AIDS in Africa: Concepts of Behaviour Change
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Background

The concept of behaviour change has long been the rallying cry of HIV/AIDS prevention interventions and campaigns and has been grounded in theories and models of health behaviour including the health belief model², the theory of reasoned action³, the AIDS risk reduction model⁴, and theories of social learning⁵ amongst others. A review of HIV/AIDS behaviour change communication interventions by Airhihenbuwa et al (1999) concluded that these theories and models do not provide an adequate framework for bringing about behavioural change – especially when applied to the contexts of Africa, Asia, Latin America and the Caribbean. It was noted that:

- The simple, linear relationship between individual knowledge and action… does not take into account the variation among the political, socioeconomic, and cultural contexts that prevail in the regions
- The emphasis on quantitative research results in distorted interpretation of the meanings and realities in observed behaviours.
- The assumption that individuals can or will exercise total control over their behaviour has led to a focus on the individual rather than on the social context within which the individual functions and a disregard for the influence of contextual variables, such as culture and gender relationships, and
- The assumption that decisions about HIV/AIDS prevention are based on rational, volitional thinking with no regard to more true-to-life emotional responses in engaging in sexual behaviour (1999:24-25)

Over the past two decades, millions of dollars have been invested in behavioural interventions oriented towards education for behaviour change, and although many of these interventions have made impacts on knowledge and awareness, and have contributed to HIV risk reduction, they have been insufficient to the task of ensuring the rapid changes necessary for containing the HIV epidemic in many countries.

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² See Becker MH (1974) The health belief model and personal health behaviour, Health education Monographs, 2:324-508
This brief review examines behaviour change concepts in relation to risk of HIV infection, and argues for a greater emphasis on public health approaches that focus on addressing contexts of risk with a view to supporting a more rigorous response to HIV prevention. In contexts where HIV infection is generalised, it is also argued that HIV prevention activities should be integrated into the continuum of HIV/AIDS treatment, care, support and rights.

**Sexual activity and the limits of choice**

Concepts of behaviour change focus on the individual, and individual capacity to moderate risk to HIV infection. In the case of sexual risk, the formulation is that an individual will adopt a number of strategies to mitigate risk – for example choosing not to have sex, choosing to have non-penetrative sex, choosing to be faithful, choosing to reduce his or her number of partners, choosing to use an HIV barrier method. What is not problematised in this individualized conception is that any act of sex, consensual or not, involves more than one individual and sexual activity thus implicitly involves dynamics of power. In the case of consensual sex, risk reduction involves a range of conscious strategies, but conscious strategies are not always readily negotiable, and differentials of power may extend beyond mutually consensual sex. Emotional, psychological and physiological factors are at play in sexual interactions, and these may readily overwhelm a rational approach. Such choices might be further diminished as a result of consumption of alcohol or drugs.

Power imbalances in sexual relations are not readily addressed within the frameworks implicit in behaviour change approaches. For example, an individual may adopt the strategy of staying faithful to his/her sexual partner, but still face infection because of an unfaithful partner; a young person may be coerced or persuaded to engage in sexual activity by a person older than themselves, towards whom trust and authority is a culturally determined norm; emotional needs for love, comfort and support may overwhelm imperatives for HIV risk reduction; physical needs for food and shelter may be exchanged for sex as a matter of survival; desire for material goods such as fashion items, cellphones or money may foster transactional sexual relationships; fear of physical violence may influence sexual decision-making within an established relationship; differential power relationships within the family or within school and other institutions pose risks for coercion, child sexual abuse and rape; and fragmented social contexts, along with poor policing and justice systems contribute to sexual violence and rape.

**Sexual activity and behaviour change**

Behaviour change approaches assume that individuals move from an existing condition of risk – for example risk of exposure to HIV infection – to safer sexual practices by adopting a range of strategies. Such approaches to behaviour change are rooted in the early responses to the epidemic where behavioural interventions targeted relatively homogenous groups such as gay men, intravenous drug users, sex workers and transport workers. Some successes have been demonstrated – particularly amongst gay men in the US, in relation to condom use.

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amongst sex workers in Thailand, and in needle exchange programmes targeting intravenous drug users. In these instances, target groups were relatively homogenous and behaviour change interventions were multifaceted, explicitly targeting clearly defined risk practices.

A premise of behaviour change is an assumption that a particular group or population need to change from one condition of behaviour – for example, exposure to HIV through unprotected sex – to another set of conditions – protected sex through condom use or other risk reduction strategies. However, in many instances particular populations may already be ‘doing the right thing’ and should be maintaining their current practices rather than changing them. An obvious case in point is youth, many of whom are not sexually active, and for whom interventions endorsing existing practices may be far more appropriate than entreaties to change their behaviour.

The notion that changes in behaviour are sequential and sustained is also implicit in some approaches to behaviour change. However, changes are not necessarily sustainable, even if they are consciously made. For example, sexual activity over a lifetime is subject to many variations that are a product of relationships and contexts, and specific behavioural choices (such as safer sex) may be moderated by these changing conditions.

**Sexual activity and disabling contexts**

Differentials in country level HIV epidemics have been noted, and HIV prevalence is considerably more severe in poorer countries. Contextual factors that influence HIV risk include poverty, unemployment, labour migration, rapid urbanization, and war. Related factors include limited health and social service infrastructures, poor communications infrastructure, differentials in language which limit effective communication, varying cultural practices, gender power differentials, economic status differentials, lack of political will, lack of financial commitment and inadequate strategic responses to HIV. Risk to HIV infection is mediated by these contexts at an inter-country and intra-country level – poverty and unemployment are related to sex for survival; labour migration breaks up families and shifts the dynamics of marital relationships; rapid urbanization gives rise to fragmented communities and informal urban settlements where social cohesion is low; war disrupts the social fabric. Such factors disable volitional control over sexual activity and contribute to overall vulnerability to HIV infection.

**Addressing prevention more broadly**

The foregrounding of sexual behaviour change is limited by the factors outlined above. However, the predominance of behaviour change concepts has also tended to limit understanding of HIV risks that lie beyond consensual sex and individual choice-based risk reduction. For example, safety of blood transfusions, sterilization of medical equipment, entrenching universal precautions amongst health workers, provision of post-exposure prophylaxis (PEP) for occupationally acquired injuries, and provision of PEP to survivors of child sexual abuse and rape. Similarly, cultural practices such as scarification and circumcision may include HIV infection risks.

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One way of approaching the problem is a pragmatic focus on the range of resources necessary to foster HIV prevention practices. At a practical level this involves rapid scaling up in efficiency of basic prevention measures that support HIV risk reduction. In South Africa, for example, high levels of public sector condom procurement combined with efficiencies in quality control and distribution logistics have contributed to high rates of condom use. As pointed out above, there is much that can be done at a health service provision level – for example, reducing direct risks through blood transfusions to patients, sharps injuries to health care workers, sterile practices in health care settings, and systematic provision of post-exposure HIV prophylaxis. Systematic attention should also be given to cultural practices that present HIV risks, such as scarification and circumcision, and modification of practices to ensure use of sterile instruments do not necessarily compromise the cultural practices themselves.

In many countries approaches to sexual behaviour change have failed to problematise coercion and sexual violence. In the case of youth, for example, research findings that show incidence of sexual activity below the age of consent has been presented as a context for behaviour change communication, rather than being problematised within the context of existing legislative frameworks that foreground the illegality of child sexual abuse and statutory rape. Models have been constructed for expansion of health facilities towards ‘youth friendly’ approaches that ensure children as young as twelve can freely obtain contraceptives and condoms, but fail to address the real needs and vulnerabilities of youth – specifically sexual abuse, sexual coercion and rape and the need for PEP, trauma and related counselling, and support to violations of law and rights. Young people are also vulnerable as a results of the effects of HIV on their families and communities – illness and death of parents, siblings, relatives and friends is traumatic and may have severe psychological effects; HIV within the family compromises capacity to generate income and introduces higher levels of expenditure; orphaning increases vulnerability to HIV as a result of loss of economic support, love and care. Similarly, adult vulnerabilities to HIV need to be acknowledged, and addressed in line with the higher levels of HIV prevalence in adult groups.

*Behaviour change is one aspect of a complex whole*

HIV prevention approaches framed by behaviour change concepts have tended to segment populations on the basis of assumed HIV negative and HIV positive status. HIV prevention and behaviour change discourses largely address assumed HIV negative audiences and place less emphasis on individuals already living with HIV. The merits of focusing primarily on the concept of behaviour change as opposed to the concept of communicating and addressing broader elements of HIV risk has been problematised. However, it is also necessary to consider a closer integration between prevention discourses and interventions, and those related to treatment, care, support, rights and social mobilization. A number of studies have shown, for example, that HIV preventive practices are associated with personally knowing

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9 Typically the age of 16 in most countries.
10 Some countries might need to further address legislation in relation to sexual violence.
people who are HIV positive or who have died of AIDS. Promoting involvement in HIV response, including, for example wearing a red ribbon, taking part in AIDS memorial events, joining community AIDS support groups and organizations, and providing care to orphans, HIV positive individuals and affected families, may further contribute to HIV risk reduction.

Conclusions

Behaviour change theories and interventions are clearly constrained by a range of conceptual and contextual factors. These factors do not negate the value of behaviour change concepts and interventions, but recognition needs to be given to the broader milieu of prevention. In many instances there has been an over-reliance and over-investment in ‘behaviour change communication’ with little parallel investment or strategic support being given to the development of an enabling environment for HIV prevention.

Mechanisms for supporting behaviour changes also need to be explored and these extend to approaches driven by community involvement, addressing material conditions, and integrating concepts of basic human rights as well as HIV-related rights.

In high prevalence contexts there is little merit in separating prevention activities from the broader continuum of HIV response in relation to treatment, care, support, rights and social mobilization, and there is evidence that such integration further contributes to prevention impacts. Integration should also be extended to broader development issues, and the urgent imperatives the HIV/AIDS epidemic should be used to leverage attention and resources to some of the developmental issues that underpin the epidemic.

With regard to communication interventions per se, recent developments have foregrounded the need to move beyond top-down communication (which have largely been employed by behaviour change interventions) towards horizontal and participatory approaches. Such approaches incorporate the concept of addressing enabling environments and contextual factors and are framed by the concept of ‘communication for social change’. Elements of this framework include: moving away from people as objects for change, towards people and communities as agents for change; moving away from delivering messages, towards supporting dialogue and debate on key issues; moving away from a focus on individual behaviour, towards a focus on social norms, policies, culture and supportive environments; moving away from persuasion, towards negotiation and partnership; moving away from external technical expertise, towards integrating communities in assessing issues of concern at local level.

See for example, Shisana et al (2002).


References


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