NUIG, KERNENA CONSULTANTS & REACH TRUST

Evaluation of Interventions to Reduce Women's vulnerability to HIV in Malawi

Combined Report

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Evaluation of Interventions to Reduce Women's vulnerability to HIV in Malawi

Executive Summary

Overview

The Trócaire Malawi Gender and HIV Programme (2011-2015) 'aim[ed] to explore women's vulnerability to HIV and AIDS and promote gender equality through a focus on culture, engaging men, engagement with traditional and religious leaders and the social and economic empowerment of women' (Trócaire, 2010). Trócaire's approach involved providing funding and operational and development support to local Malawian organisations who implemented interventions to reduce women's vulnerability to HIV in the Central region of Malawi. The four organisations that secured Trócaire support were: SWAM (Society for Women and AIDS Malawi) who worked in Nkhotakota through a community-mobilisation approach called STAR (Societies Tackling AIDS through Rights); COWLHA (Coalition of Women Living with HIV and AIDS) who worked in Dowa district and similarly employed the STAR methodology; MIAA (Malawi Interfaith AIDS Association) working in Salima and using a men-engaging-men and working with leaders as change agents approach; and, CCJP (Catholic Commission for Justice and Peace) who also focussed on men-engaging-men and leaders to challenge gender inequality and vulnerability to HIV.

To maximise effectivity and learn from experience, Trócaire commissioned a research project to accompany the programme. NUI Galway designed an evaluative research study comprising a baseline and endline, led these quantitative components and contributed to the analysis of a further qualitative study conducted over the course of the intervention. Kernena Consulting designed and led the qualitative components of the research which took a close up look at how the intervention was impacting life in 8 villages. REACH Trust, Malawi, led the qualitative and quantitative data collection, transcription and cleaning, and took part in the analysis of the qualitative data. The research team, composed of the three research organisations, engaged in a collaborative practice to ensure that all researchers were aware of and involved in interpreting findings from both the qualitative and quantitative component.

Methodology

The study used a mixed methods approach applying both qualitative and quantitative methods. A baseline quantitative survey was conducted in 2011, involving over 700 participants in the four study districts in Malawi and captured information including demographic details, socio-economic characteristics, attitudes towards gender, intimate partner violence, and PLHIV (People Living with HIV), knowledge about HIV and some behaviours, such as age of sexual debut. Study sites included both villages in which interventions would be implemented and others in which there would be no Trócaire intervention implemented which acted as control sites. A fully anonymous section was also included to allow respondents to provide details about condom use and discrimination, and experiences of gender based physical and sexual violence. In 2015, at least 6 months following the end of intervention implementation, the survey was repeated. Comparisons were made between baseline and endline, control and study sites, participants and non-participants.

The qualitative research took a close up look at life in eight villages at three points over the course of the programme. Four of the villages reflected each of the two intervention types (Focused Interventions/Men Engaging Men and Community Interventions /STAR circles) and two , each of the implementing partners. Data collection was done through in-depth interviews with cultural custodians, community leaders and programme implementers and focus group discussions with programme participants and non-participants. Case studies were developed for one programme participant in each village through participant observation, in depth informal and formal interview at the three points of data collection. Participant observation and field notes were used to construct village profiles. Over the 3 data collection points 150 in-depth interviews were undertaken and 111 FGDs with 399 men and 435 women in the 8 sample villages. 8 individuals were followed up over time as case studies. At the final round in-depth interviews were conducted with the senior staff from partner organisations implementing the programme.

Summary of Key Findings

The study found mixed results in relation to changes in attitudes, norms and behaviours that contribute towards women's vulnerability to HIV. Positive changes were found in relation to ending or modifying cultural practices, with such changes appearing to occur as part of more generalised social change, and improvements in knowledge of HIV risks. There were also positive changes found in relation to increased numbers of respondents expressing equitable sexual norms. However, there were mixed findings on gender equality with the qualitative research finding a general consensus that gender equality had improved, but the quantitative research suggesting little change to gender equitable norms or a worsening of gender equitable norms. Interesting findings on violence emerged, which depicted ambiguity of meaning about what constitutes violence and what types of violence were most serious among qualitative research participants, while, in the survey findings, no improvement in lack of acceptance of intimate partner violence was found. Overall, findings of positive change were more conservative than anticipated. Changes, and lack thereof, were likely heavily influenced by Partner capacity, the local social environment and other interventions ongoing in the specific districts.

Below, we provide highlights of findings which indicate the mixed nature of findings:

Cultural Practices:

- ✓ Strong evidence from the qualitative research to show changes to cultural practices identified as a risk for contracting HIV, including wife inheritance, kuchotsa/kusasa fumbi, and night dances.
- ✓ Modifications to existing cultural practices to reduce risk also apparent, such as reduced periods of sexual seclusion and changes to initiation practices.
- ✗ Explicit link made by partners between sexual seclusion practices and risk of HIV due to unfaithfulness may contradict messaging on men's sexual responsibility.

Changes in relation to cultural practices to reduce risk of contracting HIV appeared to have begun prior to the commencement of the programme, however partner programmes were credited with intensifying these changes.

Knowledge

✓ Improvement in overall in comprehensive knowledge on HIV.

- Stronger positive change among men than among women.
- Stronger positive change in intervention sites compared to control sites.
- Stronger change in community-based interventions than in focused interventions.

Messages

✓ Programme messages known throughout districts

- Significant increase in those reporting having heard messages from religious leaders and community leaders but a significant decrease in those reporting to have heard messages on HIV from chiefs.
    - Quantitative research found that women in community based intervention sites more likely to hear messages than in focused intervention sites

Stigma & Discrimination

✓ Very little evidence of discrimination against PLHIV in qualitative or quantitative findings

✓ Though stigmatising attitudes recorded in the quantitative survey remain high, there is a positive shift, with fewer expressing stigmatising attitudes.

✓ Greater positive changes were seen in intervention sites compared to control sites.

- Greater positive changes in focused interventions compared to community-based interventions.

Both the qualitative and quantitative study found blaming attitudes were still common, but these did not appear to translate into discrimination.

Equitable sexual attitudes

✓ Improvement in equitable sexual attitudes found in both qualitative and quantitative research

✓ Stronger changes in intervention sites compared to control sites.

- Stronger positive changes in focused interventions compared to community based interventions.

Equitable gender attitudes

Mixed findings on different attitudes from qualitative and quantitative research

✗ Quantitative findings show less gender equitable attitudes overall in both intervention sites and control sites however intervention sites did not deteriorate to the extent that control sites did and differences observed in different types of intervention sites.

- Community based intervention sites did not see any deterioration
- Within focused interventions, significant deterioration seen among women's attitudes, with no deterioration among men.

In qualitative research, in intervention sites most agreed that there was

✓ More gender equitable role sharing and involvement of women in decision making

Intimate Partner Violence

Among respondents violence was broadly understood as cruelty and GBV is understood broadly as violence by a man or woman perpetrated against a member of the opposite sex.

- Acceptance of male to female intimate partner violence had increased among the intervention and group control group as well as among community intervention sites. This negative change was strongest in control sites suggesting a general worsening of attitudes
    - Within community intervention sites, the negative shift primarily occurred in Nkhotakota among women and non-participants.

  Findings from the qualitative research suggest that interventions positively contributed to a reduction of violence by men toward their spouses, including reduced beatings and a reduction in controlling behaviours. However, qualitative results indicate a lack of consensus on what constitutes serious forms of violence and distinctions between forms of major and minor consequences. For example, not all groups ranked child rape as the most serious form of violence while denial of sex was considered an important form of violence

Changes in risk patterns

- ✓ The qualitative research saw consensus among participants and non-participants that interventions had positively influenced a decline in multiple concurrent partnerships. However, this finding received limited support from the quantitative research where no significant changes were noted among men indicating they had been involved in multiple concurrent partnerships in the previous 12 months in intervention sites.
- ✓ New risk factors identified in the qualitative research were migration to South Africa and environments which provide opportunity for sexual relations outside marriage (night screenings of videos, plays etc.)
- ✓ Transactional sex, driven by poverty, was reported to be reduced as a result of VSLs.
- ✓ There was no consensus on an impact in relation to alcohol reduction.

While social control was seen as an appropriate strategy to combat risk, empowerment of individuals within risky environment and harm reduction should be considered as alternatives.

Prevention

- ✓ Testing appears widely ***available*** with little change between 2011 and 2015
- ✓ Interventions appear to have improved the ***uptake*** of testing, with a greater increase among respondents in intervention sites stating that they had taken an HIV test compared to the control sites.
- Mixed results were found relating to condom use. Most respondents indicated that condoms were available, but this did not always mean they were accessible.
- Respondents reported that condoms were primarily used outside of marriage, particularly in casual sexual relationships.

Economic impact and impact of VSLs

- ✓ The quantitative survey found that VSL members were better off economically across some measures than non VSL members.
- ✓ In all sites where implemented the VSLs were reported as having benefited the members by providing a source of loans in times of need and as a capital for small businesses
- ✓ Quantitative and qualitative findings suggest VSLs may have a role in reducing involvement in transactional sex

- ✕ Qualitative findings caution against possible negative consequences of not being able to repay loans.

Discussion

Within the Trócaire HIV programme in Malawi, effort was made to fund interventions that aimed for transformative change so as to reduce women's vulnerability to HIV. This approach and the changes that were expected to emanate from the programmes, fall in-line with accepted good-practice approaches that target HIV risk reduction, gender equality, and GBV reduction (e.g. Jewkes et.al. 2007). However, the findings from this study give reason to consider what change means and how programmer and researcher expectations of change may need to be re-examined and tempered.

As can be seen by from the key findings above positive changes were not as momentous or as common as anticipated. This finding may in fact reflect the reality that deep normative and social change cannot be achieved through community-level interventions alone, particularly where, as with changes in some gender norms, they conflict with locally held beliefs.

Our analysis aligns with recent research which acknowledges that social change is not something that can be easily imposed and that interventions are most effective where they support those that are already occurring. This analysis recognises the unintended consequences of interventions that are 'negotiated and reinterpreted' in local contexts and through local dynamics which can end up transforming interventions significantly (Aberlan et.al. 2016:8). The emergence of such a perspective presents a conceptual challenge about the evidence base for interventions that aim to effect sustained social change within observable time-frames.

The Malawi research study has importantly contributed towards a more nuanced understanding of the process of change by revealing the ways through which strategies were filtered through existing values, supported by the patriarchal structure of Malawian society, to reproduce rather than challenge the existing gendered power dynamics. This was seen in the adoption and implementation of the 'openness' strategy.

This analysis also sheds light on the attempt to answer the guiding question of this study: what combination of strategies is most effective in reducing women's vulnerability to HIV? (Duvvury and Scriver, 2012:3). The findings from the study suggest that a combined approach, involving aspects of the focused intervention and aspects of the community-based intervention, is most valuable in order to address different risks and vulnerabilities.

Key lessons include

- Gender equality and HIV risk reduction strategies in patriarchal contexts may not always be compatible.
- The expectations of 'success' and what counts as success requires moderation.
- Evolving programmes challenge attribution of change to specific activities and interventions.
- Qualitative and quantitative findings measure different types of change and may not always co-align.

Recommendations for Programmers

- At a community-level, seeking spaces where positive change has begun to occur and focussing efforts to strengthen such change or to engage with communities through their articulated needs (e.g. address poverty, provide knowledge, etc.) is more likely to be well-received and may open new spaces for change as basic needs are met.
- Communities develop and change in different ways but also within the larger context of societal change. Programmes need to be sensitive to the myriad unintended consequences of interventions.
- Real normative change is a process that may be better expected to occur over decades or even over generations. Such changes are also likely to require societal shifts that are beyond the scope of community-level interventions.
- It is critical that design of evaluation research prioritise doing no harm to participants and be sensitive to identifying unintended consequences
- Build on successes by integrating the most effective components of a variety of intervention approaches: While community-based interventions appeared to be most effective at supporting normative change, albeit slowly, the focused interventions appeared most successful at supporting behavioural change – in particular by engaging with authority figures and leaders in the community who are able to issue directives and spread knowledge regarding acceptable/unacceptable behaviour
- Close the gap in perspective between funders, programmers and partners: brief trainings and discussions may not be sufficient to ensure an alignment in interests and perspectives between funders, programmers and partners. Similarly, the interests of researchers may not be fully aligned with those of funders, programmers and/or partners. Clarity of purpose and an understanding of one another's' perspectives is critical to ensure coherent approaches and avoid dissonance in implementation.

Evaluation of Interventions to Reduce Women's vulnerability to HIV in Malawi

Introduction:

The Trócaire Malawi Gender and HIV Programme (2011-2015) 'aim[ed] to explore women's vulnerability to HIV and AIDS and promote gender equality through a focus on culture, engaging men, engagement with traditional and religious leaders and the social and economic empowerment of women' (Trócaire, 2010). Furthermore, Trócaire aimed to ensure quality documentation of programme activities to feed into knowledge on good practice and effective implementation. To meet these objectives, Trócaire Malawi funded four Malawi-based partners in the Central Region of Malawi to implement interventions targeted at reducing women's vulnerability to HIV. These interventions work in rural areas in the districts of Dowa, Ntcheu, Salima and Nkhotakota[1]. In order to evaluate programme effectiveness and assess differential impacts between partner intervention strategies, researchers at National University of Ireland, Galway, KERNENA Consulting, and the Research for Equity And Community Health (REACH) Trust, in collaboration with Trócaire Ireland, Trócaire Malawi, and local partners, designed a study that included baseline and endline surveys and three rounds of qualitative data collection. In total, the findings of this report represent the input of more than 1500 respondents across the quantitative research and over 800 participants in the qualitative research.

Trócaire Malawi has identified the primary research questions as: what combination of strategies is most effective in reducing women's vulnerability to HIV? This question was used to guide the research design and the selection of tools in preparing the baseline study

[1] For further information about the partners and interventions implemented please see Partner Programme Review and Field Visit: Trócaire, Malawi (2011).

and in revising the survey for the endline study. Between the baseline and endline an extensive qualitative component was designed to take a close up look at how the interventions were impacting the lives of people in 8 sample villages. This qualitative work involving in-depth interviews and Focus Group Discussions (FGDs) was undertaken over a number of weeks in 2013, 2014 and 2015. Below we provide first an overview of the structure of the report and then further information about the partners and their approaches to reducing women's vulnerability to HIV.

1.1 Structure of this Report

This report combines the quantitative and qualitative findings. The report is structured around the social phenomena which the programme intended to change e.g. violence, cultural practice gender norms etc which were identified at the outset of the programme as key contributors towards women's vulnerability to HIV. The main quantitative and qualitative findings on these are presented under each theme.

The quantitative baseline and endline survey findings are compared. Unweighted results are used in this report for both baseline and endline. Thus, results for some scales will appear different than those reported in the Baseline Summary Report (2013) as weighted scales were used. Unweighted scales were used to ensure an accurate comparison between baseline and endline. All results reported are significant unless specifically stated otherwise. District level findings are reported in district level reports separately. Participant vs nonparticipant differences and gender differenced are reported where significant or for key variables even if not achieving significance.

Qualitative findings are derived from the overall final third round qualitative report. The overall qualitative report combines 4 district level reports and compares findings with round 2 and 1 qualitative finding.

Baseline and endline surveys were designed to be representative at the level of districts. The qualitative component was designed to add thick and rich description to improve understand of how programmes were impacting communities. Qualitative data was collected in 8 villages in 4 district and provides context and depth but unlike quantitative findings are not representative of those districts.

1.2 Overview of Intervention Sites and Partners' Programmes

Coalition of Women Living with HIV and AIDS (COWLHA), in Dowa District

Dowa is a district located at about 50 kilometres from Lilongwe the Capital City of Malawi. A main tarmac road that goes to the northern region passes through the district. However, the district headquarters is situated at about 30 kilometres from the main road. The majority of the people of the area are of the Chewa ethnic group with the dominant religion being Christianity, especially Protestant and Catholics. Muslims were not found in the area although few were found around Nambuma Trading Centre a distance of about 8 kilometres. The main economic activity in the area is farming. Maize is grown as a staple crop while tobacco, soya beans and groundnuts are grown for sale

The Coalition of Women Living with HIV and AIDS (COWLHA) was established to enhance the protection and promotion of rights of women living with HIV and AIDS. With funding from Trócaire, COWLHA has been implementing an intervention project in five villages (Malunga, Msampha, Kamoto, Chidangwe and Siwinda) of Traditional Authority (TA) Kayembe. This is implemented through the Society Tackling AIDS through Rights (STAR) methodology, an innovative participatory methodology designed to empower communities to analyse and respond to issues that affect their community, including gender inequalities, education on HIV, stigma reduction and more (e.g. Action Aid, Concern. 2010). STAR 'circles' or groups are formed of community members to facilitate discussion and engagement leading to community mobilisation, empowerment and response to HIV and AIDS and gender issues. Groups are led by one male and one female facilitator who have been trained on gender, HIV and AIDS and human rights, and how to lead and manage the STAR circles. Facilitators are provided with ongoing support and supervision and have their capacity further developed through monthly supervisory meetings. A total of 10 STAR circles were established.

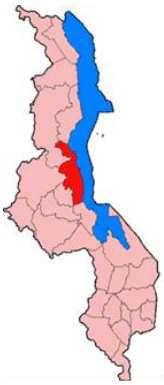
COWLHA Intervention: Numbers involved

- 10 star circles (20 facilitators 10 male 10 female)
- 10 PLWHIV support groups
- 6 trainings for chiefs and religious leaders.
- 23 VSLs

COWLHA's activities aimed to reduce gender inequality, gender-based violence, enhance mutual respect among couples and encourage people to go for HIV Testing and Counselling (HTC). Trócaire's

decision to include economic empowerment through Village Savings and Loans schemes was made after round one of the qualitative in response to community requests and the positive reports by respondents in Nkhotakota.

Society for Women and AIDS in Malawi (SWAM) in Nkhotakota District



Nkhotakota is a multi-ethnic, multi-religious district located close to the lake. While the Chewa ethnic group is in the majority, Yao and Tonga are also represented and both Christian and Islamic religions are practiced, along with a variety of minority religions. Due to the multi-cultural and multi-religious composition of the community, the cultural practices are also varied. The main economic activity in the district is subsistence farming of rice, maize and cassava. Tobacco and rice are grown for income on a small scale. Although the villages are less than 10 km from the lake fishing activities were hardly reported or observed.

The programme was implemented by the Society for Women and AIDS in Malawi (SWAM) in three sites of TA Mwadzama namely; Zidyana, Damba and Zidyana villages. SWAM's intervention utilised the STAR approach, described above, which uses participatory methods for community mobilisation, empowerment and response to HIV and AIDS and gender issues. There were a total of 10 STAR circles in the target area.

SWAM also organised HIV testing supported by the District Health Office (DHO) each year and the local chiefs who mobilise their subjects. Economic empowerment through the introduction of village savings and loans was also supported by SWAM since the early stages of the programme. CARE Malawi trained the STAR circle facilitators on management, implementation and monitoring of the VSL programme.

SWAM Interventions: Numbers involved

- 10 Star circle groups with 20 Star circle facilitators
- 7 Modern Couple groups.
- 2 Support groups.
- 23 VSL groups.
- 2 Youth Clubs.
- 2 religious & traditional leaders groups.

Apart from the core programme initiatives, the circle members also established community-based child care centres which they had identified as a need. These were kindergartens where pre-school children were enrolled. Some circle members voluntarily taught the children.

Malawi Interfaith AIDS Association (MIAA), in Salima District

Salima is located approximately 100 kilometres from Lilongwe. The district is dominated by the Chewa ethnic group although Yao's contribute around 10% of the population. The intervention sites are TA's Maganga and Pemba. Both sites host a predominantly Muslim society and polygamous marriages are common. The majority of the population in the intervention site in TA Maganga is Yao, while TA Pemba comprised mostly Chewa. The area borders Lake Malawi and the main economic activities are fishing and farming maize and rice for staple food and fishing. The area has high migration especially among young men who travel to South Africa for employment.

The intervention is implemented by the Malawi Interfaith AIDS Association (MIAA) which is composed of representatives of the major Christian and Islamic bodies in Malawi at district level. In order to further improve its operations and coordination, MIAA facilitated the establishment of District Interfaith AIDS Committees (DIACs) across the country. The intervention focuses on addressing women's vulnerability to HIV by working with community leaders and with men through discussion groups and providing training seminars.

In TA Maganga the intervention took place in more than 40 villages across two Group Village Headmen (GVH) namely Mikute and Ngolowindo. In TA Pemba, the intervention was implemented in GVH Pemba and Gwirize, covering over 30 villages

MIAA targets specific groups of men to work as male motivators such as bicycle taxi drivers and fishermen. The male motivators are trained in a number of topics, focusing on HIV and AIDS, gender issues, and abuse/violence. They are then expected to return to their communities and spread the messages they have learned in training.

MIAA works with the Village Head in the selection of male motivators. Those who have a poor reputation, for instance as being alcohol dependent, are not selected for training. Rather, those with standing in the community and thus a better possibility of adequately disseminating their learning are chosen.

MIAA Interventions: Numbers Involved642 trained male motivators

16 Men's Forums established

200 Traditional & religious Leaders trained

2 Networks of Traditional & Religious Leaders established

Catholic Commission for Justice and Peace (CCJP), Ntcheu

Ntcheu district is located along the main tarmac road that runs between Lilongwe and Blantyre at about 160 kilometres. In Ntcheu the project was implemented by Catholic Commission for Justice and Peace (National Office in collaboration with Dedza Diocese). The intervention operates in two TAs within this district namely; TA Njolomole and TA Chakhumbira. The district is predominantly inhabited by the Ngoni ethnic group. The Ngoni are traditionally patrilineal by culture meaning that once married a woman is required to live at the husband's birthplace. However, due to intermarriages with other tribes, the matrilineal system is often practiced. The main religion in both sites is Christianity with a strong presence of Catholic and Presbyterian denominations.

TA Chakhumbira borders Mozambique and the main economic activity is farming; maize for consumption and while Irish potatoes, tomatoes and cabbage were grown mainly for sale. TA Njolomole also boarders Mozambique on the western side. The villages that were involved in TA Chakhumbira include Balamu, Chimkwita, Jingapansi, Mtambalika and Pilirani. The villages that were involved in the intervention in Njolomole include Phonya, Makala, Kaludzu, Chiyembekeza, Daudi, Sesani and Chipeyani.

The intervention uses the men-to-men approach to addressing women's vulnerability to HIV by including men who display 'risky' behaviour in 'men's club' discussion groups. The inclusion of men who are involved in risky behaviour is aimed at reforming and turning them into community role models and peer educators for other men.

CCJP Interventions: Numbers involved
35 Man to Man Clubs with 350 members in total established
4 Man to Man Club steering committees set up
95 Traditional & religious leaders trained
55 VSL Groups established
Use of alcohol audit tool to determine alcohol dependency integrated in to intervention monitoring

Through Trócaire funding CCJP implemented the programme through engaging men by establishing men's clubs referred to as 'abambo chitsanzo' (role model men). The aim is to create space to allow "honest and straight talk" through which the links between their socialized masculine values and roles, as well as the use of alcohol and vulnerability to HIV infection are explored and rectified. Once these men had changed their own behaviour they were used as peer educators to advise / teach others in the community (Episcopal Conference Of Malawi, 2014).The programme also targets traditional leaders who are also included in training sessions and work to spread programme messages to the community and influence change in cultural practices. VSL's were established in one of the TAs at the commencement of the programme in line with the then research design. In late 2013 VSL's were commenced also in Chakhumbira. The programme also implements a specific intervention to reduce alcohol consumption as an identified risk factor associated with HIV transmission.

1.3 The Quantitative Research Element

The quantitative element of the study was designed to provide general information about knowledge of HIV, 'source of HIV information' (e.g. leaders, health workers etc.), attitudes towards gender and sexual norms and intimate partner violence, stigmatising or discriminating attitudes towards people living with HIV, sexual communication, and to examine access to HIV testing and condoms. In addition the quantitative element was able to measure prevalence of some sexual practices including transactional sex, multiple concurrent partnerships, and age of sexual debut. A fully anonymous section of the surveys also allowed for the collection of information on more sensitive areas, including condom use, willingness to disclose HIV status to the community, and experiences of violence. This information was used to understand practices and attitudes within the districts and was used to fine-tune the topics to be more deeply examined within the qualitative studies.

An important aspect of the quantitative research was also to track changes in relation to attitudes and behaviours determined as important for reducing women's vulnerability to HIV. Thus, both a baseline survey and an endline survey were used to assess changes over time and as a result of interventions. Following the baseline study a list of important indicators were selected for quantitative tracking purposes – these are provided in Appendix C. These indicators were then used for analysis purposes in comparing changes between baseline and endline among different groups (Control vs. Intervention sites, type of interventions, districts, and participants vs. non-participants). Furthermore, where possible, important findings from the qualitative research were explored within the endline survey such as the use of *fisi*[2] and the strategy of 'openness'.

1.3.1 The Trócaire Malawi Endline Study

Following the same format and layout as the baseline survey, conducted in September 2011, the endline survey is a quantitative survey tool consisting of sets of tools validated by previous research, including work conducted by Trócaire in Kenya (2010), UNAIDS Demographic Household Survey (DHS), and Horizons (1997). Approximately 120 questions were asked of respondents, with surveys taking about one hour to complete. To prepare the endline survey the baseline survey was reviewed against findings from the qualitative analysis. For the sake of consistency and to track changes, questions asked in the baseline were repeated. To these, new questions were added relating to issues that arose during the qualitative data analysis. The endline survey also repeated the self-administered anonymous questionnaire used in the baseline study. This consisted of six questions accompanied by explanatory images. Field managers and interviewers received training by NUI Galway and REACH Trust on implementing the survey and a selection of tools from the survey were piloted in Dowa TA Msakambewa in Chiponda and Gwireni villages on 6 November,2015.

Purpose of a baseline and endline survey:

A baseline survey provides quantitative information that captures the current status of a given population. It acts as a 'snapshot' which can then be compared to further 'snapshots' taken at other times. A baseline 'aims at qualifying the distribution of certain variables in a

[2] A man who is engaged to have sex with a woman or girl. This may be in order to perform a service (such as surrogacy in the event the woman is struggling to conceive) or a ritual (such as sexually initiating girls deemed to be of age)

study population at one point in time. It involves the systemic collection and presentation of data to give a clear picture of a particular situation as it relates the following: What? Who? Where? When? Why? How?' (Anyaegbunam et. al., 2004). As such a baseline does not provide a final assessment of intervention strategies, relationships between variables or causal factors; rather it details information that can be used for comparison against repeated studies to assess changes in the status of the population. In this study the baseline survey provided one element within a study design and is accompanied by an endline survey, and supplemented with qualitative information. The endline survey repeats questions from the baseline survey to assess changes that may have occurred during this period among different populations. Using baseline and endline surveys thus allows us to measure change and assess what factors (participation, type of intervention, etc.) that influences the type and extent of change amongst the study population.

The endline study yielded 765 completed, valid, questionnaires, 280 men and 485 women. 206 surveys were completed in Ntcheu, 197 in Dowa, 166 in Nkhotakota and 196 in in Salima. Among these, some respondents had also completed the baseline survey while others only completed the endline. Differences in the percentage of repeat respondents varied by district. For example in Ntcheu 18% of respondents were repeat respondents, compared to 11% in Nkhotakota, and 3% in both Salima and Dowa respectively constituting repeat respondents.

An **anonymous survey was also administered** to gain further information about condom use in the past three months, stigma and discrimination, and experiences of physical and sexual violence in the past 12 months. Only the gender of respondents was recorded as an identifying characteristic. Results of this survey are included in the report from Dowa, Ntcheu and Salima.

1.3.2 Methodology:

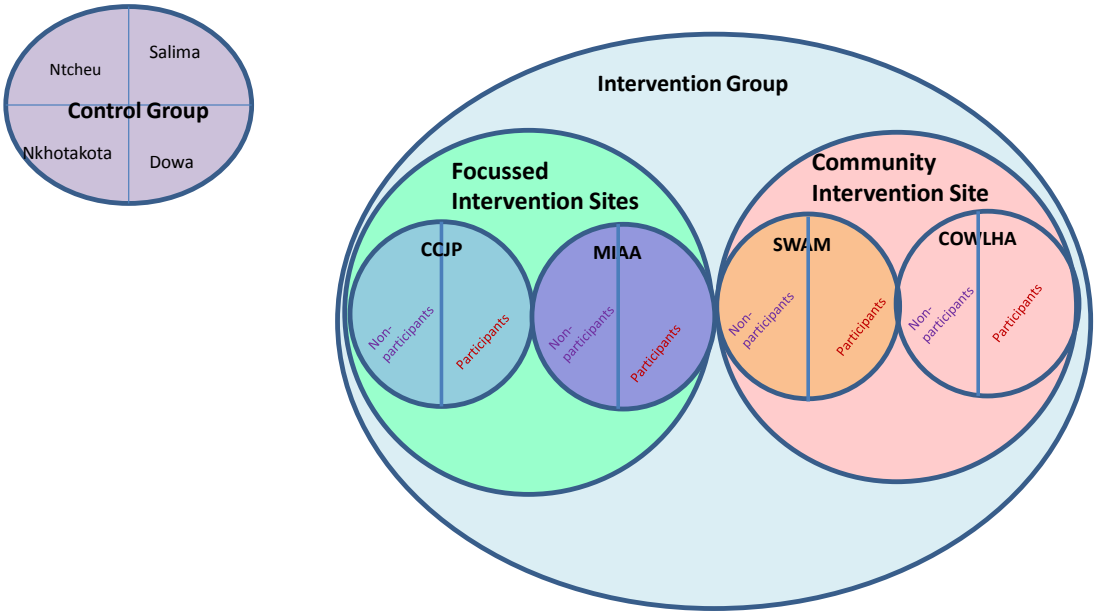
The evaluative study was designed to determine whether some approaches to addressing women's vulnerability to HIV are more successful than others. The survey tool examined areas including: Socio-economic status, awareness of NGOs and CBOs, gender roles and

norms, attitudes to violence, sexual attitudes and communication, HIV Knowledge, stigma and discrimination, condom use and testing, sexual history and behaviour. The final survey tools (baseline and endline) were translated into the local language of Chichewa and the administration of the surveys and data entry were conducted by REACH Trust. Trócaire staff in both Ireland and Malawi provided additional information and feedback on the survey design and on the report.

In each district a control sample was taken, consisting of several villages in which no interventions by partners were implemented. It cannot be guaranteed, however, that other organisations did not implement interventions on HIV or gender equality in these areas. Among the four partners, some similarities were identified allowing the four interventions to be grouped into two main approaches. The first 'intervention type' focuses on specific target groups as agents of change. This approach, referred to as focused interventions, was used by both MIAA in Salima and CCJP in Ntcheu. The second broad approach targets the entire community, involving men and women as well as chiefs and other leaders in community groups called STAR circles. In this report, we refer to this approach as the 'community interventions' which were implemented by SWAM in Nkhotakota and COWHLA in Dowa. See figure 1 below.

Figure 1: Groupings for Quantitative Research Design

Quantitative design



In order to evaluate the efficacy of the different intervention types, a layered analytic approach was used to assess changes between baseline and endline. Below we provide details about the layers, or steps of analysis, and the purpose of each of these:

i. The first layer involved a comparison (cross-tabulation) of changes between 2011 and 2015. This provides information about the overall changes that have occurred in the four districts in which the survey was undertaken.

ii. The second layer involved a comparison of changes between 2011 and 2015 of the control group and the intervention group. In this step we are seeking to understand whether perceived changes were occurring generally (e.g. in both control and intervention sites) or whether the change was only present in the intervention site, suggesting an impact by the intervention. The strength of such changes is also assessed providing an indication of how strong the effect of changes were in the control and in the intervention site. This can help to better understand whether the interventions had a likely additional impact even where changes were occurring more generally.

iii. The third layer excluded the control group and assessed changes between 2011 and 2015 of the two broad intervention approaches – the focused interventions (MIAA and CCJP) and the community-based interventions (COWHLA and SWAM). In this step we seek to determine whether approaches that target specific change agents (e.g. men and leaders) or approaches that target the community more broadly (e.g. the STAR methodology) are more effective in creating positive change.

iv. The fifth layer examined changes between 2011 and 2015 by district to determine whether any specific intervention had a greater effect. The Control group was excluded.

v. The final sixth layer, compared the outcomes of the endline between participants of any VSL or Trócaire supported intervention and non-participants within intervention sites. This step was designed to examine the extent to which we may see changes spreading beyond the immediate recipients of the intervention. Control group was excluded in this analysis.

In addition to these steps, significant findings were then re-examined by gender to test whether impacts may be differently experienced by men and women.

The baseline and endline surveys were implemented as population based surveys in four Districts in Malawi. A breakdown of the sampling at District, Traditional Authority, Group Village and Village level is included in Appendix II. Cluster sampling was done to randomly select group villages and within these a random sampling method was used – 'the spin the bottle' method in which the team supervisor would locate the centre of a village and use a bottle to select the first house to be surveyed. Previous liaison with local headmen ensured that researchers would be welcome in the village. To the extent possible the endline replicated the sample from the baseline, with researchers returning to the same villages.

The endline survey was conducted approximately 6 months after the end of intervention implementation in each district. The timing was chosen to allow participants to 'settle' back into life post-intervention and to assess whether changes and learnings from the intervention were maintained after the intervention came to a close.

The sample sizes for the findings presented in this report are as follows:

Full sample: 1561 respondents (573 men, 988 women), Intervention Sample: 1055 respondents. Control Sample: 506 respondents. In Ntcheu there were 404 respondents, in Dowa, 398 respondents, in Nkhotakota, 361 respondents and in Salima, 398 respondents. Further details are provided in the table below. Some variation in these figures is present for specific questions due to missing responses.

Table 1: Sample Size Breakdown

Sample	Total	Baseline									Endline								
		Total			Men			Women			Total			Men			Women		
		T	C	I	T	C	I	T	C	I	T	C	I	T	C	I	T	C	I
Full	1561	796	286	510	293	114	179	503	172	350	765	220	545	280	85	195	485	135	350
Control	506	286	NA	NA	114	NA	NA	172	NA	NA	220	NA	NA	85	NA	NA	135	NA	NA
Intervention	1055	510	NA	NA	179	NA	NA	350	NA	NA	545	NA	NA	195	NA	NA	350	NA	NA
Ntcheu (D)	404	198	50	148	75	19	56	123	31	92	206	51	155	74	17	57	132	34	98
Dowa (D)	398	201	126	75	85	53	32	116	73	43	197	91	106	86	39	47	111	52	59
Nkhotakota (D)	361	195	65	130	86	35	51	109	30	79	166	37	129	72	22	50	94	15	79
Salima (D)	398	202	45	157	47	7	50	155	38	117	196	41	155	48	7	41	148	34	114

T=Total, C=Control, I=Intervention, D=District

1.2.2.1 Methods

The baseline and endline surveys were analysed via quantitative methodologies. PASW (previously known as SPSS) version 20 was used to analyse the data. Cross tabulations were used between discreet variables to uncover significant relationships, with Phi or Cramer's V (*V*) used to test the strength of relationships. Paired sample t-tests were used to assess the relationships between baseline and endline for continuous variables (*t*). For continuous and scaled variables, correlations (Spearman's Rho= P) were used to assess the direction and strength of relationships. Statistical significance (probability = *p*) was set at 0.05 to ensure that the effects perceived were not by chance. A *p*-level of 0.05 indicates that the finding has at least a 95% chance of being true. This level holds to academic standards of rigor (Miller et. al. 2002, p. 118).

Important Statistical Terminology

Statistical significance refers to the likelihood that the perceived change or difference in the results is not a product of random chance. Statistical significance is given as a 'p' or probability value that ranges from 0 to 1. A value of 0.05 is considered to be statistically significant, indicating that there is less than a 5% chance that the change could be explained by chance. If a change is not significant (or close to significance) no further statistical examination is required as we cannot rule out the possibility that the finding is false or an effect of chance. Of note, achieving significance requires a minimum number of responses, to rule out chance. As the sample size becomes smaller (e.g. women participants, in Ntcheu) achieving significance becomes more difficult.

Strength of association is another important statistical finding. A change or difference may be significant, but that does not necessarily mean that the association between the variables examined is strong. For example, we may find that the change in HIV knowledge among participants is significant between 2011 and 2015, but the association between participation and HIV knowledge may not be strong, suggesting that other factors may have had a greater influence on the change seen. Thus, the strength of the association between the change and the associated variables should also be considered. The measure of association used to assess the strength of the relationship in this study was primarily Cramer's V (*V*). This measure is compatible where tables are of different sizes and thus allows us to compare results from different sub-samples. Cramer's V ranges from 0 where there is no relationship between variables to 1 where there is a perfect relationship. Larger values indicate a stronger relationship, and smaller values indicate a weaker relationship.

1.2.2.2 Limitations

In order to ensure respondent compliance with the survey, direct questions relating to sexual behaviour were limited. While necessary, this has resulted in a reduced ability to make direct links between demographic factors, attitudes and knowledge, and specific behaviours and experiences.

While the number of respondents was adequate to achieve statistical significance in the majority of cross tabulations and correlations, in some cases this was not possible. As male respondents were in the minority it was found that where respondents were broken down by gender, district and other variables containing multiple answers, cell counts were in some cases too low to produce significant results. Furthermore, the low numbers of men involved in the study may result in significance not being achieved in relation to some analysis, where higher numbers of men would achieve significance. Wherever possible, researchers grouped answers to produce higher cell counts; however, some detailed information may have been lost. The anonymous survey data from Nkhotakota was misplaced prior to coding resulting in just 24 anonymous surveys from this district. Managing this error was further complicated by the fact that district was not coded in the baseline anonymous questionnaire and therefore we were unable to exclude Nkhotakota from the baseline to enable comparison between the three districts. This has compromised our ability to draw robust findings in relation to the questions asked on the anonymous questionnaire.

The baseline survey was conducted in September 2011, approximately 12 months after the commencement of the programme at the completion of the programme pilot phase. The majority of interventions were underway before the baseline survey was conducted. The result of this timing was that the baseline may have captured some of the changes that may have already taken place due to intervention impacts and thus does not, in all cases, present 'virgin' attitudes, behaviours, and knowledge. The endline survey was conducted in November and December of 2015, approximately six months after the completion of the programme. The timing was chosen to allow 'normal' life to resume post-intervention and to assess whether change was maintained after the intervention came to a close.

1.4 Qualitative Research Element

The qualitative study aimed to understand the effect of programme approaches on vulnerability to HIV for women and girls. The design took a close up look at the effect of the programme in a sample of eight villages at three points in time over the course of the programme: In March and April 2013, 2014 and June and July 2015.

1.4.1 Methodology

Four villages from the focused interventions (Men Engaging Men) and four villages from the community interventions (STAR Circles) were included. Selection of the villages considered distance to social amenities, health facilities, main road, and market, the size of the village as well as livelihood activities and dominant ethnic group. The number of villages selected per district and partner organisation, took account of the size and intensity of the programme interventions. For example one village in Dowa was selected and three were selected in Nkhotakota.

Qualitative research typically includes small numbers and aims for depth of understanding instead of representation. However, in this study we achieve depth as well as significant numbers as can be seen below. The qualitative work, however, does not aim to be representative at a population level.

Over the 3 data collection points 150 in-depth interviews were undertaken and 111 FGDs with 399 men and 435 women in the 8 sample villages. 8 individuals were followed up over time as case studies and interviews were conducted with them and, in some cases, their spouses. At the final round in-depth interviews were conducted with the senior staff from partner organisations implementing the programme.

Table 2: Qualitative sample

	Total 2013	Total 2014	Total 2015	Total
In-depth Interviews	86	24	40	150
FDGs	30	42	39	111
Men	100	129	170	399
Women	87	188	160	435
Total	187	317	330	834
Case study interviews	8	12	8	28

The field research was conducted by REACH Trust under the guidance of Mr Lifah Sanudi. The field team consisting of experienced researchers who spent 2 to 3 days in each of the selected villages. Different methods were employed including structured, unstructured and semi structured in-depth interviews, informal interviews, focus group discussions as well as

a tool designed for this research to quantify group attitudes, namely the Gender Attitudes Assessment (GAA) tool. The field research team also used participant observation, making notes to describe scenes, activities and behaviours. They sometimes participated in village activities (playing a popular board game called 'Bao', watching dramas enacted by community members, etc.). This approach enabled the building of a relationship that goes further than the simple administration of a questionnaire. It encourages trust, openness and honest communications. Very quickly after the initial introductions, and once it had been established that the team would be around for a few days, village life returned to normal. This allowed the researchers to move around the village getting a sense of normal life and gathering information unobtrusively.

1.4.1 Analysis

A content analysis approach was used. Interviews were recorded and transcribed and imported to MAXQDA software for analysis and a code template was developed for use by the three researchers (O'Reilly, Sanudi and Scriver) conducting the analysis. This template covered all the information categories sought and reflected the Results Framework (RF) for the programme, and the question guides. Thousands of pages of qualitative data were read and coded by the three analysts who communicated at regular intervals to cross check interpretations and share insights on emerging findings. Themes were determined under each broad information category. Themes were largely pre-defined according to questions asked of the data, however, some new themes did emerge.

1.4.2 Limitations

Due to community events, difficulties were often encountered on site trying to achieve the required numbers of participant types. Typically funerals in villages reduced the numbers of available participants. This in most cases was overcome by the team returning to the site a day or two later. However in some cases it could not be overcome and planned FGDs could not be conducted (e.g. with participants in Kandulu in the final round). In other cases, participants refused to take part without material incentives or in some cases the particular aspect of the programme (VSL's Dowa final round) had ceased. These were unavoidable but rare occurrences.

The limitations of this kind of research have consequences for generalizability, reliability, and objectivity. The quantitative component deals with these issues. Any weaknesses

inherent in design were countered through a rigorous and systematic approach and by providing rich data. Importantly the three researchers (two of whom were involved in the quantitative study) tested interpretations with one another and against data from other sources.

1.4.3 Ethical considerations

REACH Trust applied for and received ethical approval to conduct the study from the National Malawi Commission of Science and Technology (Sanudi L 2013). Prior to arriving at any site access was negotiated at district and local levels by Reach and facilitated by Trócaire's Partner organisations. At village level participation was voluntary and an explanation of the research process was given and informed consent forms signed prior to interview or focus group participation.

1.5 Population Overview

Across the four districts, the population largely represents a poor, largely agricultural-based population. 72% of the respondents had attended some formal schooling. However, of these, 80% had completed only primary school, 19% only secondary school and less than 1% had completed college or university. These statistics hold largely steady since the baseline in 2011. Of note, while more women than men had completed primary school at the endline (85% vs. 72%), far fewer women had completed secondary school compared to men (10% vs. 21%). Although a small majority of the population (55%) were literate (could read and write), 37% were neither able to read or write. There is a notable gender gap in literacy rates in 2015 with 65% of men capable of reading and writing in comparison to 49% of women (X=1.61, p=0.000, n=765). These findings are somewhat lower than the national average literacy rate of 70% (NSO, 2009). However, national statistics indicate a 20% literacy gap between men and women (ibid.) which has been largely borne out in both the baseline and endline studies.

The sample population is religious with less than 1% of respondents stating they did not belong to any religion. Religious affiliation also tended towards the recognised world religions, only 1% off the sample stated they belonged to an indigenous religion. Although Christianity was the most common religion (more than 60%), this included CCAP (19%), Catholic (15%), Pentecostal (10%), Protestant (9%), , and Seventh Day Adventist, (1%) . A further 7% belonged to other Christian Churches. 36% stated Islam as their religion. While the number of respondents identifying as Catholic, Muslim and

Protestant remained steady since the baseline, there was a notable drop from 18% to less than 1% in the number of respondents identifying as Jehovah's Witness and an increase from 7% to 19% among respondents identifying as CCAP. Thus the endline respondents' religious affiliation represents a slight shift in comparison to the baseline with more CCAP respondents than Catholics, and more Pentecostal respondents than Protestants.

At endline it was found that the vast majority of respondents were in a monogamous relationship with a spouse/partner (71%) while a further 9% were in a polygamous relationship. However, there were clear and significant (p=0.000) differences in relationship status between men and women. Women were twice as likely as men to be in polygamous relationships, or to be divorced, and three times more likely to be widowed. However, men were more likely to be in a monogamous union (married or living together) and more likely to be single. For both men and women having a regular partner with whom they were not living was rare, accounting for less than 1% of respondents These gender differences demonstrate little change since the baseline.

Very early marriage/partnership (<15) was rare among the sample population at both baseline and endline. Amongst those who were ever married/partnered (n=664), nearly three quarters of women and half of men married/partnered between the ages of 18 and 22, with a further third of men marrying/partnering between 23 and 27. However, there were clear gender differences among those who married/partnered early (<18). In 2015, 19% of women (n=467) were married/partnered before the age of 18 compared to just 2% of men (n=266). This difference was statistically significant (X=0.534, p=0.00). The age of the respondent's first cohabitating partner/spouse demonstrates a similar age distribution, with 20% of ever-partnered men indicating their partner/spouse was under the age of 18 and 70% stating they were between the age of 18 and 22 (n=218). For women, just 5% stated their partner/spouse was under 18 while for 41% they were between 18 and 22, and for 35% between 23 and 27 (n=275). There was little evidence of significant age discrepancies between partners during first partnership/marriage with the age of marriage of the spouse/partner positively correlated to the age of the respondent (R=0.410, p=0.000, n=732). A general pattern is evident whereby men are usually older by several years (2-3) compared to women.

99% of men and 97% of women stated that they had a say in their choice of spouse/partner. Forced marriage thus appears as a rarity among the sample population, albeit still a factor in approximately 3% of marriages. The majority of marriages did involve a bride price (93% for men and 84% of women).

The sample population did not have, on average, a very large number of children. Similar to findings in the baseline, 54% of respondents had three children or less while a further 39% had between four

and 6 children. This result is comparable to the Malawi Demographic and Health Survey, 2010, which identified the mean number of children born, per woman aged between 18-47 years as 3.07 (NSO/ICF MACRO, 2011: 47).

32% of those with children, also care for children apart from their own in their homes (n=487). This finding has not changed since the baseline study and is also substantiated by national statistics which finds that 33% of households care for foster children or orphans (NSO, 2011, 10). Amongst this group, three quarters care for one or two additional children. Common reasons for caring for these children were due to the death of parents (55%), migration of parents (28%) or illness of parents (5%) and 15% for other reasons. Migration as a reason for caring for other children has risen considerably, from 11% in 2011 to 28% in 2015, but the figures are not directly comparable due to a different structure in the coding.

Amongst those with children, 81% stated that all school aged children who lived with them attended school. Among those who cared for children who did not attend school (n=37), 22% said it was because the child did not want to attend school; a further 22% stated the school was too far away; 20% said it was because they could not afford to send them; 11% because they are too sick; 8% because they have their own children to care for; and 3% because the children work outside the home with the remainder indicating 'other' reasons. Notably, no respondents stated that the reason for a child's non-attendance at school was because they (the parents) did not want them to attend or because they were needed for work at home.

Both men and women in the sample regularly worked for cash income: 96% of men and 87% of women received some form of cash income. 64% of both men and women received income from farming and 20% of men and women from vending. Men were more likely to indicate they were self-employed than women (27% vs. 20%) - an increase of 7% for both men and women since the baseline - Women were more likely to receive income from casual work (18% vs. 16%).

In the baseline study, respondents were asked how many meals they consumed in the previous day. In the endline this question was changed to ask whether the respondent had gone without food for a day or more in the last month due to low income. Results from this question indicate a high level of hunger among the study population in the previous month with 48% of men and 46% of women going without food. When compared against primary economic activities, differences were noted: While 64% of those whose primary activity was farming had gone for a day or more without food in the last month, this was true for 24% of those whose primary activity was casual labour, 18% of those who were self-employed and 17% of those whose income came from vending. Statistically significant relationships were found for some relationships. Particularly, self-employed women were

less likely to miss eating for a day or more compared to women in other occupations (p=0.039, n=418), while men engaged in vending were less likely to go hungry than men in other occupations (p=0.026, n=268). For both men and women, casual labour was significantly associated with missing food for a day or more due to low income (p=0.000, n=686)

To understand the level and impact of poverty, respondents were asked if they agreed, neither agreed nor disagreed, or disagreed with three statements. 26% disagreed with the statement that they could usually manage to replace plates and utensils when needed. 32% disagreed that they could buy meat or fish at least once a week and 33% disagreed that they could usually replace clothes when they needed to. Gender differences were also evident in relation to the questions on replacing plates and utensils with women more likely to disagree with the statement (28% vs. 24%, V=0.162, p=0.001) and in relation to ability to purchase meat or fish at least once a week with women more likely to disagree (34% vs. 31%, V=0.128, p=0.029).

70% of respondents had been to an event organised by an NGO such as a play or information session. 48% had also been involved in a programme or training in HIV and AIDS or gender by an NGO/CBO in the past twelve months. Among those who were able to provide the name of the NGO/CBO (n=181), 30% had received training from SWAM, 23% had received training from CCJP, 10% from MIAA and 2% from each COWLHA and from Trócaire, while others listed a number of different organisations including Dan Church Aid, Care International, Action AID and 'others'. Among those who had taken part in a training or programme, 83% stated they were participants and 9% stated they were facilitators while a further 8% indicated their role as 'other' (6%) or unsure (2%)

27% of respondents (n=101) stated that someone else in their household had participated in a programme or training in HIV and AIDS or gender in the past twelve months. Amongst these the majority participated as participants (77%) with a further 10% acting as facilitators. 32% stated the training was provided by SWAM, 19% by CCJP, 7% by MIAA. 3% stated that this training/programme was provided by Trócaire, 2% by COWLHA,

A further 8% of participants (7% of men (n=19) and 8% of women (n=40)) were members of a VSL supported by one of the Trócaire interventions in Malawi, with the vast majority belonging to VSL's supported by SWAM (n=26) and CCJP (n=27).

District Overview Snapshot:

Although differences between districts are not vast (with the exception of religious affiliation) there are nevertheless some significant variances in population demographics found in the endline survey.

Ntcheu: The population of Ntcheu is the most educated and literate of the four districts. Respondents from Ntcheu were the least likely to care for orphans or foster children among the four districts. The rate of divorce/separation was notably high in Ntcheu (15%) as was the rate of widowhood compared to the other three districts. Respondents from Ntcheu were also highly likely to belong to a group (52%) e.g. a VSL or a support group in the programme or, a church / prayer group in the community. Respondents from Ntcheu were most likely to earn income from farming (67%) followed by self-employment (19%) and vending (18%). While Ntcheu represents as relatively well-off in many indicators, 46% of respondents stated that they had gone without food for one day or more in the past month. 44% of respondents in Ntcheu had taken part in a training on HIV/AIDS or gender provided by an NGO/CBO and 28% of respondents had a member of their household take part in such trainings in the past 12 months.

Salima: Salima is a predominantly Muslim district, with 93% of respondents from this district indicating their religion as Islam and the remaining minority (>3%) being Catholics and Protestants. Correspondingly, Salima also has a relatively high percentage of polygamous unions at 15% (down from 22% in 2011). As was found in the baseline, the survey population from Salima had a comparatively low level (along with Nkhotakota) of formal school attendance at 59% and a literacy rate of 42% (a drop from 53% in 2011). Group membership, as found during the baseline, was the lowest in Salima with 25% (an increase from 20% in 2011) of respondents from this district belonging to a group. 48% of respondents from Salima, the second highest rate after Dowa, had gone without food in the past month. Respondents from Salima were the most likely to be in salaried work of the four districts (3% - a drop from 8% in 2011) and to state that casual labour (26%) or self-employment (33%) was their primary economic activity. They were also the most likely to care for children in addition to their own with 48% indicating that they did so – an increase of 20% compared to Ntcheu. 44% of respondents in Salima had taken part in a training on HIV and AIDS or gender provided by an NGO/CBO and 22% of respondents had a member of their household take part in such trainings in the past 12 months.

Nkhotakota: Nkhotakota represents the most religiously diverse of the four districts, with 54% of respondents indicating their religion as Islam, 23% as Protestant, 7% as CCAP and 4% each as Catholic. 15% of respondents from this district were in a polygamous relationship, with no significant change since 2011. Nkhotakota had, along with Salima, the poorest level of attendance at formal school at 58% and the lowest literacy rate of 39%. However, Nkhotakota seemed to be the least affected by food poverty, with 42% stating that they had gone without food for one day or more due

to low income. Furthermore, respondents from Nkhotakota were most likely to earn income through farming (58%) or vending (30%). Of the four districts, respondents from Nkhotakota were the most likely to earn income from vending marking a significant shift in vending activities in Nkhotakota since 2011, when they were the least likely to be involved. Respondents from Nkhotakota were the most likely to be involved in a group (56%) and they were also by far the most likely to have participated in a training in HIV and AIDs or gender provided by an NGO/CBO in the past 12 months (61%) or have someone else in their household take part in such a training (36%)

Dowa: Respondents from Dowa were predominantly Christian with 41% Catholic, 22% CCAP, 12% Pentecostal, and 6% Protestant. 84% of respondents from Dowa were in a monogamous partnership at the time of the interview – the highest rate of such partnerships among the four districts. 82% had attended school and 67% stated that they could read and write. 71% of respondents from Dowa relied on farming as their primary economic activity. While 18% of respondents in the baseline said they were Jehovah's Witnesses, only one respondent identified as belonging to this religion in the endline. 49% of respondents stated that they had gone without food for a day or more in the past month due to low income, the highest among the four districts. 30% of respondents cared for children who were not their own in Dowa, suggesting no change in this activity since 2011. 46% of respondents were involved in a group e.g. a VSL or a support group in the programme or, a church / prayer group in the community. 43% of respondents in Dowa had taken part in a training on HIV/AIDS or gender provided by an NGO/CBO and 21% of respondents had a member of their household take part in such trainings in the past 12 months.

2. Findings:

2.1 Knowledge

Highlights:

- Improvement in overall in comprehensive knowledge on HIV.
- Stronger positive change among men than among women.
- Stronger positive change in intervention sites compared to control sites.
- Stronger change in community-based interventions than in focused interventions.

In the baseline knowledge was found to be generally good, with most respondents able to name both risks for contracting HIV and ways of preventing HIV. However, comprehensive knowledge was found to be much less common with particular stumbling blocks in relation to the statement 'men who go to sex workers are the only ones who need to worry about contracting HIV', where the majority agreed with this statement.

The endline utilised the same questions as were included in the baseline in order to compare possible changes. However, an additional statement was included in order to test understanding of the question described above, to rule out the possibility that respondents were misconstruing the question. Thus a paired statement was added, 'Men who only have sex with their wives and/or regular girlfriends don't need to worry about HIV' which addresses the same knowledge – i.e. that it is not only through unfaithfulness that HIV may be contracted. Responses to both statements were similar, suggesting that the statement was understood as intended.

The findings show that HIV knowledge has significantly improved overall, increasing from 77% who had good knowledge in 2011 to 83% with good knowledge in 2015 ($p=0.002$)[3]. This included a significant shift from 73 to 87% of men with good knowledge, while women's knowledge remained steady, increasing by 1% from 79%. However, this change appears to be primarily a shift that is happening in general rather than because of the effect of interventions as no statistically significant differences existed between the changes witnessed in the control group and those in the intervention group although intervention sites did show a stronger relationship to changes in knowledge of HIV ($V=0.076$ and came close to significance at $p=0.072$). Significant shifts in knowledge scores were found among both intervention types, but community interventions demonstrated a somewhat stronger effect ($V=0.90$ vs. $V=0.83$). Within districts however, Ntcheu does show a statistically significant shift from 70% who demonstrated good knowledge in 2011 (the lowest among the three districts) to 88% in 2015 (the highest among the districts). While the difference between participants and non-participants in Ntcheu showed that 5% more participants compared to non-participants had good knowledge, this did not reach significance (although this may be an effect of the small sample size of n=156).

A positive shift was also seen in relation to the proportion of respondents who could answer four HIV knowledge questions correctly from 9% to 13%.

[3] The HIV knowledge scale was composed of responses to four questions: 601: An HIV+ pregnant woman can reduce the risk of transmission of HIV to her unborn child by taking medication (anti-retrovirals); 602: Circumcising boys with a clean blade can reduce their risk of HIV; 605: Men who go to sex workers are the **only** ones who have to worry about getting HIV; 604: initiation ceremonies for girls can be modified to reduce the risk of HIV transmission.

In relation to knowledge about prevention methods and risk factors, there was no change found in those who could name three or more risk factors overall (24%, n=1350). No differences were found between control and intervention sites, or between districts. However, within districts some differences were noted between participants and non-participants. 28% of participants compared to 20% of non-participants were able to name 3 or more risk factors. The difference between participants and non-participants was significant for Salima and Nkhotakota when examined within districts. In Salima, 39% of participants vs. 19% of non-participants were able to name three or more risk factors (p= 0.014). In Nkhotakota, 33% of participants vs. 19% of non-participants (p= 0.50) named three or more risk factors.

An insignificant change overall from 16% to 17% of respondents who were able to name 3 or more prevention methods between 2011 and 2015 was found. No differences were found between control and intervention sites, between types of interventions or between districts. However, it was found that in Salima, participants were significantly more likely to name three or more prevention methods (19%) compared to non-participants (10%), p= 0.022.

Presence of other NGO's

While control sites were used in the quantitative analysis, in which no Trócaire supported programmes were working, this does not necessarily mean that no other programmes were working in the area. When survey respondents were asked if they knew of other NGOs working in their community, some NGOs were identified as shown below:

Ntcheu: SAFE Motherhood

Dowa: World Vision & Hope International

Nkhotakota: Nkhotakhota Aids Support Organisation/National Aids Commission

Overall, the findings suggest general improvements in knowledge about HIV in the districts in Malawi. There is evidence of the impact of interventions. In Ntcheu, the considerable improvement in knowledge scores also show just a 5% difference between direct participants and non-participants, suggesting that the impact may be felt beyond the primary beneficiaries.

2.2 Messaging

Highlights

- Wide spread of programme messages throughout districts
- Low reporting of having heard messages on HIV from local leaders in 6 months prior to survey in both baseline and endline.
- Significant increase in those reporting having heard messages from religious leaders and community leaders but a significant decrease in those reporting to have heard messages on HIV from chiefs.
- District level differences in likelihood of hearing messages on HIV from community leaders
- Women in focused intervention sites less likely to hear messages
- Reduced messaging in some sites

Source

The source of messages differed between intervention areas and depending on the programme approach. In Salima, the qualitative research identified leaders and men who have been trained by the programme as the source of messages for the community. In Ntcheu men who have been trained to change their own behavior are the main source of messages. In Nkhotakota and Dowa the STAR circle members are the main source of messages. Nevertheless it was clear that chiefs and elders were involved in all sites to help spread programme messages to community members.

> *After discussing in our circle we take the issue to the chief who in turn organizes a big community awareness meeting…. we also use door to door visits to reach those who were not able to come to the community meeting* …. (IDI_KK_MV_FK_01).

The endline survey found that relatively few participants indicated that local leaders[4] were involved in delivering messages on HIV to the communities. On average, among men and women who had heard a message on HIV from any source in the 6 months prior to responding to the survey, 88% of 2011 had not heard messaging from local leaders, compared to 86% who had not heard any HIV messages from local leaders prior to the endline survey in 2015. This finding indicates the low level of communication on HIV between local leaders and the general population. Overall it was found that messaging heard from chiefs declined from 12% to 9% between 2011 and 2015 ($p<0.05$), while the percentage of those who indicated hearing messages from religious leaders increased from 8% to 11% between 2011 and 2015 ($p<0.05$). Messaging on HIV heard from community leaders also increased from 16% to 21% between 2011 and 2015 ($p<0.05$).

[4] Local leaders include religious leaders, Chiefs and community leaders.

Significant differences in the source of messaging were noted by district/intervention area. Some notable changes are evident between the baseline and endline in relation to leaders delivering messaging on HIV in the different districts. In Nkhotakota (n=268) for instance, respondents note substantial changes in leaders delivering messages. In 2011, only 3% of respondents had heard a Chief deliver an HIV message compared to 19% in 2015. Messaging heard from religious leaders also increased from 3% in Nkhotakota to 18% and from community leaders from 4% to 33% ($p<0.05$).

Messages heard from leaders[5]		% in 2011	% in 2015
Ntcheu (n=286)	Chief	22	8*
	Religious Leader	20	8*
	Community leader	27	12*
Dowa (n=298)	Chief	19	6*
	Religious Leader	5	9
	Community Leader	11	13
Nkhotakota (n=268)	Chief	3	19*
	Religious Leader	3	18*
	Community Leader	4	33*
Salima (n=245)	Chief	3	3
	Religious Leader	6	12
	Community Leader	22	30

*Denotes a statistically significant relationship ($p<0.05$)

[5] Percentages provided in this table relate to the percentage of those who had heard messages from specific sources among those who had heard any message. E.g. 22% of those who had heard any message on HIV, had heard a message from a Chief.

Improvements in the percentage of respondents who stated hearing a message on HIV from a Chief, religious or community leader were noted in Dowa, Salima and Nkhotakota. Only in Ntcheu was there a reduction in reported messaging from all leaders. Particularly notable improvements were found in Nkhotakota among all leaders and in Salima for religious and community leaders, however, none of the changes in Salima reached statistical significance. These findings reflect some shifts in the engagement of leaders in spreading messaging on HIV, with Ntcheu, where leaders appeared to be the most engaged in 2011 now appearing less engaged, and Nkhotakota, previously exhibiting the poorest engagement by leaders in this regard, now the best.

Women and HIV messaging – evidence from the quantitative data

In 2011, 72% of women reported having heard messaging about HIV in the past 6 months. In 2015, we find fewer women (59%) reporting hearing messages in the previous six month. The trend towards not hearing messages is happening generally and this is more evident for the control sites (V=0.164) compared to the intervention sites (V=0.117). When examined by type of intervention, there is no decline in hearing messages for women in community intervention sites but a significant decline for women in focused interventions sites from 71% to 58%, p= 0.006. Further exploration shows that it is within Salima that this effect is significant, with a drop from 69% of women stating they had heard messages in the past six months in 2011 to 54% in 2015.

Content

While in focused intervention sites some participants spoke of men only as the target of messages, in others couples were also the target. It was clear in all sites that much of the content was aimed at men and at families. The purpose was to promote family unity and reduce vulnerability to HIV. Content of messaging included: Openness in the family, reducing gender based violence, promoting gender equality, messages relating to HIV, modifications of risky cultural practices, reduction in alcohol consumption and multiple concurrent partnerships, and encouraging safe circumcision and, less frequently, safe motherhood. Notably, few women provided concrete examples of messaging. However, some messaging that women heard related to concurrent partnerships, openness and modifications to cultural practices.

Spread

Messaging appears to have reached beyond participants with women and non-participant men indicating that they had heard various messages. There was a difference, however, between villages in Salima and Ntcheu in how diffused messages were among the population. In Salima, leaders passed what they had learned from trainings to community members. Not all leaders were involved (female chief in one of the sites). Leaders also were involved in more than spreading messages with reports of by-laws being passed to reduce risks by stopping what were considered risky practices and controlling the social environment. Members of men's forums and motivators also passed on what they had

learned through word of mouth. There appeared to be less activities held by programme members for the purpose of spreading messages in the past year in both sites.

In Nkhotakota and Dowa messages were usually disseminated by the STAR circle members or local community leaders. The direct programme participants reported that the messages were disseminated using a door to door approach and community meetings. The messages were packaged in a way that the same message would be given to both males and females.

In Dowa the STAR circle group was no longer meeting since the facilitator left the area. The circle membership reconvened only when visitors sent messages of their coming.

Clarity of messages

Most messages appeared to be consistent and clear and received with the emphasis intended. Messages on violence, however, were broadly interpreted reflecting the wide ranging understandings as to what violence meant. The intent of some programme messages was changed through varying interpretations that failed to challenge the dominant narrative that privileged men. Messages about openness therefore, often included the advice that women should satisfy their husband's in order to reduce the risk of unfaithfulness.

Receipt of messages

All the facilitators as well as the community members reported that the messages were well received by the community. A theme that emerged through the data was the almost unquestioning acceptance of messages, with respondents often describing becoming 'enlightened' upon hearing messages. Debate and/or interrogation about the wisdom of these messages did not emerge. Community members also were seen to accept unquestioningly by-laws and rules to curtail movement and opportunities in which risk may prevail. This manner of programming and indeed response to programming highlights what at times appears to be a lack of individual autonomy and agency. It is also possible that the expected debate and struggle on these issues predated the qualitative data collection, or happened at another level, for example with leaders not with community members who accept the wisdom of their leaders. Another possible explanation for the seemingly easy acceptance of the messages is that the intervention came at a time when communities were ready to change and so was pushing an open door. It is also possible that reports of acceptance of messages are exaggerated.

In Summary

Programme messages appeared to have been heard and well received in all areas. Women in focused intervention were less likely to hear clear programme messages. The 'men engaging men' strategy has been interpreted as 'men only' so that messages on sensitive gender and sexual issues are being delivered in a gender biased way. The almost unquestioning acceptance of messages, often described as becoming 'enlightened' and messages about change to cultural practices appeared to be pushing an open door. Some interpretations of messages on openness challenge modern ideas of gender equality. Programme interventions in some sites were less active in spreading messages than in previous rounds, possibly due to the six months implementation break prior to the endline.

2.3 Cultural Practices

Highlights:

- Strong evidence from the qualitative research to show changes to cultural practices identified as a risk for contracting HIV, including wife inheritance, kuchotsa/kusasa fumbi, and night dances.
- Modifications to existing cultural practices to reduce risk also apparent, such as reduced periods of sexual seclusion and changes to initiation practices.
- While such changes appeared to have begun prior to the commencement of the programme, partner programmes were credited with intensifying these changes.
- Explicit link made by partners between sexual seclusion practices and risk of HIV due to unfaithfulness may contradict messaging on men's sexual responsibility.

Changes in cultural practices were primarily assessed through qualitative means, although the baseline and endline surveys included some questions relating to cultural practices that help to validate the findings from the qualitative research. Changes in cultural practices predate the first round of data collection and are reported as being prompted by the HIV pandemic itself and advocated for by religious teachings, other NGOs, and health service advice. For example in 2002 health service providers advised that the use of one tool during circumcision would transmit HIV between initiates. Findings from round one of the qualitative research showed that while there was strong adherence to cultural practices in all study areas, respondents reported the decline or end of practices identified as posing a direct risk of HIV transmission. Extremely risky practices such as *chokolo* (wife inheritance) or sex with adolescent virgins (kusasa fumbi/kuchotsa fumbi), were reported by most as abolished prior to the intervention and as a consequence of the HIV pandemic itself. In the quantitative endline, 14% of women 18 or older (n=339) indicated that they had gone through kusasa fumbi. However, significant changes were noted between 2011 and 2015 in relation to agreement with the statement, 'Girls who have been initiated and have undergone *kuchotsa fumbi* make better sexual partners'. Agreement with this statement declined in general (n=1275) and in intervention sites (n=863), with a reduction also present in the control group, although not reaching significance (n=412). This suggests that interventions may have strengthened the effect of already-occurring changes in attitude to kuchotsa fumbi.

Table 2: Kuchotsa Fumbi

Statement	All- % agree		Control - % Agree		Intervention - % Agree	
	2011	2015	2011	2015	2011	2015
Girls who have been initiated and have undergone Kuchotsa fumbi make better sexual partners'	78	72	74	69*	80	74

*Statistically insignificant change

Other practices that posed direct risk and were said to be on the decline or rare at round one, such as the use of fisi, were even less evident by round three. In fact, just 9 respondents, or 3% of those who responded (n=280) to this question in the endline, stated that they had ever been engaged a fisi. While this practice was reported as rare in round one (2013) of the qualitative data collection some respondents reported first-hand experience of this practice. By round 3 reports were speculative with no reports of a formal arrangement that sanctioned this practice.

"I would say we no longer have chokolo practices and also kusasa fumbi. Again fisi practices vanished. We no longer hear that such such a man was used as a fisi in such and such a house."
IDI_DA_MS_FK_01

The three rounds of data collection saw initiations modified, celebrations curtailed and periods of sexual seclusion reduced significantly for the purpose of reducing risk and vulnerability.

2.3.1 Initiations

Initiation practices for girls appear to have undergone considerable transformation in recent years often ascribed to the influence of the Programme Partners and other civil society organisations, as well as religious teachings. Respondents noted that girls are no longer brought to the bush by traditional counsellors for extended periods to undergo initiation as occurred previously, but arecounselled at their homes by their parents, or community or Church Elders. In some sites a small minority were reported to continue to engage in traditional practices, however, even these were modified in some way e.g. the traditional surgeon (Ngaliba) responsible for the circumcision of young men was trained and equipped with clean blades while respondents also reported an increase in hospital-based circumcisions and the length of girls initiations was reduced so that they did not miss school.

2.3.2 Dances

While dances continue, modifications, as described in previous reports have been made. By-laws were reported to ban or curtail overnight celebrations after the initiations and indeed for other purposes e.g. weddings.

> *I can see some changes in terms of peoples' behavior as well as culture in this area. In the past, we used to have Michezo whenever we had wedding ceremonies but this Michezo is no longer practiced* (IDI_KK_ZD_AA_03).

In Dowa and Nkhotakota (Mvalamanja village) the 'big dance' gule wamkulu was banned although it was still performed in neighbouring communities.

2.3.3 Seclusion

The cultural practices recognise various events where couples need to be in sexual seclusion/abstinence. The period of time for sexual abstinence around life events such as births, funerals and initiations was said to have reduced as a result of the programme. In all sites, respondents (men and women, participants and non-participants) noted changes in these practices perceived as reducing the risk of HIV, primarily through a reduction in the likelihood of men being unfaithful. The specific timings that people were advised that they could continue sexual intercourse up to, and prior to childbirth, and to resume sexual activity post-partum, varied from site to site and within sites. These changes appeared to be favourably regarded by all, and several respondents specifically ascribed these changes to the partners in each site. There were nuanced interpretations articulated about when sexual intercourse ***could*** stop and resume or when it ***should*** stop and resume as seen in the quotes below, the first places the decision in the woman's hands unlike the second:

> ***Facil:*** *Was there a special ritual that was done during the period of kuika mwana kumalo or I should say is there something taking place now that the practice was modified?*
> ***Resp:*** *At the moment there is not any ritual that is done. Once you know you are well and* ***you want to have sex*** *with your husband you just discuss and then you resume your sexual intercourse. There is no prescribed period that you have to wait* (female STAR circle facilitator, IDI_KK_ZD_FK_01).

> *Today this kind of practice [seclusion] has brought risk of HIV infection and it is not good for a person to spend many months without conducting sex with his wife, to avoid him conducting immoral sexual behaviour. DIAC has taught us that a person* ***should not go***

beyond *40 days before resuming sex with his wife after baby delivery*

IDI_SA_KD_PP_01(chairman of motivators)

This distinction between when sex *can* occur and when it *should* occur is important. Once misinformation is dispelled about when it is safe to have sex, no further advice is warranted. Women should not be advised to have sex to stop their husbands' infidelity as this suggests the reverse causes it.

These changes, however, appeared as consistent with teachings and messages external to the programme e.g. health professionals and marriage counsellors. Changes were also reported which reduced the mandatory period of seclusion for widows and widowers. In some villages (e.g. Makala) these changes were reported to be effected through by-laws.

2. 3. 4 Gender differences

In relation to cultural practices, there were few differences in opinion between men and women or participants and non-participants. Overall, evidence supports a continuation of the shifts in cultural practices to reduce HIV risk as was seen in previous rounds.

2. 3. 5 Differences between districts

While the method of intervention differed in each district the reported changes to cultural practices were similar. In each district Partners were seen as influencing Cultural Practices. In Salima, MIAA was particularly associated with stopping traditional circumcisions. MIAA was also seen as influencing risk associated with celebrations through the leaders and Chiefs who would use their positions to ban or curtail night celebrations. CCJP, SWAM and MIAA were seen as reducing seclusion periods established as a result of cultural beliefs.

2. 3. 6 Summary of changes in cultural practices

The Trócaire funded Programme Partners joined efforts to change dangerous cultural practices and were seen in all sites to reduce risks at girls and boys initiations, curb associated celebrations and reduce the period that couples abstained from sex at different life events as had been dictated by traditional beliefs. Their aims appeared consistent with religious teachings and new societal norms, NGO and health professional advice. Throughout the data a distinction is not made between advice that states when a couple *can* have sex, and when a couple *should* have sex. This is discussed later. Also the direct link that is made between the practice of seclusion and a husband's unfaithfulness leans toward absolving men from personal responsibility.

2.4 Stigma and Discrimination

Highlights:

- Very little evidence of discrimination against PLHIV in qualitative or quantitative findings
- Stigmatising attitudes recorded in the quantitative survey remain high but show a positive shift, with fewer expressing stigmatising attitudes in 2015.
- Greater positive changes were seen in intervention sites compared to control sites, and focused interventions compared to community-based interventions.
- Both the qualitative and quantitative study found blaming attitudes were still common, but these did not appear to translate into discrimination.

Discriminating attitudes were found to be very low in the quantitative baseline. At endline we see similarly low levels of discrimination with just 1% of respondents in baseline and endline scoring discriminatory attitudes on the discriminations scale[6].

Stigmatising attitudes were found to be high in the baseline and thus were considered to be an important tracking indicator. Stigma was assessed at baseline and endline using a scale[7] that aggregated scores to specific questions which were then re-grouped into very stigmatising, somewhat stigmatising, neutral, somewhat non-stigmatising, and very non-stigmatising attitudes. It was found that positive changes occurred between 2011 and 2015 in the overall sample, with stigmatising attitudes dropping from 76% to 73% ($p<0.05$, $n=1495$). This included a drop from 74% to 69% expressing stigmatising attitudes for men, and for women a drop from 78% to 75% between 2011 and 2015. Positive changes occurred in both the intervention and control sites, with 76% of respondents from intervention sites expressing stigmatising attitudes in 2011 compared to 72% in 2015, and 77% of respondents from control sites expressing stigmatising attitudes in 2011 compared to 75% in 2015. The strength of this change was however stronger in the intervention sites then in the control site ($V=0.211$ vs. $V=0.151$).

[6] Discrimination Scale included the following questions: 703reverse coded (People with HIV should still be allowed to get married, as long as both partners know about it) +704 reverse coded (It is safe for children with HIV and without HIV to play together)+705(HIV positive women should not get pregnant) +708 reverse coded (It is safe to buy food from a shopkeeper or seller who has the HIV) +710 reverse coded (If a teacher has the HIV virus but is not sick, he/she should be allowed to continue teaching in school) +711(It is unsafe for other family members to care for an AIDS patient in the family home).

[7] Stigma Scale included the following questions: 701 (HIV spreads due to immoral behaviour) +702 (men who get HIV get what they deserve) +706 (A woman who gets HIV gets what she deserves) +707 (HIV is a punishment from God) +709Reverse coded (If you found out you had HIV, you WOULD be willing to disclose).

Community-based and focused interventions both demonstrated positive change, but the strength of the change was greater among the focused interventions (V=0.181 vs. V=0.256). However, when examined by district, only Nkhotakota demonstrated a significant overall reduction in stigmatising attitudes, dropping from 80% expressing these in 2011 to 65% in 2015 in the intervention sites. When the sample was split by gender within districts, it was found that in Salima there was a strong, significant change with stigmatising attitudes among men dropping from 85% to 58% (V=0.304, $p<0.05$). Among women, a significant effect occurred only in Nkhotakota where stigmatising attitudes dropped from 84% to 68% (V=0.200, p= 0.05).

When stigmatising attitudes were compared among participants and non-participants in sites where focused and community based interventions were being implemented, it was found that overall community based interventions demonstrated a stronger effect in reducing stigmatising attitudes among participants, whereby 63% of participants expressed stigmatising views compared to 83% of non-participants (V=0.272, p= 0.003). Whereas in focused interventions 61% of participants expressed stigmatising views compared to 72% of non-participants (V=0.178, p= 0.05). This may suggest that while community based interventions were effective at initiating change among participants the effect has not yet spread to the wider community. Below we demonstrate changes in agreement to specific statements relating to HIV stigma.

Table 3: Stigma Statements

Statement	Overall		Control		Intervention		Focused Intervention		Community Intervention	
	2011	2015	2011	2015	2011	2015	2011	2015	2011	2015
Men who get HIV get what they deserve	79%	75%	78%	73%*	79%	75%	74%	73%	86%	77%
Women who get HIV get what they deserve	74%	69%	74%	70%*	74%	70%	72%	66%	79%	74%
HIV is a punishment from God	52%	57%	50%	57%*	53%	57%	50%	56%	58%	59%*
HIV spreads due to immoral behaviour	94%	93%	96%	92%*	93%	93%	92%	93%	94%	95%*
HIV + women should not get pregnant	65%	47%	62%	48%	67%	46%	68%	47%	64%	44%
People with HIV should be allowed to get married as long as both partners know about it	93%	92%	92%	91%	92%	91%	90%	92%	94%	90%
If you had HIV, you would be willing to disclose to your community	72%	80%	75%	84%*	70%	79%	68%	72%	72%	88%

*Statistically insignificant change between 2011 and 2015

The evidence suggests that there has been a general drop in attitudes that assign blame to men or women for contracting HIV, an acceptance of HIV+ women becoming pregnant, and an increased willingness to disclose an HIV + status, particularly evident in community intervention sites. However, these positive impacts are somewhat tempered by the increased numbers in intervention sites in general and in focused intervention sites in particular, where agreement with the statement that 'HIV is a punishment from god and HIV spreads due to immoral behaviour' has increased. While stigmatising attitudes have decreased overall, this change is largely driven by the positive changes in the community intervention sites and particularly in Nkhotakota, though the positive impact on men's attitudes in Salima is also notable.

The anonymous endline survey also provided some information on stigma and discrimination towards PLHIV.

- 75% of respondents would be willing to drink out of the same cup as someone who has HIV.
- 81% would not be ashamed if someone in their family had HIV.
- 75% would disclose to their status to their community if they were HIV positive.

Differences between districts were not found in relation to drinking out of the same cup, but respondents from Salima were less likely to state that they would not be ashamed if someone in their family had HIV (75% vs. 82% in Dowa and 84% Ntcheu) a finding which came close to significance (p=0.097). Respondents from Salima were also significantly less likely to state that they would disclose their status if they were HIV+, with just 50% in Salima willing to disclose compared to 81% in Dowa and 82% in Ntcheu (V=0.303, p=0.000).

2.4.1 Treatment and Access to Care: Evidence from the Qualitative Research

People living with HIV are reported to have good access to treatment and care and not to suffer stigma and discrimination. Attitudes appeared to have begun to change prior to the start of the Trócaire programme. It must be noted, however, that this research is reporting, in the main, views of community members not PLHIV. People are encouraged to disclose to access treatment and support groups. It would appear that the programme has contributed to the tidal change in community members attitudes to PLHIV. There are nevertheless some stigmatizing attitudes remaining because the mode of transmission involves sexual intercourse and assumed immoral behaviour. There is some evidence that a barrier to disclosure might be the reduction in marital prospects. Women are at a disadvantage as there is compulsory testing as part of maternity care.

2.4.2 Disclosure: Overview of Findings from the Qualitative Research

In the quantitative analysis, it was found that there were significant increases in participants who stated they would be willing to disclose their HIV status. In the qualitative, there were mixed reports on disclosure between sites and dependent on participant status. In Nkhotakota it was reported that the numbers who were in support groups and had disclosed their status had increased dramatically. In Salima, however, there was suggestion that people were given incentives to disclose by another organisation. However, a number of individuals interviewed as part of the research disclosed to the researchers in front of others and confirmed they neither stigmatised nor discriminated against PLHIV.

One HIV positive woman said most still don't disclose because the

> "*the mode of transmitting the virus is very shameful as it is mostly transmitted through sexual intercourse"*

Some said people travelled distances for testing, so that others would not know if they tested positive but eventually and in order to benefit materially and otherwise from support groups, they would disclose. Counselling and the availability of treatment was said to encourage people to disclose.

Though discrimination was reported as non-existent fear of discrimination was said to effect disclosure. The reason for non-disclosure was speculated as *shyness, anxiety, ignorance and fear that people would laugh at them*). Interestingly while people said there was no stigma or discrimination they also said that PLHIV feared being laughed at or gossiped about and agreed that these fears were justified.

Some differences were noted between participants and non-participants in the assessment of how common disclosures are within the community. While both participants and non-participants knew of individuals within their community who were open about their HIV positive status, non-participants more commonly stated that this was rare. Participants were more positive about the numbers disclosing than non-participants, but concur that not all are disclosing.

Overall, the findings in Round 3 concur with Round 2. PLHIV appear to rarely experience direct discrimination but stigmatisation may in some cases still occur.

2.5 Equitable sexual attitudes

Highlights:

- Improvement in equitable sexual attitudes found in both qualitative and quantitative research
- Positive changes in equitable sexual attitudes found in all sites, but demonstrated stronger changes in intervention sites compared to control sites, and focused interventions compared to community-based interventions.
- Attitudes that support male sexual privilege and power show a positive decline with fewer respondents expressing such views.
- Sexual communication has also improved, with stronger positive changes among the intervention group and in the focused interventions.
- Evidence from qualitative research that attitudes that associate being a real man with multiple partners have been challenged and that there is greater equality in relation to sexual norms.
- 'Openness' as a strategy was perceived very favourably by respondents, with the most common perceived benefit being the reduction of unfaithfulness. However, in some cases the message on openness appeared to translate into pressure for women to sexually satisfy their spouses in order to keep them from being unfaithful.

Equitable sexual norms have improved in general. As shown below, the sexual norm scale[8] demonstrates improvements among all groups, however the strength of change was greater in intervention sites compared to control sites (V=0.257 vs. V=0.196), suggesting that while general positive changes are occurring, interventions are intensifying these positive changes.

Both focused and community interventions

Impact of Programmes on Understandings of Masculinity and Femininity: Qualitative Findings

Aspects of what it means to be a man and a woman in Malawian society have been challenged through the programme. The traditional views of a real man were challenged and a new ideal was being constructed. By the end of the programme most respondents interviewed saw similar attributes for men and women in that both should have good appearance and character and be faithful and hard working. MCP is less seen as an attractive feature of men and being sexually forward is less seen as an unattractive characteristic of women.

Qualitative Report Round 3, 2016

[8] Sex Norm Scale was constructed using the following statements: 501 (Men need to have more than one sexual partner, often at the same time)+503reverse coded(It is important for women to experience pleasure during sex) +504 reverse coded (It is okay for a woman/girl to suggest condom use) + 507 (It is difficult for men to refuse an offer of sex from a woman that is not his wife/primary partner) +508 Reverse coded (foreplay is an important part of sex) + 510 (if a wife refuses her husband sex, he has good reason to have sex with another woman)+512(A girl who refuses to have sex will probably lose her boyfriend).

demonstrated significant positive change in relation to sexual attitudes as measured by the sexual norm scale, however, the focused interventions had a stronger effect than community interventions (V=0.335 vs. V=0.164). When divided by district we find that no significant effect was found in Nkhotakota or Dowa but the effect was significant in both Ntcheu (V=0.286, p<0.05) and in Salima where it was particularly strong (V=0.389, p<0.05). Notably Salima had the lowest equitable sexual norms scores in 2011 and has now increased to the strongest equitable sexual norms.

Some differences were also noted in relations to differences between men and women. Focused interventions had significant positive impacts on both men and women's attitudes, while community interventions demonstrated significant positive changes only for women.

Table 4: Sexual norm scales

Indicator	Overall Change %		Control Group % Positive		Intervention Group % Positive		Focused Intervention % Positive		Community Intervention % Positive	
	2011	2015	2011	2015	2011	2015	2011	2015	2011	2015
Equitable Sexual Norms	52%	72%	57%	75%	49%	71%	42%	70%	53%	65%
Challenging attitudes towards Male Sexual Privilege and Power	62%	81%	68%	85%	58%	80%	56%	83%	62%	76%

As shown in the table above, attitudes that are challenging to male sexual privilege and power, as measured by the Sexual Privilege Scale[9], have also demonstrated improvement among all, but with stronger effects noted in the intervention group (V=0.275 vs. V=0.183). Focused interventions demonstrated a stronger effect although both focused and community interventions had a positive

Gendered Views on Sexual Desire: Qualitative Evidence

Many women and men believed that men had greater sexual desires and therefore needs. Others believed that both men and women had equal desires but that men were in a better position to express these. The programme was seen to be influencing a change in promoting women's expression of sexual desires. This was to combat cultural norms that required women to be submissive.

[9] The Sexual Privilege Scale was constructed using the following statements: 501 (Men need to have more than one sexual partner, often at the same time)+503reverse coded(It is important for women to experience pleasure during sex) +504 reverse coded (It is okay for a woman/girl to suggest condom use) +506 (A real man feels proud if he has multiple sex partners)+507 (It is difficult for men to refuse an offer of sex from a woman that is not his wife/primary partner) +510 (If a wife refuses her husband sex, he has good reason to have sex with another woman).

impact (V=0.338 vs. V=0.194).

Significant ($p<0.05$) effects were found in all four districts with greatest strength of effect in Ntcheu (V=0.354), followed by Salima (0.350), Dowa (V=0.294) and Nkhotakota (V=0.225). An increase from 63% who had attitudes that challenged male sexual privilege and power in 2011 to 91% was found in Ntcheu, from 64% to 83% in Dowa, from 61% to 70% in Nkhotakota and in Salima an increase from 49% to 75% in the intervention sites. Only in Nkhotakota were significant differences between participants and non-participants found, where 82% of participants vs. 58% of non-participants expressed attitudes that were challenging of males sexual privilege and power (V=0.354, p=0.004).

Table 5: Changes in Agreement with Statements that Assess Sexual Attitudes

Statement	% Agree 2011	% Agree 2015
If a wife refuses her husband sex, he has good reason to have sex with another woman.	62	51
Foreplay is an important part of sex	96	97
A real man feels proud if he has multiple sexual partners	21	12
It is OK for a woman/girl to suggest condom use	63	74
It is important for women to experience pleasure during sex	97	97
Men need to have more than one sexual partner, often at the same time	19	10
It is difficult for a man to refuse sex if a woman who is not his wife/partner offers it	55	45

The evidence thus suggests that the interventions have had an effect in strengthening changes in sexual norms that were already changing to some extent in the districts generally. Notably, changes were stronger among women, whom expressed more inequitable views in the baseline, then for men and were stronger in the focused interventions sites, where both MIAA and CCJP work with men and leaders.

Changes in perception of sexual preferences

The qualitative component found a positive change in the perception that men preferred 'dry sex'. This had been a common perception at round 1. At round 3 this perception had changed among men and women towards those suggesting more gender equitable sexual

Sexual communication is another important aspect of sexual equality. Respondents were asked a number of questions relating to communication within their relationships as regards sexual matters.

Table 5: Sexual Communication

Indicator	Overall Change % Positive		Control Group % Positive		Intervention Group % Positive		Focused Intervention % Positive		Community Intervention % Positive	
	2011	2015	2011	2015	2011	2015	2011	2015	2011	2015
I find some sexual matters too embarrassing to talk about with my primary partner	27%	22%	25%	20%*	29%	22%	30%	24%	28%	21%
I think it is difficult for my primary partner to tell me what he/she likes to do sexually	29%	22%	29%	22%*	29%	23%	30%	20%	28%	26%
It is easy for me to tell my primary partner what I do or don't like to do sexually	80%	83%	80%	86%*	80%	81%	78%	83%	82%	79%

*Statistically insignificant change between 2011 and 2015

Interventions appear to have a positive impact on sexual communication. For the statements on finding sexual matters too embarrassing to talk about with my primary partner and thinking it is difficult for my primary partner to tell me what he/she likes to do sexually, focused interventions had a stronger effect while for the last statement regarding the respondent telling their primary partner what they do or don't like to do sexually, the community intervention had a stronger effect, but this was negative in direction.

When divided by gender it was found that in responses to the first statement, on finding some sexual matters too embarrassing to talk about, no differences were found between baseline and endline for men, but both focused interventions and community interventions demonstrated significant relationships for women, with a slightly stronger effect for focused interventions (V=0.233 vs V=0.223) with women showing improved responses since 2011.

In responses to the second statement, community interventions were found to be insignificant when divided by gender, but both men and women in focused interventions sites showed significant changes with a somewhat stronger effect for men then for women (V=0.278 vs. V=0.256). For the final question, the only significant relationship was for women and focused

intervention sites where women's agreement showed an improvement from 77% to 80% (V=0.195, p<0.05).

Openness: Overview of Qualitative findings

Participants and non-participants were all aware of the strategy of openness and across all groups it was described as benefitting both men and women with no known disadvantages. However messages about openness appeared to be interpreted differently by different people at different levels of the programme. Openness was not restricted to sexual behaviour but also meant better communication between couples on things that previously women could not bring up e.g. birth spacing, initiating sexual activity. Sharing between the couple was spoken about as openness including work roles, verbal communication, resources, thoughts and feelings. This breath of meaning was spoken about more by programme participants than non-participants in some districts (Salima). In other districts the majority of participants associated openness with sexual relations – particularly availability of women for sex, greater willingness on the part of women to initiate sex and better communication about sexual desire between spouses. A minority, and more men than women, also associated openness as shared decision-making and general communication. Respondents in Nkhotakota initially responded about sexual openness mentioning other forms only after probing

> *F: You mentioned about openness, would tell me who promote openness and how?*
> *R5: A husband should be the one to begin promoting openness in the family. A husband demonstrates the counselling that he got from SWAM by taking off all his clothes and ask the wife to follow suit. (Male, FGD_KK_DB_PP_01).*

The intended message to address HIV risk through strengthening relationships resulted at times in interpretations that could not be seen as promoting women's empowerment where sexual openness emphasised the aim of male sexual satisfaction as seen below.

> *We discuss issues like violence, family issues, and sexual openness in the family in such that a man should be open with his wife for him not to think of going out with other partners. You have to make your wife do everything for you in order for you to be satisfied. (Male motivator FGD_SA_MT_HA_01)*

Nevertheless marital relations were reported to be more harmonious with more sharing between couples. Participants saw the benefits of openness more than non-participants.

There was consensus among respondents that the programme partners (MIAA, SWAM, CCJP, COWLAH) promoted openness in the community. However it was clear that this was part of a wider societal push for better marital relations. Health professionals, counsellors, religious leaders and other organisations also were reported to back the strategy. All respondents saw it in a positive light.

> In the quantitative endline it was found that the strategy of openness was known to a strong majority (83% in intervention sites, 77% in control sites). Respondents were asked what the primary benefit of openness was to them. The most common response, given by 49% or respondents, was that it reduced the risk of unfaithfulness. No differences in responses were found between control and intervention sites.

The evidence suggests positive impacts from interventions on sexual communication overall. Focused interventions appeared to have a stronger positive effect, which was particularly experienced by women.

Abstinence

The programme was not reported to have influenced specifically men's ability to abstain from sexual intercourse. However there was an implicit link between programme approaches and abstinence in that reduction of seclusion acknowledged difficulties around abstinence. There was consensus that men were unlikely to be able to be abstinent for long periods. Though a minority did say this was possible and gave testimony of doing so most men and women believed that abstinence was unhealthy for men and could lead to back pain illness or infidelity. The tolerance for men's inability to abstain is seen in this quote from a cultural custodian

> *They (women) should stop having sexual partnerships because there are diseases. May be if it was the man who can bring the disease in the house then that can be okay because they cannot hold themselves but if they do just like I did then they will grow old like me* (Female, IDI_KK_MV_JN_01)

The acceptance that men cannot be sexually abstinent, in some cases associated with significant ill-health symptoms, and the assumption therefore that women must be available to them suggests hegemonic masculinity which promotes the dominant social position of men, and the subordinate social position of women.

2.6 Equitable gender attitudes

Highlights

- Less gender equitable attitudes in both intervention sites and control sites
- Intervention sites did not deteriorate to the extent that control sites did
    - Community based intervention sites did not see any deterioration
    - Within focused interventions, significant deterioration seen among women's attitudes, with no deterioration among men.
- Mixed findings on different attitudes from qualitative and quantitative research:
- from the qualitative research, in intervention sites most agreed that there was:
    - More gender equitable role sharing
    - More involvement of women in decision making
    - Less overt control of women's behaviour by men
- Within quantitative research, evidence that:
    - More equitable decision making in relation to income
    - Little change or worsening of attitudes that relate to men's authority within the family and women's independence.

2.6.1 Changes to Gender Equitable Attitudes in the Quantitative Findings

Gender equitable attitudes were measured through an aggregation of responses to specific questions to form a Gender Norm Scale[10]. In relation to this indicator, some unexpected results were found with an overall change and a change within intervention sites that indicate fewer respondents expressing gender equitable attitudes. Results from specific questions which demonstrated significant change are examined, see table 6 below, before results from the Gender Norm Scale are reviewed.

Table 6: Changes in Statements that Assess Gender Equitable Attitudes

Indicator	Right direction	Overall Change		Control Group % Agree		Intervention Group % Agree		Focused Intervention % Agree		Community Intervention % Agree	
		2011	2015	2011	2015	2011	2015	2011	2015	2011	2015
A good wife obeys even if she disagrees	mixed	70%	73%	67%	74%*	70%	73%	70%	75%	73%	69%
It is a wife's obligation to have sex with her spouse even if she doesn't feel like it	✓	66%	63%	65%	66%*	66%	62%	63%	60%	71%	64%
A woman should be able to choose her own friends even if her husband disapproves	X	46%	40%	46%	45%*	45%	38%	51%	37%	36%	41%
A woman can work outside the home even without her husband's approval	X	36%	27%	35%	27%	36%	27%	41%	29%	27%	24%
It is important for a man to show his wife/partner who is the boss	_	93%	95%	90%	96%	95%	94%	94%	95%*	96%	93%*
A man is always the final decision-maker in the family	X	79%	84%	80%	85%	79%	83%	79%	84%	80%	82%

[10] The gender norm scale was constructed using the following statements: 301(a man should always be the main provider for the family)+302(a good wife obeys her husband even if she disagrees) +303 (it is important for a man to show his wife/partner who is boss)+ 304reverse coded (a woman can work outside of the home even without her husband's approval) +306 (A man is always the final decision maker in the family) +307reversecoded (A woman should be able to choose her own friends even if her husband disapproves) + 308 (it is a wife's obligation to have sex with her husband, even if she does not feel like it)+309 reverse coded (If a man mistreats his wife, others outside of the family should intervene) and 310 reverse coded (Men and women should have equal say in how income from the harvest or other business is spent).

Men and women should have equal say in how income is spent	✓	90%	92%	90%	92%*	90%	92%	90%	93%	91%	92%*

*statistically insignificant change between 2011 and 2015.

As shown above, the statements that show an overall decline in gender equitable attitudes include, *'A woman should be able to choose her own friends even if her husband disapproves'*, '*A woman can work outside the home without her husband's approval*', '*It is important for a man to show his wife/partner who is boss'*, *'A man is always the final decision maker in the family'* and *'A good wife obeys her husband even if she disagrees'*. However, some other areas show improved gender equitable attitudes overall, including disagreement with the view that '*it is a wife's obligation to have sex with her spouse even if she doesn't feel like it*', and an increase in agreement that '*men and women should have equal say in how income is spent'* which showed a high positive score at both baseline and endline. Some changes showed mixed results – for instance, community based interventions demonstrated an improvement in relation to the statements, 'A good wife obeys her husband even if she disagrees' and 'a woman should be able to choose her own friends even if her husband disapproves' while focused interventions demonstrated a decline in equitable attitudes to both these statements. The statement 'it is important for a man to show his wife/partner who is boss' demonstrated nearly universal agreement with more than 90% of all groups agreeing with this statement. Although intervention sites did show an improvement of 1% in response to this statement, there was an overall decline in equitable responses and a decline in focused intervention sites.

Results from the Gender Norm Scale are presented in Table 7 below. Notably the negative changes in the control group were stronger than in the intervention group (V=0.117 vs. V=0.080), suggesting that interventions may have had a moderating effect on changes occurring in the district more generally. When examined by intervention type it was found that community interventions demonstrated no significant change between 2011 and 2015, with a significant negative change found in the focused intervention sites.

Table 7: Gender Equitable Norms Scale

Indicator	Overall Change % Positive		Control Group % Positive		Intervention Group % Positive		Focused Intervention % Positive		Community Intervention % Positive	
	2011	2015	2011	2015	2011	2015	2011	2015	2011	2015
Gender Equitable Norms Scale	10%	5%	11%	5%	10%	6%	11%	4%	9%	8%*

*Statistically insignificant change between 2011 and 2015

Further examination found that there was a significant decline in the proportion of respondents expressing gender equitable norms as defined by the scale in Ntcheu and Salima, there was no significant change in Nkhotakota, and an increase in equitable attitudes in Dowa. Salima expressed the strongest significant relationship whereby gender equitable attitudes declined between 2011 and 2015 (p= 0.000, V=0.316), followed by Ntcheu (0.002, V=0.204), with Dowa demonstrating a positive change (p= 0.048, V=0.185).

Table 8: District Changes in Gender Equitable Norms

Indicator	Ntcheu %		Dowa %		Nkhotakota %		Salima %	
	2011	2015	2011	2015	2011	2015	2011	2015
Gender Equitable Norms Scale	15	5	3	9	12	7*	7	3

*Statistically insignificant change between 2011 and 2015

When differences between participants and non-participants were examined in Salima and Ntcheu, it was found that participants had more gender equitable attitudes than non-participants, suggesting that while the interventions did not reverse the impact of changes that appear to be occurring in the districts generally, they did moderate their negative effect.

Given that both Salima and Ntcheu have focused their interventions on leaders and men, potential differences in gender norms between men and women were also explored. Both Salima and Ntcheu demonstrated significant negative changes in gender equitable attitudes among women (Salima: p= 0.00, V=0.303, Ntcheu: p= 0.003, V=0.216), but men's gender norms were not significantly changed between baseline and endline in Salima although they were in Ntcheu (p= 0.030, V=0.220). Of note, women's attitudes in Salima have declined to the same level as men's.

Table 9: Changes in Equitable Gender Norms Scale for Men and Women in Ntcheu and Salima

Equitable Gender Norms Scale	Men - %		Women -%	
	2011	2015	2011	2015
Ntcheu	19	8	15	4
Salima	4	4*	8	4

*Insignificant change

2.6.2 Gender Norms: Qualitative study overview

The qualitative study helps interpret quantitative findings more fully. While the quantitative survey defines gender equity in absolute terms, the qualitative research picks up progress in relative terms and describes the nuances of changes within this context; i.e. within the context of the gender inequitable society which has not become equitable there are nevertheless improvements in their situation though men still maintain power and control. The qualitative findings therefor do not contradict the quantitative but focus on where there have been improvements and where efforts made to improve the situation may look like deterioration from a gender equity perspective.

Over all the qualitative data shows a shift towards more equitable gender attitudes and norms as a result of the programme. Family relations improved with women given a more elevated position if not achieving equality with her husband. While women were reported to be more involved in decision making men retained their position as head of the household and therefor held overall authority. Similarly while women had more freedom and independence men were expected to guide them and if necessary control them. With regard to shared workload there were consistent reports that this had changed for the better. Families were reported as stronger as a result of the programme.

Focus group participants' gender equitable attitudes improved across three rounds of data collection. The majority agreed that "a husband and wife should make family decisions together", "a good wife is not ruled by her husband but is an equal partner" and "a man should never hit his wife whatever the reason".

House hold decision making

Respondents consistently reported that women were now more involved in decision making in many families though men appeared to retain their position as head of household. While women were now more involved and consulted regarding decision making, this did not necessarily amount to equal power sharing. Nevertheless there appeared to be more of a shift towards shared decision making which was an appreciated improvement.

Compared to round 1:

At round one data collection in 2013 the programme was said to have already influenced a change in more equitable house hold decision making. Nevertheless 'it was the man's role to make the plans for the year and decide on how money was spent. If power was to be shared or the woman to be involved it was the man's decision to do so' (Round 1 Qualitative Study 2013). Most people in the eight study villages now believed that women should be involved in household decisions. There was variation in reports of whether this happened and to what extent decision making was actually shared. In the last round of data collection however the data more strongly identified attitudes that were more gender equitable in terms of decision making than in round 1 as shown by the results of the Gender Attitude Assessment (GAA) tool applied during the FGDs. Nearly all women and most men in focus groups discussion now believed that a husband and wife should make family decisions together.

In villages across districts:
Male participants in men engaging men sites were more likely to state that there was shared decision-making than non-participants and women. In all sites people still believed men to have more authority over monetary issues, however, in Nkhotakota there was more mention of equal power sharing in decision making. In Dowa while participants reported shared decision making, non-participants saw a gender divide based on the topic (financial issues in the man's domain and reproduction in the women's). The quotes below show an important nuance in discussions around power in decision making with in the family. In the first it is clear that men have the authority (unchallenged power) while the next shows a level of involvement and lastly the third suggests equal power sharing.

> *Resp: It is controlled by men in most cases. Like in my family there are certain things which are controlled by my wife like rice and maize because she is a mother of the family and I control the money. FGD_SA_MK_AA_01 A (Non Participant men, Salima)* 2015
>
> *Resp 5: Men do make most decisions on how money can be spent but women are always consulted. FGD_KK_ZD_AA_02 (Non Participant men, Nkhotakota) 2015*
>
> *Resp 2: Before the program most decisions were made by the men because they were regarded as natural leaders traditionally but after the program trained us decisions are now made by both men and women because we are equal to each other. FGD_KK_MV_AA_03 (Participant men Nkhotakota) 2015*

Most analyses of power in decision making makes distinction between levels of participation or involvement (Cornwall Coehlo 2006; Gavanta, 2006). While many respondents described a move towards more involvement this sometimes meant that women were now consulted whereas before they were not. This should not be interpreted as equal power sharing which would appear to still be a long way off albeit closer for some couples as a result of the programme. Participation on a consultation level does not challenge men's power and position as head of household. The quantitative findings show that still there is no change in men being the final decision makers. Some writers on power dynamics have pointed out that there is often struggle / conflict before equal power sharing (Lukes, 1974; Gaventa, 2006). Struggle and confrontation was not seen through the qualitative data and while women were reported to have more say in decisions affection the household this was not by and large equal say.

Gender Roles

Across the sites and participant status most agreed that more couples were doing more together, sharing household tasks, and as a result,families were reported to be stronger. Gender roles were assessed in the quantitative only in relation to women working outside the home without their husband's permission which did not improve. On this issue the qualitative found that as a result of the programme women were more likely to work outside the home with their husband's permission and not giving this permission was considered as 'violence'.

Examples of changes in gender roles given, included women accompanying their husbands to hospital where previously this was the role of the man's relatives and men were now accompanying their wives to antenatal appointments. Although gender roles were still described as distinct, men were reported to be carrying out tasks that were previously exclusive for women not as a rule but when necessary.

> *'Things have really changed, in the past it was not possible to tell the man to go to the maize mill when the wife is sick, and he could feel shy as a result. People were sleeping without eating food while the maize and money are available….these days, the man can take the bicycle and go to the maize mill without feeling shy while he is knowing in his heart that "I am helping my family"' (women, non-participants, FGD_MU_BM_HS_01)2015*

Comparison with Round 1

In round one of the qualitative research changes had already begun to be seen in the study villages with reports from "men and women in marriages sharing the work burden and breaking the gender stereotypes of what is and is not a woman's or a man's work" (Round 1 Qualitative Report 2013). These changes appeared to have been sustained.

In villages across districts:

In Dowa, gender relations between men and women, especially those who were married, were reported to have improved greatly helped by the sharing of the burden of work. In Nkhotakota there was consensus that men perform the roles especially when the women were busy with other tasks. In Salima and Ntcheu men and women, participants and non-participants, all noted that men and women were more likely to share household chores with men taking on chores that had been previously associated with women.

Control of women's behaviours

There was less consensus when it came to men's role in controlling their wives behaviour. Though respondents described less control exerted by men over women's behaviour they never the less retained overall authority in this area. Men and women in all sites saw it as men's responsibility to 'guide' their wives. It is not surprising therefore that the quantitative survey revealed negative findings in relation to the statement 'a woman should be able to choose her own friends even if her husband disapproves'. While women had a certain amount of autonomy they were answerable to their husbands.

Comparison with round 1:

In round one 'there was a clear gender divide in the way men and women viewed men's control and power over their wives' behaviour.'(Round 1 Qualitative Report 2013). Among FGD participants most women believed it was not necessary for a woman to be ruled by her husband in order to be a good wife, however, very few men did as can be seen in the results of the GAA tool (below). While women held gender equitable views over time the programme has managed to change men's views. The biggest contribution to this change was the focused interventions in Salima and Ntcheu which saw men changing their attitude to the need for wives 'obedience' over the three rounds of data collection. In 2013 'there were very set views held by men on the woman's subordinate position within the relationship in terms of doing what he says' (Round 1 qualitative report, 2013). These appeared to have changed significantly with 2/3 of men in focus groups now saying that wives didn't need to ruled by their husbands compared to 1/5 in2013. This however does not translate into a view that women do not need guidance from their husband and control if she is not doing what he considers as right.

In villages across districts:

In intervention sites (men engaging men) men were more likely to describe increased changes than women with women suggesting that change was more evident among programme participants *"those that go for training help us".* In Dowa there were mixed views with STAR circle members suggesting the woman didn't have to be led by men. However, there was a distinction about which of women's behaviours was under the control of men.

> *A woman does that on her own she chooses who to chat with but business it is the man who does that because he is the one who gives capital so that you can be doing business (Female Participants, Dowa: 2015. FGD_DA_MS_JU_01)*

Whether marriages were patrilineal or matrilineal influenced the level of control men had over their wives. In Nkhotakota (patrilineal) both men and women participants suggested that this meant that women were under more pressure to "do everything they wanted". However, the situation was reported to have changed after the intervention by SWAM.

In summary while there has been a shift in set views again a subtle form of control remains in that men accepted women making their own decisions so long as they made the 'right' decisions, in their view. In Ntcheu participants felt it was their right to intervene if they felt such decisions looked badly upon their family *(FGD_NU_MK_HA_01).*Similarly in Salima though a shift in men's views is acknowledged the 'guiding' authoritative role of men on women's behaviour goes unchallenged by their wives.

> *Men are the ones who guide women because they are heads of the families. (Spouses of men forum participants)*

2.6.2 Overview of findings from study on gender equitable norms and attitudes

Overall, the quantitative findings suggest a complex interaction of both positive and negative changes in relation to gender norms. While women's sexual negotiation appears to have improved, with greater acceptance of a woman's right to refuse sex, the overall acceptance of this statement remains low with just one quarter agreeing. This concurs with findings on sexual norms which encourage women to be sexually available to their partners. Positive changes are also evident in relation to deciding how money is spent with women having more of a say if not quite an equal say.

However, as assessed in absolute terms on a population basis attitudes towards male authority appear to have remained the same or strengthened and, likely in relation, attitudes regarding men's control over their spouses' behaviour have similarly strengthened. Within this context men are seen through the qualitative data as allowing more shared decision making and allowing women to make decisions for themselves. As long as men's permission is required for equal rights for women equality has not been achieved. The qualitative data shows women as grateful for the improvements in their lives as a result of the programme however it concurs with the quantitative findings that while things have improved in many lives as a result of the programme it has not managed to change crucial gender equitable attitudes that see women as equal to men.

2.7 Intimate Partner Violence

Highlights:

- Violence is broadly understood among respondents as cruelty and GBV is understood broadly as violence by a man or woman perpetrated against a member of the opposite sex.
- Acceptance of male to female intimate partner violence had increased among control group and intervention group, as well as among community intervention sites. This negative change was strongest in control sites suggesting a general worsening of attitudes.
    - Within community intervention sites, the negative shift primarily occurred in Nkhotakota among women compared to men, and non-participants were more accepting of IPV than participants.
    - A woman returning home late was the most common justification given for accepting male to female IPV.
- Findings from the qualitative research suggest that interventions positively contributed to a reduction of violence by men toward their spouses, including reduced beatings and a reduction in controlling behaviours.
- While most Focus Groups indicated that child rape was the most serious form of violence, not all did so. Wife beating and emotional violence were also ranked highly.
- Differences emerged in ranking of denial of sex, forced sex and cheating with many groups ranking denial of sex as more serious than forced sex or cheating.

2.7.1 Acceptance of Intimate Partner Violence

Acceptance of violence also demonstrates unexpected results, as shown below, with significant increases in acceptance of male to female intimate partner violence, measured by agreement with one or more reasons that justify a man shouting/hitting his wife/partner[11]. In total, 66% of survey respondents in 2015 agreed with at least one reason that justified a man hitting/shouting at his wife. This

Understandings of Violence: Evidence from the Qualitative Research

Interpretations of violence appeared complex and wide ranging. This study found a very broad and subjective understanding of violence. The closest translation for the concept is *cruelty* and this explains much of its variation in meaning. As in round one and two almost anything that could be viewed subjectively as cruel or unfair or as undermining ones perceived 'rights' was considered as violence (read 'cruelty'). Not sharing family money, wife beating, child marriages, husband beating, forced marriages, forced child bearing, marital rape, corruption of leaders, child rape, women's rudeness, a lack of openness in marriage, emotional violence, denying sex, neglect of the family or sending children to do farming activities during school time were all considered as forms of violence.

[11] In your opinion, does a man have a good reason to shout/hit his wife/partner **IF…….: A)** She does not complete her household work to his satisfaction? **B)** She disobeys him. **C)** She refuses to have sexual relations with him. **D)** She asks him

is higher than found in the 2014 MDG Endline Survey Report which indicated that 12% of women and 8% of men in the Central Regions justified a man *beating* his wife for at least of one of five proposed reasons (NSO, 2015:201). The addition of 'shouting' in the Trócaire survey is likely to have elevated the numbers overall compared with the MES report. A 2016 UNICEF/DFID report, however, found that among women aged 18-24 42% found at least one reason to justify a man *beating* his wife (2016:148). The finding from the Trócaire survey was true overall, for the control group, the intervention group, and the community intervention site (control excluded). This suggests that the change is occurring generally in the districts in Malawi, although the focused intervention may have moderated the effect resulting in no significant change between 2011 and 2015. This is supported by the fact that the negative change was stronger in control sites (V=0.104) than in intervention sites (V=0.82).

Table 10: Changes in Acceptance of Male to Female Intimate Partner Violence

Indicator	Overall Change %		Control Group %		Intervention Group %		Focused Intervention %		Community Intervention %	
	2011	2015	2011	2015	2011	2015	2011	2015	2011	2015
Acceptance of Male to Female IP Violence	58%	66%	58%	68%	58%	66%	58%	61%*	58%	66%

*Statistically insignificant change between 2011 and 2015

When this finding was further examined by district, it was found that only in Nkhotakota was there a significant change between 2011 and 2015, where acceptance of violence increased from 49% to 69% in the intervention site. When participants/non-participants were examined against tolerance for violence, significant differences were found in relation to Salima and Nkhotakota. In both cases participants were less likely to express tolerance.

To better understand these findings, a selection of individual justifications for acceptance of violence were examined, as shown below. Here, little change is seen in relation to any of the justifications, bar 'she is HIV+' for the focused intervention sites. Among the intervention group as a whole, insignificant changes are found in relation to both 'she is HIV+' and 'she returns home late'. Among the control group, to these two statements are added significant change to 'She disobeys' and 'she does not complete housework'. However, all justifications showed a significant increase among the community intervention sites, suggesting a notable increase in acceptance of male to female IPV.

whether he has other girlfriends. **E)** He suspects she is unfaithful. **F)** He finds out she has been unfaithful. **G)** She is HIV+ positive. **H)** She is late returning home. **I)** She asks him how he has spent money. **J)** She spends money without his knowledge.

Table 11: Justifications for a man to shout/hit his wife/partner

In your opinion does a man have a good reason to shout/hit his wife/partner if…	Overall Change % Agree		Control Group % Agree		Intervention Group % Agree		Focused Intervention % Agree		Community Intervention % Agree	
	2011	2015	2011	2015	2011	2015	2011	2015	2011	2015
She returns home late	38	47	39	47	37	47	39	42*	35	53
She is HIV+	7	17	7	17	7	16	8	14	7	20
He suspects she is unfaithful	19	24	15	20*	21	26*	22	23*	18	30
She refuses sex	26	29	24	31*	27	28*	29	23*	24	35
She disobeys	34	38	33	41	35	36*	38	31*	30	43
She does not complete housework	19	25	16	23	20	25*	24	22*	14	29

*statistically insignificant change between 2011 and 2015

When examined within community intervention sites, it was found that only in relation to completing housework was there a significant negative change in agreement in Dowa. In relation to all justifications listed above, Nkhotakota demonstrated significant negative change between 2011 and 2015. This sample was then further divided to examine the effect on participants and non-participants as shown below and compared against the control group. It was found that there were no significant differences between participants and non-participants in relation to 'She is HIV+', 'He suspects she is unfaithful' or 'she does not complete housework'. However, the non-participant group demonstrated a greater increase in acceptance of violence than the participant group in relation to the justifications of 'she returns home late', 'she refuses sex', and 'she disobeys'. This suggests that while acceptance of violence increased among both participants and non-participants, the negative change was moderated within the participant group.

Table 12: Changes in acceptance of justification for IPV in Nkhotakota

In your opinion does a man have a good reason to shout/hit his wife/partner if…	Overall Change % Agree Nkhotakota		Participant Group, Nkhotakota % Agree	Non-participant Group , Nkhotakota % Agree	Control Group NKhotakota only (n=102)	
	2011	2015	2015	2015	2011	2015
She returns home late	29	53	44	62	19	35
She is HIV+	5	26	24	27**	0	32
He suspects she is unfaithful	13	29	26	32**	6	19
She refuses sex	21	36	26	46	23	30*
She disobeys	22	43	30	56	22	35*
She does not complete housework	12	26	20	37**	19	11*

**insignificant difference between participants and non-participants

To assess whether there were gender differences in changes in acceptance of male to female IPV, the Nkhotakota sample was split by gender. It was found that among men, the proportion who accepted one or more justifications of IPV demonstrated an insignificant change between 2011 and 2015, with 49% of men indicating acceptance in 2011 and 50% in 2015. However, significant changes were found among women with 62% indicating tolerance in 2011 and 74% in 2015 (p= 0.002, V=0.122).[12]

Examination between participant and non-participant groups suggests that the change was greater among the non-participant group. However, there appears to be some dynamic within the intervention sites that requires further examination as changes within the control group appear to be less strong. Contextual changes may go some way to explaining the general trend in increasing acceptance of violence, including pressures on families due to food scarcity, as well as potential 'backlash' against changing gender norms.

Experience of Violence

The anonymous survey captured information on the prevalence of different forms of violence in Ntcheu, Dowa and Salima. In 2015 it was found that 19% of respondents had experienced at least one form of violence, including physical violence by spouse or sexual violence by spouse, sexual violence by non-spouse family member, sexual violence by community member, and/or sexual violence by a someone else. 21% of women and 15% of men reported experiencing at least one form of violence. While baseline (which included data from Nkhotakota) and endline data are not directly comparable, for reference, the rate of any form of violence was 25%, including 21% of men and 27% of women, in 2011. The table below provides the breakdown of rates of reported violence.

[12] Includes both intervention and control site

Table 13: Type and Prevalence of Violence Reported in 2015

Type of Violence	Ntcheu		Dowa		Salima	
	Men %	Women %	Men %	Women %	Men %	Women %
In the past 12 months have you been hit, kicked, slapped or otherwise physically assaulted by your spouse/primary partner?	9	5	3	15	7	9
In the past 12 months have you been forced or coerced to have sex against your will by your spouse or primary partner	1	8	6	12	4	13
In the past 12 months have you been forced or coerced to have sex against your will by another family member	1	4	7	6	7	1
In the past 12 months have you been forced or coerced to have sex against your will by a non-family member of the community	3	4	3	6	4	6
In the past 12 months have you been forced or coerced to have sex against your will by someone else	3	3	1	5	0	2

Forms and Seriousness of Violence: Findings from the Qualitative Research

Notions of what is acceptable and unacceptable in terms of behaviour, and what constitutes harm, are culturally influenced and constantly under review as values and social norms evolve (World Health Organization, Geneva, 2002). The breadth of meaning at times undermined the relative gravity of some forms of violence and distinction between forms. 'Violence' and 'gender based violence' were used interchangeably. GBV unlike definitions which sees GBV as largely effecting women, this was not the view among study participants. Gender based violence was interpreted as violence against men or women with equal emphasis.

The understanding of denial of sex as a violence appears to be deep-rooted among men and women, participants and non-participants.

> *It is bad because if the wife refuses to do sexual intercourse with her husband, the man will go out and do sexual intercourse with other women and bring diseases in the house (Female, GD_KK_ZD_HS_01, 2015).*

This understanding together with the broad and subjective understanding of violence as well as perceptions of rights which favoured men at times rendered the GBV concept at best meaningless or at worst contrary to its intended meaning e.g. denial of sex was seen by all as form of GBV.

However, the breadth of meaning also allowed for a sophisticated interpretation of 'violence' and did not explicitly conflict with the WHO definitions of violence (as opposed to GBV). Many of the interpretations were linked to poverty and women's subordinate position to men. This is seen through the linkages between exclusion of women in decision-making about how resources are spent and the consequential coping strategies such as transitional sex to attain basic need. Family neglect was then also seen as violence which could lead a women to transactional sex to feed her children:

> *Neglecting the family is a bad violence because the wife has nowhere to get money for feeding the family as a result it makes the women to go out of the marriage to do sexual in order to get money for feeding the family because the woman fears that the children can die of hunger.* (*IDI_SA_KD_HS_01 in FDG wives of male forum members 2015)*

An example of how the breadth of meaning that 'violence' is given might reduce its usefulness as a concept to identify harm and respond to it, arose in a focus group of non-participant women who described women's non-inclusion in the programme in the men engaging men sites as a form of violence:

> *Facil: So at first you mentioned that DIAC also deals with violence, what violence are still prevalent?*
> *Res1: Not allowing women to go to seminars (FDG\FGD_SA_KD_JN_01)*

Reported Changes in Violence Attributed to Interventions: Findings from the Qualitative Research

In most groups respondents credited the programme with reducing what was considered as gender based violence. In focused interventions sites (men engaging men) participant men reported they had changed their violent behaviour (interpreted broadly as not allowing women do business) and their wives concurred that they no longer subjected to beatings. The degree to which men have power and control of their spouses is seen in the quotes:

> *Just to comment on the violence. We men were not giving our women a chance to do business because we thought they were going to engage in sexual affairs if they do so. Therefore, this is changing. Again, men were failing to tell their women how much salary we got with the reason that we will be questioned on how they spent them. This also has changed; we (men and women) are open and we tell each other on how things are to be conducted. (FGD_SA_MT_HA_01 Male motivators)*
>
> *In the past he was beating me he was not buying clothes for me and my children but now he does so I see that it has changed (FGD_SA_KD_JN_02 Male motivators' wife)*

The importance of emotional abuse as a form of violence is described below

> *F: Why have you put emotional cruelty on number one?*
> *R2: What the partner thinks even if you stay 100 years together, the thoughts of your partner cannot be known. You cannot know the partner has chiwembu (is plotting harm) in the heart to kill you or could put poison to nsima (maize porridge), you can't know. You do not know that the partner could rape you at one time, no. The violence that the partner could rape a child you do not know, you just happen to see them. The partner knew them himself that is why it is put at number one.*

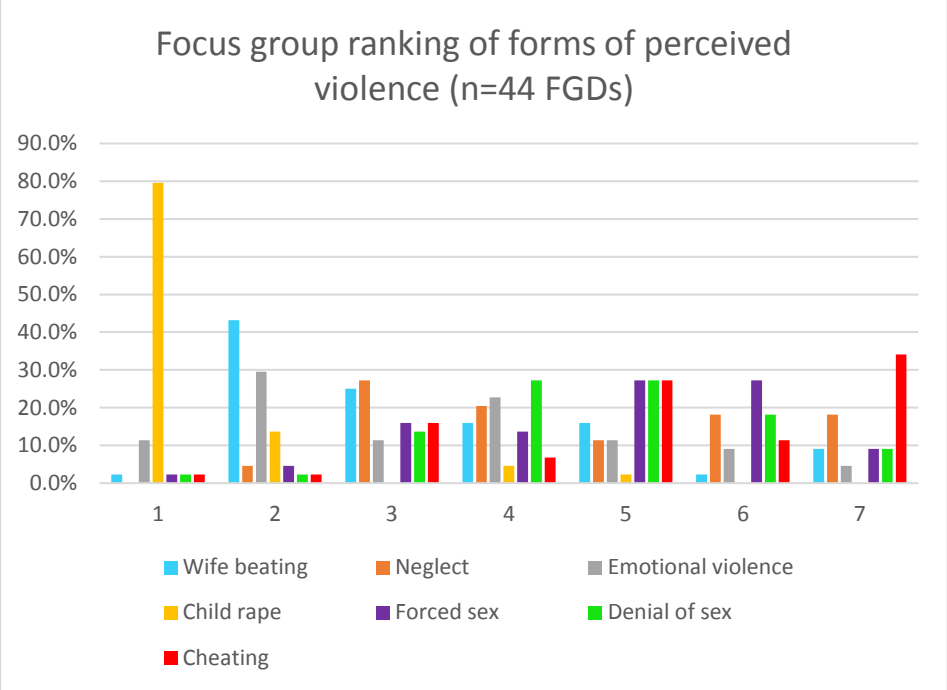
Some reported that physical violence was reported to have been reduced as a result of better family relationships

> *Aaah there are reduced cases of violence nowadays. Previously, most families engaged in fighting… for example it could happen that you have gone to draw water and your husband would just take maize or rice to sell. If the wife asked she would be beaten but now it has reduced because we do discuss, to say my wife I want to sell such to deal with such a problem. We do sell that and use the money for the particular purpose* (Female, IDI_KK_CA_F_FK_ZD_01).

Ranking of Violence: Evidence of Perceptions of Seriousness of Violence from Qualitative Research

The breadth of meaning allowed for ambiguity which facilitated a lack of distinction between more and less serious types of violence. In this round of data collection and analysis we sought information to understand if forms of violence were regarded differently and if so how they were ranked. Groups were asked to rank the forms of violence that emerged in round 2 data collection.

Figure X: Ranking types of violence by focus group participants (n=440)



While the majority (80%) agreed about the seriousness of child rape,there was less consensus on other types of perceived violence. However nine (20%) of the 44 focus groups did not rank child rape as the most serious form of violence, six of these were in the STAR sites and 3 were in the men engaging men sites. Wife beating was considered among the top 3 most serious forms of violence by most groups (70%) with 23 (52%) ranking emotional violence among the top 3 most serious forms. Denial of sex is ranked variously by the groups with over half (55%) ranking it in 4th or 5th position. Forced sex also is ranked differently by different groups with over half (55%) ranking it in 5th and 6th position. The fact that denial of sex is seen by many as more serious than rape (forced sex) is concerning. Just under half 44%, saw cheating as the least serious form of violence (ranked 6th and 7th). This may suggest a tolerance for cheating and forced sex if one was experiencing denial of sex.

Looking at gender differences in views on violence, 8 of the 22 groups of men and 7 of the 22 groups of women ranked cheating as the least serious form of violence. More women ranked emotional abuse and neglect as more serious than men. Women ranked child rape as either most serious (19) or second most serious (3), while 3 male FGDs ranked 4th & 5th most serious. Perhaps surprisingly men's focus groups considered forced sex as more serious than women with 9 of the 22 groups ranking it the top 3 most serious compared to only 1 women's group. This is likely a result of the programme in men engaging men sites as participants considered forced sex more serious than non-participants.

2.8 Changes in risk patterns

Highlights

- ✓ Respondents in the qualitative research reported that the programme positively influenced a decline in multiple concurrent partnerships
- ✓ New risk factors that were identified in the qualitative research were seen as migration to South Africa and environments which provide opportunity for sexual relations outside marriage (night screenings of videos, plays etc.)
- ✓ Transactional sex, driven by poverty, was reported to be reduced as a result of VSLs .
- ✓ There was no consensus on an impact in relation to alcohol reduction.
- ✓ While social control was seen as appropriate strategies to combat risk, empowerment of individuals within risk environment and harm reduction should be considered as alternatives

The qualitative research found that across rounds of data collection, MCP, unfaithfulness, transactional sex, and alcohol consumption were seen as risk factors for contracting HIV. Poverty and conversely men having disposable income (with which to attract women) were also seen as drivers of HIV as women would need to engage in sexual relations as a coping mechanism to meet their financial needs. The issue of men moving to South Africa was more clearly identified as a risk factor in the third round as were discos, night videos and plays particularly among the youth. Although there was consensus that MCP's and transitional sex had reduced they nevertheless still perceived as posing real risks in many communities. There were mixed views on the reduction of other risks.

2.8.1 Migration

Migration to South Africa emerged as a significant risk in this round in Salima and Nkhotakota. This was considered a risk because wives were left behind and if unsupported financially may engage in transactional sex to meet their material needs. It was also perceived as a risk as men while away for long periods may engage in sexual relationships abroad without protection. The example below suggests infidelity while the man was away led to pregnancy in two cases. It also highlights that the fate of these women lies in the hand of their husbands.

> *We have two cases in this village because the ladies as I am speaking are pregnant and we are waiting for the decision that will be made by the boys themselves from South Africa.*

One non-participant in Salima reported taking up the offer of sex from the wife of someone in South Africa for K200 (€0.25c). He said he used protection.

2.8.2 Risky environments

These risks were typically described as opportunities for sexual relationships outside the marital relationship. *Celebrations* such as night dances were seen as such an opportunity, though it was acknowledged these had reduced as a result of the programme. The concern was that "under the cover of darkness some could easily indulge in sexual relationships". A new risk mentioned was the night *screenings of videos*, discos and night plays which were seen as risks particularly for the youth. Typically it was sites and contexts that were blamed rather than the person, thus making the site / context the target for intervention rather than individuals' behaviour within these environments.

> *We are working towards closing down all the video shows because it is where our girls and boys are meeting planning to have sex and the time when these places are closing is not right because some of them closes at ten pm and some girls are getting pregnancies from these places hence dropping out from school and they are impregnated by married men. (Change agent IDI _SM_KD_AA_02)*

Similarly in Nkhotakota, football tournaments and video shows were also seen as creating environments which attracted behaviour that was considered immoral. All video shows were ordered by the community policing group to be closed by 8:00 in the evening. Even overnight prayers were described as a risky environment by one participant.

2.8.3 Transactional sex

Transactional sex was understood as sexual activity that takes place between a man and a woman in exchange for favours. Examples of ways of paying for transactional sex were cultivating in a woman's garden, giving fish at a reduced price or buying a small amount of bananas from a woman at an inflated price.

The practice of transactional sex was reported as reduced across all study villages. The reason for this change was ascribed to fear of contracting HIV and/or the influence of the Partner Programme in the area. VSLs were singled out by one FGD as contributing to

Prevalence of Transactional Sex from Quantitative Study

The quantitative study found low reporting of transactional sex. Just 1% of respondents in both the baseline and endline indicated that they had received money or gifts anytime they had sex with a casual partner in the past 12 months.

Just 1% in both 2011 and 2015 stated that they had given money or gifts to a casual partner for sex in the past 12 months.

Note: The definition for transactional sex used in the quantitative survey was narrower than was commonly used by participants in the qualitative research, including receiving money and gifts in exchange for sex but not favours.

the decline of transactional sex. Changes in gender norms to allow women to engage in businesses were also seen as contributor to the reduction in transactional sex.

In Nkotakota and Salima the common places for transactional sex were said to be at the trading centre and along the lakeshore. At the lakeshore the women engage in transactional sex when they want to have fish. At the trading centre, the main customers were reported to be businessmen who come from Lilongwe and Salima. Nevertheless, participants reported that transactional sex had significantly reduced in the community. However some feared it may re-emerge as a consequence of the poor harvest pushing people into a trap of transactional sex. This was mentioned in Dowa also as a risk factor. In Ntcheu though most reported a reduction of transactional sex in their communities men reported its existence more often than women – particularly noting that it occurred in Lizulu, on market days, and due to the opening of a new nightclub in Kaludzu village in Makala. Nevertheless, men did report a reduction in transactional sex in general.

Changes in Perception of Alcohol as a Cause of Risky Sex: Quantitative findings

In 2011, 93% of respondents in intervention sites agreed that 'alcohol affects a person's ability to make good decisions about sex'. Agreement with this statement significantly declined to 86% in 2015. A significant decline in agreement to this statement was also found in the control sites, where agreement declined from 89% to 82%. However, the decline was stronger among intervention sites. This suggests that participants are less likely to perceive alcohol consumption as an excuse for risky sexual behaviour. The effect was also stronger among community based interventions than focused interventions (V=0.306 vs. V= 0.270).

2.8.4 Early Sexual Debut

To assess changes in relation to age of sexual debut, respondents aged 18-24 in 2015 were sampled. A reduction in the percentage of women who had sexually debuted by 15 years was found from 31% to 26%, however this finding was insignificant. The low sample-size of 208 likely impacted on the significance of the result.

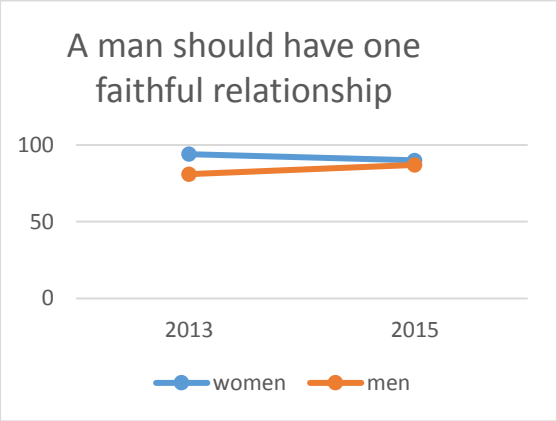
2.8.5 Alcohol

Alcohol was seen as a risk to HIV transmission mediated through unfaithful behaviour of men under its influence. This was particularly the case in Ntcheu, where in response to this risk, an alcohol audit tool and counselling was only rolled out. As seen in the last round there were mixed views about whether alcohol consumption had reduced as a result of the programme. In each of the Salima and Ntcheu study villages there was a stark contrast between the 2 study villages with positive changes in one and not in the other. Though even in villages where there was no reduction there were some individuals who reported change. One woman provided an example of how her husband had changed from being 'the number one drunkard' to no longer consuming at all after hearing CCJP's messages in Makala. In Dowa, while there were mixed reports on whether consumption had reduced or increased, field notes documented the refurbishment of the village bar with people

drinking when the research team arrived. A new type of beer was introduced in the village (rider) and the nearby trading centre (Kayembe) had been electrified and there were reports of people now drinking there as opposed to Nambuma trading centre that is farther away. In Nkhotakota there were mixed reports on alcohol consumption with no consensus. While there were testimonies from both the project participants and non-participants (male and female) on reduced alcohol consumption, it was evident that availability of cheap and high content alcohol in the area makes it accessible and affordable.

2.8.6 Multiple Concurrent Partnership (MCP):

There was a high degree of consensus among FGD participants that men should only have one partner. This was almost universal at round 1 among women and similar at round 3 according to the GAA tool results (see figure below). Most men interviewed also agreed with this statement at round 1 and agreement increased at round 3. Most respondents in the qualitative study across districts, programme status and gender said that the practice of MCP had reduced. Some reported personal experience



> *At first before SWAM I had so many outside sexual partners but with the advice from SWAM I stopped doing all that* (Male, CC_KK_ZD_MK_01).

Attitudes were said to have changed compared with the past but this change pre dated our data collection. The change and the reported reduction in the practice of MCP was ascribed to increased knowledge about the associated risks, the Partner Programmes and the HIV pandemic itself.

Across the village districts

> Most but not all said it was mainly men who practiced MCP and the reason for the practice was given as not being sexually satisfied. In Ntcheu several respondents credited the strategy of openness for the reduction in MCP. It was claimed that 'openness' increased the likelihood that men were sexually satisfied by their wives, and were therefore less likely seek sexual satisfaction outside of marriage

Conversely, in Nkhotakota, the lack of openness was seen as potentially leading to unfaithfulness

> *Facil: What can attract the man to propose another woman?*
>
> *Resp 5: Lack of openness, like refusing sexual intercourse during the day can make the man to propose other women outside the family (FGD_KK_ZD_HS_01 Female VSL).*

Though many suggested that not satisfying the husband sexually could lead to extra marital affairs this did not appear to be seen as the same as 'blaming' them for the husbands behaviour. On the issue of blame for MCP while men were clear that the man was at fault there were mixed views among women on who was responsible for men's unfaithfulness with a minority of women saying it was the wife's fault.

Though the practice of MCP was reported as having reduced, it nevertheless was reported as continuing. The quantitative findings saw only a small non-significant reduction in proportions reporting MCP among men in the intervention sites. In one FGD in Salima, 2 of the 6 young men in attendance admitted to having more than one current sexual partner. Interestingly though, those who admitted to MCPs said they always used protection while some of those who had only one current partner did not. Women in the Salima villages were less convinced than their male counterparts about the extent of the reduction of this practice.

In Dowa it was reported that incidences of having several sexual partners at once have reduced as a result of the programme.

In summary risk is seen as being mediated through all sorts of normal social living, environments and interactions including celebrations, football matches and prayer groups.

Poverty is seen as a major driver of risk which is mediated through transactional sex and purported as ameliorated through VSL's.

2.8 Prevention

Highlights:

- Testing appears widely available with little change between 2011 and 2015
- Interventions appear to have improved the uptake of testing, with a greater increase among respondents in intervention sites stating that they had taken an HIV test compared to the control sites.
- Stigma and discrimination were not identified as barriers to HIV testing, although shyness, anxiety over the result of the test, and ignorance were identified in the qualitative research as remaining barriers.
- Mixed results were found relating to condom use. Most respondents indicated that condoms were available, but access appeared to be lower.
- Evidence that condoms were primarily used outside of marriage, particularly in casual sexual relationships.

2.8.1 Testing

The quantitative analysis found no changes in the proportion of respondents in the intervention or control group who stated that it was possible for someone in their community to get a confidential HIV test, with nearly universal agreement in both 2011 and 2015 (>90%). However, a significant increase in uptake of testing was found in intervention sites between 2011 and 2015, with an increase from 73% to 83% who had ever had an HIV test. No significant change was noted in the control sites, thus indicating the positive influence of the interventions.

The qualitative findings corroborate the quantitative findings, as the programme was reported to contribute to the uptake of testing, through encouraging this practice as well as bringing testing services to the villages on occasion. Barriers to availing of testing services were reported as shyness, anxiety over the result and ignorance. Stigma and discrimination were not perceived as barriers. Women were routinely tested for HIV during ante-natal appointments. Some respondents in Ntcheu described a change witnessed was that men were now more likely to accompany women to appointments and be tested at the same time (Ntcheu). Notably, couples testing was promoted through the programme.

2.8.2 Condom use

Most reports in sites suggested a continued behavioural change towards increased condom use particularly amongst the youth and people who were HIV positive. They were reported as used for sexual relationships outside marriage. Use in marriage was seen as unlikely unless for birth spacing. Access to condoms was problematic in one of the sites in Salima but elsewhere they were accessible and available. Respondents were asked in the baseline and again at the endline if they agreed, neither agreed nor disagreed, or disagreed with the following statements

Table 15: Availability and accessibility of Condoms

Indicator	Overall Change %		Control Group % Positive		Intervention Group % Positive		Focused Intervention % Positive		Community Intervention % Positive	
	2011	2015	2011	2015	2011	2015	2011	2015	2011	2015
Condoms are readily available in your community	68%	74%	68%	69%	69%	76%	70%	76%	68%	77%
I feel confident I can get condoms if I need them	80%	73%	85%	68%	77%	75%	74%	75%	82%	75%

An interesting pattern emerged whereby more respondents stated that condoms were readily available in their community but fewer respondents felt confident they could get them if they needed them. The reason for this pattern is unclear although it is notably stronger in the control group and in community intervention sites. Further exploration of this finding is required.

The anonymous survey provided some detail on use of condoms in Ntcheu, Dowa and Salima. Overall, 19% of respondents in the three districts had used condoms in the past 3 months in 2015. More men (25%) compared to women (16%) had used condoms in the past three months ($p<0.05$). Condom use was highest in Salima (25%) followed by Dowa (20%) and Ntcheu (15%) although these differences did not quite reach significance ($p=0.08$). Comparison to the baseline however was notpossible.

2.9 Economic impact and impact of VSLs

Highlights

- The quantitative survey found that VSL members were better off economically across some measures than non VSL members.
- In all sites where implemented the VSLs were reported as having benefited the members by providing a source of loans in times of need and as a capital for small businesses
- Quantitative and qualitative findings suggest VSLs may have a role in reducing involvement in transactional sex
- Qualitative findings caution in relation to possible negative consequences of not being able to repay loans

In Nkhotakota VSLs were introduced in both TAs as part of the programme. After Round 1 findings of their benefits were disseminated, VSLs were expanded to a second TA in Ntcheu and in Dowa. VSLs had been established in one of the TAs in Ntcheu and both TAs in Nkhotakota at the commencement of the programme in line with the then research design. In Dowa the COWLHA VSL's had disbanded so participants were not available for interview. However, it was reported others in the community started their own VSLs and these were working. In Salima VSL's were not part of the Trócaire project, however, other organisations were implementing them in some of the villages and motivators reported encouraging people to join these.

Round 1 findings were very positive about the impact of VSLs noting they were credited with initiating significant, positive change in the community. Among the positive impacts of VSLs for women was a reduction in transactional sex, an increased sense of independence, improved negotiating power over economic decision-making in the family and increased economic security' (Report 1 qualitative 2013)

Where negative comments were noted, these primarily referred to the desire for more access to VSLs, rather than any problems created by VSLs. In Round 2 VSLs were understood to have played a big role in 'economically empowering both men and women in the community' and regarded as a great success. In both rounds, on probing, negative consequences were reported particularly for those who could not afford to repay loans. In round 3 while the overriding sense is one of positivity regarding VSLs more negative consequences are described, particularly in Nkhotakota where the schemes have been in operation the longest.

Positive Impact

In Nkhotakota and Ntcheu the VSLs were reported by all types of respondent groups as having benefited the members by providing source of loans in times of need, and as a capital for small businesses. Improvements included better financial management skills, development of businesses, building and repairing houses, purchase of fertilizer and other farming inputs, support for costs associated with children's schooling and being able to deal with financial emergencies. Women most commonly mentioned the benefits as engaging in businesses and sending children to school, while men more commonly discussed house building and repair. Purchase of fertilizer appeared to be an important investment made possible through VSL loans by both men and women.

Some positive differences were found in relation to responses to questions designed to assess economic well-being and participation in a VSL.76% of participants in a Trócaire supported VSL agreed that they 'could replace plates and utensils when needed' compared with 64% of those who did not participate in a VSL (p=0.003). 73% of VSL participants stated they could 'buy meat or fish at least once a week', compared to 60% of non-participants (p= 0.001).

The Village Savings and Loan groups were seen to increase access to disposable income to families and in a way improving the socio-economic status of the families. Some participants in Dowa believed these have lessened gender based violence within families.

> *"They have really changed us, they brought the VSLs project which helps us save money because previously we used to just waste our extra money, in this way our families are being helped and abusive behaviors have lessened because of this."* FGD_DA_MS_JN

VSLs were singled out by one FGD in Ntcheu as contributing to the decline of transactional sex. Nevertheless these were generally second hand reports:

Currently there is a great change in this practice. In the past people were doing it [transactional sex] with an aim of supporting their family or to acquire what they want… but now … It is not common to find a woman engaging in such act. This is so because they are able to meet their needs using the money they are getting from VSLs and businesses. (Male, Change Agent, IDI_NU_MK_MK_01)

Both men and women also noted social advantages of VSLs, including providing assistance to other members when they were unwell. Both men and women indicated that the groups provided an opportunity to discuss other issues in the community and to spread messaging around HIV and GBV reduction. Some groups indicated future plans that included elements of social entrepreneurialism, such as the following group:

While not achieving significance, there is some suggestion in the data that VSL participation may reduce the likelihood of transactional sex. It was found that 0% of VSL participants agreed that they had 'received money or gifts any time [they] had sex with a casual partner in the past 12 months' compared to 1.5% of those who were participants in other Trócaire interventions (but not in a VSL) and 2% of all those who did not participate in any interventions supported by Trócaire.

1% of respondents from intervention sites had received money or gifts for sex from a casual sexual partner compared with 3% from control sites. This finding came close to significance (sig. 0.087).

*When we are really established in our group we plan to set aside some funds that will be used to help the elderly people, and fellow friends who are infected by HIV in the community(*Men, Participants, FGD_NU_BM_PP_01)

When comparing VSL participants vs. non VSL participants who were members of other Trócaire interventions, some differences were found although they did not reach significance, likely due to small numbers (n=199), with just 59 respondents in the VSL participant category. Nevertheless, it was found that across all three economic indicators those in the VSL group were more likely to agree than participants in other Trócaire supported interventions, shown in the table below. Low numbers of has meant that further analysis is not possible.

Table 14: Comparison of deprivation indicators among VSL and other intervention participants

Indicator	VSL Participant (Trócaire supported) - % Agree	Other Intervention Participant (Trócaire supported)- % Agree
I can usually manage to replace plates and utensils when needed	76	68
We can buy meat or fish at least once a week	73	66
I can usually manage to replace clothes when needed.	71	59

Negative Impact

The negative impact of VSLs was attributed to those who failed to repay loans on-time or who were late or missed repayments. It was noted that this typically resulted in their property being grabbed and sold to recover the money they owed the group. Negative consequences for VSLs were not commonly reported in Ntcheu and the Dowa VSLs has disbanded. Where they were reports of negative consequences such as confiscating property for non-repayment of loans, this was justified and that all who took out loans were aware of this potential consequence.

In Nkhotakota some respondents reported that VSLs have been more beneficial for people who only used the VSL for saving as they receive interest and are not charged it. The benefits were said to be less for borrowers particularly if they do not make enough profits to cover the interest rates.

> *R2: Lives have changed mainly to those who only keep the money to VSL not those who borrow from it. The truth is that out of 100 members who borrow money from VSL, 95 members are finding it difficult to pay back the borrowed money. For those who only keep the money to VSL, they get the benefits because they receive it at a time when the money is needed most.*

Therefore, their farming benefits a lot because had enough money for inputs (Male, FGD_KK_ZD_PP_01).

Some respondents mentioned that VSLs have potential of driving women into transactional sex if they have failed to raise money to pay back the loans they obtain. There were strict regulations put in place expelling members if they engaged in this practice.

In summary

Quantitative findings suggests that Trócaire interventions have positively reduced experiences of deprivation. While not conclusive due to the low sample size of VSL participants, it would appear that VSLs have a stronger positive effect on economic well-being and may reduce involvement in transactional sex.

Qualitative findings support the quantitative findings showing positive impact including more financial independence for women and involvement in decision making about how money is spent. However caution on potential negative effects of not being able to repay borrowed money is noted and this should be well accounted for in the programme with lending taking account of capacity to pay back.

3. Discussion

The Trócaire HIV programme approach was designed in part to address the concern that HIV programmes have historically addressed 'the immediate constrained realities of women's lives but … [not] the underlying social constructions of gender that create the constraints in the first place (Dunkle and Jewkes, 2007:173). Within the Trócaire HIV programme in Malawi, effort was made to fund interventions that aimed for transformative change so as to reduce women's vulnerability to HIV. At the outset of the programme and following the baseline, indicators were selected to monitor and identify 'change', and a 'break' of six months minimum of implementation was instated prior to endline data collection in order to assess the sustainability of the changes observed. This approach and the changes that were expected to emanate from the programmes, fall in-line with accepted, good-practice, approaches to assessing interventions that target issues including HIV risk reduction, gender equality, and GBV reduction (e.g. Jewkes et.al. 2007).However, the findings from this study give cause to consider what change means and how programmer and research expectations of change may need to be re-examined and tempered.

Evidence from this study points to complex interactions between interventions, and rates, and directions, of change. For instance whilst participants often attributed remarkable change to interventions, the quantitative research found much more limited change. For example, stigmatising attitudes demonstrated only slight improvement, and tolerance of intimate partner violence in fact increased in some study sites. These findings align with recent analysis of outcomes of development initiatives by Agence Française de Développement which concludes that, often, 'interventions do not have the impact they initially intended' and are 'negotiated and reinterpreted through a range of analytical grids and via local contexts and dynamics that end up transforming them significantly' (Aberlan et.al. 2016:8). The emergence of such a perspective sheds light on issues of the strength, time-frame and direction of change.

Programmes like this one aimed at addressing gender inequality and vulnerability expect to see significant shifts in the balance of power between men and women and in how people think within a relatively short period (e.g. 2-5 years). Programmers may feel pressure to deliver evidence of change, and researchers may seek to identify evidence of change, at the risk of over-emphasising short-term change and under-examining deeper normative change that is sustained over the long-term. While this issue is, in part, a methodological issue affected by short-term funding cycles and the challenges of longitudinal studies, it is also a conceptual challenge: the idea that sustained social change can be achieved within observable time-frames through interventions is not supported with solid evidence. Indeed, programmes are rarely provided sufficient funding for the necessary time-frame to produce an impact and assess outcomes (Barker, 2005) and even among those few that have had longer assessment times, such as Stepping Stones, few have extended the assessment period beyond 3 years (Dworkin et.al. 2013). A rare exception to this was the IMAGE study in South Africa that followed up on initial perceived changes after an interval of two years. However, this study found that while intimate partner violence was significantly reduced, less change was seen in relation to sexual behaviour (Hargreaves et.al. 2010).

The time-frame for assessment which was used in the Trócaire Malawi Gender and HIV study (5 years), and the intervention implementation break that was initiated prior to quantitative endline, has better allowed this project to assess the sustainability of change. The fact that changes were not as momentous or as common as anticipated, may in fact point to the reality that deep normative and social change cannot be achieved through community-level interventions alone. Particularly where, as with changes to some gender equality measures, they conflict with locally held beliefs. A strong example of this is the issue of denial of sex within marriage. Both men and women

demonstrated a strong belief that denial of sex within marriage was a violation of conjugal rights and a form of violence and this view is supported generally within Malawi at the level of policy and legislation (e.g. National Action Plan to Combat Domestic Violence, 2014-2020; Chauwa, 2015). The interventions appeared to have done relatively little to challenge this belief, and conversely, may have inadvertently supported it through interpretations made on the meaning of 'openness'.

The HIV and development literature has started to recognise that social change is not something that can be imposed but rather that the goal of interventions should be to 'encourage and accompany such processes of change' as are already occurring (Aberlan et.al. 2016:7). The evidence from this study supports this view. Where social change was already occurring, to a greater or lesser extent, the interventions were able to support, strengthen and add speed to these changes, as was seen in relation to modifications in risky cultural practices and encouragement of women's involvement in decision making, particularly for women who had independent income. Indeed, the most appreciated aspects of interventions by participants were those that didn't challenge deep seated norms but rather supported living safely, or improving living conditions, within the existing social system. Thus the strategy of openness and the reduction to seclusion periods were successful as they did not challenge male dominance or the right to sexual activity for spouses. Improvements in communication between couples and consulting the wife regarding financial decisions tended to improve marital relationships without challenging the role of the husband as final arbiter of household decisions and the head of the family.

VSLs present as an example of Abelan's et al's argument, that interventions should be directed to accompany processes of change that were happening anyway. VSLs were also much appreciated by participants, with just a small minority identifying potential risks of non-repayment of loans in the final round. Again, this intervention supported families and individuals economically but did not 'yet' show signs of challenge to existing social dynamics. Women would require permission for their husbands to become involved in VSLs and benefited from their involvement. Women were already taking up economic activities outside the home, for instance, prior to the start of interventions, and men and women continued to anticipate that male heads of households would have significant influence on how income was spent. However, where change was attempted that countered the direction of existing social dynamics, little change was produced and, potentially, risks for harm were intensified. For instance, at a findings validation workshop, it was suggested that the increase in violence in Nkhotakota may have been an unintended outcome of the intervention's challenges to existing gender norms. This unintended consequence has been found in other studies (Mejia, et al.

2014, Hughes, et. al 2015) and is not entirely unexpected but does give rise to serious ethical questions for programmers who may put participants at risk by attempting deep normative change in communities who are 'not ready' for such change.

Aberlan's theory that interventions are 'negotiated and reinterpreted through a range of analytical grids and via local contexts and dynamics that end up transforming them significantly' presents a lens through which to see the 'openness' strategy. The programme objective to reduce women's vulnerability to HIV did not set out to promote openness to reduce their likelihood of extramarital affairs. Yet through a range of interpretations and local contexts and dynamics this strategy was encouraged and perceived as pragmatic and sensible by men and women in the communities and by many programme implementers. Women felt freed from old customary reticence and felt that by modifying their sexual behaviour they could protect themselves from HIV exposure through their husband's infidelities. Though there was no evidence that this strategy would safeguard women, it appealed to local wisdom and did not confront the strong norms and power differential that bestow privilege and power to men. This result was not expected by or intended by program designers.

For programmes, understanding the 'the situation in which they seek to intervene, so as to predict the reactions and reinterpretations that their projects may bring about' (Aberlan, 2016) is essential. The Malawi research study has importantly contributed towards this understanding by revealing the ways through which strategies were filtered through existing values, supported by the patriarchal structure of Malawian society, to reproduce, in relation to openness, a strategy that was prevalent throughout society and highly valued by participants as improving their everyday lived experience while not actually challenging the patriarchal structure of the Malawian family.

This analysis also sheds light on the attempt to answer the guiding question of this study: what combination of strategies is most effective in reducing women's vulnerability to HIV? (Duvvury and Scriver, 2012:3). The findings from the study suggest that a combined approach, involving aspects of the focused intervention and aspects of the community-based intervention, is most valuable in order to address different risks and vulnerabilities. Focused interventions working directly with leaders appeared to be most successful at supporting some forms of behavioural change (e.g. sexual norms and stigma and discrimination reduction), largely through the social capital and authority of leaders who can demand immediate shifts in practices, such as outlawing night dances or fining those who discriminate against PLHIV. This approach may be most successful where quick change is needed to modify specific risky behaviours. However, such an approach does not appear to be as successful in

supporting normative change[13] and thus reducing vulnerability of specific groups (e.g. women, the poor, etc.). Community-based interventions on the other hand did appear to have greater success in initiating or supporting already occurring normative change, such as the shifts in gender norms seen in Dowa and to some extent in Nkhotakota, although this appears to be a slow and incremental process that may require considerably more time than the evaluation time-frame allowed to see significant and momentous change across a range of indicators.

Overall, the findings suggest that working directly with leaders to create immediate behavioural change and with community-approaches to support normative change are both important intervention strategies that should be used as a combined approach. Implementing such a combined strategy should however take careful consideration of the social contexts of communities and focus on those areas that are ripe for change and where some shifts have already begun to occur. The evidence suggests that attempting deep changes in communities without their prior support for such change is unlikely to be effective and may result in unintended consequences that could threaten gains made in other areas or indeed cause harm to participants. Where such deep normative change is identified as essential, programmes should proceed with caution, allowing for a period of engagement and exploration with local communities to better understand community beliefs and values, and with the expectation of slow, gradual change while remaining attentive to potential risks and unintended consequences.

4. Key Lessons

This 5 year mixed-method study has provided a wealth of information not only about the strategies to reduce women's vulnerability to HIV, but also about the challenges, and lessons, of programming. The lessons listed below can be used to help inform Trócaire programming into the future, as well as other programmes and interventions aimed at improving gender equality and/or HIV risk in rural, developing contexts.

[13] Behavioural change is expressed through shifting practices and behaviours at the individual or community level. Normative change refers to shifts in attitudes and beliefs at individual or community level. While normative change is often accompanied by behavioural change (e.g. acceptance that PLHIV are not immoral is likely to mean reduction in discriminatory behaviours towards PLHIV in the community) and vice versa, this is not always the case. For example, an individual may change their behaviour due to fear of repercussions (e.g. does not discriminate against a PLHIV due to the possibility of being fined if they do so), however, they may not necessarily have changed their beliefs or values (e.g. they continue to perceive PLHIV as immoral), Thus, where behavioural change is not accompanied by normative change there is a greater risk of reverting to previous behaviours should the barrier or disincentive to this behaviour disappear.

Gender equality and HIV risk reduction strategies in patriarchal contexts may not always be compatible:

The evidence from both the qualitative and quantitative research suggests a dissonance between the efforts to reduce risk to vulnerability through modification to sexual attitudes and norms, and efforts to improve gender equality. While it is clear that men and women see the benefit of sexual openness in their relationships as the reduction of the risk of unfaithfulness and thus HIV (although noting that evidence does not support this assumption), the right of women to refuse sex appears at the same time to be undermined by this message. Within a context in which women's sexual availability is thought to be ensured through marriage (and a man's conjugal rights), enhancing women's rights to sexual autonomy, as well as to their autonomy in other areas, may not be seen as realistic, or indeed desirable by the target groups.

The expectations of 'success' and what counts as success requires moderation:

The quantitative findings suggest modest success in relation to some findings, such as the reduction in stigmatising attitudes, while in others there is a measurable deterioration of attitudes (e.g. gender equitable norms deteriorated in two intervention sites). These findings do not meet the expectations set out after the baseline in terms of measuring success and call into question, what we set as targets for success and how we measure it. As discussed previously, the expectation of significant and sustained change as a result of a time-limited intervention may not be realistic.

Evolving programmes challenge attribution of change to specific activities and interventions.

The evolution of the Partner strategies in each area into multi-faceted approaches makes it very difficult to attribute impact to specific strategies or combinations of these.

Qualitative and quantitative findings measure different types of change and may not always co-align:

Differences were found in qualitative and quantitative analysis in relation to gender equality. However, qualitative and quantitative analysis may not reflect on the same units of measurement, with qualitative research aimed at understanding the participant's point of view rather than assessing facts from a more distant and objective viewpoint. Thus, findings from the qualitative research may reflect more of a relative change and improvement in gender equality even where this

change does not meet objective standards of gender equality. Thus, while a woman may perceive improvements in gender equality within her household due to the discussions, for instance, that are now held with her husband on how the income from the harvest will be met, she may still perceive her husband as the final decision maker and may still feel it is unacceptable to deny him sex. While qualitative research may pick up on the relative improvement in her situation, thus suggesting improvements in gender equality, the quantitative research will continue to note a high level of gender inequality. The findings from the qualitative and quantitative research may thus at times be challenging to interpret; however, they should not be seen as incompatible. Rather they provide different pictures of a situation that help to better understand and temper interpretations of change in the community.

Over-time, the reported benefits of VSLs may become risks for some borrowers:

The qualitative data in particular picked up on a trend in which a minority of participants felt that over-time the VSLs could have negative consequences for those who were unable to meet repayments resulting in repossessions, the threat of repossessions or the possibility of engaging in transactional sex to meet repayments. The direction of this trend raises the concern that in future years more members will begin to feel the pressures of repayments, potentially exposing them to more risk. However, the majority of VSL members were satisfied with the functioning of VSLs and many stories of how they were used to improve the lives of members were provided. Adequate systems for screening and determining repayment capacity should offset the potential risk identified.

5. Recommendations for Programmers

More broadly, the lessons from this study also provide recommendations for future programming in developing contexts. These include:

At a community level work with changes that are ripe or already occurring

Working against very strong norms and practices is likely to result in a) resistance, or b) the conversion, on the ground, of efforts to support existing norms and practices. Seeking spaces where change has begun to occur to strengthen such change or to engage with communities through their articulated needs (e.g. address poverty, provide knowledge, etc.) is more likely to be well-received and may open new spaces for change as basic needs are met. Where more significant normative or

legislative shifts are required to support gender equality or health/well-being, these should achieved through collaborative working with national governments and agencies.

Be context sensitive

Communities develop and change in different ways but also within the larger context of societal change. Programmes need to be sensitive to the myriad unintended consequences of interventions. To the extent possible, potential consequences should be mapped, with input from local experts, prior to the commencement of a programme thus allowing for an inception period, or period of exploration, prior to commencement of the intervention.

Temper programme expectations about transformative change in social or cultural norms

Real normative change is a process that may be better expected to occur over decades or even over generations. Such changes are also likely to require societal shifts that are beyond the scope of community interventions. Nevertheless, small changes in attitudes and norms are possible, as are some behavioural changes within communities. For sustainable normative change, however, it may be necessary to focus efforts at the national or regional level, such as through working with policy-makers and legislators to, for instance, change laws on early marriage, gender equality, and women's rights in marriage etc.

Evaluation research should prioritise doing no harm

Both donors and NGO programme practitioners want to establish that change can be attributed to the funded interventions and evaluation research is the preferred tool. However in social settings it is critical that design of evaluation research prioritise doing no harm to participants and be sensitive to identifying unintended consequences, which in fact is the more valuable indication of the deeper dynamics in such settings.

Build on successes by integrating the most effective components of a variety of intervention approaches

While deep and significant normative change across communities was not seen, the findings from this study suggest that smaller changes are possible. While community-based interventions appeared to be most effective at supporting normative change, albeit slowly, the focused interventions appeared most successful at supporting behavioural change – in particular by engaging with authority figures and leaders in the community who are able to issue directives and spread knowledge regarding acceptable/unacceptable behaviour. These two approaches when combined thus offer the potential to reduce risky behaviour immediately while supporting normative change

over the long-term. Programmes should draw from previous experience by integrating successful methods to best suit the specific contexts and objectives.

Close the gap in perspective between Trócaire and partners

It is imperative that all partners/stakeholders have a clear understanding of the purpose and objectives of the programme and the research element. In terms of the programme the local partners responsible for the day to day development and implementation were subject to many of the same social and cultural norms as programme participants some of which were the target for change by the programme. There was an assumption that after brief training programme partners and Trócaire regarded complex cultural and social phenomena similarly. This was not the case with the benefits of the openness strategy being the best example. Similarly the purpose of the research was not understood in the same way by Trócaire, researchers and implementing partners. Implementing partners were focused on immediate findings to reconfigure/tweak their programmes even as the research was underway, which was problematic to maintaining distinct intervention types to which change could be attributed. Trócaire as donor, and simultaneously research partner, was at times at cross-purposes wanting reliable research results to advance knowledge of what works and at the same time strengthening interventions as formative findings became available.

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Appendix A: Cultural practices and associated terminology

The following practices and associated terms were encountered during the analysis of the data. These were interpreted as described below.

Life cycle important events	Associated terms describing a *practice*	terms describing *belief, person or place associate with the practice*	interpretation
Death	***chokolo***		*Wife inheritance: When a husband dies his brother, cousin or nephew inherits the surviving wife.*
	kulowa kufa		*A man usually a relative of the deceased has sex with a woman whose husband has just died, to put to the spirit of the deceased to rest.*
	kudika maliro		*Sexual seclusion (period of abstinence from sexual intercourse) after a death. This can last up to one month.*
	kudikira tsiku lometa		*Sleeping at the home of the deceased's family during the mourning period (duration of about one week).*
	Sadakka		A feast marking remembrance of a relative who died some time ago.
Pregnancy birth and time shortly after birth	**kuika mwana kumalo** **or** kuika mwana kumphasa or Kudikira mwana akhambe		Ritualistic sexual intercourse to mark resumption of sexual activity after the period of abstinence (seclusion) after the birth of a child. The ritual involves the couple performing the sexual act with the child lying between them. It is believed that by undergoing the ritual the child is invigorated and less likely to fall ill or die. If the husband is unable to perform this ritual or if he is absent, another man (fisi) can be engaged to perform this ritualistic sex act.
		mtayo womangony oloka zala	*This is a disease (characterised by elongation of the fingers) that a man suffers if he had sex with a woman who had given birth (or miscarried/aborted) earlier than culturally prescribed period.*

		chinyera	*A disease that one suffers after having sex earlier than the culturally prescribed period with a woman that has given birth/aborted/miscarried*
		tsempho	*A disease that a child develops when either of the parents have had extra-marital sexual intercourse when the child is younger than recommended (ranges between 3 - 6 months).*
		kumpatsa mwana mphepo yoipa	*A new born falls under the influence of evil spells because the parents did not observe the required seclusion period*
		fisi	*The direct translation is Hyena. This denotes a man who is engaged to have sexual intercourse with woman or girl to perform service (impregnation) or ritual, or to test girls post initiation to see if she has absorbed what she has learnt.*
	Chikuta		*Isolation of a new mother from the public from time of birth of the child to the falling of umbilical cord.*
	Seclusion		*Period of sexual abstinence during pregnancy or after birth to protect the foetus /infant/. The period of abstinence varies but can vary according to the ethnic group and religion.* *Seclusion can also relate to periods of sexual abstinence for other reasons e.g. mourning*
	Kulera		*Child spacing*
Coming of age / stage	***Nsondo***		*An initiation for girls aged between 7-10 years among the Yao. The initiates are gathered and encamp in one house within the village. The girls stay in the camped house for two to three weeks before being released. During that time they are advised about signs of puberty, how to take care of themselves during menses and morality. (Nsondo is also known as Msondo or Zondo)*
	Chiputu		A second initiation among Yao girls (done after puberty). It is rare in recent times

	Chilangizi		*Counselling for girls that takes place at different stages and for different purposes such as the onset of first menses and (first) pregnancy.*
	Litiwo		*First pregnancy counselling among the Yao.*
	Kuchotsa/ Kusasa fumbi		*As part of the initiation process once a girl has reached puberty, a man (fisi) has sexual intercourse with her. This is believed to 'remove dust' from the adolescent girl.*
	Gule wamkulu		*Literary meaning 'big dance' this is practiced either as a dance or as an initiation for the Chewas boys. When performed as an initiation for girls it is known as mkangali.It is also conducted during installation of a chief or on its own after harvesting period.*
	mkangali.		*An initiation for the Chewas girls, equivalent to gule wamkulu for boys.*
		dambwe	*The camp where the Chewa initiates undergoing gule wamkulu or mkangali are kept for a week or two*
		nankungwi	*The counsellor in-charge of the dambwe*
	mipingu thimbwiza		Initiation for Chewa women
	Jando		*The initiation for boys among the Yao. It involves circumcising the boys aged 6 to 12 years as well as counselling them on different aspects of life. It is considered as a religious requirement among the Muslims. It is often performed after harvesting when there is plenty of food in the village.*
		simba	*Chichewa word for initiation place. The camp in the 'bush' where the boys for Jando stay for 1 to 2 months until the circumcision wounds heal. Also known as Ndagala*
		Ndagala	Yao word used to describe a camp where boys stay after circumcision.
		ngaliba	*A traditional surgeon who performs the circumcision using traditional medicine for the healing of the wounds*
	zinamwali		Initiations (also known as chinamwali)

Celebrations & dances	***Gule wamkulu***		*As above literal meaning 'big dance' is practiced either as a dance or as an initiation for the Chewas boys. Only those who have been initiated have a right to put on gule wamkulu regalia and perform it for functions.* *The dancers wear costumes (including masks) that represent human spirits. Regalia represents fierce wild animals such as lion, elephants and others. The Dance is usually performed during installation of chiefs, during political rallies, during initiation ceremonies and during funerals of elderly people who were performers of the dance.*
	Chiterela		*A dance for girls often performed in the bright moonlight*
	Zikiri		*A dance performed by Muslim men/boys and women/girls. It is considered as a religious dance*
	Makhanya		*An erotic dance performed during celebrations such as weddings, initiations among the lakeshore dwellers.*
	Chioda and chimtali		*These are dances performed by women only while men only watch. Two men beat drums while the women dance in a circle going around the men by shaking their bodies especially the waist. It is usually performed as entertainment during wedding ceremonies, on the eve of Christmas and at political rallies.*
		Chimtali	*The intention of the dance is to warn the boys and girls about their secret friendship/meetings. The dance is also performed for entertainment purposes.*
	Michezo**(plural)*****/ Mchezo*** **(singular)**		*Performance of dances that are done all night long*
	Chingowe		A dance performed by girls on the eve of their last day in initiation camp (Msondo or Chiputu).

Marriage	***Chikamwini/ Khikamwini***		*A man leaves his village and settles at his wife's home village (matrilineal). His roles may be limited as he belongs to another place.*
	Chitengwa		*A woman leaves her village and settles ather husbands' home village. Her roles may be limited as he belongs to another place*
	Ndowa		*Wedding (used in Chi Yao but derived from Swahili)*
	Ingoma		*A dance performed during entertainment e.g. chief election and installation*
	kudika tsabola		*Couples' abstinence from sex during the time from when the pepper has started flowering till the pepper has ripened.*
		Msempho	*An illness that develops due to non-performance of some rituals*
	kulowetsa dzuwa ***Or kukuna/*** ***Makuna/*** ***Zokoka***		*Literally means 'setting the sun'. This is Labia stretching. It is done in the afternoon when the girls have finished household chores. The time between finishing household chores and sunset is used for stretching the labia, hence the name. This is done up to the time when the girl reaches puberty or when the labia have been pulled to the right size.*
	kusikitsira		*The giving of medicine, when a girl comes of age.*

Appendix B: List of Abbreviations

List of Abbreviations.

ARV: Anti-Retrovirals

ART: Anti-Retroviral Therapy

CCAP: Church of Central Africa, Presbyterian

CCJP: Catholic Commission for Justice and Peace

CHAM: Christian Health Association of Malawi

COWLHA: Coalition of Women Living with HIV and AIDS

CSO: Civil Society Organisation

DHO: District Health Office

DIAC: District Interfaith Aids Committee

GAA: Gender Attitudes and Assessment

HTC: HIV Testing and Counselling

IRLAD: Irrigation Rural Livelihood and Agricultural Development

FGD: Focus Group Discussions

GBV: Gender Based Violence

HIV: Human Immunodeficiency virus

IPV: Intimate Partner Violence

MCP: Multiple Concurrent Partnerships

MIAA: Malawi Interfaith AIDS Association

NASO: Nkhotakota AIDS Support Organisation

NGO: Non-Governmental Organisation

NUI Galway: National University of Ireland, Galway

PLHIV: People Living with HIV and AIDS

REACH Trust: Research for Equity and Community Health Trust

STAR: Societies Tackling AIDS through Rights

SWAM: Society for Women and AIDS, Malawi

TA: Traditional Authority

VSL: Village Savings and Loan scheme