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Reconceptualising behaviour change in the HIV/AIDS context

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Abstract

In this chapter the authors look closely and critically at the concept of 'behaviour change', a concept which has been much used in programmes designed to reduce HIV transmission. It is argued that approaches to behaviour change are for the most part based on cognitive models of action and it is suggested that this is a problematic foundation for developing programmes of behaviour change, and particularly HIV/AIDS intervention programmes. Models of behaviour change often do not address the contingencies which bring intentions to fruition. A behavioural outcome which appears to derive from a cognitive intention because of its proximal association therewith, is often really a product of a complex interplay of intentionality, communality and sociality. The meaning of these three sub-systems of activity in the generation of actions is explored and their interplay is emphasised.

The philosophy of action towards which the authors are drawn in developing the argument, is influenced by 'activity theory'. The problem of trying to will actions which are essentially by-products is focussed on, largely through understanding the communal and social character of action. The critique of cognitive self-agency models of action is found to be particularly inappropriate in the field of sexual activity which for reasons outlined is not readily brought within the bounds of self-agency. In developing an understanding of the implications of the proposed reconceptualisation of the concept of behaviour change for HIV/AIDS programmes, the authors move away from a message based model of health communication. The chapter closes with an outline of some elements of intervention which flow from the reconceptualisation.

Although the paper discusses interventions which aim to improve response to HIV/AIDS the philosophy of action which is discussed is of importance in other areas too. Programmes of action or change need to be conceived in the context of the total framework out of which activity derives. Whereas social psychology has developed a social analytical model of the mind and psychological life, its models of intervention remain largely tied to the concept of self-agency. Social psychology has been concerned with understanding rather than intervention and health behaviour change models are evidence that behaviour change methodologies have not been based on a coherent or sustainable social philosophy of action. The ideas presented in this paper represent a challenge arising out of an understanding of the communal and social character of action. The ideas lead to the possibility of developing programmes of action based on an understanding of how we manage the execution of states that are essentially by-products.

Context and behaviour change

In this chapter we look closely and critically at the concept of 'behaviour change', a concept which has been much used in the field of health promotion, and is the rallying call of most HIV/AIDS prevention campaigns. 'Behaviour change' is often thought of as the primary focus of HIV/AIDS prevention work and attempts to model responses to the HIV/AIDS epidemic provide fertile ground for exploring concepts of behaviour change. It will be shown following that there is good reason to think critically about concepts of behaviour change; and particularly about the relationships between individual choice and social contexts.

The applicability of 'behaviour change' approaches to HIV/AIDS was established in the early years of the epidemic when at risk groups were relatively well defined and where risk could be attached to particular sexual relationships and risk behaviours – for example, the epidemic amongst gay men in the United States, or groups such as truckers, sex workers and injecting drug users. In the case of such target groups the main patterns of transmission were fairly easy to determine and success depended on the adoption of particular behaviours. The measurement of effectiveness could also be achieved using indicators of specific behavioural change. However, advanced HIV/AIDS epidemics are different in a number of respects.

Target groups are now much larger and more diverse. Those who are at risk and the relationships and behaviours through which the virus might be transmitted, are no longer readily isolated or targeted. It is one thing to prevent needle sharing amongst injecting drug users within defined geographic areas, and quite another to try to bring about an action which occurs in a wide variety of different contexts where efforts cannot be centred on a particular practice. We can target needle sharing as a behaviour and promote specific interventions that may make a difference. The same cannot be said of HIV risk sex, where both the target behaviour and the intervention are relatively problematic to define.

Enthusiasm for promoting behaviour change as a direct route to HIV prevention, is dampened by a large body of research that demonstrates that socio-economic and cultural factors considerably influence risk of HIV infection. In the case of resource poor environments, such factors can dramatically limit personal empowerment to make safer sex choices. These factors include poverty, limited access to health and social services, labour migration, urbanisation, unemployment, poor education, the inferior social position of women, diversities in language and culture, amongst others.

There are many instances where choices concerning sexual activity are undermined by the socio-economic and cultural conditions that frame them. For example, an under-resourced criminal justice system, amongst other factors, has contributed to escalating incidence of rape and consequent risk, and actual incidence of HIV infection. Similarly, within prisons, rape is a primary risk factor for HIV infection. Clearly, individuals cannot make proactive sexual choices about rape.

There are many other instances where individuals are disempowered around sexual choices; for example, in relation to the exchange of sex for economic or other benefits. We might also consider the case of individuals who may adopt safer sexual strategies – for example remaining faithful to their sexual partner – but still face HIV infection because their partners are unfaithful. Separation from families and partners through the economic necessity of labour migrancy, or work circumstances such as long-distance trucking, offer further examples of the relevance of understanding the influence of socio-economic conditions on HIV infection.

Concepts of HIV preventive behaviour and behaviour change need to be reconceptualised. It cannot be assumed that we choose to be sexually active in the ways that we are sexually

active, or that sexual activity is only the outcome of individual decision making processes A financially destitute young woman may find herself exchanging sex for food or other benefits largely against her own will, but driven by circumstances. It would follow that appeals to individuals such as herself to 'change behaviour' are falsely premised, in that those individuals may not be in a position to undo the circumstances that led them to the activity in the first place. This is not to say that individuals do not have capacity to change their own circumstances but only that there is a very real sense in which the capacity to change is contingent on particular kinds of pre-conditions or predispositions being fulfilled. It may be more appropriate to focus on changing an individual's socio-economic circumstances, amongst other contextual factors, than to focus on the specific sexual practices that are a product of those circumstances. Taking this into account it is important in understanding the development of responses to the HIV/AIDS epidemic, to identify and study the kinds of conditions in communities which are contingently associated with different responses to the epidemic.

Elsewhere in this book Durrheim and Lindegger have shown that gendered constructs are an embedded part of the context of HIV risk behaviour, and need to be addressed in preventing the spread of the virus. There are many other mediators that need to be addressed, and some of these will be pointed out in due course. What we are interested in exploring in this chapter is what it means for the concept of behaviour change that behaviour is mediated by factors which are apparently not determined at the level of individual agency and action. Whilst the concept of behaviour change incorporates an assumption that behaviour is volitional, social psychology has shown us that this is by no means the case, and in this contribution we attempt to understand where a social psychological concept of behaviour leaves us with respect to changing behaviour.

We commence our analysis by looking closely at the concept of 'behaviour' and related concepts; namely, 'practice', 'action', 'agency' and 'activity'. Following this we apply insights gained to an analysis of existing models and approaches in the field of health communication and behaviour change. The analysis leads to a number of pointers as to how we might more fruitfully think about behaviour change in the HIV/AIDS field.

Philosophical foundations

Before examining 'sexual behaviour' as a particular kind of human activity and the problematics associated with trying to engineer sexual behaviour through health communication campaigns, the concept of behaviour and associated concepts will be closely examined.

Action and behaviour

In the philosophy of science 'action' has traditionally been distinguished from 'behaviour' (Doyal and Harris, 1986) with behaviour being the more inclusive term. The use of the term 'action' refers to that which is intentional, or that which is deliberately achieved. Behaviours in contrast are not necessarily or specifically performed as *intentional* acts. 'Behaviour' is broadly speaking 'what humans do' and refers to all human events, whether or not they are consciously willed.

Actions may be motivated, but the performance of actions must be willed in some sense. It would be inconsistent with the concept of action thus defined, to deny one's part in bringing an action about.

Sleep, feelings, spontaneous laughter and passions are behaviours without being actions, because they cannot be deliberately intended (although we might deliberately create their preconditions). To further compare behaviour and action we might say that whereas

actions are presumed to originate in the mind of the actor, the origins of behaviour may be conceived of as contingent on concurrent and preceding events.

The line of argument that is pursued following, challenges the distinction between action and behaviour, and suggests that there is much to action that is not specifically performed as intentional act, and which is not purely mediated in the individual mind. It will be suggested that intentional accounts of action are often specious, and there is much besides intentionality that weaves its way through action. Thus speaking, action is a species of behaviour, to which is attached the assumption of self-agency.

Practice

We can further understand the limited extent to which actions may be thought of as crafted in the mind of the actor, through an appreciation of the social character of action, which leads us to the role of convention, tradition and rules in the determination of action (cf. Doyal and Harris, 1985). This direction of thinking has been developed in many different ways in structuralist and social constructionist literature. It is therefore a little surprising that it has not been taken more into account in instrumental projects, such as 'behaviour change' projects in the health field.

It is important to understand how actions are derivatives of social rules. If we wish to understand why a person performs a ritual, custom or ceremony in a particular way, or why a person acts superstitiously, or what lies behind a particular set of manners, or why a person finds it difficult to refuse sex to another, it will not usually be all that helpful to ask the person *why* they feel this way. The *reason* why is not carried in the mind of the actor, but is carried in the social model of action which the person adopts with all of its attendant meanings and determinants. It is adopted in its entirety, with intentionality not being a determinant of the form of an action, but only of the subjective meaning thereof. If we ask a man why he makes way for women at a doorway and not for men, he would provide us with some reason which is simply a *post hoc* interpretation, or justification, rather than an explanation. For the real explanation we need to interpret the social practice and to understand it as a social rule which is adopted as a matter of convention. This would need to be subjected to analysis as a rule or practice which exists prior to and outside of the immediate context of its enactment.

The term *practice* will be used to refer to this social aspect of action. Practice is what we do when we adopt conventions of behaviour and in so doing enact social roles which are not of our own logic and making. We are not self-consciously aware of our practices and to the extent that our actions are practices, the reasons behind them are not intuitively available to us. We have to interpret our practices as serving functions beyond our own immediate knowing thereof.

Activity systems

The idea of activity systems is derived from 'activity theory' (Chaiklin & Lave, 1993) , which sees human behaviours as being part of complex and "continuously collectively constructed" (Engestrom, 1993, p.66) systems of activity. Activity systems have multiple determinants and are constantly changing rather than homogenous and stable. They will always contain sediments of earlier historical modes of activity, as well as buds of future trajectories of activity.

Activity system analysis amounts to an attempt to understand behaviour, in this case HIV prevention behaviour ('the central object unit' (Engestrom, 1993), in its total field of contingencies. Analysis of activity systems involves understanding the way a system is organised and operationalised, and this usually leads to identification of contradictions

inherent in a system; for example, the contradiction between the intention or wish to change and counteractive forces. The latter need to be identified, although following Lindegger and Durrheim in this volume, gender power relations are amongst them. Following this lead it would seem useful to create an analytic framework for understanding how and where gender relations come to counteract intentions.

Within any field of activity we would expect to find the assumption of self-agency, the conventionality of practice and the contingency of behaviour. Thus speaking we find it useful to think of activity in terms of three sub-systems of mediation.

The idea of sub-systems is useful to reflect that activity is organised systematically at a number of different levels, but with the understanding that each sub-system does not mediate 'raw' activity. Rather it mediates what is already mediated at each of the other levels. In other words, the sub-systems create their outcomes interactively. This will be illustrated in due course, following descriptions of these three sub-systems of mediation, termed 'intentionality', 'communality' and 'sociality'.

1. The activity sub-system of **intentionality** involves the assumption of self-agency and *action*, the outcomes of which correspond to that which is consciously willed by its purveyors. This relates to the doctrine of voluntarism, which is the assumption that we are able to initiate behaviour and influence events in a properly originary way. Voluntarism as a philosophical doctrine is set against communalism, functionalism and structuralism which will be discussed under the categories of communality and sociality below.

2. The activity sub-system of **communality** refer to the social world of *practice* and its representation in activity. This incorporates the implicit, and shared rationality which undergirds intentionality (action). It is given form through our adoption of social practices which are not of our own making, but which nonetheless give our presence in the world a particular shape and meaning. The term 'intersubjective' is sometimes used to refer to the shared meanings which underlie our ability to communicate, or to understand each others intentions. Thus speaking, we might say that there is an intersubjective aspect in action. Activities are for the most part not novel, and draw on established and meaningful repertoires of action, which are to activity as intersubjectivity is to language. This might be likened to the idea of a 'performance' which is an activity which is pre-formed, and involves the taking of a role. The 'hermeneutics' (interpretation) of performance (Kelly, 2000b) is the interpretation of activity in terms of the traditions and conventions which underlie activity. Wenger's (1999) concept of 'communities of practice' is a well chosen expression to describe this sub-system of activity, as it asserts the communal and co-intentional nature of action through the concept of practice (although it could be considered a tautology in terms of our proposed definition because the argument is that practice is a communal concept in the first place).

3. The activity sub-system of **sociality** places both intentionality and communality within the world of contingent 'events'. Here behaviour is seen as a contingent activity beyond the level of intentionality and communality, which are both seen as being contingent on a deeper system. Sociality incorporates both structuralist and functionalist explanations of human activity. Structuralism tends to portray human activity as the product of macro-social systems, including economic and political systems. Structural accounts see activities as enstructured by a surrounding world, and as being explicable according to macro-contingencies. Functionalism tends to see human activity in terms of the functions it achieves. It usually refers to the functions that institutions of activity perform. Thus gender unequal sexual interactions are functionally related to and uphold institutionalised division of labour and associated

power relations, and *vice versa*. The outcome encounter is not only instrumental in upholding the division of labour on gendered lines, but is concurrently a function of the broader social institution in an interpersonal and intimate context.

Inter-mediation

To illustrate the inter-mediation of these sub-systems of activity the assumption that 'I am responsible for managing my own risk of HIV exposure', will be considered. This is an *intentional* statement, reflected in attempts to control risk of HIV exposure, by, for example, procurement of condoms prior to a sexual encounter. This same intention might be represented and upheld in a *communality* sub-system of activity, exemplified by the statement, 'Practices within our community are determined by each taking responsible for his/her own risk prevention'. This coincidence of activity sub-systems would insert us into an intentional-communal discursive field which operates by the rule that each of us is individually responsible, and this constitutes 'our' practice. This would arguably constitute a satisfactory system of practice were both sub-systems to be incorruptible. But this is problematic in the field of HIV prevention when the ability of one party to fulfil the social contract fails, because of the influence of the sociality sub-system on the functioning of the communality sub-system, or because of contradictions within the communality sub-system itself. On a material level the factors which maintain differing levels of access to condoms - e.g. through lack of delivery of this activity tool to poor areas – might corrupt the functioning of the intentionality-communality system.

One could pursue endless interactions between activity sub-systems and we need to do so if we are to understand the outcomes which we call behaviour. The point is that behaviour is complexly determined and this makes a mockery of the expectation that appeals to change would have their intended outcomes. However, intended outcomes do sometimes occur, usually when sub-systems are felicitously co-ordinated. This is arguably most often the case in resource rich environments where there are not as many constraints at the level of sociality and where rules at the level of communality are also more fluid. Between intentions, social rules and macro-systems of influence (corresponding to the three sub-systems systems outlined above) there is likely to be interaction, with developments in one system leading to developments in the others, and to developments in their interaction. For example, communality system rules about condoms being a 'private' and a 'hidden' aspect of social exchange may be changed by development in the sociality sub-system where condoms are introduced into the public domain in large measure. It is also possible that one system could become entrenched and not subject to being influenced by the other systems. Kelly (2000a) found that in a deep rural community, individual anxieties and intentions with respect to HIV exposure and risk reduction (*intentionality*) were quite different to the attitudes of people in a group, who displayed levels of bravado and indifference in peer group conversation (*communality*). This illustrates how sub-systems of activity may be at odds with one another, or contradictory.

This systemic way of thinking about activity seems like a promising direction to take in attempting to understand the otherwise puzzling lack of congruity between knowledge and practice in the field of HIV prevention. The model no doubt needs to be developed further but even in a skeletal form it may offer us leads in understanding problems associated with the management of risk prevention activity.

At the end of this chapter we begin to explore some of the implications of this model for HIV risk reduction programmes, based on the need to change the systems which give rise to and uphold manifest behaviour. Following the general schema of activity theory the approach relies on systematic intervention at the level of all sub-systems, and it incorporates understanding of the tensions within systems (cf. Engestrom, 1993), and the

failure of coincidence of activity sub-systems.

We now turn to consider more deeply the issue of how we *manage* activity, as a prelude to thinking about the special case of sexual behaviour, and prior to considering, and problematising existing models of sexual behaviour and behaviour change.

The management of activity

Activity, because it is contingent and mediated at the levels of intentionality, communality and sociality, is not easily manipulable and when it does respond to intervention, the changes are not sustainable unless they are supported at all levels of mediation. In this section we problematise the idea that activity can be managed like so much putty, before going on to talk about how especially problematic this is in the sexual arena.

As Elster (1985) points out, we manage ourselves and perform many acts of will *indirectly* as opposed to directly. We might go so far as to say that much of our self-management is achieved by creating contexts in which desired behaviours are brought about, not by direct intentional acts, but as by-products. For example falling asleep is a by-product of a context, and cannot be directly achieved as an act in itself. Indeed, any attempt to directly fall asleep through a direct act of will, would be self-defeating; because sleep can only be a by-product of intentional action, rather than an intentional action itself. Trying to fall asleep in the absence of sleep is more likely to prevent sleep than induce it. The same may be said of many mental states and more complex 'subjectivities' such as the attempts of an adolescent to be adult-like. Elster (1985) suggests that: "Some mental and social states appear to have the property that they can only come about as the by-product of actions undertaken for other ends. They can never, that is, be brought about intelligently or intentionally, because the very attempt to do so precludes the state one is trying to bring about." (Elster, 1985, p.43). . Does this belong to a special class of activity, or might a case be made that Elster's (1985) special examples of the problem of trying to will states that are essentially by-products, are a regular feature of all intentional action? At least a case can be made, given the *contingency* of all activity, for believing that more than a few, exceptional states are essentially by-products. We will certainly argue later that a case can be made with respect to HIV risk prevention behaviour.

If actions cannot be directly achieved because we are not in a position to manage all of the conditions upon which activity is contingent, we need a model for explaining how we *do* achieve desired outcomes, when we do. One way of taking into account the communality and sociality of action, and yet still giving place to the assumption of intentionality, is to say that we change the world to change what it affords us. Whilst we cannot engineer states that are highly contingent, we can directly engineer the conditions upon which such states are contingent. Elster (1985) discusses technologies for self-management in such cases and creates an understanding of how we bring about states which cannot be willed, by intending other actions which give rise to the desired state as a by-product. If we have a sleep problem we need to bring sleep upon ourselves, or let it happen as a consequence, for example, of taking in alcohol or reading in bed. In the example of an adolescent trying to be grown up any attempt is bound to fail, because being grown up means having certain responsibilities such as earning a living, which cannot be adopted by proxy. When one earns one's own living one becomes a grown up. An adolescent may say "I must get a job" and in seeking and finding a job will have indirectly achieved a condition of adulthood. In this case the achievement of being grown up is reached indirectly, as a by-product of another action.

We might claim self-agency in performing actions whereas agency resides elsewhere, in predisposing conditions or in the combined action of contingencies. Self-understandings of how actions bring about their consequences do not usually provide satisfactory accounts of

the predisposing conditions. For example, "I always use a condom, even with my girlfriend" may 'hide' the contingent conditions of my girlfriend insisting that I use a condom against my will, and the possibility that my 'always' use is mediated by ready and confidential access to a condom distribution point. My intentionality, which must be involved to the extent that I agree to use a condom, acquire it and actually use it, may actually represent acquiescence and contingency. The point is that it does not necessarily have an initiatory function, and this point, it will presently be seen, needs to be understood in crafting health behaviour change.

Harré (1995) suggests that inability to answer the question "Why did you do it?" is not necessarily evasive and reflects a realistic answer given that action is not properly speaking the product of individual intentional life, but is rather a product of many contingencies which are not products of my own self-agency. He refers to this as the "I don't know why I did it" (IDKWIDI) problem. Unfortunately this 'problem' is all too easily lost sight of in attempts to engineer behaviour where an unjustified power of agency is given to the actions that we knowingly perform, and to the technologies of self-management that may direct such behaviours.

The idea that we are agents of our own behaviour has come, via twentieth century psychology, to be equivalent to the idea of self-agency, or the idea that our behaviours have their origins in us. Some reasons have been presented above which suggest that behaviour has wider and more contingent contexts and that the facticity of what we do derives not from the mind of the actor, but from an multiply-determined context. It does, however, seem meaningful to have a psychology of agency, to account for the fact that we are able to direct and manage our lives, even if only indirectly and strategically. We can accommodate this if we understand action as the explicit or implicit strategising of 'affordances', which might be conceived as contexts which make particular kinds of events likely, possible and so on.

Through the idea of 'contingency' it is possible to avoid having to do away with completely the voluntarist aspect of human action. Rather the line of argument followed here is that voluntarism is 'situated'; i.e. the assumption of self-agency is situated in a context. Thus, the assumption of self-agency itself has a context, rather than being an *a priori*, and it might be argued that the over-emphasis on self-agency in some forms of contemporary psychology involves an attempt to eclipse the facticities of the communal and the social by the individual and self-agentive.

Pushed to explain the executive power of 'situated voluntarism' we would be inclined to call it a management function, and to talk of self-management where voluntarists would be inclined to talk of free will. Harré (1995) in rejecting the understanding of human agency as arising from an independently active human mind to which capacities of agency are assigned, says, "We shall turn instead to a study of the discursive practices in which our agentive powers are manifested or, to put it more candidly, in which we present ourselves as agents." (Harré, 1995, p.122).

When we choose an action we choose a course of action which has bound within it conventions about doing and appropriate doing. When I choose to speak to my spouse about our sexual relationship, I do this in certain kinds of ways which uphold the structure of our relationship; that is, within certain communicative parameters which are enstructuring features of the sexual relationship itself. When we act, our schemata of possible actions are prefigured and whilst we may strategise our actions the character of social life makes it such that even the originality of our actions arises in a situated way. In this field, following Harré (1995), we are strategists and facilitators, working with the flows of our intentionality, communality and sociality to craft activities, rather than modelling ourselves at will.

Another line of thinking which throws light on the problem of intentionality and the outcome of action (effect) is pursued in Ricoeur's 'The model of the text: Meaningful action considered as a text' (Ricoeur, 1979). According to Ricoeur the interpretation of an action in the sense of 'its meaning in the social world', and the intention which lies behind an action do not usually coincide, in the same way that the meaning of the text to a reader and the author's intention in writing do not necessarily coincide. Ricoeur is concerned to establish the interpretation of the action not as a secondary, superimposed phenomenon (palimpsest), but on the contrary as revealing dimensions of the action which are not intelligible from the actors self-account of the course of the action. This amounts to saying that our actions are 'overdetermined' and as a person acting I am not a privileged interpreter of what my actions may mean. So my intention and the meaning of my actions do not coincide. Ricoeur spells out the intricacies of the relationship between these two interpretive frameworks, and gives emphasis to the world of the Other as a site where my actions are meaningful and where they are equiprimordially real. A person's actions are as much a part of the phenomenal world of the other as they are a part of the person's own intentional world. This draws us to a problem which we face as actors crafting our own actions, of whether what we set in motion by our actions is what we mean to set in motion. We will have to ask others to know the full meaning of our actions, and the meaning of our actions will continue to unfurl, leaving us behind as 'agents'. For present purposes we may conclude that the hermeneutics (interpretation) of action that we endorse in crafting or planning an action, is only part of what an action is, and this sets limits on the degree or extent to which we should think of ourselves of agents of our own actions. In thinking about how to craft actions and trying to do the same, we need to think about what meaning the world brings to our actions, and this is not determinate from where we stand. It requires an historical and social interpretation of action, and the aspects of action which operate historically and socially will need to be taken into account if an action is to have the desired course and effect.

Having looked at the problematics of managing our behaviours, we now turn to consider sexual behaviour as a form of activity, and further problematise the idea the idea of self-willed behaviour change.

Sex as activity

As Parker in Gillies (1996) comments, sex research has always been a low priority in the social sciences, but the HIV/AIDS pandemic has raised the need for better understanding of sexual behaviour. He goes on to point out that , "As the epidemic has continued to expand, dissatisfaction with current sexual behaviour research has increased." (p. 137). In response to this dissatisfaction with largely descriptive survey type research, there has been an increasing emphasis on contextual studies of sex practice, often using qualitative methods. These have unfortunately not led very far in development of theories of response to HIV/AIDS, although they have contributed to our understanding of local contexts.

As Kelly and Kalichman (1995) point out, "insufficient attention has been paid to the many psychological, relationship, cultural, affective-arousal, and situational influences that surround and form the context for human sexual behaviour" (p.907). The result has been that HIV/AIDS prevention efforts have undoubtedly underestimated the difficulty people have in following risk reduction recommendations that they refrain from sex except in a monogamous relationship, and use a condom under other circumstances.

The narrow, instrumental perspective on sexuality that has dominated AIDS research and intervention stems, to a large extent, from the fact that AIDS research has almost never been driven by a theory of sexual behaviour (Parker, 1995). This is because the study of sexual behaviour in relation to AIDS is largely a product of the tradition that has

dominated sex research within the field of public health generally. This tradition arose at least partly as a response to the moral strictures of Victorian society and science. As a result, the "primary focus of this tradition has been an attempt to 'demystify' and, in particular, to 'naturalise' human sexual behaviour – an attempt to describe as exhaustively as possible, the 'forms of sexual expression that exist in nature'." (Parker, 1995, pp. 259-260).

This has proved to be a problematic legacy and in the absence of a more convincing theory for the explanation of human sexuality and sexual diversity, it has resulted in a purely descriptive and epidemiological approach to HIV/AIDS research (Parker, 1995). Research conducted in this fashion has tended simply to reduce sexuality to 'quantifiable' behaviour, such as the percentage of people who have engaged in a particular type of risky behaviour or who used a condom the last time they had sexual intercourse. Indicators used for monitoring and evaluation have typically not looked at the background factors which might mediate sexual behaviour and there has been little accrual of understanding of these. Rather, the focus has been on measurable descriptive indicators which are designed to understand the impact of programmes, without necessarily understanding why such outcomes might have been attained. Knowledge, attitude, beliefs and practice (KABP) studies, are for the most part of this type.

The study of sexual activity through epidemiological research has largely been divorced from its socio-cultural context (Tan, 1995). In addition, the focus has been on documenting behavioural frequencies within a relatively limited range of population groups (especially in perceived 'high risk' populations such as gay men or female prostitutes). Admittedly, there is an increasing tendency to conduct behavioural surveillance in general population groups as well (Parker, 1995). However, for obvious reasons, research conducted in this way has an extremely impoverished and naïve view of what sex is (Bolton, 1995). The hope seems to have been that theoretical insights would emerge from such descriptive data (Parker, 1995), but there remains a paucity of theory both about human sexuality and risk management activity.

 "More than ten years into a rapidly expanding epidemic transmitted above all else through sexual contact, we have still failed to develop the theoretical tools that might offer a fuller understanding of sexuality in relation to AIDS as well as other aspects of health" (Parker, 1995, p.266). According to Parker (1995), this problem stems from the naturalist perspective of sexuality, referred to above, that has dominated AIDS research. In terms of this approach, "sexual desire has been treated, in many ways, as a kind of given, and the social and cultural factors shaping sexual experience in different settings have largely been ignored, even when lip service has been paid to their potential importance" (Parker, 1995, p.260). Emphasis, instead, has been placed "largely on individual determinants of sexual behaviour and behaviour change, and the diverse, cultural, economic, and political factors potentially influencing or even shaping sexual experience have more often than not been ignored" (Parker, 1995, p.261).

The above is all the more true when one ponders how multi-faceted and contingent sexual activity is in its manifestations. Most of what we might call sexual behaviour falls well within the parameters of the IDKWIDI problem and it is not difficult to appreciate why, when one considers the largely unconscious origins of sexual impulses and preferences. If we consider the word 'passion' which is so often associated with sex, but which is by no means exclusive to sex, we see that the word has the same etymological root as the word 'passive'. A passion is that which seizes us up, takes hold of us, and as such the will is not at its origins. This is not to say that we are passive in the sexual domain. Far from it. We may be very determined in pursuing or avoiding sex, and we may pursue specific sexual interests with high levels of goal directedness. Yet the underlying sexual motivation and the directions which our sexual interests take 'come upon us', so to speak.

Psychoanalysis in the early years of this century paid much attention to understanding sexuality and gave it a central role in human psychology.

In psychoanalytic discourse the origins of sexuality are seen as originating in the more general category of desire. Questions as to the origins of desire have led psychoanalysts from discussions of the role of the instincts in human activity to consideration of the place of language and signification in the field of desire. Fortunately we do not need to traverse this terrain other than to say that whatever is at the heart of human sexuality, it is so protean that sex can show itself in the most unlikely of places. Analyses have connected sex with power, with affectional needs, with transpersonal communication, with needs for affirmation, and much else besides. The study of sexual biographies reveals a large range of reasons for people wanting to have sex, apart from wanting to feel sexually fulfilled through sexual orgasm. This poses a challenge, for if sexual activity is not a unitary phenomenon it is hard to imagine how we might develop models for behaviour change in the sexual domain. The reasons why a person would have multiple sex partners without taking HIV risk reduction measures are different in each case (Lewis, 1999). We cannot analyse the reasons for not using condoms by a simple account based on the presence or absence of knowledge, attitudes and beliefs, perception of vulnerability or any other rationalistic explanation. The intentional level of activity is really the tip of the iceberg of sexuality.

We might summarise the implications of the above by stressing the need to take into account: 1. That there is unlikely to be a single psychology or sociology of risk behaviour; 2. That the motivations behind sexual activities are unlikely to be understandable without deep (psychological) and broad (anthropological and sociological) analysis.

A critical review of models of behaviour change

There is a wide range of models for understanding how behaviour change takes place and these have been reviewed in Piotrow, Kincaid, Rimon and Rinehart (1997) and UNAIDS (1999), amongst others. Four of the more prominent models will be reviewed below:

1. Rationality based theories of risk: Single and situated

"Single rationality theories of risk assume that an individual's calculations and assessments of risk acceptability and susceptibility are rooted in a single rationality of what is healthy or harmful (Douglas, 1992). Actions to avoid risk are viewed as the 'healthy choices', calculated on the basis of rational decision-making about the probability and severity of potential harm" (Rhodes, 1995, pp.127-8). Risk avoidance is regarded as being synonymous with 'reasoned action' and thus as an example of rational, rather than irrational, behaviour. Such theories do not permit risky actions to be rational choices. For this reason, risk behaviour is viewed as the product of unreasoned or 'irrational' decision-making, even if it is based on adequate knowledge and beliefs about the actual possibility and severity of harm (Rhodes, 1995).

Situated theories of rationality posit that "Individual rationality is context and situation dependent. The costs and benefits of risk-related actions are influenced by contextual factors, which may have less to do with the calculation of scientific probabilities of risk and harm than with the calculation of the *social* costs and benefits associated with acting in certain ways" (Rhodes, 1995, p.128).

If HIV-negative individuals, for example, continue to have unprotected sex with their HIV-positive partners despite knowledge of their personal susceptibility to harm, this would be construed in terms of *single* rationality theories as being a problem of individual perception

and decision-making. In fact, this behaviour would probably be categorised as being 'irrational'. A *situated* rationality approach would conceptualise such behaviour as being the "product of *rational* decision-making based on situation specific costs and benefits associated with unsafe sex" (e.g. loss of trust or intimacy between partners is seen as being a greater cost than the risk of HIV transmission) (Rhodes, 1995, p.128).

2. The Health Belief Model

The health belief model is based on the premise that perceptions of personal threats are a necessary precursor to taking preventative action (Kalichman, 1998). It is argued that an individual will engage in health behaviour, such as safer sex, if: that individual perceives him/herself as vulnerable or susceptible to a health threat; that health threat is perceived as having serious consequences; the protective action that is available is perceived to be effective; and the benefits of that action are seen as outweighing the perceived costs of the action (Bloor, 1995). Taken together, these belief elements about threats of potential risk and outcome expectancies produce a psychological readiness for action. If the degree of readiness is above a certain threshold, and the environmental conditions allow the action, the behaviour is likely to occur or change to be initiated (Kirscht & Joseph, 1989). In this way, beliefs are assumed to serve as causal agents for behaviour and "modifications of belief systems are posited to result in behaviour changes" (Kalichman, 1998, p.40).

According to this model, subjective assessments of personal susceptibility to a health threat and perceived severity of the threat are mediated by many factors: Internal states, such as bodily sensations, and environmental happenings such as media messages or other sources of information (for example, a health worker's advice) can act as cues that trigger preventative action. Beliefs can also be mediated by sociodemographic characteristics (such as age, sex, knowledge and culture), personality dispositions, and other individual difference factors (Kalichman, 1998; Kirscht & Joseph, 1989).

These variables are hypothesised to have a multiplicative effect on one another. This means that the likelihood of a condom being used as a means to prevent HIV infection will be greater when people perceive themselves as being "susceptible to HIV infection, perceive the consequences of infection as very severe, perceive protective action as very effective, see few costs or barriers to self-protection (such as embarrassment over condom purchases), have a cue to action (for example, a reminder of protective behaviours when dating) and are enabled to protect themselves (for example, have the opportunity to get condoms)" (Valdiserri, 1989, p.51).

3. The Theory of Reasoned Action

The theory of reasoned action assumes a causal chain that links beliefs to behaviour. Behaviour is viewed as a function of the intention to perform that behaviour, which is determined by a person's attitude (beliefs and expected values) towards performing the behaviour and by perceived social norms (importance and perception of others that expect the behaviour) (Fishbein, Middlestadt & Hitchcock, 1994). More specifically, "attitudes are viewed as a function of behavioural beliefs that performing the behaviour will lead to certain outcomes and one's evaluation of those outcomes. Subjective norms are viewed as a function of normative beliefs that specific referents (that is, certain individuals or groups) think one should or should not perform the behaviour and one's motivation to comply with those referents." (Fishbein, Middlestadt & Hitchcock, 1994, p.63). Changing behaviour is therefore primarily a matter of changing this cognitive structure.

Compared to the health belief model, this theory "adds an additional dimension to behaviour in that it recognises the influence of subjective norms – albeit in a totally

cognitive, information-processing way. This theory would predict that a gay man who values the approval of his peers, believes that they endorse safer sex, and also believes that safer sex can be enjoyable, would be more likely to engage in safer sex compared to men who do not have these beliefs" (Valdiserri, 1989, p.53).

4. Social Learning Theory

Social learning (cognitive) theory is based on the "premise that behaviours, environmental influences, and beliefs are highly interactive and dependent" (Kalichman, 1998, p.42). It explains human functioning in terms of "triadic reciprocal causation" (Bandura, 1994, p.30; Kalichman, 1998, p.42). In this causal model, "(1) personal determinants in the form of cognitive, affective and biological factors, (2) behaviour, and (3) environmental influences, all operate as interacting determinants of each other" (Bandura, 1994, p. 30).

Social learning theory recognises that to achieve self-directed change, people need not only to be given reasons to alter risky behaviours, but also the means and resources to do so. In this way, it recognises that effective self-regulation of behaviour requires certain skills in self-motivation and self-guidance, as well as the ability to use these skills effectively and consistently under trying circumstances (Bandura, 1989).

Central to this theory is the notion of self-efficacy, which refers to the perception that one is, or is not, capable of performing a behaviour (Valdiserri, 1989). Persons may be engaging in high-risk behaviour due to their doubt as to whether they can protect themselves from HIV infection. For example, they may have relatively low self-efficacy because the self-protective behaviours and the situations involved may be unfamiliar to them; or they may have attempted to change their behaviour in the past and failed which served to undermine their self-efficacy (Valdiserri, 1989). An implication of this is the recognition that providing people with the skills for behaviour change will improve their self-efficacy, which in turn, will increase their persistence in maintaining the behaviour change (Valdiserri, 1989).

An AIDS-prevention campaign designed in terms of this model would consist of four major components. The first would be informational so as to increase awareness and knowledge of risks associated with specific risk-producing activities. The second component would be concerned with the development of the social and self-regulative skills to allow effective action. The third component would target the provision and enhancement of skills and self-efficacy. This is usually accomplished through guided practice and corrective feedback in applying the skills in high-risk situations. The final component targets creating social supports and reinforcements for behaviour changes (Bandura, 1994; Bandura, 1989; Kalichman, 1998).

Limitations of the psychologically based individualistic models of health behaviour change

The above psychologically based, individualistic models of health behaviour, dominated the first decade of social science research into AIDS (Bajos *et al.*, 1997). The inherent assumption in these models is that individual reason provides the impetus for human action (Nzioka, 1996). As Valdiseseri (1989) asserts, these models assume that an individual's decision whether or not to engage in preventative behaviour, is based upon the perception of the risks and of the advantages and disadvantages that the individual may derive from a protective act. These theories of health behaviour therefore view risk perception and behaviour change as the product of individual cognitive rational decision-making based on the perceived costs and benefits of risk-related action (Rhodes, 1995). These models view individuals as being transformers of information, "with their pre-

existing conceptions acting as filters through which information is interpreted and given significance" (Bajos *et al.*, 1997, p.25).

Whilst these models may seem *not* to be at odds with an understanding that sexual activity is multiply mediated, they are in different ways all cognitive models in being premised on a belief that cognition initiates behaviour. However, we do not necessarily make cognitive risk assessments when we make HIV risk reduction decisions. In the throes of an unexpected and coercive sexual encounter, or in being deceived by a partner about his/her previous sexual history, one's health beliefs have little effect in determining outcome. But even in cases where we have greater capacity to influence levels of risk avoidance, and where we successfully do so, decisions may 'come upon us'. Thinking is often an accompaniment of behaviour, and sometimes an interpretation or justification, as opposed to an initiator.

Even taking into account the broader conceptual formulation of a *situated* rationality, the psychological health behaviour models such as the Health Belief Model and its derivatives (Valdiserri, 1989) implicitly "assume that health protection is the most important thing for an individual and is therefore the motivation structuring one's behaviour" (Bajos, 1997, p.228). These models therefore presume that protective health behaviour, such as the use of a condom, is the foremost consideration for any individual. "Although other behavioural motivations, such as the fear of being alone or the influence of peer group behaviour, are explored, their role is interpreted in terms of the rationale of health protection" (Bajos *et al*, 1997, pp.25-6).

The assumption in terms of these models is therefore that the provision of information concerning the health risks associated with unprotected sex should be sufficient to induce a behavioural change. This has not proven to be the case. For example, studies have revealed that in France, one in two of those who have not changed their behaviour recognise that they are at average or above average risk for contracting HIV (Bajos *et al*, 1997). This is entirely inconsistent with the postulate underlying these methods, namely that the "perception of risk is sufficient to cause a change in behaviour" (Bajos, 1997).

The assumed health rationale is also "considered in 'all or nothing' terms (exposure or non-exposure to risk). This makes the implicit assumption that sexual behaviour entailing no risk is possible, and fails to deal with the issue of degree of risk-taking" (Bajos *et al*, 1997, p.26). In reality, individuals who change their behaviour to reduce the risk of HIV infection do not have zero risk behaviour. In fact, even for those who do not abstain from sexual intercourse, there is no such thing as zero risk. Instead people aim to reduce risk, by reducing the number of partners with whom they have sexual relations, choosing them more carefully, or using condoms. For this reason, individualistic research that divides the population into two groups (exposed to risk, not exposed to risk) in an attempt to identify determinants of changes in behaviour is inappropriate. The manner in which health behaviour models reduce the lifestyles of those affected by HIV into measurable units that fall under the generic category called risk behaviour, leads Rhodes (1995) to conclude that "contemporary epidemiological thinking about HIV-risk is devoid of understanding about 'lived experience'" (p. 126).

Conceptualising change from an activity system perspective

We have seen above that appeals to intentionality undergird the most prominent health behaviour models of change, although there is deference in models based on social cognition, to the cultural and contextual frameworks that need to be set in place before individuals are empowered to adopt preventive measures. We now return to the activity system framework sketched above and consider what it may have to contribute, in place of the health behaviour models that have been used to date.

From cognition to activity

Cognition is not 'in the head' or something that people *do*. Rather it is an integral part of contexts of activity which are interwoven into the framework of intentionality, communality and sociality. What we think and what we imagine ourselves to be capable of doing is a product of our experience, of the world we live in and the affordances it offers, of the relationships we are involved in and the strictures thereof, and of the possibilities and sense of a future that our circumstances promise.

Whilst we are arguably freer to extend and change our thoughts than we are free to change in the domains of feeling and action, it is often assumed that because change may proceed through thought, that change in thinking is a *sine qua non* of change. However, consider the possibility that when individuals change in response to appeals to change their ways of thinking, that thought is not a driving force so much as a point of access. We can consider and implement a change in thought involving self-assertion in the face of a partner refusing to use a condom, when this is a possibility within the activity system. When this is achieved the affording or enabling context remains in the background and it may seem that the activity is achieved by thought alone.

When the supportive context is not in place, the required change will simply not take place, and a strategic perspective is necessary which takes into account the need to understand and develop the activity system in both *communality* and *sociality* aspects.

Contingency: Conceptualising the context of change

When we talk of a programme of action, or of strategic action, we usually refer to an action which is brought about in a stage-wise way. Most complex willed activities are programmatic in this sense, as opposed to being the direct consequences of an intention to produce an outcome.

Even when it appears that a willed activity directly produces an intended outcome it is usually the case that foundations upon which the activity is founded have already been set in place. In such cases the intentionality of the activity is specious, in that whilst we seem to have intended the outcome, our intentionality refers to a context of predisposing circumstances which we capitalise on with relatively simple interventions, and thereby bring about intended outcomes. Programmes of action are premised on the idea that it is necessary to lay the foundations for a desired outcome which make these outcomes likely to come about, as opposed to directly intending the outcome. Ultimate outcomes are thus not best aimed at directly or immediately.

In the field of HIV prevention behaviour, it would seem important in this sense to do much more than focus on information and message based programming. The activity system needs to be developed by addressing issues such as masculine and feminine gender issues, the social value structures which predispose adolescent women to have sexual relationships with older men, the sexualisation of children and adolescents through the media, the social conditions attached to migrancy, and the social values around wearing condoms, to name a few. But it may be argued that to intervene indirectly seems too indirect a path in the face of a crisis where immediate and direct results seem imperative. For example, in an evaluation of a media campaign to promote the wearing of red ribbons, there was criticism on the part of respondents of this being a focus of an HIV/AIDS campaign (Kelly, 1999). The belief on the part of respondents was that more direct consequences should be aimed at. The point is that more direct consequences, such as the use of condoms, are unlikely to take hold, except when the ground has been prepared, and no amount of the need for the situation to be different is likely to have an effect without the preconditions of activity being established. The desperateness with which insomniacs

approach their plight and the directness through which they try to achieve their ends does not speed the process and indeed may even impede it. When the ground is prepared the stimulation of desired action requires seeding and endorsement, rather than incessant appeals, and the loudness and directness of message may have little bearing on the conditions leading to desired activity.

A promising framework for conceptualising HIV/AIDS intervention strategies within the parameters of this approach, is that developed by Parker (1997) under the banner of 'Action media: Consultation, collaboration and empowerment in health promotion'. This approach arises out of an analysis of both conventional health communication models and semiotic models. It promotes a participatory action research methodology for addressing media development for HIV/AIDS communication. Parker, Dalrymple, and Durden (1998) in 'Communicating Beyond AIDS Awareness' provide practical guidelines for this approach. The underlying premise, following the general arguments above, is that changes in the area of sexual activity need to take into account the complexity and contingency of such activity. Simple appeals to change are likely to fall on deaf ears and what campaigners should be doing is understanding the way in which communities of people are engaged in jointly crafting the outcomes which we know as sexual activity. This happens differently in different contexts, through patterns of interplay of conditions of intentionality, communality and sociality. It would seem that to the extent that there are 'types' of response to the epidemic (organised around as yet unresearched patterns of discursive interaction in these three domains), it would be fruitful to study 'communities of practice' (Wenger, 1999) as contexts of change. This does not refer to geographical communities, but to communities of 'response'. Until we have understood what mediates these patterns of response, we do not really have an understanding to base our interventions upon.

If the foregoing analysis is correct the solution to the need to get people to respond more actively to the epidemic lies in creation of contexts for change, and such contexts are likely to use both direct and indirect means. Direct means involve mobilisation of concern through engaging people in activities through which their practices develop. In this sense, painting a shelter for AIDS orphans, or working in a group on an AIDS memorial quilt, may do more to develop a culture of concern, and even HIV risk avoidance, than would appealing to people to change their attitudes or sexual practices. Kelly (2000a) found ample evidence for this in a study of youth across six contexts in South Africa. Another example is use of the red ribbon as a symbol for HIV/AIDS. This input develops a 'semiotics' of HIV which is not partisan to any particular community, and in this subtle and unobtrusive way, a foundation for empathy, 'care' and minimisation of discrimination and stigmatisation are created.

It is important to extend thinking about HIV prevention beyond the realm of sexual practice. For example, promotion of male participation in community AIDS initiatives may lead to a greater involvement of men in the activity system of sexual health promotion, and ultimately to greater predisposition to the reduction of risk in the sexual terrain. Behaviour change models which try to persuade people to use condoms or not to discriminate against people with HIV/AIDS may fail to address the need to create 'contexts' of change, and communities of practice which are conducive to the desired behavioural outcomes.

There is some research to support the above views, particularly in relation to understanding how intervention at the level of social networks may influence desired risk reduction outcomes. Social networks may directly affect the risk construction process. Fisher (1988) for example, proposes that when a person's social network has norms and values that are consistent with AIDS-preventive behaviour, the group will exert normative and informational social influence supportive of AIDS-preventative behaviour. This influences group members to engage in less risky behaviour. According to Fisher (1988) group norms

can also have the opposite effect and promote risk behaviour. In this way, a behavioural change affects chains of relationships rather than isolated individuals (Bajos, 1997). Knowledge of HIV infected persons has also been shown to influence behaviour (O'Brein, Wortman, Kessler, & Joseph, 1993). So the process of risk construction is strongly linked to social networks and the communality structure within the activity system.

In the gay epidemic in America there rapidly arose a vociferous and highly active group who rallied the community to effectively adopt new codes of practice. Here there was a distinctive sense of community and mobilisation was rapid and successful. Systems for information dissemination, condom distribution, counselling and support were quickly set in place. Existing social networks were redirected for HIV/AIDS advocacy. This contrasts sharply with South African communities where there has been little opportunity or framework for social coherence and cohesion around these issues. Initiatives aimed at community mobilisation rely on 'participation', which we now examine.

Social capital: A development approach

Given that HIV risk behaviour is often dependent upon contextual factors which are not directly within the power of the individual to change, development and empowerment models of change may be more appropriate than models based on individual thought processes. To the extent that this is the case, the kinds of indicators of progress which programme evaluators should be studying would centre on social development processes involving less direct, but strategically important goals – for example, promotion of youth cultural and sporting activities and participation in HIV/AIDS related development initiatives.

Given that individual behaviours always depend upon practical and material conditions, behaviour change models need to be supported and sustained by changes at a structural level where such conditions are determined. For example, amongst a target population of irregular condom users the problem may lie not in the minds of individuals, so much as in the lack of availability of condoms, or in the way in which condoms are dispensed. Change at this level would need to proceed through the channelling of appropriate resources in the health system, and training of condom distributors, which in turn depends upon

organisational factors far removed from the minds of the potential condom user. It also involves promoting the use of facilities or resources (for example, sexual health clinics or lifeskills education) which are far removed from the behaviour of the actual sexual encounter. Again, whilst behaviour change models aim to directly achieve desired outcomes, they fail to theorise apparently remote determinants of desired outcomes, which are the building blocks of new activity systems.

Whereas much work in the field of HIV/AIDS education has been aimed at either shifting the ideas and practices of individuals, or peer groups, as Campbell (1999) points out it is important to understand the "location of peer groups within 'communities', 'social institutions' and systems of 'culture, politics, economics, and environment'." (p.8). One runs the risk in discussing HIV/AIDS at this level, of putting too much on the menu and by making success in the struggle against HIV/AIDS contingent upon all other social struggles one may well overlook more direct routes. In studying how communities differ in their responses we need to appreciate background factors which appear to set them apart, and which are arguably best described by some index of social functioning. Campbell (1999) advocates the value of the concept of 'social capital', saying that "Concepts such as social capital, which focus on formal and informal networks at the local community level of analysis, represent an important intermediary stage between the micro-social individual and the macro-social levels." (p.9). The concept of social capital provides some indication of how a community is organised in order that it may participate in development and

change processes, one important aspect of which is the horizontal networks of formal and informal community interaction. Without community communication networks being penetrated and mobilised in the interest of promoting HIV/AIDS prevention and cure, there is likely to be a capping of progress.

Kreuter et al (cited in Campbell, 1999) suggest that health promotion interventions will be effective to the extent that the target community has organisational entities and systems that are supportive of the enterprise, and that they are activated towards this end. The term 'social capital' has been used to describe the degree of functionality a community achieves through having these features. Specific features include: high levels of involvement in civic enterprises; trust (especially in people not known to them); reciprocal help and support; civic engagement; local identity; and density of local networks. It would be of value to look more closely at the characteristics of communities which appear to be more effective in responding to HIV/AIDS, and to define this effectiveness in relation to the way that the community is structured, and its ways of functioning as a community in the context of the HIV/AIDS health crisis. If we can talk more clearly about 'health-enabling' environments, we can promote the same more directly.

We can assume with certainty that the creation of social capital in the above sense, is not simply a product of building networks out of the putty of a manipulable community structure. Networks are deeply entrenched in material relations, from the access that people have to information, to the way that they pass it to each other, to the concerns that they have and the expectations that communication is aimed at fulfilling. Change at these levels are not likely to take place only as a result of communication campaigns, but require systematic and sustained community development efforts. This contrasts with the short-term, unstrategised and uncontextualised message based interventions that have prevailed.

Fast-tracking response in a time of crisis

A legitimate retort to the above suggestions may well be: "Well and good, but what when the situation does not afford the kind of time implied by a development perspective?".

One response to this echoes a major theme which emerged from the Durban 2000 AIDS Conference, "We are in it for the long haul.". We might following this say that we cannot afford to concentrate only on short-term solutions when we ought to be laying down tracks for future responses; for example, for the crisis that the society will face in caring for its ill and orphans. But even in the area of prevention a development model which assists the next generation of youth is likely to have measurably more impactful outcomes than will once off appeals to action, which may have no more than once off responses on the part of their target audiences. So, far from being a luxury which we can't afford in terms of time, a development perspective is a necessity which the medium term demands. But this perhaps skirts around the intention of the original concern about needing to have immediate and dramatic response. There is a way of conceiving of how this may be achieved using the framework we have sketched out, and the solution runs counter to much of what is currently being promoted in high profile campaigns conducted in South Africa today.

It is one thing to understand that rules of social interaction, say in the area of gender power relations, and how these may prevent the process of negotiation that leads to low HIV risk sexual intercourse; and another thing to be able to change these rules. Lindegger and Durrheim elsewhere in this volume acknowledge the need to go beyond only deconstructing 'masculinity' and towards creation of new, post-patriarchal definitions of ways of being a man. This is an interesting statement and for reasons to be explained following, to a certain extent runs counter to a good deal of what we find in development theory and in activity theory for that matter, where a negotiation and dialogical approach is adopted.

When there are role contradictions and tensions within an activity system as there so often are (Engestrom, 1993), and when these lead to the dominance of one of the roles, a commonsense solution may be to discuss or negotiate and find a solution. In HIV prevention this model often leads to promotion of the need for negotiation of condom use. But as in the community development field, dialogue can all too easily be taken over by the power dynamics which are the cause of the conflict in the first place. Furthermore, the odds are stacked against discussion in the field of sex where the activity is not conducted in the verbal-discursive realm.

Another reason to doubt the discussion model is that the acquisition of social skills requires an interpersonal interaction, and a reciprocating environment. No amount of imploring someone to wear a condom will have the desired outcome unless there is an accommodating social environment where such skills can be applied and met with at least a moderate degree of receptivity. As Harre (1998) argues, more than one person is needed to bring a skilled activity to fruition in a social practice, and all the more so when the activity is an interpersonal skill.

An alternative approach might be based on a paradigm shift rather than on a transformation model. What drives everyday behaviour is normativity. The concept of normativity is based on the use of common frameworks for doing things and understanding things. In relation to condom use, for instance, a normative approach would translate into something like: " In cases where there may be some risk of HIV transmission in the sexual relationship one of the partners must apply a barrier method to prevent the same". The point is that we should be endorsing new normative activity, rather than the need to negotiate towards the same. Interestingly Kelly (2000a) in a study of youth response to HIV/ AIDS in six sites in South Africa, found that in the most socio-economically resourced site, where there was the highest rate of condom use, there was a relatively low prevalence of partners having discussed the risk of HIV infection. It appears that condom use in this site does not have to be discussed, but it is simply something that youth, for the most part, tend to do unquestioningly.

It seems to have been assumed in most campaigns in South Africa to date, that new norms are best obtained on a case by case basis, by encouraging sexual negotiation. As important as this concept may be for promoting gender equality and a development climate for personal characteristics such as self-responsibility, it is unlikely to have been a successful approach to promoting condom use. The obstacles to such communication are part of the problem and they cannot simply be wished away.

When I learn to be assertive I engage in a normative behaviour which is an identifiable activity system which participating parties would probably respond to in predictable ways. But in so doing I am logging into a socially extant activity system or system of roles, rules, tools and outcomes. When the same does not exist as a possibility within my world, its creation through discussion is not likely to immediately lead to its creation.

In the commitment to a normative approach to HIV prevention behaviour, we do not necessarily commit ourselves to established orthodoxies, or to what is 'already there', a potential of behaviour lying dormant, waiting to be discovered and mobilised. Rather the commitment is to the creation of new orthodoxies and new activity systems. This then is the fast-track application of activity thinking. The idea is not to transform activity systems, but to create new ones. Hence our endorsement of the Lindegger and Durrheim statement above, that we need to move towards "new, post-patriarchal definitions of ways of being a man", and the activity systems that would attend this.

There is an assumption in much health communication literature that the desired behaviours operate like Skinnerian operants. An operant is a behaviour that is spontaneously produced by an organism and which can be conditioned to reoccur, much

like an evolution selects spontaneously occurring mutations. But the desired behaviours in the field of HIV prevention generally do not occur as operants, they are not there waiting to be reinforced or conditioned. They need to be constructed or created, and often their creation is more than a matter of development of an image or 'brand' of behaviour which people may choose or not to adopt. It requires creation of a context of intentionality, the setting in place of the ingredients of normative activity (a community of practice with attendant skills and roles), as well as an supporting social framework.

Engestrom (1993) says it is the contradictions within an activity system that drive disturbances and innovations, and eventually lead to change and development in the system. When contradictions are aggravated they lead to an overall crisis of the activity system. Identification of, and focus on these contradictions, is likely to augment the process of change, like heat does metabolism. Whilst we do not disagree with this change by tackling 'impasse and tension' model, it seems to be of more immediate value to imagine that in relation to a new problem we can invoke new responses.

Whereas there is a strong tendency in South African today to mobilise existing strategies of social response and particularly models based on the liberation struggle, or women's struggle for equality, this needs to be approached cautiously. It may so happen that such struggles do offer appropriate and established activity systems which the society could relatively easily adopt. But close analysis is necessary as old activity systems used to address new problems may bring with them some of the essential ingredients of the problem.

The fast track in our view involves the creation of new responses to the problem through involvement in new kinds of activities which have built into them the roles, rules and tools necessary for the desired behaviours to occur normatively, rather than through, for example, negotiation or resistance. Earlier we spoke about the wearing of red ribbons, caring for the ill, making a quilt, assisting in the care of orphans, and male involvement in AIDS campaigns. To this we might add the association of leadership to these kinds of activities, and massive endorsement of new ways of being a man, a women, a lover, a virgin or a parent. These are paths to the fast track.

Finally bringing together developmental and fast-track perspectives to behaviour change, there is a need to actively adopt an integrated model. But integrated approaches do not fit easily into existing governance frameworks and as Marais (2000) points out intersectoral collaboration is hard won. This takes political will, which then also needs to be built into our understanding of how behaviour change occurs.

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