SIGNIFICANCE OF TARGET POPULATION IN BEHAVIOUR CHANGE COMMUNICATION: THE CASE OF ZOMBA DISTRICT.

MA Thesis by

JOEL SUZI

Submitted to the University of Malawi, Chancellor College in Partial Fulfillment of the Requirement for the Degree of Master of Arts in Theatre and Media for Communication in Development

July 2008

DECLARATION

I, **Joel Suzi**, hereby certify that this is my own original work and has not previously been submitted in part or in full for any examination and is being submitted for examination with my full knowledge and authorization.

Signature: …… **Date:** ……

CERTIFICATION

We certify that this thesis has been submitted to the University of Malawi – Chancellor College with our approval.

Main Supervisor:	..……	……	…….
	Name	Signature	Date
Head of Department:	……	……	……..
	Name	Signature	Date

DEDICATION

In inspirational memory of late brother Jimmy Bowman Banda, I sincerely dedicate this work to my parents, Nathan and Rhodiana Suzi-Banda. "*Angoni saatha onse"*

ACKNOWLEDGEMENTS

Glory be to Lord Yahweh Almighty for the life, opportunity and ability.

I gratefully acknowledge all individuals and institutions that cooperated in contributing information in the production of the thesis. I am especially very appreciative to Mr. Clement Mwazambumba – Zomba District AIDS Coordinator, Mr. Chilunda – IEC officer Zomba District Health Office, Mr. Alinafe Namondwe and entire Hope for Life officers and volunteers, Mr. Symon Joseph and the Lambulira AIDS Support Organization (LASO), the chairman of Magomero AIDS Support Organization and, more greatly, the Lambulira and Magomero communities. Likewise, I am also thankful to Mr. David Nyirongo of NAPHAM and the National AIDS Commission (Resource Centre).

I am hugely indebted to Dr. Mufunanji Magalasi and Mr. Joe Chimwenje for their diligence, optimism, dedication, direction and unflagging support rendered as supervisors in the production of the thesis.

To all classmates and friends, I will always cherish the cheery moments without which my stay through the study period would have been lackluster. I am particularly thankful to Ms Lusizi Mhoni for being a motivating colleague.

Finally, I am very grateful to my family for their belief and support.

ABSTRACT

The study explores communication strategies and message development in community-based behaviour change interventions in Zomba District. The study critiques roles of implementing organisations and target communities in implementation of the discovered portfolio of activities that includes peer education, counselling sessions, Stepping Stones, drama, poetry, motivational talks and print media. The study conjectures whether the approaches to implementation of the activities ascertain active involvement of the target people and dialogue-based approaches. This is guided by insights from theoretical framework of behaviour change communication and national policy and strategic guidelines for behaviour change interventions (BCI) and HIV communications.

The ultimate lesson from this study is that best practice of behaviour change communication entails precedence of collaborative, interactive and dialogic approaches. The study detects poor interaction mechanism among intervening organizations and targeted people as implementing organizations marginalise ordinary community members in making and implementation of decisions regarding development of messages and delivery of communication methods. In the light of the theoretical overview, such a scenario compromises the effectiveness of the community-based interventions in motivating change in the community.

The study also concludes that the community-based organizations (CBOs) lack established implementation guidelines for behaviour change communications (BCC) which could be significantly contributing to such a scenario. To this effect, the study suggests familiarization of stakeholders to available national guidelines to HIV/AIDS communications whose potential has been theoretically validated.

Overall, the present study's has managed to substantiate the linkage of communication variables to the trends of behaviour change and sets the rationale for further experimental study on the context communication approaches behaviour change status among the Malawian population.

ACRONYMS

AIDS	Acquired Immuno-Deficiency Syndrome
ARRM	AIDS Risk Reduction Model
BCC	Behaviour Change Communication
BCI	Behaviour Change Intervention
CBO	Community-Based Organization
DAC	District AIDS Coordinator
ETR	End of Term Review (of the Malawi National HIV and AIDS Strategic Framework 2000-2004)
FBO	Faith-Based Organisation
FHI	Family Health International
HBC	Home-Based Care
HIV	Human Immuno-deficiency Virus
IEC	Information, Education and Communication
LASO	Lambulira Aids Support Organization
MANASO	Malawi Network for AIDS Service Organizations
MANET+	Malawi Network for People Living with HIV and AIDS
MASO	Magomero Aids Support Organization
MDHS	Malawi Demographic and Health Survey
NAC	National AIDS Commission
NACP	National AIDS Control Programme
NAF	National HIV and AIDS Action Framework 2005-2009

NBCIS	National Behaviour Change Interventions Strategy for HIV/AIDS and Sexual Reproductive Health
NGO	Non-Governmental Organization
NSF	Malawi National HIV and AIDS Strategic Framework 2000-2004
PLHIV	Persons Living with HIV and AIDS
PDC	Participatory Development Communication
UNAIDS	Joint United Nations Programme for HIV and AIDS
VCT	Voluntary Counselling and Testing
YONECO	Youth Network and Counselling

TABLE OF CONTENTS

CHAPTER THREE

CRITICAL OVERVIEW OF NATIONAL GUIDELINES FOR BEHAVIOUR CHANGE COMMUNICATION AND CASE STUDY DESCRIPTION………………..………...……………………...………………58

CHAPTER FOUR

CHAPTER FIVE

LIST OF FIGURES

CHAPTER ONE

INTRODUCTION

This chapter is about the context of the study. It sets out to present an overview of national epidemiological and response trends of HIV in light of the global situation. More importantly the chapter contains a statement of the problem, an explication of the purpose and the methodology of study as well as an overview of the conceptual framework.

1.1. BACKGROUND AND LITERATURE REVIEW

The HIV epidemic is one of the most catastrophic of modern human problems. Since its onset nearly three decades ago, the HIV and AIDS epidemic remains a critical global challenge.

UNAIDS Annual Report 2007 estimated that 33.2 million people worldwide were living with HIV; a slight but encouraging drop from the 39.5 million people in 2006. Locating 70% of global infections, the sub-Saharan African region remains the global epicentre of the epidemic. According to the UNAIDS AIDS Epidemic Update December 2007, more than 68% of the adult population and nearly 90% of children were infected with HIV live in this region, and more then 76% of

global AIDS deaths in 2007 occurred there. As regards prevalence levels, the aforementioned update indicates an overall decline across the globe. For instance, it is estimated that 1.7 million people were newly infected with HIV in 2007, bringing to 22.5 million a total of people living with the virus, declining from 38.6 million in 2006[1].

In Malawi, despite over 20 years of national response efforts since the first case of AIDS in the country was diagnosed in the mid 1980s, incidence rates and impact have aggregately dominantly been steadily high. However, the aforementioned UNAIDS 2007 epidemic update, indicates the prevalence rates have been stabilizing and reducing since the mid 1990s. According to the National HIV Prevalence Estimates Report for 2001 by Malawi National AIDS Commission, in 2001, Malawi's national adult prevalence was estimated at 15%, translating into almost 740,000 adults living with HIV. The Malawi Health and Demographic Survey 2004 (MDHS 2004) estimated national adult HIV prevalence at 12% translating to around 1.3 million people[2]. More recent, the ANC Sentinel Survey Report for 2007 estimates HIV prevalence at 12% among adults (15-49 years old) reflecting a continuing decline from 15% in 2005 and 14.4% in 2003.

[1] UNAIDS, Epidemic Update 2007, p. 15
[2] MDHS 2004, p. xxiv

Various review studies on the response efforts in Malawi have attempted to explain the cause of such decline and stabilization in infection and prevalence rates. The UNAIDS 2007 AIDS Epidemic Update recognizes existence of evidence of behavioural changes that can reduce the risk of acquiring HIV infection[3]. On the other hand, the ANC Sentinel Survey and Malawi National HIV and AIDS Monitoring and Evaluation Reports for 2007 and 2005 concur in attributing such decline, among other factors, to the impact of programmatic behaviour change interventions nationwide.[4]

In the face of both antecedent and consequent social, economic, cultural as well as political challenges due to the HIV epidemic, efforts have widely been established at both international and local levels. Policy and institutional foundations have been put in place in various countries with increasing political commitment and partnerships established in coordinating international and local response efforts. UNAIDS reports for 2006 recognized that many countries are succeeding in response efforts meant to slow or reverse HIV infection rates, improving treatment and care services as well as confronting related social, economic and cultural challenges[5].

[3] UNAIDS, Epidemic Update 2007, p.17
[4] NAC, Sentinel Survey Report 2007, p. 21
[5] UNAIDS, Annual Report 2006, p5

1.1.1. National Response Efforts to the HIV Epidemic in Malawi

According to the Malawi HIV and AIDS M&E Report for 2007, since the first HIV case was reported in 1985, response efforts and mechanisms in Malawi have been instituted by both government and non-government organizations with policies and strategies laid for guidance. Initially, Malawi's response to the HIV and AIDS epidemic was slow as public discussion of sex and sexuality was not condoned during the one-party rule. Nonetheless, mechanisms were being put in place to guide the response to the new epidemic. The National AIDS Control Programme (NACP) was established under the Ministry of Health in 1989 to coordinate the national response. Early efforts included and broad national awareness campaign to ensure that Malawians were aware of the HIV and AIDS epidemic.

Five-year strategic planning and implementation frameworks for response efforts have well been adopted since 1989 when the Ministry of Health developed the Medium Term Plan (MTP-I) that covered the period 1989 - 1994. The plan drew emphasis on blood screening for safe transfusion, public awareness and placement of frameworks for surveillance of the epidemic. This was followed by Medium Term Plan (1995-99) (MTP-II) that focused on mobilization of resources for response efforts and setting up of care and treatment programmes for persons living with HIV and AIDS. The MTP-II was succeeded by the National Strategic

Framework (NSF) for the period of 2000-2004. The overall goal of the NSF was to reduce incidence of HIV and STIs and improve the quality of life of those infected and affected by HIV and AIDS. Within the five-year implementation period of the NSF (2000-2004) several significant structural changes happened. Key among these changes was the replacement of NACP with the National AIDS Commission (NAC) under the Office of President and Cabinet in 2002, and the launching of National HIV and AIDS Policy in 2003. Guided by the NSF and the standpoints of the established policy, NAC coordinated with various stakeholders to develop guidelines for delivery of various HIV and AIDS services such as testing and counselling, and prevention of mother to child transmission (PMTCT).

The policy provides guiding principles and clarifies priority areas for the national response. In the light of the lessons from the End of Term Review of NSF (ETR of NSF), the National HIV and AIDS Action Framework (NAF) was developed for the five-year period of 2005 - 2009. The NAF is established as the overall implementation strategy for mobilizing broader and multi-sectoral involvement in the national fight against the epidemic. Its overall goal being to prevent the spread of HIV infection among Malawians, provide access to treatment for PLHIVs and mitigate the health, socio-economic and psychological impact of the HIV and AIDS epidemic on individuals, families, communities and the nation. NAF espouses eight key priority areas for the national response activities, namely:

prevention and behaviour change; treatment, care and support; mitigation: socio-economic and psychological impact; research and development; monitoring and evaluation, resource mobilisation, tracking and utilisation, and national policy, coordination and programme planning. A number of strategies have been put in place to guide implementation of the NAF and these include the National Behaviour Change Strategy for HIV/AIDS and Sexual Reproductive Health (NBCIS); HIV and AIDS Mainstreaming Framework; Ant-retroviral Therapy (ART) Equity Policy Paper; Impact Mitigation Framework among others[6].

NAC plays the role of leadership authority in the institutional framework for planning and delivery of interventions in the national response, which includes public and private institutions, NGOs, faith-based organizations (FBOs) and community-based organizations (CBOs)[7].

1.1.2.The Context of HIV related Behaviour Change in Malawi

With no medical cure or vaccine breakthrough yet, prevention of infection remains crucial in prospect of success in the fight against the HIV epidemic. UNAIDS 2006 Annual Report explains that HIV infection is first and foremost a consequence of sexual behaviour with 90% of all infections principally contracted

[6] NAC, HIV and AIDS M&E Reports. 2007, pp 5-7 & 2005, pp 4-5
[7] NAC, ETR of NSF, 2004, pp 29-32

through sexual intercourse. Hence, behaviour change, as individual and collective modification or change of risk-related sexual behaviours remains key to prevention and reduction of vulnerability to HIV infection[8].

Overall policy and strategic issues in terms of national objectives, goals and suggested activities for behaviour change have importantly been set in the National HIV and AIDS Policy and the National HIV and AIDS Action Framework 2005-2009 (NAF). The overall national goal for prevention and behaviour change is to reduce the spread of HIV in the general population and in high-risk subgroups such as sex workers and truck drivers. In pursuit of this goal, the NAF espouses a variety of strategies and action areas to guide effective communication for behaviour change, which define type of interventions, approaches, defined roles of stakeholders and guide effective execution of activities. These have been reinforced within the National Behaviour Change Interventions Strategy for HIV and AIDS and Sexual Reproductive Health (NBCIS) which was commissioned in 2003 to guide the planning and implementation of behaviour change interventions. The NBCIS explicates three complementary and interrelated thematic areas for operationalising behaviour change interventions, namely: *Information, Education and Communication (IEC), Community Mobilisation* and *Advocacy*. Against each of the three thematic areas,

[8] Parker W. M et al., 2000, pp 5-6

NAC has developed sets of guidelines for BCI implementation and HIV and AIDS communication meant to be used by stakeholders from government, NGOs, CBOs, faith-based organisations, District Assembly, training institutions, committees and associations at community level. The guidelines define the goals, objectives for conducting advocacy, social mobilization and IEC interventions; and also outline the essential principles and practices for the successful implementation of communication interventions.

At field level, behaviour change interventions have been undertaken by the government through the National AIDS Commission and Ministry of Health; non-governmental and faith-based organizations such as World Vision Malawi, Actionaid, Care International and Youth Net and Counselling (YONECO). Lined interventions include: national mass media awareness campaigns, targeted and interpersonal communication initiatives, training and support of local institutions. In this framework, significant roles have also been undertaken by community-based organisations that coordinate with partners drawn at area, district, regional and national levels in directly reaching out to the majority of the population at the grassroots. Despite extensive activity in behaviour change interventions, various studies and reports such as the MDHS 2004, ETR of NSF and the Malawi HIV and AIDS M&E Report 2007 concurrently indicate slow progress in terms of people's adoption and maintenance of safe behaviours. Significant progress is

reported to have been done in terms of widespread awareness of facts about the epidemic among the general population. For example, MDHS 2004 indicates that knowledge of AIDS being almost universal among women and men in Malawi[9]. Conversely, the widespread awareness appears to be failing to necessitate commensurate behaviour change. Since the start of formal response efforts, high-risk behaviours persistently dent the appreciation of progress in the national HIV and AIDS response. As evidenced in subsequent evaluation of the Medium Term Plan (1994-98) (MTP-II), through the End of Term Review of Malawi National Strategic Framework (NSF) 2000-2004 as well as the MDHS (2004), and the Malawi HIV and AIDS M&E Report 2005[10], the proportion of people engaging in high-risk sexual behaviours has either increased or remained stagnant over years. For example, 62.1% of males aged between 15 and 24 reported to have engaged in sex with non-marital and non-cohabiting partners during the 2004 Malawi Demographic and Health Survey; an increase from 56.0% that was reported during a similar survey in 2000[11]. Though sparse, literature available on behaviour change trends in Malawi substantiates this scenario and some attempts to speculate the causative factors.

Both the Malawi HIV and AIDS M&E Reports for 2005 and 2007 chiefly allude

[9] MDHS 2004, pp. 186-187
[10] NAC, 2004. ETR of NSF: p. iv concurring with Malawi HIV and AIDS M&E Report 2005, pp. 12-13
[11] Malawi HIV and AIDS M&E Report 2005, p. 43

to the socio-economic and cultural contexts as prominently factoring risky behaviours hence increasing vulnerability of the population to infection. Illustratively, the report picks out on socio-economic and cultural factors as responsible for poor knowledge about HIV prevention among rural women.[12] On the other hand, Kondowe et al. (1999) critique challenges within programme frameworks of behaviour change interventions. First, their study reveals existence of poor research frameworks in which a number of research studies have been undertaken but are not accessible to inform appropriate interventions[13]. Secondly, the Kondowe et al. (1999) implicates poor networking of implementing organizations for duplication of efforts among population groups, critical of the fact that no information is exchanged leading to wastage of resources[14]. In this case, organizations may conduct baseline research, program reviews not sharing lessons or best practices with other institutions. Furthermore, the aforesaid study also expound the shortfall among some organizations whose policy or strategic approaches tend to be judgemental and insensitive to the cultural context of target populations despite their potential value in other circumstances. In their study, they mention an example of a prominent Malawian organisation that has consistently been hostile to local cultural issues along its interest on condom

[12] Malawi HIV and AIDS M&E Report 2005, p. 44
[13] Kondowe E. B. Z et al., 1999, p. 13
[14] Ibid, p. 14

use.[15]

1.2. STATEMENT OF THE PROBLEM

Reflections from the explication of the explored behaviour change theories and overview of the behaviour change process, communication features as prominent element of behaviour change[16]. Policy and strategic frameworks guiding HIV and AIDS response in Malawi have importantly recognised this value by incorporating special guidelines for programming HIV and AIDS communications. However, theory-based study on the relevance of the dynamics of communication to the context of behaviour change trends in Malawi is lacking. Missing specifically are experimental analyses attempting to examine competency and effectiveness of the communication approaches in behaviour change interventions (BCI) in Malawi. As can be verified from a cross-section of literature reviewed for this study, much critical attention appears directed at factoring the problem in the social, economic and cultural issues such as poverty and initiation ceremonies. Attempts to tackle issues relating to programme frameworks of BCI as demonstrated by Kondowe et al. (1999) have lacked theory-based critique of communication issues. This accounts to a crucial shortfall in the quest to explain the basis of the persistent slowness and stagnation of

[15] Kondowe E. B. Z. et al., 1999, pp. 13-14
[16] UNAIDS & PENN STATE, 1999, p. 19

achievement of positive behaviour change in Malawi.

1.3. OBJECTIVE OF THE STUDY

The current study mainly investigated the designing and implementation processes of community-based behaviour change communication interventions so as to appreciate their value in ascertaining *active involvement and empowerment of target community players* and *dialogue-based approaches,* as active elements of effective BCC.

To achieve the main objective, following specific objectives were drawn:

- Examine the procedures and approaches for development of messages and appropriation of communication methods.
- Investigate the terms of collaboration among the stakeholders in light of principles of BCC which espouse participatory approaches that entail dialogue among stakeholders with emphasis on active roles for target communities at all stages of intervention.
- Explore the level and manner of awareness and application of national guidelines for programming communication for HIV among implementers of community-based interventions.

On each of the specific objectives, the collection of empirical field data among

selected informants at district and community levels was preceded by a comprehensive study of relevant national strategic provisions in the National HIV and AIDS Policy, NSF, NBCIS as well as the guidelines for HIV communications.

1.4. SIGNIFICANCE OF THE STUDY

As mentioned above and is explained under the theoretical framework below, success in behaviour change relies on a set of factors including social, religious, economic, and cultural as well as communication (as in type, quality and means by which information is disseminated)[17]. According to PATH and IPAS (2005) communication is an exceptionally significant element in drawing effective strategies behaviour change interventions[18]. Thus examining the milieu of communication in relation to behaviour change trends is an equally important direction of inquiry.

In view of the shortage of theory-based studies on the local context of behaviour change communication, this study set out to investigate the viability of communication values and practices in community-based behaviour change interventions to ascertain behaviour change among the target population. The

[17] Malawi HIV and AIDS M&E Report 2005, p. 12
[18] PATH & IPAS, 2005, p. 3

study is anticipated to illuminate innovative insights for policymakers and other implementing stakeholders, from the national to the grassroots levels on better practices in planning and implementation of policy and strategic frameworks for effective community-based HIV and AIDS behaviour change communication interventions in the country.

To the present writer, the present study was set not only as a fulfilment of an academic requirement but, more importantly, as a scholarly critical response to the call by the Malawi National AIDS Commission for involvement of all sectors of society towards the promotion of interventions to reduce high-risk sexual behaviour[19].

1.5. THEORETICAL FRAMEWORK

1.5.1. An Overview of Behaviour Change Theories

HIV preventions strategies and interventions have prominently been underpinned by principles of various psychological as well as communication theories (herein also referred to as models). Prominent theories such as the *Health Belief Model, Theory of Reason Action, Stage Models of Change, Social Cognitive (or Learning),* and *AIDS Risk Reduction Model (ARRM)* concur in reflecting that

[19] NAC, 2003, p. 1

change in individual behaviour happens by altering a person's perceptions and attitudes as well as unsafe social relationships. On the other hand, *Diffusion of Innovations Theory, Social influence* or *Social Inoculation Model* and *Social Marketing Theory* exemplify theories which share the presupposition that social environment significantly shapes a person's behaviour[20]. According to this perspective, effective prevention efforts, especially in vulnerable communities that do not have the larger societal support, will depend on the development of strategies that can enlist community mobilization to modify the norms of this peer network to support positive changes in behaviour[21].

1.5.1.1. Health Belief Model

The key assumption under the *Health Belief Model* is that health related behaviour is dependent on individual's socio-demographic characteristics, knowledge and attitudes, which influence personal beliefs. The process of change in behaviour sets off from individual level through comparative perception of risks at hand, benefits of effectuating change against costs and barriers to it which is affected by a number of interrelated factors. Such factors include: *perceived risk* - understanding how HIV infection would affect them personally and that they perceive their behaviour to be risky*; self-efficacy* - belief that the positive

[20] UNAIDS, Sexual behavioural change: Where have theories taken us?, 1999. p. 6 & 19
[21] Ibid, p. 8

consequences to change would outweigh the negative consequences; *confidence and skills* necessary to avoid unsafe behaviour, or negotiate safer behaviour with partners and to resist social pressures and; and *perceived norms* – perception of behaviour of other people in the community[22].

Interventions following the *Health Belief Model* often target perception of risk, beliefs in severity of AIDS, beliefs in effectiveness and benefits of available prevention methods available and their benefits or delaying onset[23].

1.5.1.2. Theory of Reasoned Action

Since late 1960's, The *Theory of Reasoned Action* attempts to explain individual behaviour by linking attitude, beliefs, and behavioural intentions; observed and expressed actions. Underlying the theory is the assumption that people achieve behaviour change systematically on the basis of rational consideration of the implications of their actions, social context and self-efficacy which shape a person's intention to perform behaviour[24].

The *social cognitive or learning theory* assumes that new behaviour is principally learned from others or by one's direct experience with the environment or own

[22] Glanz et al, 2002, p. 52-53
[23] UNAIDS, Sexual behavioural change: Where theories have taken us?, 1999, p. 6
[24] Jemmott, L.S et al., 1991, pp. 228-34

physiology. Bandura (1986) asserts that the belief of confidence in the ability to implement change to from risky to safer behaviour –self efficacy, and expectation of the viability of the outcome of the implementation are the central precepts of the theory.

Interventions bearing the *social cognitive* theoretical outlook specifically tend to focus on people's experiences in discussing sexuality and safer behaviour as condom use with their partners; the beliefs about adopting condom use, and the types of environmental or community-based barriers to achieving risk reduction i.e. behaviour change[25].

1.5.1.3. Stage Theories of Change

The basic concept underlying the *Stage Theories of Change* is that individual behaviour change goes through a process involving a series of interrelated stages. The theory presupposes that individual behaviour change progresses through a series of stages, namely: *pre-contemplation*: no consideration of severity of problem and need for change; *contemplation*: recognition of the problem and the need to change; *preparation for action*: intention to change within a given time;

[25] UNAIDS, Sexual behavioural change: Where theories have taken us?, 1999, p. 7

action: an individual enacts consistent behaviour for less than 6 months; *maintenance*: an individual sustains new behaviour for six months or more[26].

Prochaska and DiClemente (1986) assert that behaviour change occurs in a cyclic process involving both progress and periodic relapse with people likely moving back and forth between the stages, before moving once again through all the stages. Stabilization of behaviour and the avoidance of relapse are viewed as characteristic of the maintenance stage.

A series of contextual factors exert influence on the progress of an individual through the stages. Socially, key factors include: nature of personal relationship, age, gender, access to knowledge and/or information. Key cultural factors include the behaviours, attitudes, personal and shared values and morality considered acceptable in given contexts.[27]

1.5.1.4. AIDS Risk Reduction Model (ARRM)

Since early 1990s, behaviour change efforts have largely been conceptualised upon the AIDS Risk Reduction Model (ARRM). The model principally infers ideas from other theories, most especially the *Health Belief Model, Social*

[26] Prochaska, J.O. et al., 1986, pp. -27
[27] Oldenburg, B et al., 1999, pp. 503-516

Cognitive Theory and the *Stages of Change Theory*.

The ARRM provides a three-stage framework to explain the process individuals or communities pass through while changing HIV related behaviour. The model conjectures emotional influences and social processes as having influence on the success of the change process through the stages.

The stages in ARRM include: first, *recognition and labelling* of ones behaviour as high risk influenced by perceived HIV susceptibility, as well as aversive emotions; second, *commitment to change* shaped by perceptions of self-efficacy, social norms as well as aversive sentiments; and thirdly, *taking action*, which includes seeking and accessing of sexual information and remedies, and enactment of solutions. Personal emotions, available information, social networks affect the problem-solving choices and decision-making of people in the last stage. Interventions conceived on the ARRM model focus on assessing levels and manners of people's risk; influencing the decision to reduce risk through positive perceptions of enjoyment or self-efficacy and supporting their enactment of change. [28]

1.5.1.5. Diffusion of Innovation Theory

Developed by Rogers, (1983), *Diffusion of Innovation theory* essentially explains

[28] UNAIDS, Sexual behavioural change: Where theories have taken us? 1999, p. 8.

achievement of behaviour change in the light of the process of how new ideas or innovations are disseminated and adopted throughout a target community over time.

According to Rogers (1983), the theory hypothesizes that behaviour diffuses within the societal networks and that people presumably adopt new behaviours from favourable evaluations by highly regarded social members. The theory is marked by four elements that determine the process of behaviour change: the *idea or innovation* sought to be adopted; its communication (channels or processes); the *social system* as in networks among peers, family, friends etc.; societal norms, values and beliefs; and *time* for the innovation to reach target population and different intervals at which people receive and/or accept messages.

Interventions founded on the *Diffusion of Innovation Theory* generally adopt the usage of role models or local leaders in dispersing messages within a target community.[29]

1.5.1.6. Social Influence or Social Inoculation Model

This model is based on the concept that young people engage in behaviours including early sexual activity partly because of general societal influences, but more specifically from their peers.

[29] Ibid.: p9

The model suggests interventions that apply actual examples or cases of social challenges, risky behaviour and outcomes to teach them to examine and develop skills on how they can deal with such. The model often relies on role models such as teenagers slightly older than programme participants to present factual information, identify pressures, role-play responses to pressures, teach assertiveness skills and discuss problem situations[30].

1.5.1.7. Social Marketing Model

Drawing its basic tenets from the principles of marketing and incorporating ideas from a variety of the aforementioned individual psychology theories as well as dynamics of mass communication, the *Social Marketing model* might not deserve the identity of a theory but a framework for promoting the acceptability of ideas and innovation.

The Social Marketing model focuses on four key elements, which include: first, *development of a product*; second, *promotion of the product*; third, *place*; and fourthly, *price*[31].

As is also demonstrated in Malawi, the social marketing approach has widely

[30] Howard M, et al., 1990, pp. 21-26.
[31] UNAIDS, Sexual behavioural change: Where theories have taken us?, 1999, p. 20

been applied in promotion of condom use with measurable success as in the case of Population Services International[32].

In the light of the theories of behaviour change, HIV prevention interventions basically come from development and practice of risk-reduction skills building on personal perception, reasoning and the societal context, in the gradual process of change. The societal context herein includes social, economic as well as cultural issues. Across the theories, the process of change is presumed to start with personal or social consciousness of the existent socio-demographic characteristics, knowledge, attitudes and practices which define the behaviour context[33]. The said consciousness is set to be induced by information on the context hence the subject and milieu of communication emerges as a key feature in the process of behaviour change. Subsequently, the success in behaviour change has been recognised to be equally dependent on the dynamics of communication in terms of type and quality of information, as well as networks by which that information is disseminated[34].

FHI (2002) assert that as a prerequisite to change in behaviour, individual and community targets must access *information* to raise their awareness about the

[32] Ibid.
[33] FHI, 2002, pp. 5-6
[34] Malawi HIV and AIDS M&E Report 2005: p12

basic facts of the epidemic, adopt desirable attitudes and practices; and should be *educated* or *taught* safer behaviour skills.[35] Thus communication processes are significant to behaviour change. This does establish the dynamics of information and communication as a key feature in the process of behaviour change and a potent variable for understanding the progress of the process. Evidently, in sub-Saharan Africa, a comparative appreciation of behaviour change interventions experience of Uganda is usually referred to as demonstrating how approaches to communication influence behaviour change trends. The experiences of Uganda since the onset of response efforts in the mid 1980s demonstrate the significance of precedence of interpersonal approaches to communication in behaviour change interventions.[36] Uganda boasts of improved trends of awareness, popular participation, positive behaviour change and ultimate reduction in prevalence rates due to interpersonal communication approaches to behaviour change interventions and HIV and AIDS communications in general, as compared to other countries where mass media and a series of one-way top-down strategies have dominated.[37]

1.5.2. Theoretical Overview of Behaviour Change Communication

The present study employs a theoretical base linking the principles of behaviour

[35] FHI, 2002, pp. 5-6
[36] Low-Beer & Stoneburner, 2004, p. 2
[37] Low-Beer & Stoneburner, 2004, p. 5

change communication to those of participatory development communication. Principles of BCC and participatory development communication commonly emphasize application of participatory approaches to individual and social change interventions intended towards *mobilization* and *empowerment* of the target people to cooperate and make use of their potentials to articulate and manage the processes of their change, respectively[38].

The contemporary strategic outlook of HIV behaviour change interventions, communication has become an important self-directing integral component with its strategic activities established under the specialist discipline called "behaviour change communication" (herein to be abbreviated as BCC) [39].

Though at times confused with Information, Education and Communication (IEC), BCC is in itself a unique concept. Explaining this outlook, FHI (2002) defines IEC as development of communication strategies and production of discrete support materials aimed at influencing behaviour among specific target groups. On the other hand, BCC is defined as an interactive process with communities to develop messages and approaches using a variety of communication channels to develop positive behaviour s; promote and sustain

[38] Melkotte S., 1991, p. 228 and Low-Beer & Stoneburner, 2004, p. 6
[39] PATH & Ipas, 2005, pp. 3

individual, community and societal behaviour change; and maintain appropriate behaviour s.[40]. Similarly, PATH & Ipas (2005) explain BCC as strategic, evidence-based communication activities that help bring about personal and interpersonal changes (in knowledge, perceptions, beliefs, attitudes and skills) which empower people to exploit new freedoms and to absorb new ideas leading new behaviours[41].

FHI (2002) and PATH & Ipas (2005) illustrate succinct criteria for planning and implementing BCC strategy whose elements correspond to those addressed in the national guidelines for BCI and HIV and AIDS communications in Malawi. Gradually, key elements include: *definition and integration of programme objectives and goals, identification of target population, formative assessment, identification of implementation stakeholders, development and channelling of message, and monitoring and evaluation plan.* All through these elements, participatory approaches are emphasised. Interventions are set to be inclusive; engaging involvement of various stakeholders from the policymakers to the grassroots; more essentially, the target people emerges. According to UNAIDS & PENN STATE (1999), the rationale behind application of participatory approaches in BCC is to increase the opportunity for close interaction between the

[40] FHI,2002, p. 3
[41] PATH & Ipas, 2005, p. 3 & 5

target people and message sources so as to help the people solve their own behavioural problems[42].

As regards participatory development communication (herein abbreviated as PDC), the present study samples the perspectives of White (2003) and Melkotte (1994). According to Melkotte (1991), PDC denotes a communication process in which target populations identify and discuss their needs, conceptualize and decide on plan of action, and then use a specific communication medium of their choice for conveyance of information based on their appropriate needs[43]. This ascertains people's control not only over their communication processes but own change processes and the environment that affects their behaviours as well. As White (2003) understands, as a community comes together to identify their own challenges, suggest solutions and develop messages, their interaction functions as catalyst for action knowledge acquisition and sharing. In such a setup, the communication process not only serves to convey the messages but also mobilize the community action as well as empowers the target people to interact and dig deeper to understand their own challenges. Ultimately, the underlying rationale of participatory approaches can necessarily be understood as being to stimulate target people's collective creativity and critical thinking to set their own priorities

[42] UNAIDS & PENN STATE, 1999, p. 55
[43] Melkotte S.,1991, p. 206 & 270

and standards unique to the context of their social environment and nature of problems.

1.6. METHODOLOGY

Specifically, the present study co-opted a qualitative case study approach to draw a holistic picture of communication practices for behaviour change in the sampled cases in light of drawn theoretical framework and the relevant provisions of the national policy guidelines on programming communication processes for behaviour change.

1.6.1. Data Sources, Informants and Sites

Field research for the study was conducted in Zomba District. Zomba was purposively selected under several considerations. First, as indicated in MDHS (2004) and Malawi HIV and AIDS M&E Report for 2005, HIV prevalence rates, awareness and behaviour change district indexes of Zomba are among the few that are closest to the overall national and regional (southern) indexes. This sets the substantial justification for Zomba as a satisfactory model. Secondly, Zomba district was opted for due to the present researcher's familiarity with the structures and players in HIV and AIDS work in the district owing to previous consultancy assignments. This reduced problems in selection and accessibility of informants and locations. Likewise, due to limited financial resources that would capacitate

study beyond Zomba, proximity and cost-effectiveness reasonably gave an advantage as the present researcher was resident in the district.

The study data was collected through key informant interviews, focus group discussions, observation and document reviews. Informants included purposefully selected district and community stakeholders. At community level, data was collected on members of CBOs and their affiliated groups, and ordinary community members – as non-members of the CBOs. Herein pseudonyms are used in reference of personal informants to preserve confidentiality as an agreed condition for consent before study.

1.6.1.1. Key Informant Interviews

In-depth interviews were conducted with informants at district and community levels to appraise their awareness and practice of national policy directives, and the implementation of guidelines for practicing communication for behaviour change, and their experiences in community-based interventions.

A total of 7 interviews were conducted. At district level, informants were purposefully selected to represent district-level institutions which collaborate with community-based organizations in BCI. Several potential institutions were listed but only 2 that consented were interviewed, namely: the District Aids Coordinator

for Zomba District Assembly; and the Executive Director of Hope for Life aids organisation.

At the community level, a total of 20 interviews were conducted as follows:

- **Lambulira**
    - 1 Director and 1 project officer for Lambulira Aids Support Organisation (LASO)
    - 1 representative of the village headman Lambulira
    - 1 member of Home-Based Care group
    - 2 member of Youth Club: girl and boy (14-24 year old)
    - 1 ordinary woman (24+ year old)
    - I ordinary man (24+ year old)
    - 2 ordinary youth (14-24 year old)
- **Magomero**
    - 1 Chairman and 1 project officer for Magomero Aids Support Organisation (MASO)
    - 1 village headman
    - 1 member of Home-Based Care group
    - 2 member of Youth Club: girl and boy (14-24 year old)
    - 1 ordinary woman (24+ year old)
    - I ordinary man (24+ year old)

- 2 ordinary youth: girl and boy (14-24 year old)

1.6.1.2. Focus Group Discussions (FGDs)

FGDs served as key tool for sourcing data from community-based informants. The dialogue-oriented nature of FGDs provided a co-equal based opportunity for both the researcher and target participants as they discussed issues around the questions from a guiding checklist. Data sought was on their knowledge of the behaviour change communication practices, their experiences and feedback thereof. A total of 8 FGDs were conducted across the two study sites. Within each study site FGDs were conducted as follows:

- 1 with CBOs committee members
- 1 with Home-Based Care women group
- 1 with youth club
- 1 with youth not involved in youth clubs

1.6.1.3. Observations

Observations were employed over the implementation process of the communication activities so as to get firsthand outlook of the specificity of the methodological procedures identified with each of the studied methods. This involved the researcher attending a sample of Peer Education sessions, Community Outreach Meetings and Stepping Stones workshops. The

observations focused on the demonstration of active involvement of the participants, level and manner of dialogue between the CBO personnel and the participants as well as among the participants.

1.6.1.4. Document Review

Documents included in this exercise were the National HIV and AIDS Policy, National HIV and AIDS Action Framework (2005-2009), the National Behaviour Change Intervention Strategy for HIV and AIDS and Sexual and Reproductive Health (NBCIS) and the three sets of HIV and AIDS Communications Guidelines (Advocacy, Social Mobilization, and Information, Education and Communication).

1.7. CHAPTER BREAKDOWN

Chapter 2: Critical Overview of National Guidelines for Behaviour Change Communication and Case Study Description

This chapter establishes the context of national policy and strategies and the empirical cases under study. The first part presents a critical exposé of the thematic and structural context of the national strategic standpoints and their critical implications on BCC. As regards the cases under study, the chapter presents an overview of findings on programme context in terms of identity and

setup of communication methods and terms of collaboration among the stakeholders.

Chapter 3: Critique of Communication Methods

This chapter explores and critiques the format of the communication methods employed by the community-based organisations. Subsequent to the description of the setup of the identified channels is a critical analysis that attempts to deduce overall conclusions from the specific implications of each of the methods regarding how they ascertain active involvement of the target community members. Shaping the critique are conceptual precepts of BCC and national strategic guidelines on the choice and set-up of communication techniques or media for bringing change messages to the intended audience.

Chapter 4: Critique of Findings on the Process of Message Development

This chapter explores and critiques the identified aspects in the mechanism of developing messages and setting up issues informing the communication activities carried out by community-based organisations. Subsequent to the description of the processes observed in the identifying critical issues and developing messages is a critical analysis that cuts across the established communication methods. The analysis attempts to deduce overall conclusions in the light of the conceptual insights on activity and involvement of target

populations in BCC as understood from the theoretical framework of BCC and national guidelines for BCI and HIV and AIDS communication.

Chapter 5: Conclusion

This Chapter summarizes the key observations and implications of the findings of the study. It draws conclusions around the empirical lessons and sets suggestions for improvement in practice and policy appropriation regarding programming of communication interventions for behaviour change. In addition, the Chapter hints on areas for further research in the context of behaviour change communication programming in Malawi.

CHAPTER TWO

CRITICAL OVERVIEW OF NATIONAL GUIDELINES FOR BEHAVIOUR CHANGE COMMUNICATION AND CASE STUDY DESCRIPTION

2.1 INTRODUCTION

This chapter establishes the context of national policy and strategies and the empirical case under study. The first part presents a critical exposé of the thematic and structural context of the national BCI implementation plans and HIV and AIDS communication guidelines and their critical implications in light of the behaviour change communication theory. The last part of the chapter examines the findings on the identity and implementation process of portfolio of behaviour change communication activities in the studied communities and framework of collaboration among stakeholders.

2.2 OVERVIEW OF BCI IMPLEMENTATION PLANS AND HIV AND AIDS COMMUNICATION GUIDELINES IN MALAWI

As previously exposed in Chapter 1, the national policy and strategic issues in terms of specific national objectives, goals and line activities for behaviour change have been reinforced with the National Behaviour Change Interventions

Strategy for HIV and AIDS and Sexual Reproductive Health (NBCIS).

The NBCIS and the guidelines identify six key social groups for BCI. In this categorisation, *Women of Child-bearing Age*, *Men and Women engaging in high-risk Behaviours* and *Young People Aged 7-24* are identified as most vulnerable and are prioritised for action.

- *Young People Aged 7-24* (in-school and out-of school) to ensure their health and safe transition into adulthood.

- *Men and Women engaging in high-risk Behaviours* to avoid risky practices and situations.

- *Women of Child-bearing Age* to be able to choose number of children they want to have, and ensure that each birth is safe.

On the other hand, *Opinion Leaders* (including faith leaders, traditional leaders and politicians), *Service Providers* (including health workers, Traditional Birth Attendants, Home-Based Care providers, and teachers) and *Policy Makers* (including relevant government departments and parliamentarians) are pronounced as specific groups that play an important role in determining

conduciveness of environment to behaviour change.

- *Opinion Leaders* are anticipated to play the crucial role of mobilizing social dialogue, participation and lead in confronting inimical beliefs and practices related to stigma and gender inequality.
- *Service Providers* are identified as key partners that can assist in information dissemination, and provision and strengthening quality of services and service and, referral.
- *Policy Makers* are recognised as being in a quality position to assist in determining national priorities and laws to prevent stigma and gender inequalities and set guidelines to service improvements and access to needed products.[44]

The NBCIS explicates that BCI operate through three thematic areas that are basically complementary and interrelated, namely: *Information, Education and Communication (IEC), Community Mobilisation* and *Advocacy*. Against each of the three thematic areas, NAC has developed sets of guidelines for BCI implementation and HIV and AIDS communication that are meant to be used by stakeholders from government, NGOs, CBOs, faith-based organisations, District Assemblies, training institutions, committees and associations at community

[44] NAC, NBCIS, 2003, pp. 18-19 & Appendix I-VII

level[45].

2.2.1 Information, Education and Communication (IEC) Guidelines

As established within the national guidelines, the process of IEC begins with *developing of objectives* whereby the aims and expected outcomes of intervention are specified and clarified. This initial exercise is set to involve, most importantly, consultations with various stakeholders and closely refer to programme policy statements for priority areas. This is followed by *identification of the target group,* which establishes detailed understanding of behaviour challenges, awareness and knowledge needs and specific characteristics of the target social group.

After identifying the target populations, the guidelines point to the need for *identification of stakeholders* that will be partnered with at all levels and stages of the implementing process of any IEC intervention. These stakeholders are expected to be organisations or persons with expertise and experience that would ensure their technical contributions to the process from their experience working with the target population. The range of possible stakeholders include: the target groups, local leaders, government and non-governmental organisations, health

[45] NAC, NBCIS, 2003, p. 23

and communication experts.

Subsequently, the intervening party is set to engage *formative research* to explore behavioural issues and the contextual background that will inform appropriate messages and strategies for the planned intervention. Adding to the clarification of the rationale for the formative research, the NBCIS states that the exercise helps in ensuring that intervention are contextualized to the actual local challenges and needs among the target people. The belief is that this would assist in development and production of specific messages, apart from the effective use of materials[46].

Basing on the insights of the formative research, messages are set to be created in collaboration with various stakeholders taking critical consideration of insights from the preceding formative research. Subsequently, it is further recommended that the implementers collaborate with the other stakeholders in the *choosing of communication techniques*, which specifically involves assessment and application of communication methods to effectively deliver change messages. The guidelines recognise a variety of possible media to be employed in implementation of IEC interventions. These include mass media such as print IEC materials like flyers, posters, calendars and pamphlets; and interpersonal

[46] NAC & SRHU, 2003, p. 15

approaches such as peer education, besides outreach events such as drama.

Ultimately, the IEC guidelines recognise the featuring of *monitoring and evaluation* along and after the implementation process, respectively. The NBCIS identifies monitoring and evaluation as the process which involves collection and assessment information to help in determining whether efforts are achieving objectives and established frameworks[47]. Thus monitoring and evaluation is identified to be a valuable element from the initial stages of formative research and message development processes, through the implementation to people's reception of the messages and appreciation of the effect thereof. Likewise, implementing agents are encouraged to collaborate with other stakeholders, especially, target groups in collecting and evaluation of IEC processes.

2.2.2 Community/Social Mobilization Guidelines

The NBCIS defines community mobilization as the use of community networks which initiate dialogue on sensitive but critical issues[48]. The strategy points out that mobilisation of community targets is required to encourage their involvement in dissemination of messages, establishment of community support groups, and to strengthen links and referrals between community and providers of such related

[47] Ibid, p. 25
[48] NAC, NBCIS, 2003, p. 23

services as HIV testing and treatment. Accordingly, the HIV and AIDS communication guidelines assert that social mobilization interventions should aim at cooperative problem analysis and determining of community solutions; mobilization and management of resources; apart from facilitating active participation in processes of transforming their lives[49].

The process of community mobilization is set to depart from *identification of specific issues* in the local context of the intended target people through formative research into their experiences for behavioural concerns and their relevant factoring issues. Subsequently, *analysis of the situation* is suggested so as to get an in-depth understanding of priority issues and their possible causative factors environmental influences. Basing on the analysis of the causes and effects of the concerns solutions are to be proposed thus marking the specific intent and direction of the intervention. The guidelines recognise the value of an inclusive approach to the collection and analysis of information. Various stakeholders, especially the people who are directly affected by the identified challenges, are set to actively participate in the identification and of the issues. The process is expected to benefit from the diversified critical analysis by various stakeholders and the target people's in-depth understanding of the problems at hand that would

[49] NAC, 2006, p. 4

ensure accurate research information[50]. Thus involvement of various stakeholders, most especially target communities, is of significant value towards effective community mobilization process in BCI.

After analysing the situation, objectives and goals are developed as respective short-term and long-term ideals for the intended intervention. The objectives are set to be developed and circulated for review among the stakeholders. This is followed by creation and implementation of an action plan which identifies and defines behavioural issues and specific set of activities within a specified timeline and players that will be responsible with implementation[51]. The guidelines recommend involvement of target communities when identifying activities so as to have them tailored to the people's specific needs and interest.

Finally, the guidelines encourage implementing institutions to set up procedures for monitoring of implementation activities and evaluation of the overall progress of the social mobilization interventions. The procedures are set to specifically measure the success of line activities in achieving intended objectives and set goals. Suggested methods for carrying out monitoring and evaluation include: keeping records of stories and conversations with target audience; keeping

[50] NAC, 2006, p. 12
[51] Ibid, p. 14

significant records of the activities that have been implemented; carrying surveys and interviews to determine the impact of specific activities and the intervention as a whole[52].

2.2.3 Advocacy Guidelines

Portraying a gradual process whose elements are similar to those for social mobilization, the implementation plan and corresponding guidelines on advocacy are set to raise political commitment, social will and resources at all levels of society as a way of creating conducive environment for behaviour change. Targeted stakeholders include policy and decision-makers and the general public about issues relating to HIV and AIDS response.

2.2.4 Summary

The interplay of advocacy, social mobilisation and IEC aspects of BCI programming suggest customised and inclusive approaches to communication for behaviour change. From the early stage of setting of programme objectives, through development and delivery of messages, national to grassroots stakeholders are set to be actively involved and committed in initiating and managing BCC. In light of the theoretical framework established in Chapter 2, this substantiates important relevance of the national BCI and HIV and AIDS communication guidelines to the underlying principles of effective BCC. FHI

[52] NAC, 2006, pp. 26-27

(2002) and PATH & Ipas (2005) concur in explaining BCC as being underlay by inclusive approaches that initiate and enhance close interaction among and between target people and intervening agents[53]. Such a setup reflects the BCC process as a typical participatory communication practice that creates interplay of the expertise of the external agents and the target people's familiarity with their behaviour in tackling challenges and needs, and managing the change processes. As UNAIDS & PENN STATE (1999) observe, involvement and commitment of all stakeholders creates conducive environment that empowers target people to articulate and address own behaviour-related problems[54]. The present study builds on the demonstrated potential of the national BCI implementation plans and HIV and AIDS communication guidelines in ascertaining active involvement of target communities and application of dialogue-based approaches to critique community-based behaviour change communication practice.

2.3 CASE STUDY DESCRIPTION

2.3.1 Brief Description of Zomba District

Zomba District is located in the southern part of the Republic of Malawi. The old capital of Malawi covers an area of 2,580 km² and is bordered by Mozambique to

[53] FHI, 2002, p. 2 concurring with PATH & Ipas, 2005, p. 3
[54] UNAIDS & PENN STATE, 1999, pp. 63-64

the east, Chiradzulu and Phalombe districts to the south, Machinga to the north and Blantyre to the west[55]. According to the 1998 Housing and Population Census Report, Zomba has a population of 540,352, indicating a growth of about 23% from the 436,162 count during 1987 national census. *(Refer Figure 1 on Page 40 for population distribution in Zomba)*

There are 6 traditional authorities (TAs) and 1 sub traditional authority (Sub TAs), namely: Mwambo, Chikowi, Kuntumanji, Mkumbira, Mlumbe, Malemia, and Mbiza, respectively.

There are three main tribes in the district namely Yao, Lomwe and Mang'anja. Islam and Christianity are two major religions in the district with approximately 78% of the people as Christians, 20% as Moslems.[56]

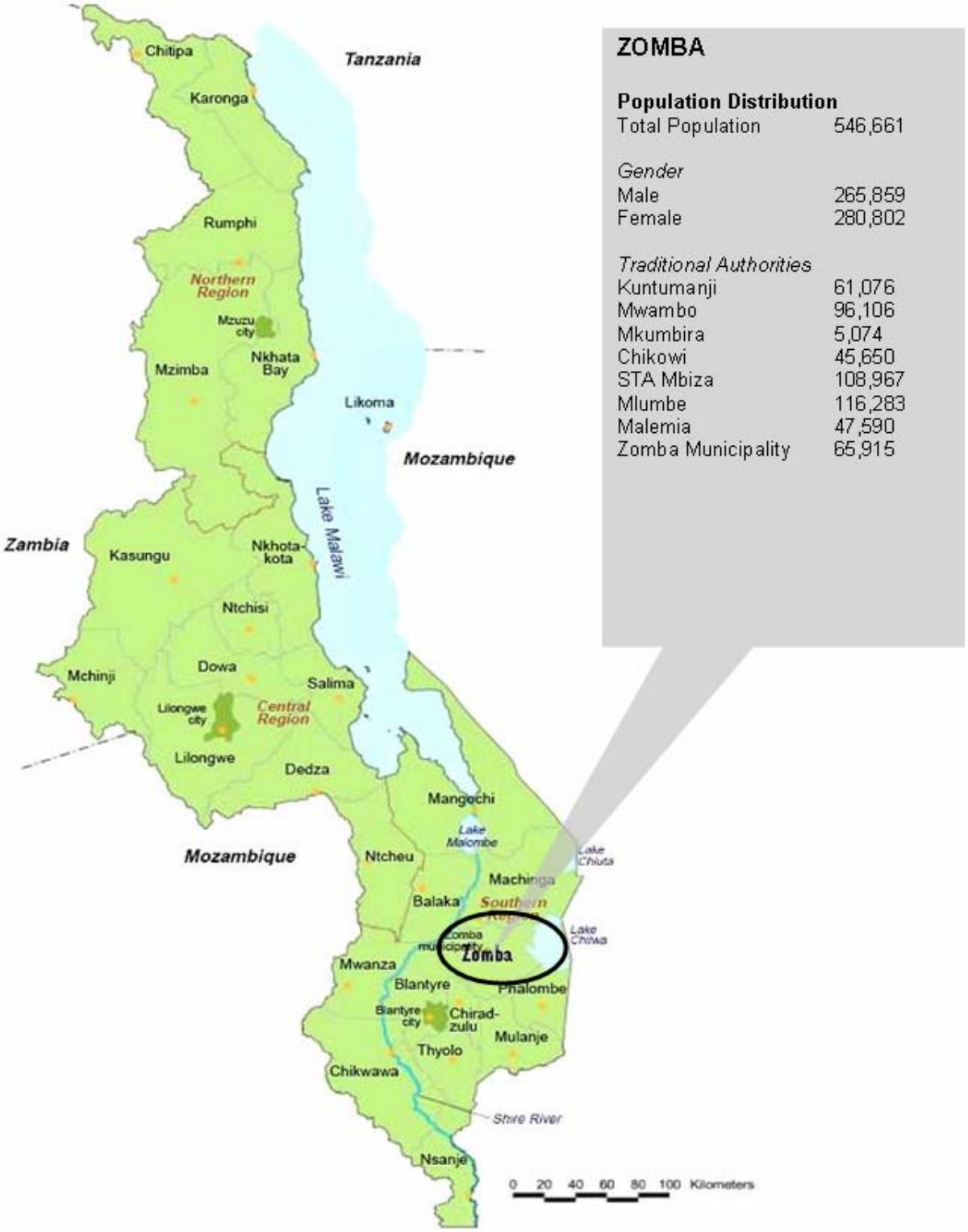
Majority of the population engages in agriculture. Apart from crop agriculture, fish farming is done along the shores of Lake Chilwa in the eastern part. There is also commerce and light industry services. Key social development problems

[55] Zomba District Education Plan, 2007, p. 8
[56] Zomba District Profile. 2006, p. 4

include HIV and AIDS, infant mortality, high illiteracy (with 60% of the population estimated to be literate)[57].

[57] Zomba District Education Plan. 2007, pp. 7-8

Figure 1: **MAP OF MALAWI LOCATING ZOMBA DISTRICT AND POPULATION**



Source: 1998 Malawi Population and Housing Census

2.3.2 HIV and AIDS Situation

From the outlook of the Malawi Demographic and Health Survey (MDHS) 2004 and the Malawi HIV and AIDS M&E Reports for 2005 and 2007, the HIV prevalence, awareness and behaviour change indexes of Zomba are closest to the overall national and Southern Region indexes. The MDHS for 2004 indicated that the adult HIV prevalence rate for Zomba was at 17.8%, while the Southern Region had 17.6%, overall. Regarding awareness, 46.6% of sampled women in Zomba indicated awareness of condom use and limiting sex to one partner as some key methods of preventing HIV infection.

As regards HIV and AIDS related sexual behaviours, the MDHS (2004) locates Zomba among one of the districts with high incidence of high-risk sex activity. This may be attributed to district boasts of high social interaction and economic activity exerts a great deal of influence on the people's sexual behaviours. The MDHS (2004) estimates that 2.5% of sampled women from Zomba indicated engaging in higher-risk sex (with multiple partners or without condom) against the regional 10.4% index. However, no quantitative data was available that specifically estimates the infection and prevalence rates of HIV and AIDS in the sampled case study sites.

The impact of HIV and AIDS on livelihood of the population has equally been

felt in Zomba, most importantly in the specific study sites. Informants to the study cited growing numbers of orphans, poverty, broken family ties, and loss of productive persons as some key problems brought by the epidemic. In response to the epidemic, interventions are being undertaken by various organisations in the district, mainly in the areas of prevention and behaviour change; treatment, care and support, and impact mitigation. However, despite increased exposure to community-based and mass media awareness campaigns, the study found that indulgence in risky behaviours and stigma and discrimination towards persons living with HIV (PLHIVs) commonly reported widespread in the study sites. Regarding risky behaviours, multiple and concurrent sexual relationships were indicated as key challenge among the youth. Illustratively, a female community informant explained that: *"Achinyamata ambiri akumakonda kuyenda ndi zibwenzi zingapo. Anyamata umakhala ngati mpikisano, kwa atsikana, limangokhala dyera ndi tizithandizo tomwe amalandira kwa omwe amanyengana nawowo"* (Most youths are having more than one partner. Most boys take it as competition for girls, while for most girls; they are just greedy for the small gifts they are given by the men whom they go out with).

When asked to explain the local people's prevailing attitudes towards PLHIVs, most respondents confirmed existence of negative attitudes. Living with HIV, as

reported by majority of informants, is commonly viewed by most people as *"chinthu cha manyazi"* (a shameful thing in vernacular). The study included a set of questions in attempt to measure prevailing levels of stigma and discrimination. Key questions focused on how PLHIVs are generally regarded in informant's own opinion and prevailing attitudes among the general community; willingness to access voluntary counselling and testing (VCT) services. The study found that there is general fear of isolation and ridicule if known to be HIV positive hence many people shun VCT services and a few that have tested positive are reluctant to publicize their status. Illustrating this situation, an HIV positive CBO volunteer from Magomero indicated that *"ambiri amaopa kukambidwa miseche ndi kusalidwa, nchifukwa chakenso ena amawoperatu kukayezetsa"* (people fear being subjected to gossip and discrimination, thus the majority shuns going for testing). Consequently, this was reported to have led to poor community participation in response activities such as home-based care of the sick and orphans (HBC). A case was cited in Lambulira where a local well-to-do businessman is known to be refusing care for his daughter who has HIV because, he believes, she is only receiving retribution for her past promiscuity.

Women groups engaging in HBC commonly reported general lack of interest and support to their work among most of their fellow women in their areas. Demonstrably, an HBC group member from Lambulira lamented that *"amati*

ndikufuna kwathu kutero komanso tili ndi nthawi chifukwa odwalayo ali ndi achibale awo" (they ridicule us by saying that it is our own choice to do that because the sick have got their own relatives who should take care of them).

The above explication confirms a context faced with crucial behaviour challenges. More encouraging is that all community informants expressed that the situation has improved with the increased local awareness' meetings and programs on the radio.

2.3.3 HIV and AIDS Response In Zomba District

The framework of players involving in HIV and AIDS response activity in Zomba includes government departments such as the District Health Office and District Assembly; educational institutions such as including University of Malawi; NGOs such as Actionaid and Dignitas, the District Assembly, and many community-based organizations (CBOs). Much of the response activity is collaborated between CBOs and other institutional partners at both district and national levels. According to the reviewed records from the office District AIDS Coordinator of the Zomba District Assembly, approximately 150 CBOs are implementing various activities in the district. Key focus areas for most of the NGOs such Actionaid, Dignitas and YONECO and CBOs was found to be *impact mitigation,* and *treatment, care and support.* Only a few NGOS such as Youth Net and

Counselling (YONECO) and Hope of Life and several CBOs were reported engaging BCI as their main area of intervention with outreach community meetings and distribution of print IEC materials being the most common BCI interventions.

This reflects direction of much interest and resource in response action towards consequent instead of causative challenges of the epidemic, which may prove a helpful approach if the hope for reversal of prevalence rates as prevention of infection is, as learnt, apparently treated as secondary.

2.3.3.1 BCI Players At District Level

Among the identified key players in BCI activity in the district, the study purposively sampled the office District AIDS Coordinator and Hope for Life AIDS organisation at the district level, Lambulira AIDS Support Organisation (LASO) and Magomero AIDS Support Organisation (MASO) at the community level.

2.3.3.1.1 The Office of the District AIDS Coordinator

The office of the District AIDS Coordinator (DAC) is established as a local authority for HIV and AIDS response coordination within the decentralised

district administration under the District Assembly. Its key functions include the facilitation and coordination of all district HIV and AIDS response activities, mobilization of resources for its partners. Its jurisdiction at the district level is analogous to that of the National AIDS Commission (NAC) at national level.

Regarding BCI, the DAC take up a three-fold coordinating task in ensuring smooth implementation. Firstly, the office is expected to check the process of behaviour change intervention by critiquing the set plans, checking progress of activities, and collect reports from all players in the district, according to the provisions of the national policy and strategic framework. Secondly, the office initiates capacity building and training for its partners, especially CBOs. To achieve this task, the DAC engages NAC headquarters, other relevant national partners or private consultants. Thirdly, the office brokers the distribution and access of BCI support materials. Playing the intermediary role of receiving IEC materials and other intervention documents accessed from NAC and other national partners, the office distributes to various implementing agents at district and community level.

2.3.3.1.2 Hope for Life AIDS Organisation

Hope for Life started its work in 2003 with the aim of facilitating and coordinating a network for people living with HIV and AIDS (PLHIVS). The

organization, whose membership is exclusively for PLHIVs, implements its activities in all five Traditional Authorities in Zomba namely: Kuntumanji, Mwambo, Mkumbira, Malemia, Chikowi and Mlumbe. It has voluntary facilitators initiating various activities in Home Based Care, Youth and Outreach Programme, Human Rights and Gender, and Voluntary Counselling and Testing.

The organisation's mission to promote better livelihood among those positive living among the infected, the organisation has won reputation as a key players in general BCI built on a strong networking with various district and community stakeholders. Hope for Life provides both technical and material support to the CBOs. It also stands as one of the key referral agents for VCT in the district, to which CBOs like Lambulira AIDS Support Organisation and Magomero AIDS Support Organisation refer their clients. As the clients come, for counselling the emphasis is on values of positive living and social acceptance of PLHIV.

Hope for Life is funded by NAC and also receives small grants and constant support from other partner s such as Actionaid and Dignitas.

The main communication strategies employed by Hope for Life in the BCI approach include role modelling, peer education, drama, and print IEC material. These are developed by the organisation itself or acquired from their national

partners such as Malawi Network for Aids Service Organisations (MANASO) and National Association for Persons Living with HIV and AIDS (NAPHAM). The materials are distributed among various CBOs to support their communication activities for behaviour change.

2.3.3.2 BCI Players at Community Level

2.3.3.2.1 Lambulira AIDS Support Organisation (LASO)

Lambulira AIDS Support Organisation (LASO) was founded in 1994 in Lambulira Village, which is under Traditional Authority Chikowi. In liaison with other community members, LASO's was initiated to promote awareness and initiating support of AIDS patients. Presently, LASO is working in 59 villages covering the whole area of T/A Chikowi, Sub T/A Tholowa and part of T/A Mlumbe. Though no specific data describing the HIV and AIDS prevalence for the area are available, district and community informants indicated that unofficial records from HIV testing referrals indicate high incidence of infection in the area. With majority of sampled ordinary community respondents able to explain basic facts about prevention and transmission of the HIV and AIDS, the CBOs claim that most people are aware of HIV and AIDS was clearly substantiated.

According to programme records made available to the study, LASO's key areas

of intervention include: *Home-Based Care (HBC), Prevention, Positive Living* and *Gender* and *HIV and AIDS.* HBC, Prevention and Positive Living were indicated by the director of the organisation as the earliest intervention areas of the organisation when it was founded in 1994. The activities were reported to have been suggested by the some concerned local individuals who admired what other were doing in other of the district and other areas nationwide as heard on the radio. Through, LASO reaches out to AIDS patients and orphans with care and support to by providing them with domestic necessities such as soap, food, including assistance in domestic chores such as gardening. They also provide medication (painkillers) and transportation to hospital to the seriously sick. As regards Prevention, LASO coordinates various awareness and behaviour change activities. These include peer education for the youth, BCI trainings for women groups involved in HBC, and community outreach events such as drama, songs and testimony sessions by PLHIVs.

Regarding positive living, LASO focuses on promotion of social acceptance of PLHIVs through community awareness activities as well as support for AIDS patients in their households, counselling and testing (VCT). PLHIVs are actively involved as role models to encourage community interest and support to the interventions. They implement this sharing their own status and life experiences to inspire positive attitudes towards HIV and AIDS. In the area *Gender* and *HIV*

and AIDS, LASO initiated establishment of affiliated women groups with the aim of encouraging respect of women-rights in the face of the epidemic and encourage the women's support and participation in HIV and AIDS activities, especially in the HBC and VCT activities.

2.3.3.2.2 Magomero AIDS Support Organisation (MASO)

MASO was established in 1993 from an AIDS Toto Club at St Pius Primary School at Magomero in the southern part of Zomba District. It is presently, working in 39 villages covering the area of Sub T/A Tholowa and part of T/A Chikowi. MASO operates on voluntary basis. It has 5 trustees, a management committee consisting of a director, secretary, project volunteers for each of its intervention areas, and four committee members.

Main areas of interventions include *Prevention* and *Home Based Care*. Under prevention, key areas of focus include awareness, behaviour change and voluntary counselling and testing. Activities include: village outreach activities that include drama, poetry and song performances. They also distribute IEC support materials such as pamphlet, posters and booklets which they received from external partner organisations such as NAC, YONECO, the DAC office as well as LASO. As regards home-based care, MASO provides care and support to those infected (patients and those just infected) and affected (especially the elderly and orphans)

individuals and households. LASO volunteers also provide care and support to AIDS patients and counselling for the infected. Support provisions include toiletries, food stuffs and medication, and services like assistance in domestic tasks such as gardening and building houses.

2.4 CONCLUSION

As explored in this chapter, the scope of the national BCI guidelines espouses three aspects, namely: IEC, Social Mobilization and Advocacy. This reflects a multi-dimensional and inclusive approach to tailor-made behaviour change communication. Thus BCC activity is set to be built on strategies that ensure emphasizing on active participation of diverse stakeholders and customization of process in light of researched behavioural challenges and social characteristics of the target people. This affirms relevance of the national BCI and HIV and AIDS communication guidelines to the underlying principles of BCC that emphasise broad-based and participatory approaches that initiate and enhance close interaction among and between target people and intervening agents[58].

It has also been explored that the partnership framework in community-based BCC in the studied cases includes community, district ad national stakeholders who play roles in implementation of a portfolio of interventions.

[58] FHI, 2002, p. 11

CHAPTER THREE

CRITIQUE OF COMMUNICATION METHODS

3.1 INTRODUCTION

This chapter explores and critiques the format of the communication methods employed by the community-based organisations. The description of the setup of identified channels will be followed by a critical analysis that attempts to deduce overall conclusions from each of the methods regarding how they ascertain active involvement of the target community members. Shaping the critique will be conceptual precepts of BCC and national strategic guidelines on how communication techniques or media bring messages for change to the intended audience.

3.2 CONCEPTUAL AND OPERATIONAL OVERVIEW OF MESSAGE DELIVERY METHODS IN BEHAVIOUR CHANGE COMMUNICATION

With regards to the theoretical outlook of BCC, consideration of interest and characteristics of the targeted population does not end at message development rather it is also instrumental in deciding message delivery methods. Correspondingly, the national HIV and AIDS IEC guidelines aver that after

designing and developing messages, stakeholders, especially the target population, agree on appropriate techniques to be employed to effectively deliver the message amongst them. As PATH & Ipas (2005) explain, in appropriating communication strategies, target groups are regarded not as a single entity but of different behavioural challenges, needs and contextual characteristics that require different levels and manner of approach[59]. This implies that communication methods are set to be employed on the basis of how best they fit to a specific context. To this realisation, not only is it necessary for change messages to be tailor-made, but the methods as well.

As explicated in the theoretical framework in Chapter 1, the rationale for tailor-made procedures in the behaviour change communication process is rooted in the intent to bring out actual issues on the ground, effectively respond to them and ensure that the target people easily draw meanings from the messages thereof. In accordance with the inferred participatory nature of BCC that is set on stimulating target people's activity to bring lasting solutions to their behavioural challenges[60], the appropriate setup of message delivery methods would systematically be expected to espouse the close interaction between the communicators and receivers.

[59] PATH& Ipas, 2005, pp. 3-4
[60] FHI, 2002, p. 3

One-way communication approaches such as radio and printed informational materials are argued to be effective in promoting and maintaining awareness of facts about HIV and AIDS[61]. Across all the studied theories, good awareness is necessary from the onset and sustenance of the process of behaviour change, hence the value of one-way mass media approaches cannot be ruled out in the setup of effective BCC. However, in light of the definition given in Chapter 1, BCC transcends mere awareness to concern itself with mobilizing and sustaining dialogue among stakeholders, most importantly among the target people. In a way, BCC endeavours to develop, promote and sustain positive behaviours by promoting dialogue that empowers communities to physically and intellectually get involved in customizing communication interventions for their behavioural change. This sets the rationale for dialogue-based communication methods such as peer education and counselling services over one-way media such as print IEC materials blamed for inhibiting active roles by the target audience. Dialogue-based approaches entail close interaction between communicators and target groups, and interpersonal activities with communities themselves. As Melkotte puts it (1991), through community dialogue, the people discuss their needs; decide on plan of action, and appropriate media that fits their context.[62]. Subsequently, it can be concluded that dialogue-based communication methods

[61] UNAIDS & PENN STATE, 1999, p. 75
[62] Melkotte S., 1991, p, 206 & 270

draw target communities or individuals as principal actors in the setup of communication methods for behaviour change. With the target people actively contributing to the process, they can not only bring in accurate description of their context but also ensure its representation in the messages and the choice of appropriate media.

Eventually, recognising that both hold special importance to the behaviour change process, one-way and interpersonal communication methods are set to complement each other for effective intervention. Thus, concurring with UNAIDS/PENN STATE (1999), it is recommendable that BCC intervention draws simultaneously on the power of the one-way and the behaviour-changing effectiveness of interpersonal approaches[63].

3.3 ANALYSIS OF IDENTIFIED COMMUNICATION METHODS

The identified common communication methods found to be practiced in the sampled sites can be perceived in two categories, namely *interpersonal communication* and *small media.* Interpersonal communication methods include Stepping Stones workshops, Peer Education, Counselling Services and Community Outreach events encompassing drama, poetry, dances, and quiz sessions. In the context of this study *small media* exclusively denote print IEC

[63] UNAIDS & PENN STATE, 1999, p. 70

materials such as leaflets, booklets and posters that were found to be distributed by the CBOs. Delimitation of the functioning rationale of participatory media and small media in BCC has been well modelled by Parker W. et al (2000).

3.3.1 Participatory Communication Methods

Drawing the target people into the media ensures that the messages and the delivery methods are customized to the specific information needs of the group, in a language that they speak and in representations that they understand. Close interaction between implementing agents and targeted peoples ascertains the latter's direct feedback into making and understanding of meaning[64]. As critical views arise, messages can immediately scrutinised and personalised in light of ideas and opinions from the target until they are clear to the group and their target audience.

Secondly, the process of working together and creating a media product can be very empowering for the group and the individuals involved. Making the media with the people assures involvement of their physical, emotional and intellectual levels as they work collectively and participate actively, to identify their beliefs and attitudes and how to express them. This stimulates the people's creative and

[64] Parker W. et al., 2000, p. 60

critical thinking which raises their consciousness, orienting efficacy, action and providing opportunities to learn or improve basic technical skills[65]. Furthermore, the process of working as a group also provides an excellent opportunity for the people to learn various skills. Primarily, people learn to assert themselves, to negotiate ideas, communicate and understand that it is possible to agree to differ amicably[66].

Finally, once the participatory media have been developed the group also takes responsibility of distribution of the media. The process of choosing where to present own developed media requires thought and discussion a process which empowers the group and builds commitment to the development of a community front[67]. The community is herein set to deliberate on the venue for presentation of media products. The involvement of the target population ensures that the choice of venue is tailored to the people's interests and is cautious about contextual eventualities such as their day-to-day personal or domestic engagements and geographical location of venue that might have an effect on the levels of attendance.

[65] Ibid.
[66] Ibid.
[67] Parker W. et al. 2000: pp59-60

3.3.1.1 Community Outreach Meetings

A total of 4 outreach events were observed during the study: 2 in Lambulira and another 2 in Magomero. The community meetings involved presentation of a collection of communication activities by the CBO to the community at a specific date and place. Across the two study sites, the frequency of outreach meetings was reported to be at least once in a month with the venue rotating amongst the villages. Presented articles included drama sketches, songs, poetry and dances, motivational talks by persons living with HIV or AIDS patients. Also commonly included were quiz sessions whereby the community members in audience are asked questions about some basic facts about HIV and AIDS as a way of assessing their level and manner of awareness. Thematic focus included basic facts about HIV and AIDS, VCT, stigma and discrimination, and Prevention of Mother to Child Transmission (PMTCT).

Affiliated groups such as youth clubs and support groups of persons living with HIV and AIDS (PLHIVs) made their presentations at all of the studied events. Youth clubs commonly presented drama sketches and poetry with stigma and discrimination featuring as their main thematic focus area alongside multiple and concurrent partnerships. On the other hand, PLHIVs gave testimonies and motivational talks on living positively and benefits of VCT through narration of how their lives have progressed since they got to know their status. .

The method was found to be the major behaviour change communication activity across MASO and LASO project communities. Both CBO membership and majority target community informants considered the community outreach meetings their most effective and preferred method, respectively. The CBO committees commonly commended that outreach meetings attract large turnout of the community members as compared to other methods, hence they ensure that many people access the messages. The majority of the ordinary community informants explained their preference of outreach meetings as they enable them to get information from human sources which are more believable and easy to understand as touch on their real issues than radio or print IEC materials. that they take pleasure in the entertainment nature of drama sketches, songs, dance and poetry. Illustratively, a female informant from Lambulira said: "*Masewero aja amawuluritsa makhalidwe a uve ochitika m'midzi mwathumu"* (The drama plays expose various risky and immoral behaviours happening in our communities)[68]. Another male informant from Magomero stated: "*Maumboni a abale omwe ali ndi kachirombo amatichenjeza kuti edzi ilipodi komanso nkopindulitsa kudziwa mmene magazi ako alili"* (The testimonies by those living with HIV caution us that AIDS is real amongst us and that it is important to go for test and know your sero-status)[69].

[68] Female FGD participant from Lambulira on Wednesday 2nd May 2007.
[69] Male participant from Magomero contributing during focus group discussions held on Friday 4th

The identification of content issues, and creative preparation and performance of drama, dance and quiz activities was found to be done by CBO volunteers and officers with occasional collaboration of Youth Clubs in drama sketches. The communities are only called to watch the performance, at times they participate in the dances and answering to the questions that are posed along the drama performances and during the quiz sessions.

On a critical note, the organization of activities showcased in the outreach meetings such as drama sketches, songs, poetry and dances replicates passivity and disempowerment on the part of the community members in audience as the CBO committee members make the decisions and implement activities with no tracked consultations with the general community. The interpersonal potential of activities such as the drama sketches, dances and song is not fully exploited as in letting the people take part in the performances or engage in dialogue. An attempt to engage the audience was only found limited to the quiz sessions whereby members participate by answering to randomly asked questions about various HIV and AIDS related issues. However, in the event of a wrong answer, the questioner would always come in lastly to give the final correct standpoint. Rarely would there be an effort to get the final explanation amongst the audience. This confirms divergence from the inclusive and participatory stipulations of

---

May 2007.

effective BCC which, as introduced above, are intended at mobilizing and empowering the target people through dynamic interaction with the information sources.

3.3.1.2 Stepping Stones

Stepping Stones is a is a training package on HIV and AIDS focusing on relationships and communication skills, with the aim of reducing HIV transmission, improving sexual and reproductive health and fostering gender empowerment[70].

It was originally designed in the mid-1990s to address the prevention and spread of HIV and AIDS in sub-Saharan Africa and increase the care of PLHIVs. Stepping Stones involves people working in separate age and gender groups of 10 to 20 participants, to encourage openness and discussion so as to enable individuals and wider community to decide how to promote respect, listening and communication between sexual partners and within families, and how best to care for the PLHIVs[71].

Within its basic framework, Stepping Stones provides a flexible and creative

[70] Welbourn, A., 2006, pp. 2-3

[71] Wallace T., 2006, p. 6

approach that depends on the participants to draw on their behaviour context, culture and develop own locally appropriate solutions to their behaviour challenges. All sessions employ participatory learning approaches of group discussion accompanied by creative activities basing on participant's own experiences[72]. Participants discuss, enact and analyse their experiences. They consider alternative outcomes, agree on and develop strategies for achieving them as a group.

The framework of its practice renders mobilisation and empowerment of communities to deal with their personal and shared community behaviour challenges as the ultimate goals of Stepping Stones. Stepping Stones aims at mobilising cohorts to take matters into their own hands and create force for change and improvement of HIV and AIDS related behaviours. By dealing with cohorts in groups, the package is argued to assume that people do share certain challenges in their lives.

Factors that enhance this mobilisation potential include: involvement of local leadership, commitment and capacity of facilitator to empower communities to take action for change, group dynamics as changes in the individual are reinforced by the group, collaboration with other organisations that can provide

[72] Welbourn, A., 2006, p. 1

complementary services. Furthermore, key standards of implementing Stepping Stones workshops rests on such areas as training of facilitators; level of attendance; continuity of participation; facilitation style; and adherence to number and sequence of sessions. Consequently, Stepping Stones can reasonably be understood as fitting within the conceptual and operational principles of effective BCC as it espouses active roles for participants in tailoring topics of the workshop sessions and local communication and behaviour change processes to their local contexts. The present study takes up the terms explicated in the description of Stepping Stones approach in drawing an analysis of the findings on the setup of the Stepping Stones as communication method.

The method was found being actively practiced by LASO since receiving training from Actionaid in 2006. According to LASO, participation was set to be voluntary and anybody interested would register, however, due to poor turnout in the onset, especially among men and local leaders, the method was suspended only to be resumed later targeting a pool of women groups collaborating in Home Based Care activities. As a result, it was found that the method is mainly known among the women groups while the majority of other ordinary community members reported that they did not know it and others said to have never heard of it.

While acknowledging having received training from Actionaid in 2006, MASO indicated not to have rolled out any activities due to lack of funds. The CBO leadership indicated having exhausted their efforts for support to acquire resources from NAC and other organisations through the District AIDS Coordinator's office.

In LASO's area, Stepping Stones sessions were commonly referred to as *"maphunziro"* (lessons) by members of both LASO and HBC women groups. It was established that the implementation process follow a set of facilitation guidelines that was provided at the end of the training. The sessions take the form of discussion involving small groups of 10 to 20 women purposively selected from women groups established in most of the 59 villages in which LASO works. It was reported that more than a hundred women have benefited from the sessions. However no clear records were available to substantiate this estimation.

It was found, planning for the sessions starts with a group composed of trained officers or volunteers meeting to review challenging behavioural issues observed in the communities. In their deliberations, they rank the problems and accordingly prepare topics which are tackled in the following workshops, whose date is set in agreement with other officers. As confirmed by women that have been involved in the sessions, participants deliberate on behavioural challenges specific to their

personal stories or share experiences in taking care of AIDS patients and orphans: which are key activities under Home Based Care[73]. Upon analysis of the challenges, they brainstorm how they can effectively overcome the problems at hand and influence positive behaviours in their communities. For example, one woman who participates in the sessions said: *"Tikakafufuza mavuto omwe timakumana nawo monga kusafuna kuthandiza nawo odwala, timakambirana momwe tingathanirane nawo ndikulimbikitsa kutenga anthu kutenga nawo mbali patokhapatokha komanso ngati gulu"* (After identifying the problems such as shunning of participation in taking care of the sick, we discuss solutions and how we can change such as individuals and as a group)[74]. Almost all sampled participants testified having been positively affected by the workshops, personally and in their work as Home Based Care volunteers. Commonly cited benefits include life and communication skills that enable them to approach and motivate their peers, understand the attitudes and their fears and negotiate positive change among fellow women who tend to shun Home Based Care activities. For example Mayi Esme Kunje, a regular participant of the workshops testified that: *"Pandekha komanso ngati gulu timatha kuzindikiritsa anzathu kuti kulimbana kwabwino ndi matendawa nkutenga nayo mbali mzochitika mdera mwathu"* (personally and as a group we are able to assist our fellow women realise that

[73] FGD with HBC women group participating in Stepping Stones community workshops on Wednesday, 2nd May 2007 at Lambulira.

[74] Malinesi Bakuwa, participant of Stepping Stones community workshops. Contributing during a focus group discussion held on Wednesday, 2nd May 2007 at Lambulira.

participating in HIV and AIDS activities is the crucial to the fight against the epidemic)[75]. Another woman testified to having been influenced to engage in HBC activities by one of her friend who was among the first participants of Stepping Stones workshops in her village. She said: *"poyamba ndinalibe chidwi ndi za magulu a HBC koma nzangayu anandilimbikitsa pondilangiza kuti ndi chinthu cha umunthu kusamalira odwala angakhale sim'bale wako"* (at first I had no interest in HBC issues but my friend explained to me that it is human to be humane for the sick regardless whether they are your relation or not).

Generally, the setup of the Stepping Stones sessions by LASO can be appreciated to satisfy key conceptual and operational principles of BCC in terms. Despite not being a problem for both the CBO personnel and the participants, the key shortfall in carrying out the method is noted at the message development stage. The targeted women groups are not engaged in identification of topics for discussion, instead of CBO officer and volunteers were shown to exclusively take up this role. This indicates sidelining of the people to take active role in identifying own challenges as topics for discussion, which substantiates relevance to the fundamental principles of participatory approaches underlying BCC as expounded under the theoretical framework in Chapter 1.

[75] One of the women interviewed on Wednesday 2nd May 2007 at Lambulira Aids Support Organization.

3.3.1.3 Peer Education

Peer education involves recruitment of leaders in communities at risk to be implementers of the education programme to their colleagues. As regards benefits of the peer education method, peer educators may be a more credible source of information for women, may communicate in a more understandable language, and may serve as positive role models[76]. Furthermore, various studies have suggested that when the group at risk is very different culturally from the majority, peers know the cultural risks and most appropriate and realistic risk-reduction strategies from experience[77]. In such a way, peer education can be viewed to be a naturally tailor-made approach that attempts to customize content and the approach of communication to the context of the targeted people.

From the study, peer education was found increasingly employed among the youth through youth clubs established across LASO and MASO project communities. As a package, the method was found to encompass informal group discussions and individual counselling sessions. The group sessions are held weekly among LASO's affiliated youth clubs, while in the project area of MASO they take place monthly and individual counselling is held variably to the convenience of the client. The procedures through the method were found to be

[76] UNAIDS, Sexual behavioural change: Where theories have taken us?, 1999, p. 15
[77] Ibid.

led by youth peer educators trained around sexual and reproductive health, behaviour themes relevant to the behavioural challenges, values, attitudes and practices of youth in the context of HIV and AIDS in the area. The themes are initially identified by the CBO or youth club members. Around the thematic areas established by the CBO, the group discussion set out to draw real experiences among the participants around the themes, which is followed by discussion of possible ways of confronting their challenges and achieving favourable behaviours. Illustratively, an informant from one of the involved youth clubs indicated that: *"Ngati gulu timagwirizana njira zoti tingatsate kuti tikwanitse makhalidwe abwino ndikuphunzitsa anzathu"* (as a club we agree on what we can do as youth to achieve changes in our behaviours and how we can reach out to our peers)[78].

It was further established that at the end of the sessions participants are given print IEC materials such as booklets, flyers and pamphlets relating to the issues covered. In this case, the IEC materials serve to complement the messages initiated primarily set through the discussion and counselling sessions.

On a critical note, the strengths of the peer education can be understood to lie

[78] A male member of Six Miles Youth Active, one of the youth clubs collaborating with LASO. Interviewed on the Tuesday 8th May 2007.

within the whole idea of training youths to educate and motivate change amongst them. This demonstrates empowerment of the youth to take principal roles building and sharing knowledge and skills that will enable them to take action of their behavioural problem and improve their lives. Such a setup is essential to the success of behaviour change and participatory communication processes[79].

With socialisation and peer-pressure commonly mentioned by community informants as key factors influencing inimical attitudes and sexual practices among the youth across the two sites, facilitating the youths to confront their challenges raises the guarantee that the communication and change processes are tailored to their interests and needs as they themselves are in a better position to know better about their own situations[80].

3.3.1.4 Counselling Sessions

According to Parker W. et al. (2000), counselling refers to a one-on-one dialogue-based approach that involves a trained professional who helps guide clients towards solving their (behavioural) problems[81].

From the study, the method was commonly identified as "*ulangizi*" or "*uphungu*"

[79] Rodgers, 1976, p. 33 & White, 2003, pp. 37-38
[80] Onyango, G.M., 2003, p. 36
[81] Parker W. et al., 2000, p. 46

which literally translates to "giving advice". The method was described as involving individual trained volunteers of the CBO offering support information and advice to individual community members who voluntarily come or are visited in their households. During the sessions, clients have the opportunity to ask questions and seek clarification around the issues at hand or any other issue relevant to HIV and AIDS. Apparently, the setup and approach to dissemination of information was found to be observed both conceptually and operationally similar to that in the peer education implemented through youth clubs. The only difference being the specification of the target group which also determined the content themes. In this case while peer education is only available to youths, counselling sessions were found to be targeted the general community population understanding from the expression of a project officer from LASO that *"Uphungu ndi ulangizi zimapereka kwa aliyense amene amabwera okha kumaofesi kwathu komanso amene tiwafikira khomo ndi khomo"*. (Counselling services are offered to those who voluntarily come for them at our quarters and through outreach to households)[82].

However, rampant stigma and fear of consequent discrimination and trauma was found to be the main cause of poor turnout for the services. For example a counsellor from MASO indicated that "*masiku ano uphungu wathu wagona*

[82] A project officer from LASO interviewed on Wednesday 2nd May 2007.

pazochotsa mantha ndi kusazindikira pa nkhani yoyezetsa magazi" (Nowadays our counselling is tailored to rid the common fear and lack of proper awareness of the benefits of VCT)[83]. Verifying such state of affairs, a female ordinary community respondent from Lambulira reported that *"zimapatsa mantha kuti atandipeza ndi kachilomboko anthu aziti chiyani"* (It is scaring when you imagine what will say about you if you are found to be positive)[84]. Similarly, a male middle-aged respondent from Magomero stated that "*Sindingapiteko chifukwa anthu amawona ngati ukudzikayikira*" (I cannot because people will start thinking that I am doubt my own status)[85].

On a critical note, the setup of the counselling session portrays a personalised interpersonal approach to information creation and exchange, which has potential to motivate and empower the client to achieve change in behaviour[86]. The strengths of the method lie firstly in its being demand-driven as persons come voluntarily for the services. This reflects empowerment on the part of the target group as they make their own decisions to access the services. Secondly, the close interaction between the counsellor and the client assures thorough understanding of the issues at hand and achievement of shared meaning as both have the

[83] Gresham Phokoso, a counselling volunteer with Magomero Aids Support Organization (MASO) interviewed on Friday 4th May 2007.
[84]Unnamed female ordinary community member responding as participant in focus group discussion held at Magomero on Monday 7th May 2007.
[85] A middle-aged male from Magomero. Interviewed on Friday 4th May 2007.
[86] Parker W. et al., 2000, p. 60

opportunity to ask for clarification and can construct meaning through their interaction[87]. Ultimately, despite the problems with patronage, the setup of the counselling sessions reflects customization of the communication process to the behavioural challenges, needs, interests and contextual characteristics of the individual clients as well as their empowerment, as they are actively involved in articulating and managing their own change.

3.3.2 Small Media Methods

For the most part, the objectives of small media such as print IEC materials relate to providing support to other activities[88]. For example, leaflets on VCT were found in the present study to be providing useful support to counselling services and peer education as the recipients are enabled to draw further reflection on issues tackled.

The establishment of small media in BCC is argued to take into consideration several issues among which the present study takes interest in *language*, *literacy* and *distribution*[89]. Literacy and language are said to affect people's level and manner of interpretation of printed messages. On language, Parker W. et al (2000) contends that most people prefer to receive information in their first language, and

[87] Ibid, p. 21

[88] Parker W. et al., 2000, p. 36

[89] Parker W. et al., 2000, pp. 36-40

it is therefore necessary that sources be proficient in the target group's language so that materials produced can easily be understandable. On the other hand, literacy is understood as an obvious constraint to the reading of the printed word as in booklets and pamphlets, as well as ability of people to interpret visual material – for example, pictorial posters[90]. Hence small media should consider the levels and distribution of literacy among intended targets so that messages are packaged in the best way for meaning to be easily drawn. Thus, for example reading IEC materials may prove ineffective in most rural areas in Malawi where illiteracy is excessive.

As previously mentioned, small media is most commonly applied as support to other initiatives as such its distribution would accordingly have to be dependent on and determined by the supported activities as entry points. According to Parker W. et al. (2000), it is unlikely that small media would make impact on their own. This is why when it comes to *distribution* the key challenge is identifying the potential of the available activities in attracting intended target group[91]. Just as is the case with the interpersonal communication, Parker W. et al. (2000) further suggests that the distribution systems of small media be tailored to provide the

[90] Ibid, pp. 36-37
[91] Parker W. et al., 2000, pp. 37-38

most efficient and cost-effective access to defined target groups[92]. This means that the interests and opinions of the target people should be considered when setting the distribution systems of small media. Thus active involvement of the target communities is essential to the effectiveness of the small media.

3.3.2.1 Print IEC Materials

Across the two study sites, print IEC materials such as booklets, posters and flyers are solely the small media in practice. The most common of the materials in circulation included *"Kukhala m'Chiyembekezo"* a Chiwewa version of the "Living Positively" booklet published by the Pakachere Health and Development Programme under the Population Services International (PSI). The booklet covers topics on nutrition and basic health care practices on how one can live healthily while HIV positive. It contains succinct basic information on basic issues supported by drawings and photographs. This booklet, along with other print IEC materials for example flyers and pamphlets covering topics such as voluntary counselling and testing, prevention of mother to child HIV transmission were reported being received from District Aids Coordinator, Youth Net and Counselling (YONECO), and Hope for Life among other district partners.

With none of the two sampled CBOs lacking resources to capacitate production of

[92] Ibid, p. 41

own print IEC materials, consignments were reported solely accessed from external partners at district and national level.

The print IEC materials were found to be commonly employed as support mechanisms all through the interpersonal methods. Explaining the rationale of such a procedure Richard Simon, LASO's Prevention Project Officer indicated that *"Zowerenga zija zimathandiza kuti panthawi yawo akathe kumazikumbutsa ndi kuzama pamitu yomwe timakhala tikulangizana"* (The print IEC materials help the people have in-depth understanding of the issues tabled in discussion and counselling sessions)[93]. The materials are distributed to the community members in audience during community outreach activities and as Stepping Stones and Peer Education participants. Some materials, mainly posters are pasted around the villages for public access. Access to the materials was found to be dependent on voluntary interest of the community members. Any client of the counselling sessions, participant of Stepping Stones and Peer Education, as well as members of the audience members outreach meetings would be given the materials without verifying whether they are able to read or not. A female community member from Lambulira acknowledged to having got her fears about HIV testing and post-testing living after reading the aforementioned Pakachere booklet accessed from LASO. She testified that the booklet has been important to her as it has offered

[93] Richard Simon, Prevention Project s Officer with LASO interviewed on the 2nd May 2007

her detailed information on the subject, and has been convenient information source as she can access it whenever she needs it and can re-read it to refresh her knowledge. This case illustrates the importance of small media in raising and maintaining knowledge levels building on messages that could be initiated through other strategies.

On a critical note, the feature of the print IEC materials as support to other communication activities substantiates a positive mark for the studied community-based communication methods. According to Parker W. et al (2000), in an effective BCC setup, small media are set to provide support to other communication activities[94]. However, the setup falls short in the distribution mechanism for lack of measures that ascertain active involvement of the target people proven crucial to effective BCC under the theoretical framework. The identification of the type of materials to be distributed and the actual process of distribution was found to be solely planned and carried out by the CBO personnel. Substantiating this observation, a female community member from Lambulira stated that: *"Timangolandira zowerengazo kapena kumvetsera mauthenga omwe a za Edziwo amapereka maderamu"* (We only receive the literature or hear the messages from the AIDS people in our communities)[95]. No opportunity is

[94] Parker W. et al., 2000, p36
[95] A female contributor during focus group discussions held at Lambulira on Friday 4th May 2007.

provided for the target people to directly express their views, opinions and interests to be tailored into the distribution process. Thus the process is understood alienating the very same people it is supposed to empower[96].

3.4 CONCLUSION

As understood from the above analysis, on the overall, the variety of the identified communication methods demonstrates a complementary combination of interpersonal approaches such as peer education and Stepping Stones and one-way small media printed IEC strategies which, as expounded, conceptually characterize an effective recipe for BCC[97].

Primarily, the implementation of the communication methods earns credit understanding that most of the methods are appropriate for specific target group to address their specific behavioural challenges. As illustrated in the case of Stepping Stones and Peer Education, the specification of methods for specific target audience was reached at to fit the varying interests and needs of people. This appears to be guaranteeing optimal attendance and commitment of the specified target people. However, the operationalisation of the methods divulges reprehensible aspects as far as actualisation of the values of BCC. Evidently, the

[96] Low-Beer & Stoneburner, 2004, p. 24 concurring with Melkotte S., 199, p. 228
[97] UNAIDS & PENN STATE, 1999, p. 70

process choosing the dialogue-based methods, as well as direction of the distribution systems of IEC materials shows clear dominance of the CBO personnel. Across most of the studied methods, the target audience was established in the periphery as passive participants in the implementation of the interventions whose themes and approaches are preset by the CBOs. For example, in the setup of community outreach meetings the ordinary community members were found not involved neither in the preparation of the articles nor their performance. This demonstrates denial and disempowerment of the target people to play decisive roles in appropriating the communication needs and processes which, as argued under the theoretical framework in Chapter 1 ensures customization to the actual needs and contextual characteristics of the targeted people hence effective BCC.

CHAPTER FOUR

CRITIQUE OF FINDINGS ON THE PROCESS OF MESSAGE DEVELOPMENT

2.5 INTRODUCTION

This chapter explores and critiques the identified aspects in the mechanism of developing messages and setting up issues informing the communication activities carried out by community-based organisations. The presentation begins with a descriptive outlook of the processes of identifying critical issues and developing messages. This is followed by a critical analysis which attempts to deduce overall conclusions in the light of the conceptual insights on activity and involvement of target populations in BCC as understood from the theoretical framework of BCC and national guidelines for BCI and HIV and AIDS communication.

2.6 CONCEPTUAL AND OPERATIONAL OVERVIEW OF MESSAGE DEVELOPMENT IN BEHAVIOUR CHANGE COMMUNICATION

Whether one-way or two-way, communication basically involves expression of messages between senders and receivers. Reasonably, the way messages are

expressed is based on a close understanding of the receiver's ability to understand them. Hence understanding is the core of meaning[98]. Meaning is herein defined as the idea(s) intended to be interpreted and constructed in the mind of the receiver. Thus, for an effective setup of the communication process, messages should be formulated and clearly sent with an understanding of how target audience will be able to draw the actual meaning. Whilst the communicator might create the *message*, it is the receiver who creates *meaning* thus whether one works at national, provincial, regional or community level, it is necessary to have a clear understanding of the intended audiences[99].

Understanding from the theoretical overview of BCC explored in Chapter 1, coming up with change messages requires understanding and consideration of issues defining the personal and social behavioural context. The said context is defined by various issues that bear direct and indirect influence on people's behaviour. According to FHI (2002), such issues include: cultural traditional beliefs, values and practices, age, gender, educational and economic status, people's perception of risk and HIV and AIDS, opinion leaders, media and entertainment habits[100].

[98] Parker W. et al., 2000, p. 32
[99] Parker W. et al., 2000, pp. 21-22
[100] FHI, 2002, p. 6 & p12

As Ekong (2003) puts it, for enhanced relevance and effectiveness, change messages should be based on researched information and be customised to the diverse behavioural challenges and information needs of the target communities[101]. This suggests importance of gathering information and analysis of key issues and processes relevant to the context of the intended population upon which messages will be tailored. As regards appropriate method of collecting information for behaviour change programming Onyango (2003) observes the value of participatory approaches that build on people's perceptions and experiences and acknowledge that the community knows its own situation best[102]. Correspondingly, participation of target communities will help achieve a variety of information that defines the uniqueness of the context[103].

The above explication of key process of gathering information entails that receivers of messages are not passive that messages can be developed for them and meaning poured into their heads. Instead, active involvement of the target communities in researching their own situation and therefrom creating messages would assure clarity and broad comprehension of their actual behavioural challenges hence guaranteeing viable input to development of messages. Consequently, alienation of the target community members from knowing the

[101] Ekong Emah, 2003, p. 12
[102] Onyango, G. M., 2003, pp. 36-37
[103] FHI, 2002, p. 11

processes involved as well as taking part in both identification of critical issues and creation of messages is certainly set to compromise target people's understanding and correctness of the message content to the specific behavioural challenges and information needs on the ground.

2.7 ANALYSIS OF THE PROCESS OF MESSAGE DEVELOPMENT IN IDENTIFIED COMMUNICATION ACTIVITIES

Across the two study sites, out of 52 community informants (including local leaders and their subjects), 46 reported not knowing how messages are developed and had never been involved in any related procedure to their knowledge. For example, when an ordinary community members' focus group from Lambulira was asked whether they know how the messages they receive from LASO are reached, Maria Nachulu, a female participant, said: *"Akamanena monga zamauthenga akupewa kwa mayi kupatsira HIV kwa mwana wosabadwa, sitidziwa kuti zonena zawo zija amaganiza okha kapena amazitenga kuti. Ife timangomvetsera"* (When they talk about prevention of mother to child transmission, we do not know where they take the message. We just listen to them)[104]. The remaining 6 reported that they were not sure and cited such

[104] Maria Nachulu: middle-aged female participant in focus group discussion held at Lambulira on Friday 4th May 2007

speculations as this one given by a female respondent at Magomero that *"mwina amawuzidwa ku boma ndi kumabungwe"* (they get them from the government or other organisations), or *"athanso kuti amatengera pa wailesi"* (they may also be adapting from radio messages) as said by a Mr Anafi James, village elder from Lambulira. [105]

According to the reported experiences and intervention mechanism of the CBOs covered in the present study, messages that are carried in communication interventions are conceived from experiences in other areas of interventions such as Home Based Care (HBC) and Voluntary Counselling and Testing (VCT). It was found that responsible project officers are expected to report on behaviour related challenges among the target group(s). For example, Mr. Focus Chiwalo from Magomero said *"tikawona kuti anthu pamudzi sakumusamalira munthu odwala matendawa, timazindikira kuti pakufunika uthenga owazindikiritsa cholakwika ndikuwaphunzitsa chikhalidwe chabwino"* (if we observe that are shunning a patient (during HBC), we understand that there is need to intervene with messages that can teach them positive behaviours)[106]. The CBO personnel then discuss around the reported behavioural challenges and strategise type of messages to be taken to the people and how they can be best delivered. A female

[105] Male community informant from Magomero in the project area of MASO
[106] Mr Focus Chiwalo heads the Magomero AIDS Support Organisation. This is excerpt from an interview held at Magomero on the 8th of May 2007

voluntary officer with LASO said *"tikakumana ngati agulu timakambitsana nkuwona kuti tiyenera kuwapatsa uthenga wanji anthu komanso kudzera mnjira yake"* (When we meet as a group we discuss and identify messages and their delivery methods)[107]. It was further indicated that messages are adapted from print IEC materials accessed from district or national partner organisations. Substantiating this scenario, a CBO outreach volunteer from LASO informed the study that: *"mauthenga ena timapereka kuchokera mabuku ndi zowerenga zina monga pa uthenga wokhudza mmene munthu ungadzisamalilire ngati uli ndi HIV, timawupeza kwambiri mbuku la Pakachere"* (we draw some of messages from various print IEC materials, for example, the Pakachere "Living Positively" booklet) from which we draw insights on best practices for nutrition and healthcare linked to HIV and AIDS are mostly referred from[108].

2.7.1 Community Outreach Meetings

As indicated in Chapter 2 communication methods presented in the community outreach meetings include drama sketches, songs and poetry; testimonies and motivational talks by persons living with HIV or AIDS patients (PLHIVs). Also commonly included are quiz sessions whereby audience members are randomly asked questions about HIV and AIDS.

[107] Female volunteer with LASO contributing to a focus group discussion on Friday 4th May 2007 at Lambulira.
[108] Contributing during a CBO members' focus group discussion held at Lambulira on Monday 7th May 2007

It was found that the messages carried in the performed activities are thought over by the performers, basing on experiences and observation from activities in other areas of intervention as well as day-to-day life events in the communities. A member of a youth club from Lambulira who was involved in a drama performance said that they usually tackle behavioural issues commonly affecting their age group in the area such as multiple sexual relationships and distaste of VCT services. Concurrently, a youth club member from Magomero said explained *"ngati gulu timakhala ndizokambirana kamodzi pasabata pomwe timawona zamavuto amene akukhudza makhalidwe achinyamata. Timapeka mitu yamasewero ndi ndakatulo pofanizira zochitika zenizeni mogwirizana ndiuthenga umene takonza kuti ufikire anthu"* (as a youth club we meet once a week to discuss behaviour related issues affecting the youth in our area. We compose messages for our poems and plays around real life events)[109]. Despite that the performance is done before the general community members, the youth clubs indicated that their outreach acts are mainly targeted at fellow youths.

Similar procedures were observed in how the CBOs prepare their articles for the community outreach meetings. Basically, informants from both LASO and MASO indicated that they mainly identify messages from discussions within the

[109] Youth club member collaborating with Magomero Aids Support Organization contributing during a focus group discussion held at Magomero on Tuesday 8th May 2007

CBO as they brainstorm on issues observed through other areas of intervention and previous communication activities. For example, a trained Stepping Stones facilitator from LASO cited that sessions have specially helped in bringing out issues indicative of the HIV and AIDS awareness, attitude or behavioural challenges existent in the communities. She stated that *"Amayi ambiri amadandaula kuti akabweretsa maganizo oyezetsa magazi abambo amakalipa kuti wayamba kuwakayikira ndiye kuli bwino banja lithe. Apo timazindikira za mavuto amene alipo ndikufunika kofikira abambo ndi uthenga owazindikiritsa zakufunika kwa VCT"* (asked to explain why they shun VCT services, a group of women during a Stepping Stones workshop cmplain that their husbands are angered by any suggestion idea of going for the service. They suspect that the wives doubt their faithfulness and threaten to end the marriage. In such a situation, we realise the problem on the ground and the need for a message targeting the husbands on the importance of VCT)[110].

From the above explained overview of how issues are identified and messages developed for outreach activities, it is reflected that it is all an exclusive activity of the CBO personnel as they refer to their reports and own observations. All along the processes the target people are typically reduced to a sideshow as mere recipients of already made messages.

[110] A female Stepping Stones facilitator with LASO informing an interview held on Friday 4th May 2007

2.7.2 Stepping Stones

As stated in the preceding chapter, it was found that Stepping Stones method is exclusively being practiced on women groups engaging in Home-Based Care (HBC) activities. The issues feeding into the workshops were found to be generally behaviour related challenges encountered by the women in their day-to-day activities in taking care of AIDS patients. Mayi Noria Misale, a participant in the Stepping Stones illustrated that most of their discussion issues currently surrounding how to overcome stigma and discrimination of the HIV infected. She reported that *"anthu ambiri amakana kutithandiza kusamalira odwala ena chifukwa cha mantha kuti atengera matendawa koma ambiri amati nkutaya nthawi chifukwa odwalayo akulandira malipiro amchitidwe wake wa chiwerewere"* (many people shun getting involved in Home Based Care activities; for some, it is out of fear of contracting it most consider it as wasting time as the patients are facing deserved retribution of their past promiscuity). According to a Stepping Stones facilitator from LASO, the process of identifying such issues sets out from evaluation of field reports and observations from HBC and interventions such as outreach meetings, counselling and peer education sessions by a selection of CBO members. The facilitator explained that: *"Timawunika mitu yomwe ikukhuza umoyo ndi gawo la amayi posamalira amene alikuvutika ndi matendawa"* (We look out for issues affecting the livelihood and role of women in taking care of those affected and infected). The identified issues were thus

found to inform topics of discussion for the Stepping Stones workshops.

While the setup of the Stepping Stone sessions allowed the women to bring in their opinion on how best change in behaviour can be achieved within their setting, the establishment of the process of identifying issues for discussion marginalised them. The targeted women groups are brought to a workshop that limits the understanding of their own situation around subjects preconceived by the CBO members.

2.7.3 Peer Education

As indicated in the preceding chapter, across the two study sites, peer education was found to be exclusively applied as an intervention for the youth. A member of Six Miles Youth Active, a youth club that works with LASO, stated that: *"mitu yomwe timakambirana timayitengera pazochitika zomwe timaziwona mdera lathu zowopseza umoyo wathu achinyamata pankhani ya Edzi"* (We draw themes from issues and events factoring risk of us as youths in the face of HIV and AIDS in our area). These areas were found to be tackled in informal discussions and individual sessions are identified by the CBO or youth club members. The group discussion set out at verifying relevance of the issues in the day to day lives of the participants. The process involves peer educator facilitating discussions that are aimed at provoking the youth to reflect and discuss their own experiences. Their

discussion leads to suggestions of possible ways to successfully confront their challenges, solve their problems and practice safer behaviours.

It was practically reflected that those targeted by the method are not accorded any roles in the initial steps of identifying issues to be responded to in the intervention. Perceptibly, problematic areas are preconceived by the CBOs or youth club committee members and only brought for reflection among targeted youths.

2.7.4 Counselling sessions

Just like in the setup of peer education, the common topics concerning values of testing and post-test living were found to be identified and commissioned by the CBO members. From a review of reports from various interventions the CBO personnel establishes issues that are of concern and relevance among the local population. The sessions were found to involve in-depth discussion of clients' personal experiences building around issues identified by the CBO. For example, a focus group of project officers and volunteers from LASO reported of discrimination of infected persons and low turn-out for VCT services as their current popular focus areas in the counselling sessions. One discussant reported that *"uphungu wathu kwenikweni ukulondoloza zifukwa za nkhawa ya anthu pankhani yoyezetsa magazi yomwe timayizindikira muntchito yathu yamdera"*

(the counselling sessions are focuses at the widespread fears that we note in the communities). An female community member from the same area indicated that: *"Uphungu umatifika motifunsa mavuto ndi maganizo athu pankhani yoyezetsa magazi komanso kutilimbikitsa zaubwino wodziwa ngati tili ndi HIV"* (the counselling sessions involve questions on our problems and standpoint on test for HIV and the benefits on knowing our HIV status).

From a critical perspective, it can be understood that the themes of the sessions are dictated by the CBOs. The active roles are found to be taken by the CBO personnel and the targeted clients have no influence on them apart from engaging in discussions on fixed subjects.

2.8 CRITICAL OVERVIEW

Empirical insights drawn from the critical observations of the sampled target community informants provides an empirical justification of the theoretical critique of the shortfall message development processes in the studied community-based activities. A good number of the informants criticised the selection of content issues in the messages given by the CBOs. They complained that most messages do not relevantly capture the current HIV and AIDS situation or misrepresent their local problems. For example, Divason Kuleti, a male community member from Magomero reported that during outreach events, CBOs

take much time talking down traditional practices such as usage of one razor blade to circumcise more than one initiates during *chinamwali* (initiation ceremony) or *chokolo* (arranged remarriage of a widow to deceased husband's brother), which are no longer practiced. He explained that: "*Mmadera mwathumu za chokolo kaya malezala akuchinamwali zinasinthika ndithu koma pali mavuto ena monga kugonanagonana kwa achinyamata; chodabwitsa izi sizikumakambidwa mowilikiza ngati mmene akachitira ndi zakalezo"* (the problems of *Chokolo* and unsafe usage of razor blades during initiation ceremonies have so far changed but the CBOs seem to be taking serious concern on them overlooking current problems such as rampant promiscuity among the youth)[111]. Concurrently, a young man in his early twenties cited that: "*Zimawonetsa ngati kuti alibe chenicheni chatsopano nchifukwa, misonkhano yawoyi siimandipatsanso chidwi."* (It seems they do not have anything new to tells us hence I no longer have interest to attend their meetings)[112].

The above stated observations evidence effects of a flawed process of message development. Taking into consideration the empirical observations and perception of informants in light of the theoretical precepts guiding this study, there are two key flaws reflected in the message development processes. First is insensitivity to

[111] Excerpt from an interview held on 8th May at Magomero.
[112] Contributing during a focus group discussion on 8th May 2007 at Magomero.

people's current specific behavioural issues and sticking to general and obsolete issues. As is illustrated from the overview of the behaviour change theories in Chapter 1, effectiveness BCC process has to accord principal importance to the current context target people, which, includes their socio-demographic characteristics, knowledge, attitudes and practices. According to FHI (2002) these stipulate the behavioural context[113] and as Ekong (2003) observes, has to be importantly mulled over for relevant and effective tailoring of issues into behaviour change messages[114]. Furthermore, as Onyanngo (2003) understands, the participatory communication precepts of the BCC theory consistently imply that active involvement of and close interaction with the target people in the messaging process ascertains relevance of the messages to the actual and unique challenges and needs of the target people as they are in the best to know their situation.[115] Consequently, the observed inaccuracy of the messages in most community-based BCC activities to actual behavioural concerns among the target population illustrates an important shortfall in the set-up of the communication process.

In the same way, lack of involvement of ordinary community members, as CBO members are found dominating the identification of problematic issues, is proven

[113] FHI, 2002, pp. 5-6
[114] Ekong Emah, 2003, p. 12
[115] Onyango, G. M., 2003, pp. 36-37

to compromise the value of the messages among the target auideinces. Jairosi Changaya, an elderly male community member from Lambulira stated that *"samabwera kufunsa akulu amudzi muno nzeru. Amangotenga zomwezo aweruza okha. Ife akulu timangopenya izo akonza iwo eni."* (they do not seek anybody's views; they make their own judgements and we just watch what they have prepared)[116]. Across the two sampled sites, it was commonly observed that community members largely distance themselves from ownership of the behaviour change activities carried out by local CBOs. Most informants regarded the activities as belonging to the CBOs. Illustrating this claim, were such statements as *"misonkhano yawoyi"* (their outreach meetings) and *"ntchito zawozo"* (their activities) when referring to the interventions led by their local CBOs in both Lambulira and Magomero areas. According to White (2003), target people are supposed to be and at the centre and in control of their own change processes through identify and discussion of challenges, suggest solutions and develop appropriate messages. As explained under the theoretical framework in Chapter 1, such a setup not only assures development of effective messages as the people critique their own lives but also empowers, mobilizes and instils self-efficacy feeling among them to solve their own behavioural problems. Thus sideling of the target people in the message development processes greatly compromises the viability of the messages therefrom.

[116] Contribution during focus group discussion at Lambulira on 4th May 2007

2.9 CONCLUSION

Beyond the theoretical justification of its significance to effective BCC activity, the above exploration of the identified communication activities substantiates message development as a crucial subject in the setup of effective behaviour change programming. More importantly, it has been established that effective inception of behaviour change communication activity requires close understanding of the personal and social context of the target populations. Close interaction between the community members as message targets and the CBOs as message sources is subsequently shown to be essential towards achieving accurate messages as it enhances in-depth mutual investigation and knowledge of the target population needs and situation. As observed in the sampled cases, selectiveness of the approaches employed of CBOs at the expense of the target community members does not only disempower them to take lead in tackling their own challenges[117] but also threatens to compromise the relevance of the content issues of the messages to the actual behavioural challenges on the ground as well as drawing meaning from the messages. Much as the CBO committee are community members but it would be more practical if consultation procedures were clearly outlined and observed in their implementation processes to ensure and reinforce acquisition and keying in of ordinary community members' perspectives.

[117] Parker W. et al, 2000, p. 59-60

CHAPTER FIVE

CONCLUSION

5.1 INTRODUCTION

The present study set out to examine both latent and demonstrated capability to realise *active involvement and empowerment of target community players* and *dialogue-based approaches* in the community-based behaviour change communication interventions. Specifically, the investigation focused on the procedures and approaches for development of messages and appropriation of communication methods. The study also examined terms of collaboration among the interested stakeholders in community-based BCC activities. Initially, the study analysed the national BCI and related communication strategic provisions in the National HIV and AIDS Policy, Malawi HIV and AIDS National Strategic Framework (2005-2009), the National Behaviour Change Intervention Strategy for HIV and AIDS and Sexual and Reproduction Health (NBCIS) as well as the HIV and AIDS communication guidelines. In light of the given theoretical outlook of BCC, this was meant to appreciate their latent potential to guide effective BCC practice. The analysis of the policy issues and empirical findings was guided by a theoretical framework of BCC, which espouses participatory approaches at all levels of programming interventions. As explored in Chapter 1,

key entailments of BCC theory include active roles for target communities, and dialogue between community-based and external players, as well as within communities in decision-making and execution of messages developing processes and communication methods.

5.2 OVERVIEW OF STUDY

The study set out with a background overview of the epidemiological context and national HIV and AIDS response in Malawi. Following descriptive exposé of the cases under study, the critique has focused on the communication methods and message development processes in community-based BCI. The identified communication methods were specifically assessed in terms of how their natural format and implementation process ascertains dialogue among stakeholders and, more importantly, active roles for the target communities.

The findings of the study indicate that interpersonal methods such as peer education and Stepping Stones and one-way small media solely represented by print IEC strategies complement each other. In theory, such a setup in which print media complement other strategies is viewed to characterise effective BCC[118].

On the other hand, the assessment of the national BCI implementation plans and

[118] UNAIDS & PENN STATE, 1999, p. 70

HIV and AIDS communication guidelines reveals interplay of advocacy, social mobilisation and IEC aspects suggests a customised and inclusive approach to behaviour change communication intervention. From development and delivery of messages, the strategies advocate for active and committed participation by national to grassroots in initiating and managing behaviour change and related communication interventions. With key theoretical reference from FHI (2002), PATH & Ipas (2005) as well as UNAIDS & PENN STATE (1999) observe that involvement and commitment of all stakeholders creates conducive environment for behaviour change as the target people play decisive roles in articulating and addressing their own behaviour problems and appropriating their communication needs. To the empirical context, this implies primacy of employment of mechanisms that would allow and support the general community to contribute and critique issues that would inform messages and direction of their communication methods. However, the study has managed to discover more weakness than strength in the setup of both message development and application of communication methods.

As regards the choice and implementation of communication methods, the study conclusively observes dominance of CBOs' personnel while the ultimate target audience stays in the periphery as passive targets of the interventions.

With regard to the process and mechanism of message development carried for the community-based behaviour change communication, the study began with a descriptive outlook of the processes observed. This was followed by a critical analysis that aimed at appreciating the competence of the observed procedures guarantee active involvement of ordinary target populations in light of the precepts of the present study's theoretical framework and standpoints on the national guidelines for BCI planning and HIV and AIDS communication. The study has discovered that effective inception of behaviour change communication activity requires close understanding of the personal and social context of the target populations. Close interaction between the community members as message targets and the CBOs as message sources was subsequently shown to be essential towards achieving accurate messages. Such interaction has been found to enhance in-depth mutual investigation and knowledge of the target population needs and situation for well-informed messages based on shared knowledge between the intervening agencies and target communities. As observed from the study findings, dominance of the CBOs at the expense of the target community members violates the people's deserved role in tackling their own challenges. This has also been observed to compromise the relevance of the content issues for messages to the actual behavioural challenges on the ground as well as understanding of their meaning.

5.3 LESSONS ON BEST PRACTICE OF COMMUNITY-BASED BCC

From the overall outlook of observations on the empirical findings of the study and the theoretical precept of behaviour change and BCC, in particular, communication is found to be an importantly influential element in the process of individual and social change[119] alongside such factors as social, religious, economic, and cultural. To this effect, the milieu of communication in the context of BCI in Malawi is an equally important direction of inquiry which deserves serious attention in the quest to understand and explain the cause(s) of poor HIV and AIDS related behaviour change in Malawi.

From the analysis of experiences in community-based communication interventions for behaviour change, the scope of present study goes beyond mere diagnosis of identified field practices to set insights for the advancement of policy and strategic frameworks for designing and implementation of BCC at the community level and beyond. Consistently, the ultimate lesson from this study is that the best practice of behaviour change communication entails a collaborative, interactive and dialogic approach with prime emphasis on active roles of the target population. Therefore, a practical setup of BCC intervention should oblige collaboration between implementing agencies and intended targets in tailoring the

[119] Melkotte S., 1991, p. 259

communication processes. While stakeholders with programme experiences and expertise are important in the framework of human resource for the programme, the community player is inimitable importance to the contextualisation of programme approaches and content as well. Both individual and social behaviour theories assert that people whose behaviours are targeted to be modified would be in a better position to understand them (problems) and make significant contribution to the process of their own change[120]. Thus, target populations deserve recognition not only as objects but also active partners in the definition, design and execution of change interventions. Consequently, the observed general passivity of target community members from the empirical findings on message development, the choice and application of communication methods alludes to the unfeasibility of the processes to ascertain effective BCC hence not guaranteeing people's behaviour change.

5.4 POLICY AND BEST PRACTICE RECOMMENDATIONS ON COMMUNITY-BASED BCC

To remedy the abovementioned problematic empirical scenario in the backdrop of observed general limited awareness of the national HIV and AIDS communications guidelines, it is herein recommended that the national guidelines for HIV and AIDS communications and the implementation frameworks for BCI

[120] UNAIDS.1999. Where the theories have taken us: pp6-20

be promoted and familiarised among all relevant stakeholders, more especially the community-based players. Such a makeover would easily be carried out within available structures and policy jurisdiction. For example, the office of the District Aids Coordinator (DAC) as local coordinating authority would be sanctioned and supported to promote and police the appropriation of the available HIV and AIDS communications guidelines by all stakeholders involved in community-based behaviour change communication interventions. As regards its relevance to policy and strategic context, the National HIV and AIDS Policy and the National Action Framework (2005-2009) establish the mandate that all HIV and AIDS response activities in Malawi be guided along the standpoints of the National HIV and AIDS Policy and its action frameworks under the principle of the "Three Ones"[121]. Consequently, the mainstreaming of implementation frameworks of the BCI and HIV and AIDS communication guidelines, which are essentially an annexe to the policy, would be strategically justified.

5.5 SUGGESTION OF FURTHER RESEARCH

The present study's validation of the potential of communication variables on the level of success in behaviour change sets the rationale for further study in the area. A diversity of themes for new study can be directly drawn or implied from the insights and limitations of the present study. Firstly, the present study has

[121] NAF (Final Draft). 2002, p. x

endeavoured to critique the competence of the national strategic provisions at the textual level. Understanding that in the sampled cases the national guidelines were unknown and are not in practice, an evaluation-oriented study in the areas where the guidelines are known and/or have been practiced is critically important as it would provide empirical verification on the level of their competence. Secondly, recognizing the limitations of absolutely generalizing the insights of the present study to the national situation, it would be recommendable to undertake studies of similar dimension in other districts.

BIBLIOGRAPHY

***African Charter for Popular Participation in Development and Transformation*.** International Conference on Participation in the Recovery and Development Process in Africa – Arusha.1990.

Ashford L. S., ***How HIV and AIDS Affect Populations,*** Population Reference Bureau: Washington, 2006

BCC Network for Africa: First Regional Meeting for East. Central and Southern Africa - Kampala.2003.

Boyd-Barret, O. et al. (eds.), ***Approaches to Media: a Reader,*** Arnold: London, 1995.

Creswell, J. W., ***Qualitative Inquiry and Research Design: Choosing among Five Traditions,*** Sage publications: California, 1998.

Creswell, J. W., ***Research Design: Qualitative and Quantitative Approaches,*** Sage Publications: London, 1993.

Dagron, A.G., ***Making Waves: Stories of Participatory Communication for Change,*** The Rockefeller Foundation: New York, 2001.

FHI, ***Behaviour Change Communication (BCC) for HIV and AIDS: A Strategic Framework,*** Family Health International Institute for HIV and AIDS: Virginia, 2002.

Fussell, W., *The Value of Local Knowledge and Importance of Shifting Beliefs in the Process of Social Change* in ***Community Development Journal: an International Forum*** Vol. 31 No. 1. Oxford University Press: London, 1996. pp. 44 - 53

Gill K. et al, ***A Guide to Participatory Monitoring of Behaviour Change Communication for HIV and AIDS: Getting the Community and Program Staff Involved in Assessing and Improving Programs,*** PATH: Washington, DC, 2005.

Glanz, K. et al., ***Health Behaviour and Health Education: Theory, Research and Practice,*** San Francisco: Wiley & Sons, 2002.

Hanson, R.E., ***Mass Communication: Living in a Media World,*** McGraw Hill: New York, 2005.

Howard M, et al., ***Helping Teenagers Postpone Sexual Involvement*** in *Family Planning Perspectives,* Vol. 22 No. 1, 1990, pp. 21-26

Hybels, S. et al., ***Communicating Effectively*** **(6th Ed.)**, McGraw Hill: New York, 2001.

Israel et al., *Health Education and Community Empowerment: Conceptualizing and Measuring Perceptions of Individual, Organizational and Community Control* in ***Health Educational Quarterly,*** Vol. 21 No.2, 1994, pp. 149 - 170.

Joint United Nations Programme on HIV and AIDS (UNAIDS) and Pennysylvania State University (PennState), ***Communications Framework for HIV and AIDS: A New Direction,*** UNAIDS/PENN STATE: Geneva, 1999.

Kishindo, P., *Sexual behaviour in the face of risk: the case of bar girls in Malawi major cities* in ***Health Transition Review***, Vol.5. 1995, pp.153 - 160.

Kalichman S., ***Preventing AIDS: a Sourcebook for Behaviour al Interventions,*** Lawrence Erlbaum Associates Inc. Publishers: Mahwah, 1998.

Kelly, J., ***Changing HIV Risk Behaviour: Practical Strategies,*** The Guilford Press: New York, 1995.

Kondowe, E.B.Z. et al., ***UNESCO/UNAIDS: County Report Cultural Approach to HIV and AIDS Prevention and Care: Malawi's Experience***, *Country report for UNESCO and UNAIDS,* Cultural Policies for Development Unit: UNESCO: Washington DC, 1999.

Low-Beer, D. & R.L. Stoneburner., *Behaviour and Communication Change in Reducing HIV: Is Uganda Unique?* in ***African Journal of Aids Research (AJAR),*** Vol.1 No.2, 2004, pp. 1 - 11

Malawi HIV and AIDS Monitoring and Evaluation Report 2005, Department of Nutrition, HIV and AIDS, Office of President and Cabinet: Lilongwe.

Malawi National HIV and AIDS Monitoring and Evaluation Report 2007, Department of Nutrition, HIV and AIDS and Office of President and Cabinet:

Lilongwe.

Malawi Government and World Bank, ***Malawi Aids Assessment Study: Volume ,*** 1998.

National AIDS Commission, ***HIV and Syphillis Sero-Survey: National Prevalence and AIDS Estimates Report for 2007,*** NAC: Lilongwe, 2008.

National AIDS Commission, ***HIV and AIDS in Malawi Estimates of the prevalence of infection and the Implications,*** NAC: Lilongwe, 2003.

National AIDS Commission, ***National HIV Prevalence Estimates Report for 2001.*** NAC: Lilongwe.

Mann, J et al., ***AIDS in the World II,*** Oxford University Press: New York, 1996.

Melkotte, S.R., ***Communication for Development in the Third World: Theory and Practice,*** Sage Publications: New Delhi, 1991.

National AIDS Commission, ***Behavioural Surveillance Survey (BSS) Report,*** Lilongwe, 2004.

National HIV/Policy: A Call for Renewed Action, Office of President and Cabinet and National Aids Commission, 2003.

National Statistics Office, ***National Population and Housing Census 1998,*** NSO: Zomba, 1998.

National Statistics Office and ORC Macro, ***Malawi Demographic and Health Survey 2004,*** Calverton, Maryland: NSO and ORC Macro, 2005.

Oldenburg B. et al., *The Application of Staging Models to the Understanding of Health Behaviour Change and the Promotion of Health* in ***Psychology and Health,***1999, Vol. 14, pp. 503-516

Parker W. W et al., ***Communication Beyond Awareness: a Manual for South African* (2nd ed.)**, Department of Health, South Africa, Johannesburg, 2000.

Population Services International (PSI), ***Social Marketing and Communications for Health,*** PSI: Washington D.C, 1991.

Prochaska J.O. et al., *In Search of How People Change: Applications to Addictive Behaviours* in ***American Psychologist***, Vol. 47 No. 9, 1992, pp. 1102-1114.

Prochaska, J.O. & C.C. DiClemente, *Towards a Comprehensive Model of Change* in U. Miller, et al. (eds.) ***Treating Addictive Behaviours***, Plenum Press: New York, 1986, pp. 3-27.

Program for Appropriate Technology in Health (PATH) and Ipas, 2005. *Sparking Dialogue: Community Conversation on Safe Abortion.* PATH & Ipas. Nepal.

Prochaska, J.O. et al., *Measuring processes of change: Application to the cessation of smoking* in ***Journal of Consulting and Clinical Psychology,*** Vol. 56 No. 4, 1988, pp. 520-528.

Robson, C., ***Real World Research: A Resource for Social Scientists and Practitioner-Researchers,*** Blackwell: Oxford, 1993.

Rogers, E. M., *Communication and Development – The Passing of the Dominant Paradigm* in ***Communication and Development: Critical Perspectives,*** Sage Publications: Beverly Hills, 1976.

Schramm, W., ***Mass Media and National Development: The Role of Information in the Developing Countries***, Stanford University Press: Sanford, 1964.

SURF & UNDP, ***Participatory Development: Risks and Conditions for Success,*** SURF: Beirut, 1999.

Toffolon - Weiss M. et al., *The Results Framework: An Innovative Tool for Program Planning and Evaluation* in ***Evaluation Review,*** Vol.23 No.3, 1999, pp. 336-359.

UNAIDS, ***Sexual Behavioural Change for HIV: Where the theories have taken us?*** UNAIDS: Geneva, 1999.

UNAIDS, ***The HIV and AIDS Epidemic in Malawi: The Situation and the Response,*** 2000.

UNAIDS, ***Report on the Global AIDS Epidemic.*** 2006

UNAIDS, ***Intensifying HIV Prevention: UNAIDS Policy Position Paper,*** Joint United Nations Programme on HIV and AIDS, Geneva, 2005.

UNAIDS, ***Annual Report: Knowing Your Epidemic,*** 2007.

UNAIDS, ***Epidemic Update,*** 2007.

United Nations, ***The Impact of AIDS.*** UN Department of Economic and Social Affairs/Population Division: New York, 2004.

Uphoff, N., ***Fitting Projects to People*** in Cernea, M.M. (ed.) *Putting People First: Sociological Variables in Rural Development*, Oxford University Press: Oxford, 1985, pp. 369-378.

Walden, V.M. et al, *Measuring the Impact of a Behaviour Change Intervention for Commercial Sex Workers and their Potential Clients in Malawi* ***Health Education Research: Theory & Practice,*** Vol.14 No.4 1999, pp545-554

Wallace, T., ***Evaluating Stepping Stones: A review of existing evaluations and ideas for future M&E work,*** Actionaid International, 2006.

Welbourn, A., ***Stepping Stones: a Training Package in HIV and AIDS, Communication and Relationship Skills,*** Actionaid and Strategies of Hope: London, 1995.

Wangel, A., ***Aids in Malawi - a case study: A Conspiracy of Silence?*** Dissertation: Master Science Degree in Public Health in Developing Countries, London School of Hygiene and Tropical Medicine: London, 1995.

White, S. A., *Involving People in a Participatory Process*, S.A. White (ed.). ***Participatory Video: Images that Transform and Empower,*** Sage Publications: New Delhi, 2003, pp33-61

Witte, K., ***Managing Fear, Giving Hope: HIV and AIDS and Family Planning Behaviour Change Communication Guidelines for Urban Youth,*** JHU/CCP and Ethiopian National Office of Population: Addis Ababa, 2001.

World Health Organization (WHO), ***Summary Country Profile for HIV and AIDS Treatment Scale-up: Malawi,*** WHO: Geneva, 2005.

Yin, R.K., ***Case Study Research: Design and Tools - Applied Social Research Methods Series Vol. 5***, Sage Publications: Beverly Hills, 1989.

Zomba District Assembly. ***Zomba Rural Education District: District Education Plan 2008/09 – 2010/2011.*** 2007