

M A L A W I BRIDGE II PROJECT

2009 - 2015



END OF PROJECT REPORT



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JOHNS HOPKINS
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Programs



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Letter from the Director of the National AIDS Commission of Malawi

Dear Reader:

June, 2015

Since 1985, when the first case of AIDS was diagnosed in the country, the Government of Malawi, in collaboration with partners, has made some remarkable progress in the management and implementation of HIV & AIDS programs. The government adheres to the principle of the "Three Ones" and the National AIDS Commission (NAC) is the sole coordinating authority of the national response to HIV & AIDS in Malawi. The Government of Malawi in collaboration with its stakeholders developed and implemented several HIV prevention strategies and plans aimed at reducing the further transmission of HIV through unprotected sexual intercourse, mother to child, invasive procedures, and blood and blood products. These include: National Behaviour Change Interventions Strategy for HIV/AIDS and Sexual Reproductive Health (2003), National Plan of Action for Scaling up Sexual and Reproductive Health HIV Prevention for Young People (2008-2012), Plan for Scaling up HIV Testing and Counselling (2006-2010), Plan for Scaling up Prevention of Mother to Child Transmission of HIV Services in Malawi (2008-2012), ART Scale up Plan (2006-2010), Condom Strategy (2006), Abstinence Strategy (2008), Mutual Faithfulness Strategy (2008-2012) and HIV prevention strategy 2009-2013. HIV prevention interventions being implemented address behaviour change, HTC, PMTCT, STI management and blood safety.

Although government, through the National AIDS Commission (NAC) and its collaborating partners, have registered success, gaps in the national response and the implementation of HIV & AIDS programs still exist and require immediate attention. It is for this reason that the NAC appreciates the speedy response from the government of the United States of America (USG), through the United States Agency for International Development (USAID) to support HIV prevention interventions through BRIDGE II whose goal is to contribute towards reduction of new HIV infections by promoting normative behavior change and increasing HIV preventative behaviors among the adult population in Malawi.

From 2009 to 2015, BRIDGE II worked closely with NAC, the Ministry of Health and other cooperating partners to deal with social and cultural norms (e.g. wife inheritance, multiple and concurrent sexual partnerships) that fueled the spread of HIV in the Southern Region of Malawi. The project strengthened individual perception of HIV risk and self-efficacy to prevent HIV infection, mobilized communities to adopt social norms, attitudes, and values that reduce vulnerability to HIV, linked HIV prevention interventions to other services, and, supported Malawian institutions for effective leadership and coordination

There is no doubt that efforts by the BRIDGE II project have positively contributed to the national HIV response. I wish to thank every member of this remarkable team and all their collaborating partners for the excellent contribution they have made and will continue to make in the national response to HIV & AIDS in this country. The efforts of BRIDGE II wouldn't have materialized if it was not for the support from USAID and I would like to take this opportunity to acknowledge this timely support.

As a Commission, we acknowledge the support we receive from various players and I wish to encourage everyone working in the HIV & AIDS sector to read this report. I have no doubt you will find it informative and useful in your undertakings.

Tasankha!



Mr. Davie Kalomba
Acting Executive Director
National AIDS Commission

Acknowledgements

The BRIDGE II project was made possible by funding from the President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID). We thank them for their generous financial and technical support of this project.

The Johns Hopkins Center for Communications Program (CCP) would like to recognize all governmental, international and local partners who collaborated on BRIDGE II – without them, this project would not have been possible. These include:

- Various Ministries of the Government of Malawi:
 - Ministry of Health (HIV and AIDS Unit, Health Education Services, Reproductive Health Directorate, District Health Offices in all the 11 implementation districts, National AIDS Commission)
 - Ministry of Local Government and Rural Development
 - Ministry of Gender, Children, Disaster and Social Welfare
- BRIDGE II local and international partners:
 - Save the Children International
 - International HIV Alliance (IHAA)
 - Pact Malawi
 - Corporate Graphics
 - Story Workshop Educational Trust (SWET)
 - Galaxy Media Consultants (Galaxy)
 - Youth Net and Counseling (YONECO)
 - National Association of People Living with HIV and AIDS in Malawi (NAPHAM)
- Thousands of community volunteers who served in various BRIDGE II portfolios
 - Traditional Leaders Forum
 - Area Development Community Mobilization Teams
 - Community Action Group Members
 - Community Facilitators
 - Condom Distributors
 - Community Referral Agents

Note: The contents in this report are the responsibility of CCP and do not necessarily reflect the views of USAID or the United States Government.

Acronyms

ABC	Abstinence, Be Faithful, Use Condoms
ADC-CMT	Area Development Committee–Community Mobilization Team
AIDS	Auto-Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
AT	<i>African Transformation</i>
BCI-STC	Behavior Change Intervention Sub-Technical Committee
BPC	Best Practices Conferences
CAC	Community Action Cycle
CAG	Community Action Group
CBO	Community-Based Organization
CCN	<i>Chenicheni Nchiti?</i>
CCP	Johns Hopkins Center for Communication Programs
CRA	Community Referral Agent
DACC	District AIDS Coordinating Committee
DCMT	District Community Mobilization Team
DNST	District Network Strengthening Teams
GVH	Group Village Head
HC	Health Center
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
ICD	Informal Condom Distributor
IHAA	International HIV/AIDS Alliance
LSHC	Leadership in Strategic Health Communication
MBC	Malawi Broadcasting Corporation
MOU	Memorandum of Understanding
NAC	National AIDS Commission
NAPHAM	National Association of People Living with HIV/AIDS in Malawi
NGO	Non-Governmental Organization
ONA	Organizational Network Analysis
PLHIV	People Living With HIV
PMTCT	Preventing Mother-to-Child Transmission of HIV
SBCC	Social and Behavior Change Communication
SWET	Story Workshop Educational Trust
TA	Traditional Authority
TLF	Traditional Leaders Forum
TOT	Training of Trainers
VDG	Village Discussion Group
VMMC	Voluntary Male Medical Circumcision
ZBS	Zodiak Broadcasting Station

Executive Summary

BRIDGE II was a six-year (2009-2015) HIV prevention program funded by the United States Agency for International Development (USAID). The project was developed as a follow on to the BRIDGE I project, which promoted small, doable actions among individuals to prevent the spread of HIV. BRIDGE II subsequently set a goal of promoting normative behavior change and increasing HIV preventative behaviors among the adult population in Malawi.

Four key objectives provided focus for achieving the BRIDGE II goal:

- Individual perception of HIV risk and self-efficacy to prevent HIV infection strengthened,
- Communities mobilized to adopt social norms, attitudes, and values that reduce vulnerability to HIV,
- Prevention interventions strategically linked to services, and,
- Malawian institutions supported for effective leadership and coordination.

To achieve these objectives, BRIDGE II implemented a multi-level HIV prevention program, intervening at the individual, district/community and national level to influence norms and behaviors. Key interventions included: a mass media campaign platform, reality radio programming, community mobilization, referral and linkages to services, and capacity building. These interventions aimed at all levels of the socio-ecological environment: At **national level**, the *Tasankha* mass media campaign and other radio programming served as the backbone of the project, and provided strategic behavior change messages on key issues, and complemented efforts at the district and community levels. At the **district and community levels**, one-on-one and group discussions supported individuals and communities to change risky behaviors and adopt healthier behaviors, seek out health services, and instilled a sense of ownership of the project, ensuring sustainability. Small group sessions were held with **individuals and couples** (where appropriate) that enabled them to access their risk, explore their options for reducing risk and make a plan to do so, including accessing services. Cross cutting activities such as **capacity building** served to strengthen capacity of local organizations and groups, empowering them to lead behavior change efforts. **Collaboration and coordination** were improved at all levels.

Preliminary cross-sectional evaluation results for BRIDGE II indicate positive correlations between exposure to BRIDGE II interventions and HIV related outcomes. These include:

- Higher HIV related knowledge among both women and men
- Getting tested for HIV in the last twelve months
- Greater self-efficacy to protect oneself from HIV
- Greater intention to have only one partner and use condoms every time one has sex
- Greater reported condom use at last sex
- Higher ability to negotiate condom use
- More positive attitudes towards gender equality

In addition to achieving these significant changes among those exposed to BRIDGE II interventions, the project also invested in ensuring sustainability through capacity building efforts with structures at all levels, from community-level to national. Based on field reports, interviews and anecdotal evidence, there are strong indications that many communities are continuing to engage in HIV prevention activities initiated by the project. As Margaret John, Village Head of the Mapanje community in Zomba, stated, *“We own the project. As they leave, we will continue the interventions so that even our children benefit.”*

Recommendations emerging from implementation and research findings include:

- Engage traditional leaders in a meaningful way
- Invest in relationships with the media, as active partners not just as conduits for information

- Continue to use an overarching campaign platform
- Foster public dialogue through mass media as well as local interventions
- Trust people to make the right choices
- Continue to strengthen couple communication
- Build in sustainability at the start
- Continue to make the case for investments in SBCC
- Strengthen SBCC efforts by bringing services to people
- Continue to address underlying gender dynamics

In conclusion, BRIDGE II achieved significant progress towards preventing HIV and mitigating its impact in Malawi. Continual investment and commitment is needed to ensure that gains made in addressing HIV become entrenched and that adequate funding is available in Malawi for SBCC for HIV prevention, linking people to HIV prevention and treatment services, increasing treatment adherence, and building community-level capacity.

Overview

BRIDGE II was a six-year (2009-2015) HIV prevention program funded by the United States Agency for International Development (USAID). The project was developed as a follow on to the BRIDGE I project, which promoted small, doable actions among individuals to prevent the spread of HIV. From 2003 to 2009, BRIDGE I worked closely with NAC, the Ministry of Health, the Ministry of Local Government and Community Development and other cooperating partners to foster an environment of hope and openness regarding HIV and AIDS among Malawians, while giving them the knowledge, tools and inspiration to take appropriate action to protect themselves, their families, communities and their loved ones. By the end of the project in 2009, risk perception was clearly enhanced from the baseline six years earlier. There were also significant gains in self-efficacy with regard to abstinence, faithfulness and condom use. Strides were made in reducing stigma towards people living with HIV as well as significant improvements in HIV testing rates.

As BRIDGE I was coming to a close, the planning for BRIDGE II was underway with the realization that while individuals were taking steps to protect themselves from HIV, some prevailing social and cultural norms were preventing wider change and in some cases, putting these same individuals at risk. Evidence showed that many adults were becoming infected while in so called “stable” relationships¹. Strategies used in BRIDGE II reinforced and sustained BRIDGE I efforts by dealing with these social and cultural norms (e.g. wife inheritance, multiple and concurrent sexual partnerships, lack of open couple communication, low partner testing). Thus, **BRIDGE II set a goal** of promoting normative behavior change and increasing HIV preventative behaviors among the adult population in Malawi.

BRIDGE II Objectives:

Four key objectives provided focus for achieving the BRIDGE II goal:

- Individual perception of HIV risk and self-efficacy to prevent HIV infection strengthened,
- Communities mobilized to adopt social norms, attitudes, and values that reduce vulnerability to HIV,
- Prevention interventions strategically linked to services, and,
- Malawian institutions supported for effective leadership and coordination.

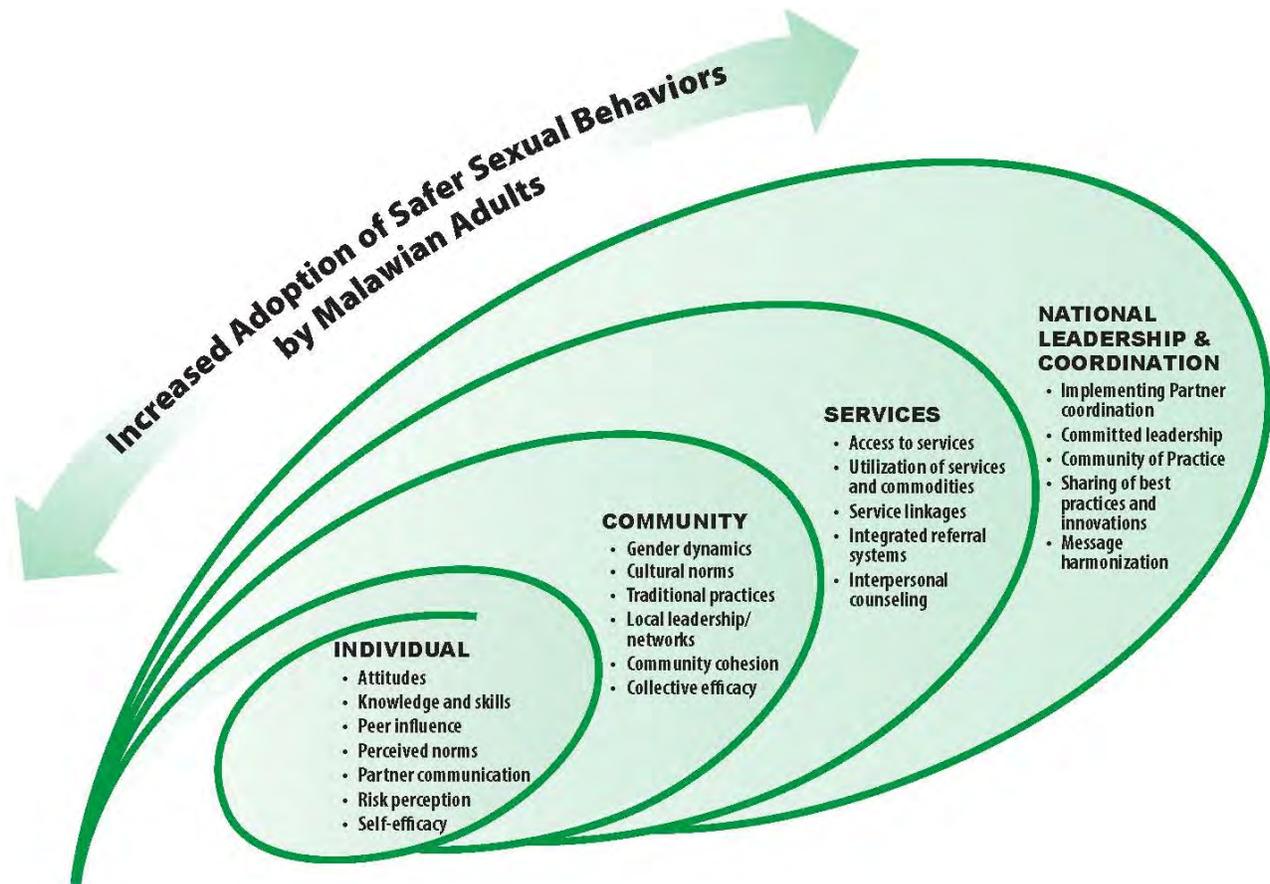
Strategic Approach:

To achieve these objectives, BRIDGE II implemented a multi-level HIV prevention program, intervening at the individual, district/community and national level to influence norms and behaviors. Key interventions included: a mass media campaign platform, reality radio programming, community mobilization, referral and linkages to services, and capacity building (for more detail, see section on Key Interventions).

Two broad **theoretical perspectives** informed the development of BRIDGE II interventions. The first, the **Risk Perception Attitude framework (RPA)**, focuses on two key variables – risk perception and efficacy beliefs – to promote HIV prevention behaviors. In the RPA framework, self-efficacy is key. The second, the **Social Ecological framework**, is built upon the principles that compelled BRIDGE II to consider the social milieu and structural characteristics fueling Malawi’s epidemic.

¹ Watkins, S. (2010). Desk review of HIV determinants in Malawi. Lilongwe, University of Pennsylvania and BRIDGE-II Project.

Risk Perception Attitude Framework: According to the Risk Perception Attitude (RPA) framework, perceptions about one’s risk for a disease are usually not sufficient to motivate people to take preventive action. However, when high risk perceptions are coupled with strong efficacy beliefs, people are motivated and able to engage in self-protective behaviors. As articulated in a number of theories of health-behavior change, the RPA framework conceptualizes perceived risk as a motivator of change, which needs to be facilitated by a belief that something can be done to avert the threat; individuals need to feel efficacious in their ability to change if change is to occur.² The RPA was used to inform the design of the different phases of BRIDGE II’s **Tasankha** mass media campaign.



Social Ecological Framework: The BRIDGE II project was based on the Social–Ecological framework (see above) that calls for a strategically integrated response where interventions at one level (individual, community, service, or institutional) affect drivers of HIV infection at other levels. It articulates the effect individual knowledge and self-efficacy have on behavior change and demonstrates the importance of addressing structural or social drivers like traditional practices, integrated services, and coordinated leadership. Using this framework, the BRIDGE II Team linked the cutting edge in behavior/social change theory to the practical realities of program implementation.

² Rimal et al: Extending the Purview of the Risk Perception Attitude Framework: Findings from HIV/AIDS Prevention Research in Malawi. *Health Communication*, 24: 210–218, 2009.

Summary of Key Interventions

The key components of BRIDGE II included:

National Level - At the national level, the *Tasankha* mass media campaign and other radio programming served as the backbone of the project, and provided strategic behavior change messages on key issues such as PMTCT, HTC, VMMC, and complemented efforts at the district and community levels. Interventions included:

- *Tasankha* Mass Media Campaign
- *Chenicheni Nchiti?* Reality Radio Program (which incorporated the Radio Diaries of PLHIVs)
- National Dialogue Media Campaign

District and Community Levels - At the district and community levels, one-on-one and group discussions led by the community supported individuals and communities to change risky behaviors and adopt healthier behaviors, seek out health services, and instilled a sense of ownership of the project, ensuring sustainability. Interventions included:

- Community Mobilization
- Community Wide Events
- Support for Workplace Interventions

Individual Level - Small group sessions were held with individuals and couples (where appropriate) that enabled individuals and couples to assess their risk, explore their options for reducing risk and make a plan to do so, including accessing services.

- Transformative Tools
- Engaging People Living with HIV
- Couple Counseling
- Linking People to Services

Cross Cutting Interventions - Cross cutting activities such as **capacity building** served to strengthen capacity of local organizations and groups, empowering them to lead behavior change efforts. **Collaboration and coordination** were improved at all levels.

Research, Monitoring and Evaluation

BRIDGE II was a research-based program. It conducted robust research, monitoring, and evaluation activities whose results influenced the direction of the project. The project implemented baseline, midline, and end line research, conducted evaluations of specific program activities (informal condom distribution and VMMC), and integrated routine monitoring tools into program activities.

Partners and Collaboration at National and Local Level

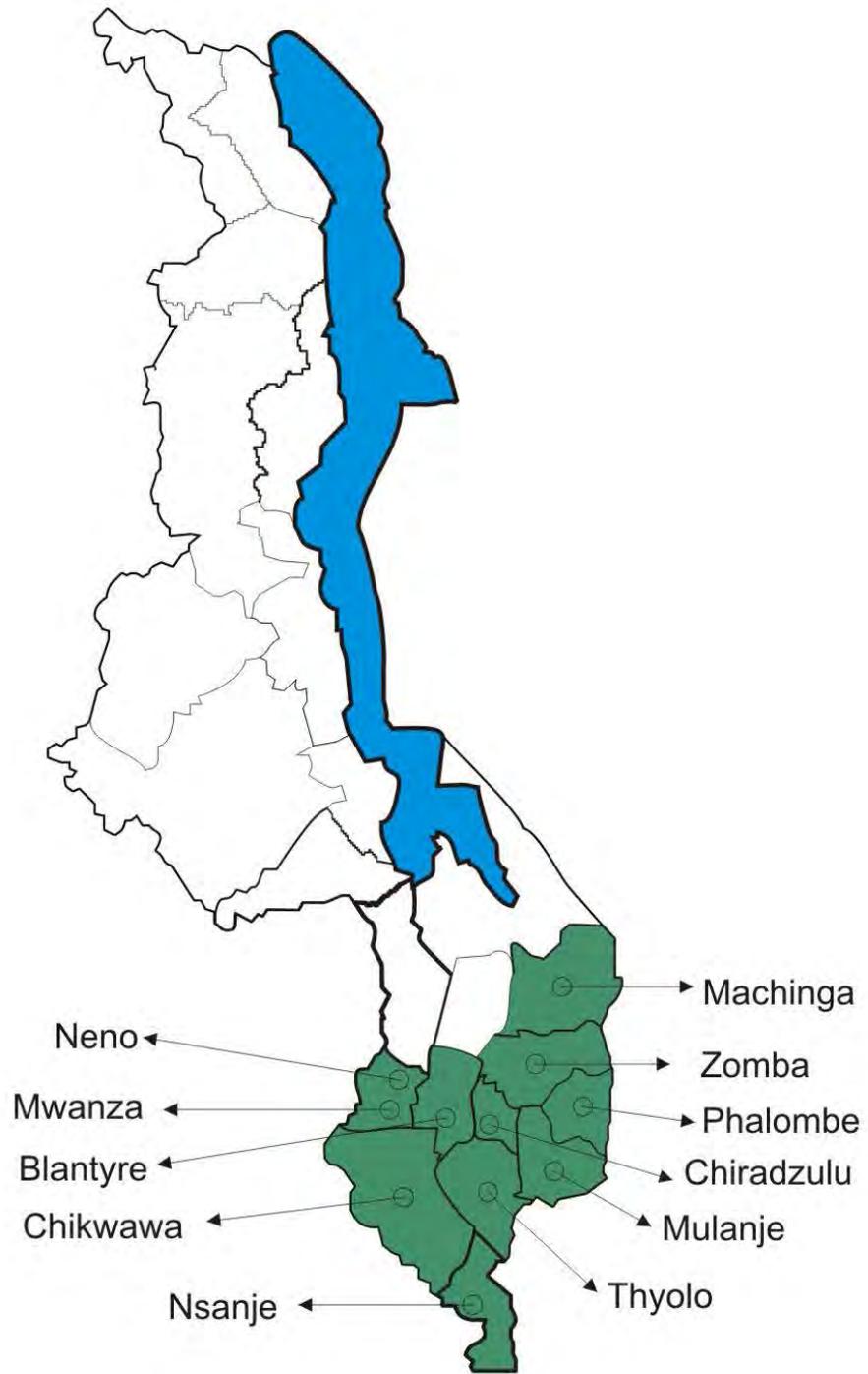
The project was implemented by the Johns Hopkins Center for Communication Programs (CCP) in partnership with three international partners: Save the Children International, Pact Malawi and the International HIV and AIDS Alliance (IHAA). Local partners included Corporate Graphics, Galaxy Media Consultants, National Association of People Living with HIV/AIDS in Malawi (NAPHAM), Youth Net and Counseling (YONECO) and Story Workshop Educational Trust (SWET). The project worked closely with a number of key government partners representing the Ministry of Local Government and Rural Development, Ministry of Gender, Children, Disaster and Social Welfare and the Ministry of Health --HIV and AIDS Unit, the Reproductive Health Directorate, and Health Education Services, District Health Offices, as well as the National AIDS Commission.

The project was funded by the President's Emergency Fund for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID).

Geographic Coverage:

BRIDGE II was implemented in eleven districts in the Southern Region of Malawi: Blantyre, Chikhwawa, Chiradzulu, Machinga, Mulanje, Mwanza, Neno, Nsanje, Phalombe, Thyolo and Zomba. The rationale for this choice was that the rural south remained as the region with the highest HIV prevalence rates. While the interventions on the ground took place in those 11 districts, the mass media interventions (particularly radio), by necessity covered the entire country.

BRIDGE II was implemented in 11 districts which can be seen in the map below, marked in Green.



Tasankha

Mass Media Campaign

Malawi has a high rate of HIV infection, particularly in the Southern part of the country where BRIDGE II was implemented³. BRIDGE II developed and implemented a vibrant *Tasankha* (“we have chosen”) mass media campaign with the end goal of enabling and inspiring people to prevent HIV infection. The campaign’s key idea was that choices are central to behavior and that everyday choices can lead to negative or positive outcomes, such as preventing or contracting HIV. *Tasankha* then promoted and modeled the positive choices adults could make to prevent HIV infection. *Tasankha* built upon the successful *Nditha!* (“I can do it!”) campaign, implemented under BRIDGE I, but shifted public discourse from strengthening *individual* self-efficacy to prevent HIV to a *collective* response among families, communities and the nation to stop the spread of HIV.

The *Tasankha* campaign formed the foundation and platform for all other BRIDGE II core interventions: 1) reality programming, including the *Chenicheni Nchiti?* (CCN) radio program and the Radio Diaries, 2) community mobilization, including outreach to traditional leaders, the use of Transformative Tools, working with people living with HIV, and work with Faith Based Organizations, 3) capacity building for social and behavior change communication, and 4) linking people to HIV-related services. All these and other BRIDGE II activities underscored the benefit of positive choices in one’s life.

The campaign was implemented in two phases; the first focused on multiple and concurrent partnerships as a key driver of the HIV epidemic, and the second on linking people to HIV prevention services with HIV testing as the entry point. BRIDGE II spread campaign messages through multiple channels: a community discussion guide, nine radio spots, eight posters, a colorful chart detailing how to prevent mother-to-child transmission of HIV, community theater groups, local Traditional Leaders’ Fora, Village Discussion Groups (VDGs), PLHIV Support Groups and support materials such as bandanas, t-shirts and stickers. CCN was the flagship radio program of the *Tasankha* campaign and generated interactive dialogue about choices among listeners.

Campaign Development and Implementation Process

Tasankha Message Development and Audience Identification

BRIDGE II conceptualized the *Tasankha* Campaign during a strategic interactive Message Development and Material Design Workshop involving several government and NGO stakeholders. The strategy built on available evidence which indicated that: HIV prevention knowledge amongst adults was consistently high but had not translated into behavior change; people were tired of proscribed messages; and that transmission was concentrated in stable relationships, including marriage, which many people assumed to be safer than short-term relationships. The new campaign shifted the emphasis from Bridge I’s successful *Nditha!* (“I can do it!”) which emphasized *potential* action for an *individual*, to *Tasankha* (“We have chosen”) which emphasized a more collective firm action. *Tasankha* also focused on *making (good) choices* which helped people understand that choices are central to behavior and that everyday positive choices can lead to better health outcomes.

³ <http://www.usaid.gov/malawi/global-health>

BRIDGE II designed the campaign to enable people to think about the consequences of their choices for themselves, their families and their community. Client profiles were created for the primary audiences - men, women and couples 15-49 years old – and for the secondary audience, traditional leaders. These profiles and creative briefs formed the foundation for further campaign message and materials development.

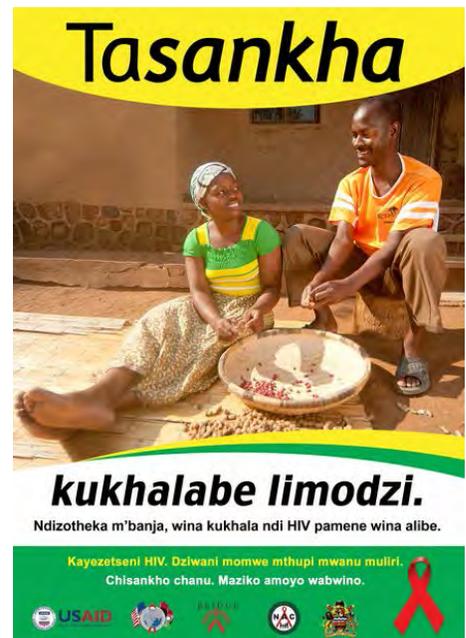
Phases of the Tasankha Campaign

The first phase focused on addressing multiple and concurrent partnerships as a key driver of the HIV epidemic. This phase was further broken down into three focused themes: The first addressed Family Values, asking people to define who and what they value most, with the intention to motivate people to cherish, support and protect their loved ones. The second theme was Know Your Risk, which aimed at increasing peoples’ risk perception regarding multiple and concurrent partnerships and other related behaviors. Messages under this phase highlighted the risks of sexual networks; that the choice to have more than one sexual partner is a choice to join a sexual network and put oneself and one’s family at risk of HIV. The third theme was Reduce Your Risk, which focused on reducing sexual partners, leaving the sexual network and using condoms consistently and correctly.

The second phase of the campaign focused on linking people to various HIV prevention services with HIV testing as an entry point. Issues covered included couple communication, couple HIV testing and counseling, prevention of mother to child transmission (PMTCT), HIV discordancy within a couple, voluntary medical male circumcision (VMMC), and condom use. Importantly, this phase encouraged people to use available HIV services as evidence of their changed behavior.

Implementing the Campaign

The campaign produced a community discussion guide, eight posters, nine radio spots and one detailed chart that highlighted critical steps in preventing transmission of HIV from mother to child. Other support materials that helped in building the campaign identity included bandanas, t-shirts and stickers. Campaign materials were distributed to CBOs and NGOs, who further distributed and posted the materials in strategic places such as trading centers and health centers. All radio stations aired the spots in Chichewa; select



Phase 1 and Phase 2 posters from the Tasankha Campaign. The Phase 1 poster focuses on leaving the sexual network, while the phase 2 poster focuses on HIV-discordant relationships.



A Tasankha Phase 1 poster being used during a community discussion in the Phalombe district in 2011. Photo Credit: Fayyaz Ahmad Khan, 2011.

spots were produced and aired in Sena and Yao. Trained community facilitators and Health Center staff used *Tasankha* posters in small group discussions and health education sessions. Community-based discussions helped to reinforce messages heard through mass media and created an opportunity for further clarification.

The *Tasankha* campaign served as a platform and foundation for core BRIDGE II interventions and provided campaign messages and themes that were used across the entirety of the BRIDGE II project, focusing on the benefit of *making positive choices* in ones' life.

Results

Overall, BRIDGE II reached over 500,000 people *directly* and multiple times with HIV prevention messages through *Tasankha* branded materials, community wide events, *Tasankha* open days, village discussion groups, and local interactive drama. The mass media component reached well over 2 million adults across the country many hundreds of times, through the flagship CCN radio program and the radio spots, and the two National Radio Dialogues on Couple Communication. The campaign reach included:

- 10,199 radio spots aired in Chichewa on MBC 1, MBC 2, ZBS, Joy Radio, Malawi MIJ Radio, Dzimwe Community Radio, Capital FM and Nkhotakota Radio Station.
- 200,000 posters and 2,000 PMTCT flip charts printed and strategically displayed and used during small group discussions and health education sessions in community buildings and health centers.
- Distribution of promotional materials that built the campaign identity including 2,269 T-shirts, 3,400 sticker sand 1,500 bandanas.

Chenicheni Nchiti?

Chenicheni Nchiti? (CCN), translated as *What Is the Reality?* was a weekly reality radio program that focused mainly on HIV and AIDS. What made CCN unique is that it was built on real people's experiences, feelings and opinions and was told in their own voices. The radio program offered a platform for open discussion about HIV and AIDS, while encouraging positive behavioral choices.

The overall goal of CCN was to spark dialogue and action across Malawi on HIV and AIDS related issues — including prevention, treatment, living positively with HIV, and stigma and discrimination against people living with HIV — by broadcasting household and community conversations at a national level.

Exposing the public to this on-going dialogue then stimulated more conversations on HIV and AIDS-related topics in homes and communities around the country. Topics such as linking people to HIV-related services including voluntary medical male circumcision and preventing mother-to-child transmission of HIV were also incorporated.

To gather stories for the show, community-based field reporters were recruited from communities where BRIDGE II and SSDI-Communication (CCP's other USAID funded project in Malawi) worked. They were provided



A CCN radio field producer collects a story.

equipment and trained with basic investigation, interviewing, and recording skills. These field reporters recorded stories of community members for use in the program, which also featured interviews with professionals working in the field of HIV prevention. CCN actively engaged audience members, asking them to share their views on the personal stories and topics covered via phone call or SMS message, and to respond to questions posted on Facebook. After collecting audience questions and responses to each CCN program, a *feedback program* was produced each week to provide rapid and accurate responses to the most common questions and further promote discussion among listeners. The feedback program was aired at the end of the same week that the initial program was broadcast.

***Chenicheni Nchiti?* Reality Radio Program Production Process**

The production of *Chenicheni Nchiti?* (CCN) was a collaborative process involving several partners. Technical experts from CCP worked with the Story Workshop Educational Trust (SWET) to develop the program thematic areas and issues that would be addressed each quarter. SWET then produced the program and Galaxy Media facilitated the airing of CCN with commercial and community radio stations. These organizations worked together during quarterly editorial meetings to produce tools that guided content collection and studio production of the program according to the agreed upon thematic areas.

Episode and Message Development

Since CCN was based on reality and real life stories, it was not possible to dictate the exact content of each program. In order to ensure that the appropriate topics were covered, BRIDGE II developed the Message Matrix. This tool was used collaboratively by CCP technical experts and its partners to guide the creation of each CCN program.

Table 1: Message Matrix Example

Issues	Negative behaviours, beliefs, misconceptions, practices	Consequences	Positive behaviours, beliefs, misconceptions, practices	Benefits
Men not coming forth to support their pregnant HIV positive spouses	The belief that safe motherhood issues are women's issues	-Low uptake of HTC and PMTCT services -Mother to Child transmission of HIV -Increase in infant and maternal mortality -Lack of status disclosure between spouses	-Men to accompany their partners for ANC -Men to test for HIV with their partners -Men should regard mother and child health issues as their own	-Increased uptake of HTC and PMTCT services -Reduced number of children contracting HIV from their mothers -Reduction in infant and maternal mortality

Using the Message Matrix, SWET and Galaxy Media developed a Program Matrix to outline each episode. Program producers decided which issues should go into which episodes as well as the sequencing of issues and episodes. An example Program Matrix can be found below.

Table 2: *Chenicheni Nchiti?* Episode Matrix Example.

ISSUE	COMMUNICATION OBJECTIVE	TARGET AUDIENCE	SOURCES	MESSAGE	QUESTIONS	NOTES	Possible Outcomes
Men not coming forth to support their pregnant HIV positive spouses	To explain what PMTCT B+ is all about To encourage men to: -Accompany their partners for ANC -Test for HIV with their partners -Regard mother and Child health issues as their own	Men Couples expecting a child Couples intending to have children	Role model: A COUPLE explaining benefits/support A man who has had consequences because he never supported his partner	Pregnant women: go for HIV testing, and if positive start taking ARVs and will continue for life. Men: support and provide for your wives (family) especially when they are pregnant and living with HIV.	Why do most men not support their women in PMTCT? Why is it important for men to support their wives in PMTCT? Why is it important for a couple to test while expectant? When, why did you support your wife? What kind of support did you give to your wife? Why ARVs for life? What are the benefits of supporting your partner What are the consequences of not supporting your partner	All PMTCT programs include the following: pregnant women sleep in treated mosquito nets every night, eat nutritious food, malaria treatment	Increased uptake of HTC and PMTCT services -Reduced number of children contracting HIV from their mothers -Reduction in infant and maternal mortality

Quarterly field producers' workshops were held where the producers were oriented on selected program messages as well as the Program Matrix so that they understood what the key messages were for that particular quarter and what stories they needed to collect for each program. They also received guidance on the particular stories they should seek out.

Production

The Senior Producer further built the capacity of the field producers by providing constructive feedback and tips for sharpening their skills during quarterly field visits to collect the recorded interviews. The interviews were then taken to SWET studios where the Senior Producer and Program Presenter incorporated the relevant stories into the overall program and edited it for broadcast.

Program Distribution

CCN was originally only aired on Malawi Broadcasting Corporation (MBC) radio 1 and Zodiak Broadcasting Station (ZBS), which both have nationwide coverage. Broadcast coverage was eventually extended to air on MBC radio 2 and 13 additional private and community radio stations⁴, bringing the total number of radio stations airing CCN every week to 16. Each of these stations agreed to broadcast at no cost. In exchange for free airtime, BRIDGE II provided each of these stations with additional institutional support (e.g. laptops, recorders, and capacity building on HIV and AIDS programming).

Frontline SMS and the *Chenicheni Nchiti?* Feedback Program

During the main CCN program, which was pre-recorded, presenters asked questions that the listeners were encouraged to answer via an SMS line or the program's dedicated Facebook page. The listeners were also encouraged to ask their own questions and provide comments on the theme of the program during the week in

⁴ Joy Radio, Radio Islam, MIJ FM, Star Radio, Trans World Radio, Living Waters Radio, Dzimwe Community Radio, Nkhotakota Community Radio, Mudziwathu Community Radio, Power 101 Radio, Chanco Community Radio, Radio Maria and Voice of Livingstonia.

which it was broadcast. The CCN program had a dedicated SMS line separate from the other radio programs, making it possible for SWET radio producers to receive and go through the SMS feedback and select the issues that formed the basis of the feedback program. The SMS messages were managed through a computer program called Frontline SMS, which was installed on a computer at SWET. There were 500 SMS messages and 200 Facebook comments received per program on average.

Jingle, Promo, and Additional Story Production and Airing

The SWET producers/presenters wrote lyrics and scripts and produced jingles that reinforced specific messages from the show's thematic areas. SWET also produced and distributed promotional spots of excerpts from CCN episodes to increase the program's visibility as well as advertise broadcast times.

Galaxy Media also produced additional individual stories from materials gathered by field producers that SWET did not air in the main CCN program. These additional stories were provided free to radio stations to use in any context they saw fit—e.g. in news programs, feature stories, talk shows, etc. The radio stations saw these additional stories as a valuable resource, as many of them lacked the funds to send their own field producers out to record original stories.

Results

The program's approach was so successful that SSDI-Communication joined forces with BRIDGE II to incorporate other health topics, including nutrition, malaria, family planning, maternal health, and water, sanitation, and hygiene into the featured discussions, and continued to fund and provide support to the production and airing of the show after BRIDGE II ended.

- According to data collected by SSDI-Communication⁵, roughly 40% of adults in Malawi listened to CCN at least once a week during the implementation of BRIDGE II.
- CCN was aired on 16 radio stations, providing regular access to millions of individuals throughout the country.
- 201 main programs and 200 feedback programs aired during the implementation of BRIDGE II.

Radio Diaries of People Living with HIV and AIDS

In response to the environment of stigma and discrimination against people living with HIV (PLHIV) in Malawi, the short weekly Radio Diaries program provided PLHIV an opportunity to share the realities of their lives with the public and helped listeners to understand better how PLHIV overcame challenges in their daily lives. The overall objectives of the Radio Diaries program were:

- Reduce stigma and discrimination against people living with and affected by HIV and AIDS in Malawian communities.
- Reduce stigma that prevents people from taking action to know their HIV status and discuss HIV prevention with their partners.
- Increase involvement of the general public in HIV and AIDS issues.
- Increase understanding of personal risk and vulnerability to HIV and AIDS among the general population.

The Radio Diaries were initiated under BRIDGE I and continued under BRIDGE II through a collaborative effort with many different partners: Galaxy Media, Story Workshop Educational Trust, National Association of People Living with HIV (NAPHAM) and 14 radio stations.

⁵ Findings from the 2012 Baseline Survey of 15 Districts in Malawi, 2012, Johns Hopkins Center for Communication Programs.

The concept of the Radio Diaries emerged from the idea that creating an emotional connection between listeners and HIV-positive diarists can reduce stigma and make society more accepting of people living with HIV. Through the stories told in the Radio Diaries, listeners would identify with the life experiences discussed on the program, even if they do not have HIV. In this way, listeners would feel a personal connection with the HIV-positive diarists, and be less likely to stigmatize or discriminate against people living with HIV that they encounter in their daily lives.

Producing the Radio Diaries through Collaboration

A number of implementing partners (Galaxy Media, Story Workshop Educational Trust, National Association of People Living with HIV and AIDS in Malawi [NAPHAM] and 16 radio stations) worked together to produce and air the Radio Diaries. Galaxy Media, in collaboration with NAPHAM, identified HIV positive individuals who were willing to become Radio Diarists and discuss their day-to-day lives openly. Galaxy Media trained the Radio Diarists alongside radio producers drawn from the various radio stations. This presented an opportunity for the two groups to get to know each other and share experiences and input into the project. Radio Producers received training on interviewing and other technical skills to improve the quality of their recordings (e.g., sound quality and content). The Radio Diarists learned how to tell their stories creatively to elicit a powerful reaction from listeners. After the training, Galaxy Media supported radio stations in interviewing the Radio Diarists and later edited the interviews into five-minute inserts, which were sent to Story Workshop to be incorporated into *Chenicheni Nchiti?* BRIDGE II provided technical support throughout this process.

Creating Compelling Stories

Every week, Radio Diarists focused on one issue or event and highlighted the impact that the event had in their lives. Over time, Diarists covered a wide range of everyday topics, including relationships with partners, family, friends, and the broader community; medical issues and perceptions of response from health service providers; work and leisure activities; diminished

RADIO DIARIES SUCCESS STORY

Fatima Makawa, a 56-year-old woman from Chemboma in Blantyre, was a Radio Diarist who shared the reality of her life with HIV on radio.

Fatima discovered she had HIV 16 years ago when her husband passed away. She did not tell anyone at the time and did not go for treatment because she was convinced that the hospital had made a mistake about her diagnosis. It was only when she started developing symptoms such as frequent fever, dry throat, body pains, and shingles that she decided to take a confirmatory HIV test. The second test confirmed her HIV status and soon thereafter, she started Antiretroviral Therapy (ART) and began to feel better.

Fatima became a Diarist in 2009 in order to spread awareness about HIV in the country. "Becoming a Diarist for the BRIDGE II Project and sharing my story took away all the fears regarding HIV and AIDS from my mind. On top of that, people from my community are more open with me and they come to me for advice on positive living," she said.

Fatima said that sharing her story through the BRIDGE II Radio Diaries motivated many people from her community to go for HIV Testing and Counselling.



"People come to me for advice on HIV and AIDS because they heard I have lived with HIV for over 16 years but I am still healthy and strong. Good health and strength have enabled me to work at an orphanage, work on my farm and collect sand for sale to support myself," said Fatima.

capacity, emotional stress and coming to terms with the realities of HIV.

Developing a Following and Gaining Exposure

The Radio Diaries was initially a standalone program broadcast on 8 radio stations but was subsequently incorporated into CCN and broadcast on 16 stations. This greatly increased the reach of the Radio Diaries, as CCN has many more listeners overall.

Many of the original radio stations have continued to air the Diaries on their own, without the involvement of the BRIDGE II project, as it has become such a popular program. The project started with low profile Diarists in its early years, but during BRIDGE II, several high profile diarists were engaged to expand awareness that HIV can affect people from all walks of life. One of them was a PhD holder and lecturer at the University of Malawi and another one was a Chief Executive Officer for one of the District Councils.

Results

During the implementation of BRIDGE II:

- Over 320 Radio Diaries were produced and aired on 16 radio stations.
- Twenty-one radio diarists (20 PLHIV and 1 HIV-negative individual in a discordant relationship with an HIV-positive partner) were engaged to share their life stories through the Radio Diaries.
- Sixteen producers were trained in reality programming.

National Dialogues

The National Dialogue Media Campaigns were initiated by BRIDGE II to spark discussions across the country about specific topics relating to HIV and AIDS and sexuality among couples, families, communities and the nation at large. Three rounds of National Dialogues were broadcast, each for 4-5 weeks. By stimulating dialogue between the sexes and within communities, BRIDGE II aimed to increase and improve understanding between men and women in relationships regarding what their partner values and how couples can work together to improve and sustain their relationships. Increasing communication on these topics at the individual, family, community, and national level lessens the likelihood of couples participating in behaviors that would expose them and their partner to HIV. Qualitative research findings from Malawi indicate that lack of good and open communication in relationships, particularly around issues of sexuality, is a key reason men and women look outside the home for other partners, increasing their risk of contracting HIV and passing it on to their partners⁶.

The plan for rolling out each National Dialogue was simple and bold: BRIDGE II engaged as many radio stations in Malawi as possible in incorporating these topics into one of their most popular programs each week during the National Dialogue Campaign. In any given week during the campaign, every radio station in the country was discussing the same issue and inviting their regular listeners to contribute to the discussion by calling in, sending SMS messages, or writing letters.

The topics chosen for discussion during the National Dialogues were broad, but the questions developed to stimulate the discussions were crafted in such a way that people were able to link social and behavior issues to HIV (for example, gender-based violence and how it relates to HIV risk). The topics discussed during the campaigns were:

⁶ Limaye, R. J., Rimal, R. N., Mkandawire, G., Roberts, P., Dothi, W., & Brown, J. (2012). Talking about sex in Malawi: toward a better understanding of interpersonal communication for HIV prevention. *Journal of Public Health Research, 1*(e17), 117–125.

- Battle of the sexes: Understanding the opposite sex.
- What women and men want out of relationships.
- Couple communication on sex leading to more satisfying sex lives, better marriages and better relationships.
- Gender-based violence.
- Living as a couple and staying safe in the age of HIV and AIDS.

While the first two National Dialogues were focused solely on HIV/AIDS, BRIDGE II, in partnership with SSDI-Communication and in collaboration with 13 radio stations organized the third round of national dialogues under the theme “Life Choices and Wellness” that incorporated additional health topics, such as malaria, family planning, and WASH. The choice of this theme was strategic as it highlighted the link between better life choices as advocated by the BRIDGE II *Tasankha* campaign and the treasure behind good health as emphasized by the SSDI-Communication’s *Moyo Ndi Mpamba* (Life is Precious) campaign. Topics covered in the “Life Choices and Wellness” National Dialogue included:

- Cultural practices and beliefs: what is more important to uphold, our culture or our lives?
- Living our lives: what matters more, is it our life or money and material things?
- The family and people's wellbeing: does the family do enough to give its members the best life?
- The community working together: communities as perpetrators of good life values.
- Disease treatment versus healthy living: taking responsibility for our own wellbeing and health.

Process

Engaging Malawi’s Radio Stations

In order to get national, district, and community radio stations on board to participate in the three National Dialogue campaigns, Galaxy Media Consultants (Galaxy) reached out to the radio stations that broadcast *Chenicheni Nchiti?* Galaxy negotiated a Memorandum of Understanding (MOU) with the radio stations to: gain their buy-in and participation, broadcast the National

NATIONAL DIALOGUES SUCCESS STORY

Rachel Mhango from Malawi Institute of Journalism radio station said, “BRIDGE II has changed the way health programs are handled. Previously sexuality issues like condom use and sexual satisfaction were not discussed on radio. As a result, people could not make informed decisions in preventing HIV as crucial issues like these were kept from them.”

BRIDGE II has enabled the discussion of these seemingly controversial issues on radio through a media campaign themed National Dialogue. The process of designing the National Dialogue brings together radio stations for a common cause, namely promoting normative behavior change through sharing of skills and knowledge in HIV radio program designing. Rachel stressed that radio programs that discuss sex are aired at night when children are asleep as the content is inappropriate for them.



“I put off all the reservations I had about discussing sensitive topics on radio as I’ve realized that its avoidance of discussing these issues that contributes to more people getting infected with HIV” says Rachel.

Dialogue content according to the BRIDGE II guidelines and during existing popular programming, collect monitoring and evaluation data, and air the programs free of charge. Of the 16 radio stations that broadcast CCN, 13 agreed to participate, including a mix of national, regional and community radio stations, enabling the National Dialogues to potentially reach nearly all Malawians. Eleven of the stations broadcast the National Dialogue content at no charge to BRIDGE II. In exchange for the radio stations providing free airtime, they received capacity building in reality programming, and radio equipment such as recorders and laptop computers each time a campaign took place. BRIDGE II also provided content guidelines to facilitate on-air discussions.

Orientation of Radio Staff

Galaxy organized workshops to train producers and presenters from participating radio stations on how to produce an effective dialogue program, using content guidelines developed for each round of the campaign. The workshops were facilitated by Galaxy, along with BRIDGE II staff and officials from the Ministry of Health and National AIDS Commission (NAC). The training focused on acquainting workshop participants with the themes for the National Dialogue, orienting producers and presenters on how to design and produce a reality radio program and presenting issues in such a way that generates open and honest discussion around sensitive issues.

Airing of the National Dialogue Campaigns

Each radio station produced its own shows each week, focusing on the pre-determined themes. The shows used varied formats, depending on the stations' existing programming and producers' decisions, but all of the programs were created to stimulate open dialogue. Program formats were largely live radio programs with phone-in segments and pre-recorded programs with feedback through SMS. Galaxy mentored and monitored the radio stations during the campaign and organized a review meeting for all the participating partners at the end of each National Dialogue to reflect on the challenges and successes of the campaign and make plans for the next round.

Results

During the lifetime of BRIDGE II, three National Dialogue Media Campaigns were implemented, in collaboration with 13 radio stations between August of 2012 and October of 2014.

The participating stations included two national radio stations with nation-wide coverage and broad popularity (Malawi Broadcasting Corporation and Zodiak Broadcasting Station) and 11 community radio stations.

The process of designing the National Dialogues brought all the radio stations together and forged collaboration in promoting normative behavior change through sharing of skills and knowledge in HIV radio program design. Radio stations eagerly participated based on the successful partnership established with BRIDGE II through the *Chenicheni Nchiti?* reality radio program; 11 out of the 13 stations provided free air time making the intervention very cost-effective.

Other achievements included:

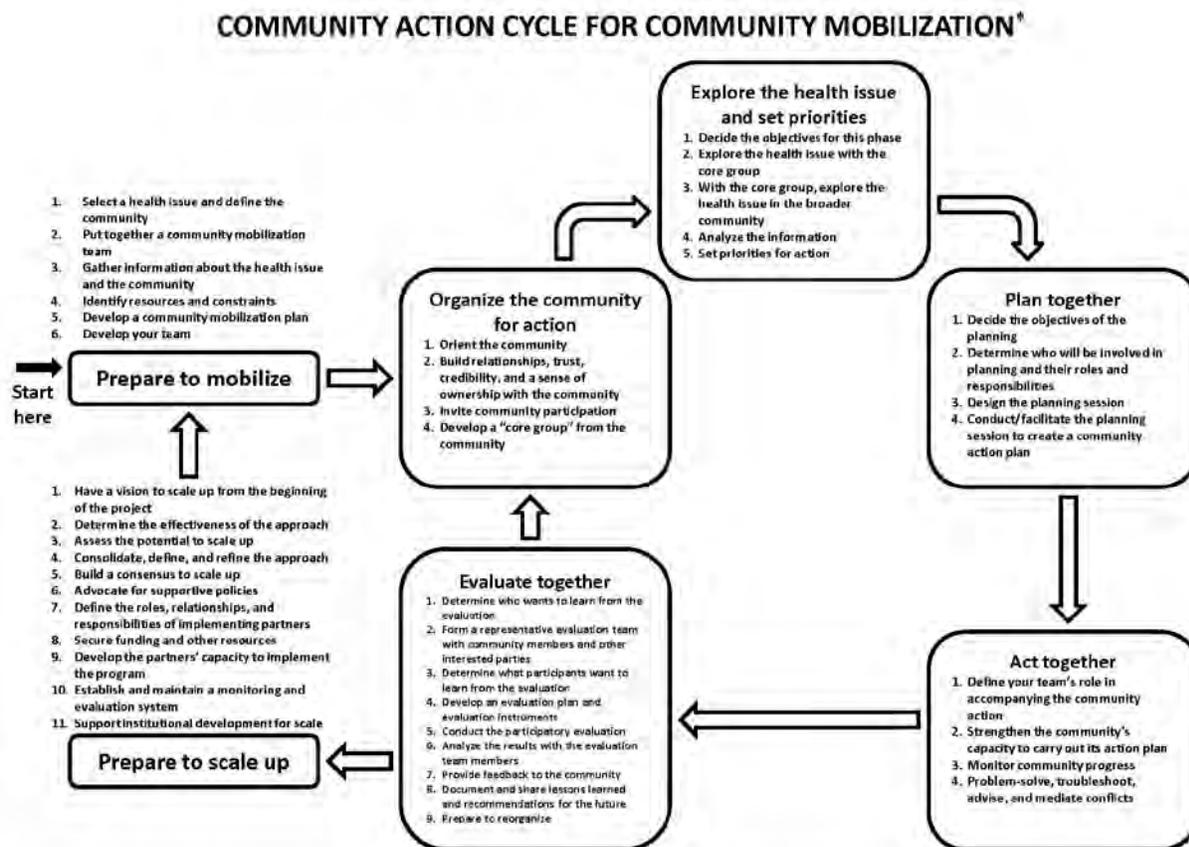
- 520 radio programs aired during the three national dialogue campaigns.
- 20 hours of radio programming covering the campaign themes broadcast per week, reaching a listenership of between 4-5 million people per week for 15 weeks.
- Over 3,000 SMS feedback received for each National Dialogue Campaign with sizeable additional feedback obtained through phone calls and Facebook.

Community Mobilization

Community mobilization is a capacity-building process through which community members, groups, or organizations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health and other conditions either on their own initiative or stimulated by others. Community mobilization is a powerful tool for preventing HIV, as it empowers community members to work together and actively participate in creating change, thereby building collective efficacy and increasing the likelihood that the change created is sustainable.

Save the Children International spearheaded the Community Mobilization activities using the Community Action Cycle⁷ (CAC) to provide communities with the tools and skills to create social change, identify and address key drivers of HIV infection in their communities and combat other health and social issues on their own in the future.

The Community Action Cycle has seven phases, as seen in the diagram below. Under BRIDGE II, the CAC was first introduced at the district level with key stakeholders, and then at the Traditional Authority (TA) and community levels.



*L. Howard-Grabman and G. Snetro, How to Mobilize Communities for Health and Social Change, (Baltimore, MD: Health Communication Partnership/USAID, 2003), 3.

⁷ Health Communication Partnership. (2003). How to Mobilize Communities for Social Change. Baltimore, MD: Howard-Grabman, L., & Snetro, G.

Process

The community mobilization process that BRIDGE II employed for HIV prevention in Malawi was complex, involving many partners in different sectors and at many levels. These partners included representatives from the government at the District, Traditional Authority, Group Village Headman, and at village level including community-based organizations. A key aspect of the community mobilization process was that partners at all levels were engaged in capacity building.

Engaging Community Leaders

Engaging District and Local Leaders

Acknowledging the crucial role that community leaders play in facilitating change, BRIDGE II engaged them in mobilizing their communities for HIV prevention. BRIDGE II worked with leaders at district level in order to get their buy in and support for the implementation of the project, and to ensure sustainability of activities after project closure. A District Community Mobilization Team (DCMT) was formed in each district, with 10 members participating from the Behavior Change Intervention Sub-Technical Committee (BCI-STC) of the District AIDS Coordinating Committee (DACC). Representatives of this committee come from different government departments and non-governmental organizations doing HIV work in the district; the District AIDS Coordinating Officer is an unofficial member. The DCMT was trained in community mobilization and then provided guidance on implementation of mobilization activities in the district, through mentoring and coaching of community level structures.

Traditional Leaders Forums

At community level, BRIDGE II worked with Traditional Authorities (TAs) and Group Village Headman (GVH) structures. BRIDGE II was active in 67 TAs (geographic units within each district) and 567 GVH. Under each TA there are five to ten GVHs, each responsible for 10 to 15 villages. Traditional Leaders and Group Village Headmen were engaged by BRIDGE II in each TA via a committee called a Traditional Leaders Forum (TLF), comprising all group village heads in a TA plus additional opinion leaders. Twenty to 40 leaders met every quarter to discuss cultural beliefs, norms and traditions that promoted or facilitated the spread of HIV in their communities. Traditional leaders were trained by the DCMT in different topics to prepare them for their role of supporting the project in mobilizing communities for HIV prevention, including basic HIV and AIDS information, gender and HIV, leadership and group dynamics. Traditional leaders then sensitized community members on the dangers of traditional practices and norms that predispose people to acquiring HIV and set by-laws banning some of the more harmful practices.

Area Development Community Mobilization Teams

To assist the DCMTs with supervising community structures and their activities, BRIDGE II organized formation of Area Development Committee-Community Mobilization Teams (ADC-CMTs) comprised community extension workers and some members of existing Area Development Committees (ADCs). ADCs are government structures at each TA level responsible for development activities and comprised all Group Village Headmen in a TA, all government extension workers in that area and opinion leaders in that community. From the ADC, three to four members were chosen to form the ADC-CMTs and assist facilitation of community mobilization activities at community level. Team members were trained by the DCMT in community mobilization, facilitation, monitoring and evaluation, leadership and group dynamics.

Engaging Community Organizations: Strengthening the Capacity of Malawian Community-Based Organizations for HIV Prevention through Community Mobilization

Community-Based Organizations

BRIDGE II worked with Community Based Organizations (CBOs), legal entities, registered by District Councils, which implement social development programs in their communities. Membership in CBOs is voluntary and each CBO has four main technical sub-committees, including a Behavior Change Intervention Sub-Technical Committee (BCI-STC) which oversees implementation of behavior change activities in the community. BRIDGE II selected ten members from each BCI-STC to form Community Action Groups, and strengthened their capacity based on experience that using existing structures would more likely result in project activities continuing after BRIDGE II ended.

Community-Based Organization Networks

In order to strengthen the capacity of CBOs and promote sharing among them, existing CBO networks were strengthened or rejuvenated at TA and at district level. The CBO networks comprise all CBOs in the Traditional Area and in the district. Working with the CBO networks enhanced the dissemination of project activities even to those areas where BRIDGE II was not working directly. BRIDGE II partners built the capacity of leaders from CBOs and CBO networks in resource mobilization, monitoring and evaluation and leadership in order to enable them to source funds for implementation of activities.

Community Action Groups

The Community Action Groups (CAGs) were one of the key structures in the implementation of the Community Action Cycle, facilitating the process of community mobilization by engaging community members and promoting widespread community participation. CAG members led the community in exploration of issues that facilitate the transmission of HIV and development and implementation of community action plans.

As noted above, CAGs, composed of 10 community members drawn from the BCI-STC of each local CBO at Group Village Headman Level, were formed in all BRIDGE II implementation communities. The selection process of CAG members was done in such a way that ensured equal representation of women and men, people with disabilities and people living with HIV to make sure that their voices were heard. CAG members were trained on basic

COMMUNITY MOBILIZATION SUCCESS STORY

The Gunda Community Action Group (CAG), from the Phalombe District of Malawi, is an example of community mobilization at its best. The dedicated group of ten members successfully developed a plan of action and implement it independently, after receiving training from BRIDGE II. It helped 21 families in the Gunda Group Village Head stay together, though they were on the brink of splitting up. They have directed countless community members to HIV counseling and testing (HCT) services through their Open Days and Village Discussion Groups.

The Group Village Headman of Gunda expressed joy over the changes that occurred in Gunda due to the efforts of the CAG, stating, "This behavior change is doing magic in my villages. Imagine couples [who] are able to discuss freely and sharing ideas on how to satisfy each other in their marriages. Couples are able to go for HCT services together and young people are going for HCT services before getting married. This is wonderful because issues of sex were not openly discussed; let alone the norm of having multiple sexual partners."



The Gunda CAG, in uniforms they created themselves, making plans for community mobilization activities.

facts about HIV and AIDS, group dynamics, group facilitation, leadership, and resource mobilization.

Village Discussion Groups

As one way of enhancing communication between married partners, BRIDGE II formed village discussion groups (VDGs), to prompt discussions around HIV in marriages, which was initially identified as difficult and/or impossible by married couples in the communities. VDGs comprised both men and women with a total of 25 people in each group, and were formed in each village with a maximum of 8 groups per village. Four Facilitators were selected from local CBOs in each GVH and trained to lead discussions amongst group members. To maximize information sharing, these groups were not permanent structures; after completing discussion topics in the *Tasankha* Discussion Guide and *Journey of Hope* (see below), they were dismantled and the Facilitators formed new groups and/or began discussions with already existing groups formed by other projects, such as those doing village savings and loans schemes. In year 5, facilitators were also trained to do referrals under the Promotional Model of Referrals (see below)

Results

BRIDGE II engaged 567 communities through the Community Action Cycle. They identified key drivers of HIV infection in their communities, created action plans for addressing them and implemented activities to create social and behavior change focused on reducing HIV infection. Some communities went so far as to institute community by-laws banning cultural practices that the community identified as major contributors to the spread of HIV.

- 567 Community Action Groups created and approximately 5,670 Community Action Group members trained in how to mobilize their communities in HIV prevention.
- Over 800 Community Action Plans developed and implemented.
- 67 Traditional Leaders Forums, including approximately 1,005 traditional leaders, had their capacity built in community mobilization.
- Approximately 22,680 small discussion groups formed at the community level.

Engaging People Living with HIV

Over the past several decades, support groups for people living with HIV and AIDs (PLHIVs) in Malawi have remained an important avenue through which PLHIVs discuss and develop strategies for coping with the effects of HIV on their mental and physical health and relationships with their families and communities. The National Association of People Living with HIV and AIDS in Malawi (NAPHAM) oversees and provides technical support to these groups across the country.

BRIDGE II partnered with NAPHAM to implement BRIDGE II transformative activities through its support groups in Southern Malawi. Trained Facilitators took their support groups through a number of different, highly interactive activities using BRIDGE II Transformative Tools (see below for description of toolkits) including the *Planting Our Tree of Hope* Tool Kit which addresses issues relevant to PHLIV. Groups also listened to *Chenicheni Nchiti?* every week and discussed the issues highlighted on the radio program in depth. BRIDGE II additionally trained some support group members on how to use interactive drama to disseminate HIV prevention messages. Use of interactive drama helped PLHIVs to easily reach their fellow community members with key HIV prevention messages and demonstrate the impact of stigma and discrimination on their lives and how it derails efforts in the fight against HIV.

Anecdotally, project staff and the trained support group facilitators found that after engaging with PLHIV, BRIDGE II inspired them, their sexual partners, and their families to adapt and maintain positive behaviors that

prevent the transmission of HIV, reduce stigma and discrimination and help PLHIVs to live positively. Additionally, after facilitating small group discussions with fellow HIV positive individuals for some time, facilitators scaled up interventions and conducted outreach activities in their communities with people who were not members of their support groups using the *Journey of Hope* Toolkit. This helped in normalizing discussions around HIV and reduced stigma toward PLHIVs in their communities.

BRIDGE II's Process for Engaging People Living with HIV

Partnership with National Association for People Living with HIV and AIDS Support Groups

The National Association for People Living with HIV and AIDS (NAPHAM) works with support groups for People Living with HIV and AIDS (PLHIV) in communities throughout Malawi. Some of these support groups are based in BRIDGE II project implementation communities (Phalombe, Thyolo, Chiradzulu and Nsanje). BRIDGE II therefore partnered with NAPHAM to strengthen the groups' ability to address HIV and AIDS-related challenges that affect the lives of PLHIV. Support group membership ranges from 25 to over 100 people. When implementing BRIDGE II activities, members were sub-divided into smaller groups of not more than 25 people to give room for in-depth discussions on key issues. This encouraged participation of all members who consequently became very engaged and actively applied their newly acquired skills to improve their lives. BRIDGE II supported NAPHAM through the training of Facilitators who then implemented the project's Transformative Tools with group members and also formed listening groups that gathered to listen to and discuss the *Chenicheni Nchiti?* radio program.



One of the many CCN Radio Listening Groups.

Use of Transformative Tools

Facilitators were trained to implement the *Planting Our Tree of Hope* toolkit, *Journey of Hope* toolkit and *Tasankha* Discussion Guide with their support groups. The training included how to facilitate participatory sessions, address fears commonly held by many PLHIV, and better understand the gender dimensions underlying many HIV and AIDS-related issues. One female and one male were paired to facilitate all small group activities together to ensure the perspectives of both men and women were taken into account.

Listening Groups

The majority of NAPHAM support groups listened to the *Chenicheni Nchiti?* (CCN) radio program together throughout the implementation of BRIDGE II. The members listened to CCN to acquire more knowledge and skills to practice positive living. As the program began to incorporate other issues, such as malaria, members were encouraged to put into practice other preventive health behaviors to help them maintain a healthy life.

On days that CCN aired, support group members would meet in one place. One support group member would bring a radio, while another would bring batteries. After listening to the program, the batteries were removed and returned to the member who did not own a radio set, for safekeeping. Members contributed money towards the purchase of batteries when they ran out, as part of their contribution towards the project. One positive aspect of this practice was that some support groups bought their own radio sets and stopped relying on individual members to bring radio sets from home.

All 1,450 members of the 24 support groups affiliated with the BRIDGE II Project participated in the radio listening sessions. To facilitate in-depth discussion, members were divided into small groups of not more than 25 people. Each small group had 2 facilitators who led discussions on the radio program, guided by a set of questions provided by BRIDGE II.

Impact of Radio Listening Group Participation

Discussions on issues raised in the program filtered into the homes of radio listening group participants. Female listening group members were especially prone to discussing issues from the program in cases where the husband was not a support group member. Some even listened to the program in the evening with their partners. Further, some female members testified about the positive change of behaviors by their husbands after listening to the radio programs on their own in their homes. Some radio listening group members reported that other support group members across the country listened to CCN and appreciated the issues being raised in the program.

Reducing Stigma and Making Connections in Communities

After facilitating small group discussions with fellow HIV positive individuals for some time, Facilitators scaled up interventions and started conducting outreach activities in their communities with people who were not members of their support groups using the *Journey of Hope* Toolkit. This helped in normalizing discussions around HIV and reduced stigma toward PLHIVs in their communities. The Facilitators also engaged in conversations with members of other nearby NAPHAM support groups where BRIDGE II had not yet introduced its activities, thereby expanding the social support network of PLHIV. During these conversations, the Facilitators used the *Planting Our Tree of Hope* toolkit to guide group discussions. After conducting these outreach activities and discussion sessions, the Facilitators reported back to BRIDGE II how many people were reached. Additionally, the support group leaders (including the support group chair, secretary, and others) met every month at NAPHAM district offices to discuss progress being made with their support groups and exchange ideas and best practices.

Results

In providing support to NAPHAM and working with PLHIV:

- In total, 617 people were trained in group facilitation, and implemented BRIDGE II activities in 24 support groups which had a membership of ~60 people each. With 1,450 support group members participating in an average of one BRIDGE II session per month, these group members collectively completed 87,618 BRIDGE II activities, including radio listening sessions, *Planting Our Tree of Hope* sessions, *Hope Kit* sessions, and *Tasankha* sessions.
- Anecdotal reports indicate that these efforts promoted awareness and openness around HIV, which contributed to a decrease in stigma and discrimination.
- Support group members testified to overcoming fear of rejection by spouses, family members and friends; others comfortably disclosed their HIV status to people whom they initially feared, many of whom are now their main source of support.
- Many PLHIVs now say they want to invest in their future, something they couldn't imagine when they first learned of their HIV positive status.

Transformative Tools

People are more likely to take action and make positive choices for their health when they engage in interactive dialogue about health issues. This is why throughout its implementation, BRIDGE II produced and utilized Transformative Tools to promote and inspire HIV prevention practices in communities in Southern Malawi.

Transformative Tools are participatory, interactive behavior change interventions that promote interpersonal and community dialogue on HIV prevention and related issues and inspire communities and individuals to make positive choices that enable them to live healthy and happy lives. The Transformative Tools were disseminated to BRIDGE II partners – community based organizations that work to prevent HIV – who were trained and supported to implement them with groups of community members.

Journey of Hope

The *Journey of Hope* toolkit encourages individuals and communities to develop appropriate HIV prevention strategies. This toolkit offers a range of interactive, participatory and experiential learning activities to address HIV and AIDS related topics including: understanding the mechanisms of HIV transmission, actions that can be taken to prevent HIV, testing for HIV, and differentiating HIV and AIDS.

The *Journey of Hope* was developed in 2005 under the BRIDGE I project and was the first of the BRIDGE Transformative Tools or toolkits developed. The *Journey of Hope* uses a series of analogies to communicate important HIV prevention messages, for example wildfires illustrate how HIV and other sexually transmitted infections can spread in a community; crossing a narrow bridge represents the importance of applying the ‘ABC’ message of HIV prevention (Abstinence, Be faithful, Condom use); avoiding falling into the water and being attacked by crocodiles (an analogy for HIV infection); and future islands represent future aspirations in life.

The overarching objectives of the *Journey of Hope* toolkit are to:

- Stimulate open conversations about sexual behavior and issues related to HIV and AIDS
- Empower participants to make choices that protect them from HIV infection (abstinence, faithfulness and condom use)
- Promote a healthy lifestyle
- Develop skills in negotiating sexual matters in a relationship
- Promote HIV counseling and testing
- Debunk myths about HIV and AIDS
- Promote support, compassion and positive living for those living with HIV and AIDS



A woman participates in a Journey of Hope participatory activity.

The *Journey of Hope* toolkit includes a facilitator’s guide with activities and questions to stimulate discussions around HIV and AIDS and a collection of stories and pictures of people who have publicly declared their HIV status. These real stories are used to show that people with HIV can look healthy and you can only tell someone’s status (and one’s own) by getting an HIV test.

Planting Our Tree of Hope

The *Planting Our Tree of Hope* toolkit was designed to help people living with HIV to live positively while protecting their health and that of their sexual partners and unborn children by preventing HIV transmission. The toolkit provokes discussions on specific topics, including: positive prevention, discordance of HIV status between sexual partners, preventing mother-to-child transmission of HIV, HIV treatment and stigma and discrimination. In order to inspire individuals to adapt and maintain positive behaviors, this toolkit includes a range of activities for people living with HIV, their partners, and their families to do together.

The toolkit consists of two main components: a flip chart describing the real-life experiences of five men, women and couples who have overcome barriers to living with HIV, and a facilitator's guide, organized by theme, and including activities and questions to stimulate discussions around HIV and AIDS. The *Planting Our Tree of Hope* toolkit is used with groups of people living with HIV and AIDS.

With guidance from trained facilitators, the *Planting Our Tree of Hope* toolkit helps to:

- Identify concrete actions that will help people living with HIV, their partners and families to live healthy and productive lives
- Stimulate discussions within couples about discordance and protecting partners from HIV infection
- Promote shared decision-making within couples on family planning issues
- Raise awareness about the importance of PMTCT, including through safe feeding practices
- Identify ways to overcome barriers to treatment adherence;
- Help individuals and families deal with stigma and discrimination associated with HIV positive status
- Empower people living with HIV, their partners, and their families to believe that they can contribute positively to their family and community

The Tasankha Discussion Guide

The *Tasankha* Discussion Guide, a Transformative Tool that was an integral part of BRIDGE II's *Tasankha* Campaign, was created to spark community dialogue and motivate people to make choices that will promote good health and prevent HIV infection. The guide includes activities that are informative, interactive and

TRANSFORMATIVE TOOLS SUCCESS STORY

Joseph Chilewe was diagnosed with HIV in November of 2007. In 2009, his support group began participating in BRIDGE II activities, and took control of his health. Through his participation in BRIDGE II, Joseph was exposed to the Journey of Hope Kit, the Planting Our Tree of Hope Kit, and radio listening sessions. He also eventually became an interactive dramatist, spreading HIV prevention messages to his community.

Joseph said that his life changed for the better when he learned about Austin Kajologo's story at his support group, saying, "I learned that Austin has lived with HIV for over 10 years without getting enrolled in ART. This encouraged me a lot and today my life has completely changed. I used to drink beer, but I stopped... and at first [after learning my diagnosis] I used to sleep with my wife without using a condom, but now condoms have become a party of our sex life. I use them consistently."



Today, Joseph is not only a vegetable farmer, but also raises goats, which he was able to buy through profits from farming.

participatory and that enhance individual and community understanding of the issues surrounding HIV transmission and prevention. The activities in the guide were developed to strengthen individual perception of HIV risk and the collective efficacy of communities to prevent HIV infection. Through *Tasankha* Discussion Guide activities, communities took collective action to prevent further spread of HIV in their communities. For example, men could convince each other on the benefits of voluntary male medical circumcision, motivate each other to go for the procedure and register with a CBO network within their community which consequently would approach a nearby health facility to organize an outreach VMMC site so that the men could be circumcised. Some communities developed bylaws/community charters, signed by the Traditional Authority, which helped in regulating behaviors that fuel the spread of HIV. The efforts of individuals and families to lower their own risk contributed to addressing community-level factors driving ongoing HIV infection.

The following topics make up the 10 modules in the guide:

- Couple communication and improving sexual satisfaction
- Concurrent sexual partnerships
- HIV discordant couples
- Prevention-of-mother-to-child transmission (PMTCT)
- Male circumcision
- HIV counseling and testing (HCT) and couple counseling
- Gender norms
- Prevention with positives
- ART and treatment
- Post Exposure Prophylaxis (PEP)

African Transformation

The *African Transformation* toolkit is a transformative tool used to stimulate community dialogue about gender and social roles in order to create social change and address gender-related barriers that can affect HIV transmission, treatment and care. *African Transformation* provides women and men with the tools to explore how gender norms and social roles operate in their lives. This in turn assists them to begin changing norms and roles that are negative, while reinforcing those that are positive. The ultimate goal of *African Transformation* is to create an equitable and tolerant society where women and men mutually respect each other, critically examine and change gender inequities, and participate in equitable decision-making and resource allocation.

The toolkit comprises two main components: personal stories of women, men and couples on video who have challenged traditional gender and social roles to achieve their goals; and an accompanying facilitator's guide that includes activities and questions to stimulate discussions around gender and social roles, and how these roles and norms can positively or negatively influence HIV-related practices. The guide helps trained facilitators lead group discussions on gender and HIV-related themes including those emerging from these personal stories. The toolkit is suitable for women and men of all ages, cultural backgrounds, religions and literacy levels. Ideally, discussion groups are comprised of an even number of women and men between the ages of 18 and 50, and facilitated by both a man and a woman.

With guidance from trained facilitators, *African Transformation* enables participants to:

- Challenge stereotypical social norms that dictate gender roles, responsibilities and expectations
- Recognize that certain gender-related social norms are harmful
- Make decisions and share household resources equitably
- Empower individuals to make positive individual, family and community-level changes
- Replace harmful social norms with positive social norms and eliminate harmful gender related practices

A Happy Married Life: A Couple Counseling Guide

Effective couple communication is essential for a healthy family. Qualitative research findings from Malawi indicate that lack of open communication, particularly around issues of sexuality, is a key reason men and women look outside the home for other partners, increasing their risk of contracting HIV and passing it to their partner⁸.

To strengthen couples' communication skills, BRIDGE II, in collaboration with local faith-based organizations from different religions and sects, developed *A Happy Married Life: A Couple Counseling Guide*. Faith-based counselors trained by BRIDGE II used the guide at the community level. The overall objectives of the counseling sessions were to:

⁸ Limaye, R. J., Rimal, R. N., Mkandawire, G., Roberts, P., Dothi, W., & Brown, J. (2012). Talking About Sex in Malawi: Toward a Better Understanding of Interpersonal Communication for HIV Prevention. *Journal of Public Health Research*, 1(2), 117–125. doi:10.4081/jphr.2012.e17

COUPLE COUNSELING SUCCESS STORY

The decision to attend faith-based marriage counseling was life-changing for Christopher and Ndazona Kachingwe from Ng'ombe, Machinga. With encouragement from marriage counselors, Christopher and Ndazona went for HIV testing and learned that they were both HIV positive. Knowing their HIV status allowed them to take action. They adopted healthy eating habits and learned to support each other.

"My husband started helping out with household chores. For instance, he prepares food while I bathe our children," explained Ndazona. The couple learned to communicate openly about difficult topics whereas they used to avoid those conversations in the past.



Ndazona said, "Faith-based marriage counseling under BRIDGE II encouraged me and my husband to go for HIV testing. People from my community were discouraging us from going to marriage counseling, arguing that there was nothing new we could learn."

Mr. and Mrs. Chimenya, the counselors who counseled the Kachingwes, are working to change this perception in their community, and believe that, as a result of counseling, couples are more open, loving and trusting, and more willing to go for HIV testing.

- Support people planning to get married by helping them choose a partner who is right for them.
- Improve couple communication and strengthen intimacy between married couples.
- Assure married partners and those entering marriage that obeying the commands of God/Allah is one way to help prevent HIV from entering the home.
- Help men and women think through and take responsibility for acting on what they need to do to have a happy family life.

The guide also helped couples resolve conflict in their marriage and enabled faith-based counselors to assist couples in addressing issues previously regarded as taboo or difficult to bring into the open. The guide accomplished this through the use of several different participatory methods, allowing couples to express themselves including group discussion, brainstorming, role-play, small group work, drama, and storytelling.

Participating faith-based institutions and couples counselors reported that the guide was well accepted by both Christian and Muslim communities. Participating couples testified that the counseling sessions helped them find solutions to marital problems and improved their overall communication. Many couples acknowledged that counseling has made them more open to discussing difficult but important issues, such as sex and money, and has increased their knowledge about HIV and AIDS.

Caring for Children Living with HIV: A Toolkit for Parents and Caregivers

Caring for Children Living with HIV: A Toolkit for Parents and Caregivers is designed to ensure that children who are HIV positive have the best care and treatment possible. This toolkit addresses the specific needs of children between 6 and 12 years of age and the parents and caregivers who support them. It also provides information on pediatric HIV to enable extended families, community-based organizations, and others to provide an enabling environment for children to access care and treatment. The toolkit includes three components: a children's booklet, a parent's booklet, and a facilitator's guide. As it was developed towards the end of BRIDGE II, the project was able to finalize the tools based on feedback from a TOT/pre-test, produce them and disseminate the package to partners, but did not roll out implementation.

Implementation and Monitoring of the Transformative Tools

In order to build the groundwork for the use of these toolkits, BRIDGE II trained Trainers of Trainers (TOTs) who in turn trained Community Facilitators who conducted the discussions on the ground in communities.

Additionally, BRIDGE II set minimum standards for effective monitoring and evaluation of the positive impact and change the Transformative Tools were making in people's lives. In order to facilitate the necessary collection of information on participants' exposure to Transformative Tools' activities and concepts, attendance reporting forms for each toolkit were tailored to include gathering data on participation in each individual activity. This allowed BRIDGE II to track who had participated in each activity for each Transformative Tool. TOTs and subsequently Community Facilitators were trained on appropriate data collection using the attendance reporting forms.

Results

Hundreds of thousands of people participated in BRIDGE II Transformative Tools' activities. There was a remarkable positive impact on individuals, families and communities as shown by the number of success stories for each of the toolkits. In addition, some organizations, such as the Clinton Foundation, Goal Malawi and the US Peace Corps, who were not formally involved with BRIDGE II, began implementing activities from the Transformative Tools in their HIV prevention work of their own accord.

- 2,500 *Journey of Hope* toolkits produced and over 227,690 people reached (80,143 men and 147,547 women).
- 2,220 *Tasankha* Discussion Guides produced and 121,395 people reached (45,731 men and 75,664 women).
- 1,000 *Planting Our Tree of Hope – Positive Prevention* toolkits produced and 12,702 people reached (3,292 men and 9,410 women).
- 970 *African Transformation* toolkits produced and 46,692 people reached (20,070 men and 26,622 women).
- 519 couples (1,038 people) from 10 Faith Based Organizations trained in using the Happy Married Life guide to provide counseling services.
- More than 55,000 people participated in couple counseling sessions.
- 20 Trainer of Trainers skilled in implementing the Caring for Children toolkit.
- 50 copies of the Caring for Children toolkit produced and distributed to NAPHAM as a start up package

Capacity Building

Capacity building can empower individuals, communities, and local and national organizations and governments by equipping them with the knowledge, skills, technology and competencies necessary to take an active role in disease prevention. BRIDGE II focused on building the capacity of Malawian institutions, local communities and individuals to assure the sustainability of its HIV prevention strategies. Capacity building was one of the projects' strategic approaches and it remained crucial and cross cutting in all project activities at all levels.

At the community level, BRIDGE II worked with community based organizations (CBOs) to strengthen their overall capacity to plan and implement strategic behavior change communication (SBCC) programs and conduct community mobilization around HIV and AIDS prevention and related issues; the project also created opportunities for strengthening networking and linkages across CBOs. At the district level, BRIDGE II helped to strengthen the capacity of the District AIDS Coordinating Committee (DACC) in both community mobilization and SBCC. Nationally, BRIDGE II enhanced the capacity of government, NGOs and private sector partners through formal educational workshops, active participation in Technical Working Group meetings and providing opportunities for "learning by doing" through the development of campaigns, radio programs, toolkits and other materials. For example, BRIDGE II implemented CCP's flagship Leadership in Strategic Health Communication workshop for participants from the Malawi Ministry of Health, NGOs and others and provided opportunities for Malawian media institutions to improve their ability to produce quality reality radio programs through collaboration on the National Dialogues campaigns addressing HIV and AIDS and gender related issues.

National-Level Capacity Building

Leadership in Strategic Health Communication

At the national level, BRIDGE II facilitated two sessions of the Leadership in Strategic Health Communication (LSHC) workshop, a renowned course developed by CCP. The course enhanced the capacity of over 50 people (program managers, senior program officers and communication officers) from the Ministry of Health and selected organizations across Malawi that implement HIV-focused communication programs. The workshop covered how to strategically design, plan and implement strategic communication programs around HIV and AIDS.

Strengthening Capacity of Media Institutions

BRIDGE II trained media professionals to develop quality reality radio programs that address HIV- and AIDS-related issues and improve access of Malawians to relevant information and knowledge about HIV prevention. Capacity building efforts included: involving partner institutions in designing reality radio programs; mentoring local radio stations on reality programming (including the sharing of skills, programs and real life stories addressing HIV issues using the reality programming approach); offering basic computer skills to support production of HIV programs and distributing laptops and digital recorders to local radio stations to support their work through improved access to high-quality equipment; empowering media houses to accurately report on voluntary male medical circumcision (VMMC), and actively involving the media houses in designing the National Dialogue, which strengthened their capacity to lead this activity in the future.

Strengthening National Organizations and Institutions

BRIDGE II worked closely with the Malawi National AIDS Commission (NAC) and the Health Education Services (HES) sector of the Ministry of Health, and encouraged the development of strong SBCC programs within these institutions. BRIDGE II leadership participated in the Malawi HIV Prevention Technical Working Group as well as the BCC Sub-Technical Committee of that working group that met quarterly to review HIV prevention efforts in the Malawi National HIV Response. BRIDGE II took a leading role in developing the VMMC Communication Strategy, provided technical support to NAC and the Health Education Section of the Ministry of Health in reviewing the HIV Prevention Strategy and many other strategic documents on HIV prevention.

District- and Community-Level Capacity Building

BRIDGE II's general approach to capacity building at the district and community level was multifaceted and based on a cascade model. First, BRIDGE II provided formal trainings to individuals at district level on topics such as use of transformative tools, community mobilization, SBCC and CBO network strengthening. The trained individuals then trained others at Traditional Authority level on the same topics, reinforcing their own skills in the process. Those trained at TA level later facilitated sessions with people at Group Village Head level. In this way, skills learned at the district level were cascaded to the TA and community levels. After applying their skills for some time, each person went through a refresher course at least once in order to review the basic principles of their activity and find solutions to common challenges they encountered in the field. BRIDGE II also facilitated quarterly mentoring sessions, review meetings and supervisory visits throughout the implementation period to reinforce the skills and knowledge of those implementing program activities.

An Example of the Cascade Training Model

Capacity building conducted with District AIDS Coordinating Committees (DACCs) provides a good example of BRIDGE II's cascaded model of training. DACCs are structures of the Malawi government that include participation from local government officials and NGO representatives. DACCs provide oversight, support and coordination of HIV related activities in each district.

BRIDGE II trained 10 members of the DACC sub-committee and the Behavior Change Intervention Sub Technical Committee (BCI -STC), on community mobilization using the Community Action Cycle (CAC) – a tool for helping communities identify and prioritize issues affecting their community, and develop strategies for addressing them. These 10 individuals formed the District Community Mobilization Team (DCMT). The DCMT later trained members of the Area Development Committee–Community Mobilization Team (ADC-CMT) members (a structure at the Traditional Authority level) through a similar training on community mobilization and the CAC. The ADC-CMT further built the capacity of Community Action Groups (CAGs) at the Group Village Headman (GVH) level. The CAGs then facilitated sessions with their communities using the CAC to explore key drivers of

HIV in their communities and come up with plans for addressing those key drivers. They then worked with community members to implement interventions for dealing with the spread of HIV in their community and later evaluated their efforts and re-planned according to the findings.

Strengthening the Capacity of Community Structures

BRIDGE II strengthened the capacity of structures at the community level to implement activities related to HIV prevention in their communities and to sustain BRIDGE II activities after the project ended. BRIDGE II:

- Oriented traditional leaders on how some cultural beliefs and norms fuel the spread of HIV in their localities and how they can address them.
- Trained CBOs and CBO networks on proposal writing, CBO management and leadership, conflict management, team building and supervision.
- Held Best Practices Conferences—forums through which CBOs within each district learnt from each other how to better manage their CBOs.
- Built capacity of the Behavior Change and Intervention Sub Technical Committee (BSI-STC) (which were also called Community Action Groups) of each CBO in:
 - Use of the CAC to support the community mobilization process.
 - Facilitation of discussions using BRIDGE II Transformative Tools.
 - Referral of people to services through the two referral models that the project developed- the Community Referral Agent Model of Referral and the Promotional Model of Referral.

District-Level Capacity Building

At the district level, the project built the capacity of the technical arm of each DACC in the form of the BCI-STC that helped supervise BRIDGE II activities at district and community levels. The capacity building of each district's BCI-STC and the formation of a DCMT within each district are described above.

BRIDGE II also formed and built the capacity of District Network Strengthening Teams (DNSTs) in all implementation districts. Members of these teams included the District AIDs Coordinator, the District Social Welfare Officer, DCMT members and the DACC Chairperson. The role of this team was to ensure that CBOs are effective and executing their responsibilities in a coordinated way. The teams worked closely with BRIDGE II in conducting Organizational Network Analyses (ONA) of local CBOs, analyzing the results and drawing action plans for strengthening the CBOs based on the findings. As part of BRIDGE II's exit strategy, the project trained DNSTs on how to use NodeXL, free and user-friendly software for analyzing the interaction of organizations within a locality.

Community-Based Organization Network Strengthening

BRIDGE II worked to strengthen Community-Based Organization (CBO) Networks in all its implementation districts. This contributed to BRIDGE II's overall goal of supporting Malawian institutions in effective leadership and coordination of HIV prevention efforts.

To begin the process of strengthening CBO networks, BRIDGE II implementation partner PACT Malawi conducted two Organizational Network Analyses (ONA) surveys in the project's phase I districts (Chiradzulu, Thyolo, Mulanje, Phalombe, Nsanje and Chikwawa) and one ONA survey in phase II districts (Zomba, Mwanza, Neno, Blantyre and Machinga) to determine patterns of interaction among CBOs and within CBO networks. The results were used by CBO Networks to strengthen themselves by better utilizing their resources and further involving members that were isolated and/or not fully engaged.

In addition to conducting ONA surveys, BRIDGE II trained CBO and CBO Network members in proposal writing, CBO management and leadership, conflict management, team building and supervision. The project also facilitated Best Practices Conferences which enabled representatives from CBOs and CBO networks within the districts to learn from each other's experience and expertise.

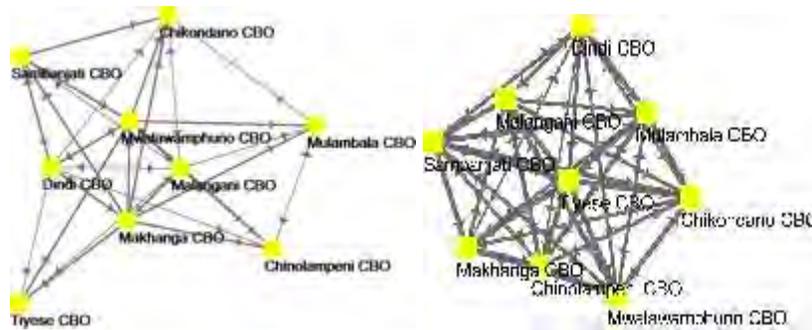
BRIDGE II formed and strengthened the capacity of District Network Strengthening Teams (DNSTs) in all implementation districts. DNSTs ensured that CBO networks were effective and carrying out their responsibilities in a coordinated way.

Throughout the life of the BRIDGE II project, 67 CBO Networks were engaged in capacity strengthening activities. Through their involvement in BRIDGE II, the CBOs in these networks gained expertise in the implementation of HIV prevention activities. Many of them are now taking commendable steps to promote HIV prevention that exceed their efforts prior to participation in the project. For example, some CBO networks have advocated with higher government authorities for improved health services (e.g., HIV counseling and testing, voluntary medical male circumcision) to be brought to their areas and others have taken BRIDGE II approaches, such as the use of Transformative Tools, beyond project catchment areas. Through capacity and network strengthening, BRIDGE II is confident that participating CBO networks will be able to sustain and build upon the advances they have made.

Process for Conducting Organization Network Analysis (ONA) Surveys

The ONA surveys were designed in such a way that they provided learning opportunities for all involved. First, the project developed a network analysis survey tool, which was distributed to participants for their input. Questions in this tool were targeted at capturing the flow of information and resources among and between CBOs and CBO Network members. Participating CBOs and CBO Network members were later brought together during a one-day session where the survey was administered. The CBO and CBO Network representatives present at the session took the survey individually and submitted their completed questionnaires for analysis.

The data was analyzed using InFlow, a network analysis software application that generates network maps, positioning organizations or individuals according to their connections with others. InFlow also includes a range of performance measurements that can be used to generate deeper understanding and support the monitoring of network development over time. The main output of ONA surveys is therefore network maps that show network nodes and ties. Nodes are the individual organizations within a network, and ties are the relationships between those organizations. A feedback meeting with participating organizations and the District Network Strengthening Team on how to strengthen the networks according to the survey results was then held. Districts that had two rounds of ONA surveys compared maps in the two subsequent years to analyze progress made by members in strengthening relationships among them. For example, two ONA maps (below) from Traditional Authority Chiwalo in Phalombe district show an increase in the density of networking in 2012 as compared to the 2011 results. The image on the left shows results from the 2011 ONA survey, while the image on the right shows results from the 2012 survey:



Best Practices Conference for CBO and CBO Network Strengthening

Best Practices Conferences were two-day gatherings of representatives from all CBOs and CBO Networks from BRIDGE II catchment areas in each district. During the conferences, participants learnt from each other and shared expertise on CBO management, resource mobilization, the importance of documentation and how to run effective social and behavior change communication programs. Before each conference, each district formed a task force involving the District AIDS Coordinator, the District Social Welfare Officer, and some members of the District AIDS Coordinating Committee. The task force sent out a call for abstracts to all CBOs and CBO networks for them to submit proposals and express their interest to present their achievements during the conferences. Participants could either share their achievements through presentations or displays during the marketplace—an opportunity for informal networking during which conference attendees could ask questions of presenters and exchange contact information to allow for further collaboration after the workshop. The task force later reviewed the proposals and shortlisted institutions that went through mentoring sessions. This involved the task force helping presenters prepare and package their presentations so others could best learn from them. The first day of the two-day conference involved plenary discussions and formal presentations; the second day was dedicated to interaction through the marketplace.

Process for Establishing District Network Strengthening Teams

A District Network Strengthening Team (DNST) was instituted by BRIDGE II in each implementation district to oversee the network strengthening activities among CBOs and CBO Networks. Each seven person DNST was comprised of the District AIDS Coordinator, a representative from the District Social Welfare Office, some members of the District AIDS Coordinating Committee and CBO Network members. These individuals were trained during a week-long network strengthening training where they learnt how to conduct their own ONA surveys using free software called NodeXL; analyze and interpret results and help CBO network members develop and implement capacity strengthening plans. DNSTs have been instrumental in supervising CBO networks.

Results

Overall, BRIDGE II’s capacity efforts have had a significant impact on the capacity of Malawian institutions and individuals to develop and implement health communication programs, achievements include:

- Building the capacity of 13 media institutions in reality programming through National Dialogue Media Campaigns, and these radio stations are now able to produce National Dialogue programs on their own.
- Distributing 23 Laptops and 53 recorders to 13 media houses to support their work in producing HIV- and AIDS-focused reality radio programs.

- Following BRIDGE II capacity building initiatives, some community volunteers whom BRIDGE II engaged secured full time jobs with other development partners (radio stations, African Parks Majete). Others were nominated by their communities to compete for parliamentary and council ward seats during the 2014 tripartite elections as a way of involving them.
- Strengthening the capacity of 67 CBO networks, which are now leading implementation of HIV prevention activities including advocating with higher government authorities for improved health services (e.g., HIV counseling and testing, voluntary medical male circumcision) to be brought to their communities.
- Strengthening SBCC skills of over 50 government, local and national NGOs, FBOs and individuals through the Leadership in Strategic Health Communication workshop.
- Facilitating the formation of a Leadership in Strategic Health Communication Alumni group in collaboration with CCP's other USAID-funded project in Malawi, SSDI-Communication, creating an opportunity for continued sharing of knowledge, skills and expertise among health communicators in the country.

Linking People to Services

In Southern Malawi, lack of awareness of HIV testing, prevention, and treatment resources is a major barrier to accessing HIV services. In an effort to address this — and bridge the gap between awareness of the importance of HIV-related health-seeking behaviors and adoption of those behaviors — BRIDGE II worked within communities to connect families and individuals to the HIV services they needed. BRIDGE II used a variety of approaches to do this: referring people to services using community and promotional referral, the informal distribution of condoms, linking people to HIV counseling and testing and PMTCT services through the *Tasankha* campaign and Transformative Tools, workplace HIV prevention interventions, and to VMMC services through the *Ndife Otsogola* campaign.

Referring People to Services

Throughout the BRIDGE II project, people were linked to HIV prevention, testing, and treatment services, as well as other health services, through two models of referral: the Community Referral Agent Model, and the Promotional Model of Referral.

The International HIV/AIDS Alliance (IHAA), a BRIDGE II implementation partner, took the lead in this effort. Their goal was to strengthen referrals and links between community members, formal service providers (health centers, hospitals), and informal service providers (community-based organizations, home-based care groups, support groups) to increase the uptake of HIV and AIDS-related health services. They also worked to encourage appropriate HIV prevention, testing, and treatment-seeking behaviors and promote provider follow-up with clients after they received these services.

The Community Referral Agent Model

BRIDGE II trained CRAs to conduct community-based needs assessments for HIV services, and provide individuals and families with information and referrals for those services available within BRIDGE II implementation districts.

This 5 day training was guided by the Resource Manual for Community Referral Agents and enabled the CRAs to: understand their duties and responsibilities; address the psycho-social and physiological health needs of their clients; understand challenges that vulnerable groups (orphans, individuals and families in situations of poverty, child-headed households) encounter and the type of referral that they might need; enhance their interpersonal communication skills; and learn about best practices for assessing client needs and selecting referral services. The training also included basic information on HIV prevention, care, and treatment. CRAs were trained to refer clients for several HIV and sexual health-related services, including HIV testing, prevention of mother-to-child transmission of HIV, family planning and antenatal care, voluntary medical male circumcision, treatment of sexually transmitted infections, family planning and how and where to access condoms. The CRAs-in-training also received a copy of the Resource Manual for Community Referral Agents in Malawi, booklets containing forms needed to refer clients to HIV services, a referral directory of places where clients could access HIV and health services, CRA t-shirts, bags and bicycles to support their work.

The implementation of the CRA model began with door-to-door visits to identify clients who could benefit from HIV services. During these visits, CRAs conducted an assessment of individual and family HIV service needs using documented guidelines laid out in their Resource Manual. CRAs explained to individuals and families why HIV testing, prevention, and treatment services were relevant and beneficial; where to find the services within the area or district; what days and times services were available; and whether a fee was required for each recommended service. Then they discussed with clients what they should expect when visiting a service provider and what they should do to get the most out of their visit. The CRAs completed and provided their clients with referral forms indicating the client's age, sex, marital status and the service required. The referral forms were in triplicate: the CRA's copy remained in the referral booklet, and the client and service provider's copies were given to the client to take to the service provider. Upon arrival at the service point,

COMMUNITY REFERRAL AGENT MODEL SUCCESS STORY

Christina Samuel from Nkusa village in Thyolo is one of the CRAs who have helped many people find solutions to their problems and has a positive attitude about it. "I can't just stay without telling people about the available services. I do it all the time whether I am at a maize mill, church, market place, water points, funerals and many more places. My goal is to save lives and this motivates me."

Christina informs and refers people for HIV Counseling and Testing (HCT), family planning, Voluntary Medical Male Circumcision (VMMC), antiretroviral therapy (ART), nutrition, and screening for TB and cancer.

Christina refers approximately 30 clients a month and has so far referred 780 people since 2011, the year she started working as a CRA. Some community members have expressed happiness because of these referrals. One of the beneficiaries of the program said, "My beautiful baby girl is HIV negative because Christina referred me to PMTCT services. I am now a proud mother." Many other women from Christina's community who accessed PMTCT services after being referred by her are yet to know the status of their children as they are still under two years.



Christina (in purple) during a household visit to one of her clients, whom she referred for PMTCT. The baby in the picture is HIV negative despite her mother's HIV positive status.

the client presented the two copies to the provider who signed on both of them after providing the HIV or health service. The client took back his or her copy and left the service provider copy at the service point where they were stored in a box until the end of the month when the CRA came to collect them. The service provider forms were a means of feedback to the CRA on the proportion of people who went and accessed service against the total number of people whom he or she sent as indicated in his or her referral booklet. The service providers' forms were later sent to BRIDGE II offices alongside CRA monthly reports as evidence that the reported number of people indeed accessed services.

CRA's compiled and submitted monthly CRA reports to BRIDGE II and District Health Offices, highlighting the number of people whom they referred in a particular month and the number of people who accessed services, disaggregated by gender. The reports also included challenges encountered by the CRA's in the previous month, along with suggestions on how to address and remedy them. Quarterly supervisory visits, conducted by IHAA, also helped the CRA's to find solutions to common problems in addition to providing a forum for sharing experiences and success stories. The project also facilitated quarterly stakeholder meetings that brought together CRA representatives, service providers, District AIDS Coordinators, Social Welfare Officers, representatives from the District Health Offices and any other concerned office to interface on the work of CRA's. These gatherings helped in addressing some bottlenecks in referral work and facilitated the resolution of their root causes.

The CRA model was implemented in four of the 11 BRIDGE II implementation districts. It was piloted in Chiradzulu and the lessons learned were used to scale up the intervention to three more districts: Thyolo, Mulanje and Phalombe. While effective, the CRA model was also found to be costly, which led to the creation of the Promotional Model of Referral.

The Promotional Model

In this model, referral services were provided by Community Facilitators, which the project had already trained to engage communities in small group discussions on HIV prevention using its Transformative Tools. In line with the BRIDGE II *Tasankha* campaign, the small group discussions highlighted, among other things, the importance of seeking health services early and the kind of services that are available within their area and district. After group discussions on a particular topic, community facilitators referred people who expressed interest to go for services by giving them a referral form. The Community Facilitators later expanded their reach and referred people from within their villages whom they knew to have health problems.

Promotional Model Referral forms were simple and in duplicate. The forms outlined client biographic data just like those of the CRA Model. A duplicate of the referral form remained in the referral booklet while the other was given to the client to present to the service provider. The service provider signed the form after attending to the client as proof of providing the service. The client took back the referral form to the referral agent who used it for reporting. The referral agent referred to the duplicate that remained in the referral booklet to follow up with clients who did not bring back the referral form after some days or weeks depending on the date when the client indicated that he or she would go for the services. During this follow up visit, the agent would find out from the client if they managed to visit the service point and received the service or if they had not and reasons why. The referral agent provided additional support and encouragement to the client if he or she did not go for the services.

The community facilitators participating in the Promotional Model received a one-day training before starting to refer people. Taking advantage of their existing knowledge and expertise on interpersonal communication skills and basic facts about HIV and AIDs, the Promotional Model training focused on how the referral agents could identify and approach people requiring referral services, how to take care of psycho-social and physiological

health needs of their clients and discussed the type of services available in their communities where they could refer people. After the training, the referral agents received a referral booklet to support their work. They were also encouraged to sensitize their communities, through other BRIDGE II structures, on their new role. The referral agents also introduced themselves to the Health Center staff, who had previously been introduced to BRIDGE II's Promotional Model and with whom BRIDGE II had established a working relationship, to plan how they would work together over the course of time. This interface built confidence in the referral agents and enabled them later to approach Health Center staff with problems they encountered with ease. The project held quarterly review meetings with the referral agents as one way of promoting the sharing of best practices and to address challenges referral agents encountered. Under BRIDGE II, the Promotional Model was introduced during the summer of 2013 in the seven districts where the CRA model was not being implemented.

The Promotional Model proved to be more cost effective than the CRA model. This was due to the fact that unpaid volunteers referred people from within their villages, and therefore did not need bicycles for transport or identity cards during travel. However, establishment of the Promotional Model took quite some time due to low literacy levels of the volunteers, which made it hard for them to fill in the referral forms and protests from health center staff, who thought they were being asked to take on extra work. Through quarterly supervisory meetings with both volunteers and health center staff, these issues were successfully addressed.

Informal Condom Distribution

In 2012, BRIDGE II and other stakeholders observed critical shortages in the supply of condoms and other supplies to individuals living in rural Malawi, including BRIDGE II catchment communities. After noting the shortages and realizing its impact on the health of Malawians, BRIDGE II came up with an innovative plan to facilitate the distribution of free condoms through informal channels to the public. Informal condom distribution was implemented in eight of the 11 BRIDGE

INFORMAL CONDOM DISTRIBUTION SUCCESS STORY

In 2012, BRIDGE II and other stakeholders observed critical shortages in the supply of condoms to individuals living in rural Malawi, including BRIDGE II catchment communities. After noting the shortages and realizing its impact on the health of Malawians, USAID entrusted BRIDGE II with the responsibility of facilitating distribution of free condoms through informal channels to the public. BRIDGE II trained 1,390 Informal Condom Distributors (ICDs) (bicycle taxi drivers, market women and Community Based Organization members) in communities around 161 Health Centers (HC) to distribute the free condoms locally and demonstrate how to use them correctly.

Wyson Chilemba, a BRIDGE II informal condom distributor who can be seen in the image below on his way to distribute condoms, says his family and the community are benefitting a lot from the intervention. He also added that informal condom distribution has provided easy access to condoms in the community and that most people who were previously shy of asking for condoms from the Health Center approach him with ease to ask for condoms since they have known him for a long time in the community.

Wyson reports that he will continue distributing even once BRIDGE II ends as long as the Health Center continues to supply the condoms. Wyson received high-quality training from BRIDGE II which has helped him to perform his role well, and as a volunteer, the absence of BRIDGE II would have no major negative effect on his ability to continue distributing free condoms in his community.



II implementation districts: Mulanje, Thyolo, Phalombe, Nsanje, Chikwawa, Zomba, Chiradzulu and Mwanza.

Collaboration with Local, National, and International Partners

BRIDGE II developed and implemented the condom distribution program in collaboration with the USAID-funded, JSI-implemented Deliver Project and participating District Health Offices. USAID procured the condoms, and the Deliver Project delivered them to the Health Centers along with other health commodities. BRIDGE II trained 1,390 Informal Condom Distributors (ICDs) (bicycle taxi drivers, market women and Community Based Organization members) in communities around 139 Health Centers (HC) to distribute the free condoms locally and demonstrate how to use them correctly. Each of the 139 HCs had 10 informal condom distributors and they all worked on a voluntary basis. Condom distribution activities in a particular district were coordinated by a district focal person from the District Health Office. There was also another desk officer, usually a Senior Health Surveillance Assistant, at HC level who managed activities within the catchment area.

The ICDs received their monthly consignments from their local HCs. At the end of the month, each ICD compiled a report, outlining the number of condoms that he or she received at the start of the month, the number of condoms distributed and the number at hand. S/He then sent this to the HC where an aggregated report for a particular HC catchment area was compiled and sent to BRIDGE II through Frontline SMS. BRIDGE II calculated monthly projections for the next month for each HC catchment area based on consumption levels as extracted from the reports and sent it to JSI/Deliver for the next round of delivery.

BRIDGE II conducted quarterly review and planning meetings with district and HC focal persons and the ICDs to collect and share successful strategies, challenges, and develop solutions to common challenges encountered. The project also supplied the HC desk officers with airtime for sending SMS based reports to BRIDGE II.

Linking People to HIV Counseling and Testing

HIV Counseling and Testing (HCT) remains a critical entry point to other HIV and AIDS-related services: initiation of anti-retro viral therapy, Prevention of Mother to Child Transmission of HIV (PMTCT) and many others. In relation to this, BRIDGE II promoted HCT in all its catchment areas in southern Malawi through its various activities and campaigns: the *Tasankha* mass media campaign, Transformative Tools, and other community mobilization activities such as open days.

The *Tasankha* campaign: The second phase of BRIDGE IIs' *Tasankha* ("We have chosen") mass media campaign focused on linking people to HIV prevention services, with HIV counselling and testing as the entry point. The campaign encouraged all community members (couples, men and women, pregnant women, boys and girls) to go for HIV testing, know their status and make better choices for their future. The project developed posters and radio spots that underlined the benefit of knowing ones' status and the services that are available for people who are HIV positive.

Chenicheni Nchiti?: the BRIDGE II flagship radio program also promoted HCT through personal testimonies of people who dealt with the realities of knowing their HIV positive status and developed strategies to live positively. This gave hope to many people who consequently went for HCT.

Transformative Tools: BRIDGE II used its Transformative Tools such as the *Tasankha* Community Discussion Guide, A Happy Married Life: A Couple Counseling Guide and the *Journey of Hope* toolkit during community discussions and community wide events to promote HCT.

Community Wide Events: BRIDGE II took advantage of community mobilization activities such as open days and road shows to link people to HCT services by collaborating with nearby health facilities to set up mobile HCT sites during these events. This approach worked well because people were motivated to get tested after hearing

encouraging messages and it was easy to take the next step of testing with the services so accessible. People living with HIV also gave testimonies during these functions on their positive living strategies. Over 30,000 people were tested for HIV during open days organized by BRIDGE II.

Community Referral Work: the project worked with community referral agents who referred people to HIV prevention services, including HCT services.

Workplace Interventions: Some workplace institutions in southern Malawi partnered with BRIDGE II to implement HIV prevention activities. Some of these activities, like the use of the *Tasankha* Community Discussion Guide and the *Journey of Hope* toolkit, encouraged people to go for HCT services. Eastern Produce, one of the workplaces implementing BRIDGE II activities indicated they noticed an increase in the number of employees and families seeking HCT services since the start of BRIDGE II activities in their estates. These observations encouraged Eastern Produce management to continue expanding BRIDGE II activities.

Linking People to PMTCT Services

BRIDGE II promoted Prevention of Mother-to-Child Transmission of HIV (PMTCT) Option B+ to prevent pregnant women infected with HIV from passing on the virus to their unborn babies. Option B+ offers all HIV-positive pregnant women lifelong antiretroviral therapy regardless of their CD4 count. This strategy was selected due to limitations in accessing reliable CD4 testing in Malawi. BRIDGE II created awareness about Option B+ and referred couples to PMTCT services.

To encourage HIV positive women to access PMTCT services, and their partners to support them, BRIDGE II incorporated the promotion of Option B+ into its popular *Tasankha* campaign. The second phase of *Tasankha* took a rigorous approach by promoting PMTCT through radio spots, the *Chenicheni Nchiti?* radio program, open days, print materials, interactive dramas, and through the *Tasankha* Discussion Guide. BRIDGE II produced 3 radio spots and two posters on PMTCT, and printed and distributed over 2,000 PMTCT communication charts used during counseling sessions and client education in Antenatal Care, under-5 and family planning clinics. The charts were also used by community facilitators to disseminate PMTCT Option B+ messages during small group discussions.

Furthermore, BRIDGE II Community Referral Agents referred community members to PMTCT services through group meetings and door-to-door visits.

Linking People to VMMC Services

BRIDGE II, in collaboration with the Ministry of Health, took a lead role in creating demand for VMMC. The project branded the VMMC campaign; produced and distributed VMMC materials; harmonized VMMC messages throughout the country; built the capacity of media houses to report on and promote VMMC and provided technical support to national and district level stakeholders on community mobilization for VMMC.



BRIDGE II's PMTCT Communication Chart, used during counseling sessions and client education at Antenatal Care Clinics, under-5 clinics and family planning clinics.

Objectives for VMMC Demand Creation under BRIDGE II were:

- To increase levels of knowledge on the benefits of VMMC.
- To increase demand for uptake of VMMC services.
- To create an enabling environment for VMMC and foster its widespread acceptance.
- To increase consistent safer sexual practices post-VMMC.



Developing the Malawi VMMC Brand

At national level, BRIDGE II led stakeholders in developing the Malawi VMMC brand that identified the campaign and compelled its target audience to access VMMC. The project produced a campaign name “Ndife Otsogola” which portrays a community and individual who is forward thinking and would choose to go for beneficial interventions being promoted without hesitancy. This goes along with the “thumbs up” and “hats off” illustrations which connotes something being well done. The Malawi flag colors, green, red and black on the campaign logo communicate that this service is for all Malawians. BRIDGE II produced three different posters aimed at young men, older men and couples; five leaflets for traditional and faith based leaders, women, young men and older men; VMMC radio spots and a VMMC flip chart for use by service providers during VMMC counselling sessions.

Supporting Districts and Communities for VMMC

In the first two years of its involvement in VMMC, the project created demand for VMMC services in three (Phalombe, Mulanje and Thyolo) of its eleven implementation districts. The project used high intensity and low intensity activities to reach people with motivating VMMC messages. High intensity activities happened during VMMC mass campaign periods within a Health Center catchment area a week before circumcision services were available. Activities included: open days that featured testimonials, interactive drama performances, traditional dances speeches and poems; VMMC road shows; football matches; school festivals; and evening VMMC video shows when the project used a story from its *African Transformation* Toolkit to motivate people to go for VMMC. Community Referral Agents referred clients for VMMC services while CBO networks registered people requesting VMMC in their communities and sent the list to District Health Offices to call for an outreach VMMC site. The project distributed VMMC posters and leaflets during these high intensity activities. Low intensity activities happened on an ongoing basis in all BRIDGE II communities and included Village Discussion Group sessions on VMMC using the *Tasankha* Discussion Guide and advocacy for VMMC through the Traditional Leaders Forums.

Before the start of all these activities, BRIDGE II briefed all stakeholders at district level, including the District Executive Committee, workplace institutional leadership, Education Division Managers, Secondary and Primary school leadership and Extended Traditional Leaders Forums on the proposed campaign for their buy-in. The project also oriented structures that it worked with at community level to equip them with correct information on VMMC. They consequently worked as VMMC information points in their communities during the campaign.

Coordinating Demand Creation Activities at National Level

From 2013 to 2014, BRIDGE II, together with the Health Education Services of the Malawi Ministry of Health, coordinated demand creation activities at the national level. The project assisted PEPFAR-funded implementing partners with demand creation plans and made sure that all partners were following the demand creation

model that was developed. BRIDGE II was also involved in conducting supervisory field visits together with Health Education Services and providing feedback to district demand creation teams on their efforts and making recommendations where necessary. The project also conducted a refresher training for Information, Education and Communication Officers and District Mobilization Officers on how to conduct demand creation activities. Additionally, after service providers started doing demand creation activities, BRIDGE II oversaw their work in conjunction with Health Education Services.

VMMC Media Capacity Building

BRIDGE II built the capacity of media houses on how they can professionally report on VMMC. The project developed a VMMC Media Guide to direct media institutions for effective and accurate reporting and coverage around VMMC. The project then conducted a three day training session for journalists and editors, based on the Guide. A site visit during the training gave participants an opportunity to witness VMMC services in action.



Malawian journalists participating in a BRIDGE II VMMC workshop in April of 2014.

BRIDGE II also participated in VMMC coordination meetings with all other stakeholders in the country: Ministry of Health personnel, representatives from USAID and VMMC service providers. The meetings were essential for planning VMMC promotion activities and to review the progress of specific activities within the VMMC campaign.

Results:

From 2010 to 2014, the BRIDGE II referral program registered overwhelming success in enabling people to access HIV testing, condoms and other health services. Specific achievements include:

- Over twenty million male condoms were distributed over the lifetime of the project.
- After one year of intervention, research findings indicated that informal condom distribution at community level increased condom uptake and acceptance. The odds of using male condoms for those who received condoms from ICDs were 58% higher than those who did not⁹. Additionally, the odds of using male condoms were 28% higher for those who ever received training on condom use from the distributors than those who did not¹⁰.
- Over 30,000 people were tested for HIV during open days organized by BRIDGE II.
- Over 1,344 women and 21,577 couples were referred for PMTCT services.
- Referring over 200,000 people to access HIV testing and other health services through the Community Referral Agent and Promotional Models of Referral.

Support for Workplace HIV Prevention Interventions

Workplaces are ideal environments to reach large groups of people with social and behavior change HIV prevention interventions and can help reduce HIV-related stigma. Recognizing this, BRIDGE II advocated for HIV prevention interventions within some of Malawi's largest work sites.

⁹ adj OR = 1.58, p< .001

¹⁰ adj OR = 1.28, p< .05

BRIDGE II conducted two needs assessments to identify companies with whom to work. The first was conducted with Conforzi, Makwasa, Mini-mini and Chitakale Tea Estates, African Parks Majete and Illovo Sugar Limited. The second with BAKHRESA Grain and Milling Company, Blantyre Water Board, Rabs Processors and the Electricity Supply Commission of Malawi. In order to garner their participation, BRIDGE II reached out to these companies and advocated for their involvement in the needs assessments; questionnaires were then sent to the Human Resources Managers or HIV Coordinators at each company to gather the needed information.

The needs assessment process entailed identifying the number of employees at each company and assessing the impact HIV had on the company overall in areas such as increased absenteeism, reduced productivity, and increased company costs related to HIV and AIDS. BRIDGE II also examined: previous and ongoing HIV prevention interventions implemented by the government (that companies could participate in) and by the companies themselves; the level of resources available for allocation to HIV prevention in the workplace; the availability of a committee to lead workplace HIV prevention efforts; and the willingness of company management to work with BRIDGE II in supporting the Workplace HIV Prevention Program. Information on whether the companies had HIV workplace policies was also collected.

Following the completion of the needs assessments, the participating companies were triaged into the following categories:

- Companies that had a workplace HIV prevention program but needed it to be strengthened.
- Companies that did not have a program but were interested in developing one.

All companies except for African Parks Majete and Chitakale Tea Plantations had pre-existing HIV prevention interventions. However, the quality of these programs varied dramatically from company to company; several were run with few resources and had little to no impact, and others were new programs. Additionally, it was found that all of the companies except for African Parks Majete had HIV workplace policies, but that in general these policies were not widely shared with employees.

Based on the results of the needs assessment, the BRIDGE II team identified Eastern Produce, Makwasa, Minimini, Conforz, and Chitakale Tea Estates; Illovo Sugar Malawi Ltd. and African Parks Majete Game Reserve as collaborating partners. Later Bakhresa Grain and Milling and the Blantyre Water Board and Electricity Supply Commission of Malawi were added. Eastern Produce Tea Estates, which began participating in only 2 of its 18 estates, scaled up their interventions to 16 out of 18 estates.

Supporting the Establishment of Workplace HIV Prevention Interventions

BRIDGE II held a series of joint meetings with the participating companies to discuss and provide guidance on workplace HIV interventions and promote inter-company learning. National AIDS Commission statistics indicated high HIV prevalence rates among male and female workers (19.9% and 17.5% respectively)¹¹; BRIDGE II used this information to advocate with the participating companies to invest in and support the strengthening of their workplace HIV prevention interventions. Companies were also encouraged to effectively disseminate their HIV and AIDS workplace policies to their employees if such policies were already in place. In the meetings, the Malawi Business Coalition Against AIDS shared the International Labour Organization Code of Practice on HIV/AIDS and the World of Work¹² with company managers as a guideline for how HIV and AIDS should be

¹¹ [Malawi National HIV and AIDS Prevention Strategy \(2009-2013\)](#)

¹² *International Labour Organization Code of Practice on HIV/AIDS and the World of Work* can be accessed at the following hyperlink: http://www.ilo.org/aids/Publications/WCMS_113783/lang--en/index.htm

handled in the workplace and stressed that workplace HIV prevention interventions should be grounded in the guidelines laid out in the Code of Practice.

BRIDGE II worked to ensure that all workplace HIV prevention programs in participating companies met the minimum requirements set by the Code of Practice. To reach employees directly, BRIDGE II trained peer educators within each company to use BRIDGE II's Transformative Tools and provided them with the *Journey of Hope*, *African Transformation*, and *Tasankha* Toolkits to educate their peers about HIV prevention. To further aid in behavior change processes, BRIDGE II provided companies with *Tasankha*--branded HIV prevention posters and projectors in order to view the videos included in *African Transformation*.

Through advocacy with organizational leadership, BRIDGE II set minimum standards for HIV prevention programs and facilitated inter-company learning.

Results:

Overall, 16 large companies in Southern Malawi participated and thousands of people were exposed to BRIDGE II Workplace HIV Prevention Interventions:

- 906 peer educators were trained on how to use the *Journey of Hope* toolkit and interactive drama.
- 16,019 people were reached with *Journey of Hope* toolkit small group interventions.
- 6,346 people were reached with HIV prevention messages through community wide events.
- 3,967 people participated in *Tasankha* open days.
- 17,736 people were reached with HIV prevention activities in their respective work places.
- 405 people were linked to HIV counseling and testing during community wide events.
- According to reports from employers and employees, the interventions also resulted in: reduced stigma against people living with HIV; more employees disclosing their HIV status in the workplace; and employers granting leave to access HIV treatment, making condoms more available and organizing HIV testing days. They also reported absenteeism was reduced as more HIV-positive employees were accessing needed HIV treatment.

WORKPLACE HIV PREVENTION SUCCESS STORY

BRIDGE II trained company peer educators to use the Hope kit and other Transformative Tools to promote HIV prevention in the workplace. The peer educators received Transformative Tools and *Tasankha* posters to assist them in promoting HIV prevention practices. Although this was the main aim of the intervention, other desirable outcomes have been born out of the initiative. One worthy of mention is the reduction of HIV related stigma and discrimination in the workplace. People have become more tolerant of others infected or affected by HIV as a result of participating in BRIDGE II Transformative Tools activities.

A peer educator from Eastern Produce Tea Estates, a workplace supported by BRIDGE II said, "Before the introduction of the workplace interventions, most laborers kept away from skinny and sickly looking people with the assumption that those people had HIV and they could not share eating or drinking utensils with them for fear of contracting the virus". He added that such discrimination has gone away as people now understand how HIV is spread and that the only way to know if you have HIV is through an HIV test.

One female machine operator from the same company, Mary Lemea (pictured below), added that before learning about HIV/AIDS through the workplace interventions, she used to judge other employees on whether they had HIV or not from their appearance and would then say bad things about their appearance and also how she thought they contracted the virus.



Research and Evaluation

Baseline and Midline Studies

BRIDGE II performed a quantitative baseline cross-sectional study as well as qualitative research at the start of the project in 2009. Quantitative data was collected in the 11 BRIDGE II focal districts in Southern Malawi. For each Traditional Authority within these districts where BRIDGE II was set to be implemented, another Traditional Authority where BRIDGE II was not planning to implement activities was also selected for data collection in order to allow researchers to compare their outcomes over time. The qualitative part of the study involved conducting fifteen focus group discussion and sixteen key informant interviews in eight rural communities and four semi-urban communities within the BRIDGE II implementation area.

In 2011, BRIDGE II conducted a Midline survey, where 50% of those surveyed at baseline were re-contacted, resulting in a subset of participants that became a longitudinal cohort sample. This subsample was contacted again at the endline survey in order to assess the impact of BRIDGE II on these individuals over time. Additionally, a new cross-sectional sample was selected at Midline.

Findings from the Baseline and Midline studies, as well as findings from the baseline qualitative research, can be found in the BRIDGE II eToolkit at <https://www.k4health.org/toolkits/bridge-ii-project-toolkit/research-monitoring-and-evaluation>.

Endline Study and Results

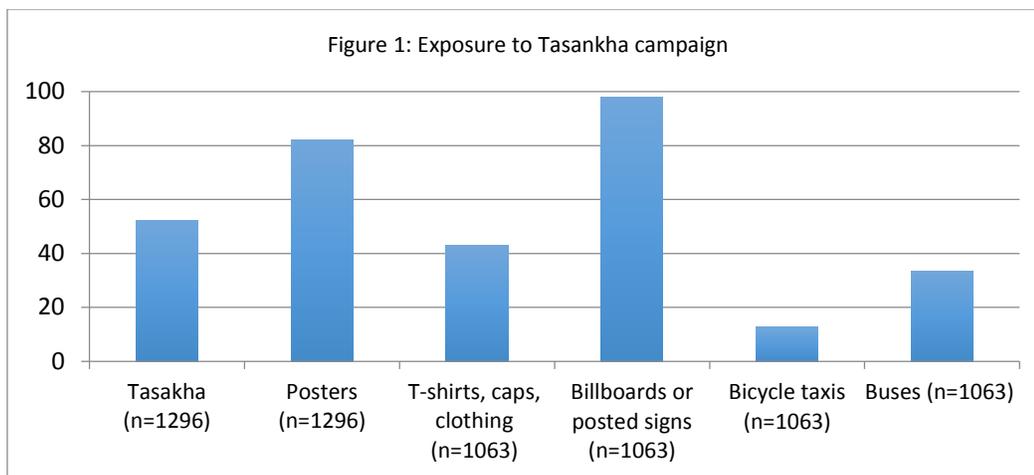
The project endline survey was conducted in 2014 with additional data collected in 2015. Similar to the midline, a new cross-sectional sample was selected, while those in the longitudinal cohort were re-interviewed. Data analysis for the longitudinal sample is still in progress, and results will be reported in a separate document.

Respondent Profile

Data from the 1,296 cross-sectional respondents showed the sample was comprised of 60% females and 40% males with a mean age of 31.44 (SD = 10.86). Approximately three quarters (74.31%) were cohabiting or married, while the remaining quarter (25.69%) were never married, divorced, or widowed. Forty three percent of the respondents had attended standard 6-8, and only 10.65% had no education. The vast majority (85.65%) of respondents reported they were Christian. Most of the sample was employed, with 75.54% reporting full time employment.

Exposure to BRIDGE II at Endline

At endline, a majority (62.27%) of respondents had heard about the Malawi BRIDGE program. Probing deeper on the programs of interest, it was found that of the 824 respondents who were asked, approximately half of them had heard of the Couples Counseling Activities. About half of the respondents indicated they had heard of the *Tasanhka* campaign (Figure 1), and approximately two thirds (67.16%) reported they had heard of *Chenicheni Nchiti*.



To analyze the relationship between exposure and outcomes, a dichotomous exposure variable was created using six questions; the scores were then added to create a summative score ranging from zero to six. We recoded those with a score of zero (had not heard of BRIDGE nor had been exposed to any of the programs) and one (had heard of BRIDGE and knew what it was but had not been exposed to any of the programs) as unexposed. Those with a score of two through six (had been exposed to one to four programs) were coded as exposed to the program. Based on this coding, 28.03% (n=338) of the sample were exposed to the program, and 71.97% (n=868) were not exposed.

Results

Similar to the midline survey findings, the preliminary endline results for the cross-sectional data indicate positive correlations between exposure to BRIDGE II interventions and HIV related outcomes. These include:

- Higher HIV related knowledge among both women and men
- Getting tested for HIV in the last twelve months
- Greater self-efficacy to protect oneself from HIV
- Greater intention to have only one partner and use condoms every time one has sex
- Greater reported condom use at last sex
- Higher ability to negotiate condom use
- More positive attitudes towards gender equality

It is of particular interest that exposure to BRIDGE II generally had more impact on women than men. This is important given that due to cultural and other factors, women in Malawi are more vulnerable to HIV than their male counterparts and generally have less power to control their risk factors and take preventive action.

Knowledge about HIV:

To measure knowledge of HIV, a summative index of 18 statements was created. Participants received one point for each statement answered correctly. Knowledge scores ranged from five to eighteen, with a mean score of 15.14 across the sample. Bivariate analysis showed a significantly different mean score on the knowledge measure when comparing the exposed and unexposed groups. Those who had been exposed to BRIDGE had a mean score of 15.81 compared to 14.9 among those who were unexposed ($t=-6.46$; $p<0.001$). When disaggregated by gender, exposure to the BRIDGE II program was significantly associated with higher mean knowledge score values among both males and females. Males exposed to the program had a mean knowledge score of 15.63 compared to males who were not exposed (mean score= 14.91; $t=-3.62$; $p=0.0003$).

Females who were exposed to the program had a mean knowledge score of 16.0 and those unexposed had a score of 14.90 ($t=-5.53$; $p<0.0001$).

HIV testing:

The results of the endline survey showed mixed results of exposure to BRIDGE II and HIV testing. The proportion of respondents who had ever tested for HIV was high (89%), and there was not a significant difference in testing behavior between those who had and had not been exposed to BRIDGE ($\chi^2=1.2846$; $p=0.257$). However, when looking at the proportion of those who tested for HIV in the past 12 months (perhaps a more meaningful indicator due to the limited time frame), there was a significant difference for those exposed compared to unexposed, with those exposed reporting higher rates of testing ($\chi^2=5.27$; $p=0.022$). Approximately 80% of those who were exposed had tested for HIV in the past 12 months, while 73.37% of those who were unexposed had tested within that timeframe. Once stratified by gender, there was a significant difference in the percent who tested for HIV in the past 12 months among females only ($p=0.019$).

Efficacy beliefs:

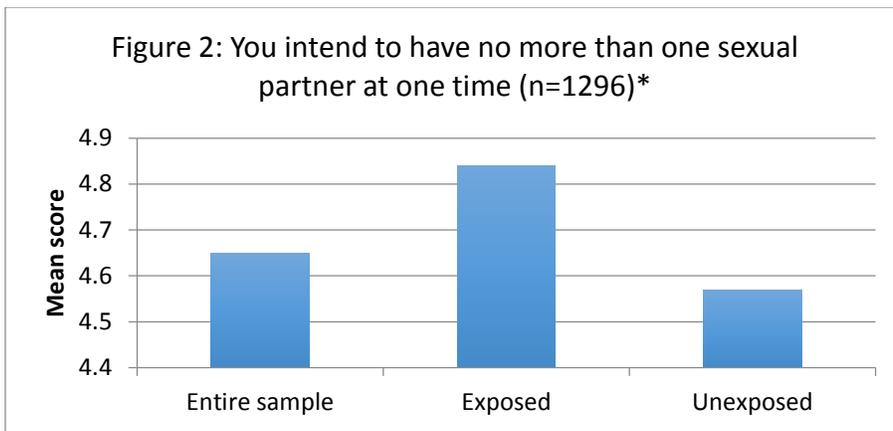
To assess self-efficacy to protect oneself from HIV, a self-efficacy score using nine items was created, with a possible range of scores from zero to 36. The higher the score, the greater the self-efficacy to protect oneself from HIV. The mean self-efficacy score among those exposed to the intervention was 33.94, significantly higher than the mean score among the unexposed group of 33.04 ($t=-3.42$; $p=0.0006$). When stratified by gender, there were significant differences by exposure among females ($t=-3.10$; $p=0.002$) but not among males ($t=-1.50$; $p=0.1348$).

Risk perception:

According to the Health Belief Model, perceived susceptibility and perceived severity are meaningful predictors of health behavior. To measure the perceived threat of HIV/AIDS, a scale using three assessments of susceptibility to HIV was created. Those who were exposed to the BRIDGE II program had significantly lower risk perception (mean=5.28) compared to those who were unexposed (mean=6.096) ($t=3.978$; $p=0.0001$). There were significant differences in the mean risk perception score among females ($t=2.71$; $p=0.0068$) and males ($t=2.84$; $p=0.0047$). It is possible that women and men exposed to BRIDGE II had lower risk perception because they were taking actions to reduce their risk. Regardless, these findings highlight the importance of continuing work around ensuring people make the connection between understanding how HIV is transmitted and the actions they take in their daily lives that put them at risk.

Sexual behavioral intentions:

Since behavioral intentions are closely associated with behavior, the endline survey asked about intention to perform a number of HIV prevention behaviors. Respondents were asked to report their level of agreement (on a scale of 1 to 5) with several intention statements. Intention to have only one sexual partner at a time was high overall (mean=4.65), but those who had been exposed to the program had significantly higher intention to have one partner than those who had not been exposed ($t=4.00$; $p=0.0001$).



Significant differences by exposure in this variable (intention to have no more than one partner at a time) were found for both males ($t=-2.16$; $p=0.0314$) and females ($t=-3.0650$; $p=0.0023$).

Individuals who had been exposed to BRIDGE II also reported significantly higher intention to use a condom the next time they have sex relative to those who had not been exposed ($t=-2.0370$; $p=0.0419$). Among those who were exposed, the mean score was 4.62 compared to a mean score of 4.47 among those not exposed.

Condom use:

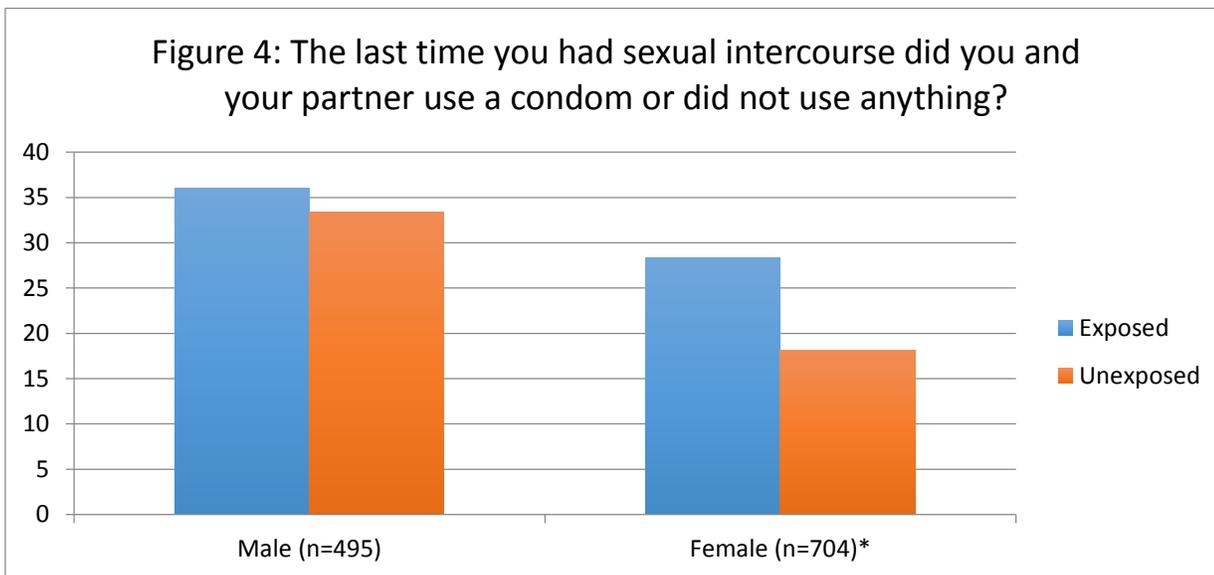
The endline survey measured a number of outcomes related to condom use behavior and communication. Using a Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree), self-efficacy to use condoms at every sex act was measured. Those who were exposed to BRIDGE II had significantly higher self-efficacy related to condom use at every sex act than those who were not exposed ($t=-2.58$; $p=0.0100$). When stratified by gender, only females showed a significant relationship between exposure to the campaign and believing they could use condoms at each sex act ($t=-2.7769$; $p=0.0056$).

In terms of condom use within non-primary partnerships, approximately half of the sample (44.87%) reported always using condoms. This item was measured using a Likert scale including answer options of never (1), only sometimes (2), most of the time (3), and always (4). The mean of this measure among those exposed to the campaign was 2.97 compared to a mean of 2.65 for those not exposed ($t=-2.58$; $p=0.0101$). The effect of the intervention appears to have been larger among women, who reported using condoms more frequently with non-primary partners if they had been exposed to BRIDGE ($t=-3.73$; $p=0.0002$).



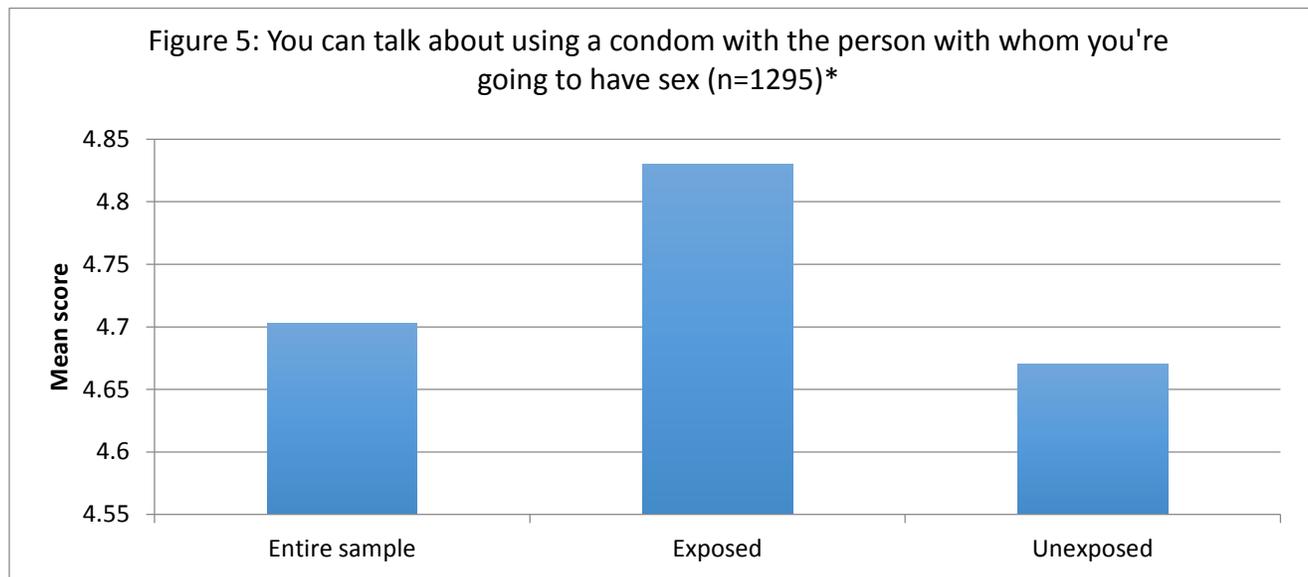
Among all cross-sectional endline respondents, approximately 26% used a condom the last time they had sex regardless of partner status. The proportion using a condom at last sex was significantly higher among those who had been exposed to the BRIDGE II program than among those who had not been exposed ($X^2=9.1899$; $p=0.002$). In this item, too, females showed a significant increase in the percent using a condom by exposure to the campaign ($X^2=8.1542$; $p=0.004$). The male respondents, however, did not demonstrate a significant increase in condom use ($X^2=0.3294$; $p=0.566$).

It is of interest that exposure to BRIDGE II seemed to have a greater impact on women’s belief that they could use condoms and their use of condoms at last sex than it did for men. Prevailing gender dynamics in Malawi concerning sex and condom negotiation often make it difficult for women to broach these subjects with their partners or to feel like they have control over condom use. Indications that shifts in gender norms around condom were achieved are therefore notable, and future programs should build on the inroads made to continue to ensure women are empowered to protect themselves.



Condom communication and negotiation is an important determinant of condom use. In this endline sample, communication with a partner about condom use was measured using a Likert scale of one to five (1=strongly disagree, 5=strongly agree). This question was asked in two slightly different ways (“If your sexual partner does not talk about condoms, you can bring up the topic” and “You can talk about using a condom with the person with whom you are going to have sex.”) and in both cases, ability to communicate with one’s partner was

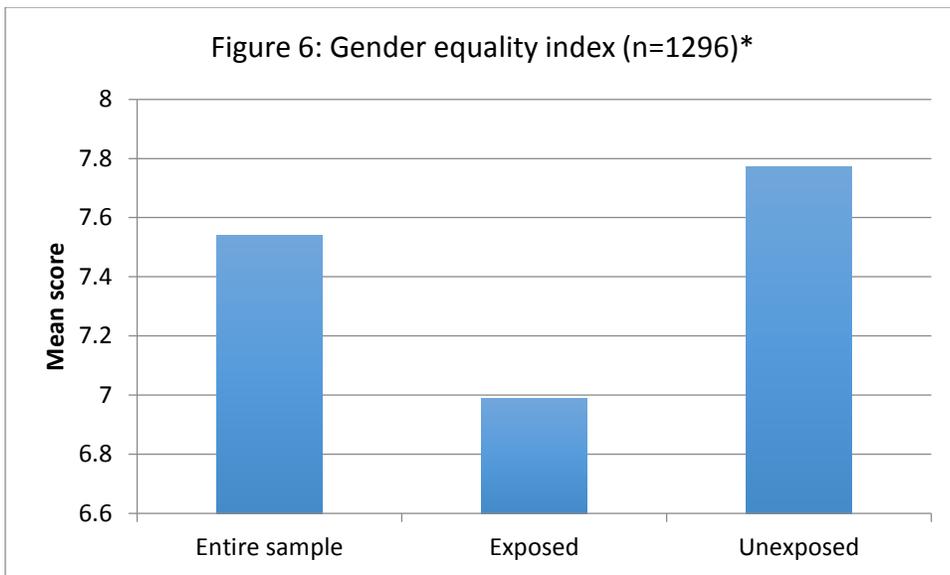
significantly higher among those who had been exposed to the BRIDGE program as opposed to those who were not exposed ($t=-3.5035$, $p=0.0005$; $t=2.8808$, $p=0.004$).



Interestingly, when these questions were stratified by gender, the results were slightly different. In response to whether the respondent could bring up condoms with a partner who did not broach the subject, both males ($t=-2.056$; $p=0.0403$) and females ($t=-2.69$; $p=0.0073$) had significantly higher mean scores (more likely to report that they could) when exposed to BRIDGE II programming as opposed to those who were not exposed. In the item asking whether the respondent could talk about condom use with the person with which they were going to have sex, only females had significantly higher scores when exposed to the intervention as compared to those who were not exposed ($t=-2.51$; $p=0.0124$).

Gender and sexual norms:

In order to measure attitudes towards gender equality, an index was created from items asking how much respondents agreed/disagreed with statements (strongly disagree=1; strongly agree=5). Scores ranged from three to fifteen, with lower scores indicating more gender equitable beliefs. Those who had been exposed to the BRIDGE program had significantly lower scores (more gender equitable attitudes) than those who had not been exposed ($t=3.63$; $p=0.0003$).



While the exposure to the campaign was associated with lower scores on the gender equality score for both males and females, exposure was significant only among females ($t=3.91$; $p=0.0001$). Among males, those exposed to the campaign had lower scores than those who were not exposed, but this difference was not significant ($t=1.17$; $p=0.2427$).



A scale assessing gender stereotyped sexual norms was also used and was answered using the same Likert scale (strongly disagree=1, strongly agree=5). Lower scores on the scale indicated less acceptance of stereotyped sexual norms. The mean score for the entire sample was 5.95. While there was not a significant difference in gender stereotyped sexual norms by exposure to BRIDGE II ($p>.05$), the trend was in the expected direction, with lower values among those who had been exposed as compared to those not exposed.

Special Studies

Informal Condom Distribution Program Evaluation¹³

In response to severe condom shortages of government-distributed condoms in clinics and at the community level, an informal distribution program was put into place (see above for details). An evaluation survey was conducted to determine how many people receive condoms from volunteer distributors versus other venues; where people are most comfortable acquiring condoms; and if those who access condoms and receive condom use training from volunteers are more likely to use condoms consistently than those who do not.

Street intercept surveys were conducted in various BRIDGE II communities with sexually active adults. Participants were asked about places of condom acquisition, condom use behavior, and interaction with volunteer condom distributors. A total of 1,428 participants were included in the analyses. Linear regression analyses were used to determine factors related to condom use, specifically interaction with condom distribution volunteers.

The findings indicated the informal condom distribution was having an impact. Marital status (being unmarried) and having received both condoms and training from volunteers were significant factors related to condom use frequency, $\beta = .090$, $p = .001$, even after controlling for demographics (age, gender, education, religion).

Based on the analysis, BRIDGE II determined that establishing networks of trained community volunteers working in consort with local health facilities to freely distribute condoms can be a simple, effective, and sustainable way to ensure condoms remain a key part of any HIV prevention effort.

Process Evaluation of Voluntary Male Medical Circumcision Demand-Generation Activities¹⁴

As mentioned previously in this report, BRIDGE II played a leadership role in enabling the government to actively promote VMMC and address barriers to uptake. In 2013, BRIDGE II conducted a study to describe the VMMC experiences of a sample of men in targeted BRIDGE II communities, including 1) their experiences of circumcision, 2) exposure to BRIDGE II messaging, 3) communication with sexual partners regarding VMMC, 4) factors relevant in decision-making around VMMC, 5) adherence to healing protocols, and 6) overall satisfaction with the procedure.

Data was collected in four districts in the Southern region where VMMC messages and services were being promoted and offered. Messaging regarding the benefits of VMMC was present in all four districts, however, three of the districts (Phalombe, Thyolo, Mulanje) received *intensive* messaging focused on VMMC, while in the fourth district, Chiradzulu, VMMC related messaging was *integrated* into other HIV prevention and health promotion. Participants were recruited as they came to the service area. They completed a pre-procedure survey in person and 3- and 6-week post-procedure follow up surveys by phone to understand their experiences regarding the procedure, healing, and HIV risk profile.

The results of this process evaluation demonstrate the promising impact messaging can have on behavior around recommended opt-in procedures in Malawi. Knowledge of the protective effect of VMMC against HIV was generally high in this sample, and protection from HIV and STIs were the primary motivations for seeking services. For those who had sex at the six week follow up (albeit a small number), a vast majority said sex was better after circumcision than before—no one reported sexual satisfaction decreasing post-procedure. These findings, taken together, suggest future demand creation campaigns might consider highlighting the reported sexual benefits of VMMC in addition to HIV/STI risk reduction. Another promising finding was that while most

¹³ Manuscript under review.

¹⁴ Manuscript in preparation.

respondents knew VMMC was protective against HIV, approximately 95% reported they needed to take additional precautions to protect against HIV. Only about 3% of respondents reported they would increase their number of sexual partners post-circumcision.

Fear of pain has been reported as one of the major barriers to uptake of the procedure¹⁵. However, in the current study, participants tended to report overall satisfaction, little pain, and ease in caring for the wound. Furthermore, almost all men interviewed recommended another man receive the procedure—another indication of overall satisfaction. Again, these findings point to successful strategies for the design of future demand generation campaigns. Another promising finding in the current study was adherence to healing protocols, particularly abstinence and attendance at follow up appointments. This appeared to be more pronounced in the *intensive* regions versus the *integrated* regions, and may be more successful than similar outcomes reported in previous studies. Since tests of significance looking at differences between the *intensive* and *integrated* regions in the current study were not possible due to the small sample size in the *integrated* region, we cannot know for sure whether the specific messaging approach affected this outcome, or if it was due to another variable, such as availability of service providers in each area for the weeks following the procedures.

Future research should scale up this research design to include a larger sample and include a qualitative component to provide insights into the lived experiences of men and couples seeking VMMC.

Documentation and Sustainability

BRIDGE II built local ownership into project activities from the onset and developed plans for sustained implementation that was reinforced during the last year of the project at community, district, and national levels.

The BRIDGE II approach valued engagement and participation of existing structures at all levels. At the community level, the project worked with and built the capacity of traditional leaders, faith based leaders, Area Development Committees, CBOs, CBO networks and many others. These structures will enable the BRIDGE II efforts to be sustained beyond the life of the project. For example, CBO networks will continue coordinating HIV prevention efforts at community level while traditional leaders' forums will take lead in dealing with gender inequality and its consequences. Signed community charters will go a long way in regulating behaviors. The project engaged relevant government ministries/departments at district and national levels and BRIDGE II hopes that these will keep passing on lessons learned from BRIDGE II to other initiatives coming into their districts. The project started witnessing diffusion of its approaches even before it ended when district councils encouraged new projects to learn from BRIDGE II approaches in their development efforts.

BRIDGE II created a meticulous and detailed electronic toolkit (“eToolkit”) of its program activities, reports, tools, and success stories. This toolkit includes descriptions of all program activities; guides, tools, and resources used to implement the activities; success stories from BRIDGE II implementation; as well as a comprehensive description of the process of developing said program activities and how BRIDGE II carried them out so they can be easily replicated or adapted.

¹⁵ Hatzold K, Mavhu W, Jasi P, Chatora K, Cowan FM, Taruberekera N, et al. Barriers and motivators to voluntary medical male circumcision uptake among different age groups of men in Zimbabwe: results from a mixed methods study. PLOS one, 2014; 9(5):e85051.

This eToolkit” was disseminated during district handover meetings that took place in July of 2014 and the national dissemination meeting that happened in February 2015. During these meetings, it was ensured that structures at the community and district levels had the needed resources to continue carrying out BRIDGE II activities. The eToolkit is also available online so that those in Malawi and around the world can benefit from the resources, tools, and knowledge created during the implementation of BRIDGE II. It can be found at <https://www.k4health.org/toolkits/bridge-ii-project-toolkit>.

BRIDGE II helped ensure sustainable impact through the development, production, and dissemination of Transformative Tools and the training of Transformative Tools facilitators. Thousands of trained Transformative Tools facilitators, CRAs, condom distributors, CAG members, and others trained by BRIDGE II remain in BRIDGE II districts and communities as valuable and known resources to other community members. The leadership and skills developed in these individuals will have a positive impact on BRIDGE II communities for years to come. Other volunteers were nominated by their communities, encouraged to compete for ward councilor positions and won the elections so that their communities could continue reaping from BRIDGE II capacity building efforts. Some continue to carry on the work through volunteer efforts. The tools have all been accepted as valuable contributions to HIV prevention and mitigation efforts at the community level and beyond. External organizations such as Goal Malawi, Catholic Relief Services, Project Concern International and the US Peace Corps, who were not formally involved in BRIDGE II, began implementing activities from BRIDGE II Transformative Tools in their HIV prevention work of their own accord and it is anticipated they will continue to do so. BRIDGE II implementing partners have also scaled up use of the tool kits beyond BRIDGE II catchment areas and resources. For example, Evangelical Lutheran is now rolling out the Couple Counseling Guide in the northern region of Malawi while other faith based organizations received funding from the National AIDS Commission to continue using the Couples Counseling Guide after BRIDGE II ended.

BRIDGE II’s work mobilizing communities and conducting capacity strengthening at the community level was captured in the BRIDGE II documentary “The BRIDGE II Legacy: Inspiring HIV Prevention in Malawi 2009 -2015”. Quotes from two of those interviewed sum up the sustained impact of BRIDGE II. Margaret John, Village Head of the Mapanje community in Zomba, stated, *“We own the project. As they leave, we will continue the interventions so that even our children benefit.”* Samuel Likwakwa, a CAG member in Zomba, commented, *“BRIDGE II has come to an end. They have however left us with the necessary capacity to carry out our activities. We have been able to conduct open days and discussion forums through our own initiative without any support from BRIDGE II.”*

Challenges

10% Institutional Review Board (IRB) Fee: The Malawi National Health Sciences Research Committee (NHSRC) charges a standard capacity building fee amounting to 10% of the total research budget before issuing IRB approval for research studies, but this was not an allowable expense under this award. Negotiations to waive the fee delayed fielding of the endline project research, and meant that some special studies were not undertaken.

Changes in the country’s economy and fuel shortages: Implementation of BRIDGE II coincided with periods of economic challenges in Malawi that resulted in critical fuel shortages as well as frequent dearth of essential hospital supplies like HIV test kits, condoms and many others. This poor economic situation affected implementation and resulted in delays of some critical project activities. CCP continued to monitor the situation and identified opportunities that helped to move project activities forward such as the partnership with Total Filling station that enabled drivers more consistent access to fuel using Malswitch cards. The project also made several adjustments to its initial plans in order to support the Ministry of Health and ensure that commodities were available and accessible to individuals at community level. For instance, BRIDGE II embarked on the condom distribution program discussed previously in this report.

Recommendations

While BRIDGE II was able to achieve significant progress towards preventing HIV and mitigating its impact, there is still much work to be done to stop HIV transmission in Malawi. Based on lessons learned, research findings and observations from the field, the following recommendations are offered for future programs addressing HIV to consider.

Engage traditional leaders in a meaningful way: Every project understands that traditional leaders are gatekeepers whose approval must be obtained in order to implement local activities. But BRIDGE II learned from the mid-term evaluation that many leaders wanted to go beyond the role of being a “rubber stamp” and desired opportunities to play a more significant role in HIV prevention in their communities. As a result, BRIDGE II supported the work of traditional leaders by strengthening their capacity so that they can take the lead in dealing with some normative behaviors that fueled the spread of HIV in their communities. Formation and active involvement of traditional leaders’ forums kept the traditional leaders abreast of what was happening in their communities and enabled them to take the lead in helping communities change. This motivated their subjects resulting in more vibrant community interventions.

Invest in relationships with the media: The relationships BRIDGE II built with the media on its own and through its partner Galaxy were key to the success of many of the radio programs. Through relatively small but on-going investments in capacity building, BRIDGE II was able to leverage free airtime for the broadcast of its flagship radio program, *Chenicheni Nchiti?*, enabling the show to have widespread exposure. When BRIDGE II approached the stations to participate in the National Dialogue Campaigns, the trusted relationship with the project was cited as one of the main reasons many of the stations agreed to participate often at no cost to the project. Projects like BRIDGE II need to develop true partnerships with local media, bringing them on as full partners in the development of programming that fosters debate and discussion among their listeners, rather than using media simply as a conduit for messages.

Continue to use an overarching campaign platform: From *Nditha!* in BRIDGE I to *Tasankha* in BRIDGE II, having an umbrella platform created synergy at national, district and community levels enabling individual activities to have an even greater impact. While campaign themes should be revised every few years to ensure they stay responsive and relevant to audience needs, using the technique of an overarching call to action can be very powerful.

Foster public dialogue: The overwhelming success of *Chenicheni Nchiti?* and the National Dialogues points to the desire and need for people to have interactive public forums where they can discuss HIV and health related issues and express their views. Radio is a particularly good channel for fostering this public discourse because people can air their opinions and experiences anonymously. This can be especially important when discussing sex, gender based violence and other topics considered taboo or highly sensitive.

Trust people to make the right choices: The foundation for the *Tasankha* campaign was to inspire people to make positive healthy choices by providing them with correct information, an opportunity to explore the consequences of choices they and others had made, skills and tools to make life affirming decisions and greater access to services. While it is important to provide people with “messages”, it is equally if not more important to not be proscriptive and trust that people will make the right decisions when they can come to an understanding and realization of the benefits of doing so.

Continue to strengthen couple communication: Enabling couples to build a more honest and open relationship is a critical factor in reducing HIV transmission. Many couples struggle with talking openly about their sex and love lives, often leading to one or both of them to seek partners outside the home and/or avoid discussions on

how they can protect each other by using condoms, getting tested for HIV and supporting each other to adhere to ART. Couples participating in BRIDGE II's couple counseling initiative reported they were able to have such conversations for the first time and that it not only brought them closer together, but enabled them to make positive health choices to reduce their risk of HIV. While BRIDGE II worked primarily within the religious community context, such interventions should be expanded more widely.

Build in sustainability at the start: While many project implementers appreciate that sustainability of their efforts is key for effective community development, very few incorporate sustainability plans at the start of the project. BRIDGE II however learned through its implementation that building sustainability efforts right from the start of the project is more beneficial and more cost effective as it allows for ample time for the communities to acquire the necessary skills to sustain the efforts, helps avoid unnecessary repetitions and minimizes missed opportunities. The project worked with the existing formal and informal district and community structures right from the beginning; built capacity of volunteers and nurtured their skills throughout the entire life of the project; involved traditional leaders and other decision makers; produced necessary packages for the communities and trained them on how to use such packages and aligned itself with the government system at district level. All these efforts helped in ensuring sustainability of the project.

Continue to make the case for investments in SBCC: The global debate on whether SBCC makes an impact did not spare BRIDGE II, especially in its last year of implementation. Some National AIDS Commission and Ministry of Health representatives continually suggested that there was no scientific evidence on the impact of SBCC interventions, even when BRIDGE II was sharing publications that came out of the project and other peer reviewed articles. The role of SBCC in preventing HIV transmission and mitigating its impact remains as important as ever and investments by governments and donors needs to continue. On-going advocacy efforts to ensure SBCC study findings are disseminated to policy and decision makers are crucial.

Strengthen SBCC efforts by bringing services to people: The BRIDGE II team further recommends that SBCC HIV prevention efforts should always consider and find ways of making the advocated services readily available and accessible to the people. Reaching people with behavior change messages alone is not enough. There is rather a need to make the recommended services available just when people are motivated to use them. BRIDGE II linked people to services or brought services such as condoms and HTC closer to people by working with community referral agents who were always available in the communities to answer questions and provide directions on the type of service that people needed. Informal condom distributors dispersed condoms right at village level. These strategies added value to this SBCC project. The converse is also true: It is clear that biomedical interventions benefit significantly from the support of SBCC in providing information about or promoting access to those services, if and when they are available, whether they be PMTCT, HTC, VMMC services or other HIV related services.

Continue to address underlying gender dynamics: Exposure to BRIDGE II generally had more impact on women than men. For example, the condom distribution component had a greater impact on women's belief that they could use condoms and their use of condoms at last sex than it did for men. This is encouraging considering that due to cultural and other factors, women in Malawi are more vulnerable to HIV than their male counterparts. They also generally have less power to control their risk factors and take preventive action. The project therefore recommends that future programs should build on the inroads made to continue to ensure women are empowered to protect themselves; continually focus on promoting condom use and making sure that people have access to condoms.

Conclusion

BRIDGE II achieved significant progress towards preventing HIV and mitigating its impact in Malawi. BRIDGE II's successful innovations in programming and investment in ensuring sustainability of key programs will enable Malawi to continue to address the epidemic and make progress towards being AIDS free in the future. Continual investment and commitment is needed to ensure that the gains made in addressing HIV become entrenched, that adequate funding is available in Malawi for SBCC for HIV prevention, that SBCC efforts help to link people to HIV prevention and treatment services and treatment adherence, and that we continue to build capacity at community level.

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