **Community based health workers:** Trained TBAs, traditional healers, CBDAs, growth monitoring volunteers, home based care providers **2. Non Health Service Providers** Community development assistants Traditional initiators Teachers Media personnel	Service providers give clients complete and accurate information on all the services available (VCT, emergency contraception, condoms and other FP methods) Service providers counsel young pregnant women and couples Service providers refer clients for post abortion care	Reduce number of unsafe abortions Increase the knowledge and skills of service providers in post abortion care Increase the facilities that provide post abortion care	Train service providers on post abortion care Train community leaders on effects of abortion	Ante and postnatal care clinics Communities Mass media Youth clubs Traditional healers Policy makers Opinion leaders	Decreased number of reported unsafe abortions Increased number of post abortion care services Increased % of clients accessing post abortion care Increased % of young clients using contraception	**Lead Org** MOHP/PAM **Partners** BLM, Media, CHAM, Ministry of Justice Human Rights Orgs.

Chapter 5 BCI Strategy for Working with Opinion Leaders

Key Lead Organization: Ministry of Sports Youth and Culture
Partners: All Faith-based Organizations
All organization that are leading interventions on HIV/AIDS and 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 religious leaders, traditional leaders, traditional healers, local politicians and celebrities who have authority and have large 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 risky cultural practices, misleading norms, values and beliefs.

- 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 often wields significant authority and influence, particularly at any community level.

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

Traditional leaders (chiefs, village headmen, counsellors) are custodians of traditional norms, practices and values. Any HIV/AIDS and SRH activity requires their support to eliminate harmful practices that facilitate HIV transmission. They have to promote dialogue on HIV/AIDS and SRH issues that are still considered as a toboo.

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.

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

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

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

B. Barriers to Address:

1. Knowledge gaps on issues of HIV/AIDS/SRH including condoms and condom use
2. Lack of community dialogue on sexuality
3. Lack of role models on positive behaviours among famous people for others to emulate
4. Harmful cultural practices in communities that predispose people especially youth and women to HIV infection
5. High stigma and discrimination
6. Inappropriate planning and programming HIV/AIDS/SRH activities in most communities
7. Inadequate SRH and HIV/AIDS services

Barrier: 1. Lack of dialogue on sex, sexuality and HIV/AIDS issues

Problems Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
1.Unsafe Sex Some traditional leaders still encourage first sexual intercourse around age 15 and perhaps as early as 12 to 13 during initiation ceremonies. Some traditional healers demand sex from their clients as a healing method Some famous artists and celebrities have multiple sexual partners **2.Inconsistent health seeking behaviour** Opinion leaders do not encourage their subjects to go for VCT, SRH services and STI treatment Traditional leaders strongly hold secrecy around issues of sex, pregnancy, abortion and child bearing Some traditional leaders encourage their subjects to visit traditional healers when infected with STIs	Strong cultural norms and values that consider open discussion and education on sex and sexuality as a taboo Strong religious beliefs that consider open discussion and education on sex and sexuality as a sin Knowledge gaps on sex sexuality and HIV/AIDS among religious and traditional leaders Most traditional leaders fail to relate HIV/AIDS, food security and other socio-economic development Famous people do not discuss sex, sexuality and HIV/AIDS with their audiences	Traditional and religious leaders Traditional and religious counsellors Traditional initiators Traditional healers Celebrities and other influential personalities	Traditional leaders initiate open discussion about sex, sexuality and HIV/AIDS Religious leaders discuss sex, sexuality and HIV/AIDS issues within the context of spirituality Leaders (traditional, religious, celebrities) sensitize their people on the impact of HIV/AIDS on food security and other socio-economic development Religious leaders willing to provide accurate and objective information on HIV/AIDS/SRH to members of their churches/mosques Churches and mosques promote abstinence and mutual faithfulness among followers Musicians, drama artists, radio and TV personalities disseminate messages on dangers of indulging in promiscuity especially unprotected sex	Increase number of opinion leaders who sensitize their subjects on SHR/HIV/AIDS Increase opportunities for open discussion at community level on HIV/AIDS/SRH issues Create environment where the life experiences of sex, sexuality and HIV/AIDS issues are discussed and heard without fear or judgment of traditional or faith-based convictions Increase number of musicians, drama artists and other personalities who disseminate HIV/AIDS/SRH issues in their activities and shows Promote abstinence and mutual faithfulness as fundamental values for faith-based community	Train faith leaders to understand the scientific nature of HIV and the social, cultural and economic factors that predispose people to HIV infection Train musicians, artists and personalities on HIV/AIDS/SRH especially on message development and dissemination	Pastors, elders, deacons Hajjis, Bishops All cadres of religious leaders men's and women's guilds. Religious youth organization AIDS programmes Electronic Media (TV, Rural cinema & radio) Print media (newspapers, newsletters, fact sheets, leaflets etc) Traditional leaders themselves Training Seminars Health workers	Increased number of traditional leaders who engage themselves in dialogue on HIV/AIDS/SRH issues Increased number of religious leaders who engage themselves in dialogue on HIV/AIDS/SRH issues Increased number of artists, musicians, radio and TV personalities who incorporate HIV/AIDS/SRH messages in their shows Increased knowledge levels and change of attitudes on HIV/AIDS/SRH Increased number of debates on HIV/AIDS/SRH issues in the communities	**Lead Org.** MOSYC **Partners** PSI, BLM, Media, CHAM, FPAM, MOEST, MOGYC-Dept of Youth NGOs

Barrier: 2. Harmful cultural practices

Problems Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
1.Unsafe Sex Some traditional leaders still encourage first sexual intercourse around age 15 and perhaps as early as 12 to 13 during initiation ceremonies. Some traditional healers demand sex from their clients as a healing method Some famous artists and celebrities have multiple sexual partners **2.Inconsistent health seeking behaviour** Opinion leaders do not encourage their subjects to go for VCT, SRH services and STI treatment Traditional leaders strongly hold secrecy around issues of sex, pregnancy, abortion and child bearing Some traditional leaders encourage their subjects to visit traditional healers when infected with STIs	Traditional practices that promote early sex such *fisi, kuchotsa fumbi* Traditional beliefs that encourage multiple sexual partners such as wife inheritance, *chimwanamaye, kupita kufa, kulowa kufa* (ritual cleansing during funeral ceremonies*)* Strong beliefs that traditional medicines are more powerful than modern drug therapies Sharing of one stick during application of herbs to patients by most herbalists	Traditional leaders Traditional counsellors Religious leaders and counsellors Traditional initiators Traditional healers Celebrities and other influential personalities	Religious and traditional leaders advocate for elimination of harmful cultural practices that contribute to the spread of HIV/AIDS Traditional leaders and healers promote cultural norms and values that promote abstinence and mutual faithfulness Traditional counsellors utilize initiation ceremonies to encourage delay sexual debut Religious and traditional leaders, healers and counsellors provide accurate information on sex, sexuality and HIV/AIDS Traditional healers observe safe practices when treating their patients (one razor blade and one stick for applying herbs to one person)	Increase the number of leaders who advocate against cultural practices that predispose people to HIV/STI infection Increase number of traditional healers who adopt safer practices when treating their patients Increase the number of communities that report adoption of safer practices during initiation ceremonies and circumcision Increase the numbers of leaders who provide accurate information about HIV/AIDS/SRH	Train chiefs, village headmen, counsellors on HIV/AIDS especially on the nature and modes of transmission of HIV Mobilize communities to form groups and clubs that will work against or report any form of harmful cultural practice perpetuated in the communities	Pastors, elders, deacons Hajjis, Bishops All cadres of religious leaders men's and women's guilds. Religious youth organization Media Traditional leaders themselves Health workers Training Seminars	Reported number of harmful cultural practices modified Reported number of harmful cultural practices eliminated Number of HIV/AIDS clubs formed within communities Increased number of sensitization meetings conducted with healers, religious and traditional leaders	**Lead Org.** MOSYC **Partners** PSI, BLM, Media, CHAM, FPAM, MOEST, MOGYC-Dept of Youth NGOs

Barrier: 3. Stigma and discrimination

Problems Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
1. Unsafe Sex Some traditional healers demand sex from their clients as a healing method Some famous artists and celebrities have multiple sexual partners Inconsistent health seeking behaviour Opinion leaders do not encourage their subjects to go for VCT, SRH services and STI treatment Traditional leaders strongly hold secrecy around issues of sex, pregnancy, abortion and child bearing Some traditional leaders encourage their subjects to visit traditional healers when infected with STIs	Stigma around HIV and PLWAs that makes VCT and disclosure of status difficult Stigma around STIs and people infected with STIs that makes those infected with the disease not to seek appropriate treatment early Religious leaders stigmatize PLWAs as sinners deserving punishment from God or Allah Stigma around condom and condom use as communities, churches and mosques associate condoms with promiscuity Lack of knowledge on the rights of PLWAs	Traditional leaders Traditional counsellors Religious leaders and counsellors Traditional initiators Traditional healers Celebrities and other influential personalities	Leaders show compassion to PLWAs and those affected by the epidemic Faith-based communities promote the rights of PLWAs Communities, churches and mosques encourage their subjects to go for VCT and disclose their HIV status Traditional leaders support condom promotion Leaders establish support groups for PLWAs	Increase support and acceptance of PLWAs within communities, churches and mosques Promote VCT and disclosure of HIV status Increase knowledge on the rights of PLWAs Increase number of leaders and communities that report any form of discrimination especially against PLWAs Promote positive community dialogue on condom and condom use, PLWAs, and STI infected persons	Train leaders on the rights of PLWAs and people infected with STIs Mobilize communities and faith-based institutions to establish support groups for PLWAs	Pastors, elders, deacons Hajjis, Bishops All cadres of religious leaders men's and women's guilds. Religious youth organization Media Traditional leaders themselves Health workers Training Seminars	Increased number of sensitization meetings on dangers of stigma and discrimination Increased number of educational materials produced focusing on the rights of PLWAs and positive living Increased number of support groups established for PLWAs Increased % of clients accessing VCT and STI treatment Number of PLWAs reporting discrimination in communities, churches and mosques	**Lead Org.** MOSYC **Partners** PSI, BLM, Media, CHAM, FPAM, MOEST, MOGYC-Dept of Youth **NGOs**

Barrier: 4. Lack of role models

Problems Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
1. Unsafe Sex Some traditional healers demand sex from their clients as a healing method Some famous artists and celebrities have multiple sexual partners **2. Inconsistent health seeking behaviour** Opinion leaders do not encourage their subjects to go for VCT, SRH services and STI treatment Traditional leaders strongly hold secrecy around issues of sex, pregnancy, abortion and child bearing Some traditional leaders encourage their subjects to visit traditional healers when infected with STIs	There is no individual commitment and willingness among celebrities to take a leading role in advocating for HIV/AIDS/SRH issues Some religious leaders do not display exemplary behaviours (not faithful to their spouses, young leaders fail to abstain) Some faith-based institutions discriminate against PLWAs by condemning them as 'sinners deserving the fate' Some celebrities have multiple sexual partners, do not use condoms correctly and consistently Most traditional leaders do not support modern family planning methods (they even encourage their subjects to have more children)	Traditional leaders Traditional counsellors Religious leaders and counsellors Traditional initiators Traditional healers Celebrities and other influential personalities	Celebrities take lead in educating the general public on HIV/AIDS/SRH issues More celebrities use condom correctly and consistently Celebrities advocate for increased financial allocation for HIV/AIDS/SRH programmes Religious leaders practice mutual faithfulness Young religious leaders practice total abstinence Traditional leaders encourage their subjects to go for family planning Traditional leaders promote condom use and VCT in their communities Traditional leaders and celebrities disclose their HIV status and give experiences on positive living	Promote role models among musicians, drama artists, radio and TV personalities, traditional and religious leaders Promote social will and commitment in the fight against HIV/AIDS Promote social responsibility in SRH issues especially family planning and safe motherhood	Train artists radio and TV personalities on skills development Mobilize celebrities to take lead in advocating HIV/AIDS/SRH activities	Pastors, elders, deacons Hajjis, Bishops All cadres of religious leaders men's and women's guilds. Religious youth organization Media Traditional leaders themselves Health workers Training Seminars	Increased number of role models among celebrities, traditional and religious leaders who take lead in HIV/AIDS/SRH education Increased number of public testimonies on positive living by traditional and religious leaders and other famous people and artists Increased number of debates and panel discussions on radio, TV, churches, Mosques and communities on HVI/AIDS/SRH Increased media coverage on HVI/AIDS/SRH especially featuring roles models Increased number of artists and celebrities trained in HIV/AIDS/SRH and life skills Reported number of projects and activities initiates by traditional and religious leaders on HIV/AIDS/SRH	**Lead Org.** MOSYC **Partners** PSI, BLM, Media, CHAM, FPAM, MOEST, MOGYC-Dept of Youth NGOs

Barrier: 5. Inadequate involvement of traditional and religious leaders in the planning and implementation of HIV/AIDS/SRH projects

Problems Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
1 .Unsafe Sex Some traditional healers demand sex from their clients as a healing method Some famous artists and celebrities have multiple sexual partners **2.Inconsistent health seeking behaviour** Opinion leaders do not encourage their subjects to go for VCT, SRH services and STI treatment Traditional leaders strongly hold secrecy around issues of sex, pregnancy, abortion and child bearing Some traditional leaders encourage their subjects to visit traditional healers when infected with STIs t	Most project are planned and implemented without full involvement of community leaders Most projects are implemented without taking into consideration views, concerns and beliefs of leaders who can influence change	Traditional leaders Traditional counsellors Religious leaders and counsellors Traditional initiators Traditional healers Celebrities and other influential personalities	Leaders take lead in the implementation, monitoring and evaluation of HIV/AIDS/SRH programmes Leaders fully support any efforts in the fight against HIV/AIDS in their communities Faith-based institutions (churches, Mosques) establish support groups for people infected and affected by HIV/AIDS	Increase leaders' involvement in the planning, implementation, monitoring and evaluation of HIV/AIDSA/SRH projects Increase material and financial support for HIV/AIDS/SRH activities in the communities	Train church leaders, sheikhs, chiefs, counsellors in project planning and management Mobilize communities to identify major HIIV/AIDS/SRH issues to address	Pastors, elders, deacons Hajjis, Bishops All cadres of religious leaders men's and women's guilds. Religious youth organization Media Traditional leaders themselves Health workers Training Seminars	Reported number of community leaders who participate in HIV/AIDS/SRH programmes Reported % of leaders trained in project planning and management Increased material and financial resources mobilized to support HIV/AIDS/SRH activities Increased number of media tours and field visits conducted to projects implementing HIV/AIDS/SRH activities	**Lead Org.** MOSYC **Partners** PSI, BLM, Media, CHAM, FPAM, MOEST, MOGYC-Dept of Youth NGOs

Chapter 6 BCI Strategy for Working with Policy Makers

Key Lead Organization: Office of the President and Cabinet
Partners: All Organizations working with Policy Makers

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

Segmented Social Groups
Parliamentarians, lawyers, cabinet ministers, senior civil servants and programme officers.

Policy makers are those vested with power or authority to take action to effect desired changes. While trying to cha nge behaviours of specific special groups, it is important to target lawyers, parliamentarians, and cabinet ministers, senior civil servants and programme officers so that they change necessary laws, legislations, policies, cultural practices and programmes that could help people to adopt and sustain positive behaviours.

There is a need to engage different policy makers in order to raise financial, material and human resources. It must be emphasized that political and social leadership commitment is crucial if HV/AIDS and SRH programmes are to achieve their goals and objectives.

A. Problem Behaviours

- **Unsafe sex practices**
  - There is lack of policy guidance and direction on HIV/AIDS/SRH issues as a result there are still practices that encourage first sexual intercourse around age 15 and perhaps as early as 12 to 13 during initiation. Harmful cultural practices are still observed in most communities.
  - There are inadequate financial resources for condom promotion especially female women.
  - In some cases policy makers indulge in risk practices, for example, they have multiple sexual partners because of their fame and money, which they can afford to spend.

- **Inconsistent health seeking behaviour**
  - There is great variation in terms of penalties handed to those who rape or defile.
  - There are no penalties at the moment for those who practice, for example, fisi, chokolo despite their negative effects in contributing to the spread of HIV and STIs

B. Barriers to Address:

1. Lack of National HIV/AIDS Policy
2. Lack of role models among policy makers
3. Stigma/secrecy and discrimination of those infected and affected by HIV/AIDS including STIs
4. Lack of Resources to Increase Access to HIV/AIDS/SRH Services
5. Preference by most Malawians to go to Traditional Healers first for HIVI/AIDS/SRH related illnesses or implications

Barrier: 1. Lack of National HIV/AIDS Policy

Problems Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
1.Unsafe sexual practices Age at first sexual intercourse is very low First intercourse occurs around age 15 and perhaps as early as 12 to 13 Most girls become pregnant and have children between the ages of 15 –19 **2.Inconsistent health seeking behaviours** Most people do not access health services (anti-retroviral drug therapies, contraceptives, VCT and STI treatment	Lack of guidance on key interventions/planning/coordination on how best to implement HIV/AIDS/SRH activities There are no specific programmes aimed at modifying or eliminating harmful cultural practices There are no laws against harmful cultural practices There are no specific regulations governing people living with HIV/AIDS at workplace There are no specific regulations regarding conditional testing of HIV (before marriage, insurance purposes, employment and studies)	Parliamentarians Lawyers Cabinet ministers Senior Civil servants Programme Officers Managers of private companies	Government through National AIDS Commission initiate development process for National HIV/AIDS Policy Government, private sector and NGOs adopt and implement the National HIV/AIDS Policy Government Departments NGOs, private sector develop and implement their HIIV/AIDS workplace policies base on the National HIV/AIDS Policy Policy makers promote HIV/AIDS policies within their organizations Policy makers ensure enforcement of laws against any violation of the policies	Increase political and social leadership and support for effective implementation of HVI/AIDS/SRH activities Promote coordination and leadership in the planning and implementation of HIV/AIDS/SRH programmes Promote ethical and professional panning, programming and implementation of HIV/AIDS/SRH activities according to accepted standards Set up an agenda that each organization can tap on issues that apply to their organizations	Conduct wider consultations for consensus building across all sectors on National HIV/AIDS policy development	Seminars Conferences Panel discussions Civil societies Media Parliamentary debates Sensitization meetings	Increased number of consensus building meetings conducted for the development of the policies Comprehensive National HIV/AIDS policy developed and adopted Increased number of private sector organizations developing their HIV/AIDS policies based on the National HIV/AIDS Policy Increased number of government departments developing their HIV/AIDS policy based on the National HIV/AIDS Policy Increased number of government departments, companies and NGOs mainstreaming HIV/AIDS Increased financial allocation for HIV/AIDS activities in the public and private sector	**Lead Org** OPC **Partners** MOHP H/rights NGOs Manaso PSI, BLM, Media, CHAM, FPAM, MOEST, MOGYC-Dept of Youth NGOs MOI

Barrier: 2. Lack of role models among policy makers

Problems Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
1.Unsafe sexual practices Age at first sexual intercourse is very low First intercourse occurs around age 15 and perhaps as early as 12 to 13 Most girls become pregnant and have children between the ages of 15 –19 **2.Inconsistent health seeking behaviours** Most people do not access health services (anti-retroviral drug therapies, contraceptives, VCT and STI treatment	Lack of individual commitment and willingness to take a leading role in advocating for HIV/AIDS/SRH issues Some policy makers do not adequately promote SRH/HIV/AIDS services (condom use, VCT, PMTCT and contraceptives)	Parliamentarians Lawyers Cabinet ministers Senior Civil servants Programme Officers Managers of private companies	More policy makers go for HIV test and disclose their status More policy makers especially those of child bearing age go for family planning Policy makers take lead in initiating and implementing HIV/AIDS/SRH projects in their organizations or areas Policy makers lobby for increased financial and material resources for implementation of HIV/AIDS/SRH activities	Promote role models among policy makers Promote social and political will and commitment in HIV/AIDS/SRH activities	Train policy makers on their role in HIV/AIDS/SRH education	Seminars Conferences Panel discussions Civil societies Media Parliamentary debates Sensitisation meetings	Increased number of policy makers who go for HIV testing and disclose their status Increased number of policy makers who use family planning methods Increased number of policy makers who share experiences on positive living Increased number of reported policy makers who address SRH/HIV/AIDS in meetings Increase number of people who access VCT, family planning methods and treatment for sexually transmitted infections	**Lead Org.** OPC **Partners** MOHP H/rights NGOs Manaso PSI, BLM, Media, CHAM, FPAM, MOEST, MOGYC-Dept of Youth NGOs MOI

Barrier: 3. Stigma/secrecy and discrimination of those infected and affected by HIV/AIDS including STIs

Problems Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
1.Unsafe sexual practices Age at first sexual intercourse is very low First intercourse occurs around age 15 and perhaps as early as 12 to 13 Most girls become pregnant and have children between the ages of 15 –19 **2.Inconsistent health seeking behaviours** Most people do not access health services (anti-retroviral drug therapies, contraceptives, VCT and STI treatment	Lack of knowledge on the rights of PLWAs among policy makers and the general public There is imbalance between human rights and customary law in relation to PLWAs and those affected by HIV/AIDS/STIs Lack of enforcement of laws against discrimination of PLWAs Stigma and discrimination make people not to go for HVI testing Stigma and discrimination make those who go for HIV test not to disclose their HIV status especially when found positive	Parliamentarians Lawyers Cabinet ministers Senior Civil servants Programme Officers Managers of private companies	More policy makers promoting the rights of PLWAs Policy makers formulate and pass laws that protect PLWAs Policy makers ensure enforcement of laws against individuals and employers that discriminate PLWAs More policy makers go for HIV test and disclose their status Traditional leaders observe customary laws that are supportive to the infected and affected people	Reduce stigma and stigmatization surrounding HIV/AIDS/SRH especially PLWAs and those infected with STIs Remove conflict between customary laws and international conventions in order to safeguard human rights especially for PLWAs Eliminate all forms of discrimination against PLWAs Increase number of policy makers who support PLWAs Promote open dialogue and discussion of HIV/AIDS/SRH issues	Train policy makers on human rights as they relate HIV/AIDS especially positive living Incorporate accepted customary practices into formal education, planning and legislation	Seminars Conferences Panel discussions Civil societies Media Parliamentary debates Sensitisation meetings	Increased number of lawyers and civil societies trained on human rights as they relate to HIV/AIDS Reduced number of reported forms of stigma and discrimination Increased % of people accessing VCT Number of laws passed protecting PLWAs and the affected Increased % of PLWAs who disclose their HIV status Increased number of support groups established (for those discriminated including PLWAs) Increased number of IEC materials adequately addressing issues of customary practices, stigma and discrimination	**Lead Org.** OPC **Partners** MOHP H/rights NGOs Manaso PSI, BLM, Media, CHAM, FPAM, MOEST, MOGYC-Dept of Youth NGOs MOI

Barrier: 4. Lack of Resources to increase access to HIV/AIDS/SRH services

Problems Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
1.Unsafe sexual practices Age at first sexual intercourse is very low First intercourse occurs around age 15 and perhaps as early as 12 to 13 Most girls become pregnant and have children between the ages of 15 –19 **2.Inconsistent health seeking behaviours** Most people do not access health services (anti-retroviral drug therapies, contraceptives, VCT and STI treatment	Inadequate health facilities providing STI treatment and HIV testing in most communities Shortage of essential drug to treat opportunistic infections and STIs in most hospitals, health centres and clinics Lack of anti-retroviral drug therapies in hospitals, health centres and clinics Shortage of highly trained health personnel Lack of high quality SRH/HIV/AIDS services Lack of emergency transport at health centre, clinic and community level (e. g. bicycles and bicycle ambulances) There is poor communication infrastructure at health centres (most health centres have no telephones, wireless message equipment)	Parliamentarians Lawyers Cabinet ministers Senior Civil servants Programme Officers Managers of private companies	Policy makers ensure constant supply of drugs at health centres including ARVs, reagents, contraceptives and drugs used to treat opportunistic infections More people satisfied with HVI/AIDS/SRH services offered in health centres Policy makers mobilize resources for recruitment and training of more health personnel Policy makers advocating for provision of HIV/AIDS/SRH services within easy reach Policy makers allocate more funds to the health sector for procurement of equipment (communication, transport, essential health machines)	Increase people's access to HIV/AIDS/SRH services	Mobilize communities to establish community based service delivery points and change agents Train more community-based agents in service provision (youth club leaders, TBAs, CBDAs, HSAs) .	Seminars Conferences Panel discussions Civil societies Media Parliamentary debates Sensitisation meetings	Increased % of clients who report satisfied with HIV/AIDS/SRH services offered at health centres, clinics and hospitals Increased % of PLWAs accessing free ARVs and other essential drugs for treatment of opportunistic infections and STIs Increased % of financial allocation for HIV/AIDS/SRH services from both public and private sector Increased number of community- based delivery points for HIV/AIDS and SRH services Number of community based agents trained in HIV/AIDS/SRH service provision	**Lead Org.** OPC **Partners** MOHP H/rights NGOs Manaso PSI, BLM, Media, CHAM, FPAM, MOEST, MOGYC-Dept of Youth NGOs MOI

Barrier: 5. Preference by most Malawians to go to Traditional Healers first for HIVI/AIDS/SRH related illnesses or implications

Problems Behaviours	Barriers	KSG Segmented	Desired Behaviours	Strategic Objectives	BCI	Channels	Indicators	Responsibility
1.Unsafe sexual practices Age at first sexual intercourse is very low First intercourse occurs around age 15 and perhaps as early as 12 to 13 Most girls become pregnant and have children between the ages of 15 – 19 **2.Inconsistent Health seeking behaviours** Most people do not access health services (anti-retroviral drug therapies, contraceptives VCT and STI treatment	There are still strong beliefs, misconceptions and myths that traditional medicines are more powerful than modern medicines Long waiting in most health centres before one gets treatment makes clients to visit traditional healers where there is no waiting Poor attitude of some service providers force clients to seek services from traditional healers Lack of knowledge by clients that treatment at traditional healers is done without proper diagnosis Referrals to formal health centres are not made, sometimes are made but too late Popular belief that some traditional headers cure AIDS	Parliamentarians Lawyers Cabinet ministers Senior Civil servants Programme Officers Managers of private companies	People access HIV/AIDS/SRH services from formal health centres More people satisfied with HVI/AIDS/SRH services offered at formal health centres Policy makers advocating for provision of HIV/AIDS/SRH services within easy reach Policy makers ensure constant supply of drugs at health centres including ARVs, reagents, contraceptives and drugs used to treat opportunistic infections Formal health service providers offer health friendly services to all clients Traditional healers make referrals AIDS	Increase policy maker's involvement in the planning, implementation, monitoring and evaluation of HIV/AIDSA/SRH projects Increase material, human and financial support for HIV/AIDS/SRH activities in the communities Increase people's access to appropriate HIV/AIDS/SRH services Promote health friendly service provision in all health centres Strengthen referrals by traditional healers to formal health centres Promote referrals by traditional healers to formal health centres	Train traditional healers on HIV/AIDS/SRH issues Train/conduct refresher courses for nurses, health assistants and doctors on HVI/AIDS/SRH service provision	Seminars Conferences Panel discussions Civil societies Media Parliamentary debates Sensitization meetings	Reduced number of clients who report going to traditional healers first before formal health centre Reduced number of people accessing HIV/AIDS/SRH related problems from traditional healers Increased number of clients referred to formal health centres by traditional healers Increased number of traditional healers trained in HIV/AIDS/SRH issues Increased financial support to traditional healers including Herbalist Association of Malawi for HIV/AIDS/SRH related activities	**Lead Org.** OPC **Partners** MOHP H/rights NGOs Manaso PSI, BLM, Media, CHAM, FPAM, MOEST, MOGYC-Dept of Youth NGOs MOI

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