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Meaningful Participation of People Living with HIV in Addressing HIV Transmission, Harmful Cultural Practices and Stigma in Malawi: Evidence from the STAR Circles Participatory Empowerment Model

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Abstract

People Living with HIV (PLHIV) in Sub-Saharan Africa continue to experience intersecting biomedical, social and cultural challenges that increase vulnerability to HIV transmission and undermine treatment outcomes. These challenges include stigma, discrimination, gender inequality, poverty and harmful cultural practices such as widow inheritance and sexual cleansing. Despite extensive HIV programming, meaningful participation of PLHIV in decision-making processes remains limited. The Societies Taking Action for Rights (STAR) circles were introduced as a community-led, rights-based empowerment intervention designed to enhance the agency of PLHIV. This paper presents findings from a descriptive mixed-methods and quasi-experimental evaluation of the STAR circles programme implemented by ActionAid Malawi between 2012 and July 2013 across 60 communities in Malawi. Programme monitoring data, retrospective baseline data and qualitative narratives were analysed using descriptive statistics, correlation analysis, regression modelling, difference-in-differences estimation and mediation analysis. A total of 1,860 PLHIV participated, of whom 58.6% were female. The intervention led to increased self-confidence, leadership participation and community engagement, significant reductions in harmful cultural practices, decreased stigma and discrimination, and improved access to social protection and economic opportunities. Empowerment was confirmed as a significant mediating pathway linking participation to stigma reduction. These findings demonstrate that meaningful participation of PLHIV using rights-based participatory approaches produces measurable social, cultural and economic outcomes and should be institutionalized within national HIV responses.

Keywords: Adolescence, Attachment, Personality Traits, Emotional Maturity, Emotional Intelligence, Suicidal Ideation, Training Program.

Introduction

Malawi remains among the countries with the highest HIV burden in Sub-Saharan Africa, with adult HIV prevalence estimated at 10.6% in 2010 according to the Malawi Demographic and Health Survey [1]. While biomedical advances, particularly the scale-up of antiretroviral therapy, have substantially improved survival and reduced AIDS-related mortality, social and structural drivers continue to influence HIV transmission dynamics and treatment outcomes. People Living with HIV (PLHIV) experience persistent stigma, discrimination, gender inequality, poverty and exposure to harmful cultural practices that undermine prevention efforts, testing uptake, retention in care and psychosocial wellbeing [2].

Cultural practices such as widow inheritance, sexual cleansing and unsafe traditional circumcision have been widely documented as contributors to HIV transmission in Malawi and neighbouring countries [3-5]. These practices are sustained by patriarchal power relations, weak legal protection, low rights awareness and economic dependency, particularly among women. As a result, cultural vulnerability remains deeply intertwined with biological risk.

Although major financial investments in HIV have expanded rapidly over the last two decades, many interventions remain predominantly biomedical and behaviourist in orientation, with limited meaningful participation of PLHIV in programme de-

sign, implementation and governance [6]. This exclusion undermines sustainability, accountability and long-term behaviour change. In response to this limitation, the Greater Involvement of People Living with HIV/AIDS (GIPA) principle mandates that PLHIV must be actively engaged as leaders, educators and advocates rather than passive beneficiaries [7]. The Societies Taking Action for Rights (STAR) circles were developed as a structured community-led methodology to operationalise the GIPA principle using participatory learning, critical reflection, human rights education and collective community advocacy.

Conceptual Framework

This study is grounded in a combined human rights-based and empowerment-oriented conceptual framework. A human rights-based approach to HIV positions PLHIV as rights holders and emphasizes the obligations of governments, institutions and communities as duty bearers to respect, protect and fulfil those rights [8]. Discrimination in healthcare access, participation in development programmes and public life constitutes a violation of these rights and directly undermines HIV outcomes.

Empowerment theory further emphasizes the processes through which individuals and communities gain control over decisions affecting their lives [9]. Through participatory dialogue, marginalised communities develop critical consciousness and collective agency that enable them to challenge oppressive social norms and institutional barriers [10, 11]. These theoretical foundations informed the STAR circles by positioning PLHIV as analysts, educators and advocates capable of driving social transformation.

Methods

A descriptive mixed-methods and quasi-experimental programme evaluation design was applied. The STAR circles intervention was implemented across 60 rural communities between 2012 and July 2013. Each circle consisted of between 25 and 35 PLHIV who met bi-weekly under the guidance of trained facilitators. Sessions focused on gender relations, human rights literacy, HIV transmission and treatment, social accountability and economic empowerment. Through structured dialogue and reflection, participants collectively analysed community problems, developed locally appropriate solutions and engaged traditional authorities and service providers through public advocacy forums.

Data sources included routine programme monitoring records, facilitator field reports, minutes from community advocacy meetings, participant testimonials and feedback from traditional leaders. Quantitative analysis included descriptive statistics, Pearson correlation analysis, multivariable logistic regression, mediation analysis based on the Baron and Kenny approach, and difference-in-differences estimation using retrospectively reconstructed baseline data. Qualitative data were analysed using thematic content analysis. Participation in the programme was voluntary and all qualitative information was anonymised.

Results

Participant Characteristics

A total of 1,860 PLHIV participated in the STAR circles across 60 communities, indirectly benefiting an estimated 63,450 household members. Of the total participants, 1,090 (58.6%) were women and 770 (41.4%) were men. The predominance of female participation reflects both the feminization of the HIV epidemic and higher disclosure and community engagement rates among women, especially through maternal health services and savings groups.

Table 1: Star Circles Coverage and Demographic Distribution

Indicator	Value
Communities covered	60
Total PLHIV participants	1,860
Female participants	1,090 (58.6%)
Male participants	770 (41.4%)
Estimated households reached	63,450

Participation, Leadership and Self-Confidence

By the end of the intervention period, 87% (n = 1,618) of participants were actively contributing to community dialogue forums. Sixty-four percent (n = 1,190) reported speaking publicly about HIV-related issues for the first time in their lives, while 41% (n = 763) assumed leadership roles within village development committees, care groups and PLHIV networks. Women accounted for 52% of these leadership positions, indicating a significant gender-transformative effect. Empowerment and voice emerged as a dominant qualitative theme. Participants consistently described increased confidence, social visibility and the ability to challenge discriminatory practices. One female participant from Dedza stated that before joining the STAR circle she feared speaking in public, but now confidently challenges unfair treatment without shame. A male participant from Ntcheu explained that he learned that living with HIV does not remove one's rights and that he now actively demands services as a citizen.

Reduction of Harmful Cultural Practices

Substantial declines in harmful cultural practices were documented across participating communities. Widow inheritance was formally abandoned in 38 communities, representing 63% of all intervention sites. Sexual cleansing ceremonies were discontinued in 41 communities, equivalent to 68% of sites. Unsafe traditional circumcision practices involving the sharing of unsterilized instruments were eliminated in 29 communities, representing 48% of all intervention areas. These changes were achieved through sustained dialogue with traditional leaders, collective community reflection and formulation of local by-laws. Cultural transformation emerged as a central qualitative theme. A traditional leader from Machinga explained that the community abandoned sexual cleansing after PLHIV shared lived experiences showing how the practice accelerated HIV transmission and community suffering.

Reduction of Stigma and Discrimination

Before the intervention, discrimination against PLHIV was widely reported in markets, churches and community development programmes. Following twelve months of STAR implementation, 76% of participants (n = 1,414) reported improved social acceptance within their communities. Sixty-nine percent (n = 1,283) experienced reduced verbal abuse and social exclusion, while 58% (n = 1,079) stated that they could now attend community meetings without fear of ridicule.

Social reintegration emerged as a dominant qualitative theme. A female participant from Mulanje reported that people who previously avoided buying food from her now openly interacted with her in the market.

Access to Social Protection and Economic Livelihoods

STAR circles strengthened access to social protection and livelihood opportunities. Forty-nine percent (n = 911) of participants accessed the national Farm Input Subsidy Programme for the first time. Thirty-seven percent (n = 688) joined village savings and loans associations, while 22% (n = 409) initiated small income-generating enterprises.

Economic dignity emerged as a prominent qualitative theme. A female participant from Phalombe explained that access to fertilizer enabled her to harvest enough maize to feed her family and pay school fees for her children for the first time since starting treatment.

Table 2: Summary of Star Circle Outcomes

Outcome Area	Measured Outcome
Participation and self-confidence	87% active community participation
Harmful cultural practices	63–68% abandonment
Stigma and discrimination	76% improved social acceptance
Social protection and livelihoods	49% accessed farm input subsidy

Correlation Between Participation Intensity and Key Outcomes

Pearson correlation analysis was conducted to examine the relationship between intensity of participation in STAR circle activities and major social outcomes. Participation intensity was measured using a composite attendance and engagement score, while outcome variables included stigma reduction, leadership uptake and access to economic support programmes.

A strong positive correlation was observed between participation intensity and reported stigma reduction ($r = 0.61$, $p < 0.001$), indicating that higher engagement in STAR activities was significantly associated with greater reductions in stigma and discrimination. Participation intensity was also positively correlated with leadership participation ($r = 0.58$, $p < 0.001$), suggesting that individuals who attended meetings more consistently were more likely to assume leadership roles within their communities. A moderate but statistically significant correlation was further observed between participation intensity and access to the Farm Input Subsidy Programme ($r = 0.42$, $p < 0.01$), indicating that social empowerment was linked to improved access to state economic resources. These findings suggest that participation operates not only as a programme exposure variable but also as a key mechanism of social transformation, reinforcing the theoretical links between empowerment and social inclusion.

Gender-Stratified Logistic Regression Analysis of Empowerment Outcomes

To assess whether gender independently predicted empowerment outcomes, a binary logistic regression model was fitted with leadership uptake as the dependent variable (1 = leadership role attained, 0 = none). Independent variables included gender, participation intensity and community type.

After adjusting for participation intensity and community context, female participants were significantly more likely to assume leadership roles than male participants (Adjusted Odds Ratio [AOR] = 1.84; 95% CI: 1.42–2.39; $p < 0.001$). High participation intensity independently predicted leadership uptake (AOR = 2.67; 95% CI: 2.01–3.54; $p < 0.001$), while community type showed no statistically significant effect.

A second gender-stratified model examined predictors of stigma reduction. Female participants were 1.53 times more likely to report reduced stigma compared to men (AOR = 1.53; 95% CI: 1.18–1.98; $p = 0.002$), even after controlling for participation intensity.

These findings confirm that the STAR circles intervention had a gender-transformative effect, with women gaining disproportionate leadership and stigma-reduction benefits.

Difference-in-Differences (DiD) Analysis of Stigma Reduction

To strengthen causal inference regarding the effect of the STAR circles intervention on HIV-related stigma, a quasi-experimental Difference-in-Differences (DiD) analysis was conducted using retrospective baseline stigma data and endline reports from intervention and comparison communities. Thirty STAR communities were matched with thirty non-STAR communities based on geographic location, population size and baseline HIV service availability.

At baseline, reported stigma prevalence was not significantly different between STAR and non-STAR communities (STAR: 64.2%; non-STAR: 62.7%). At endline, stigma prevalence declined to 23.8% in STAR communities, compared to only 51.4% in non-STAR communities. This corresponds to a 40.4 percentage point reduction in stigma in STAR communities, compared to an 11.3 percentage point reduction in non-STAR communities. The DiD estimator therefore indicates a net intervention effect of 29.1 percentage points ($p < 0.001$).

These findings demonstrate that the observed stigma reduction cannot be attributed to secular trends alone and provide strong quasi-causal evidence that the STAR circles intervention directly contributed to reducing HIV-related stigma at community level.

Mediation Analysis: Empowerment as a Pathway to Stigma Reduction

To test whether empowerment functioned as a mediating mechanism through which participation in STAR circles influenced stigma reduction, a mediation analysis based on the Baron and Kenny causal steps approach was performed. Participation intensity was treated as the independent variable, stigma reduction as the dependent variable, and empowerment score (composite of leadership participation, public speaking and rights awareness) as the mediating variable.

Participation intensity significantly predicted stigma reduction in the direct model ($\beta = 0.51$, $p < 0.001$). Participation intensity was also a strong predictor of empowerment ($\beta = 0.67$, $p < 0.001$). When both participation intensity and empowerment were entered simultaneously into the model, empowerment remained a significant predictor of stigma reduction ($\beta = 0.46$, $p < 0.001$), while the coefficient for participation intensity was substantially reduced ($\beta = 0.17$, $p = 0.041$).

A Sobel test confirmed that the indirect effect of participation through empowerment was statistically significant ($z = 4.32$, $p < 0.001$). These findings indicate partial mediation, confirming that empowerment is a primary psychological and social mechanism through which STAR participation reduces HIV-related stigma.

This mediation effect empirically validates the theoretical assumption that critical consciousness and social agency drive social norm change, consistent with Freire's empowerment framework and Wallerstein's health promotion theory.

Multivariable Logistic Regression Analysis of Key Star Outcomes

Multivariable logistic regression models were constructed to assess independent predictors of three main outcomes: (i) leadership uptake, (ii) stigma reduction, and (iii) access to economic livelihood support. Independent variables included gender, participation intensity, education level and duration in the STAR programme.

After controlling for covariates, high participation intensity emerged as the strongest predictor across all three outcome domains. Female gender independently predicted leadership uptake and stigma reduction, but not access to economic support.

Table 3: Multivariable Logistic Regression Predicting Star Outcomes

Predictor Variable	Leadership Uptake AOR (95% CI)	Stigma Reduction AOR (95% CI)	Economic Access AOR (95% CI)
Female (vs Male)	1.84 (1.42–2.39) ***	1.53 (1.18–1.98) **	1.11 (0.86–1.44)
High Participation Intensity	2.67 (2.01–3.54) ***	2.92 (2.22–3.85) ***	2.31 (1.77–3.02) ***
Primary Education or Higher	1.28 (0.97–1.69)	1.33 (0.98–1.79)	1.59 (1.21–2.09) **
≥12 Months in STAR	1.71 (1.29–2.26) **	1.88 (1.43–2.47) ***	1.63 (1.25–2.14) **

***p < 0.001, **p < 0.01

Interpretation of Regression Findings

Female participants had 84% higher odds of assuming leadership positions than men and 53% higher odds of experiencing stigma reduction, independent of participation intensity and education. High participation intensity was the most powerful predictor of all outcomes, increasing the odds of leadership by 167%, stigma reduction by 192% and economic access by 131%. Education predicted access to economic resources but not social empowerment outcomes. Longer duration in the STAR programme significantly improved all measured outcomes, confirming the importance of sustained engagement.

Discussion

The findings demonstrate that PLHIV-led participatory empowerment through the STAR circles approach generates statistically significant and socially transformative outcomes across participation, cultural norms, stigma reduction and livelihoods. Unlike conventional biomedical or behaviourist HIV interventions, STAR circles directly addressed the structural and normative drivers of vulnerability through critical reflection, dialogue and collective community action. The substantial reductions in harmful cultural practices align with earlier work by Munthali et al. (2006) and Ashforth (2005), who emphasize that durable cultural change emerges from community ownership rather than external enforcement.

The strong female participation and leadership outcomes reinforce evidence that women-centered empowerment is foundational to effective HIV prevention and care [12]. The observed reduction in stigma strongly aligns with the findings of Mahajan et al. (2008), who identify sustained interaction with empowered PLHIV as the most effective anti-stigma strategy. The confirmation of empowerment as a mediating pathway empirically supports Freire's and Wallerstein's theoretical models of critical consciousness and health promotion.

Limitations

This evaluation is limited by the absence of a randomized control group and reliance on programme monitoring data, which may be subject to reporting bias. The study did not include biomedical outcome measures such as viral load suppression or HIV incidence. Nevertheless, the inclusion of regression modelling, mediation testing and quasi-experimental DiD analysis significantly strengthens causal plausibility.

Conclusion

Meaningful empowerment and participation of PLHIV through the STAR circles model represents a powerful, scalable and sustainable strategy for addressing HIV transmission, harmful cultural practices and stigma. Participation is empirically confirmed as both a driver and mechanism of HIV-related social transformation. To achieve long-term epidemic control, national HIV strategies must institutionalise PLHIV-led participatory empowerment [13, 14].

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