ART&GLOBAL HEALTH CENTER
AFRICA

Endline Evaluation

Of the Umunthu Program Phase I implemented by the Art and Global Health Centre Africa (ArtGlo) in Malawi

March 2022

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ONE SOUTH

One South produced this report for the Art and Global Health Centre Africa as part of the Endline Evaluation of the Umunthu Program Phase I.

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Chapter 1: Executive Summary

The Umunthu Program

Umunthu[1] (in Chichewa) is a pan-African concept of humanity that celebrates interconnectedness and interdependence[2]. Umunthu's goal is to improve health access as a basic human right for lesbian, gay, bisexual, transgender, and intersexual (LGBTI) people in Malawi.

In Malawi, Umunthu can be understood to mean: "I am because we are"[3]; "to be in someone else's shoes"[4]; and "the feeling I have towards others."[5].

The programme aimed to improve health service delivery by reducing discrimination against LGBTI people by health workers and by building the capacity of civil society and health service providers to support and implement inclusive policies and practices.

Umunthu targets three main objectives:

- **Objective 1**: to enable Malawi health workers and health worker students better understand LGBTI persons and to act on their responsibilities towards them and other minority populations.
- **Objective 2**: to have members of civil society and communities engage with healthcare workers and discuss ways in which health issues can be addressed.
- **Objective 3**: to integrate workshop activities into civil society, educational institutions, and government training and curricula.

The program was implemented in eight districts across Malawi: Mulanje, Zomba, Nsanje, Nkhotakota, Dedza, Thyolo, Phalombe, and Mchinji. It aimed at reaching 930 Health Workers, 310 community leaders, 60 partner organization members and 420 Health Worker Students across 32 Health Clusters.

[1] Battle, Michael (2007). Reconciliation: The ubuntu theology of Desmond Tutu. Pilgrim Press. ISBN 978-0-8298-1158-2

[2] Umunthu Program Summary (2016) AGCHA

[3] Performance Story Workshop: What is Umunthu (August 2017)
[4] Performance Story Workshop: What is Umunthu (August 2017)
[5] Performance Story Workshop: What is Umunthu (August 2017)

Findings

Through the inclusive outlook that Umunthu provides, the programme's workshops were successful at increasing health workers' awareness about their role in ensuring health access for all persons. After the workshops, more health workers know that LGBTI persons are discriminated against in the community and in health facilities, recognizing that this diminishes LGBTI persons' access to health and worsens health outcomes for all.

After the workshop statistically significant more health workers acknowledged LGBTI people's increased risk of discrimination in their daily lives (+11%)[6], the negative impact discrimination has on LGBTI people's access to health (+75%)[7] and that LGBTI people are at a greater risk of depression and suicide (+15%)[8]. Qualitative evidence suggests that although the project "opened [health workers'] eyes"[9], most of them were already aware of the barriers that minorities face accessing health care.

An important first step of the project's theory of change was met, which was increasing the knowledge of health worker about the needs of LGBTI persons as a means to improving their professional practice.

Attitudes towards LGBTI people improved for health workers after attending the workshop. This made Health Workers reflect on how their own practices can be more inclusive. However, LGBTI persons still face discrimination in health facilities because as not everyone participated in Umunthu workshops.

The Umunthu workshop supported the development or strengthening of acceptance of LGBTI persons. After the workshop the following statistically significant differences were found:

- There were 16% more health workers who disagreed with the statement that they would not join a church that has transgender members[10].
- There were 17% more health workers who demonstrated increased acceptance of LGBTI persons, that is, who disagreed that "*increasing acceptance of LGBTI in our society aids the deterioration of morals*"[11].
- 27% more health workers agreed with the statement that homosexual couples should have the same rights as heterosexual couples[12].
- Health workers began to understand that being, lesbian, gay, bisexual, transgender or intersex can be in someone's nature and cannot change.

[6] Results of Indep. Samples T-Test: Pre-Test (m=3.8, sd=1.1) vs. Post-Test (m=4.1, sd=1.2), t (1752) = -4.7, p <0.001
[7] Results of Indep. Samples T-Test: Pre-Test (m=3.1, sd=0.5) vs. Post-Test (m=4.2, sd=1.1), t (1752) = -29.5, p <0.001
[8] Results of Indep. Samples T-Test: Pre-Test (m=3.2, sd=1.2) vs. Post-Test (m=3.4, sd=1.4), t (1752) = -4.0, p <0.001
[9] FGD with HW Women, Mchinji
[10] Results of Indep. Samples T-Test: Pre-Test (m=1.8, sd=0.9) vs. Post-Test (m=1.5, sd=0.8), t (1070) = 4.2, p =0.004
[11] Results of Indep. Samples T-Test: Pre-Test (m=2.2, sd=0.8) vs. Post-Test (m=2.0, sd=0.9), t (1070) = 4.7, p <0.001
[12] Results of Indep. Samples T-Test: Pre-Test (m=2.2, sd=0.9) vs. Post-Test (m=2.7, sd=0.7), t (1070) = -9.3, p <0.001

The changes were similar for health worker students.

Similar to the findings at midline, three in four participants believed that LGBTI people could change if they really tried both, before and after the workshop. This is likely because the items tap more deeply into religious and cultural beliefs. It should be acknowledged that a change in attitudes may be slower for some persons, as knowledge and convictions take different times to set root between different persons.

However, these findings are challenged by the qualitative research. Workshop participants qualitatively link the workshop to strengthened knowledge and acceptance about LGBTI persons, and the view that sexuality expression is not a choice but a right. The change in mindset of many participants was expressed as "It is nothing they can change, "now we see them as normal people", "it is their nature" and "we understood that the hospital is not a place where someone should be judged"[13].

Health care workers also provided specific examples of how their attitudinal change translated into improved health care practices not only for LGBTI people but also for other minorities.

Notwithstanding, discrimination against LGBTI persons still occurs at health access points because there are many people involved in service provision, many which did not participate in Umunthu workshops. Focus group participants said that there are still many clinics where they experience discrimination because of their sexual expression, where they are denied access to treatments like HIV post-exposure prophylaxis, or where their confidentiality is broken by some member of staff. A participant said: *"we agreed to go to clinic for my friend to get PEP, upon our arrival we were denied medical help as they said they could not assist us because of what we do. They told us to go to another clinic."*[14]

This highlights a need for interventions like Umunthu, which are linked to improvements in attitudinal changes amongst health worker staff. This is expected to improve LGBTI's access to health because they fear discrimination at clinics and discourages them to seek health services. Social norms change after a critical number of individuals have changed their own attitudes and therefore a need to scale-up Umunthu's or similar programme activities is still needed.

Improving attitudes contributed to positive changes in the protection of the confidentiality of patients, such as receiving one patient at a time or actively asking for feedback through suggestion boxes. However, some gaps remain as only one in four health workers asked patients for permission before disclosing information to others. LGBTI persons also said their confidentiality is sometimes broken by members of clinic staff.

Quantitative findings at the aggregate level indicate that only 28% of health workers confirmed respecting patients' confidentiality at pre-tests. Levels were similar at the time of post-tests suggesting that additional awareness raising, and a broader understanding of confidentiality is needed.

[13] FGD with HW Women, Mchinji
[14] FGD with LGBTI persons in Thyolo

LGBTI persons also said that the Umunthu programme contributed to improvements in the protection of their confidentiality but that clinics have many personnel, some of which might break this protection of confidentiality, and tell members of the community about their sexual or gender expression: *"When you go to a clinic we meet different people like cleaners, pharmacist, nurses, those in charge of STIs just to mention a few. So it happens that some have difficulty in understanding that, even after attending Umunthu training, they still do not have the wish to assist those who are LGBTI. Some will assist yet behind the scenes they will talk about you and you will hear your story somewhere else. It is surprising that you talk to health personnel but hear it somewhere else".*

Heath workers said that they are not attending only one patient at a time and respecting his or her confidentiality.

Health workers also referred to the possibility to provide anonymous feedback through suggestion boxes and ombudspersons.

As a response, the Umunth programme's Phase II included a section in its *convergence workshops* where LGBTI people meet with HCW to discuss those issues. The midline of Phase II will unearth the progress, as currently the MSC stories attest to improvements in this regard[15].

Four in five health workers reported they would provide services to LGBTI persons after the workshop and most feel equipped to support the access to health for LGBTI persons. The biggest constraint to behaviour change is in the fear health workers have of speaking out in favour of health access for LGBTI persons amongst their colleagues, as they would be perceived as LGBTI themselves and would, in turn, be stigmatised.

Prior to the workshop 70% of participants agreed to provide services to LGBTI. The share increased to 82% after the workshop. However, 60% of health worker students report that their colleagues will judge them negatively if they speak out in favour of LGBTI rights. Health worker students in Nsanje were the most confident in not being judged (78%) followed by health workers from Dedza (57%). Health workers from Blantyre (25%) and Chiradzulu (31%) felt the least confident. Most of them did however report their co-workers being concerned with improving the health access of minorities (73%).

Results from items measuring perceived behaviour control are slightly higher for male health workers. Female health workers continue to believe that they have slightly less control over their ability to support LGBTI people to access health than their male colleagues. Similarly, health care students report slightly less degrees of behavioural control compared to health care workers which could be due to the fear of being stigmatised by fellow colleagues if they were to transfer information from the workshop to them.

9 out of 10 workshop participants indicated implementing the pledge committed to in the workshop. They believe to have the necessary skills and knowledge as well as support from

[15] Project's response.

supervisors and colleagues. Participants indicate the lack of resources being the biggest barrier to implementation of the action plan.

Health knowledge about intersex and transgender people has improved among health workers. Still, 73% of participants believe in corrective surgeries for intersex babies and 37% that transgender people should be forced to have psychological treatment.

The results from the surveys as well as the qualitative evidence suggests the need for additional health messaging regarding intersex and transgender people. Health workers recalled that time spent on this topic in the workshop was not enough. Results from follow-up tests with health workers indicated a slight longer lasting improvement on knowledge items. The percentage of health workers agreeing with carrying out corrective surgery was at the same level as during pre-tests, suggesting that despite knowledge improvements, cultural beliefs are stronger.

Findings for health worker students were very similar with 38% reporting that "transgender people should be forced to have psychological treatment" and 80% believing in corrective surgeries for intersex babies after the workshop.

The project said that Malawi is entrenched in the cultural belief that intersexuality should not exist and should be corrected. Through the Umunthu programme, Health Workers are told they should give a choice to the mother on whether to carry out corrective surgery or not, which did not happen before.

The proportion of participants who are aware that they would not face legal consequences for providing treatment to LGBTI people increased after attending the workshop.

Results from follow-up show that awareness levels remained slightly above pre-workshop levels in the longer term. In interviews participants understood that it is everyone's right to access health care.

9 out of 10 health workers and health worker students see the value in a regular dialogue with community stakeholders and want to work with them to promote the health rights of minority populations.

Involving community stakeholders was regarded essential to raise awareness and promote the health rights of minority populations. Health workers in Thyolo who did not participate in Umunthu workshops stated "*people in the community must be told. They have to know that there are minorities among us. It is not their intention but nature*". Qualitative evidence provided for several positive examples of the engagement of civil society and community leaders to tackle health access disparities in communities. At the same time, the study found cases of potential power abuses through established liaisons negatively affecting LGBTI people that the project will have to carefully analyze throughout Phase II.

A problem was seen in government policies being contrary to such policies" and inhibiting such "campaigns"[16] with the LGBTI people officially not "having rights in Malawi"[17]. There is also a lack of data regarding the size and needs of minority populations.

The Umunthu approach is highly relevant. Qualitative evidence suggests that the methodology is starting to be integrated into civil society, educational institutions, and trainings.

In interviews, participants appreciated the "way facilitators were facilitating", not "teaching from the front" but "Involving everyone", ensuring that "nobody was wrong or right, all the comments were good and encouraging"[18]. The methodology was considered "brilliant and unique"[19]. A female CSO leader in Blantyre mentioned using the "very good and helpful skills" learned. These included "sitting in a circle", "giving exercises that everyone has to answer", "answering in pairs" or asking someone to stand up and start a song so the group would start to dance and then continue. Trainers of Trainers (TOT) mentioned the Umunthu construct and participatory methodologies learnt from the workshops were highly relevant and helped them grow professionally.

Results from the follow-up tests with health workers suggest that positive attitudinal changes have the potential to be long-lasting.

Differences in aggregate attitudinal mean scores between pre- and post-tests were statistically significant. Health worker's aggregate attitudinal mean score increased from 3.0 in the pre-test to 3.3 at the post-tests. Especially female health workers from Mchinji and Phalombe improved their scores. At the time of follow-up workshops, the score remained at 3.3 suggesting that health workers' attitudinal changes lasted beyond the workshop.

Mean attitudinal results show that attitudes also improved of health worker students in all districts. It increased from 2.7 to 3.3. Especially male health worker students from Chiradzulo and Phalombe increased their attitudinal scores.

Lessons Learned and Recommendations

1. The concept of "Umunthu" with its approach of "humanity" being interpreted as "helping everyone regardless of status and "LGBTI people being the way they are because God made them like this" is an accessible and understandable construct and helps integrate people who are critical because of religious beliefs as well as people being able to apply the concept not only in health care but also in other aspects of life.

   We recommend to continue promoting Umunthu as a mechanism for attitudinal change in domains that share similar outlooks, as it is the field of health, where there is a universal claim to it. Umunthu has also the advantage of being a shared construct

[16] Ibid.
[17] KII Trans, Thyolo
[18] KII with CSO Female (LGBTI), Blantyre
[19] KII DHMT Mchinji, Male

amongst Malawians, which makes the concept suitable for attitudinal change in communities as well.

2. For Umunthu to become widespread and produce a change in social norms, health workers should be able to speak about that they learned from the workshop with their colleagues or superiors. However, health workers fear to speak in favour of improved health services for LGBTI persons out of fear of being perceived as LGBTI and therefore being discriminated against. LGBTI persons said they have lost employment because of who they are.

   Therefore, we recommend that workers' superiors from health care facilities, are invited to participate in the Umunthu Workshops. This is because health authorities should create an environment where health workers can communicate about patient's needs without taboos or risks to their confidentiality. Programmatic action should therefore concentrate on sensitising health workers superiors, who can in turn protect health workers from discrimination at work resulting from their advocacy of LGBTI health rights. Trainers of Trainers can work with health authorities and share knowledge learnt from the project.

3. Health workers who participate in the workshop report to preserve the confidentiality of participants and have more acceptance of LGBTI persons. However, LGBTI persons said that health service delivery has many people involved. This includes nurses, doctors, and pharmacists, some of whom may not have attended the workshop and could therefore break the chain of confidentiality; disclosing LGBTI persons' information in the community and putting them at risk.

   We recommend inviting unit heads to participate in the workshop or engaging them through trainers of trainers to strengthen their knowledge on how to preserve the confidentiality of participants. If done with all units, confidentiality may be preserved through the full triage for each patient and therefore improve health outcomes, such as adherence to treatment.

4. There were other suggestions made LGBTI persons on how to improve the confidentiality of health services including **(1) having one patient a time; and (2) renaming rooms with more neutral terms; for example, not an "STI treatment room" but rather "Case Management Room" or similar.** These strategies are subtle but impactful ways to preserve the confidentiality of patients.

5. **Continuing or increasing use of participatory or artistic methodologies improved the learning experience of workshop participants.** These methodologies were praised by participants, who called it interactive and participatory. Participatory methods that were referenced as useful by Trainers of Trainers included drama and storytelling. These methods are being reproduced by TOTs in their own practice and transferred to other CSOs.

6. **Continue inviting guest speakers and involve LGBTI persons in the workshop.** Guest speakers were considered knowledgeable and well prepared by workshop participants. This is because direct involvement with LGBTI people, hearing their stories and being able to ask questions was perceived as very "authentic". It was suggested to include

representatives of the police in the workshop (as participants) since legal issues remain and there is a need for sensitization.

7. Workshops were useful in strengthening the knowledge on intersex and transgender persons. In many instances they were perceived as having a disability or persons who will necessarily experience a tough life. However, they have a right to assert their gender and it is not doing so what leads them to difficulties. **Therefore, we recommend adding sensitivity training on how to speak about transgender and intersex persons, if not providing an overview of the health services that are offered to them in more advanced development settings and should be offered in Malawi.**

8. Sensitization of communities is crucial to achieve long-lasting impact giving that normative change is necessary to end the discrimination and stigmatisation of LGBTI persons. A start has been made but further outreach needs to be done (through ArtGlo as well as community leaders, CSOs, chiefs etc.). **Consider engaging even additional community and religious leaders in workshops due to their influence (also for ToT workshops).**

9. Feedback systems are an important mechanism for change because they ensure that facilities stay relevant to patient's needs. **Support the establishment or strengthening of feedback systems in health care facilities whilst also promoting their use.** This can be done through feedback boxes or exit surveys, through the use of signs at the facility, radio, and community leaders. **Work with ombudspersons so that they are responsive and work towards institutional change.**

10. The legal situation remains a barrier in Malawi as it inhibits campaigns and justifies discriminatory attitudes and actions. There is also a lack of data regarding the LGBTI community in Malawi, which makes it difficult to advocate for in a policy setting. **We recommend to work institutional actors such as donors, NGOs and CSOs, sharing information on the relationship between health outcomes and human rights and working with the government of Malawi to update health training manuals and curricula.**

Chapter 2: Programme Summary

Context

Access to health is a constitutional right in Malawi but the country's health sector is heavily underfunded.

Under sections 13(c), 16 and 45 in their constitution, the people of Malawi entrenched an inalienable right to life for all citizens and directed the state to provide adequate health care commensurate with the needs of society and international standards of health care[20].

With only 9.3% of the national budget spent on health in 2020/2021, allocations fell short of international benchmarks, such as the 15% threshold of the Abuja Agreement[21].

Malawi's healthcare system is blighted by insufficient funding and poor services, making it difficult to access for Malawians due to a lack of medical staff, supplies and facilities.

Same-sex relations are illegal in Malawi and discrimination prevents LGBTI people from accessing health services.

Same sex acts are officially illegal and punishable by up to five years for women and 14 years for men in prison. In 2012, the government stated that it will no longer arrest and prosecute persons under this legislation and reviewed its anti-gay law, putting a moratorium in place. While there have been a reduction in arrests and prosecutions, they still occur[22].

LGBTI persons experience violence, abuse, blackmailing, and unemployment for being LGBTI.

According to Human Rights Watch, LGBTI people often face violence, threats, and discrimination in all aspects of their daily lives[23]. Police physically assault, arbitrarily arrest and detain LGBTI people, sometimes without due process or a legal bias, and at other times as punishment for simply exercising basic rights, including seeking treatment in health institutions[24].

In FGDs, LGBTI persons said they were often victims of stigmatisation because of their sexuality in communities and at work, with some of them falling victim to extorsion and violence somewhat frequently, or losing their employment after their sexuality becomes known[25].

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[20] https://www.constituteproject.org/constitution/Malawi_2017.pdf?lang=en
[21] https://www.unicef.org/esa/media/8991/file/UNICEF-Malawi-2020-2021-Health-Budget-Brief.pdf
[22] UK Home Office: Country Information and Guidance. Malawi: Sexual orientation and gender Identity, 2016: https://www.refworld.org/pdfid/56b843da4.pdf
[23] Human Rights Watch (2018): "Let Posterity Judge": Violence and Discrimination against LGBT people in Malawi": https://www.hrw.org/report/2018/10/26/let-posterity-judge/violence-and-discrimination-against-lgbt-people-malawi

[24] Ibid. HRW 2018

[25] FGD with LGBTI in Thyolo

A punitive legal environment, high levels of violence against LGBTI people, stigma, and discrimination based on sexual orientation in Public Healthcare Centres and hospitals leads to a climate of fear. It ultimately fuels human rights violations and deters LGBTI people from seeking and adhering treatment, care, and support services amongst others for HIV[26].

Theory of Change

Umunthu's goal is to promote health access as a basic human right for lesbian, gay, bisexual, transgender, and intersexual (LGBTI) people in Malawi.

Umunthu[27] is a pan-African concept of humanity that celebrates interconnectedness and interdependence[28]. In Malawi, Umunthu can be understood to mean: "I am because we are"[29]; "to be in someone else's shoes"[30]; and "the feeling I have towards others."[31].

The program aimed to improve health service delivery by reducing discrimination against LGBTI people by health workers and by building the capacity of civil society and health service providers to support and implement inclusive policies and practices.

Umunthu was implemented in eleven districts across Malawi: For Health Care Workers, the project was implemented in Zomba, Chikwawa, Phalombe, Thyolo, Dedza, Mchinji, Nkhotakota and for Medical and Nursing students in Blantyre, Chiradzulu, Nsanje and Lilongwe.

The program targeted three main objectives:

The first objective was to enable Malawi health workers and health worker students to better understand LGBTI persons and to act on their responsibilities towards them and other minority populations.

To achieve this, the Art and Global Health Centre organized a total of twenty-seven workshops with health workers lasting three days each and fourteen workshops with health worker students lasting two days each throughout Phase I.

These workshops allowed health workers to freely discuss health access of LGBTI people and other minorities. Guest medical, legal and LGBTI speakers were invited to enable health workers to ask follow-up medical questions, understand the legal environment surrounding health access for LGBTI people, and become acquainted with the barriers facing these key populations.

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[26] Ibid. HRW 2018

[27] Battle, Michael (2007). Reconciliation: The ubuntu theology of Desmond Tutu. Pilgrim Press. ISBN 978-0-8298-1158-2

[28] Umunthu Program Summary (2016) AGCHA

[29] Performance Story Workshop: What is Umunthu (August 2017)

[30] Performance Story Workshop: What is Umunthu (August 2017)

[31] Performance Story Workshop: What is Umunthu (August 2017)

The second objective was to have members of civil society and communities engage with healthcare workers and discuss ways in which health issues can be addressed.

On the final day of the workshops, Umunthu gathered local community leaders from the surrounding health cluster, including members of the Health Management Committee (HMC) and Civil Society Organisation (CSO) to participate in joint meetings together with health workers. During these meetings, health workers shared their learning with community leaders and CSO representatives.

These meetings resulted in joint Action Plans or pledge that promoted non-discrimination of LGBTI people and other minorities when seeking health services. This was done through small group discussions and interactive role playing. After six months, ArtGlo organized a follow up workshop for a day to further examine the progress of the action plan.

The third objective was to integrate workshop activities into civil society, educational institutions, and government training and curricula.

The Umunthu program conducted two trainings of trainer (ToT) workshops with civil society, government, and partner representatives lasting one two days each. These workshops aimed at familiarizing participants with the Umunthu program and encouraging replication of successful program components into existing curricula. The program developed a communications and advocacy strategy to highlight the success of program components in local media outlets and generate a broader interest in the Umunthu approach.

Image 1. The Umunthu Workshop Participatory Methodology

Chapter 3: Methodology

Sampling

Quantitative

The study used three surveys. The sample sizes for each of these surveys at endline is shown in the table following.

Table 1. Sample sizes quantitative data

Category	Pre-Test (n)	Post-Test (n)	Follow-up Test (n)
Health Workers	572	500	432
Health Worker Students	390	293	0
Total	**962**	**793**	**432**

A total of 2,187 tests were answered, 1,504 (69%) by health workers and 683 (31%) by health worker students. No follow-up workshops were held with health worker students. Sample sizes by sex and district are shown in Table 2 and 3.

Table 2. Sample size quantitative data by sex

Sex	Pre-Test	Post-Test	Follow-up Test
Male	525	434	252
Female	416	348	176
Other	21	10	4

Table 3. Sample sizes quantitative data by district

District	Pre-Test (n)		Post-Test (n)		Follow-up Test (n)
	HW	HW Student	HW	HW Student	HW
Blantyre	0	112	0	67	0
Chikwawa	87	0	59	0	0
Chiradzulo	0	28	0	29	0
Dedza	84	0	53	0	85
Lilongwe	0	128	0	89	0
Mchinji	102	0	90	0	72
Nkhotakota	47	0	41	0	92
Nsanje	0	60	0	58	0
Phalombe	50	30	48	21	97
Thyolo	94	0	109	0	86
Zomba	108	32	99	29	0
Unknown	0	0	1	0	0
Total	**572**	**390**	**500**	**293**	**432**

Qualitative

To expand and complement quantitative findings, the study also conducted 27 focus group discussions and key informant interviews with health workers, supervisors, community stakeholders, and LGBTI people in various district. Each focus group included 3-4 mixed-sex participants.

Table 4. Session overview qualitative data

Name of Session	Thyolo	Mchinji	Total
FGD with HW Men	1	1	2
FGD with HW Women	1	2	3
FGD with LGBTI who visited health clinics with trained health workers	1	1	2
Interview with trans who had accessed health at clinic with trained health workers	2	2	4
FGD with HW not trained by the project but in target health facilities	1		1
KIIs with Health Worker Supervisors in clinics targeted by the project	2	1	3
KII with Community Leaders	2	2	4
KII with District Health Management Team Member responsible	2	2	4
KII with curriculum expert at health training colleges	1	1	2
KII with member of Civil Society Organization targeted for replication by the project	1	1	2

Limitations

The evaluation team acknowledges two limitations:

1. Pre-, post- and follow- up tests were conducted by all participants who attended the workshop. In some cases, fewer participants responded to at the post-test than the pre-test. However, the composition of the group did not change overtime.
2. As respondents were not assigned a unique identifier, responses to pre- post- and follow-up tests could not be matched at the individual level and therefore aggregate-level analyses were used.

Chapter 4: Findings

Has the program influenced health workers' understanding of LGBTI and supported them to provide more accessible services?

By conducting workshops to improve health workers' and health worker students' awareness of the health concerns of LGBTI when they seek access to health, Umunthu aims that Malawian health workers (including health worker students) consider and better understand LGBTI persons through the local perspective of the Umunthu and that this results in them acting on their responsibilities to support the access to health of LGBTI people and other minority populations.

In line with the baseline study from 2017 and midline study from 2018, accessible services for LGBTI means services that uphold (1) a right to privacy and non-disclosure, (2) right to non-discrimination, and a (3) right to relevant health services. When these are provided, the assumption is that LGBTI persons will seek these services and therefore become more accessible.

These three dimensions are discussed in the following sections.

Qualitative evidence suggests improvements in health workers respecting patients' confidentiality. Quantitative evidence finds that only one in four health workers asks the patient for permission before disclosing information to others.

LGBTI patients are more comfortable disclosing information about partners and sexual activities when they are assured of the confidentiality of the visit. This helps health workers assess the level of risk and the possibility of STIs, as well as tailor their counselling services to the patient.

To assess the extent to which health workers respect patients' confidentiality, they were asked to what degree they agree with the statement: "If I need advice from other staff members about providing treatment, I always ask the patients' permission before disclosing their information to others". Results show that, at the aggregate level, only a little more than one in four health workers (28%) confirmed to be asking for the patient's permission at pre-tests. At post-tests this number decreased to 25% with health workers possibly acknowledging their malpractice. By the time of follow-up workshops levels were similar to pre-test at 27% (see Figure 1) suggesting that additional awareness raising is needed in this respect.

A CSO in Blantyre was aware of the general problem whereby "instead of just helping [the patient] they [health workers] say wait, let me go and call my friends. [The patient] thinks that they are

calling an expert […]. And suddenly there are plenty of nurses and doctors coming to look at you so they can gossip and chat bad about you[32].

At midline, it was suggested that the project improve information about confidentiality amongst health service providers and how to protect it whenever they present a professional query to a colleague. A breach of confidentiality can result in a reduced willingness of LGBTI people to access health services. Qualitative evidence suggests that health workers have become more aware of this. No incidences of discussing a diagnosis or treatment with colleagues without the express consent of the patient nor incidences of calling the authorities were recorded by patients in interviews at endline. In group discussions in Mchinji health workers did acknowledge breaking confidentiality by "telling their work mates to come and see what is here [in the waiting room/line] because it is so rare [a transgender or intersex patient]". They were aware that "the attention can spoil the service" and cause discrimination by others"[33].

As a response, the Umunthu programme's Phase II included a section in its *convergence workshops* where LGBTI people meet with HCW to discuss those issues. The midline of Phase II will unearth the progress, as currently the MSC stories attest to improvements in this regard[34].

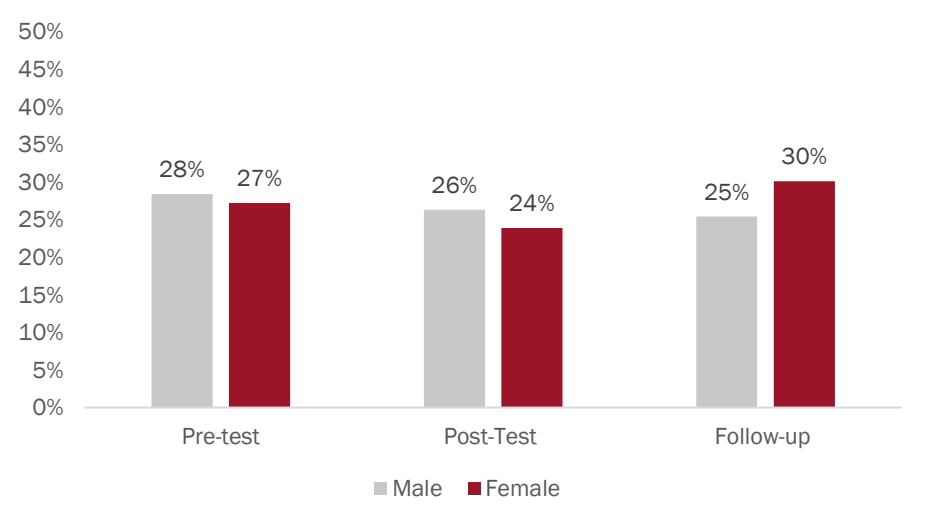
The lack of private facilities to provide consultations seems to have improved. A female health worker from Mchinji stated that now health facilities provide rooms where they make sure that only one patient is coming in at a time[35]. Health workers in Thyolo were also aware that they "should have a special place for them [LGBTI patients] to be received and given treatment so they feel free and say what is bothering them"[36]. A community leader in Thyolo stressed that "health personnel have a duty to provide confidentiality of the patient" and "welcome them well"[37]. A transgender person in Thyolo observed change, mentioning that previously health workers "would assist us after telling all the doctors with the aim of knowing your problem. Back in those days we were sometimes even sent back. But now we are assisted properly" and "have our own room"[38].

An issue raised by health workers was the discriminating set-up of hospitals. Entering a special room dedicated to the treatment of STIs makes "people feel ashamed"[39], an issue that could be easily addressed by keeping room branding neutral or conducting tests in several offices.

Health workers stressed the importance of patients providing anonymous feedback through the suggestion boxes or talking to an ombudsperson if they felt they were treated unfairly at the clinic. They mentioned that patients "are supposed to give feedback of what happened. […] considering that it can happen in a closed room, and you will not know until that person gives feedback". They assured that once suggestion boxes are opened, "important people are there who can bring about change". Health workers acknowledged the need to strengthen the system through additional advertisement, using community leaders, representative of minority groups or community radios to build people's trust and allowing them to see change[40].

[32] KII with CSO Female (LGBTI), Blantyre
[33] FGD with HW Men, Mchinji
[34] Project's response.
[35] KII DHMT F, Mchinji
[36] FGD with HW Women, Thyolo
[37] KII with Community Leader, Thyolo
[38] KII with Trans, Thyolo
[39] FGD with HW Men, Mchinji
[40] FGD with HW Men, Mchinji

Figure 1. HW and HW Students indicating to ask the patients' permission before disclosing their information to others (agree/strongly agree)



The workshops were successful at increasing awareness. After the workshop, statistically significant more health workers recognized that LGBTI people are at increased risk of discrimination in their daily lives, at risk of suicide and depression; and especially recognized the negative impact discrimination has on LGBTI people's access to health (an increase of 75%).

Between pre-and post-tests health workers exhibited substantial improvements in their awareness of the discrimination faced by LGBTI people. After the workshop statistically significant more health workers acknowledged LGBTI people's increased risk of discrimination in their daily lives (+11%)[41], the negative impact discrimination has on LGBTI people's access to health (+75%)[42], and that LGBTI people are at a greater risk of depression and suicide (+15%)[43] (see Figure 3). This suggests that the workshops were successful at increasing awareness regarding difficulties faced by LGBTI people.

At the time of the follow-up workshops, the proportion of health care workers who strongly agreed or agreed with the discrimination items decreased to pre-workshop levels except for "*discrimination negatively affecting LGBTI people's access to health*". It suggests that upon returning to their respective clinics, health workers partially regressed into former ways of thinking regarding LGBTI discrimination. At midline, the decrease across items was even larger. The project explained that there was a big gap of time between the first workshop and the follow-up workshops, and this gap was shortened in Phase II, so that participants were constantly engaged, and their knowledge refreshed.

Qualitative evidence suggests that although the project "opened [health workers'] eyes"[44], most of them were already aware of the barriers that minorities face accessing health care. These included

[41] Results of Indep. Samples T-Test: Pre-Test (m=3.8, sd=1.1) vs. Post-Test (m=4.1, sd=1.2), t (1752) = -4.7, p <0.001
[42] Results of Indep. Samples T-Test: Pre-Test (m=3.1, sd=0.5) vs. Post-Test (m=4.2, sd=1.1), t (1752) = -29.5, p <0.001
[43] Results of Indep. Samples T-Test: Pre-Test (m=3.2, sd=1.2) vs. Post-Test (m=3.4, sd=1.4), t (1752) = -4.0, p <0.001
[44] FGD with HW Women, Mchinji

"being afraid of meeting doctors", "being yelled at", "afraid of talking about their problems", negative attitudes, mockery, lack of confidentiality and knowledge by health workers[45] which all lead to "stress" and "patients inventing a different disease from the one they are actually suffering from"[46].

However, the health workers said that the workshops helped them accept different gender or sexuality expressions as natural: "now we see them as normal people", "it is their nature" and "we understood that the hospital is not a place where someone should be judged"[47].

Participants were also cognizant of the consequences of being discriminated with people *"seeing themselves as failures and not important",* starting to *"live an astray life, some using drugs, some drinking beer because they feel that they are not important to the community"*[48].

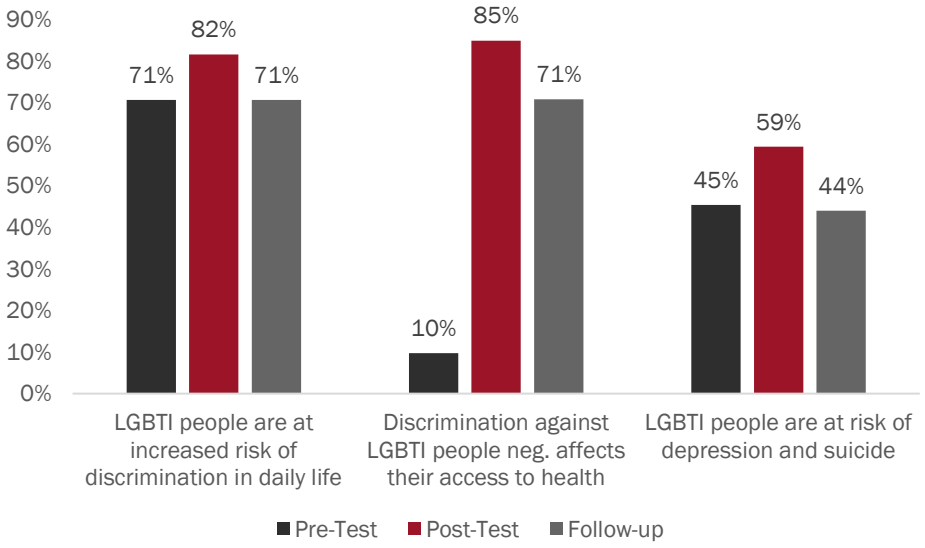
Male and female health workers interviewed in Mchinji recalled that they had learned "not to side line people but were trained to serve", that they had "sworn to offer their services in a professional manner"[49], regardless of someone's sexual orientation[50]. Both female and male health workers emphasized the need for non-discrimination, having "humanity" and that "it is right to give help to everyone regardless of their status" [since] "everyone is equal before God, whether you have money or not, whether you are literate or illiterate" or whether "you are a sex worker or a thief"[51].

Participants were aware that side-lining patients would discourage LGBTI people not only from visiting the hospital but also his or her friends[52]. They further argued that "when discriminated, they will not heal and not follow medications properly" which will result in "further spreading the disease"[53]. Male health workers agreed that "to break the spread of any disease, there is a need for everyone to receive treatment without discriminating anyone"[54]. Both health workers and LGBTI people agreed that when feeling discriminated, "patients start explaining problems they do not suffer from"[55]. Health workers also acknowledged that to some extent LGBTI people "discriminate themselves by not making their way to the hospital to tell us their problems"[56].

[45] KII with Community Leader, Thyolo
[46] KII with CSO Female (LGBTI), Blantyre
[47] FGD with HW Women, Mchinji

[48] FGD with HW Men, Mchinji
[49] FGD with HW Men, Mchinji
[50] KII CSO CT 1,2,3 (male) Mchinji
[51] FGD with HW Women, Mchinji
[52] FGD with HW Women, Mchinji
[53] FGD with HW Women, Mchinji
[54] FGD with HW Men, Mchinji
[55] KII with CSO Female (LGBTI), Blantyre
[56] FGD with HW women, Mchinji

Figure 2. Proportion of HW who agree or strongly agree with three discrimination items



Attitudes towards LGBTI people improved for health workers after attending the workshop at statistically significant levels, particularly regarding having the same rights as homosexual couples.

The project argues that discrimination on the part of health workers is driven by negative attitudes towards LGBTI people. To understand how attitudes towards LGBTI people were affected by attending the workshop, the study uses the same 4-item scale constructed at midline to measure attitudinal change. The scale is based on a contextual adaptation of the Homosexuality Attitudes Scale (HAS), a widely validated measure of attitudes towards gay men[57]. The scale was adapted to include items relevant to transgender, lesbian, intersex, and bisexual populations[58].

Attitudes towards LGBTI people improved across the first three items (see Figure 4). After the workshop statistically significant more health workers disagreed with the statement that they would not join a church that has transgender members (+16%)[59], disagreed that "increasing acceptance of LGBTI in our society aids the deterioration of morals" (+17%)[60] and agreed with the statement that homosexual couples should have the same rights as heterosexual couples (+27%)[61] (see Figure 2).

Similar to the findings at midline, three in four participants believed that LGBTI people could change if they really tried both before and after the workshop. This is likely because the items tap more deeply into religious and cultural beliefs, which associate 'normalized' sexual relations as

[57] Kite, M.E., & Deaux, K. (1986). Attitudes toward homosexuality: Assessment and behavioral consequences. Basic and Applied Social Psychology, 7, 137-162.
[58] It is based on the extent to which the respondent agrees with the following statements:
Q21/Q13 "I would not join a church that has transgender members in its congregation."
Q27/Q19 "The increasing acceptance of transgender, homosexual, or bisexual people in our society is aiding in the deterioration of morals."
Q29/Q21 "Homosexual couples should have the same rights as heterosexual couples do."
Q31/Q23 "Lesbian, gay, bisexual, and transgender people can change and be heterosexual if they really tried."
[59] Results of Indep. Samples T-Test: Pre-Test (m=1.8, sd=0.9) vs. Post-Test (m=1.5, sd=0.8), t (1070) = 4.2, p =0.004
[60] Results of Indep. Samples T-Test: Pre-Test (m=2.2, sd=0.8) vs. Post-Test (m=2.0, sd=0.9), t (1070) = 4.7, p <0.001
[61] Results of Indep. Samples T-Test: Pre-Test (m=2.2, sd=0.9) vs. Post-Test (m=2.7, sd=0.7), t (1070) = -9.3, p <0.001

being between a man and a woman. In Malawi homosexuality is seen to be something exogenous and brought in from the outside, rather than a 'natural' phenomenon. In this context it would be make sense for most participants to view homosexuality as something that can be changed. A community leader summed it up saying "we accept it though deep inside we still don't understand", referring to the biblical scriptures and "the devil [changing] what God initially put in place"[62].

Follow up tests show improvements across all items compared to the tests administered prior to the workshop but decreases compared to post-tests except for the item on LGBTI people can be heterosexual if they really tried. This suggests that the project had a longer-lasting effect on attitudinal change of health workers.

Qualitative evidence resonated with the findings. Health workers stated that the Umunthu program changed their mindset, "at first, looking at gays I was the most disappointed human being. They never pleased me", "we saw them as complete wrong doers like people who don't know their role as a male human", "complete sinners", "insane", "mentally ill", "stupid", "abnormal" and "judging them to the fullest". Lesbians were considered "Satanists", "acting contrary to nature" or "thinking like animals"[63].

Many participants' change in mindset was expressed as "now I know they [LGBTI people] have their own problems, and it is not what they want to be like so now I started to perceive them like anybody else", "It is nothing they can change, "now we see them as normal people", "it is their nature" and "we understood that the hospital is not a place where someone should be judged"[64]. They confirmed to now "treat everyone equally", "apply humanity", understood that "all are God's creation and come to seek help so we should not discriminate" and "they [LGBTI] are an important people in the society" [65]. Interviews suggest that religion as well as the fact that the Malawian law does not allow same-sex marriage has an impact on people not changing their attitudes.

Participants acknowledged that the training opened health workers' minds, equipping them to professionally "render services to each and every individual", considering it a "privilege to disturb the transmission circle of a disease", and confirming that after the workshop "most people are now aware of the kind of diseases that the LGBTI community suffers from and that the group [LGBTI people] exists"[66]. A health care supervisor in Mchinji concluded, "before the training we were chasing people away unknowingly [...]. Right now, because we are trained, we are able to know that there is a group of people that is present in this country"[67]. The workshop also contributed to an increase in knowledge, with health workers stating that "now we learnt, especially if gays have been diagnosed with STIs they should bring along their partners for medical help"[68].

Health care workers provided specific examples of how their attitudinal change translated into improved health care practices such as "I work at a private clinic and there is a transgender boy, and he does things like a girl which is irritating. Sometimes when I got annoyed, I would tell him that the doctor is not present. But now I understood that that is the way he was born"[69]. Health workers, community leaders and LGBTI people confirmed having experienced improvements in

[62] Community Leader 2, Mchinji
[63] FGD with HW Women, Mchinji
[64] FGD with HW Women, Mchinji
[65] FGD with HW Men, Mchinji
[66] KII DHMT Female, Mchinji
[67] KII with HW Supervisor, Mchinji
[68] FGD with HW Women, Mchinji
[69] FGD with HW Women, Mchinji

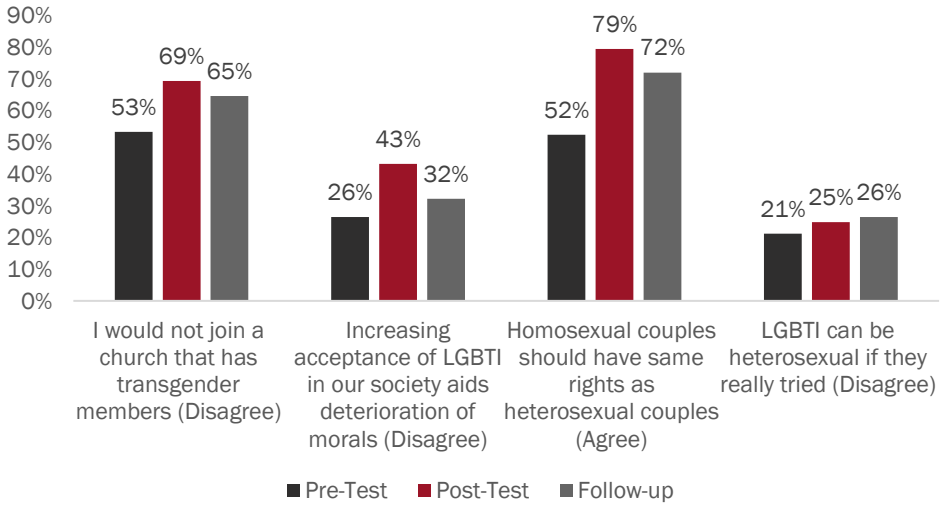
health care practices[70]. A trans person from Mchinji stated “doctors were trained and now we are comfortable to go to these hospitals. They welcome us well. Two weeks ago, I went there, I was helped and was very happy”[71]. A trans person in Thyolo confirmed from a similar visit “when I went there to see, they welcomed my friend very well and that’s when I knew that they have changed” and “that now having sores in the private parts we are able to undress and show the doctor properly”[72]. Similarly, in Mchinji a trans person mentioned that health care workers made him feel comfortable and treated him well[73]. A community leader from Mchinji stated “I went to a health facility with a gay and I realized they [LGBTI] stopped complaining compared to how they were treated in the past like being ridiculed. Things seem to have changed”[74].

Evidence suggests that attitudinal changes translate into improved healthcare practices not only for LGBTI people but also other minorities. In Mchinji, a health worker witnessed, “there was a sex worker who came looking for condoms, but she stayed for a long time. I asked her “you have stayed here for a so long, what do you want?”. She said she wanted condoms but the person she asked just left her there. I took the condoms since they weren’t far away and gave them to her. I made the conclusion that she was just ignored because she was a sex worker, and it may mean she has no voice and value”[75]. Another example was, “in the past we used to talk with anger sex worker or a little child who just got pregnant because it hurt us seeing a small kid being pregnant or the sex worker having problems because of her carelessness. But now we changed our mindset. We see them properly and treat them properly”[76]

Consequently, LGBTI and other minorities now come “in large numbers”[77], “spread the news [...] to not be afraid and visit the hospital because health personnel are now more friendly, and they will be helped because [health workers] can be trusted and are so confidential”[78].

[70] FGD with HW Men, Mchinji
[71] KII Trans, Mchinji
[72] KII Trans, Tyolo
[73] KII Trans, Mchinji
[74] Community Leader 2, Mchinji
[75] FDG with HW Women, Mchinji
[76] FGD with HW Women, Mchinji
[77] KII with HW Supervisor, Mchinji
[78] FGD with HW Women, Mchinji

Figure 3. Health Worker's (positive) attitudes towards LGBTI people

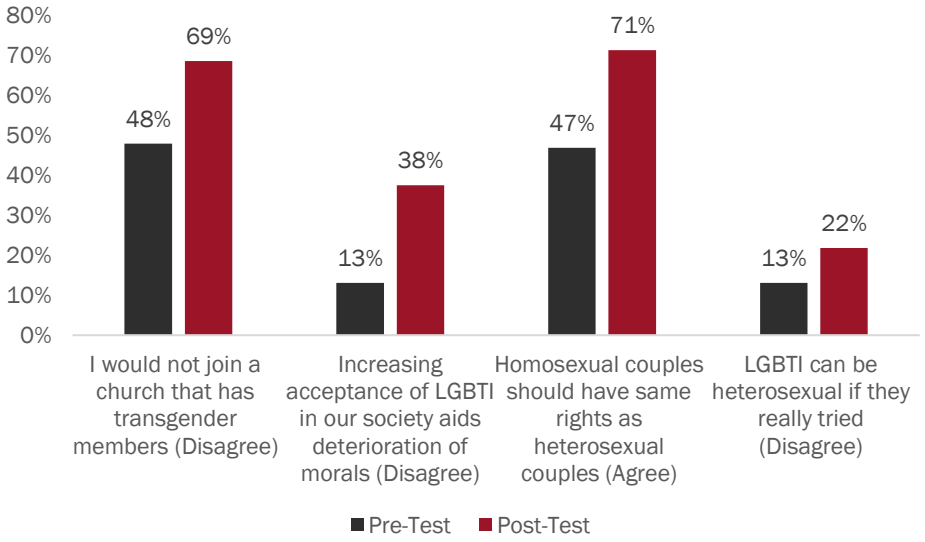


The attitude of health work students towards LGBTI people improved across all items at statistically significant levels after attending the workshop.

Health work students saw improvements in attitudes towards LGBTI people across all four items at statistically significant levels. 21% more participants disagreed with "not joining a church that has transgender members"[79], 25% more disagreed that increasing acceptance of LGBTI in our society aids deterioration of morals[80], 24% more agreed that homosexual couples should have the same rights as heterosexual couples[81] and 9% more disagreed with the statement that LGBTI can be heterosexual if they really tried[82]. This suggests that the workshops were successful at contributing towards a positive change of attitudes towards LGBTI people of health work students (see Figure 5).

[79] Results of Indep. Samples T-Test: Pre-Test (m=1.8, sd=0.9) vs. Post-Test (m=1.5, sd=0.8), t (681) = 4.9, p<0.01
[80] Results of Indep. Samples T-Test: Pre-Test (m=2.6, sd=0.7) vs. Post-Test (m=2.1, sd=0.9), t (681) = 8.4, p<0.01
[81] Results of Indep. Samples T-Test: Pre-Test (m=2.1, sd=0.9) vs. Post-Test (m=2.6, sd=0.8), t (681) = -6.5, p<0.01
[82] Results of Indep. Samples T-Test: Pre-Test (m=2.5, sd=0.7) vs. Post-Test (m=2.4, sd=0.8), t (681) = 3.1, p<0.01

Figure 4. Change of HW Student's (positive) attitudes towards LGBTI people



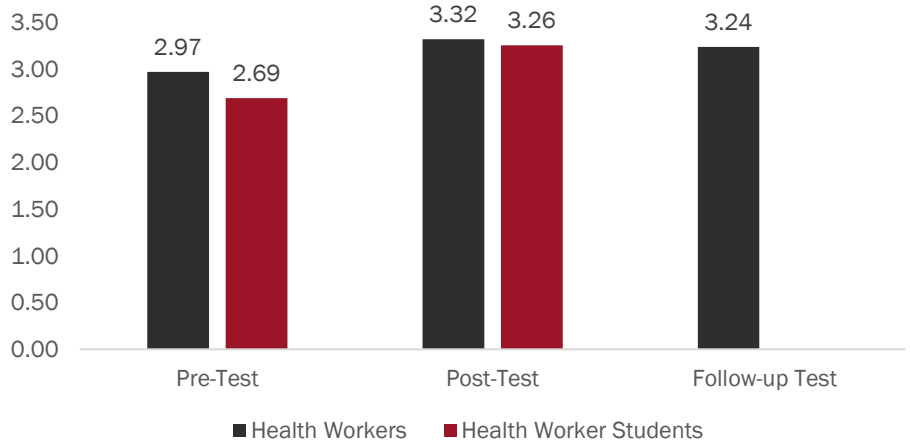
Results from follow-up tests with health workers suggest that positive attitudinal changes were longer-lasting.

The same scale from the midline study was constructed creating a mean score of the 4 attitudinal items, three of which were reversely coded. The highest score on the scale is 5 and the lowest 1.

Overall, the attitude mean score of health workers towards LGBTI people was 3.0 on the pre-test and on the post-test 3.3, a statistically significant increase demonstrating a more positive view towards LGBTI people after attending the workshop[83]. The attitude mean score of health care students stood at 2.7 prior to the workshop and increased to similar levels as health workers to 3.3. This was also an increase at statistically significant levels indicating the successful change of attitudes among health worker students after attending the workshop[84]. Differences between attitude mean scores at the time of the follow-up tests (aggregate score of 3.3) – which were not conducted for health worker students - and post-tests were not significant suggesting that health workers attitudinal changes lasted beyond the workshop.

[83] Results of Indep. Samples T-Test: Pre-Test (m=2.97, sd=0.7) vs. Post-Test (m=3.32, sd=0.8), t (1069) = -7.8, p<0.01
[84] Results of Indep. Samples T-Test: Pre-Test (m=2.69, sd=0.7) vs. Post-Test (m=3.26, sd=0.8), t (681) = -9.4, p<0.01

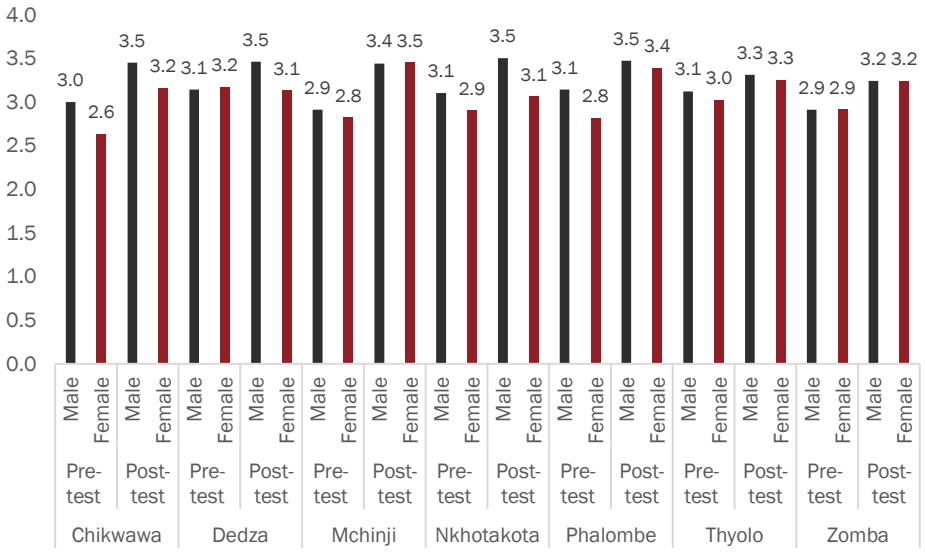
Figure 5. Mean score LGBTI attitudes of HW and HW students



Male and female health workers improved their mean attitude scores by similar levels between pre-and post-tests. Especially female health workers from Mchinji and Phalombe improved their scores.

Male health workers increased their attitudinal score at a statistically significant level from 3.0 to 3.4 between pre and post-tests[85]. Female health workers improved from 2.9 to 3.3 between both periods, also a statistically significant improvement[86]. Whereas male health worker's attitudinal scores improved across all districts, improvements of female health workers were more pronounced in Mchinji and Phalombe. Their scores least improved in Dedza and Nkhotakota.

Figure 6. Mean score LGBTI Attitude Scale HW by District & Sex

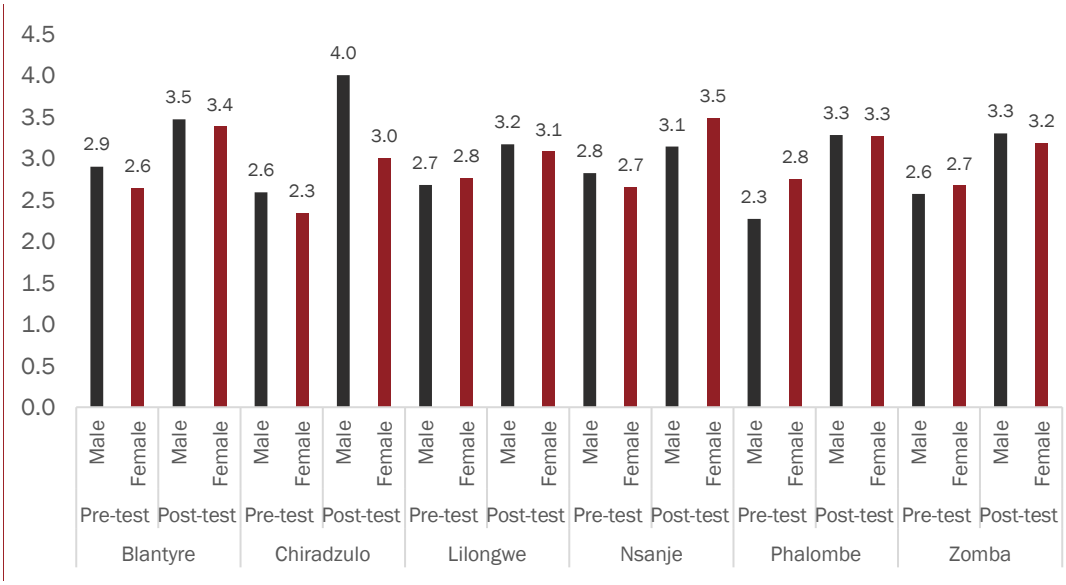


[85] Results of Indep. Samples T-Test: Pre-Test (m=3.0, sd=0.7) vs. Post-Test (m=3.4, sd=0.8), t (590) = -5.9, p<0.01
[86] Results of Indep. Samples T-Test: Pre-Test (m=2.9, sd=0.7) vs. Post-Test (m=3.3, sd=0.8), t (452) = -5.2, p<0.01

Mean attitudinal results suggest that the project improved the attitudes of male and female health worker students in all districts, especially of males in Chiradzulo and Phalombe.

Both male and female health worker students improved their attitudes towards LGBTI by a statistically significant difference, from a mean score of 2.7 at pre-tests to 3.3 at post-tests suggesting that attitudes of male health worker students were slightly better pre-workshop and after workshop compared to female health worker students' attitudes. Especially male health worker students in Chiradzulo and Phalombe improved their attitudes (see Figure 8).

Figure 7. Mean score LGBTI Attitude Scale HW Students by District & Sex



Another concern expressed by LGBTI people is a right to relevant services. Several items on the pre-, post- and follow-up surveys sought to understand knowledge items specifically for transgender and intersex people.

Image 2. The Umunthu Workshop with Health Worker Students

Health Knowledge about intersex and transgender people has improved among health workers. 64% of participants disagreed that transgender people should be forced to have psychological treatment (a change from an initial 49%) and 73% believe in corrective surgeries for intersex babies.

Prior to the workshop 73% of health workers agreed that babies can be born with ambiguous genitalia compared to 88% after the workshop. Especially female health workers (+17%) increase their knowledge on this item.

The increase in knowledge about intersex persons can be partially explained with the fact that many health workers "had never seen it" or not knowing about it, as a female health worker in Thyolo stated that "it was my first time knowing that people with two genitals exist"[87]. Others justified it saying that "they are private parts, they [intersex patients] hide them and when a person comes in a trouser or boxer you cannot know"[88]. Qualitative evidence suggests that the workshop increased the knowledge about intersex people, "my thought was that if they have two [genitalia] one becomes dormant. They use one and the other one is not functional. Through the program I realized that intersexual attitudes are influenced by both. I felt bad that I judged the creation of God in a wrong way"[89]. This resonates with another statement from a female health worker, "we thought that they were standalones but since attending the Umunthu program, we learnt we are the same and with anything that concerns their health they should be free and get help[90] as well as "we thought they had disabilities but now we assume that it is the way they are born"[91].

Analogous to the midline study, only 19% of health workers disagree that parents should be advised to carry out corrective surgery on intersex babies after childbirth. While the study observes an increase to 27% of health workers who disagree post-workshop, the vast majority still believes that parents should go ahead with corrective surgery (see Figure 9).

A male health worker from Mchinji recalled a positive example stating that "I met a mother of an intersex person. The father stressed that they should remove one of the organs [...] but the mother said no, let the kid grow so we see where it goes". In this case the parents made an impression on the health workers "to understand that when a child is born like this it is ok to let them be or let him be or let her be"[92].

However, Health Workers with negative attitude explained that they perceived intersex people as someone who has a disability[93].

The large proportion of health workers suggesting that transgender people should be forced to undergo psychological treatment could be explained by the belief that it's something "chosen", "prohibited, "childish"[94] and "opposite of the instinct of humans"[95]. While some health workers understood being transgender it being "nature", others consider transgender as being "beyond

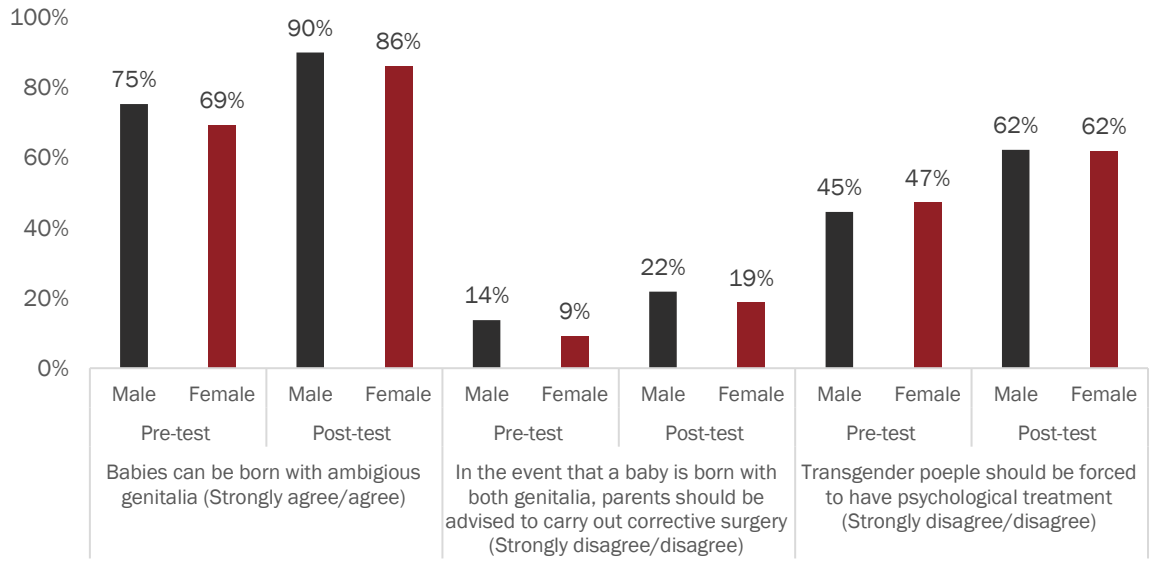
[87] FGD with HW Women, Thyolo
[88] FGD with HW not trained, Thyolo
[89] KII with HW Supervisor, Mchinji
[90] FGD with HW Women, Thyolo
[91] FGD with HW Women, Mchinji
[92] KII CSO CT 1,2,3 male, Mchinji
[93] FGD Female Health Workers- Mchinji
[94] KII with Community Leader, Thyolo
[95] FGD with HW Women, Thyolo

their will"[96] or "as a man with female hormones or a woman with male hormones and it being hard for them to choose which side they may be"[97] whereby psychological help might be considered some help in making that decision. A community leader considered the brains of transgender people "not functioning well. There is no reason they must behave like a man when they are a woman or behave like a woman when they are a man. There is a need to intervene from organizations or doctors to guide them properly, so their brain is back to normal"[98].

The results from the surveys as well as the qualitative evidence suggests the need for additional health messaging regarding intersex and transgender people. Male health workers recalled that time spent on this topic in the workshop was not enough and there was a need for "digging deeper into who these people are and why is it that they behave that way? [...] We have at least knowledge of gay and lesbians but the others? [...] How can we help if we see a person coming our way?"[99]. A community leader voiced similar concerns, "I don't really understand it because we were taught something we have never seen. I had a lot of questions. I cannot imagine how a person with both sexes would be operating"[100].

After the workshop more health workers disagreed that transgender people should be forced to have psychological treatment, an increase from 49% to 64%. More than a third still believes in psychological treatment, with some saying in the focus group discussion that they are "disabled"[101].

Figure 8. Relevant Health Knowledge of HW for Transgender and Intersex People

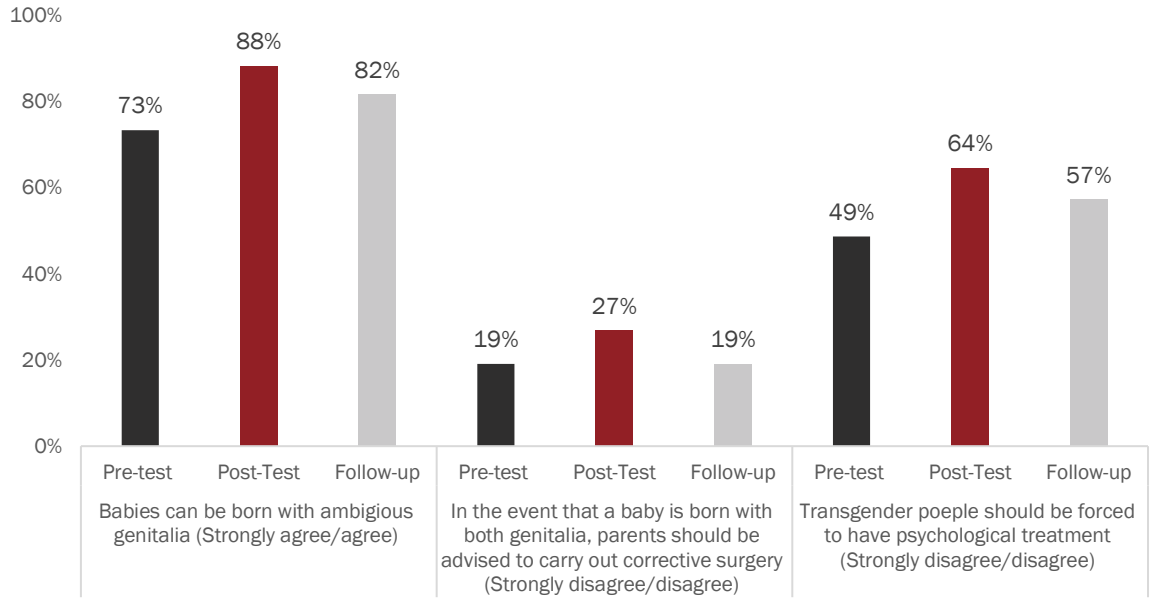


[96] KII with Community Leader, Thyolo
[97] FGD with HW Women, Mchinji
[98] KII with Community Leader, Thyolo
[99] FGD with HW Men, Mchinji
[100] Community Leader, 2, Mchinji
[101] FGD with HW Women, Mchinji

Results from follow-up tests with health workers indicate a minor longer lasting improvement on knowledge items.

Figure 10 shows the proportion of health workers at all three times of testing and their agreement or disagreement with the three knowledge items. Levels were higher than pre-tests but not as high as during post-tests. The percentage of health workers agreeing with carrying out corrective surgery was at the same level as during pre-tests, suggesting that despite knowledge improvements, cultural beliefs are stronger.

Figure 9. Health Knowledge of HW at the time of pre-, post– and follow-up tests



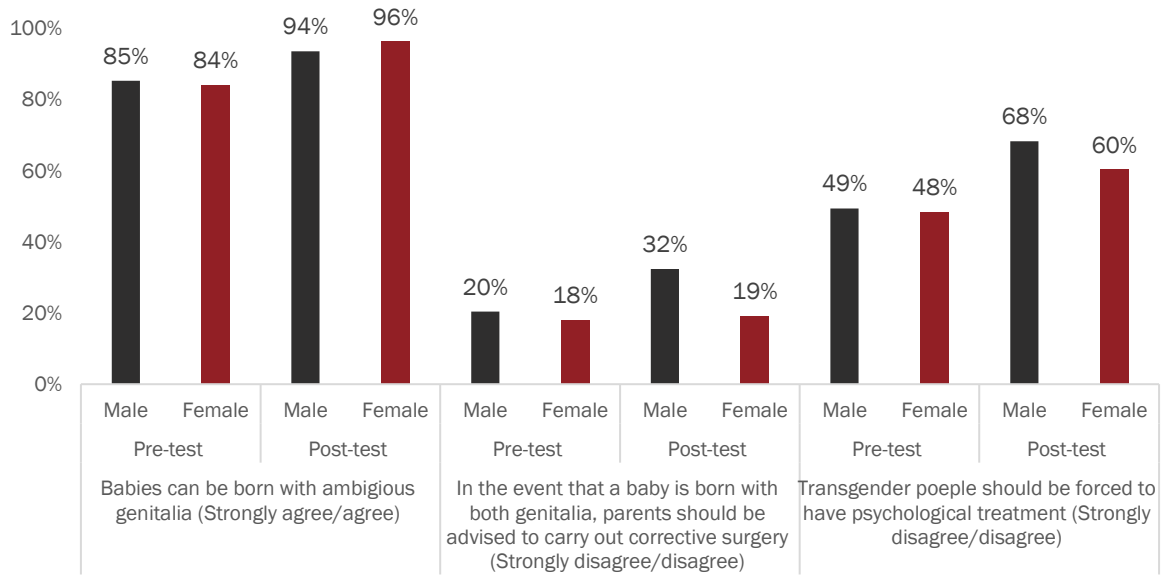
Findings for health work students were very similar with 38% supporting psychological treatments for transgender people and 80% believing in corrective surgeries for intersex babies after the workshop.

While more health worker students were aware of babies being born with ambiguous genitalia (+10%), did not support corrective surgery (+8%), or psychological treatment for transgender people (+16%), the majority still believes in corrective surgeries (80%) and a third supports psychological treatments for transgender people (38%) (see Figure 11).

In qualitative sessions, one HW explained this was because they perceived being intersex as having a disability. According to the project, Malawi is not accommodative for intersex children, so the support for corrective surgery is huge among HCW and students because they think that, without corrective surgery, they would be subjecting the child to a "*hostile, non-accommodative environment that would hinder their very growth*"[102].

[102] Umunthu Project Implementing Staff

Figure 10. Health Knowledge of HW Students regarding Transgender and Intersex People



To understand the extent to which health workers and health worker students will be likely to act on the concerns of LGBTI after attending the workshop and provide a friendly health service environment, the study uses the Theory of Planned Behaviour (TBP) to break down behavioural beliefs. According to TPB, behaviour and behavioural intentions are shaped by attitudes towards the behaviour, subjective norms, and perceived behavioural control[103].

In almost all districts, HW and HW students improved their attitudes towards providing treatment to LGBTI. Four in five agreed with providing health services to LGBTI after the workshop. Nkhotakota, Thyolo and Mchinji showed the greatest improvements. After the workshop, participants began understanding that being transgender can be in someone's nature and cannot change.

To understand general attitudes towards providing treatment to LGBTI, health workers were asked the extent to which they agree with the statement "*If I had a choice, I would prefer not to provide services to gay or lesbian patients*".

Th majority of health worker students had positive attitudes towards LGBTI persons and these number increased after the workshop and after the follow-up workshop. 70% of health workers and health worker students disagreed with the statement prior to the workshop compared to 81% after the workshop.

At the time of the follow-up workshops, 82% disagreed with the statement, suggesting that four in five health workers would provide services to LGBTI persons. The greatest improvements were observed among participants from Nkhotakota (+26%), Thyolo (+21%) and Mchinji (+20%). The least improvements were seen in Lilongwe (+3%), Chiradzulu (+1%), and Zomba (-4%).

[103]Ajzen, Icek (1991). "The theory of planned behavior". Organizational Behavior and Human Decision Processes. 50 (2): 179–211.

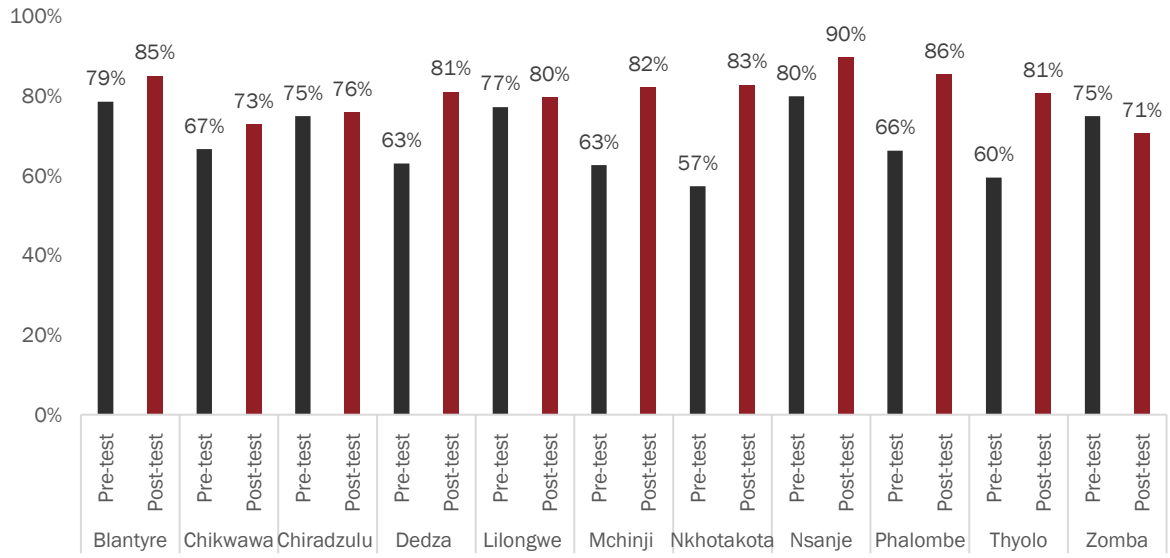
In focus group discussions, participants said that the workshop helped them realise that a person being transgender is “natural” and “cannot change”.

Participants said that before the workshop, being transgender was a choice and not considering transgender women as women: “I thought the males just loved to be a woman and they actually were doing sorts of things like women but I discovered that it is nature.”

Others expressed that it was like having a disability, “because they are in a body that does not belong to them”, suggesting health workers see it as condition where transgender persons cannot experience gender euphoria and experience, instead, additional difficulties imposed by society.

The proportion of health workers who strongly disagreed or disagreed by sex and period is shown in Figure 11.

Figure 11. HW and HW Students who disagree with "If I had a choice, I would prefer not to provide services to LGBTI patients" by district



Health workers feel pressured by social norms that discriminate or stigmatises LGBTI persons. In all districts, a the majority of health workers (60%) reported that their colleagues will judge them negatively if they speak out in favour of LGBTI rights. On the other hand, three in four health workers (73%) report that their colleagues and supervisors are concerned with improving health access of minorities.

Two items in the post-tests were used to understand subjective norms surrounding behaviour. Subjective norms can be understood as how participants believe others view their behaviour. Participants were asked the extent to which they agree with the following statements: (1) “*People who I work with will judge me negatively if I speak in favour of the rights of lesbians, gays, transgender, or bisexual people.*”; and (2) “*My colleagues and supervisors are concerned with improving the health access of minority populations*”.

Only 40% of health workers (39% male and 41% females) think that they will not be judged if speaking in favour of the right of LGBTI people. Health workers in Nsanje were most confident in not being judged (78%) followed by health workers from Dedza (57%). Health workers from Blantyre (25%) and Chiradzulu (31%) felt the least confident. At midline, the share of health workers in Chiradzulu that felt confident about not being judged upon at 8% suggesting that improvements have been made.

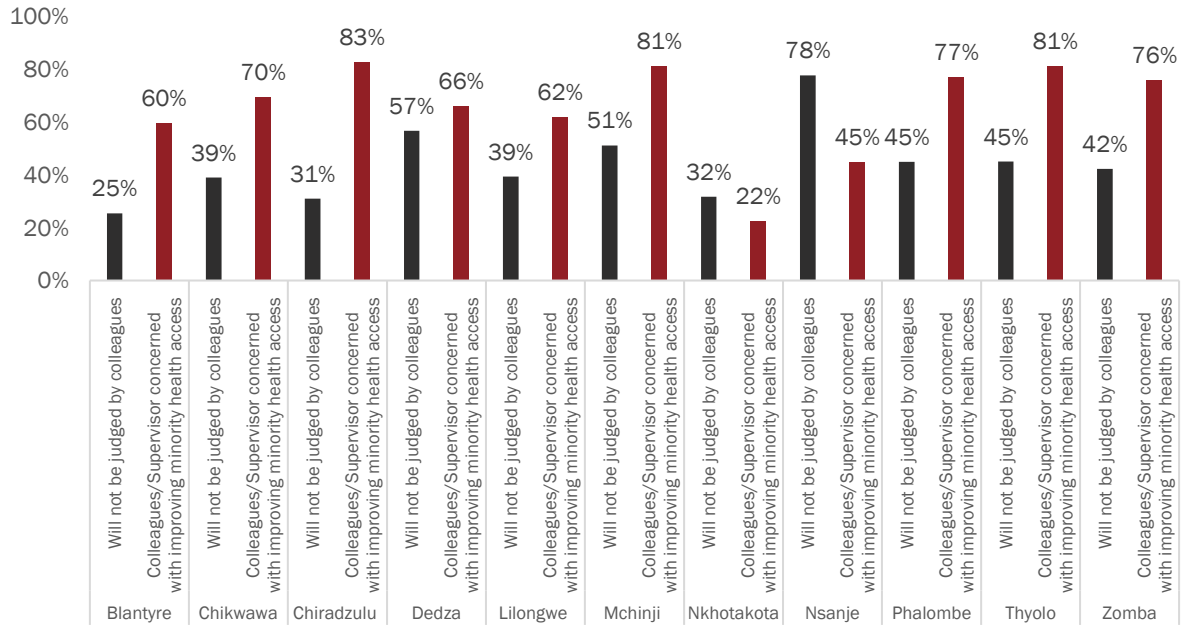
Three in four male and female health workers (73%) indicated that their colleagues and supervisors are concerned with improving access to health of minority populations. Especially colleagues in Chiradzulu (83%), Mchinji and Thyolo (both 81%) reported high levels of engagement to improve minority health access. The lowest levels were reported in Nsanje (45%) and Nkhotakota (22%).

Health workers also said their superiors who have not been involved at the workshops do not accept LGBTIs and "hate gay activities". Therefore, health workers fear that colleagues or superiors would think that they are learning "bad things"[104] or "encouraging people to be gays" and asked the project that their name as participants of the workshop should not be revealed to their superiors and colleagues. The project ensures the confidentiality of all workshops participants.

There is therefore a strong need for improved awareness in the general community and support the project's rationale of outcome 2. In interviews several stakeholders mentioned the need for more outreach activities to enable health workers to have a greater impact.

These findings also suggest that health workers are relatively constrained in the context in which they operate due to widespread beliefs in Malawi and that many are not aware or do not consider LGBTI people being part of a minority.

Figure 12. Normative belief items of HW and HW students by district (Post-Test)



[104] FGD with HW in Mchinji

Most health workers feel equipped to support the access to health for LGBTI people.

In the Theory of Planned Behaviour, there needs to be positive attitudes, social norms, and the perception that resources are available to make the behaviour happen. Perceived behavioural control refers to an someone's beliefs about factors hindering or facilitating a behaviour and an individual's perceived ease or difficulty of behaving that way.

The study relies on the extent to which participants agree or disagree with the following statements to understand perceived behavioural control:

(1) I have the necessary knowledge and skills to promote inclusive policies and practices in my health facility;
(2) It is difficult for me to actively support the health rights of discriminated populations in my day to day work;
(3) My health facility has the resources to promote inclusive policies for minority populations;
(4) I know how to provide for the health needs of lesbian, gay, and bisexual patients;
(5) I know how to provide for the health needs of transgender patients.

Health workers report to be confident about their knowledge on how to provide health services to LGBTI persons, thought fewer (but still a majority) think their clinic have the necessary resources or it is difficult for them to actively support LGBTI persons. Earlier qualitative findings point this may be out of fear of discrimination or negative judgments from colleagues or superiors.

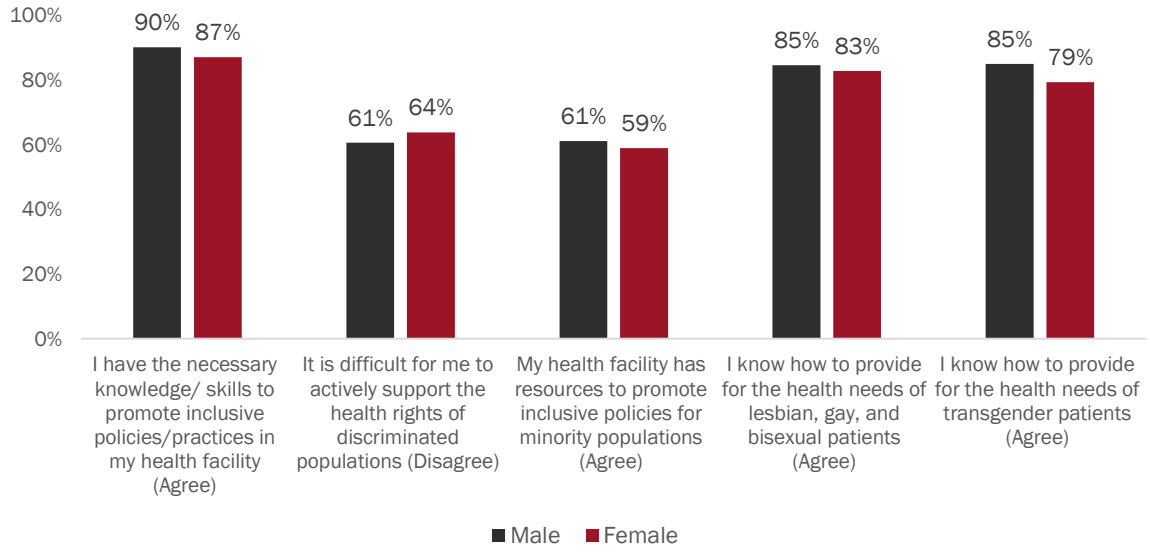
Results for male and female health workers and health worker students are largely comparable although women report slightly less degrees of perceived behavioural control across all items, except for actively supporting the health rights of discriminated populations.

Qualitative findings suggest it was an attitudinal issue, rather a perceived behavioural control issue, what drives the behaviour. Health workers said increased understanding led them to change discriminating behaviours: "*As for me it has helped me like I work at some private clinic there is a boy who is a transgender he does things like a girl so irritating. So, sometimes when I get so bored, I would be telling him that the doctor is not present. But now I understood him that, that is the way he was born*."[105]

As suggested at midline, female health workers continue to believe that they have slightly less control over their ability to support LGBTI people to access health than their male colleagues (see Figure 13).

[105] FGD with HW in Mchinji (F)

Figure 13. Perceived Behavioural Control of health workers by sex



Health care students report slightly less degrees of behaviour control compared to health care workers. This could be due to a lack of work experience and related insecurities.

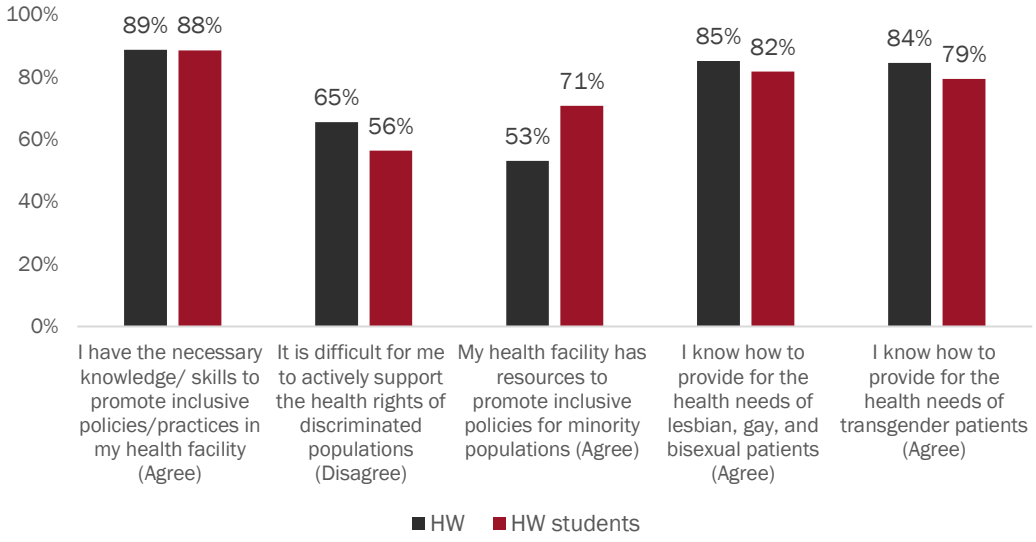
Health care students indicate having lesser knowledge to promote inclusive practices and knowing how to provide for the health needs of LGBTI.

They also find it more difficult to actively support health rights of discriminated populations.

However, they are a lot more likely to indicate that their health facility has the resources to promote inclusive policies for minority populations.

This suggests that health worker perceptions change with experience with the job.

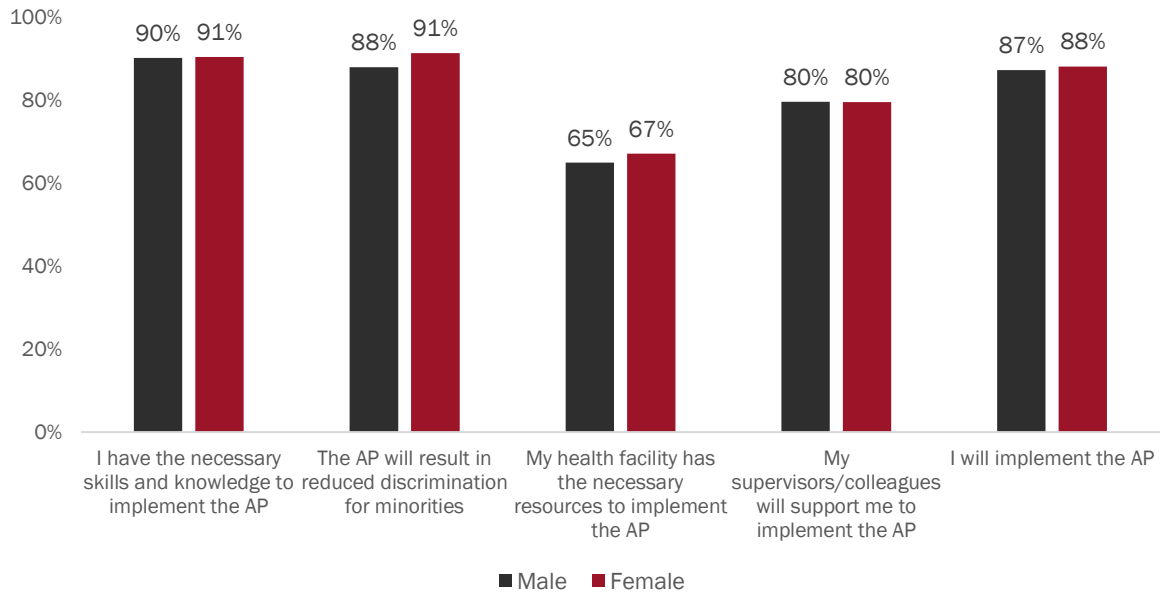
Figure 14. Perceived Behavioural Control of HW and HW students



Almost 9 out of 10 workshop participants indicated that they would implement the pledge committed to in the workshop. They believe to have the necessary skills and knowledge and support.

At the end of each workshop, participants develop commit to an action plan, also referred to as a "pledge" to improve access of minority populations to health. Results from post-tests regarding the implementation of the action plan were largely comparable between sexes with female health workers indicating to be slightly more likely to implement the action plan. Female health workers were also slightly more convinced of the action plan leading to reduced discrimination for minorities (see Figure 15). Qualitative evidence suggests that health workers face resistance implementing action plans with co-workers thinking that health workers *"are encouraging people to be free to be gays"*[106]

Figure 15. Action Plan (AP) items by Sex

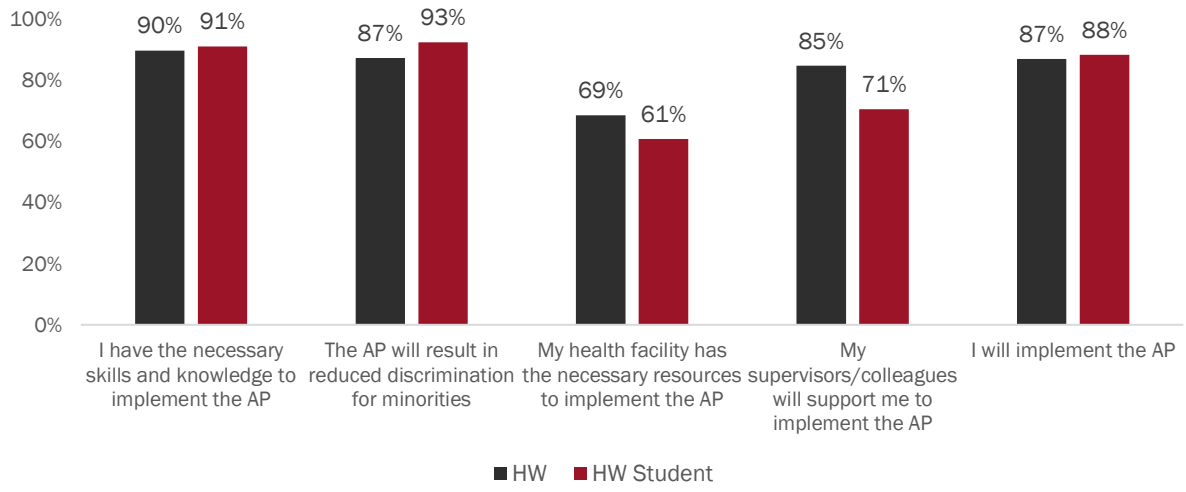


Health worker students feel similarly confident in being able to implement the action plan. HW and HW students indicate the lack of resources being the biggest barrier to implementation of the action plan.

Across items, the likelihood of implementing the action plan was similar for health workers and health worker students. About two thirds indicated that their health facility might now have the necessary resources to implement the action plan. Health worker students were less confident in terms of being able to rely on supervisor's and colleagues' support to implement the AP which could be due to their junior position at health facilities.

[106] FGD with HW Women, Mchinji

Figure 16. Action Plan Items HW and HW Students



The proportion of both male and female health workers and health worker students who were aware that they would not face legal consequences for providing treatment to LGBTI people increased after attending the workshop. Results from follow-up show that awareness levels remained slightly above pre-workshop levels in the longer term.

The workshop includes a module where a legal guest speaker is invited to clarify questions about supporting LGBTI people as a health worker. To assess the influence of this, pre- and post-tests asked health workers and health worker students whether they believed they would face legal repercussions if they provided health services to LGBTI.

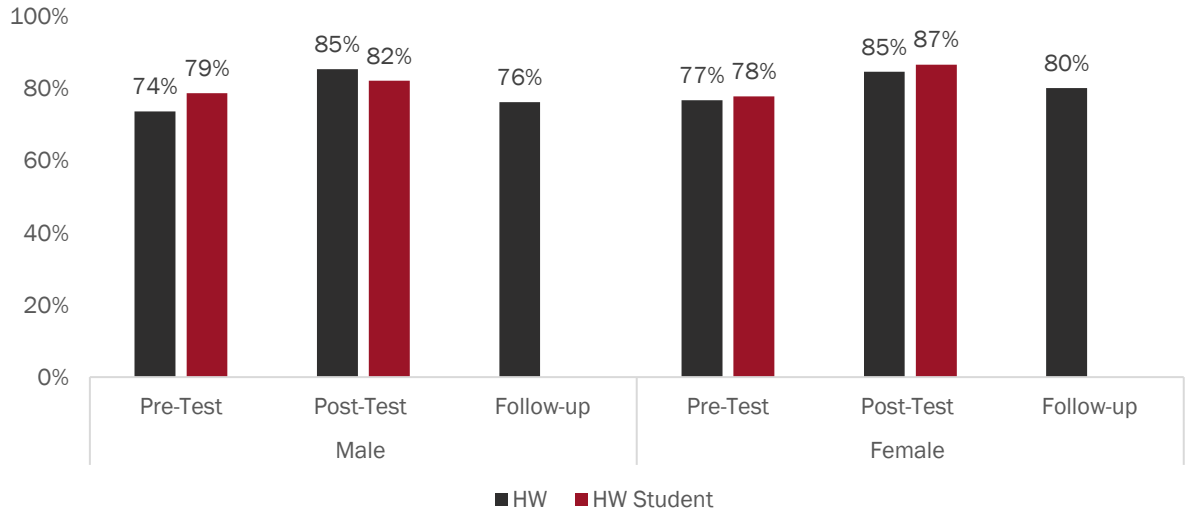
Whereas at midline, male health workers exhibited larger improvements in legal knowledge, at endline, female health workers do. In interviews participants understood that it is everyone's right to access health care. In interviews several participants recalled the sentencing of "Aunty Tiwo", a transgender woman and her partner, guilty in 2010 of "unnatural acts and gross indecency". The couple was sentenced to 14 years in prison after holding an engagement ceremony[107] but pardoned later by the president[108] and exiled to South Africa. The case drew worldwide attention as another example of the broad anti-gay sentiment in Africa.

In an interview, a female health worker even mentioned that "when we neglect a person [the patient] can go and sue us at the courts because we have sworn before starting school that we are going to help people regardless. We also help thieves whereby you would think we can just kill them, but we do our job professionally because we are not the judges"[109], "the judgement is left to religious people, police and court people but our part is to make sure that they are assisted and live a healthy life"[110] suggesting that HW face legal consequences for not providing treatment to

[107] https://www.nytimes.com/2010/05/19/world/africa/19malawi.html
[108] https://malawi24.com/2022/01/12/aunt-tiwo-goes-to-court/
[109] FGD with HW Women, Mchinji
[110] KII with HW Supervisor, Mchinji

LGBTI people. The legal perspective was also beneficial for trans people, now "knowing where to lodge a complaint" if being abused than "just to sit on the issue"[111].

Figure 17. HW and HW Students who disagree with the statement that "HW who provide treatment to LGBTI people can face legal punishment" by sex



Qualitative evidence suggests that the COVID-19 pandemic did not affect the access to health of LGBTI people.

Both health workers and LGBTI people confirmed that there was no differentiation regarding health access between LGBTI people and others as COVID-19 affected everyone[112]. The only things that were equally limiting everyone's access to medical services were preventative measures including the requirement to wear a mask[113] or certain departments having a restricted access to avoid congestion[114], as well as the fear of getting tested for COVID-19[115] and risk of getting infected with COVID-19 at the health facility itself[116].

[111] KII with Trans, Thyolo
[112] HW Supervisor – M – Thkelani; KII Trans, Mchinji
[113] FGD with HW Not trained, Thyolo
[114] KII with HW Supervisor, Mchinji
[115] FGD with HW Men, Mchinji
[116] KII with Trans, Thyolo

Has the program supported the engagement of civil society and community leaders with health workers to tackle health access disparities in communities?

The second objective of the Umunthu program is that members of the civil society and community leaders engage with health workers to discuss ways to tackle health access disparities in communities. The Art and Global Health Centre therefore invites community stakeholders, community participants including members of Health Advisory Committees to participate in the workshops. The project aims at health workers using their skills learned in the workshop to continue to consult with community stakeholders on minority health access and ensure that activities remain relevant and are supported by the surrounding communities.

9 out of 10 HW and HW students see the value in a regular dialogue with community stakeholders and want to work with them to promote the health rights of minority populations.

In post-tests participants were asked the extent to which they agreed to the following two statements: (1) Having dialogue with community stakeholders regularly can support the health access of minority populations; and (2) I want to work with community representatives to promote the health rights of minority populations.

The proportions of health workers and health worker students (see Figure 19) as well as between male and female participants (see Figure 20) strongly agreeing or agreeing with the two items on community engagement in post-tests is similar. No major differences were found across districts.

Involving community stakeholders was regarded essential to raise awareness and promote the health rights of minority populations. A curriculum expert stressed the importance of "*community sensitization [...] for people to know these people are also human beings with their dignity. They need to interact with them in whatever they do. [...] We have the problem of the legal aspect in Malawi, but it is important for people to know that [LGBTI people] also have rights*"[117].

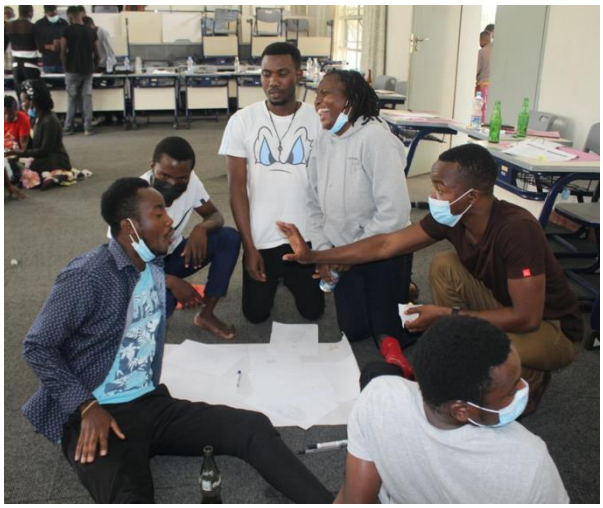


Image 3. Outreach Activity

A trans person in Thyolo shared his experience, saying that "*our villages are a challenge. [...] At my village I do not have a friend [...] I chat by myself, with my sisters or just to in the house and sleep.*

[117] KII Curriculum Expert, M-T

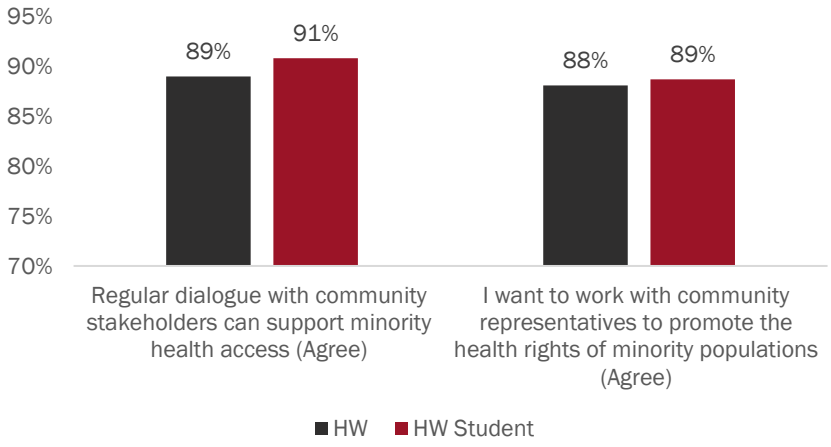
In the village we are highly discriminated"[118]. Another LGBTI person in Thyolo stressed to "*focus on the communities […] because once they become aware of your situation you become their morning tea, they mock and talk about you […]. At the clinic we are now being assisted like any other person. The great problem is in the communities"*[119].

Health workers also said their superiors and colleagues at the hospital do not share basic premises about LGBTI persons and have negative views that can be challenged through their own participation at the workshops. Targeting persons higher up in the organizational chain can also further positive normative change at health access points and improve health worker's perceived behavioural control.

Untrained health workers in Thyolo concluded the same, suggesting that "people in the community must be told. They have to know that there are minorities among us. It is not their intention but nature. People are born with different disabilities. A disability is not about physical things we can see but it can also affect your hormones which you cannot control. […] We have to accept such people be it in business, at work or at the maize mill or here at the hospital. Let's welcome them amongst us, let's love them"[120]. A problem was seen in government policies being contrary to such policies" and inhibiting such "campaigns"[121] with the LGBTI people officially not "having rights in Malawi"[122]. There is also a lack of data regarding the size and need of minority populations.

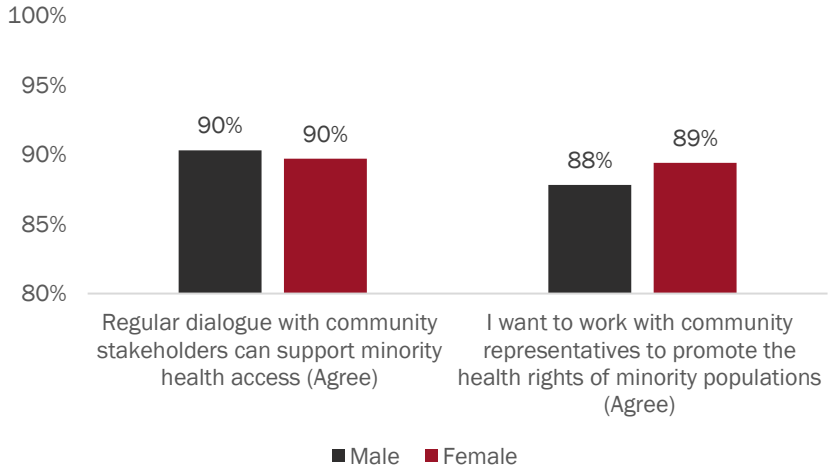
Health workers suggested to introduce referral systems within communities ensuring that people receive the best possible care closest to home. Someone who knows where to get access to drugs and where you can access to health care, "someone who by the end of the year" also knows "this year we assisted this number gays and this number of trans in total"[123]. In addition, it is important that LGBTI people within their community spread the word and "reach friends"[124]

Figure 18. HW and HW students' responses on community engagement



[118] Trans Mchinji 2
[119] FGD LGBTI Thyolo
[120] FGD with HW not trained, Thyolo
[121] Ibid.
[122] KII Trans, Thyolo
[123] KII Trans, Thyolo
[124] FGD with HW Men, Mchinji

Figure 19. Responses on community engagement by sex



The study recorded many successful instances of community leaders collaborating with health workers to tackle health access disparities in communities. At the same time, the study found cases of potential power abuses through established liaisons negatively affecting LGBTI people.

Community leaders confirmed "working well" with health workers[125] with one in Mchinji stating, "just today I was at the health facility, and we discussed a few things [...] we are working together"[126]. Another community leader mentioned that only through the project did he realize that "there is a need to be open to each other among health workers, chiefs and the community" to tackle health access disparities mentioning that he had they had a "free talk between us chiefs and health workers with the aim that the health work goes well"[127]. He continued that it in the long-term it will benefit the country's development, "because when people in the community feel free to come to the hospital and feel free to explain their problems it will help us have (...) leaders who are strong and who can help with the development of this country"[128].

He recalls that he recently took a gay person to a health facility "I escorted him regardless of the ridicule he goes through. I had to escort him because he approached me"[129]. He also mentioned how he had applied the Umunthu approach in his community by telling the story of endling a child marriage, "the girl was 16 years and was married to an old man who tested HIV positive a long time ago. We took the girl for testing, and she was HIV positive. I learned that if you don't have consciousness, you behave inhuman[130]. The community leader emphasized the helpfulness of a guide he got from the project, saying that "whenever I do my sensitizations, I normally put the

[125] Community Leader 2, Mchinji; Community Leader 1, Mchinji
[126] Community Leader 2, Mchinji
[127] Community Leader 1, Mchinji
[128] Community Leader 1, Mchinji
[129] Ibid.
[130] Ibid.

pamphlet in my diary which helps and guides me" at the same time requestion additional support from the project to implement "some of the things"[131].

Similarly, a health worker supervisor described the experiences of his fellow health workers stating that they "conduct meetings in the community and with the chiefs. I see that they have contributed to LGBTI people receiving treatment [...] and helped avoid that [...] people discriminate [the person]"[132]. Inside the health facility, they explained "fellow co-workers, clients and patients that they have to recognize that in our community there are friends who choose to be in love with fellow men [...] and we should not discriminate against them[133].

The study also found instances of community leaders not cooperating with health workers[134] or implying that through their leadership role they will put "others in the right way"[135]. A community leader described a situation of working with lesbians and health worker providers, stating that "we have about six ladies at church [...] I long for another Umunthu training so they can testify of the disadvantages of having sex with fellow ladies. I took them to the health facility where they were treated well. Now they received Jesus as their personal saviour. They are fine now. Some have since got married"[136]. One community leader who considered men having sex with men "a thing which on humanity grounds is wrong" and gay marriages "pathetic" suggested to make the "clinic aware that these people have sex. They cannot be assisted. The health personnel themselves can make a discrimination plan that they may not be assisted"[137]. Such reports suggest that there is a possibility of power abuse when linking community leaders with health care workers which needs to be carefully addressed and observed throughout Phase II.

[131] Ibid.
[132] HW Supervisor – M – Thkelani
[133] Ibid.
[134] KII Community Leader Thyolo M
[135] Community Leader 2, Mchinji
[136] Ibid.
[137] KII Community Leader Thyolo M

Has the program supported the integration of the Umunthu methodology into civil society, educational institutions or government curricula and trainings?

The third and last objective of the Umunthu project is that workshop activities will be integrated into civil society, educational institutions or government curricula and trainings. By the end of Phase I the project had conducted two Training of Trainers Workshops. The Art and Global Health Centre has planned more throughout Phase II. The objective will be reviewed in more detail during the endline of Phase II.

Umunthu conducted 2 Trainer of Trainers workshops in Lilongwe and Blantyre. Those present were from organisations that deal with LGBTIQ+ issues.

According to Trainer of Trainers, the Umunthu workshops resulted in:

The Umunthu Concept as a way to think about Inclusion

Trainers of trainers said to have mainstreamed the concept of Umunthu itself and this has helped them to mobilise others for inclusion: "*we borrowed the concept of Umunthu that highly regard the other because they are human just as everyone is. My view of people has changed for the better. The understanding has improved for the better*."[138]

The approach itself was perceived as inclusive and invited to think about inclusion in their own work: "*Inclusivity is very vital in my work where I lead discussions on post-care abortion with community members*." [139]

Some TOTs also learned the value of inclusion in the Umunthu workshop, saying that "*if they are to register success in their work then they have to include everyone*".[140]

This helped Trainer of trainers who used the knowledge from their workshop to "*discuss sensitive topics*", such as post-abortion care[141]. TOTs said that they have mainstreamed Umunthu concepts into their work to assist with the discussion of such sensitive topics and promote a more holistic view of humanity in their work.

Improved Facilitation Skills

Participants highlighted that their facilitation skills improved because they are now:

[138] FGD with Trainers of Trainers
[139] *Ibid*.
[140] *Ibid*.
[141] *Ibid*.

- ✓ TOT have become more confident when giving out presentations: "*I used to be very shy as well and this limited my level of interaction as well.*"[142]

- ✓ They have become more interactive and conversant: "*the workshop was good and it gave me the skills to be a good facilitator. I learnt that I have to be myself when facilitating but also that I have to be conversant with a topic of discussion before any activities*."[143] Another participant echoed that, "*I used to be very shy as well and this limited my level of interaction as well*."[144]

Improved Interpersonal Skills

Some TOTs also said they now approach people with more empathy and think that everyone should have something to share; not just the teacher or the more educated. They said, "*I had difficulties in approaching and interacting with people. I would present myself as a boss and that came off as being arrogant and the participants were usually reluctant to take part in the discussions. These participants were usually community leaders. I have become humble and much more aware of how I present myself and interact with participants.*"[145] Similarly, another TOT said: "*The workshop made me realize that everyone has something to share despite their level of education. That has brought so many changes.*"[146]

How to teach others about the existence of LGBTI persons and other vulnerable groups and their rights.

The concept of taking people from the *"known to the unknown"* stood out many TOT FGD participants[147]. They said, that was the element that was missing in their work and, since they adapted it, the response has improved. They said, "*these issues we facilitate have to do with mindset change so facilitating is even harder. The approach helped us to strategize how best to bring and discuss these issues openly. The aspect of taking people from the known to the unknown that Umunthu utilizes has really improved how we do our work and has helped us achieve more*."[148]

How to increase the participation of others by using participatory methodologies like drama and storytelling

TOTs learned important participatory teaching methodologies from the Umunthu workshops which they now apply in their own work: "*we no longer have boring workshops as we used to… it is what we are using right now and the participation is just vibrant*."

TOTs also said to use these methodologies in their work because they make them "*very interactive*"[149] as well as "*easier and fruitful*"[150]. They said: "*we have adapted the artistic methodologies like drama and storytelling. It opened up participants and they were able to voice*

[142] *FGD with Trainers of Trainers.*
[143] *Ibid.*
[144] *Ibid.*
[145] *Ibid.*
[146] *Ibid.*
[147] *Ibid.*
[148] *Ibid.*
[149] *Ibid.*
[150] *Ibid.*

out their opinions and it was very interactive. This is in comparison to how we would tackle same issues before and their participation was not admirable as it is now."[151] Another added that, "*we now utilize artistic methodologies like drama; forum theatre that has now encouraged and improved participation from participants. This methodology has made discussions easier and fruitful. Using drama as a medium has improved the way people understand.*"[152]

Transferring knowledge to other actors of civil society in Malawi

Trainers of trainers said to have become reference points for their colleagues at other community-based organisations (CBOs) who asked to learn Umunthu techniques; such as the Domasi Devoted Youth for Change, the Phalombe Youth Arms Organisation, and the River Of Life organisation[153].

This is confirmed by members of civil society, who perceive the Umunthu approach and teaching methodologies as highly relevant and useful to their work.

Findings from interviews with CSO participants indicate that they perceive the Umunthu approach highly relevant to their delivery systems. They appreciated the "way facilitators were facilitating", not "teaching from the front" but "Involving everyone", ensuring that "nobody was wrong or right, all the comments were good and encouraging"[154].

Image 4. Outreach Activity

A female CSO in Blantyre mentioned using the "very good and helpful skills" learned. These included "sitting in a circle", "giving exercises that everyone has to answer", "answering in pairs" or asking someone to stand up and start a song so the group would start to dance and then continue. She also gave "the opportunity to [participants] to write something in front" or "ask one of the girls to go and write for us" mentioning that "it was good because I was involving them" and making sure that "we all share the activities, and everyone can take part"[155].

The methodology was also considered useful for in tertiary education "*because learners are more motivated compared to the lecture type of class*"[156] but barriers to implementation remain, due to a large number of students and a limited time to cover the contents. The methodology was

[151] FGD with Trainers of Trainers
[152] *Ibid.*
[153] *Ibid.*
[154] KII with CSO Female (LGBTI), Blantyre
[155] KII with CSO Female, Blantyre
[156] KII Curriclum Expert, M-T

considered for covering a diverse range of topics including "palliative care, family planning or teaching GBV" [157].

Qualitative evidence suggests that the methodology is starting to be integrated into civil society, educational institutions, and trainings but the issue remains sensitive.

A curriculum expert expressed the need about "orienting students to this [LGBTI health access disparities] because they will graduate, and they will work in the communities". He mentioned that "currently there is no sensitization that [LGBTI people] are part of the community" and that the project should liaise with curriculum developers[158] to improve this.

Nonetheless, the topic of LGBTI access to health and developing an understanding of LGBTI people remains sensitive. Evidence suggests that it is difficult for participants without additional ToT training to convey contents to their colleagues or other community members. Health workers who had not been trained, recalled "[our colleagues] just explained us for a short time [...]. They were told about the science that happens in the body. There are hormones that change. Instead of being attracted to a woman you are attracted to a fellow man. Initially we thought that these people just want to be famous because they want to do things different from their friends [...] but it is their nature". They said that it was difficult to understand, and they did not fully get the "science" suggesting that these topics as well as attitudinal and behavioural change cannot be accomplished through short presentations or talks among work colleagues or community members.

The presence of LGBTI people and guest-speakers in workshops greatly contributed to outcomes.

Many participants raised the benefit of having LGBTI people participate in the workshop suggesting that it positively affected their change in attitudes. A member of the DHMT in Mchinji mentioned "It was interesting to meet a gay person and have them narrate their story to us and us having the opportunity to ask questions. This brought another level of understanding and acceptance of them [LGBTI people]. [in the workshop] we had interacted with them before they came out and that challenged our thinking in terms of stereotypes and biases we have toward such people" [159].

Guest speakers were considered "knowledgeable" and "handling questions very well"[160]. For future workshops, participants suggested to invite representatives from the police[161] to both understand their perspective and sensitize them. LBGTI people report on-going discrimination by police officers stating "there is a big change and there is no problem at the hospital now. The existing problem is with police respecting human rights and discrimination[162]. Community leaders also suggested to involving the clergy, "who discriminate other people in church which is not human at all" as well as traditional authorities[163].

[157] KII Curriclum Expert, M-T
[158] KII Curriculum Expert, M-T
[159] KII DHMT Mchinji, Male
[160] KII Curriculum Expert, M-T
[161] KII Trans, Thyolo
[162] KII Trans, Thyolo
[163] Community Leader 2, Mchinji.

Moreover, it was suggested to talk about data security and privacy, sensitizing participants regarding issues of "leaking photos with wrong captions" that will result in people judging you[164]. Lastly, the privacy of the venue was considered critical with one trans gender participant recalling "there was a motel, garden boys, guards were passing by so they could hear what we were discussing and told people. During lunch the news that there were such people was all over […] At a certain rest house they refused to accommodate us. We were two. They said no, you want to be doing such. They had all the information. If they did not have had the information, they would not have denied the two of us to sleep there"[165].

[164] KII with CSO Female, Blantyre
[165] KII Trans, Thyolo

Chapter 5: Lessons Learned and Recommendations

1. The concept of “Umunthu” with its approach of “humanity” being interpreted as “helping everyone regardless of status and “LGBTI people being the way they are because God made them like this” is an accessible and understandable construct and helps integrate people who are critical because of religious beliefs as well as people being able to apply the concept not only in health care but also in other aspects of life.**We recommend to continue promoting Umunthu as a mechanism for attitudinal change in domains that share similar outlooks, as it is the field of health, where there is a universal claim to it.** Umunthu has also the advantage of being a shared construct amongst Malawians, which makes the concept suitable for attitudinal change in communities as well.

2. For Umunthu to become widespread and produce a change in social norms, health workers should be able to speak about that they learned from the workshop with their colleagues or superiors. However, health workers fear to speak in favour of improved health services for LGBTI persons out of fear of being perceived as LGBTI and therefore being discriminated against. LGBTI persons said they have lost employment because of who they are.

   Therefore, we recommend that workers’ superiors from health care facilities, are invited to participate in the Umunthu Workshops. This is because health authorities should create an environment where health workers can communicate about patient’s needs without taboos or risks to their confidentiality. Programmatic action should therefore concentrate on sensitising health workers superiors, who can in turn protect health workers from discrimination at work resulting from their advocacy of LGBTI health rights. Trainers of Trainers can work with health authorities and share knowledge learnt from the project.

3. Health workers who participate in the workshop report to preserve the confidentiality of participants and have more acceptance of LGBTI persons. However, LGBTI persons said that health service delivery has many people involved. This includes nurses, doctors, and pharmacists, some of whom may not have attended the workshop and could therefore break the chain of confidentiality; disclosing LGBTI persons’ information in the community and putting them at risk.

   We recommend inviting unit heads to participate in the workshop or engaging them through trainers of trainers to strengthen their knowledge on how to preserve the confidentiality of participants. If done with all units, confidentiality may be preserved through the full triage for each patient and therefore improve health outcomes, such as adherence to treatment.

4. There were other suggestions made LGBTI persons on how to improve the confidentiality of health services including **(1) having one patient a time; and (2)**

renaming rooms with more neutral terms; for example, not an "STI treatment room" but rather "Case Management Room" or similar. These strategies are subtle but impactful ways to preserve the confidentiality of patients.

5. **Continuing or increasing use of participatory or artistic methodologies improved the learning experience of workshop participants.** These methodologies were praised by participants, who called it interactive and participatory. Participatory methods that were referenced as useful by Trainers of Trainers included drama and storytelling. These methods are being reproduced by TOTs in their own practice and transferred to other CSOs.

6. **Continue inviting guest speakers and involve LGBTI persons in the workshop.** Guest speakers were considered knowledgeable and well prepared by workshop participants. This is because direct involvement with LGBTI people, hearing their stories and being able to ask questions was perceived as very "authentic". It was suggested to include representatives of the police in the workshop (as participants) since legal issues remain and there is a need for sensitization.

7. Workshops were useful in strengthening the knowledge on intersex and transgender persons. In many instances they were perceived as having a disability or persons who will necessarily experience a tough life. However, they have a right to assert their gender and it is not doing so what leads them to difficulties. **Therefore, we recommend adding sensitivity training on how to speak about transgender and intersex persons, if not providing an overview of the health services that are offered to them in more advanced development settings and should be offered in Malawi.**

8. Sensitization of communities is crucial to achieve long-lasting impact giving that normative change is necessary to end the discrimination and stigmatisation of LGBTI persons. A start has been made but further outreach needs to be done (through ArtGlo as well as community leaders, CSOs, chiefs etc.). **Consider engaging even additional community and religious leaders in workshops due to their influence (also for ToT workshops).**

9. Feedback systems are an important mechanism for change because they ensure that facilities stay relevant to patient's needs. **Support the establishment or strengthening of feedback systems in health care facilities whilst also promoting their use.** This can be done through feedback boxes or exit surveys, through the use of signs at the facility, radio, and community leaders. **Work with ombudspersons so that they are responsive and work towards institutional change.**

10. The legal situation remains a barrier in Malawi as it inhibits campaigns and justifies discriminatory attitudes and actions. There is also a lack of data regarding the LGBTI community in Malawi, which makes it difficult to advocate for in a policy setting. **We recommend to work institutional actors such as donors, NGOs and CSOs, sharing information on the relationship between health outcomes and human rights and working with the government of Malawi to update health training manuals and curricula.**

Chapter 6: Conclusions

The study finds that the program influenced health workers' understanding of LGBTI persons and supported them to provide more accessible services. Findings show that health workers are now more accepting of LGBTI persons and believe that it is important to provide appropriate care and treatment to them. There are improvements in confidentiality though gaps exist when they share information with colleagues who have not participated in the workshop, who then break the chain of confidentiality in the community. This still discourages LGBTI persons to attend. Health workers are also more open to feedback and some created mechanisms for anonymous feedback provision at their clinics.

However, the largest obstacle to health service provision remains in negative social norms about LGBTI persons in the community or at the health clinic. Health workers fear that, by openly advocating or teaching their colleagues or superiors about the existence of LGBTI persons, they would be discriminated themselves by their colleagues or superiors. LGBTI persons said that, while improvements have been made, they still fear discrimination in hospitals, the community, and police and are discouraged from seeking health services. Attitudinal change was therefore most powerful amongst workshop participants. In some instance, the project was successful at engaging community leaders which drove change and, in some instances, protection from abuse.

However, negative social norms still prevail, showing the need for more sensitization work in Malawi, concentrating also in clinics and hospitals.

While health workers and students agreed that the content and curricula of the Umunthu project is highly relevant, promoting better health service provision for LGBTI persons remains sensitive and still not mainstreamed in teaching curriculums. They mentioned that the knowledge is needed and should be mainstreamed into civil society but without additional Train of trainers training, this would be difficult to achieve. CSOs who have used the methodology said they derived important skills from them, such as workshop exercises that allow everyone to participate in a meaningful way.

By sharing a concept of "togetherness" and through its innovative workshops, the Umunthu programme was able to share important knowledge about LGBTI persons with health workers and community leaders and change their attitudes as a result. However, strong negative attitudes make issue difficult to advocate for, both in communities, clinics and civil society. Notwithstanding, the methodology has set in motion a process for larger normative change, as these processes take time and require more individuals to change their own attitudes. This evaluation therefore highlights the importance of taking programmatic action such as Umunthu has done. In many communities, the programme has been the only mechanism for positive attitudinal change towards LGBTI issues in health access points. This was already felt by LGBTI persons who said that, without the Umunthu programme, the situation would be much worse. While gaps exist, the Umunthu programme has been an important stepping stone for improving health access and acceptance of LGBTI persons in its areas of implementation.