

BEHAVIOUR CHANGE PROGRAMME

Zimbabwe has experienced one of the highest levels of HIV infection in the world since the discovery of the first case in 1985. Although the country has witnessed a marked decline in HIV prevalence from a high of over 30% in the late 90's to the current 15,6 among the 15-49 age group that figure is still high .

It is estimated that around 4 in 5 HIV infections in Zimbabwe are through sexual transmission, implying that all sexually active people are at risk of contracting HIV. The decline in HIV prevalence over the years was arguably attributed to change in sexual behavior among the population following increased awareness on the transmission of HIV and preventive methods as the country implemented multi-sectoral response initiatives.

Realizing the essence of prevention, The Joint United Nations Programme on HIV and AIDS (UNAIDS) declared 2006 as the year of accelerating HIV prevention in high prevalence countries.

In line with the declaration, the Southern African Development Community (SADC) organized an Expert Think Tank Meeting on HIV prevention that was held in Maseru, Lesotho.

The meeting identified the major drivers of HIV in the SADC region. The meeting recommended that every country was to identify specific drivers of HIV and come up with practical strategies to respond to the pandemic.

In response to the SADC resolution, Zimbabwe, through the coordination of the National AIDS Council, carried out Behavior Change Review process that led to the development of a National Behavior Change Strategy which was officially launched by the then Minister of Health and Child Welfare, Dr David Parirenyatwa in Beitbridge in 2006- paving way for its implementation.

A document entitled : *Comprehensive Review of Behavioural Change for Prevention of Sexual Transmission of HIV in Zimbabwe* , was published .
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The National Behavioural Change Strategy for Prevention of Sexual Transmission of HIV 2006-2010 , commonly known as the BC strategy, was published and disseminated to stakeholders to guide the implementation of HIV prevention initiatives in the country.
Click here to view the strategy document.....

The Behavior Change review process revealed key drivers of HIV transmission in Zimbabwe while the National Behavioural Change Strategy came up with various strategies currently being implemented by implementing partners country-wide.

The National AIDS Council and the United Nations Population Fund (UNFPA) are coordinating the BC programme through eight implementing partners in 26 districts country-wide. The Expanded Support Programme is supporting 16 districts while the European Commission is supporting 10 districts.

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What drives HIV transmission in Zimbabwe?

derived from the BC review process document:

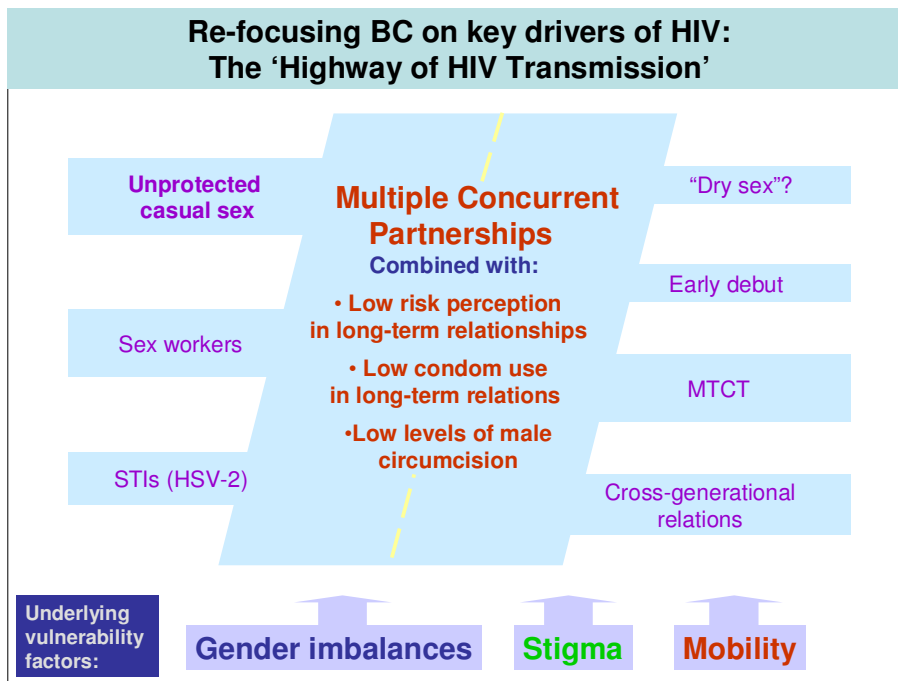
Frequent change of sex partners or having more than one partner at the same period of time, are important drivers of HIV in Zimbabwe. Concurrent partnerships (more than one partner over the same period of time like for example in unfaithful marriages) expose sex partners to very high levels of infection.

This is because the risk of passing on HIV to a sexual partner is higher if the HIV positive partner has just been newly infected within the past months. Newly infected persons have a high viral load, which makes HIV transmission very likely. Therefore newly infected persons who have more than one partner (e.g. a so-called “small house”) or short breaks between partner change have high chances of passing HIV to the other partners right after their own infection.

Although condom use with casual partners is relatively high in Zimbabwe, it is partially inconsistent. Condom use in longer-term and marriage relationships remains low despite the fact that most couples do not know their HIV status and unfaithfulness is reportedly high. This means that marriage does not protect from HIV.

As compared to other countries the majority of Zimbabwean youth do not start sex very early. What exposes young women to high HIV risk is that they start sexual relationships with men who are several years older, sexually more experienced and therefore more likely to transmit HIV to them.

Basic knowledge on HIV and infection risk in Zimbabwe is high, but many Zimbabweans (both youth and married adults) underestimate their personal risks - frequently because they do not consider the current and past infection risk of their partner. A number of other practices and values are underlying factors that make Zimbabweans vulnerable to HIV-eg imbalanced relationship between men and women as well as stigma associated with HIV.



Situation analysis

Zimbabwe is in the mature stage of a generalised HIV/AIDS epidemic although there are important age, gender and locality differences in HIV prevalence.

A recent¹ comprehensive review of epidemiological data from Zimbabwe provides evidence that HIV incidence declined over the period 2000-2004. Moreover, it was shown that sexual behaviour change has contributed to this and that it has therefore contributed to the documented change in national prevalence over the period.

Concerning perceptions of vulnerability, basic knowledge about population-level HIV infection risks and methods of prevention has been well-established since the middle 1990s at least. However, it is questionable that the levels of practical knowledge related to prevention practices are adequate.

This includes knowledge of interventions and their availability. It is important to understand knowledge in relation to new interventions such as PMTCT, ART or PEP and there is currently little known about this. Females appear to consistently lag behind males in most areas of HIV/AIDS-related knowledge.

Behaviour change has been most notable in the areas of condom use in non-regular relationships. There is some indication that these changes took place in the 1990s and that gains have continued in recent years. Condom use in regular and marriage relationships remains low.

There is no strong evidence of change in age of first sex for either sex. It is pointed out that Zimbabwe ranks among the countries with highest age of sexual debut.

Age differentials at first sex and in subsequent sexual experience are particularly high in Zimbabwe and an epidemiological vector affecting young women's vulnerability to infection.

A number of other areas of risk are identified and discussed. Most notable is the prevalence of concurrent partnerships in adult and married relationships, which are identified as a special risk, given the acute dynamics of HIV infection which predispose concurrent partners to particularly high levels of infection.

The largely urban 'small house' phenomenon and the cultural background of polygamy provide a supportive context for multiple partnering which must be seen as an important driver of the epidemic in Zimbabwe. Regular partners are a major source of infection to women and marriage rather than diminishing possibilities of infection, as is the case in some societies, exposes women to risks which are difficult to control.

Little is known about the risk and prevention behaviours of HIV-positive people.

An emerging risk identified in the report is the association between AIDS optimism and inhibition of HIV prevention behaviours and it is suggested that it will be important to research the question of whether scaling up of antiretroviral therapy will pose a risk to behavioural successes achieved.

Relatively high levels of stigma are evident in behavioural surveillance surveys. This is noted as an epidemiological risk factor given the positive relation between stigma reduction and prevention uptake.

In an advanced generalised epidemic the relative importance of targeted interventions such as STD prevention tends to diminish over time. Behavioural prevention aimed at partner reduction, particularly concurrent partners, and prevention aimed at decreasing age differentials at first sex for women are noted as the interventions that are most likely to have the largest impact at this stage, if successfully implemented.

Although a good volume of high-quality epidemiological research has been produced in Zimbabwe, a number of areas of research have been overlooked and are recommended as in need of attention: These include:

- The influence of concurrent sexual relations on HIV prevalence and decline, including the extent of the 'small house' phenomenon and its influence on HIV transmission trends.
- The prevalence of identified cultural practice risks.
- Knowledge related to new interventions including PMTCT, PEP(Post exposure prophylaxis) and ART.
- Factors related to consistent and correct condom use.
- Factors supportive of high age of sexual debut.
- The role of high viraemia following infection in the course of the Zimbabwean epidemic.
- The impact of the roll-out of ART on HIV prevention behaviour.
- Behaviour change among HIV-positive people.
- Epidemiological risk posed by resettlement of people in rural and urban areas.

There is a need to improve access to and utilisation of existing research in prevention planning and periodically to take stock of research priorities in support of prevention planning at a national level.

Response analysis

Recognition that Zimbabwe has an advanced generalised epidemic and that risk of infection is not limited to specific bridging populations or groups, led to the development of the BC strategy whose rationale and guiding principles are as follows:

Rationale and guiding principles

The purpose of this Strategy is to guide programmes for promoting behavioural change and to make all stakeholders across different sectors and all communities focus on addressing the main causes of HIV. For the strategy to succeed all stakeholders in the promotion of behavioural change should make a commitment to adhere to the following guiding principles:

- Clear messages about HIV prevention and desired behaviours are required. Any negative statements about any effective HIV prevention method (abstinence, faithfulness, condom use) need to be avoided by all stakeholders.
- It is essential to combat stigma associated with HIV as well as HIV prevention services and meaningfully involve people living with HIV in prevention initiatives.
- All stakeholders need to lead by example and involve different kinds of leaders at all levels as advocates and role models.
- There is a need to increase participation of men in HIV prevention programmes, address gender relations and reduce the vulnerability of women and girls.
- Communities need to be supported to understand their own risk, not only general population risks.
- Districts, faith-based organizations and communities need to be involved in local planning of behavioural change promotion.
- Behavioral change promotion activities should be developed based on detailed information on age, sex, values and practices of target populations
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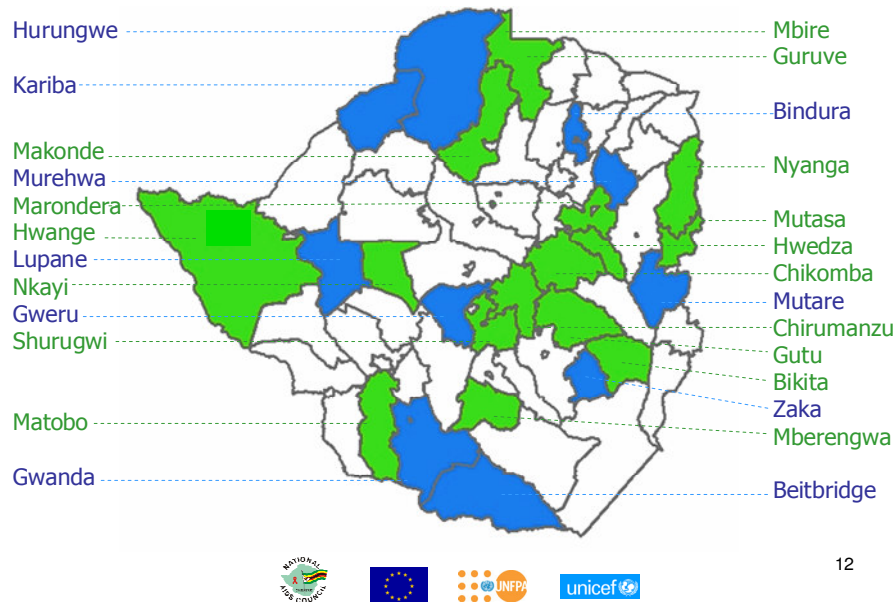
BC STRATEGY IMPLEMENTATION

Following the launch of the BC Strategy in 2006 by the Hon Minister of Health and Child Welfare, part of 2006 and 2007 were mostly devoted to development of plans and BC tools. 2008 marked the operationalisation of the programme.

Eight BC support organizations were selected to spearhead the dissemination and implementation of the BC strategy in 26 initial districts supported by the Expanded Support Programme and the European Commission.

BC PROGRAMME DISTRICTS

Coverage of BC programme: 26 districts



12

The overall coordinator is National AIDS Council. Each province has one implementing partner. The partners have been equipped with 88 full time behaviour change promotion staff.

The implementing partners have also recruited MIPA officers to promote meaningful involvement of People Living With HIV. It is anticipated that the MIPA Officers will spearhead strategies on fighting stigma and discrimination.

Behaviour Change Strategy dissemination

In an effort to ensure that the BC strategy was widely disseminated, several meetings were held with different stakeholders.

Provincial dissemination meetings were held in the following provinces; Masvingo, Bulawayo, Mat North, Mat South and Midlands.

The National BC Coordinator took advantage of several stakeholders meetings that were held to disseminate the strategy and ensure that stakeholders realign their efforts to the current policies.

Two meetings were held in Nyanga with legislators one comprising of Women's Caucus and Parliamentary Portfolio Committee on Health and Child Welfare. As part of legislators commitment to BC, a motion was passed in parliament on BC.

Below members of the Women's Caucus Committee at BC dissemination meeting in Nyanga



Behaviour Change Operationalisation.

Sixty staff members from the BC support organizations were trained in BC and use of BC tools to enable them to operationalise the National Behaviour change strategy.

Sensitisation and advocacy meetings were held with different community leadership at all levels. An intensive participatory district level assessment and participatory action planning process was carried out. Participants included CBOs, FBOs, Public sector, PLWH and other community leaders.



Participants to BC sensitization meeting pose for a photo

A total of 729 district stakeholders were trained in evidence based BC programming. BC tools were developed and piloted in several districts. Training of leaders to be role models began later in the year. Each district has planned to have a phased approach starting with 5 wards then expand to other wards to cover the whole district.

Several districts formed district Behaviour Change Fora. Composition of the BC forum varies from district to district depending on the BC implementers in the district. Generally there has been a wider appreciation of the BC program since its inception.

2008 Expanded Support Programme (ESP) Annual Independent Review of the Behavior Change Programme:

The behaviour change component under the ESP aims to support district implementation of the National Behaviour Change Strategy, and is being implemented in 16 districts with ESP support and a further 10 districts with EC support. The component is supported and coordinated at national level by UNFPA in collaboration with NAC, which is responsible for the National BC Programme, and implemented at district level by 8 NGOs.

Activities in the work plan include: conducting rapid district assessments; district action planning; sensitising national and provincial organisations; support to implementing NGOs including training, equipment and funding BC staff positions; training for community and religious leaders and for BC facilitators at ward level.

Achievements

- The process of selecting implementing NGOs was transparent and thorough. The contracted NGOs are experienced and effective. Training for NGO BC staff has been completed. NGOs

value the opportunity for sharing experience provided by quarterly review meetings organised by UNFPA.

- Good progress has been made and activities have been implemented as planned. Sensitisation has been conducted at national, provincial, district and local levels. Rapid assessments and district action planning have been completed in all districts. Training for traditional and religious leaders and ward facilitators, supported by high quality training materials, is underway. Standard guidelines and tools have been developed, for example, to guide recruitment of BC facilitators and activities.
- NAC perceives that the ESP has provided important support for implementation of the national BC strategy. Third quarter national output indicators produced by NAC report that “The number of community mobilisation sessions has increased from 6,724 in the second quarter to 8,482 in the third quarter” and attributes this to the roll out of the BC programme.
- District BC plans include detailed activities, timeframes and responsibilities. District BC forums are strengthening coordination of BC activities.
- A detailed M&E plan, linked to the national M&E system, has been developed. Indicators developed for the component have been incorporated as BC indicators in the National AIDS Reporting Framework (NARF). The M&E plan has appropriate output, outcome and impact indicators, targets, responsibilities and methods of collecting data. NGO reports are detailed and standardised.

Key issues

- The BC component is creating demand that cannot be met. There is evidence that community mobilisation has increased demand for testing and counselling (T&C) and that existing services are inadequate to meet demand. In Shurugwi, for example, NGOs and health workers reported that demand for testing had outstripped the supply of test kits and that the district hospital was unable to supply kits to all clinics. The impact of the BC component and of the ESP overall could be compromised by the limited availability of HIV and AIDS services.
- The approach taken by the BC component is intensive and there are concerns about the capacity of implementing NGOs to manage the roll out of activities. So far, activities have commenced in only five wards in each district. Demands on staff, in particular providing training and ongoing support and monitoring for around 150 ward and village BC facilitators in each district, will increase considerably as the component is expanded to additional wards, including those in less accessible areas.
- There is considerable pressure on Provincial and District AIDS Coordinators to expand the BC component to other districts, and UNFPA is also keen to roll out activities to additional districts. However, given the concerns highlighted above, it will be critical to assess the feasibility of replicating the current approach.
- The BC component is managed and implemented by UNPFA and NGOs. The fact that the component is linked to the national BC strategy gives implementing NGOs credibility with local leaders, which is critical for interventions involving community mobilisation. However, there is limited government involvement, aside from that of NAC national, provincial and district staff. Salaries and activities are supported entirely by ESP. There is no explicit GOZ funding commitment to BC programming. It is unclear where the resources will come from to support nationwide implementation.

- Sustainability is also a concern. BC staff are situated with the implementing NGOs. The component does not include capacity building for district staff to ensure that skills to manage, support and monitor BC activities are institutionalised and can be sustained after funding for ESP implementing NGOs ends. It is unclear how the incentives to BC facilitators will be sustained without ESP funding.
- Anecdotal evidence from district visits suggests that BC activities have, in addition to increasing demand for services such as T&C, resulted in more open discussion of HIV and AIDS in the community. While it is too soon to judge whether the BC component approach of training local leaders and BC facilitators will have an impact on issues such as stigma and discrimination or sexual behaviour, it will be critical to conduct rigorous assessment of effectiveness and impact before expansion to additional districts.
- The review team has some concerns about how the standard approach taken by the BC component is adapted to reflect differences between districts and to meet the specific needs of population groups that may be at elevated risk. For example, the findings of the DHS 2005-6 indicate that young people may be especially at risk, but there is no evidence that the BC component has a strategy to address the specific needs of young people.
- The rapid assessment of districts in preparation for the BC component used qualitative methods and does not provide a satisfactory baseline for measuring outcomes and impact. A concept paper for a bio-behavioural control group evaluation and a questionnaire for such research have already been developed, and this should be prioritised. Finalisation and implementation of a research protocol should be prioritized as future support for the intensive approach of this programme will require independent evidence of its outcomes and impacts. In the short term, research on the outcomes of the programme on creation of service demand and changing prevention behaviour should be conducted and this can partly be achieved through analysis of NARF data.
- **ENDS**

