IMPACT PROGRAM

JULY 2014

HIV Programming Comes of Age

The Malawi experience of co-locating HIV and livelihoods programming

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARVs	Antiretroviral medications
C-SAFE	The Consortium for Southern Africa Food Security Emergency
CBO	Community-based Organization
CGV	Care Group Volunteer
DFAP	Development Food Assistance Program
DHS	Demographic and Health Surveys
FFP	USAID Office of Food for Peace
GoM	Government of Malawi
HTC	HIV Testing and Counseling
HIV	Human Immunodeficiency Virus
HSA	Health Surveillance Assistant
IMPACT	Integrated (HIV effect) Mitigation and Positive Action for Community Transformation
M&E	Monitoring and Evaluation
MNCH	Maternal, Newborn and Child Health
MoH	Ministry of Health
NAPHAM	National Association for People Living with HIV and AIDS
NGO	Non-Governmental Organization
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PSP	Private Service Provider (for VSL methodology)
TQC	Technical Quality Coordinator
USAID	United States Agency for International Development
VSL	Village Savings and Loans
WALA	Wellness and Agriculture for Life Advancement

GLOSSARY

Agribusiness groups: A group of 15 to 25 farmers, organized with the purpose of receiving training in farming as a business, collective marketing, and improved production practices. Also known as marketing clubs.

Care Groups: The Care Group model is used throughout Malawi, as well as other countries, to deliver community-based peer counseling on Mother and Child Health and Nutrition (MCHN)-related issues. Care Group volunteers (CGVs), also known as 'lead mothers/fathers', are assigned 10-15 neighboring households and use training modules to guide them on improved infant and young child feeding (IYCF), child care techniques and water, sanitation and hygiene (WASH) practices. Communities select CGVs for their leadership skills, literacy skills and knowledge of health and nutrition.

Co-location: The locating or situating of two or more programs (or projects) within the same geographic area. Co-location on its own does not necessarily guarantee integration. Instead, successful integration relies on several factors. See "Improving Co-location" section for details.

Community Health Days (CHDs): Popular one-day events organized by IMPACT partners to showcase activities and new methodologies. Edutainment conveys messages about HIV, health, nutrition or community issues, and HIV testing and counselling is conducted on-site.

Health Surveillance Assistants (HSAs): Salaried employees of the Ministry of Health who provide primary health care. They are intended to serve as a bridge between facility and community and are responsible for preventive health as well as select curative health services.

HIV exceptionalism: The idea that the HIV and AIDS require a response above and beyond "normal" health and development interventions. Exceptionalist programming strategies are defined here as those that prioritize the targeting and recruitment of PLHIV and/or create special, often parallel, programming for PLHIV. Historically referred to as "AIDS exceptionalism."

Irrigation groups: Self-selecting groups that work together to ensure sustained operation and maintenance of a jointly managed irrigated area. An elected management committee (or irrigation water users' committee) is guided by the group constitution. The number of members varies depending on the size of the irrigated area.

Normalization: A concept derived from the field of disability that counteracts the tendency to separate certain groups of people and treat them differently, aiming instead to provide inclusive life experiences. In the context of HIV, normalization responds to the phenomenon of "HIV exceptionalism" by calling on development programs (in selected contexts) to begin to scale back the exceptional measures originally taken to ensure inclusion of PLHIV.

PLHIV support groups: The support group mechanism provides moral and psycho-social support, delivers training and capacity building and provides a voice for PLHIV within their communities and nation-wide. While support groups do exist in urban areas, their strength, numbers and influence are much greater in rural areas. As of March 2014, Malawi's National Association of People Living with HIV (NAPHAM) had 1,578 PLHIV support groups with a membership of 84,472. There are many more throughout the country that are not affiliated with NAPHAM.

Producer groups: Groups of approximately 20 farmers who meet regularly to disseminate technology and extension messages. Groups are led by lead farmers and learn about contextually-appropriate techniques to improve production, including integrated pest management, plant spacing, post-harvest handling techniques and a range of topics related to conservation agriculture.

Village Savings and Loans (VSL) groups: Self-selecting groups of 10–30 individuals who purchase shares in the group, which makes micro loans ($5–$50) available to members. With access to this capital, group members may purchase agricultural inputs and inputs for other small businesses.

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MISS INDIA

EXECUTIVE SUMMARY

Integrated HIV, food security and livelihoods programming has been an aspiration pursued by NGOs, donors and host-country governments for more than a decade with varying degrees of success. While the conceptual logic behind integrated programming has been obvious for decades, the "how to" of combining the requisite resources has been less so. Due to its exceptional circumstance of geographic overlap between HIV burden and food/livelihoods insecurity, Malawi is the only country where co-location of the United States President's Emergency Plan for AIDS Relief (PEPFAR) and USAID's Food for Peace (FFP) resources has taken place at scale.

This study looks at co-location through two CRS-led community-based programs, the Wellness and Agriculture for Life Advancement program (WALA), a five-year (2009–2014), $81 million FFP/Title II program that works to improve nutrition and livelihoods and the Integrated HIV Effect Mitigation and Positive Action for Community Transformation (IMPACT), a four-year (2010–14), $13 million PEPFAR-supported program designed to improve the well-being of orphans and vulnerable children (OVC) and enhance access to treatment and care for PLHIV. Both programs implement many of their interventions through support to community structures and formation and strengthening of community groups such as care groups; VSL groups; Producer, Irrigation and Agribusiness groups and PLHIV support groups.

This study examines the bi-directional effects of two co-located programs to determine the following: 1) how IMPACT delivers benefit to WALA, e.g., communities gain access to HIV services; and 2) how WALA delivers benefit to IMPACT, e.g., PLHIV gain improved access to livelihoods opportunities. Importantly, the study delves into the influence of stigma, discrimination and self-stigma as potential barriers to participation in WALA activities. Finally, it questions the ongoing necessity for HIV exceptionalism as a targeting/ programming strategy in Malawi's current context.

Among the findings, this research suggests that there is still a widely-held view that PLHIV have inferior health and physical strength compared to non-PLHIV. Although some individuals present for HIV treatment late in their infection (and are therefore ill) and episodic illness remains, PLHIV who participate in WALA fervently disputed the opinion that they are frail or lacking in physical stamina, contending that they are frequently healthier and physically stronger than other members of their communities. WALA activity leaders concurred, noting the many PLHIV in WALA

leadership roles.

The vast majority of barriers cited by PLHIV were not HIV or stigma related. Instead, poverty, lack of self-confidence, risk aversion, illiteracy and lack of land topped the list. The only two HIV-related barriers were self-stigma (self-imposed feelings of being incapable or unworthy) and health concerns during the early stages of antiretroviral therapy (ART).

Focus group participants in all four study districts articulated a significant decline in stigma and discrimination over the past decade, which calls into question the ongoing necessity for HIV exceptionalism as a programming and targeting strategy. Using the VSL groups as a platform for that exploration, this study found that while separate/parallel VSL programming (for PLHIV) is not imperative, PLHIV-only VSL groups do provide extra protection and comfort to more marginalized PLHIV, allowing them to experiment with new activities in a less threatening environment. The findings support advancing efforts toward "normalization" while acknowledging the value of providing extra, perhaps temporary, assistance to "more vulnerable" members of any group, irrespective of their HIV status.

Fortuitously, this research revealed an exceptionally qualified cadre of PLHIV who now, after more than two decades of training and exposure to learning, have the potential to become a tremendous resource for their communities. The findings from this study challenge the development community to leverage PLHIV support groups and position PLHIV to train, lead and capitalize on their abilities, expediting the development of the Malawian communities where they reside.

Finally, this study concludes with lessons learned for future co-location or integration efforts, as well as suggestions for ensuring PLHIV inclusion, HIV mainstreaming and HIV normalization in the current funding environment, where complementary HIV wraparound funding often is not available.

INTRODUCTION & BACKGROUND

INTEGRATED PROGRAMMING

Integrated programming is development programming that intentionally designs and implements HIV interventions alongside nutrition, food security, agriculture and/or livelihoods interventions in a way that improves the programmatic outcomes of each. Non-governmental organizations (NGOs), donors and host-country governments have advocated for integration of programming for more than a decade.

The earliest rationale for these efforts was illustrated via the "Vicious Cycle of Malnutrition and HIV" in 1999 (Figure 1). The Cycle demonstrated the devastating impact of HIV on nutrition (and vice versa) and the consequent need to address both simultaneously. In later years, the Cycle was expanded to consider the broader impacts of HIV on food and nutrition insecurity (Figure 2) as well as agriculture and livelihoods (Figure 3).

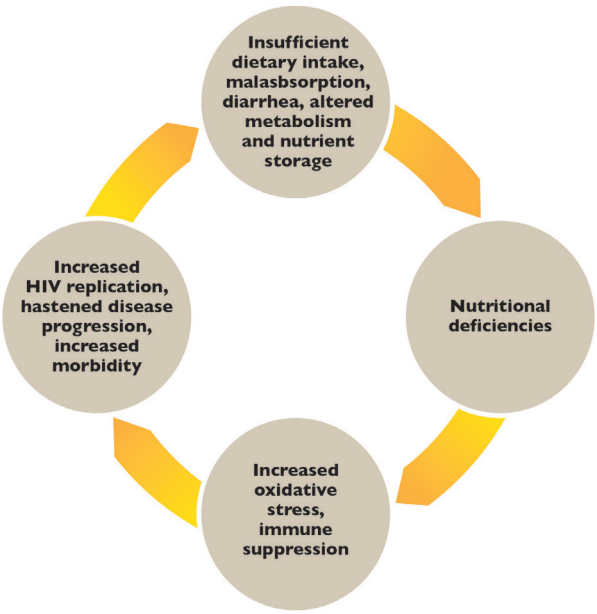

FIGURE 1
The Vicious Cycle of Malnutrition and HIV, Semba and Tang, 1999.

These and other frameworks typified intentions to illustrate the interaction between HIV, nutrition, food security and livelihoods, with an eye toward designing programs that could address the inherent challenges these interactions produced.

Early progress culminated in Durban, South Africa, where participants at the 2005 International Conference on HIV/AIDS and Food and Nutrition Security presented their research findings and called for expanded efforts to mainstream HIV into all development programming.

The following year, HIV and food security front-line practitioners hosted a conference entitled Africa Forum 2006: An Integrated Response to the Dual Epidemics of HIV and Food Insecurity, bringing together field practitioners from 20 countries to share what they had learned since the onset of the

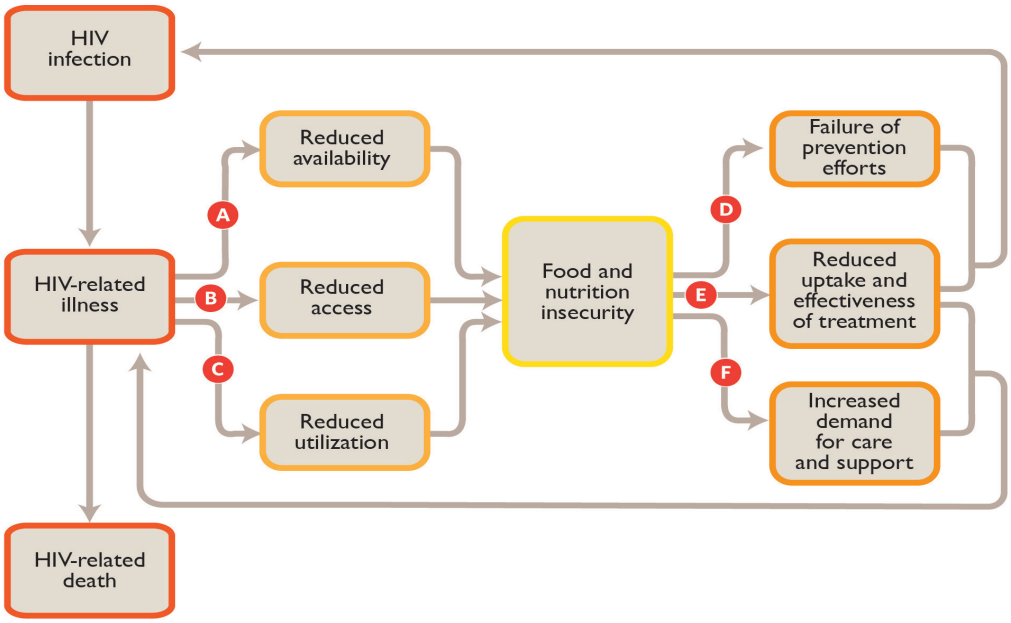

FIGURE 2
The bi-directional influence of HIV and food & nutrition insecurity on OVC, Greenblott and Greenaway, UN World Food Program, 2008.

pandemic. Importantly, participants called on donors to bring an end to siloed funding mechanisms so that truly "integrated" programming could become a reality.

The question remains: With the resolute call for integrated programming more than 10 years ago, why is the development community still struggling with how to effectively program for dual outcomes?

Co-location of PEPFAR and FFP-Title II programming

While the conceptual logic behind integrated programming has long been obvious, the "how to" of combining the requisite resources was less so. Despite the long-understood benefits of integration and the dangers of single-sector, or siloed, programming, efforts to achieve seamless programmatic integration, at scale, have fallen short of the mark.

In the early 2000s, so-called "hybrid" Food for Peace (FFP) contracts were assembled to combine HIV funding with Title II resources and allow for the first large-scale attempts at integrated programming under USAID. The Leadership and Investment in Fighting an Epidemic (LIFE) Initiative and the Consortium for Southern Africa Food Security Emergency (C-SAFE) were two such examples, with LIFE covering Kenya, Malawi, Rwanda and Uganda (2000–2004) and C-SAFE covering Zimbabwe, Zambia, Malawi and Lesotho (2002–2006).

After 2006, hybrid contracts were no longer available to FFP, but with the advent of PEPFAR (2004) it was hoped and even expected that PEPFAR and FFP would co-program in countries where they both had a presence. However, collaboration between programs funded by these two specialized sources has proven more difficult than expected.

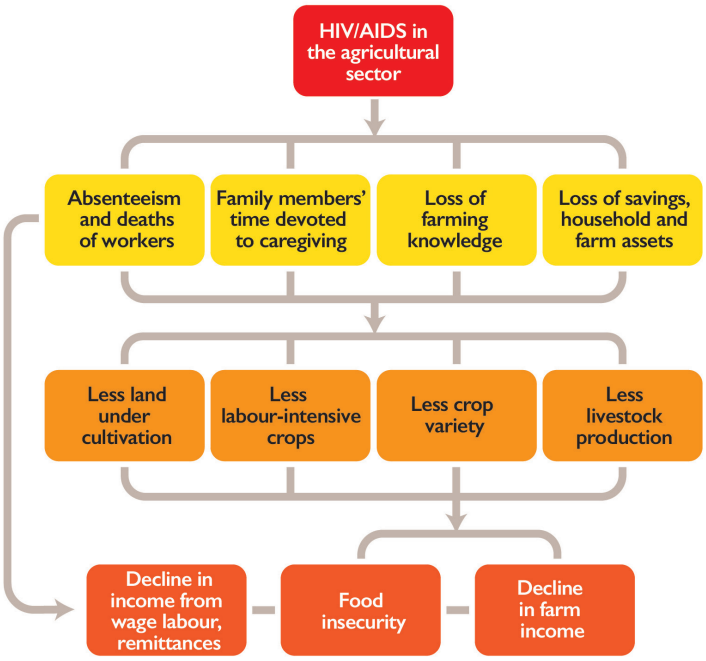

FIGURE 3
Conceptual Framework for the Impact of HIV on Agriculture.
UN Department of Economic and Social Affairs, 2004.

In 2007, USAID FFP and PEPFAR produced the HIV and Food Security Conceptual Framework. The paper described efforts to address the nutrition and food security needs of PLHIV and HIV-affected families, along with the challenges that the two agencies faced in trying to co-locate programs.

> [FFP] aid has not been targeted at HIV-infected individuals in clinical settings—with the exception of some of the more recent WFP programs—nor have the resources necessarily been programmed in conjunction with PEPFAR programs to maximize program synergies. One of the main reasons for this is that P.L. 480 Title II programs are mandated to focus on areas with the highest food insecurity prevalence, which tend to be rural, whereas the majority of HIV clinical treatment, care and support services tend to be clustered in urban areas, where HIV prevalence is higher (USAID Bureau for Democracy, 2007).

It should be noted that powerful models and success stories for integrated programs do exist, using US Government (USG) and other bi-lateral and multi-lateral donor funding. Within the realm of USG-funded programs, this integrated, or "wraparound," programming occurs mainly by creatively mixing and matching from a portfolio of funding mechanisms, including development assistance monies, country-specific mission funds, NGO private funds and Feed the Future monies. However, the originally-intended large-scale wraparound programming using FFP and PEPFAR resources has not come to fruition, except in Malawi.

Malawi as the exception: Co-locating PEPFAR and FFP-Title II resources

Despite rapid urbanization, the vast majority (85%) of Malawi's population resides in rural areas (DHS, 2010). Although urban HIV prevalence is twice as high as rural

rates (17.4% versus 8.9%), the urban/rural population distribution translates to 78% of PLHIV residing in rural areas and 69% of PLHIV living in the Southern Region (Malawi Office of the President and the Cabinet, 2009).

As in many countries, food insecurity in Malawi is more acute in rural areas, and the southern region has been hardest hit. In 2009, given this exceptional circumstance of geographic overlap between HIV burden and food/livelihoods insecurity, both PEPFAR and FFP targeted the same area: Malawi's southern region.

The programmatic outcome of joint targeting is the co-location of the PEPFAR-funded Integrated HIV Effect Mitigation and Positive Action for Community Transformation (IMPACT) program and the FFP/Title II-funded Wellness and Agriculture for Life Advancement (WALA) program.

In order to frame this examination of co-location, the study looks at the bi-directional benefits of co-location as depicted in Figure 4, looking at 1) how IMPACT delivers benefit to WALA, e.g., communities gain access to HIV services; and 2) how WALA delivers benefit to IMPACT, e.g., PLHIV gain improved access to livelihoods opportunities.

Study methodology

To better inform future HIV targeting, the study focuses only on PLHIV and does not look at households supporting OVC, although these are also a beneficiary group of IMPACT. Figure 5 represents the specific IMPACT and WALA entities that were examined in the communities visited.

This qualitative research relied on focus groups and key informant interviews as its primary data collection methodologies. The study leader conducted a literature review on HIV-sensitive targeting, HIV exceptionalism and stigma and discrimination prior to field work. The study leader also conducted interviews with USAID staff to understand the history of co-location of PEPFAR and FFP resources.

The team collected data in four of the seven districts where the IMPACT and WALA programs are co-located: Chikwawa, Zomba, Mulanje and Balaka. A total of 20 communities were visited to conduct a total of 35 focus groups and nine interviews with community members. In addition, researchers held seven focus groups and 17 interviews with staff from IMPACT, WALA and other stakeholders (Annex 1), including the following:

- PLHIV support group members who were involved in WALA activities as well as those who were not
- Care Group volunteers (CGVs); VSL private service providers (PSPs); and the leadership and members of VSL, Producer, Agribusiness and Irrigation groups (PLHIV and non-PLHIV in all groups)
- Health Surveillance Assistants (HSAs), IMPACT's Expert Clients, ART staff at health facilities and district health officers (DHOs)
- Village Headmen and Group Village Headmen[1]

1 A Group Village Headman is the traditional leader for a grouping of villages

IMPACT and WALA: Co-located

WALA: WALA is a five-year (2009–2014), $81 million FFP-Title II program. As a follow-on to two consecutive FFP programs (C-SAFE and I-LIFE), WALA intentionally went beyond the previous focus on MCHN, food security and safety nets to include a broad portfolio of livelihoods and resilience building activities, working to establish and strengthen VSL, Producer, Irrigation and Agribusiness groups. WALA Care Groups are central to the MCHN component, and aim to change behavior on a range of health and nutrition practices. The design of WALA interventions assumed the bi-directional benefit of co-location with IMPACT.

IMPACT: IMPACT is a four-year (2010–2014), $13 million PEPFAR-supported program designed to improve the well-being of orphans and vulnerable children (OVC) and enhance access to treatment and care for PLHIV. The mother-infant pair program and use of Expert Clients for tracing treatment defaulters are critical features of this program. IMPACT was intentionally located and programmed as a complement to WALA interventions, bringing OVC and HIV services to communities already engaged in WALA activities, as well as communities in three non-WALA areas.

CRS is the prime grantee for both programs, working with consortium members Africare, Emmanuel International, Project Concern International, Save the Children, World Vision and the Diocese of Chikwawa in the districts where the programs are co-located. Outside of the co-located districts, IMPACT works with three additional partners (the Catholic Health Commissions of Dedza, Lilongwe and Zomba) and brings the technical expertise of the National Association of People Living with HIV in Malawi (NAPHAM), D-tree International and Opportunity Bank of Malawi to each operational area. Similarly, WALA works with Total Land Care and brings the technical expertise of ACDI-VOCA to each operational area.

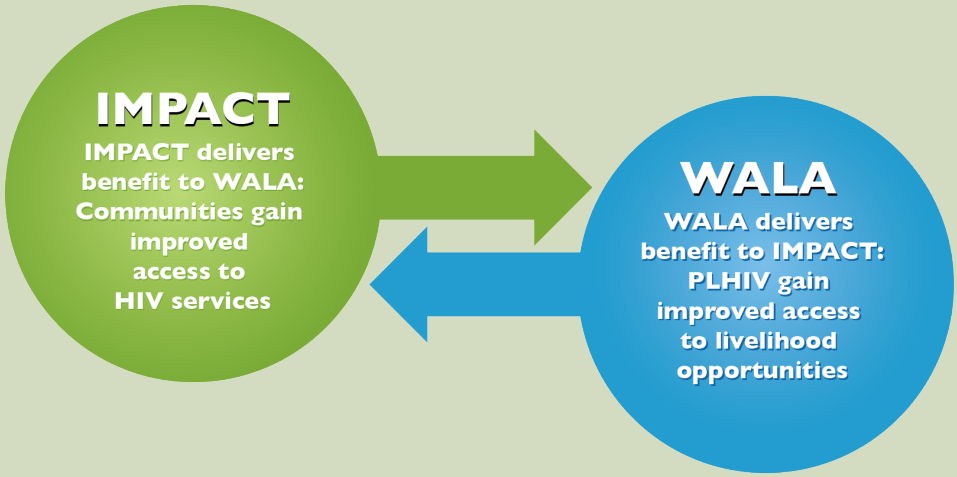

FIGURE 4
Bi-directional benefit of co-location

- NAPHAM leadership and district coordinators
- IMPACT and WALA managers and field staff
- Malawi Network of People Living with HIV (MANET+), Lilongwe
- UNAIDS, Lilongwe

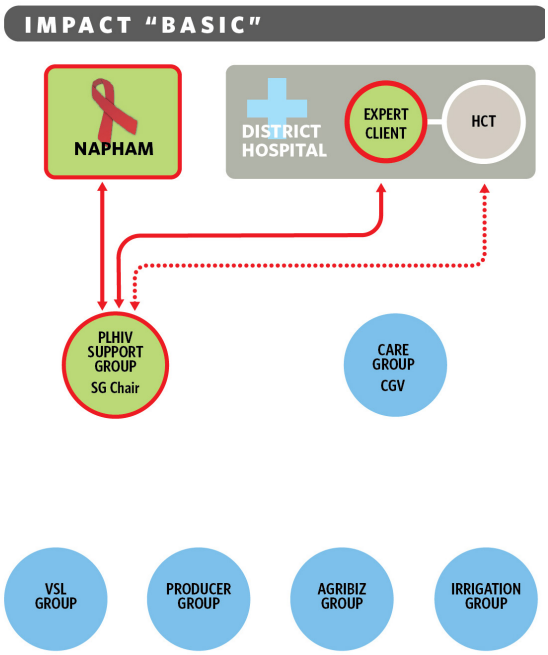

FIGURE 5

This study used "PLHIV support group members" as a proxy for all "PLHIV." Use of this proxy, as with all proxies, comes with its limitations. It should be understood that as a group, PLHIV who belong to support groups are, by virtue of their membership, more open about their HIV status. They may have different experiences and viewpoints (in relation to the research questions) than PLHIV who have decided not to disclose their status and therefore could not be included in the focus groups.

Research limitations

This research focuses exclusively on rural Malawi, where support groups have played an influential role in bringing services to PLHIV and rolling back stigma, self-stigma and the psycho-social effects of being diagnosed with the disease. Findings are not necessarily generalizable to Malawi's urban and peri-urban settings, particularly since support groups are not found as commonly in those areas[2].

Furthermore, the data collected is purely qualitative. No attempt is made here to empirically assess levels of participation or the quantitative extent to which HIV services have been delivered to communities. Finally, since only five communities were visited in each district, it is not possible to make district-wide comparisons.

2 According to NAPHAM M&E Officer Eric Matiti, "Membership in a PLHIV support group is more common in rural areas in Malawi for two reasons: 1) In urban areas people have more access to information on HIV and AIDS through newspapers, magazines, radio, TVs, internet and hospitals, whereas in rural areas people rely on information from their peers; and 2) In rural areas most people own their shelters, draw free water from communal points, grow their own food and fetch firewood from the bush for cooking. While rural populations have some cash needs, urban dwellers generally rent their houses and pay for everything. By necessity, they prioritize activities that earn them income (to pay for these things) rather than participating in support groups."

STUDY FINDINGS: CO-LOCATION WORKS

PLHIV GAIN IMPROVED ACCESS TO LIVELIHOODS ACTIVITIES

In all four study districts, PLHIV spoke enthusiastically about their involvement in the various WALA activities and the benefits of participation. Though the two programs (IMPACT and WALA) did not collect data to illustrate this, one PSP[3] from Zomba reported that 142 of 470 VSL members under his purview were PLHIV. Similarly, Emmanuel International staff in Machinga estimated that approximately 80% of support group members in the
WALA catchment areas participate in VSL groups, and many belong to VSL groups that had been established within the PLHIV support groups.

The VSL, Producer, Agribusiness and Irrigation groups all utilize a self-targeting approach. The WALA NGO partner for a given district conducts sensitization meetings with the entire community, explaining the eligibility criteria, process for group formation and likely benefits of participation. Community members then form their own groups and capitalize on the activities. Community Health Days, which brought WALA and IMPACT programs together to showcase products and approaches, were extremely popular.

PLHIV support groups serve as a springboard for WALA inclusion: In one community in Mulanje, an Irrigation group technician had visited the local support group, presented the activity and invited them to join. This resulted in relatively higher participation of PLHIV in that community than in others. Two lead farmers interviewed also used this intentional recruitment of PLHIV[4] with similar results.

WALA demonstration plots can be positioned for high PLHIV traffic: In Machinjiri, the Producer group placed a demonstration plot at the district hospital, alongside the ART clinic. The location was intentional; the aim was to encourage PLHIV to participate by demonstrating the successful cultivation of these crops in a location that is frequented by PLHIV. Training and sensitization on conservation agriculture and growing nutritious foods is conducted at the site.

3 PSPs assist with the start-up of VSLs and guide them toward organizational and financial health. They are privately contracted by the VSL groups themselves.
4 Lead farmers are Producer group leaders whose role is to share with their group members learning on improved production and crop handling techniques.

MEGAN COLLINS FOR CRS

Women in a PLHIV support group enjoy their successes in agricultural production.

Barriers to participation

In order to understand the barriers to involvement and how they were overcome, the researchers conducted focus groups with PLHIV who actively participate in VSL, Producer, Agribusiness and Irrigation groups. Those PLHIV were compared and contrasted with those who do not participate. Interestingly, the majority of the barriers cited were not HIV or stigma related (see Table 1). The two HIV-related barriers that were mentioned were self-stigma and health/physical strength.

PLHIV who were active in WALA activities insisted that health was in no way a barrier to full and effective participation in livelihoods activities.

Self-stigma: PLHIV who are active in WALA attributed non-participation of their fellow PLHIV to a belief that they are not capable or worthy of participating because of their HIV status, and fear that non-PLHIV won't want them involved. They fear being mocked and gossiped about or laughed at, and they fear having their status revealed. PLHIV active in WALA characterize these individuals as having not yet reconciled their serostatus, but they believe that with time, inactive PLHIV will shed the burden of self-stigma and engage fully in life and livelihoods.

PLHIV engaged in WALA further explained that self-stigma is eventually overcome with disclosure and increased exposure to PLHIV in circumstances similar to their own who have participated and experienced the much desired benefits. Often a mentor/mentee relationship develops spontaneously in the context of support groups and results in the less-confident member joining a livelihoods group. Stigma and self-stigma are discussed further later in this report.

Health and physical strength: The majority of non-PLHIV interviewed still believed that PLHIV have inferior health and physical strength relative to non-PLHIV, and that this is a barrier to full participation in livelihoods activities. In the context of VSL groups, non-PLHIV commented that PLHIV might have trouble repaying their loans if they become ill and can't maintain the business ventures that they had launched with their shares. With regard to Irrigation groups, many thought that

Table 1: Participation in WALA activities: Non-HIV-specific barriers and solutions

	Barriers	Solutions suggested by interviewees
Poverty	There is an inability to pay the initial joining fee and/or the purchase of initial shares.	Many did piece work to earn enough for initial cash outlays. Others said that a friend helped them pay the initial fee. PSPs explained that VSLs are specifically designed to help people at all socio-economic levels, including the very poor (e.g., some groups start with share minimums of 50 or 100 kwacha [US$0.13–$0.25]).*
Lack of self-confidence / risk aversion	Also described as "shyness," and "fear of the unknown," this was a common reason for non-participation. Several were afraid that if they had a problem making a payback, they might go to jail, or "something bad" might happen to them.	Individuals lacking self-confidence or who are risk averse are encouraged to participate by seeing someone in similar circumstances participating effectively and reaping the benefits. Mentor-mentee relationships are helpful toward this end.
Lack of education / literacy	Literacy is required for leadership roles but not for membership. However, it is helpful to be able to read and write to take notes on issues related to the group and techniques learned.	Some suggested that WALA could offer literacy courses or connect participants with an NGO or CBO that focuses on literacy.
Lack of interest	Informants referred to members of this group as "born not interested in doing things with their lives."	Showcasing the benefits and gains achieved by others in their same circumstances may convince some to experiment and try getting involved.
Land ownership	Lack of land was cited as a barrier for Producer, Agribusiness and Irrigation groups. PLHIV either did not own land, or they believed that their plot was not large enough to participate. Some also believed that their soil had too much clay and was not worth cultivating.	Land constraints were the most commonly cited barrier to participation in the Producer and Agribusiness groups. PLHIV who were active, however, explained that this barrier can be overcome by "borrowing" a portion of land from a larger landowner. Some paid a small rental fee, either up front or upon sale of produce. Those without land could also request temporary or permanent use of a plot from the Village Headman, the custodians of the community's land resources. Village Headmen interviewed said that they were accustomed to granting land to their more vulnerable subjects for growing crops.
Fertilizer	Although WALA does not advocate the use of synthetic fertilizer, many interviewees believed that it is essential to cultivating their land.	Interviewees suggested more showcasing of WALA agricultural outcomes while advocating the use of organic fertilizer/ composting.
Too busy	Some interviewees noted that they were simply too busy with other things, including caring for family. Others said that belonging to the support group and a maximum of one other group was all they could manage.	Showcasing the benefits and gains achieved by others in the same circumstances may convince some to experiment and try getting involved.
Annual entry only	For the VSL and Producer groups, new members can only join at the beginning of the annual cycle. Producer group leaders (lead farmers) said it would be difficult for new members to join partway through a cycle since lessons build on one another.	Interviewees suggested creating more frequent entry points in the curriculum.

* The WALA final evaluation noted that "The one general reason that people might not be able to take part is extreme poverty. There is a need for members to save regularly and there are examples of both 1) people who are too poor to make payments and therefore join groups, even those with very low-priced shares, and 2) people who have ended up leaving groups when they found they could not make the payments. The solution to this does not lie within the VSL system however, since people cannot save what they do not have. It would be more appropriate to address it through measures for addressing destitution."

intermittent illness and lack of physical strength might impede the full participation of PLHIV in their communities.

Non-PLHIV Irrigation group participants in Mulanje explained that when irrigation tasks are too difficult for some PLHIV, they are assigned "light tasks" such as weeding, mopping the drain and watering grass. They suggested that PLHIV could hire laborers to cover the heavy tasks at the start of the irrigation projects, then resume handling tasks once the workload is lighter. If they didn't have the money to hire laborers, the other group participants would help them instead.

"When I see someone just like me being successful, they can show me the way."

—PLHIV support group member, Chikwawa district

In direct contrast, when PLHIV themselves were interviewed, health was only cited as a barrier for those who were not adhering well to their ART regimen, or had only just started antiretrovirals (ARVs) and had not yet adjusted. Those PLHIV who had already been active in WALA activities insisted that health was in no way a barrier to full and effective participation in livelihoods activities. This opinion was seconded by many of the lead farmers who had instructed PLHIV members in their Producer groups. One lead farmer commented that some of the PLHIV in Producer groups are healthier and physically stronger than most other farmers in their community.

As noted in Table 1, the primary barriers to participation were not HIV-related. These barriers included poverty, lack of self-confidence, illiteracy, lack of interest, lack of land, etc.

Recommendations

Use support groups as the default entry mechanism: Support groups are a natural point of entry for inclusion of PLHIV in livelihoods activities and should be considered the default entry mechanism. Intentional visits to support groups by lead farmers, PSPs, VSL chairs and leaders of Agribusiness groups would help to encourage more PLHIV to join and break down participation barriers, especially those around self-stigma. This seems an obvious way to engage more PLHIV; however, it was only done by a few of the leaders interviewed. If resources are limited, this dissemination work could be done with the help of the NAPHAM district coordinator.

Guide marginalized PLHIV: Create a mechanism for identifying, mentoring and providing additional guidance to those more marginalized PLHIV (and more marginalized members of society in general) who are not sufficiently equipped or self-confident enough to join livelihoods activities and participate due to the host of reasons listed in Table 1. This could take the form of a PLHIV champion within a livelihoods group (e.g., a VSL group vulnerability champion) or a person external to the group (e.g., a kind of social worker) who provides extra support and guidance to more vulnerable members of society, helping them to engage in and extract the full benefits from future livelihoods activities.

Establish VSL group policies to cover health: In order to protect an individual (PLHIV or non-PLHIV) who falls ill or suffers an injury, VSL groups should consider including a protective clause in their constitutions, similar to those in place regarding death of a member. Policies might also encourage the use of social funds to assist the family of the sick member. This was noted in many groups but is not systematically encouraged.

SARA FAJARDO/CRS

IMPACT's facility-based Expert Clients provide adherence and positive living advice.

Strengthen referrals: Referral mechanisms between ART clinics and livelihoods activities need strengthening. In particular, there is a need for increased collaboration among Expert Clients, health promoters, CGVs, HSAs and livelihoods leadership. Community referral lists posted in HSA offices should be updated to include livelihoods opportunities and entry points. Regular coordination meetings should be held to ensure more active referral of patients to relevant livelihoods activities. From the interviews with these stakeholders, it was not clear that referrals were happening systematically or, in some cases, at all.

Where IMPACT Expert Clients are working intentionally with WALA Care Groups, PLHIV inclusion is normalized, and knowledge around management of HIV infection is improved.

COMMUNITIES GAIN IMPROVED ACCESS TO HIV SERVICES

WALA's MCHN component utilizes the Care Group methodology—used widely throughout Malawi and the region—to change behavior around health and nutrition practices. HIV messaging has been incorporated into relevant modules, and IMPACT complements these efforts by promoting access to HTC and improving retention in care through the deployment of facility-based Expert Clients and improving community-based PMTCT care[5].

What works

Expert Clients improve HIV service uptake and retention: District hospital staff and HSAs in all of the districts lauded the role of the IMPACT-supported Expert Clients, in particular for their achievements in retaining patients

5 To improve the retention of HIV-positive pregnant women in PMTCT care, IMPACT supports the training of HSAs according to the Ministry of Health's Mother-Infant Pair (MIP) guidelines. The guidelines outlines all of the services necessary to achieve maternal wellness and HIV-free survival of HIV-exposed infants, from the earliest point in pregnancy until the infant is two years of age. IMPACT, with technical support from D-tree International, has introduced a mobile phone application to support adherence to the MIP guidelines.

in the continuum of HIV care and treatment. They also suggested that the Expert Clients' role in counseling newly diagnosed patients has restored confidence and renewed motivation and hope for the future. Similarly, anxiety, shame and other forms of self-stigma, which impede uptake and adherence to ARVs, is reduced. Where IMPACT Expert Clients are working intentionally with WALA Care Groups, it is likely that PLHIV inclusion is normalized and knowledge around management of HIV infection is improved.

Community Health Days expand access to HIV testing and counseling (HTC): IMPACT's Community Health Days were cited in all four districts as a resounding success in terms of bringing HTC and HIV education to the communities and equally in terms of bringing livelihoods activities to PLHIV. Expert Clients noted that they typically ran out of testing kits on HTC days, indicating the significant demand created by bringing testing to the villages. Community Health Days have become a popular part of WALA-IMPACT programmatic integration.

HIV-positive CGVs provide community-based PMTCT support: Where the WALA CGVs happened to be HIV-positive, they demonstrated themselves to be exceptionally capable in their roles. CGVs living positively with HIV have benefitted from optimal prenatal, antenatal and post-natal care; they have been educated and counseled by IMPACT Expert Clients and Ministry of Health (MoH) service providers; and they have received training via their membership in support groups. As a result, they are adept at helping HIV-positive mothers (especially the newly diagnosed) to regain their health and to understand and adhere to PMTCT protocols. Similarly, they assist HIV-negative mothers and families in staying healthy and HIV-free.

IMPACT's Love Letter initiative increases couples' testing: Creative strategies to promote male attendance at antenatal care (ANC) and couples' testing for HIV are needed to mitigate PMTCT adherence challenges. IMPACT's "Love Letter" strategy provides pregnant women with letters to give their husbands or

DON CRAFT FOR CRS

Community Health Day dramas promote the value of early HIV testing.

MEG LANGLEY FOR CRS

Couples that attend ANC together undergo HIV testing together.

partners, explicitly inviting the men to escort them to the next ANC visit. Once at ANC, couples have the opportunity to receive counseling and HIV testing together. They are both counseled on healthy pregnancy and delivery as well as PMTCT tasks and benchmarks, and they are encouraged to bring children at home for HIV testing as well. In the first six months of implementation, 2,500 pregnant women received Love Letters. Of the women who received a letter, 33% returned to the next visit with their husbands, a noteworthy increase over the baseline of 7%.

HIV-positive CGVs provide much need guidance to newly diagnosed mothers

CGVs in Balaka explained that each had several HIV-positive mothers in their Care Groups. Since the majority of CGVs are HIV-negative (or of undisclosed serostatus), they can only provide guidance to the HIV-positive mothers based on their training, but they can't speak from experience. Those who are HIV-positive themselves can offer their own experiences, reflecting on the processes they went through to regain and maintain their own health. Their experience is complemented by all they have learned about health, immune function, nutrition and other topics in their support groups.

HIV-positive CGVs saw themselves as role models not only for the HIV-positive mothers in their Care Groups, but also for HIV-negative mothers who saw how happy and healthy the HIV-positive CGVs were. HIV-negative mothers have said, "If she who is living with the virus can do these things, surely I can also do them."

Barriers to access

Test kit supply and HTC staffing: In Zomba, ART staff noted that the combination of sensitization campaigns, Community Health Days, and the work of Expert Clients and support groups had been so successful in creating demand for testing that the facilities struggle to maintain a sufficient supply of test kits. HTC staff claimed people sometimes waited weeks and even months beyond the six-week deadline for testing exposed infants due to test kit stock-outs. When test kits became available, patient s often waited in long queues, and many were eventually turned away when kits ran out. According to the HSAs in Zomba, the limitations of the HTC counselors are an additional bottleneck; they spend part of their day conducting community outreach; in the remaining few hours, they receive at most eight patients.

Men are difficult

Women, every day we are able to express ourselves.
You men, we encourage you to go for HTC
You should get tested like we do.

But men are difficult
Men are difficult

We encourage women to go
We encourage men to go
Every day, we explain to men to go for HTC.

But men are difficult
They are difficult.

— Song written by women support group members about their efforts to get their men to test.

Insufficient mainstreaming of HIV into livelihoods curricula: WALA district-level and field staff felt that more could be done to mainstream HIV messaging into the curricula of the core WALA activities. Of those groups, only the Care Group curriculum was intentional about including HIV-related information. Furthermore, several of the HIV-positive CGVs thought that the curriculum should be updated and augmented, adding information about testing, family-centered care, coping with a HIV diagnosis and ART. According to lead farmers and PSPs interviewed, they are often encouraged by WALA staff to integrate HIV-related messages into their work. Unfortunately, they are not given sufficient guidance on how to do this and, in particular, what messages to integrate beyond "know your status."

Men and testing: Across the board, requests were made for IMPACT (and other programs) to do more about motivating men to get tested, to disclose their status, to escort their wives to the clinic for antenatal visits and to be more compassionate and accommodating when their wives test positive.

Tackling stigma

In all four districts visited, interviewees (both PLHIV and non-PLHIV) reported dramatic declines in stigma and discrimination over the past decade. Evidence of this decline in stigma includes the following:

- Marriages between discordant couples increasingly remaining intact; in some cases, young couples are getting married despite one member of the couple being HIV-positive.
- In many cases, HIV-positive women continue to have children, relying on PMTCT protocols to avoid vertical transmission. In the past, an HIV diagnosis was seen to be the end of child-bearing for a woman.
- Where someone dies of an HIV-related illness, the cause of death is more

routinely stated as such at the funeral. Just five years ago, HIV or AIDS would never have been mentioned due to the shame it would bring to the family.

The decline in stigma was partially attributed to the dramatic increase in ART access over the last decade (since 2004 in Malawi), which has literally changed the face of HIV. PLHIV are no longer "thin and covered with sores on their skin." Instead, non-PLHIV can see that "people with HIV are just like them." The fact that HIV is no longer a death sentence was identified as a major factor in the decline of stigma.

As one might predict, respondents named the high prevalence of HIV—16.5% in the southern region of Malawi—as a contributing factor to the stigma's decline. Most families (or extended families) have at least one member currently living with HIV, and many of these family members are living healthy and productive lives. Other factors seen to contribute to the decline in stigma include the following:

- Support group members cited their ability to report (or threaten to report) incidents to the Village Headman as a deterrent to discriminatory behavior. In response to requests from support groups, and facilitated by NAPHAM, most villages now have by-laws used by Village Headmen to fine or punish anyone conducting discriminatory behavior. Examples of punishments include making a verbal apology, various forms of public service, payment of small livestock and fines ranging from 1,000 to 5,000 kwacha (US$2.50 to $12.50).
- Vigorous sensitization campaigns were conducted by NAPHAM, IMPACT, WALA, the government of Malawi (GoM) and many NGOs and CBOs. NAPHAM, in particular, is credited for being at the forefront of stigma reduction. Songs, dramas and testimonials by healthy PLHIV were cited as particularly effective. They deliver messages about getting tested and showing that PLHIV are just like everyone else. It was noted that drama "touches people's hearts and helps them to think differently."
- Related to the above, the modes of transmission are now generally known, and myths have been de-bunked.
- Mainstream churches have shifted their messaging from referring to PLHIV as sinners and outcasts to calling them "people who deserve love and compassion like all God's children." Churches also preach that only God has the right to judge and, by extension, that discrimination is wrong.

"Stigma is a much smaller problem for us these days. It's not completely gone but nowadays, our members are open about their status and medical needs. For us, telling someone we are going to collect our ARVs is equivalent to saying we are stopping at the dispensary for malaria drugs or Paracetamol."

— PLHIV Support group member, Balaka district

Finally, support group members articulated the importance of being involved in development activities, not just within the group but also in the community at large. They felt that allowing people to see them making a contribution like everyone else was essential to shifting how people view PLHIV and to the process of normalization.

Self-stigma

While stigma and discrimination have generally declined, self-stigma is still problematic and was raised as an issue in all four districts. Self-stigma refers to the

process whereby people living with HIV impose on themselves feelings of difference, inferiority and unworthiness.

In addition to being cited as a barrier to participation in livelihoods activities, support group members felt that self-stigma also prevents newly diagnosed PLHIV from joining support groups and seeking help in other ways. Despite the strength, unity and growing memberships of the PLHIV support groups, there are many PLHIV who (according to group members) are still "too shy" to join. They are afraid that people from the community will point at them and laugh or mock them despite the fact that this stigmatizing behavior rarely happens anymore.

Discussions with Expert Clients were particularly revealing with regard to self-stigma. They noted that the phenomenon is most prevalent during the early stages after learning that one is HIV-positive. They see it occur frequently among newly pregnant young women who are tested as part of antenatal care. The Expert Clients noted that for many, these young women begin to accept their diagnosis only when they come into contact with other PLHIV who have knowledge and confidence.

When newly-diagnosed pregnant women learn they are HIV-positive, they are often filled with fear, shame, and self-blame. They are advised to go home and disclose to their husbands, and to bring them for testing. A number of them, however, don't return.

Interviews with PLHIV across the four districts revealed that there are several groups among whom levels of self-stigma remain exceedingly high: students (of all ages), village leadership (Village Headmen and Group Village Headmen), church leaders and the wealthy and the working classes (including HSAs and hospital staff).

When the community facilitator, HSA or Expert Client follows up, they learn that they have not told their husbands for fear of divorce or an angry response. Some of these women never come back until they are ready to deliver, and at that point they are very weak." —Expert Client, Project Concern International/NAPHAM, Balaka district

Expert Clients noted that these groups are more likely to collect their ARVs from the clinic before or after hours or to travel to distant clinics to avoid being recognized. Expert Clients in Balaka said that they only knew two out of the more than 100 HSAs in IMPACT's catchment area who had disclosed their status publicly. They explained that those who have something to lose (e.g., a job, social status or influence) are less likely to disclose their status.

Recommendations

Retain Expert Clients: Urgent efforts should be made to retain the Expert Clients in their current role beyond the life of IMPACT, maintaining a 50/50 gender ratio as nearly as possible. Given their vital role in guiding the newly diagnosed and mitigating default, finding a host organization/agency with long-term funding should be considered a priority.

Promote testing and PMTCT accompaniment for men: Greater and more creative efforts should be made to promote testing among men and to encourage their participation in PMTCT. Men who have tested and who have accompanied their wives through PMTCT should be used as role models for other men. IMPACT's Love Letter initiative was noted as an effective, scalable innovation.

JAKE LYELL FOR CRS

At the Tigwirane Manja support group, good health and productivity is grounded in ongoing nutrition education and reliable social support.

Leverage village leadership: Train Village Headmen, Group Village Headmen, church leaders and other influential village leaders on HIV-related issues, including: 'know your status," timely access to treatment and the benefits of disclosing one's HIV status. Importantly, Village Headmen who have disclosed publicly (e.g., joined support groups) are a largely untapped resource. There are only a few in each district, but they can be identified with NAPHAM's assistance.

Encourage PLHIV to pursue leadership positions: PLHIV should be encouraged to pursue CGV positions and other leadership roles in livelihoods groups and community health and development committees. This would enable communities to capitalize on investments already made in these individuals' knowledge and skill development. Also, positioning PLHIV in contributory roles erodes the stereotype of PLHIV always being on the receiving end of assistance. According to support group members, this plays an important role in normalization and stigma reduction. Care should be taken, however, to resist offering preferential treatment in the selection process. Perceived favoritism or exceptionalism can provoke envy and resentment toward PLHIV, which will manifest itself as stigma and discrimination.

Use PLHIV "champions" in livelihoods groups: Establishing PLHIV champions within each VSL, Producer, Agribusiness and Irrigation group would not only serve to improve participation of more marginalized PLHIV but would also expand uptake of HIV services for communities, since these "champions" would sensitize and educate all members of those groups on issues related to HIV and encourage all group members to be tested. Many PLHIV interviewed explained that by reaching out to others to offer support, they have benefitted through a hastened recovery from self-stigma and loss of self-esteem. This is further discussed in the section, "Stepping Up: From Personal Recovery to Serving Communities." Informal use of PLHIV champions is already happening spontaneously on a limited basis, and it could be instituted systematically throughout the program to yield results at scale.

Mainstream HIV into livelihoods curriculum: Unless HIV messaging is

specifically written into the curriculum, it is unlikely that it will be comprehensively (and appropriately) covered by the trainers or leaders in that sector. Importantly, ensure that nutrition messaging is built into agriculture programming, and continue to include labor-saving technologies and kitchen gardens under Care Groups. Technical staff and support group members alike applauded these interventions.

Provide HIV training for livelihoods leadership: As part of the previous recommendation, further training on HIV, how to talk about it, and what messages to prioritize should be done with the leadership of each livelihoods group. VSL chairs, lead farmers, PSPs and other livelihoods group leaders said that WALA encourages them to do more, and they would like to do more, but they didn't know exactly how to follow through. NAPHAM and PLHIV support group members should be considered valuable resources.

"When people see someone who is healthy and productive with HIV, this has the greatest impact in how they view PLHIV more generally. Being healthy and strong as a PLHIV and confronting stigma head-on is the best way to address stigma."

—PLHIV support group member, Chikwawa Diocese/NAPHAM, Chikwawa

Increase HTC/HIV sensitization events: Increase the frequency of events that bring HTC and HIV education to communities. Provide opportunities to test, talk about testing and disclosure and educate the community more generally. Misconceptions (e.g., mosquitos transmit HIV) and misinformation (e.g., prayer overrides the need for ARVs) should be addressed at these events. The need for regular re-testing and child testing should be reinforced. NAPHAM and PLHIV support group members should be considered a valuable resource toward these efforts, not only for testimonials, dramas and songs, but also in terms of organizing and leading such events.

MANAGING CO-LOCATION

USAID Malawi's 2013–2018 Country Development Cooperation Strategy is based on Three Cs: Co-location, Coordination, and Collaboration between the various donors, development partners and interventions. In particular, interventions funded by PEPFAR, Feed the Future, Food for Peace (FFP) and the Global Health Initiative aim to be co-located "to the extent that is feasible" in particular focus districts. This section provides recommendations on how to maximize the benefits of co-location of PEPFAR and FFP. However, the concepts are widely applicable to co-location in general, whether by one or multiple organizations.

Management recommendations that would maximize the benefits of co-location include the following:

1. Apply a joint theory of change: IMPACT was designed and implemented several months after WALA. The separate design process meant a joint theory of change or strategy for integrated HIV and livelihoods programming was never developed. For truly integrated programming, organizations should conceptualize the goals and objectives of integrated programming (possibly using the bi-directional conceptual framework proposed in this paper), and then develop strategies and interventions toward the achievement of those goals and objectives. Coordination at donor level is needed to release the call for proposals simultaneously or facilitate joint thinking between organizations to enable agreement on a joint theory of change/strategy and integration of goals/objectives.

2. Design indicators that demonstrate synergy: In addition to having a joint theory of change and integration of goals/objectives, specific "synergy indicators" are recommended for monitoring progress and outcomes. Synergy indicators for integrated programming might include the following:

   - The % of PLHIV households participating in livelihoods activities, by category (e.g., VSL, Producer groups, Irrigation groups, etc.)
   - The % of leadership positions occupied by PLHIV (similar to the way gender is considered in leadership selection)
   - The % of arable land cultivated by PLHIV households

A more extensive list of suggested synergy indicators appears in Annex 1.

Consolidation of both grants under the same lead and implementing organizations facilitated programmatic integration by simplifying WALA/IMPACT coordination and reducing interagency competition. However, the programs still faced challenges, from which the following additional recommendations have been drawn:

3. Strive to start co-located programs simultaneously: Even with the same technical and management lead, the fact that the IMPACT grant was awarded a year after the start-up of WALA caused challenges to joint working. Efforts were made to integrate with existing staff, but WALA workloads, activities and indicators were already set. IMPACT brought "extra" work, and the programs did not necessarily always pull in the same direction. Starting the two grants simultaneously would have prevented one from being seen as an add-on to the other.

4. Look for ways to streamline management infrastructure to ensure that HIV is everyone's business: While management and field staff alike applauded co-location of FFP and PEPFAR resources, many of those interviewed felt that it was unnecessary to have a separate senior management structure. Instead, several staff members suggested that it would have been more cost-effective to subsume the IMPACT grant within WALA and create a shared management infrastructure. While this study acknowledges the political barriers a truly "joint" program, researchers recommend FFP and PEPFAR overcome their legal and administrative barriers, and allow the cooperating sponsor to utilize a joint management infrastructure for the two grants (i.e. place the PEPFAR grant under the purview of the Title II management structure.) This would facilitate considerable savings (one CoP, one finance section, etc.) while promoting improved integration at all levels. It is worth noting that this option was originally proposed in the 2007 FFP / PEPFAR conceptual framework as follows: "To realize the most efficient and effective food security and nutritional support programs using resources from both, PEPFAR and FFP can explore a variety of funding options. These may include coordinated country PEPFAR and FF operation and budget plans and either "hybrid" agreements or a central mechanism that would allow PEPFAR funds to be added to individual FFP agreements with PVO cooperating sponsors to conduct appropriate HIV/AIDS activities."

ENSURING PLHIV INCLUSION AND SERVICE ACCESS

Is HIV exceptionalism passé?

Earlier discussions concerning PLHIV participation in WALA activities, and the findings that existing barriers to participation do not appear to be stigma-related, prompt questions about whether food security/livelihoods programs should continue to make special (i.e., exceptional) efforts to guarantee PLHIV inclusion. Alternatively, should targeting and programming strategies be based on a shift toward normalization? Before comparing these options, some background on HIV exceptionalism is warranted.

HIV exceptionalism (historically referred to as "AIDS exceptionalism") is the idea that HIV requires a response above and beyond "normal" health interventions. It began as a Western response to the originally terrifying and lethal nature of the virus. Later, as the pandemic evolved, exceptionalism came to refer to the disease-specific global response and the significant resources dedicated to addressing it.[6]

Exceptionalist programming strategies are defined here as those that prioritize the targeting and recruitment of PLHIV and/or create special, often parallel, programming for PLHIV. The intention is to ensure PLHIV obtain access to and benefit from much-needed health, social safety net and livelihoods interventions from which they might previously have been excluded due to stigma and discrimination.

Over the past decade, however, there has been a backlash against exceptionalism on two fronts.

First, on the funding side, critics of exceptionalism claim that HIV receives a disproportionate amount of international aid and health financing. Roger England articulates this view in his 2008 article on exceptionalism: "It is no longer heresy to point out that far too much is spent on HIV relative to other needs and that this is damaging health systems. Although HIV causes 3.7 percent of mortality, it receives 25 percent of international healthcare aid… Until we put HIV in its place, countries will not get the delivery systems they need."[7]

Second, on the program implementation side, many argue that while exceptionalist targeting strategies may have been warranted in the early years of the pandemic, particularly where stigma and discrimination were significant impediments to participation, these strategies are no longer necessary and in fact may do more harm than good. With respect to rural Malawi, the decline in HIV-related stigma, as evidenced earlier in this report, brings into question whether exceptionalist targeting and programming is still warranted or might now be passé.

Exceptionalism vs. normalization: Looking at VSL group formation

In light of the promising stigma-related findings, this section examines prospects

6 Smith, J. and Whiteside, A., The History of AIDS Exceptionalism, Journal of the International AIDS Society 2010, 13:47

7 England R: Writing is on the wall for UNAIDS. British Medical Journal 2008, 336:1072

for (and progress toward) the alternative to HIV exceptionalism: normalization. It looks at these issues, however, through the unique lens of a particular economic empowerment model: Village Savings and Loans (VSL).

VSL groups were introduced in the current WALA communities in 2009. The concept was explained at community meetings and sensitization events, and WALA trained specific individuals—currently known as Private Service Providers (PSP)—to help groups get started. VSL groups are self-targeting; people form groups among trusted friends, write their own constitutions (with assistance from the PSP) and begin a one-year cycle of buying shares, taking loans and paying back the loans from the business ventures they have started.

As with all of the WALA livelihoods activities, WALA did not make any particular efforts to specifically include PLHIV; instead, it targeted the whole community, of which PLHIV are members. By nearly all counts, the WALA VSLs were an instant success, with people from all socio-economic levels—from single mothers with limited resources to Village Headmen and other community leaders—participating and deriving significant benefit.

In the latter half of the WALA five-year term, VSL groups began appearing spontaneously in WALA districts studied under the auspices of PLHIV support groups. These particular groups have since thrived and even flourished, though establishing VSL groups exclusively for PLHIV was never part of the WALA plan. In most cases, support group members had solicited the assistance of a local WALA PSP to help them establish these new groups, or PLHIV involved in community VSLs helped create new VSL groups within their support groups.

Researchers for this study interviewed support group VSL members and PSPs to understand their rationale for forming separate VSL groups instead of joining or forming mixed ones in the community. Interviewees gave a wide range of responses, which are documented in Table 2. Some of the specific study questions were the following:

- Why have these PLHIV-specific groups appeared spontaneously in WALA districts?
- Are PLHIV ready for full integration/normalization when it comes to service provision, such as VSL programming?
- Is there still a need to treat HIV (and PLHIV) as exceptional/special, including delivering separate programming?
- What are the costs and benefits of exceptionalism (e.g., PLHIV-specific VSLs)?
- Does exceptionalism serve to mitigate or propagate existing stigma and discrimination of PLHIV?

Nearly all of the non-PLHIV stakeholders, e.g., PSPs, IMPACT and WALA technical staff, community members and Village Headmen, did not see a justification for creating special VSL activities for PLHIV. In fact, they thought it was in the best interest of PLHIV and the community for PLHIV to join VSLs with the rest of the community instead of establishing their own PLHIV-specific VSLs.

They thought that mixing with other community members would reduce stigma

Table 2: The best fit for PLHIV: Exclusive vs. community-based VSLs

OPTION 1 – PLHIV support group establishes its own VSL group

Benefits	Costs/Risks
• PLHIV are more comfortable and have greater trust doing business with their support group friends.	• PLHIV miss out on opportunities to build relationships, bonds and trust in the wider community.
• Having a VSL group within the support group attracts new members. Furthermore, the VSL social fund can be used for a community garden, buying seeds or other activities that further strengthen the support group.	• VSL groups within PLHIV support groups may not be as strong financially if they have less invested by their members or if they are drawing more frequently on their social fund. *Note: There is no empirical evidence that support group VSLs are less viable than community VSLs.*
• Incorporating VSL meetings into the monthly support group meeting agenda encourages good attendance from members; having both meetings on one day is more time-efficient.	• Some felt that having a parallel VSL network for PLHIV actually promotes stigma and discrimination since it keeps PLHIV separate from other community members.
• Support group members can sometimes receive "favors" from VSL members in the group, such as getting an extra month to pay back their loan, or not buying shares as frequently if they are going through a difficult time.	• This perpetuates an unfounded fear that community groups are less flexible or never face difficult times. Flexibility can be written into the by-laws, and the group's social fund can cater to extenuating needs.
• In some cases, minimum share size was smaller in support group VSLs than in the neighboring mixed VSLs; this was appealing to support group members.	

OPTION 2 – PLHIV join community VSL groups

Benefits	Costs/Risks
• PLHIV meet and bond with others in the community, potentially opening doors to opportunities to engage with community activities. The community VSL frequently becomes a launching point for joining Producer groups, Agribusiness groups, etc.	• There is a fear of being mocked if the share size a PLHIV purchases is too small. In the support group VSL, PLHIV feel able to purchase smaller numbers of shares than in the community groups. *Note: While several respondents mentioned this, the point is not necessarily PLHIV-specific. It may be more related to poverty than HIV-related stigma.*
• Publicly disclosed PLHIV joining mixed groups serve as role models and help to normalize the experience of living with HIV for PLHIV and non-PLHIV alike. They add value by sensitizing group members to the importance of knowing your status and sharing other HIV-related information.	• Some PLHIV were worried that if they had health issues, community VSL group members would not be as understanding as support group members. They cited examples where PLHIV had left community VSL groups because members were intolerant when health issues made it difficult for them to pay back loans.
• If, as some contend, PLHIV pose greater financial risk to the VSL, then, theoretically, it's better to spread that risk over many groups rather than concentrate it in a few PLHIV-specific groups.	
• PLHIV potentially gain exposure to a wider range of business options, given the wider diversity in the community groups.	

and discrimination and facilitate the engagement of PLHIV in other community activities as well. In the same vein, most non-PLHIV felt strongly that separate VSL infrastructures would further propagate HIV-related stigma; they referred to this as "self–discrimination."

Interestingly, however, PLHIV support group members were split in their opinion. Those who were already involved in community VSL groups (and other WALA activities) agreed that integration (i.e., normalization) was better. Most said they had been treated as equals within the community VSL groups and had not experienced stigmatizing behaviors. Importantly, they noted that in belonging to mixed groups they could assist in raising awareness and dispelling myths about HIV and even encourage their group members to know their status. One PLHIV who belonged to a community VSL group in Mulanje noted that he had convinced his entire VSL group to get tested.

An equally vocal group of PLHIV, however, countered this view. These interviewees tended to be less involved in WALA livelihoods activities, or they had never participated in a VSL before, and they strongly favored having a separate VSL just for PLHIV. They said they felt more comfortable doing business with their support group colleagues because they know them well and trust them. Trust among members is, after all, a basic prerequisite for a successful VSL. Furthermore, these members felt that, should they have trouble with illness or finances, their support group friends would be more accommodating than non-PLHIV since they could relate better to their situation.

Notably, the most cited reasons articulated by PLHIV for preferring support group VSLs were not HIV- or stigma-related. Instead, they were related to vulnerability more generally (e.g., poverty or perceived inability to buy sufficient shares, lack of self-confidence, illiteracy, risk aversion).

Table 2 provides interviewees' personal insights regarding the costs and benefits of each of the following two options: Option 1 – PLHIV support group establishes its own VSL; Option 2 – PLHIV join community VSL groups.

Reflections on HIV exceptionalism and VSL groups

The opinions and experiences articulated on this topic do not point to a distinct preference of one option over the other. Clearly, support group VSLs deliver particular benefit to those PLHIV described as "more marginalized" and needing extra guidance and mentoring. As many PLHIV responded, building a VSL into the support group acts to bolster the support group as an entity in and of itself.

Several PSPs thought that, although long-term normalization (e.g., PLHIV joining community VSLs) was preferable for all involved, establishing support group VSLs offers a stepping stone for those less confident PLHIV who felt better testing the waters within the comfort of the support group. They had seen some PLHIV become more confident as they began participating, eventually joining a community VSL after their experience in the support group VSL. Remarkably, many of the support group members interviewed belonged to both types of VSLs, noting that each offered unique benefits.

In the context of the VSL analysis, and perhaps as a metaphor for HIV exceptionalism

more generally, these findings suggest that establishing separate VSL programming for PLHIV is not absolutely necessary. Separate programming does, however, offer some PLHIV additional protection/comfort in experimenting with a venture that many of them perceive as risky. Importantly, extra support for those more-marginalized PLHIV could be considered equally relevant and necessary for other marginalized groups facing similar challenges. In this sense, these findings do not support a continuation of HIV exceptionalism, though they do support the creation of mechanisms for assisting exceptionally vulnerable members of the community, regardless of the origin of their vulnerability, to fully participate in livelihoods programming offered. PLHIV support groups present one of many targeting platforms for reaching those vulnerable members, though they are clearly not the only platform.

HIV PROGRAMMING COMES OF AGE: PLHIV AS A RESOURCE FOR THEIR COMMUNITIES

During the course of this research, an unexpected theme emerged and was consequently explored in a post-research focus group with NAPHAM management. As noted in the previous section, there is certainly a sub-group of support group members who require extra guidance and support toward achieving full participation in community development activities. However, this group should by no means be considered the norm. An equally vocal contingent of support group members proudly described the knowledge, skills and achievements they had obtained by virtue of their HIV status and support group membership, along with their desire to further these gains. This section explores the finding that, to some extent at least, PLHIV are no longer a burden their communities: They are a resource.

PLHIV cited opportunities to learn as one of the primary incentives for joining and remaining in their support groups.

PLHIV have historically been the recipients of a wide range of health and development programs and services, especially in countries with high HIV prevalence. From counseling on PMTCT and exclusive breastfeeding; from training on positive living, nutrition, kitchen gardens, psychosocial support and stigma reduction; from community mobilization to group leadership and advocacy—PLHIV have arguably received more capacity building than any other vulnerable group over the last two decades.

Furthermore, in the early days of Malawi's pandemic, most HIV services were delivered through home-based care and at health care facilities. But as the popularity of PLHIV support groups grew and PLHIV gained access to ART (thereby living longer, healthier lives), support groups become a natural targeting mechanism for delivery of a wide variety of capacity building activities. Just as importantly, support groups provided a safe space for peer mentoring between successful veterans of the disease and the newly diagnosed; this became a major attraction of the groups for both providers and recipients. In Malawi, PLHIV support groups have been a platform for building the capacity of PLHIV since the early 1990s when NAPHAM was founded.

Over the past decade, a wide range of donors, NGOs and GoM agencies have delivered training, sensitization and various forms of counseling to PLHIV,

frequently using support groups as the vehicle for delivering those initiatives. PLHIV interviewed for this study cited opportunities to learn as one of the primary incentives for joining and remaining in their support groups.

In one focus group held in Mulanje, support group participants stated that the length of time they had been members ranged from four to 12 years (with an average of eight years). They noted that they intend to remain active members for the rest of their lives, due in large part to all the capacity building to which they have access as members. In addition, members who have attended regular clinical consultations as prescribed have received some of the best care Malawi has to offer in terms of health and nutrition counseling. Table 3 lists the specific training topics that support group interviewees had received.

Table 3: PLHIV: Multi-skilled, energetic and ready to serve

A wealth of training opportunities have covered both content and process topics, including the following:

- HIV prevention, modes of transmission and positive prevention
- Prevention and treatment protocols for HIV, TB and opportunistic infections
- MNCH/PMTCT (e.g., early infant diagnosis, breastfeeding, complementary feeding)
- Nutrition, positive living and immune function
- Hygiene and sanitation
- Small business management
- Psychosocial recovery, including, e.g., acceptance, management of stigma/self-stigma, disclosure, self-esteem, depression
- Leadership, mentoring and role modeling
- Planning and managing meetings and events
- Community mobilization and outreach campaigns
- Data collection and record-keeping
- Proposal writing
- Preparing and managing a small budget
- Peer counseling
- Talking to your children about HIV
- Behavior change
- Advocacy

Learning acquired on these various topics has served PLHIV extremely well. In some communities, PLHIV were said to be among the healthiest and most successful in their communities, having repaired their houses, planted gardens and started small businesses after recovering their health. As mentioned earlier, many have become role models not only for other PLHIV, but also for non-PLHIV members of their community.

Stepping Up: From personal recovery to serving communities

Interviews with PLHIV about their own personal recovery process and, for some, their eventual steps toward offering support to others, revealed a stairway-like progression that has the potential to build healthier communities while simultaneously reinforcing the progress of individual PLHIV (Figure 6). During interviews, support group members described the process of regaining physical health and a positive psychological state of mind (Step 1). They noted the crucial involvement of their support group colleagues who coached and mentored them through bouts of shame and depression, upsets in relationships and health challenges (such as adapting to their medications), all of which are frequent following an HIV-positive diagnosis.

"Support groups are a very strong antidote to both stigma and self-stigma."

—Field staff member, Emmanuel International, Zomba district

PLHIV interviewed explained that knowledge and skills are vital to survival and the process of recovery. Some knowledge and skills are acquired via formal training from external organizations, but much of this learning is done through the informal mentorship that has become the cornerstone of support group membership.

As their recovery progressed, and after a period of consistently good health and increased self-confidence, support group members begin offering advice, moral support and coaching to newcomers (Step 2). They value this opportunity, describing it as "giving back what I received from others." Some say it bolstered their own commitment to inculcate the self-care changes they had made, since they had become role models for newer members.

With further recovery still, and courage in the face of potential stigma and discrimination, some PLHIV take a further step and reach out to other PLHIV in their communities who are not (or not yet) members of the group (Step 3). As role models for overcoming health, psychosocial and stigma-related challenges, they are ideally placed to guide others experiencing similar struggles.

In some cases, this offering of support is informal, e.g., suggesting to a neighbor

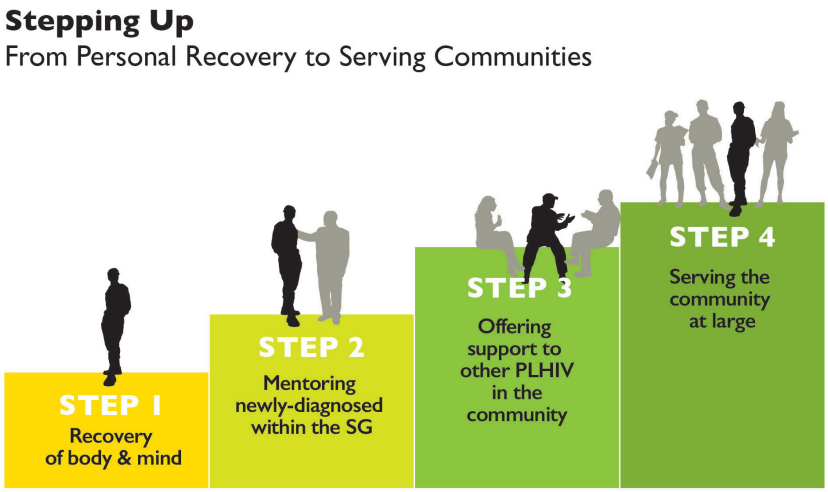

FIGURE 6

who is ill that she should go for HCT and offering to accompany her to the health facility. In other cases, this offering is more formal and becomes a career for the PLHIV. Expert Clients, ART counselors and even HIV-positive CGVs are all examples of PLHIV who have taken this courageous and rewarding step.

In a focus group in Balaka, three of the six participants had made a career of HIV counseling. One worked at the NAPHAM district office, another worked as an Expert Client and the third worked with a local CBO, counseling youth on HIV prevention. In another example, participants from the Machinjiri support group explained how they had formed a choir (with both adult and youth members) in which they compose songs about their experiences as PLHIV. The songs serve two purposes. One is self-serving—to encourage and support themselves and other group members. The second is to educate the members of their community about HIV prevention, testing, ART and the importance of knowing your status. Their songs touch on issues of stigma and discrimination and how the choir members deal with it.

To capitalize on the knowledge, skills and talents PLHIV have acquired, the development community must find ways to strategically position them where they can deliver the most benefit.

In the final step, PLHIV use their advanced knowledge and skills to bring about healthier communities and advance the socio-economic development of their communities at large (Step 4). Their training in advocacy, leadership, public speaking and management of meetings and events is particularly relevant to this more advanced role.

Historically, in the absence of treatment, health and nutrition messages were targeted to PLHIV, but such messages have always been equally valuable to all Malawians. Positive living; exclusive breast feeding for the first six months of life; dietary diversity; malaria prevention; improved water, sanitation and hygiene and many other topics that were prioritized for PLHIV are absolutely needed by all Malawian families if the coming generation of Malawians is to grow into healthy, educated, productive adults.

PLHIV should be considered, possibly even prioritized, for positions as CGVs, HSAs, health facility staff and HIV peer counselors. Beyond these more obvious positions, PLHIV are uniquely positioned for leadership roles on child protection and community development committees or as VSL chairs, lead farmers and agricultural extension staff. In these roles, they are capable not only of lending to the job their newly acquired leadership and advocacy skills, but, as mentioned earlier in this paper, they are also well-positioned to mainstream HIV, nutrition and health messaging into these multi-sectoral activities. In communities with HIV prevalence considered "high burden," mainstreaming is crucial across all sectors.

Untapped resource: PLHIV forge pathways to health and productivity

As noted earlier, this report emanates from research on the topic of integration of HIV and livelihoods programming in Malawi. The findings reveal that co-location of the PEPFAR-funded IMPACT program and the FFP-funded WALA program has produced the start of an infrastructure or pathways that promote greater participation of PLHIV in livelihoods programming and improved access to HIV-related prevention, treatment, care and support for communities at large. Furthermore, this infrastructure is emerging from within the PLHIV community, where PLHIV are gravitating toward increasing levels of involvement and responsibility for restoring health and productivity to their communities. In essence, rather than being perpetual beneficiaries of development programs, PLHIV are role models of a healthier life

Untapped Resource: PLHIV forge pathways to health and productivity

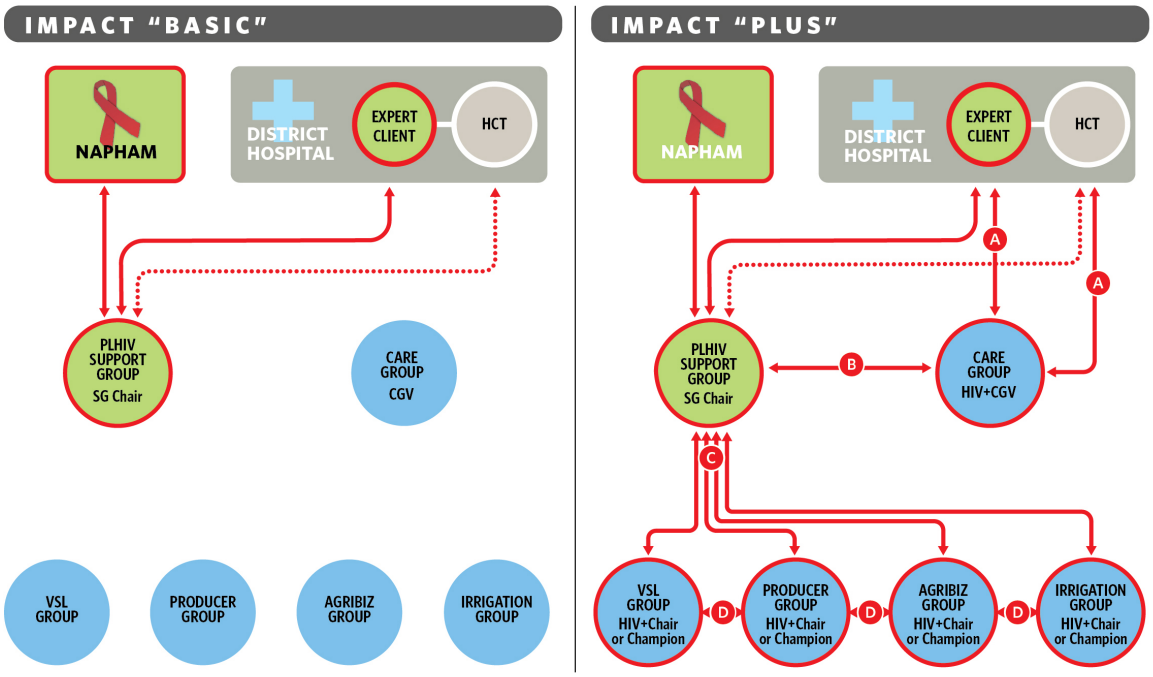

FIGURE 7

and an untapped resource for ensuring maximum reach and coverage of vulnerable individuals and households.

Figure 7 describes the original scenario (IMPACT "Basic"), which was depicted earlier in this report, and the emerging scenario (IMPACT "Plus"), poised to flourish if the current pathway is continually reinforced. Where PLHIV are in leadership positions and have forged pathways between the various WALA and IMPACT entities, linkages and referrals have in many cases already been established. Intentional strengthening of these linkages and formalizing of referral mechanisms will potentially provide benefit to the wider community. The following four pathways require strengthening in order to fully capitalize on PLHIV as an untapped resource:

Pathway "A"—between CGV and Expert Client health facility: Having a PLHIV in the role of CGV is an invaluable resource for HIV case-finding, making appropriate referrals to HTC, linking with the Expert Client and guiding each member household through the process of enrolling in ART, into PMTCT (if they are pregnant), joining the support group and overcoming self-stigma, thus steering them toward improved health and productivity. In addition, HIV-related nutrition messaging is built into the Care Group's curriculum; where children fail to thrive, they are referred by the CGV (and escorted if necessary) to HIV testing.

Pathway "B"—between CGV and PLHIV support groups: This pathway is also particularly strong when the CGV is HIV-positive and a member of the support group. As noted earlier in this report, support, encouragement and role-modeling from group members is crucial to recovery. The CGV is well-placed to provide connections to group members who can best help the newly-diagnosed individual.

Pathway "C"—between PLHIV support group and livelihoods group leadership:

This linkage fosters increased participation of PLHIV in community VSL groups and Producer, Agribusiness and Irrigation groups. PLHIV support groups should be leveraged as entry points to livelihoods programming, with briefings on livelihoods opportunities presented at monthly support group meetings.

Livelihoods groups should either prioritize PLHIV in leadership positions (e.g., chair, vice chair, secretary), or assign a "PLHIV champion" within the livelihoods group. These options serve two functions: 1) recruitment and mentoring of more marginalized PLHIV (or other vulnerable groups) to facilitate their participation in the group, and 2) advocacy for HIV testing among livelihoods group members, along with sensitization/education on other HIV-related issues.

Pathway "D"—between livelihoods groups: Finally, the two-way links between livelihoods groups should also be established/strengthened, encouraging participation in several groups to maximize dividends. The positioning of PLHIV in leadership roles or as champions will be key to ensuring that the more marginalized PLHIV (and other vulnerable groups) optimize their participation in various groups.

Support groups encourage role reversal of PLHIV

Throughout this research, it has become clear that more than 20 years after the first PLHIV support groups appeared on the Malawian landscape, they are still providing significant benefit—to PLHIV and now more broadly to Malawian communities. Not only do support groups provide a place where the newly diagnosed receive comfort and encouragement, but they are also a repository of vital knowledge and skills needed to overcome the physical and psycho-social challenges of HIV infection. Furthermore, support groups in Malawi offer an effective platform for targeting and delivering a wide range of development interventions to a sub-population with an emerging reputation as early adopters and role models.

"People don't realize how much we have learned. It's true that we received a lot of assistance, but now we have the strength and skills to make our communities strong."

—PLHIV support group member, Africare/ NAPHAM, Mulanje

As HIV programming comes of age, this study recommends that development stakeholders continue to utilize support groups in this manner. This study illuminates a potential "game changer." In light of 1) the decline of stigma, 2) a desire to normalize treatment of PLHIV in programming and 3) PLHIV emerging as a resource for their communities, there is the possibility of a reversal of roles.

A reversal of roles would mean creating opportunities to deliberately position PLHIV to deliver assistance, conduct training and provide counseling instead of receiving those services. It means considering PLHIV for positions of leadership where they can exercise their newly acquired skills in behavior change, mentoring and advocacy for the benefit of the entire community. In essence, as a result of our collective efforts to build the capacity of PLHIV support groups and to secure the Greater Involvement of People Living with HIV (GIPA), PLHIV are now a capable—and underutilized—resource for the development of the communities where they reside.

The idea of role reversal, and the use of support groups to make this happen, is proposed here as food for thought. It is predicated on the opinions, ideas and aspirations of the PLHIV and non-PLHIV who were interviewed for this study.

WHERE TO NOW?

The findings of this study point to co-location benefits that are tangible but still fragile. They are not fully inculcated within the structures that house them or the communities that implement them. Retaining the bi-directional flow of benefits will require intentional efforts by future FFP DFAP programs to do the following:

1. Leverage PLHIV support groups as an entry point for livelihoods activities and position HIV/"vulnerability" champions to mentor marginalized PLHIV and other vulnerable groups

2. Capitalize on the years of investment in capacity development of support group members, HIV-positive CGVs and other PLHIV by positioning them for leadership in their communities at large

3. Advocate for renewed support of the Expert Client role to ensure continued improvement in uptake, adherence and defaulter tracing of PLHIV

4. Mainstream and regularly update relevant HIV messaging into all livelihoods work (including curricula infusion and training)

5. Establish (and/or increase) the number and frequency of integrated HIV and livelihoods mechanisms, such as Community Health Days and other community events and meetings where both HIV and livelihoods activities are featured

While some of these efforts are feasible within the mandate of a FFP DFAP, others require complementary funding to be truly effective. As was typical in the pre-PEPFAR days, an alternative mechanism should be sought as a complement to FFP funding to ensure that comprehensive HIV care and support accompanies every DFAP in a high-burden setting. Where the prospect for co-location does not exist, it is recommended that USAID FFP be intentional about HIV integration in planned programming where HIV prevalence is high. The 2014 DFAP Request for Applications (Malawi) was almost silent on HIV. Unfortunately, without explicit guidance, cooperating sponsors are unlikely to prioritize HIV appropriately, since deviating from the guidance might jeopardize their bidding prospects. In this sense, the onus for integration begins with USAID FFP, as DFAPs must thoroughly consider HIV implications in their design and ensure that HIV-related concerns do not slip off the radar.

Finally, FFP, PEPFAR and the implementing NGOs should be congratulated on a successful co-location experiment. In both directions of the framework used for this research, there are strong examples of how IMPACT and WALA participants benefited from co-location. Importantly, these benefits, as well as the findings and recommendations throughout this paper, are not unique to USAID-funded interventions. In fact, they are generalizable to any effort to co-locate and integrate food security, livelihoods and HIV programming where the goal is to achieve the bi-directional benefits of integration described herein. It is hoped that future efforts toward programmatic integration will benefit from the learning captured here and that future donors, host governments and other development partners continue to capitalize on the significant investment in PLHIV human capacity made to date.

Annex 1: Sample Synergy Indicators

1. Participation rates of PLHIV households (from initial registration) in livelihoods activities by category, e.g., VSLs, Producer groups, Irrigation groups, Agribusiness groups

2. Participation rates of support group members in livelihoods activities by category, e.g., VSLs, Producer groups, Irrigation groups, Agribusiness groups

3. Percentage of leadership positions occupied by PLHIV (using support group membership as a proxy)

4. Livelihoods outcome data disaggregated for PLHIV households, e.g., % change of arable land cultivated; % change in capacity to access seeds

5. Number of integrated events; e.g., events where PLHIV gain improved access to livelihoods and communities gain improved access to services; examples include the following:

    a) Host Community Health Days (or similar events) where both IMPACT and WALA activities are showcased and community members have the opportunity to learn, ask questions and register/become involved

    b) Following an IMPACT community outreach meeting (on HIV-related topics), have WALA technical staff members present on a particular WALA activity, discussing the process, eligibility and potential benefits of becoming involved

    c) Have a WALA agri-business technician present at a PLHIV support group meeting on the benefits of VSL

    d) Locate an agribusiness demonstration plot (with maize, pigeon peas and other vegetables) at the hospital so that PLHIV may learn about them when they collect their ARVs

Annex 2: Key Informants and Focus Group Participants

List of key informants interviewed

IMPACT

- Kate Greenaway, Chief of Party
- Hazel Simpson, Deputy Chief of Party (and former Deputy Chief of Party of WALA)
- Alinafe Chibwana, Care and Support Technical Quality Coordinator (TQC)
- Antonio Kasote, OVC TQC
- Peter Mwamlima, Senior Project Officer, Care and Support
- Isaac Nyirongo, IMPACT M&E TQC
- Cynthia Mambo (former Deputy Chief of Party, IMPACT)

WALA

- Catherine Chiphaza, MCHN TQC
- Wales Magumbi, Agriculture and Natural Resources Management TQC
- Chizi Jana, Agribusiness Team Associate
- Juma Masumba, Irrigation TQC
- David Nthakomwa, Senior Program Manager, Agriculture Programs Officer
- Jerome Sigamani, (currently with PCI, and former Chief of Party for WALA)

NAPHAM

- Master Mphande, Executive Director
- Paul Manyamba, Programs Manager
- Dickens Kolondo, Assistant Programs Manager
- Eric Matiti, M&E Officer
- Eric Mcheka, Resource Mobilization Officer
- Mtawinga Msumba, Chikwawa District Coordinator
- Elizabeth Adisoni, M&E Assistant
- Charles Siabu, M&E Assistant

USAID

- Ritu Singh, HIV Team Lead
- Wina Sangala, HIV Team Consultant
- Tim Quick, Senior Technical Advisor for HIV/AIDS & Nutrition
- Judy Canahuati, MCH, Nutrition and HIV Advisor, FFP

Chikwawa Diocese

- Nicolas Mkwapata, Program Manager for IMPACT and WALA

- Linly Kamanga, IMPACT Coordinator
- Bernardoh Gideon, Monitoring, Evaluation and Logistics Manager for IMPACT and WALA

Emmanuel International

- Jones Chimpukuso, Program Manager for IMPACT and WALA
- Feston Chizenga, Care and Support Officer
- Faith Nsonga, Irrigation Technician
- Pearte Kankhande, Agribusiness Technician
- Vitumbiko Lungu, Health and Nutrition Technician
- Thokozani Nchizi, OVC Supervisor
- James Muhowa, Agriculture Extension Officer

Africare

- Geoffrey Nkata, IMPACT Coordinator
- James Madeya, IMPACT OVC Facilitator
- Tiyaone Maloya, M&E Officer
- Venacio Chome, Field Project Manager
- Godfrey Chisunkha, DRR and Good Governance
- Wellings Kalua, Irrigation Coordinator
- Hellen Phallaza, MCHN Coordinator
- Pitilosi Banda, VSL Coordinator
- Mwayi Sonkhanani, Commodity Accountant

Project Concern International

- Grandstone Mlenga, Program Manager, WALA and IMPACT
- Onani Bokosi, IMPACT Coordinator
- Scholastica Mkandawire, MCHN Coordinator, WALA
- Misozi Kambanje, M&E Officer, WALA and IMPACT

Manet Plus

- Eddie Banda, Programs Manager
- George Kampango, Program Officer for Research and Advocacy

LIFT

- Henry Swira, Regional Technical Advisor, LIFT II, CARE
- Zachary Andersson, Leland Fellow, LIFT II, FHI-360

UNAIDS

- Musa Bullaleh, Human Rights and Gender Adviser

List of focus groups conducted

# of focus group participants	Type of participant	District	Location
CHIKWAWA			
5	HIV-positive Care Group volunteers	Chikwawa	Msomo/Ngabu
5	PLHIV support group members	Chikwawa	Msomo/ Ngabu
8	PLHIV support group members	Chikwawa	Chapomoka/Ngabu
6	PLHIV support group members that participate in VSL	Chikwawa	Chiwembu/Ngabu
10	WALA participants (mix of VSL members, producer group members and Agribusiness group members)	Chikwawa	Ngabu
2	Health Surveillance Assistants	Chikwawa	Ngabu Hospital
2	Expert Clients	Chikwawa	Ngabu Hospital
5	Care Group volunteers	Chikwawa	Chapomoka/Ngabu
3	HIV-positive Care Group volunteers	Chikwawa	Chapomoka/Ngabu
1	Village Headman	Chikwawa	Meja
1	Nurse Midwife and Expert Client Focal Point	Chikwawa	Chikwawa District Hospital
1	ART Coordinator	Chikwawa	Chikwawa District Hospital
4	Private Service Providers and VSL leadership	Chikwawa	Balala
1	Senior Group Village Headman	Chikwawa	Balala
4	Leadership of Producer groups, Agribusiness groups and VSL groups	Chikwawa	Balala
ZOMBA			
1	District Health Officer (representative)	Zomba	Matawale Health Center
5	PLHIV support group members with no WALA experience	Zomba	Machinjiri

4	Care Group volunteers who are also PLHIV support group members and very active in other WALA activities	Zomba	Machinjiri
5	PLHIV support group members who are involved in WALA activities	Zomba	Machinjiri
4	Expert Clients (2), Private Service Provider (1) and Farm Extension Facilitator (1)	Zomba	Machinjiri
1	Senior Group Village Head Man	Zomba	Machinjiri
5	Health Surveillance Assistants	Zomba	Machinjiri Health Center
2	Private Service Provider	Zomba	Chilonga
8	PLHIV support group members	Zomba	Jali
10	WALA participants (mix of VSL, Producer Groups, Agribusiness and Irrigation)	Zomba	Mbalu
4	WALA Health Promoters	Zomba	Jali
MULANJE			
4	Village Headmen (3) and Group Village Headman (1)	Mulanje	Gulumba
4	Health Surveillance Assistants	Mulanje	Gulumba
1	Nurse mid-wife and HTC Coordinator	Mulanje	Mulanje District Hospital
6	HIV-positive Care Group volunteers	Mulanje	Gulumba
5	PLHIV support group members who are active in WALA	Mulanje	Gulumba
5	PLHIV support group members who are not active in WALA	Mulanje	Gulumba
1	Village Headman	Mulanje	Tchete/Mbewa
3	Lead Farmers	Mulanje	Tchete/Mbewa
2	Private Service Providers	Mulanje	Tchete/Mbewa
8	WALA participants (mix of VSL, Producer Groups, Agribusiness and Irrigation)	Mulanje	Tchete/Mbewa

2	Expert Clients	Mulanje	Mulanje District Hospital
BALAKA			
2	Lead Farmers	Balaka	Zalengera
4	WALA participants, one who is a support group member	Balaka	Kachinga
5	Agriculture and Health Promoters (WALA)	Balaka	Kachenga
6	Health Surveillance Assistants (5) and MCHN Facilitator (1) for WALA	Balaka	Mtumbwe/Kachenga
6	Care Group volunteers (5) who are support group members, and Group Village Headman (1–who is a support group member)	Balaka	Dankeni/Kachenga
1	ART Nurse	Balaka	Balaka District Hospital
2	Expert Clients	Balaka	Mbera Health Center
2	Private Service Providers	Balaka	Kachenga
5	PLHIV support group members active in WALA	Balaka	Kachenga

(Footnotes)

1 The WALA final evaluation noted that "The one general reason that people might not be able to take part is extreme poverty. There is a need for members to save regularly and there are examples of both 1) people who are too poor to make payments and therefore join groups, even those with very low-priced shares, and 2) people who have ended up leaving groups when they found they could not make the payments. The solution to this does not lie within the VSL system however, since people cannot save what they do not have. It would be more appropriate to address it through measures for addressing destitution."

CHIKWAWA DIOCESE

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