An HIV/AIDS Intervention Through Churches in Mulanje District, Malawi

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Project Overview

When HIV/AIDS was first mentioned in the 1980s, few people could imagine what an international plague this virus would become. Though the disease is completely preventable, thousands of people die each day and the numbers continue to rise. East and southern sub-Saharan Africa is the world’s “hot spot” for HIV/AIDS, yet people there continue to engage in risky sexual behaviors due to a lack of knowledge about the disease and how it is transmitted, cultures that discourage the use of condoms, societal denial, and a low perceived susceptibility of acquiring the disease. In order to combat these attitudes and behaviors that continue to force people into an unnecessary cycle of hopelessness and death, we have crafted a plan, using Green and Kreuter’s PRECEDE/PROCEED model, to raise awareness and emphasize prevention of HIV/AIDS one community at a time. We chose to focus on Malawi, because it is one of the poorest countries in sub-Saharan Africa, and fewer interventions have been implemented there than in other adjacent nations. The goal of this program plan is to decrease the incidence of HIV in Mulanje, the district with the highest prevalence of HIV outside of urban areas. Through churches we will establish a multi-dimensional intervention to educate and prevent adolescents and young adults, both single and married, from acquiring HIV.

Significance of the Problem

The HIV/AIDS epidemic that has plagued our world is incomprehensively disastrous and complex. History has never known a disease that could orphan over 15.6 million children, crush economies, destabilize the politics of a continent, run depression and other mental health diseases rampant, aggregate poverty, and kill almost 13.9 million men, women, and children worldwide (Hunter and Williamson, 2000).

Sub-Saharan Africa is “where 71 percent of the world’s HIV-infected population lives and has contributed 61 percent of the lives sacrificed to AIDS” (Vick, 2000). There, HIV/AIDS, a disease that takes 5,500 people a day or 2 million a year, is referred to as “the plague.” Since there is little affordable treatment available for HIV, discovering one’s positive status is invariably a death sentence. Weekly, people attend funerals for lost family and friends taken by a virus that no one seems to be able to control and few understand. Daily, children lose their parents and become disenfranchised from society. If they are lucky, a local orphanage will take them in; if not, they may be left alone in the streets to die. Experience tells us that the stigma of HIV/AIDS is so threatening that people who test HIV positive are instantly outcast from their families, friends, and society as a whole. Therefore, to avoid the shame and pain of losing one’s family and life, people refuse to get tested. Churches, families, and
communities deny that their people are dying of AIDS. Doctors often even refuse to put AIDS as the cause of death on death certificates to alleviate shame (McGeary, 2001).

Malawi is one of the world’s countries that is most plagued by AIDS. The backdrop there is extraordinarily bleak. It is a country in Eastern Africa with a population of 10,640,000. Malawi is an extremely poor nation with a life expectancy from birth of only 39 years. This is a country where 135 out of every 1000 dies during infancy, and a place where now an estimated 10-14 percent of the population is HIV positive and risky behaviors, such as lack of protection and multiple partners, continue (Ministry of Health, 1999).

In 1998, the highest prevalence of HIV was found in Malawians between the ages of 30-34. In that age category, 22.2% or one in five people are HIV positive (UNAIDS, 2000). Though the incidence of HIV is higher in urban areas, which can be explained by a higher prominence of sex traders, still 28 percent of women in rural areas tested positive. Additionally, AIDS has brought to the surface many other issues that negatively affect the quality of life in Malawi. These issues such as poverty, stress, instability, and mental illness desperately need to be addressed.

Poverty is not only causing a trend that increases the transmission rate of HIV, but it is also an indirect result of HIV. Poverty in Malawi has caused many men to migrate long distances to find better paying jobs. Often they go home to their wives no more than twice a year, and engage in sexual relationships that result in infection while away. This trend has become so popular that many poor women exploit themselves sexually to feed their families. Then, due to high morbidity and mortality from AIDS, the economy becomes unstable. This deadly cycle is common throughout sub-Saharan Africa.

Stress and instability are natural reactions to disaster. Since the first AIDS case was discovered in Malawi in 1985 the country has lost over 450,000 people to the disease. This loss has contributed to a suffering economy, broken families, an increase in malnutrition, and millions of children who have lost either one or both parents, all of which create an unstable, stressful environment (Save the Children, 2000).

Not surprisingly the AIDS epidemic has negative implications for mental health. The loss of life is overwhelming, but the effects of that loss cause life circumstances to be so precarious that for some, life is little better than death. With the death toll so great, the economy is crumbling, children are being orphaned, women are giving themselves over to prostitution, the overall quality of life is depleted of anything positive and hope has vanished.

In addition to quality of life issues there are also many underlying social issues that perpetuate the spread of HIV such as gender roles, stigma, church denial, and education. It is vital to understand these issues in the context
of Malawi, as they present a more dire picture of AIDS than one would find in a developed country. Since their importance is so great in the fight against AIDS, many interventions have already addressed them.

Gender roles are a part of the culture in Malawi that favors men and disempowers women. Women have little to no status and their voices are rarely heard. Among other negative consequences, this issue has exacerbated the transmission of HIV/AIDS. Women cannot freely talk to their husbands or partners about using a condom, nor can they deny a man sex without risking public shame or a painful consequence (i.e. a beating). This lack of communication between men and women about sexual matters plays a key role in the rapid transmission of HIV in sub-Saharan Africa.

The stigma of HIV/AIDS is ubiquitous, undeniable, and deeply imbedded in the social norms of Malawi and many other African nations. To have HIV/AIDS is seen to be so shameful, that people refuse testing to avoid discrimination. However, in Uganda an intervention has shown that “if ignorance, isolation, and stigma can be eradicated, communities can be very willing to play a big role in prevention and care of people with AIDS” (Luba, 1998). A group of community leaders and volunteers from local churches came together to fight against the behaviors that cause HIV/AIDS and offered skills training to identify cultural behaviors that needed to change. They went to homes, schools, funerals, churches, and markets to give out information, distribute condoms, and to refer people to testing centers, counseling, and medical services. Within two years, the community demanded that the Ugandan government bring in AIDS services. The churches encouraged people to begin addressing the true causes of death at funerals, and families were encouraged to support orphans and widows (Luba, 1998).

Churches have been historically influential in the Malawian culture over the last century. The people are very traditional and respect greatly the mission and leaders of the church. Until recently, most churches have been in denial about the AIDS problem in Africa. However, many are starting to realize the necessity of approaching the subject. In Luzira, Uganda, a project was organized through churches to educate the community and offer counseling at the grass roots level. The project workers were two Reverends, four lay health advisors (LHAs), two community workers, and two visiting counselors. These workers provided counseling, sex education, moral rehabilitation, and condom distribution to the community. This was a huge feat because the idea of condom distribution in churches is an extremely controversial issue. There are also many myths that condoms are evil, do not work properly, or are a part of a conspiracy from the West to kill Africans (McGeary, 2000). A key to this intervention’s success was the participation of the pastors. In most of East and Southern Africa, pastors are so respected and revered that if they encourage people to change their behaviors, people will often act in accordance
with their teachings. However, the primary lesson learned from this program was that all future HIV interventions must involve community members at the grass roots level.

Information about HIV and sex education are two areas that must be addressed when discussing the prevalence of AIDS in Malawi. Though many African countries have instilled HIV/AIDS education programs and many people know how HIV is transmitted and how to prevent it, evidence suggests that there is “a large disparity between information and knowledge about HIV/AIDS and human sexual behavior” (Kamara, 1998). Since knowledge alone does not change behavior, a Ugandan intervention integrated various “life skills” such as self-esteem, into their HIV/AIDS preventive initiative, which was directed at adolescents, to enable them to effectively change their behaviors (Kamara, 1998). Since this intervention was successful, we hope to affect similar change in Malawi through churches.

HIV is a pervasive virus that is sweeping sub-Saharan Africa, including Malawi. This disease has already caused millions of unnecessary deaths and daily thousands more die. Though the disease is preventable, there are many social issues in Malawi and surrounding countries that perpetuate its spread. These issues demean the quality of life throughout the country and they make life for many hopeless and unbearable.

**Target Population**

The target population is comprised of Malawians living in the non-urban district of Mulanje. More specifically, it is those who attend the churches whose pastors have agreed to participate in the church-based intervention. In effect, all members of the churches are part of the target population, since the whole congregation will hear messages from their pastor about HIV, Biblical passages about caring for the sick, and how spouses are to treat each other. However, some members will voluntarily be involved in more intense participation through an intervention using church LHAS. This component focuses on adolescents, young adults, and married couples who attend the participating churches. The population includes those who are not yet sexually active and those who are, both male and female.

Since HIV is most prevalent among Malawians aged 30-34, the health educators will target adolescents from age ten to young adults aged 30 to prevent continued transmission among sexually active adults. Adolescents are a key target audience in this population because it is important for them to know the risks, susceptibility, threat, and means of HIV transmission prior to the onset of sexual activity in order to prevent risk behaviors from taking place and taking root. This generation is going to determine the direction of HIV prevalence, along with all its consequences, in Malawi’s future; so targeting them lies at the heart of prevention.
Apart from the demographic characteristics of the target population, it is crucial to gain an understanding of its social context in order to plan an effective intervention. Malawians, and even more so rural Malawians, are very traditional and hold religiously conservative values. The church plays a central role in the lives of many people and its leaders are influential and highly respected. In addition to a strong Christian influence in the community, many parts of Malawi, particularly in more rural areas, retain many traditional values separate from Christianity. As a result, practices of polygamy continue to exist in some regions, and rituals and customs related to it.

**Environmental and Behavioral Determinants**

In Phase Three of PRECEDE it is necessary to identify all of the behavioral and environmental determinants that contribute to high prevalence and incidence of HIV/AIDS, which in turn negatively impact the quality of life in Mulanje District, Malawi. Once identified, each determinant will be prioritized by importance and changeability. The determinants that remain will be targeted. Please see Appendix A for the detailed PRECEDE diagram.

**Environmental**

The environmental determinants of HIV transmission in Mulanje District are broad. According to a UNAIDS report, stigma towards HIV and those infected with it pervades every level of society and results in deadly consequences. This leads to a lack of open discussion about sex and HIV transmission, which perpetuates risky behavior (UNAIDS, 2000).

The low status of women is another determinant of HIV transmission, which, like stigma, is pervasive at every level of society. The glaring inequality between men and women manifests itself in, among other things, lack of negotiation power in condom use, and resorting to prostitution for survival (UNAIDS 2001). Women’s lack of power in society increases their dependence on men, which can lead to coercive (and often unprotected) sex, sometimes at an early age.

Access to and affordability of healthcare also determine the transmission of HIV, and inhibit the diagnosis of AIDS symptoms, and care for those suffering. Clinics and hospitals are often difficult to reach for people living in rural areas and, for others, are underutilized due to cost.

As discussed earlier in the previous section, the popularity and prevalence of migratory labor contributes to the HIV problem since migrant workers who work away from their families for prolonged periods of time frequently bring back infection and expose their wives to HIV (McGeary, 2000).
Finally, the national leadership stance on HIV/AIDS is another determinant impacting the spread of HIV. The level of support from national leaders impacts the number and type of prevention interventions in addition to the amount of government funds allocated to health and education, which in turn, impact the spread of the disease.

Behavioral

Numerous behavioral determinants of HIV transmission exist in the Mulanje District. Like much of Africa, these generally do not include injection drug use and men having sex with men (MSM). Unprotected heterosexual sex, however, is a major determinant. The lack of condom use is a serious concern, because it leads to the spread of HIV, among other sexually transmitted diseases. Having multiple sex partners, largely due to a high rate of infidelity between regular partners, is another determinant contributing to the spread of the disease. The availability of commercial sex workers to migrant laborers is part of this issue, as is a silent tolerance of extra-marital and pre-marital sex (UNAIDS, 2000).

The lack of testing for HIV is another behavioral determinant impacting transmission. This ties into the environmental determinant of stigma and results in people not knowing (or wanting to know) their status and engaging in risky behaviors as a result. “Where people with AIDS risk rejection and discrimination, those who suspect they have HIV may avoid getting tested and taking precautionary measures” (UNAIDS, 2000). Without being tested, a person may assume that they are already infected and therefore do not use protection (because they do not see a reason to). Also, they do not have to confront the disease and can therefore behave like it does not exist, thereby exacerbating the problem.

The norm of an early onset of sexual activity also contributes to the spread of HIV, because it lengthens the years of sexual exposure, which increases the likelihood of acquiring the virus. Apart from traditional practices, this may be a symptom of the low status of women, as discussed in the previous section. Breastfeeding is another behavioral determinant that results in the infection of numerous babies. Since this is a common practice, women who refrain from breastfeeding are viewed suspiciously and, as a result of stigma, may suffer the consequences of discrimination. Furthermore, breast milk may be the only affordable sustenance for their babies and they are therefore left with little or no choice.

All of the environmental and behavioral factors impacting the transmission of HIV in Malawi are important, but not all are easily changeable. Below we have divided the determinants, into “more” and “less” changeable categories. Unprotected sex, multiple partners, testing, and access to healthcare were placed in the more
important, more changeable quadrant and are therefore target behaviors. However, stigma, early onset of sexual activity, migrant labor, affordability of healthcare, national leadership stance on AIDS, allocation of government funds, status of women, and breastfeeding were placed in the more important, less changeable quadrant for various reasons. The issue of the status of women is deeply imbedded in the culture of the nation. Breastfeeding and migrant labor are necessary for the continuation of life. The national leadership stance on AIDS, the affordability of healthcare, and the allocation of government funds are issues on the national level and are presumably less likely to change. Although stigma and early onset of sexual activity are less changeable, the program designers believe they are a good fit with the other target determinants and have therefore prioritized them by putting an asterisk by them. Please see Table 1 for more information.

Table 1: Prioritization of Determinants

<table>
<thead>
<tr>
<th>More Changeable</th>
<th>Less Changeable</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Unprotected sex</td>
<td>*Stigma</td>
</tr>
<tr>
<td>*Multiple partners</td>
<td>*Early onset of sexual activity</td>
</tr>
<tr>
<td>*Testing</td>
<td>Migrant labor</td>
</tr>
<tr>
<td>*Access to healthcare</td>
<td>Affordability of healthcare</td>
</tr>
<tr>
<td></td>
<td>National leadership stance</td>
</tr>
<tr>
<td></td>
<td>Allocation of govt. funds</td>
</tr>
<tr>
<td></td>
<td>Status of women</td>
</tr>
<tr>
<td>Less Important</td>
<td></td>
</tr>
<tr>
<td>Breastfeeding</td>
<td></td>
</tr>
</tbody>
</table>

* Prioritized Determinants

**Setting Priorities Among Categories of Determinants**

In phase four of PRECEDE, it is necessary to identify and address all of the predisposing, reinforcing, and enabling factors that are the root causes of the aforementioned behavioral and environmental determinants. In order to have an appreciation for this section, it is necessary to have a full understanding of these terms. Lawrence Green, the author of *Health Promotion Planning*, defines them as follows: predisposing factors are “any characteristic of a person or population that motivates behavior prior to the occurrence of the behavior.” Reinforcing factors are “any reward or punishment following or anticipated as a consequence of a behavior, serving to strengthen the motivation for or against the behavior.” An enabling factor can be defined as “any characteristic of the environment that facilitates action and any skill or resource required to attain a specific behavior” (Green 1999). All
The predisposing factors that impact behavior are the perceptions and beliefs about strict gender roles, the belief in polygamy, the low perceived susceptibility of HIV, and lack of knowledge. Embedded in Malawian society is the belief that men are superior to women. This attitude leads to unprotected sex, because women are unable to discuss condom use with their partners. Historically, polygamy has been an accepted practice in much of sub-Saharan Africa, including Malawi. This belief leads to an acceptance of multiple sexual partners. Polygamous beliefs also encourage women to compete to have more children, which leads to unprotected sex. Low perceived susceptibility of acquiring HIV is the belief that one is unlikely to get the virus. There is also a misunderstanding that people without full-blown AIDS can be HIV positive. As a result, people continue to be sexually active with many partners because they are unaware of their risk and therefore do not feel susceptible. Low perceived susceptibility also causes many people not to get tested. If they do not feel they are at risk, why get tested? Finally, lack of knowledge is perhaps the most crucial predisposing factor as it affects all of the determinants we deemed most important and changeable in this project: having multiple sexual partners, unprotected sex, an early onset of sexual activity, and not going to get tested.

The reinforcing factors that cause negative behavior change are a lack of family support, lack of support from political leaders, and church/religious denial. In Malawi to have AIDS in one's family is shameful. Therefore, if a family member tests HIV positive, he or she is often outcast from the family. This directly causes people to refuse HIV testing, because they would rather not know they have the virus than experience rejection. Unfortunately, despite many governmental advances in the fight against AIDS, there are many political leaders that do not have AIDS awareness or education on their agendas. This attitude of denial or avoidance from respected government officials causes people to discount the importance of changing their sexual behaviors or getting tested. Additionally, church denial plays a vast role in perpetuating unprotected sex. Since many churches continue to preach against birth control, people who respect the church are torn as to whether or not to use a condom. Furthermore, many churches refuse to face the fact that members are sexually active, pre- and extra-maritally, and avoid discussion of sex in general. Churches also encourage many traditional beliefs and customs, which may contribute to the early onset of sexual activity.

Enabling factors that contribute to the behavioral and environmental determinants of HIV are the availability of condoms, lack of education, government laws and priorities, social attitudes towards condoms, and
social norms that inhibit the discussion of sex. Low availability of condoms directly contributes to unprotected sex. Lack of education, especially for girls, affects the low status of women in Malawian society and also causes many girls to marry at a young age, which naturally promotes an early onset of sexual activity. Like political leaders, lack of emphasis on AIDS in government laws and priorities promotes the stigma of AIDS in Malawi and causes people to continue in their risky sexual behaviors. Negative societal attitudes towards condoms results in high levels of unprotected sex. Many believe that condoms are a part of a conspiracy; some think they are evil, while others think that they spread HIV (McGeary 2001). These popular myths have indirectly led to the deaths of those who had access to a condom, but did not use one due to misinformation. Social norms that prevent the discussion of sex affect stigma, unprotected sex, multiple partners, and refusal to go for testing. Since risky sexual behaviors are rarely discussed and are even culturally tolerated, people feel justified in their actions.

After assessing each causal factor for its changeability and importance, we chose to place low perceived susceptibility of HIV, social attitudes towards condoms, church denial of HIV, availability of condoms, and lack of knowledge in the more important, more changeable quadrant. These prioritized factors fit well together and will be targeted later in an intervention. However, given the scope of our intervention and time constraints, several factors had to be placed in the more important, less changeable quadrant. These factors: family support, government laws and priorities, political leaders, beliefs about strict gender roles, lack of education, and social norms, are highly unlikely to change from the results of one intervention. Social norms inhibiting the discussion of sex was also placed in this quadrant however; we felt its impact on person/environment fit was so great it warranted a place in our program plan and is therefore noted by an asterisk. Finally, polygamous beliefs was placed in the less important, less changeable quadrant because if polygamy is strictly adhered to, and there is no extra-marital intercourse on the part of the husband or any of the wives, there will not be an increased risk for HIV transmission. Also, we viewed it as a cultural belief and therefore deemed it “less changeable.” Please see Table 2 for more information.

Table 2: Prioritized Factors

<table>
<thead>
<tr>
<th>More Changeable</th>
<th>Less Changeable</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Low perceived threat of HIV</td>
<td>Political leaders</td>
</tr>
<tr>
<td>* Social attitudes towards condoms</td>
<td>Family support</td>
</tr>
<tr>
<td>* Church denial of HIV</td>
<td>Government Laws and Priorities</td>
</tr>
<tr>
<td>* Availability of condoms</td>
<td>Beliefs about strict gender roles</td>
</tr>
<tr>
<td>* Lack of knowledge</td>
<td>Lack of education</td>
</tr>
<tr>
<td>* Social Norms (prohibit discussion of sex)</td>
<td></td>
</tr>
<tr>
<td>Beliefs about Polygamy</td>
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</tbody>
</table>
Administrative/Policy Assessment

In Phase Five of PRECEDE, it is necessary to do an administrative and a policy assessment. Malawi’s Ministry of Health launched its Fifth National Health Plan (NHP) in 2000, which included a section devoted to HIV/AIDS prevention. The Government of Malawi has expressed its desire to address the issue through the National AIDS Control Program, which benefits the planning process (UNAIDS 2000). A supportive government not only lends credibility to prevention efforts, but also serves as a potential ally, guide, and financial resource. Furthermore, expressed government support will hopefully begin to impact the destructive stigma of HIV in the population, by making it a more public issue. This will bolster our intervention efforts and give some credence to its goals.

In addition to the HIV/AIDS component of the NHP, this document outlines the means by which district decentralization of the healthcare system will occur. Essentially, this means that centralized power will be devolved to district-level. This change may make community-based intervention efforts like ours more effective in that more participation of local people can occur in their planning and implementation. Also, the financial and personnel support will be more accessible and manageable, making the intervention more efficient.

As always, the economy plays an important role in the planning and implementation of the intervention. Malawi is among the poorest of African countries, with a GNP per capita of approximately $190 (The World Bank 2000). This does not amount to much in government coffers, particularly for health and education. The major implication of this is that despite government support for prevention work, money is either non-existent or scarce. Such a lack of financial resources forces many organizations and programs to seek funding from non-governmental organizations (NGOs), foreign assistance, and private voluntary organizations (PVOs). Although this renders many programs and interventions unsustainable, it may be the only means by which a program can operate. Currently, Malawi receives fairly large amounts of foreign aid, much of which could be harnessed for HIV prevention work.

Perhaps the biggest barrier looms from the societal and historical level. The interplay between history and culture makes any change very difficult, given the retention of tradition, both in religious and non-religious aspects. Societal norms, fashioned by history, tradition, and culture, pose a huge barrier to HIV work because HIV prevention demands that people openly discuss issues normally kept private. Not only does this intervention ask
that Mulanje churchgoers discuss sex, but that churches themselves address some of the issues surrounding HIV/AIDS.

The administrative barrier of religious norms is daunting, and yet recent articles and documentaries suggest that religious institutions are gradually warming to the idea of playing a role in HIV prevention. Once leaders in the church agree to participate, tradition suggests that the community will follow, as exemplified in Uganda. In this manner, we intend to gain the support of churchgoers in Mulanje. Furthermore, the community circumstances are dire enough that a positive response from staff members is likely. The rate of change is difficult to determine, since the intervention will have to be well established before any results are noticeable, especially since the target population includes adolescents. Indeed, the rate of change may only be measurable after several years. However, numbers of people getting tested can be measured immediately.

Now that we have completed PRECEDE steps one through five, we will enter into the PROCEED section of this document, which will describe the proposed intervention in detail.

**Intervention Overview**

The role of theory must not be underestimated in how it can inform the design of an intervention. Two theories at each of the two levels of the ecologic framework – intrapersonal and community - will shape the HELP (HIV Education, Learning and Prevention) Malawi intervention for reducing the transmission and incidence of HIV in Mulanje District. The intervention involves three key players: pastors, lay health advisors (LHAs), and a community health worker (CHW) to implement educational and skill-building activities to address the virus in their rural community.

At the intrapersonal level, key concepts from the Health Belief Model (HBM) and Social Cognitive Theory (SCT) inform the design of the program. According to Strecher and Rosenstock (1997) the HBM is a motivational theory, based on constructs including perceived susceptibility (one’s opinion of the likelihood of getting a condition), perceived severity (one’s perception of the severity of getting a condition), perceived benefits (one’s perception of the benefits reaped from a specific behavior), perceived barriers (one’s perception of the barriers to performing healthy behaviors), cues to action (ways to activate one’s “readiness”), and self-efficacy (one’s confidence in performing a behavior), all of which are featured in numerous studies on HIV prevention. A number of studies based on the HBM highlight the value of using this theory to guide the intervention approaches and materials. A study by Bryan, Aiken, and West (1997) was driven by constructs from several theories, and found that the construct of perceived susceptibility to acquiring HIV (among other constructs from other theories) was a
strong determinant of intentions for condom use. Other studies by Petosa and Jackson (1991) and Brown, DiClemente and Reynolds (1991) validate the use of HBM in predicting safer sex intentions among adolescents. Based on this theory, the HELP Malawi intervention will address knowledge, beliefs and skills among community and church members through implementing LHA training and promoting voluntary counseling and testing (VCT). These methods are designed using the HBM constructs in the context of HIV, such as changing perceived susceptibility to acquiring HIV among community and church members.

Furthermore, the perceived barriers in condom and VCT use are clearly a challenge in the fight against HIV in Malawi. These include suspicion of condoms, the fear of learning one’s HIV status, lack of self-efficacy in condom use, and the shame of visiting a VCT clinic. It is these barriers that the intervention must address through providing appropriate cues to action in order increase the perceived benefits of these behaviors.

Social Cognitive Theory is the second theory to guide our intervention at the intrapersonal level. The relationship between behavior, personal factors, and the environment makes this theory both broad and deep in its relevance to the spread of HIV in Malawi. Intrapersonal constructs of situation (one’s perception of the environment), behavioral capability (knowledge and skills to perform a behavior), expectations (anticipated outcomes of a behavior), and reinforcements (responses to a behavior that will increase or decrease likelihood of reoccurrence) are perhaps the most pertinent in the design of the HELP Malawi intervention because of their applicability to HIV prevention in Malawi (Baranowski et al. 1997). The need for skills training in condom use and an examination of the values and perceptions placed on outcomes (e.g. from going to get tested), are important areas that require careful attention and planning. One SCT-driven study examined self-efficacy, outcome expectancies, and condom-use intention among black adolescent women (Jemmott 1992), and underscored the importance of the constructs in intervention design. They suggested that condom use intention was strongly dependent on the presence of these SCT constructs.

At the community level of the ecologic framework, Community Organizing through Freirian praxis in health education (empowerment education) and SCT guide the intervention. Brazilian educator Paolo Freire’s goal of this dialogue approach to education was praxis, the “ongoing interaction between reflection and the actions that people take to promote individual and community change” (Wallerstein et al. 1997). Key concepts of community organization informing HELP Malawi include participation and relevance (“starting where the people are” and engaging them as equals), critical consciousness (consciousness based on reflection and action in making change),
and issue selection (identification of achievable targets of change that strengthen and unify the community) (Minkler and Wallerstein, 1997).

Since we seek a reduction in stigma towards HIV at the community level (in order to eventually reduce HIV transmission), community organizing through empowerment education can provide an effective approach to changing community norms. The ASAP (Adolescent Social Action Program) youth-centered experiential prevention program to reduce mortality and morbidity from alcohol and substance abuse using the educational empowerment approach resulted in community involvement by participants (Wallerstein et al. 1997). The gained knowledge and planned actions by the participants were taken into the community to affect change. This community organizing approach operates by “taking the emphasis off the individual as lone actor… and places individuals within their social and political context” (Wallerstein et al. 1997). The intervention will utilize this approach in order to better understand, contextualize and address the problem of HIV in Mulanje District.

Due to the breadth of SCT, it can be applied to both the community and intrapersonal levels. The constructs most relevant to the community level are environment (factors physically external to the person) and reciprocal determinism (the dynamic interaction between the person, environment, and behavior). Given the numerous and various factors contributing to HIV transmission – lack of access to health care, social norms, availability of condoms, and economics – the community environment must be a key in guiding the intervention. Reciprocal determinism is the most comprehensive construct, which in essence, represents all the concepts of the SCT model, including all levels of the ecologic framework. It therefore requires the intervention to consider all aspects of this triadic relationship. For example, the ways in which the cultural stigma of HIV/AIDS impacts an individual’s expectations of going for VCT and the consequent action (or inaction) must be examined in depth. The HELP Malawi intervention seeks to make the relationship between behavior, environment and individuals more conducive to HIV prevention through components addressing each point of the triad.

Additionally, it might be said that there is a low level of “person-environment fit” in Malawi, with respect to the situation of HIV/AIDS. Although people might be willing to take preventive measures against the virus, the environment (lack of access to clinics, lack of availability of condoms, lack of knowledge and skills, stigma, poverty, and gender inequality) does not allow that willingness to be effectively realized. It is our hope that through this intervention, we can improve the person-environment fit in Mulanje District.

Although this paper focuses on only two levels of the ecologic framework, an interpersonal level is included (but not discussed) in the intervention. Given the lack of social support available to people with a positive HIV
status, it is important to have a component that meets this need in the intervention. The use of a social support approach is not only ethical, but it contributes to the use of VCTs, since people do not have to be afraid of being alone and rejected if they are seropositive. Rather, the implementation of social support in the intervention will show community members that one can engage in the risk preventive behavior of VCT without sacrificing support afterwards. Although this segment is not discussed at greater length, it should be considered as part of the intervention.

**Conceptual Model of the Intervention**

The conceptual model of this intervention provides a clear picture of the process that will take place in order to achieve the overall goal of decreasing the incidence of HIV/AIDS in Mulanje, Malawi. The model is broken down into two levels of the ecologic framework, the community level and the intrapersonal level. The interpersonal level is included in the lower left hand corner, but is separated from the rest of the program model, because this paper will not discuss it in detail due to time and space constraints.

On the community level, all the boxes are shown in white, while on the intrapersonal level, they are displayed in black. In the instances where the intervention overlaps levels, the boxes are gray. Each of the boxes has arrows coming from it that relay to the viewer the expected outcome of the intervention component in the previous box. Several boxes have multiple arrows. Please see Appendix B for more information about the conceptual model.

**Intervention Goals and Objectives**

After researching the situation of HIV in Malawi, it was clear that there are several areas that need to be addressed before change can even be attempted. Therefore, we have narrowed our focus to accomplishing four goals, two that will address change on the community level and two on the intrapersonal level. Each goal below is accompanied by an outcome and a process objective that explain exactly how our intervention intends to meet these goals.

I. Community Level
   a. Goal: To decrease the stigma of people living with AIDS (PLWAs) in churches in Mulanje, Malawi.
      i. Outcome Objective: To decrease churches’ negative attitudes towards PLWAs by 25% by one year after program implementation as measured by pre- and post-intervention surveys.
      ii. Process Objective: By July 2002, pastors will deliver one sermon per month, incorporating HIV/AIDS issues and the importance of VCT services as measured by LHA report.
   b. Goal: To increase community awareness about social ecological factors that perpetuate the spread of HIV in Mulanje.
      i. Outcome Objective: To increase knowledge of social factors that perpetuate the spread of HIV by 50% in discussion groups by one year after program implementation as measured by pre- and post-intervention survey.
II. Intrapersonal Level

a. Goal: To increase awareness of HIV risk factors among church members in Mulanje, Malawi.
   i. Outcome Objective: To increase knowledge of modes of HIV transmission to 100% in program participants by one year after program initiation as measured by pre- and post-training session surveys.
   ii. Process Objective: By July 2002, to enroll 50% of church members over age 10 in HIV educational training as measured by attendance roster.

b. Goal: To increase HIV prevention behaviors among church members in Mulanje.
   i. Outcome Objective: To increase use of VCT by 25% in church members by one year after program initiation as measured by VCT records.
   ii. Process Objective: By July 2002, to refer 100% of intervention participants to local VCT as measured by a one-question participant survey.

**Intervention Methods**

The problem of HIV/AIDS in sub-Saharan Africa is complex and multi-faceted. Therefore, we have narrowed our approach to reach a community in Malawi, Mulanje District. The end goal of our intervention is to decrease the incidence of HIV/AIDS in this community, though there are also many intermediate goals. Since Mulanje, generally speaking, is a Christian district with high church attendance, we will focus our intervention there, in the churches. The All Africa Conference of Churches stated that “there is an urgent need for the Churches in Africa to break the silence and myth surrounding the deadly virus and create awareness, improve pastoral care for the affected, share information on various approaches.” (African Church Information Service 2001). In 1998 at the international AIDS conference, this approach was commended and encouraged, as the church is often a community’s primary agent for change.

Given that our project addresses the issue of HIV/AIDS on two different levels, it was necessary to be creative in our approach. In order to meet the goals of our program plan, we created an intervention that uses many different methods such as training sessions, discussion groups, LHAs, sermons, support groups, referrals, demonstrations, illustrations, storytelling, and role-playing to address the problem of HIV/AIDS in Malawi.

The scope of the intervention is broad; therefore in this document we make several assumptions. First, that we are working in conjunction with the Christian Health Association of Malawi (CHAM) to recruit and train 15 pastors in Mulanje District, and that 15 pastors have been enrolled (see Appendix C). We will use CHAM since information on churches and pastors is readily available to them and they may know some of the pastors personally. As a Christian organization promoting the intervention, others are more likely to consider it. Second, we are assuming that once pastors are enrolled, they will have drafted a list of potential LHAs who would be willing to volunteer for the intervention. We (health educators) would have provided a “job description” for pastors to use in...
recruitment. We will train LHAs in HIV information, group facilitation, and counseling. As an incentive, food will be provided and LHAs will be awarded a certificate upon completion of a 3-night training course (see Appendix C).

On the community level, one goal is to decrease the stigma of HIV, which currently paralyzes the community from change. To combat this paralysis, our intervention uses two unique intervention methods to initiate change. First, enrolled pastors must agree to incorporate messages into their sermons about people’s attitudes towards HIV/AIDS, the importance of being faithful to their spouse, how PLWAs should not be ostracized, and how they should be treated with compassion. Further, they will explain that AIDS is no longer a disease to be ignored and that certain risky behaviors must change to stop the spread of HIV, the virus that causes AIDS. The pastors will also announce and encourage LHA training. Finally, they will refer and encourage their congregations to go to the local VCT for testing. According to the National Strategic Framework this segment of our intervention will strongly reduce people’s negative attitudes towards people with HIV, as Malawians greatly respect clergy and strive to adhere to their teachings (Malawi Ministry of Health 1999).

In order to increase community awareness about social factors that perpetuate the spread of HIV, another approach at the community level will be community discussion groups. This portion of the intervention will necessitate the hiring and training of one full-time paid employee, a Community Health Worker (CHW). This person, given cultural considerations, will be a woman and will have many responsibilities. On the community level she will lead the ladies’ community discussion group. However, she will work in other dimensions as well, as she will also assist in training the LHAs, be a translator for the health educators if necessary, manage the LHAs, lead support groups for HIV positive people, and recruit a male discussion group leader.

Community discussion groups will be advertised by the CHW, who will distribute and post flyers in the markets. The community discussion groups will be offered for one year with two cycles. Cycle One will be from July 2001 through December 2001. Cycle Two will start in January of 2002 and finish in June 2002. A different social issue will be discussed weekly for one month and the topics of discussion will be: educational norms, gender roles, cultural practices, power, lack of social support, and the role of the church in HIV issues. This segment of the intervention is designed to provide an open environment to discuss issues for the non-church members as well as the church members in Mulanje. Therefore, the meetings will be held in a local school and will be open to anyone in Mulanje District who wants to attend. For each session, the CHW will attempt to recruit at least 15 men and 15 women to attend.
During the meeting, the community members will be divided up by sex to ensure the highest level of honesty and forthrightness. Each group will have a discussion leader to maintain order and to keep the people focused on the issue at hand. The role of the discussion group leader will be comparable to that of a facilitator, since he or she will not always be an active group participant. Each session will start with a trigger and then use the SHOWED method to facilitate discussion. This Freirian educational empowerment method relies on the participation of group members to think through specified problems and find doable tasks to address them (see Appendix D for SHOWED questions). Finally at the close of the meeting, the group will choose a challenge to take on together. The challenge will typically be to do something the following week to change a community norm that inhibits HIV preventive behavior. The goal of these discussions will be for the community members to engage in an active dialogue that will lead to increased social awareness, which will lead to a reduction of negative attitudes towards PLWAs, and promote social change. Table 3 outlines this component of the intervention.

Table 3: Social Factors Affecting HIV Transmission: Discussion Group Topics

<table>
<thead>
<tr>
<th>Month</th>
<th>Discussion Group Topic</th>
<th>Triggers and Activities</th>
</tr>
</thead>
</table>
| July 2001/ January 2002| Education                | *Trigger:* skit about lack of education  
                       | *Discussion* about importance of education and literacy in HIV prevention  
                       | *Weekly challenge* chosen by participants.                                           |
| August 2001/ February 2002| Gender                  | *Trigger:* Male testimony about equal rights  
                       | *Discussion* about gender inequalities  
                       | *Weekly challenge* chosen by participants                                             |
| September 2001/ March 2002| Cultural Practices      | *Trigger:* Story about HIV transmission through a cultural practice  
                       | *Discussion* about strengths and dangers of various cultural practices  
                       | *Weekly challenge* chosen by participants                                              |
| October 2001/ April 2002| Power through Social Action| *Trigger:* show a picture of people going to local health department  
                       | *Discussion* about power through social action  
                       | *Weekly challenge* chosen by participants                                               |
| November 2001/ May 2002| Social Support            | *Trigger:* PLWA testimony  
                       | *Discussion* about lack and importance of social support for community members  
                       | *Weekly challenge* chosen by participants                                               |
| December 2001/ June 2002| Role of the Church       | *Trigger:* Mulanje pastors testimonies about becoming involved with HIV/AIDS  
                       | *Discussion* on how their churches should respond to the HIV epidemic.  
                       | *Weekly challenge* chosen by participants                                               |

On the intrapersonal level, there are several goals of the intervention. The first is to increase awareness of HIV/AIDS risk factors among church members in Mulanje. This is the foundation of the intervention as it includes
the information sessions about the transmission of HIV/AIDS and how to prevent it. Church pastors will announce the training in church. This four-hour training, broken into two two-hour sessions, will be available to all program participants, both adolescents as well as married adults, and will be taught in a single-sex small group setting by a same sex LHA (see Table 4). The first training session will focus on general HIV/AIDS knowledge and modes of transmission. These sessions will use illustrations, storytelling, games, and lecture as methods of intervention. The second session will focus on prevention and use demonstrations, games, and role-playing as methods of training. For married couples only, a skills course will be offered about condoms and how to use them appropriately. This segment of the intervention will include an information session about condoms, as well as a demonstration by the LHA of how to put a condom on properly, using a model. Women and men will each have an opportunity to practice putting a condom on a model. The goals of this training will be for each enrolled individual to increase their knowledge about factors related to HIV, to increase their perceived susceptibility to the virus, and to increase skill in condom use.

The use of LHAs in health intervention has become increasingly popular due to the recognition of their effectiveness. They are valuable resources not only because they hold knowledge about health, but also because they are considered trustworthy and helpful members in their communities. This is especially relevant to interventions involving personal and intimate issues, such as HIV. LHAs provide “four basic types of social support – emotional, instrumental, informational, and appraisal support” (Eng and Young 1992), including counseling services. Each type of support is necessary in the HELP components involving LHAs.

Church members will be urged to attend training sessions through announcements in church by pastors and LHAs, and all Sunday school classes for children 10 and older will be required to attend.

**Table 4: Addressing Knowledge, Attitudes, Beliefs and Skills through Education and Training**

<table>
<thead>
<tr>
<th>Topic Area</th>
<th>Session 1</th>
<th>Methods/Activities</th>
</tr>
</thead>
</table>
| General Education | - Brief lecture on what HIV is and its effects on the human body.  
- Use photos and illustrations.  
- Game to learn fundamental concepts. |
| Transmission | - Illustrations of modes of transmission through breastmilk, semen, vaginal fluid, and blood.  
- Games to learn the 4 transmission fluids and means of transmission |

<table>
<thead>
<tr>
<th>Topic Area</th>
<th>Session 2</th>
<th>Methods/Activities</th>
</tr>
</thead>
</table>
| Prevention | - Brief lecture on abstinence, fidelity in marriage, VCT, condoms, breastfeeding alternatives  
- Demonstration of how to put on a condom (married couples only) |
The second goal on the intrapersonal level is to increase HIV/AIDS prevention behaviors. In order to accomplish this, LHAs will refer all church member participants to the local VCT clinic in an attempt to increase the HIV testing and other services. The local VCT clinic, which is open to everyone despite marital status or age, offers testing, as well as professional counselors, free condom distribution, and self-efficacy courses in using a condom. These courses include role-playing of negotiation skills, mostly among women, in how to ask their husbands to use a condom.

Additionally, LHAs will be available for individual counseling for anyone interested in discussing HIV and how to prevent it. Their comprehensive roles lead to an end of decreasing HIV risk behaviors in the community as well as the stigma of HIV. In turn, this will decrease the HIV incidence in Mulanje.

**Barriers, Assets and Unintended Consequences**

The intervention has a myriad of potential collaborators. First and foremost, the Malawi Ministry of Health’s National AIDS Control Programme (NACP) has demonstrated full support of interventions through religious leaders and churches. This is specifically outlined in the NACP’s National HIV/AIDS Strategic Framework 2000-2004 (1999), Section 7.5.1, which includes the strategy to “supporting religious leaders in the development of a positive theology which lays emphasis on building hope, faith and spiritual support for PLWAs, people sick with AIDS and those affected by the epidemic.” Additionally, the strategy aims to “facilitate a closer relationship between religious institutions and government, NGO and private HIV/AIDS programme workers” (Malawi Ministry of Health 1999).

The Strategic Framework clearly states the need to address predisposing, enabling and reinforcing factors, including gender inequality (Section 6.5), abstinence and mutual faithfulness (Section 10.5.1), cultural values (Section 5.5), stigma (Section 1.2.5) and VCT (Section 12.1). In fact, this government document outlines all the factors the intervention seeks to address, making it attractive to government assistance through technical, and possibly financial, support. Additional potential collaborators are non-governmental organizations (NGOs) and existing missions, both of which abound in Malawi and share similar goals in terms of HIV prevention.
One feature that will enhance the likelihood of the intervention’s success is the current socioeconomic climate in Malawi. The ravages of HIV/AIDS have forced people to confront their beliefs, their cultural norms and practices, and themselves perhaps in ways that were never warranted before. This includes churches and their leaders, who for too long stayed aloof of the deaths and sickness caused by AIDS around them. The magnitude of the devastation has been so great that the political, economic and social stability of the country and its future have been crippled and churches and other institutions are forced to confront HIV/AIDS in their congregations, businesses and homes. Churches throughout East and Southern Africa have begun to play important roles in HIV education and prevention, so our intervention is designed at a time when churches and leaders are increasingly interested and vested in addressing the issue.

Another strength of the intervention is its attempt to address sensitive and culturally entrenched topics such as gender inequality, and the roles they play in contributing to the spread of HIV in a non-threatening manner (through discussion groups). The intervention respects Malawian culture, as reflected by the separation of sexes and age groups in many of its activities, yet simultaneously seeks to raise awareness and challenge beliefs about issues that perpetuate the transmission of HIV at an alarming rate. As mentioned earlier, the time is ripe to bring these issues to bear; given the devastating impact HIV/AIDS has had on Malawian communities, families, and individuals and their desperation to stop the epidemic.

The HELP Malawi intervention is also strong because it draws on theory to support its various components. The use of theory to inform the intervention lends it credence and provides a reason for designing it based on constructs and key concepts. The intervention’s incorporation of local LHAs and the CHW strengthens the program in several ways. First, it prevents the program from being perceived as “foreign,” thereby creating a more comfortable environment for participation. It also fosters the empowerment of the LHAs themselves – a goal that is inherently HIV-preventive. Thirdly, female LHAs can also serve as role models for other women, which can begin a process of empowerment and consciousness-raising.

As with any intervention, barriers and unintended consequences exist. Lack of church member time and energy is one that will affect the whole intervention. If people are too busy taking care of the sick or trying to make their living, they may see little reason to attend HIV programs at their church. An even larger potential barrier is the lack of interest from pastors to get involved and enroll. This may also pertain to LHAs – will they be available and willing? Resistance to change, especially surrounding issues of gender imbalances, is another barrier that could
hinder specific components of the intervention, like the discussion groups. Resistance may also come from people not yet ready to address HIV in church, and members may decide not to participate in the intervention.

An unintended consequence might be a power imbalance between the CHW and the LHAs and church members. If the CHW has access to more resources and earns an income from her work, it might create some resentment in the community and among LHAs. This could, however, be addressed by hiring someone already working in that capacity so that changes in income or status are not accentuated. Another possible consequence would be a lack of confidentiality at the VCT clinics, which would discredit the program and its goals. Since the communities are small and rural, the likelihood of a counselor knowing a church member is high, and this could compromise a person’s confidence is VCT use. It is hoped that the strengths of the intervention will far outweigh the limitations and potential weaknesses, and thereby effectively combat the transmission of HIV/AIDS in Malawi.

Evaluation Overview

In order to evaluate our program’s success, and to make it generalizable to similar populations, it is essential to include an evaluation component to our intervention that assesses both our process and our outcome objectives. The process evaluation segment will measure the extent to which the program is implemented and received, while the outcome evaluation segment of our intervention will measure if the program had the intended effects on the target population. Since our plan is a pre-experimental one-group design, our evaluation plan will primarily assess the quality and thoroughness of each activity in our intervention through pre- and post-intervention tests, though once only a post-intervention design will be used. However, the evaluation plan also includes measurement methods such as: LHA reports, church and VCT attendance records, and a one-question survey. Due to time, logistical, and financial constraints, a comparison group is not a viable option. Additionally, the urgency of the HIV/AIDS issue also renders an ethical dilemma when the consideration of excluding some people from the intervention arises.

Our process evaluation will attempt to answer questions such as: were sermons regarding HIV/AIDS delivered, what social factors were discussed in community discussion groups, did church members attend training sessions, and were community members referred to the local VCT? Questions such as: to what extent did attitudes towards PLWAs improve, to what extent was knowledge about social factors impacting HIV increased, did participants know all of the modes of HIV transmission, and did VCT use increase, will be answered in the outcome evaluation segment.
There are three primary timeframes in which evaluation will take place. First, at baseline in June 2001, several pre-intervention tests will be given to measure knowledge and beliefs. Next, upon the return of the health educators at mid-intervention in November 2001, the community discussion groups and sermons will be assessed. Finally, at the end of the intervention year, from June through August 2002, an entire evaluation phase of the intervention will take place. During this time, post-intervention tests will be given; final assessments of the intervention activities will be completed; data will be coded and analyzed; and feedback will be given to intervention participants, LHAs, the CHW, CHAM, and the pastors.

**Evaluation Plan**

This section of the document provides a detailed table outlining the evaluation phase of PROCEED. (See Table 5) It explains how each intervention activity will be monitored and evaluated before, during, and after the intervention. Please see Appendix E for a detailed timeline for the intervention. In the table below, each goal and objective of the program are presented in the far left column. Next, the program activity that will serve as the means for addressing the objectives will be presented. In the third column, the evaluation methods will be explained in a detailed manner by including the method of measurement, the data collection tools used, and the item(s) of interest. It should be noted that all “self-administered” surveys will be read aloud to accommodate illiterate individuals in the churches and the Mulanje community. Finally, the last column will indicate the time frame in which the evaluation will take place.
<table>
<thead>
<tr>
<th>Program Objectives</th>
<th>Program Activities</th>
<th>Evaluation Methods</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community Goal 1 for HELP MALAWI program: To decrease the churches’ negative attitudes towards PLWAs in churches in Mulanje, Malawi</strong></td>
<td>Monthly Sermon</td>
<td>Method: Review of LHA report on sermon delivery&lt;br&gt;Data Collection Tools: LHA report&lt;br&gt;Items of Interest: Were sermons regarding stigma, compassion, and Christian duty around HIV/AIDS delivered? (yes/no)</td>
<td>Monthly assessment of sermon delivery for one year</td>
</tr>
<tr>
<td>Process Objective: By July 2002, pastors will deliver one sermon per month, incorporating HIV/AIDS issues and the importance of VCT services.</td>
<td>Challenge negative attitudes and stigma surrounding HIV/AIDS</td>
<td>Method: Self-administered pre- and post-intervention survey&lt;br&gt;Data Collection Tools (instruments/scales): Satow/Hackney HIV attitude scale&lt;br&gt;Items/Constructs of Interest: Extent of positive change in attitudes towards PLWAs</td>
<td>At baseline and post-intervention</td>
</tr>
<tr>
<td><strong>Community Goal 2 for HELP MALAWI program: To increase community awareness about social ecological factors that perpetuate the spread of HIV in Mulanje</strong></td>
<td>Weekly community discussion groups</td>
<td>Method: Self-administered post-intervention survey&lt;br&gt;Data Collection Tools: Survey assessing whether or not social factors were discussed&lt;br&gt;Items of Interest: What social factors were discussed?</td>
<td>Six months from baseline (end of Cycle 1) &amp; at 12 months after baseline (end of Cycle 2)</td>
</tr>
<tr>
<td>Process Objective: By July 2002, to hold weekly discussion groups for 15 men and 15 women to discuss how educational norms, gender roles, power differentials, lack of social support, the role of the church, and cultural norms contribute to the spread of HIV.</td>
<td>Discussing social factors that impact HIV transmission</td>
<td>Method: Self-administered pre- and post-intervention surveys&lt;br&gt;Data Collection Tools (instruments/scales): Survey of knowledge of social factors that impact the spread of HIV&lt;br&gt;Items/Constructs of Interest: extent of increased knowledge</td>
<td>Baseline, at 6 months (mid-intervention) and at 12 months (post-intervention)</td>
</tr>
</tbody>
</table>
**Intrapersonal Goal 1 for HELP MALAWI program: To increase awareness of HIV risk factors among church members in Mulanje, Malawi**

| Process Objective: By July 2002, to enroll 50% of church members over age 10 in HIV educational training | Method: review of attendance records | Data Collection Tools: attendance record | At the end of the intervention, attendance at training workshops will be compared to church membership |
| Enroll church members in HIV information training sessions | Items of Interest: Did 50% of church members attend training sessions? (yes/no) |

| Outcome Objective: To increase knowledge of modes of HIV transmission to 100% in program participants by one year after program initiation | Method: Pre- and post-training session surveys | Data Collection Tools (instruments/scales): Survey of HIV transmission knowledge | Measured at completion of the intervention |
| Teaching HIV modes of transmission | Items/Constructs of Interest: Do participants know all of the modes of HIV transmission? |

**Intrapersonal Goal 2 for HELP MALAWI program: To increase HIV prevention behaviors among church members in Mulanje**

| Process Objective: By July 2002, to refer 100% of intervention participants to local VCT | Method: Review participant surveys | Data Collection Tools: Intervention one-question survey | Completion of one-year implementation phase |
| Refer to VCT | Items of Interest: Were you referred? (yes/no) |

| Outcome Objective: To increase use of VCT by 25% in church members by one year after program initiation | Method: Review of VCT attendance records | Data Collection Tools (instruments/scales): VCT attendance records | Completion of one-year implementation phase |
| Encourage use of VCT | Items/Constructs of Interest: Did VCT use increase by 25%? |
Final Summary

The impact of this intervention, given that it will be delivered and implemented as designed, will initially be local. It is anticipated that HIV incidence in Mulanje District will begin to decrease. But the intervention is designed such that it can be sustained and implemented elsewhere. This is made possible due to the low costs involved in-country and cultural sensitivity with which the intervention has been fashioned. Ultimately, the intervention’s impact could be wide-reaching, starting in Mulanje District and decreasing HIV risk behaviors and attitudes, increasing VCT use, and changing societal norms surrounding the issue. In turn, we hope that these changes will decrease the incidence of HIV in rural communities, and thereby improve the quality of life for rural Malawians.
References


Appendix A – HELP MALAWI (PRECEDE Planning Model Phases 1-4)

Predisposing factors
- Polygamous society/history (beliefs)
- Lack of knowledge
- Strict gender roles (beliefs)
  - favors men
  - disempowers women
- Low perceived threat of HIV/AIDS

Reinforcing factors
- Church/religious denial
- Political leaders
- Family support

Enabling factors
- Availability of condoms
- Lack of education
- Government laws and priorities
- Social attitudes towards condoms
- Societal norms that inhibit discussion of sex

Behavior
- Multiple sexual partners (including extra-marital sex)
- Unprotected sex
- Early onset of sexual activity
- Will not go for HIV testing
- Breastfeeding

Health
- Prevalence / Incidence of HIV/AIDS
- High mortality
- High morbidity

Environment
- Stigma
- Status of Women
- Affordability of Healthcare
- Access to healthcare
- Popularity of Migratory Labor
- National leadership stance on AIDS
- Allocation of government funds to health and education

Quality of life
- Poverty
- Stress
- Instability
- Depression (among Malawians in Mulanje)

HACKNEY & SATOW
Appendix B: Conceptual Model for HELP MALAWI

**COMMUNITY LEVEL**

- **Pastors**
  - Address stigma and attitudes about HIV in teachings and church events
  - Emphasize marital faithfulness
  - Announce and encourage LHA training
  - Announce and encourage use of VCT services
  - Encourage HIV prevention training

- **Health Educators**
  - CHW will lead a (female) Community Awareness Discussion Group(s) about social issues that impact the spread of HIV

**INTRAPERSONAL LEVEL**

- **Pastors**
  - Address stigma and attitudes about HIV in teachings and church events

- **LHAs**
  - Hire and train one CHW
  - CHW will train a male discussion leader to lead male discussion group
  - LHAs make referrals to VCT clinics and encourage church members to use their services
  - LHAs provide educational and prevention training for church members
    - Married couples (separate sexes)
    - Adolescents

- **VCT**
  - HIV testing
  - Counseling
  - Condom distribution
  - Self-efficacy training for condom use

**INTERPERSONAL**

- **Married couples and adolescents**
  - Increase knowledge about HIV
  - Increase perceived susceptibility to HIV
  - Increase condom skill level (married couples only)

**Key**
- **LHA** – Lay Health Advisors
- **CHW** – Community Health Worker
- **PLWA** – People living with AIDS
- **VCT** – Voluntary Counseling and Testing

- **Recruit LHAs**
  - Train LHAs

- **Support Groups for HIV positive people**

- **Reduce community’s negative norms towards PLWAs**

- **Increase community awareness about HIV related factors**

- **Decrease HIV risk behaviors in Mulanje**

- **Decrease HIV incidence in Mulanje, Malawi**

- **Decrease stigma of HIV**

- **Decrease HIV incidence in Mulanje, Malawi**

- **Decrease HIV incidence in Mulanje, Malawi**
Appendix C: Budget Justification and Budget

Personnel

Tara Hackney, MPH, Principle Investigator: Ms. Hackney will devote varying amount of time throughout the course of this intervention. In the first three months of planning (Phase 1) and the final 3 months of evaluation (Phase 3) the level of effort will be 100%, as all of that time will be spent in Malawi. The implementation Phase (Phase 2) will mostly be spent in the United States, where she will carry out other responsibilities required by her job, and therefore involves 25% of her time. Ms. Hackney is an MPH student at the University of North Carolina- Chapel Hill's School of Public Health in the Department of Health Behavior/Health Education. She will oversee both the planning (March-May 2001) and evaluation (June-August 2002) phases of the project in-country (Malawi), including the training of LHAs and the hiring of a full-time CHW, and the collection of surveys and evaluation data. In addition, she will monitor the intervention by visiting Mulanje District mid-intervention (November 2001). She will be the primary contact with CHAM, who will be involved in the identification and recruitment of pastors in Mulanje District. Ms. Hackney's experience with community work, both domestically and internationally, makes her a valuable member of the project team.

Priya Satow, MPH, Co-Investigator: Ms. Satow will serve as a member of the investigative team. Her level of effort is divided the same as Ms. Hackney: 100% for the planning and evaluation phases in-country, and 25% for the implementation phase. Ms. Satow will work with Ms. Hackney in collaboration efforts with CHAM, in addition to LHA training, CHW hiring, and evaluation data collection. Ms. Satow is an MPH student at the University of North Carolina - Chapel Hill's School of Public Health in the Department of Health Behavior/Health Education.

Note: The exchange rate and cost of living in Malawi is vastly different from the U.S. The costs below may appear very low, but these have been adjusted according to local exchange rates and local fees in Malawi.

Consultants

TBN, Lay Health Advisor (LHA), Consultant (x30): A male and female LHA will be identified for each of the 15 participating churches, totaling 30. Each LHA will be identified by the church pastor and trained in HIV information, group facilitation, and counseling techniques. Each LHA will have the following responsibilities: refer church members to VCT clinic; and hold same-sex HIV education and training sessions for church adults and adolescents. The very nature of LHAs discourages monetary compensation due to their “natural helper” characteristics, but since they will be carrying out additional responsibilities (education sessions, etc.), they will be compensated $5/month throughout Phase 2, totaling $1,800 for all 30 LHAs. Meals and transportation will be provided during LHA training and each LHA will receive a certificate upon completion of the training.

TBN, Community Health Worker (CHW), Consultant: This consultant will already have had community health work experience and will be responsible for recruiting participants for community discussion groups, facilitating them, and recruiting a male discussion group leader. Furthermore, she will assist in the training of LHAs, translate for health educators if necessary, and lead support groups for HIV positive community members. She will serve as a link between church LHAs and pastors in the district, given the access she has to the project vehicle. The CHW will devote 20% of her time in the planning phase, 100% of her time in the implementation phase, and 50% in the evaluation phase.

TBN, Male Discussion Group Leader, Consultant: The CHW will help to recruit a male group discussion leader, who will serve this purpose for all community discussion groups. This will be his sole responsibility and therefore only 10% effort is assumed for this position. He will be compensated $30 for Phase 2, as his responsibilities are low in comparison to the CHW. He will have access to the CHW vehicle on a limited basis.
Permanent Equipment

A vehicle will be purchased for the intervention, to be used by the CHW in Mulanje District. Although the CHW will have primary use of the vehicle, the vehicle will serve the project as a whole, to be used for various church and LHA needs. $25,000 is budgeted for this.

Supplies

$100/month is budgeted for supplies in Phase 1 for in-country start-up costs. These will include supplies for the 15 churches during recruitment, including pens, markers, paper, and any supplies LHAs require for teaching. The amount is approximated from local currency (Kwacha) and costs. $500 is budgeted for the supplies during intervention, since the intervention itself requires limited supplies and the currency conversion makes this amount sufficient. $100/month is budgeted for Phase 3 (3 months of evaluation), as funds for evaluation paperwork will be necessary.

Travel

Both the Primary Investigator and Co-Investigator will make a total of 3 round trips between the US and Malawi, budgeted at $1500/trip ($3000 per phase). The first trip will be during Phase 1 (planning), the second at mid-intervention (middle of Phase 2) and the third for Phase 3 (evaluation). The trips will involve recruitment, training, monitoring and evaluation.

Lodging and per diem rates have been calculated based on a standard per diem rate used by the parent organization. Lodging is budgeted based on 3 months of stay (90 days) for planning and evaluation phases, and 2 weeks for the mid-intervention visit, at approximately $17/night for both personnel, totaling $3,000 per visit. Although this is significantly lower than hotels charge foreigners in Malawi, it is expected that the majority of nights stayed will be in rural inns, churches and with church families. Per diem rates budgeted ($12/day) are far below standard per diem rates for US travel to Malawi, but personnel are willing to forgo the remainder in order to keep costs low.

For local in-country travel, $200 has been budgeted gas/petrol expenses for the planning phase, $2,000 is budgeted for Phase 2, when the CHW will need for transport around the district, and $300 for Phase 3. Again, these are estimates using costs in local currency. Gas is sold at inflated rates in Malawi, and therefore represents a significant cost in the budget.

Miscellaneous

Communication costs will be significant, given that the project personnel are based in the US and will need to communicate with counterparts in Malawi. International calls and faxes will be necessary, particularly in Phase 2, when personnel are in the US. $5000 is budgeted for all communication expenses during this phase. $1000 is budgeted for both Phases 1 and 2, since personnel will be in Malawi and will need to communicate with US colleagues and counterparts.

LHA training costs are minimal, but include costs covering meals, certificates, and training materials, estimated at $400 for 30 LHAs for two evenings

Educational materials including brochures, pamphlets and teaching tools (such as a model penis for condom demonstration) will cost $400 in Phase 1 when LHAs start to gather materials. $2400 is budgeted for Phase 2, when LHAs will require re-stocking of educational materials and will need to purchase materials once they learn the specific needs of participants.

$500 is budgeted for vehicle maintenance costs during Phase 2 and $100 for Phase 3. These costs are kept to a minimum, given the vehicle will be new.
Subcontracts

We will subcontract with the Christian Health Association of Malawi (CHAM) to provide initial support in recruiting and training 15 pastors in Mulanje District. A total of $3000 will be paid to the organization for this assistance and continued support through the intervention and evaluation. Although minimal, this support after Phase 1 will include giving access to office phone and fax use while personnel visit Malawi, and emergency access of these facilities to the CHW or LHAs if necessary (e.g. if the use of a phone is required). The amount of $3000 will be paid in three installments of $1000, one payment per phase of the intervention.
### Budget (continued)

#### A. Personnel

<table>
<thead>
<tr>
<th>Role</th>
<th>Phase 1 (Mar-May '01)</th>
<th>Phase 2 (Jun '01-May '02)</th>
<th>Phase 3** (Jun '02-Aug '02)</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% Effort</td>
<td>Cost (US $)</td>
<td>% Effort</td>
<td>Cost (US $)</td>
</tr>
<tr>
<td>Tara Hackney</td>
<td>100</td>
<td>8,751</td>
<td>25</td>
<td>8,751</td>
</tr>
<tr>
<td>Priya Satow</td>
<td>100</td>
<td>8,751</td>
<td>25</td>
<td>8,751</td>
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<tr>
<td>Fringe Benefits Total*</td>
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<td>0</td>
<td>20</td>
<td>1,800</td>
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<td><strong>Category Total</strong></td>
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<td>20,827</td>
<td>21,658</td>
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#### B. Consultants

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<tr>
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<th>% Effort</th>
<th>Cost (US $)</th>
<th>% Effort</th>
<th>Cost (US $)</th>
<th>% Effort</th>
<th>Cost (US $)</th>
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<tbody>
<tr>
<td>TBN X 30 Lay Health Advisor</td>
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<td>0</td>
<td>20</td>
<td>1,800</td>
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<tr>
<td>TBN x1 Comm. Health Worker</td>
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<td>30</td>
<td>100</td>
<td>1,000</td>
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<td>130</td>
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<tr>
<td>TBN x1 Male Grp. Disc. Leader</td>
<td>5</td>
<td>0</td>
<td>10</td>
<td>30</td>
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<tr>
<td>TBN x 15 Pastors</td>
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<td><strong>Category Total</strong></td>
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#### C. Permanent Equipment

<table>
<thead>
<tr>
<th>Category</th>
<th>Cost (US $)</th>
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<tr>
<td>Vehicle</td>
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<td><strong>Category Total</strong></td>
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#### D. Supplies

<table>
<thead>
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<th>Cost (US $)</th>
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<tr>
<td>Project Supplies (Malawi)</td>
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<td><strong>Category Total</strong></td>
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#### E. Travel

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<thead>
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<td>US-Malawi-US (x6)</td>
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</tr>
<tr>
<td>Lodging</td>
<td>3,000</td>
</tr>
<tr>
<td>Per Diem</td>
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<td>In-country travel (Malawi)</td>
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<td><strong>Category Total</strong></td>
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#### F. Miscellaneous

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<th>Category</th>
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<tr>
<td>Communications</td>
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<tr>
<td>LHA Training</td>
<td>200</td>
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<tr>
<td>Education Materials</td>
<td>400</td>
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<td>Vehicle Maintenance</td>
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#### G. Subcontracts

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<tr>
<td>CHAM</td>
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<td><strong>Category Total</strong></td>
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#### DIRECT TOTAL COSTS

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<th>Cost (US $)</th>
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<td>57,137</td>
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<td>38,977</td>
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<tr>
<td>32,648</td>
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<td><strong>TOTAL</strong></td>
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#### H. INDIRECT COSTS TOTAL (30%)

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<th>Cost (US $)</th>
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<tr>
<td>17141</td>
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<tr>
<td>11693</td>
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<tr>
<td>9794</td>
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<td><strong>TOTAL</strong></td>
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#### ANNUAL TOTAL

<table>
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<tr>
<th>Cost (US $)</th>
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<tbody>
<tr>
<td>74,279</td>
</tr>
<tr>
<td>50,671</td>
</tr>
<tr>
<td>42,442</td>
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<td><strong>TOTAL</strong></td>
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#### I. Total Amount Requested

<table>
<thead>
<tr>
<th>Cost (US $)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$167,392</td>
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* Includes 19% for Retirement & Social Security

** Year 3 salaries have been adjusted for 4% inflation.
Appendix D: SHOWED

SHOWED

Method of questioning that moves discussion from concrete and personal level to a societal analysis and action stage.

See  Naming the problem. What do we see here? Use your five senses.

Happening  What is happening?
How  How do the people in the story feel?

Our  How does the story relate to our lives?
How do we feel about it?

Why  Why has the problem arisen (on an individual, family and societal level)?
What are the root causes – political, social, economic?

Empowered  Explore how we can become empowered with our new social understanding.

Evaluate  How do we evaluate our experience?
What are the take-home messages?

Do  What can we do about these problems in our lives?
Move to action.

### Appendix E: Timeline for HELP Malawi

#### TABLE A – PHASE 1 (PLANNING)

<table>
<thead>
<tr>
<th>TASKS</th>
<th>March 2001</th>
<th>April 2001</th>
<th>May 2001</th>
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<tbody>
<tr>
<td>Planning meetings with CHAM</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Recruit Pastors</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Train Pastors</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Recruit and Train LHAs</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Hire and Train CHW</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Hire and Train Male Discussion Group Leader</td>
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#### TABLE B – PHASE 2 (IMPLEMENTATION)

<table>
<thead>
<tr>
<th>TASKS</th>
<th>JUNE '01</th>
<th>JULY '01</th>
<th>AUG. '01</th>
<th>SEPT. '01</th>
<th>OCT. '01</th>
<th>NOV. '01</th>
<th>DEC. '01</th>
<th>JAN. '02</th>
<th>FEB. '02</th>
<th>MAR. '02</th>
<th>APR. '02</th>
<th>MAY '02</th>
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</thead>
<tbody>
<tr>
<td>Pastors deliver sermons related to HIV/AIDS</td>
<td>1x</td>
<td>1x</td>
<td>1x</td>
<td>1x</td>
<td>1x</td>
<td>1x</td>
<td>1x</td>
<td>1x</td>
<td>1x</td>
<td>1x</td>
<td>1x</td>
<td>1x</td>
</tr>
<tr>
<td>Community Discussion Groups</td>
<td>4x</td>
<td>4x</td>
<td>4x</td>
<td>4x</td>
<td>4x</td>
<td>4x</td>
<td>4x</td>
<td>4x</td>
<td>4x</td>
<td>4x</td>
<td>4x</td>
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<tr>
<td>Educational &amp; Prevention HIV/AIDS Training</td>
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<td>2x</td>
<td>2x</td>
<td>2x</td>
<td>2x</td>
<td>2x</td>
<td>2x</td>
<td>2x</td>
<td>2x</td>
<td>2x</td>
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<tr>
<td>LHAs refer participants to VCT</td>
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<td>X</td>
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<td>X</td>
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<td>---------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Assessment of delivered sermons (monthly)</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td></td>
<td></td>
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<tr>
<td>Assessment of what factors were discussed at Community Discussion Groups</td>
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</tr>
<tr>
<td>Measure knowledge of social factors that contribute to HIV</td>
<td>X – Pre-test Cycle 1</td>
<td>X – Post-test Cycle 1</td>
<td>X – Post-test Cycle 2</td>
<td></td>
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<tr>
<td>Measure attitudes towards PLWAs</td>
<td>X</td>
<td></td>
<td>X</td>
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<tr>
<td>Assess if 50% of church members attended HIV workshops</td>
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<td></td>
<td>X</td>
<td>X</td>
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</tr>
<tr>
<td>Measure knowledge of HIV modes of transmission</td>
<td>X</td>
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<td>X</td>
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<tr>
<td>Assess VCT use</td>
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<tr>
<td>Provide Feedback</td>
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<td>Data Entry, Cleaning, Analysis</td>
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