CADRE
CENTRE FOR AIDS DEVELOPMENT, RESEARCH AND EVALUATION

cadrejhb@cadre.org.za
www.cadre.org.za

COMMUNICATING AIDS NEEDS PROJECT • CAN

Rethinking conceptual approaches to behaviour change: The importance of context

Warren Parker (2004)

This article critically reviews the concept of behaviour change as it has been applied to individual behaviour in relation to HIV/AIDS. It notes the limits of cognitive approaches to behaviour change when applied within complex contexts and variations of risk to HIV infection.With regard to communication, there is a need to move beyond top-down approaches and to incorporate horizontal and participatory approaches. These include recognising and resourcing the role of civil society responses to HIV/AIDS. An earlier version of this article was published as part of the UNAIDS AIDS in Africa: Scenarios for the Future project.

The concept of behaviour change has long been the rallying cry of HIV/AIDS prevention interventions and campaigns. Behaviour change approaches have predominantly been grounded in cognitive theories and models of health behaviour including the health belief model[1], the theory of reasoned action[2], the AIDS risk reduction model[3], and theories of social learning[4] 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 problematises:

- 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).[5]

Melkote et al (2000)[6] note that cognitive theories that are largely centred around volitional control over behaviour, do not take into account individual, cultural (including gender and race), and socio-economic contexts and related differentials of self-efficacy and power in sexual interactions.

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

Sexual activity and the limits of choice

Concepts of behaviour change have tended to focus on individuals as the unit of intervention and analysis. In the case of HIV/AIDS, this has been applied to

The Communicating AIDS Needs Project (CAN) was established in 2003 to draw together lessons learned in African contexts with a particular focus on individual and community level responses to the epidemic. The first year of the project is funded by DFID and USAID/Johns Hopkins University Center for Communications Programs. The views expressed in this report are not necessarily endorsed by the project funders.

individuals in relation to their capacity to moderate risk to HIV infection. The predominant formulation for reduction of risk through sex, is that an individual is encouraged to 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. Whilst there is an obvious logic to this type of choice-making, what is largely overlooked is that any act of sex involves more than one individual and sexual activity implicitly involves dynamics of interpersonal power – consequently, individual intent is mediated by this power dynamic.

Sexual interactions take place in a wide range of contexts and along a continuum of consent that extends from willed or conscious engagement in sexual activity through to unwilled non-consensual sex, that includes the use of coercion and possibly physical violence. In the case of consensual sex, risk reduction involves a range of conscious strategies, but even such strategies are not always readily negotiable, and differentials of power may extend beyond mutually consensual sex. Emotional, psychological and physiological factors[7] are at play in sexual interactions, and these may readily overwhelm rational choice-making. 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; gender power relations are predominantly weighted towards male decision-making in cultural life, extending to decision-making over sex; 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, money or transport, may foster risky 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, sexual abuse and rape; and fragmented social contexts, along with poor policing and justice systems may contribute to high levels of sexual violence. Thus, the limits of volitional control, in conjunction with contextual variables, need to be integrated into conceptualising sexual ‘behaviour change’ and expectations about ‘change’ need to be moderated by these limitations on individual behaviour.

Sexual activity and behaviour change

Behaviour change approaches assume that individuals move from an existing condition of risk of HIV exposure to a condition of lower risk by adopting a range of risk reducing strategies. Such approaches are rooted in the early responses to the epidemic where behavioural interventions were targeted towards relatively homogenous, groups such as gay men, intravenousdrug users, sex workers and transport workers, where levels of risk were relatively high and could be generalized to these groups as a whole. Some successes have been demonstrated – particularly amongst gay men in the US[8], sex workers in Thailand,[9] and drug users. In these instances, target groups were relatively homogenous in terms of language, culture, context and risk practices, and behaviour change interventions could be constructed with a clear vision of risks and strategies for risk reduction.

This notion of homogenous risk through risky sexual practices has been carried over into less homogenous groups that have less generalised exposure to risk – for example youth, or women, or particular race and/or cultural groups. In heterogeneous populations, degrees of risk vary considerably and as a consequence, messages about risk in reality only apply to a narrow sub-section of the ‘target’ group. In many instances, a large proportion within any given heterogeneous group, may already be ‘doing the right thing’ and should be maintaining their current practices rather than changing them. For example, many adolescents are not sexually active, so interventions endorsing the existing practice of abstinence or delayed sexual debut may be far more appropriate than entreaties to ‘change their behaviour’. It follows that interventions need to take heterogeneity into account, and integrate an understanding of differentials of risk within given populations rather rather than focusing specifically on assumed risk practices and the need to ‘change’.

The concept of ‘behaviour change’ has also tended to be applied in quite a narrow way in terms of a person’s sexual lifespan. For example, the tendency to imply a change from one state of practice (inappropriate and risky behaviour) to another state of practice (appropriate and low/no risk behaviour) is something that, as a matter of course, will be consistently maintained is a weak assumption. Specifically, this assumption overlooks the complexity of sexual relationships and interactions over a lifetime that are influenced by diverse changing contexts – for example, changing partnerships, changing contexts and changing relative empowerment/disempowerment. Exposure to risk and individual capacity to moderate risk, is thus relative to these changing conditions.

Sexual activity and disabling contexts

Differences 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 inadequate health and social service infrastructure, poor communications infrastructure, differentials in language which limit effective communication, varying cultural practices, gender power differentials, racial, ethnic, and economic differentials, lack of political will, and lack of local

and national-level strategic response to addressing the HIV/AIDS epidemic. Risk to HIV infection is mediated by these contexts at inter-country and intra-country levels – 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; and 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 emphasis on volitional sex as the primary means of HIV transmission has led to other modes of infection being overlooked, often to the point of exclusion: – for example, safety of blood transfusions, sterilization of medical equipment, entrenching universal precautions amongst health workers, effectively managing medical waste (particularly in economically disadvantaged and rural settings), providing post-exposure prophylaxis (PEP) for occupationally acquired injuries, and child sexual abuse and rape. Similarly, cultural practices such as scarification and circumcision may include HIV infection risks yet are seldom brought into mainstream prevention campaigns.

One way of addressing these issues is a pragmatic focus on the range of resources necessary to reduce HIV risk exposure through sexual and other means. In South Africa, for example, risk exposure has been reduced through the provision of an efficient distribution and logistics system that has allowed for condoms to become ubiquitous, and has contributed to high rates of condom use.[10] Less has been done however, at a health service provision level, in relation to reducing direct risks through blood transfusions to patients, sharps injuries to health care workers, sterile practices in health care settings, medical waste disposal and systematic provision of post-exposure HIV prophylaxis to moderate such risks. Here 'behaviour change' relates to the need for new practices amongst health-care workers and others within the health care system. Similarly, attention also needs to be given to cultural practices that involve HIV risk, such as scarification and circumcision.

In many countries, campaigns for sexual behaviour change have failed to focus sufficiently on coercion and sexual violence. In the case of youth, research findings show sexual activity occurs, in many societies, at an age below the age of sexual consent,[11] yet this is not problematised within the context of existing legislative frameworks that foreground the illegality of under-age sex, child sexual abuse and statutory rape[12]. Instead the trend has been to facilitate preventive choice-making through service provision, for example, 'youth friendly' clinics, where children as young as twelve can freely obtain contraceptives and condoms. Such approaches may fail to address the real needs and vulnerabilities of youth. Clinic-based services are generally biomedical in orientation, and seledom extend to the provision other forms of support that may be necessary to HIV prevention – for example individual and/or family counselling or legal support or support systems necessary for addressing sexual abuse, sexual coercion, and rape (including statutory rape). Family and community contexts of AIDS further influence youth risk. Young people become more vulnerable as a result of illness and death of parents. Illness and death of parents, siblings, relatives and friends is traumatic and may have severe long-term psychological effects that are risk inducing. HIV/AIDS, at family level, compromises a capacity to generate income and introduces higher levels of family expenditure. Orphaning increases vulnerability to HIV as a result of loss of economic support, love and care and the need to ensure economic survival.

Behaviour change and communication interventions

As HIV/AIDS epidemics have advanced in various countries, considerable mobilization has taken place around the concept of behaviour-change and communication interventions. These have generally involved a focus on knowledge provision, incorporating promotion of health services (eg. Condom provision, STI treatment, VCT). Some of the earliest successes however, were not specifically intervention led in this way – for example, the response within gay communities in the United States included a range of vertically and horizontally organised communication activities and resources including combinations of interaction with health and counselling services, epidemiological tracking and disease management, political activism and peer counselling and support. Alongside these activities was the tangible reality of high mortality rates amongst gay men. As a consequence, HIV infection rates were rapidly reduced. Similarly, horizontal and vertical communications (alongside community-based service provision) have been associated with HIV reduction amongst sex workers in Thailand, and in Uganda.[13]

Large scale national level interventions have demonstrated impacts at the level of knowledge and awareness, but these have seldom devolved to massive changes in HIV infection, unless they have been accompanied by strengthened local level mobilization. This suggests that a number of factors need to be recognized – firstly, that national level communication interventions serve as an important and useful backdrop to local level activities, and are vital for general knowledge and awareness; secondly, that services have to match the needs of individuals at risk, including addressing the range of risks and vulnerabilities; thirdly, that emphasis should be placed on both vertical (including bottom-up and top-down) and horizontal processes of communication; fourthly, it should be recognized that the HIV/AIDS epidemic changes rapidly, and increasing tangibility (such as rising mortality[14]) strengthens individual and community motivation to become involved in responding to the epidemic[15] with a consequent need to invest in civl society responses.

There is also a need to refocus attention on risk factors not directly related to sexual transmission – notably within health care settings; medical waste disposal; circumcision, scarification and other cultural practices.

Community level and horizontal communication interventions can be supported through 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.[16]

Conclusions

Behaviour change theories and interventions are limited by a range of conceptual and contextual factors. These factors do not negate the value of 'choice-based' behaviour change approaches, but recognition needs to be given to the broader milieu of risk and prevention. In many instances, there has been an over-reliance and over-investment in 'behaviour change communication'. 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 include 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 cognitive behaviour change theories) 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'.[17] Elements of this framework include: moving away from people as objects of change, towards people and communities as agents of 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; and finally moving away from external technical expertise, towards integrating communities in assessing issues of concern at local level.

Acknowledgement

Funding for an earlier version of this paper was made available by UNAIDS as part of the *AIDS in Africa: Scenarios for the Future project.*

References

Ajzen I (1980) Understanding the attitudes and predicting social behaviour, New Jersey: Prentice-Hall; Fishbein M (1996) Behavioural science and public health: A necessary partnership for HIV prevention. Public Health Reports, 111 (Supl 1): 5-10

Airhihenbuwa CO, Makinwa B, Frith M and Obregon R (1999) Communication frameworks for HIV/AIDS: A new direction, Geneva: UNAIDS/Penn State. Available at www.unaids.org/publications/documents/ supporting/communications/unacomm.pdf

Bandura A (1986) Social foundations of thought and action: A social cognitive theory, NJ: Prentice Hall

Becker MH (1974) The health belief model and personal health behaviour, Health education Monographs, 2: 324-508

Catania JA, Kegeles SM, & Coates TJ (1990) Towards an understanding of risk behaviour: The AIDS Risk Reduction Model (ARRM). Health Education Monographs, 17: 53-72.

Hardeman W, Johnston M, Johnston DW, Bonettie D, Wareham NJ and Kinmonth AL (2002) Application of the theory of planned behaviour in behaviour change interventions: A systematic review, Psychology and Health 17(2):123-158

Jewkes R, Levin J, Mbananga N and Bradshaw D (2002) Rape of girls in South Africa, Lancet 359: 319–20

Kincaid L (2000) Mass media, ideation and behaviour: A longitudinal analysis of contraceptive change in the Philippines, Communication Research 27(6):723-763

Figueroa ME, Bertrand JT and Kincaid L (2001) Evaluating the impact of communication programs, North Carolina: Measure Programme

Figueroa ME, Kincaid DL, Rani M and Lewis G (2002) Communication for social change: An integrated model for measuring the process and its outcomes, New York: Rockefeller Foundation

Fishbein M (2000) The role of theory in HIV prevention, AIDS Care 12(3):273-278

Hunter M (2002) The materiality of everyday sex: Thinking beyond prostitution, African Studies 61(1): 99-120

Kelly K, Parker W and Lewis G (2001) Re-conceptualising behaviour change in the HIV/AIDS context. In Stones C (ed) Socio-political and psychological perspectives on South Africa, London: Nova Science. Available at www.cadre.org.za

Kelly K, Ntlabati P, Oyosi S, van der Riet M and Parker W (2002) Making HIV/AIDS our problem: Young people and the development challenge in South Africa, Pretoria: Save the Children. Available at www.cadre.org.za

Kelly K, Parker W and Oyosi S (2002) Pathways to action: HIV/AIDS prevention, children and young people in South Africa, Pretoria: Save the Children. Available at www.cadre.org.za

Low Beer D & Stoneburner R (2003) Communication and behaviour change in reducing HIV: Is Uganda unique? African Journal of AIDS Research 2(1)

MacNeil JM, Mberesero F and Kionzo G (1999) Is care and support associated with preventive behaviour

among people with HIV? AIDS Care 11(5):537-546
McKusick L, Coates TH, Morin SF, Pollack L and Hoff C (1990) Longitudinal predictors of reductions in unprotected anal intercourse among gay men in San Francisco: the AIDS Behavioral Research Project American Journal of Public Health, 80(8):978-983
Melkote SR, Muppidi SR & Goswami D (2000) Social and economic factors in an integrated behavioural and societal approach to communication in HIV/AIDS, Journal of Health Communication, 5:17-27
Myhre SL & Flora JA (2000) HIV/AIDS communication campaigns: Progress and prospects, Journal of Health Communication 5(supp):29-45
Panford S, Nyaney MO, Amoah SO and Aidoo NG (2001) Using folk media in HIV/AIDS prevention in rural Ghana, American Journal of Public Health 91(10)
Parker R (2001) Sexuality, culture and power in HIV/AIDS research, Annual Review of Anthropology 30: 163-179
Parker W, Dalrymple L & Durden E (2000) Communicating beyond AIDS Awareness: A manual for South Africa, Pretoria: Department of Health. Available at www.cadre.org.za
Scalway T (2002) Critical challenges in HIV communication, London: Panos
Schuftan C (2003) Poverty and inequity in the era of globalization: Our need to change and to re-conceptualise, International Journal for Equity in Health 2(1):4
Shisana et al (2002) Nelson Mandela HSRC study of HIV/AIDS: South African national HIV prevalence, behavioural risks and mass media, Cape Town, HSRC. Available at www.cadre.org.za
Slater MD (1999) Integrating application of media effects, persuasion and behaviour change theories to communication campaigns: A stages of change framework, Health Communication 11(4)335-354
Terry DJ, Gallois C, McCamish M eds (1993) Theory of Reasoned Action: Its Application to AIDS-Preventive Behaviour, NY, Pergamon Press.
UNFPA (2001) Background paper for communication for development round table, London: Panos Institute
UNFPA (2001) Communication for development: Focus on HIV/AIDS communication and evaluation, New York: UNFPA
USAID (2002) What happened in Uganda: Declining HIV prevalence, behaviour change and the national response, Washington: The Synergy Project. Available at: www.usaid.gov/pop_health/aids/Countries/ africa/ uganda_report.pdf
UNAIDS (2000) Evaluation of the 100% condom programme in Thailand, Geneva: UNAIDS
Yun H, Govender K and Mody B (2001) Factoring poverty and culture into HIV/AIDS campaigns: Empirical support for audience segmentation, Gazette 63(1)73-95

Footnotes

1 See Becker MH (1974) The health belief model and personal health behaviour, Health education Monographs, 2:324-508

2 See Ajzen I (1980) Understanding the attitudes and predicting social behaviour, New Jersey: Prentice-Hall; Fishbein M (1996) Behavioural science and public health: A necessary partnership for HIV prevention. Public Health Reports, 111 (Supl 1): 5-10 and Terry DJ, Gallois C, McCamish M eds (1993) Theory of Reasoned Action: Its Application to AIDS-Preventive Behaviour, NY, Pergamon Press.

3 Catania JA, Kegeles SM, & Coates TJ (1990) Towards an understanding of risk behaviour: The AIDS Risk Reduction Model (ARRM). Health Education Monographs, 17: 53-72.

4 Bandura A (1986) Social foundations of thought and action: A social cognitive theory, NJ: Prentice Hall

5 UNAIDS/Penn State (1999) Communications framework for HIV/AIDS: A new direction, Geneva: UNAIDS

6 Melkote SR, Muppidi SR & Goswami D (2000) Social and economic factors in an integrated behavioural and societal approach to communication in HIV/AIDS, Journal of Health Communication, 5:17-27

7 These may extend to diminished rationality as a result of alcohol or drug consumption.

8 McKusick L, Coates TH, Morin SF, Pollack L and Hoff C (1990) Longitudinal predictors of reductions in unprotected anal intercourse among gay men in San Francisco: the AIDS Behavioral Research Project American Journal of Public Health, 80(8):978-983

9 UNAIDS (2000) Evaluation of the 100% condom programme in Thailand, Geneva: UNAIDS

10 See Shisana et al (2002) Nelson Mandela HSRC study of HIV/AIDS: South African national HIV prevalence, behavioural risks and mass media, Cape Town, HSRC. Available at www.cadre.org.za

11 Typically the age of 16 in most countries.

12 Some countries might need to further address legislation in relation to sexual violence.

13 See for example, Low-Beer D and Stoneburner R (2003) Social communications and AIDS population behaviour changes in Uganda compared to other countries, mimeo.

14 See for example, Shisana et al (2002).

15 Thornton has for, example, noted an exponential growth in civil society HIV/AIDS organizations in Uganda over the past decade. Thornton R (2003), The Uganda HIV/AIDS success story examined: The role of civil society and linkage to social and economic development, presentation at The Edge Seminar Series, University of Witwatersrand. Resourcing civil society responses thus appears to be an important part of extending the potential impact of behaviour change communication interventions.

16 See for example, Low Beer D & Stoneburner R (2003) Communication and behaviour change in reducing HIV: Is Uganda unique? African Journal of AIDS Research 2(1); USAID (2002) What happened in Uganda: Declining HIV prevalence, behaviour change

and the national response, Washington: The Synergy Project; and MacNeil JM, Mberesero F and Kionzo G (1999) Is care and support associated with preventive behaviour among people with HIV? AIDS Care 11(5): 537-546

17 See UNFPA (2001) Background paper for communication for development round table, London: Panos Institute; UNFPA (2001) Communication for development: Focus on HIV/AIDS communication and evaluation, New York: UNFPA; Airhihenbuwa CO, Makinwa B, Frith M and Obregon R (1999) Communication frameworks for HIV/AIDS: A new direction, Geneva: UNAIDS/Penn State; Panford S, Nyaney MO, Amoah SO and Aidoo NG (2001) Using folk media in HIV/AIDS prevention in rural Ghana, American Journal of Public Health 91(10)