Contemporary Issues in Education, Health and Sports

The Way Forward

BOOK OF READING IN HONOUR OF PROF. J. A. AJALA

Edited by
B. O. Ogundele
O. A. Moronkola
J. F. Babalola

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Ibadan, Nigeria.

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Elegbe O.

Abstract

Communication is central to any health intervention programme worldwide. This paper documented various communication and learning related theories that can be applied to change at risk behaviour facilitating the spread of HIV and AIDS in Africa. It also looks at barriers to behaviour change.

Introduction

Communication theory explores "who says what, in which channels, to whom, and with what effects." It investigates how messages are created, transmitted, received, and assimilated. When applied to public health problems, the central questions that theories of communication seek to answer is, "How do communication processes contribute to, or discourage, behavioural change?" Communication theories used in programmes to support social or behavioural change focused primarily on the individual and interpersonal levels of communication. Contemporary research, however, shows that, all four levels of communication are interconnected: society and its institutions influence individuals, who, in turn, influence the larger social and institutional groups of which they are members. For example, prevailing social values undoubtedly influence individual behavior, while individual behaviour and expressions of opinion help shape social values.

Therefore, more recent communication theories describe a balance across levels of communication (De Fossard, Baptiste,

Corrales and Bosch, 1993). The goal of AIDS education is to help people and community translate information about AIDS into the adoption of the safest protective behaviour possible. Looking at the behavioural change communication strategy, communication seeks to move people beyond being "aware" to being "knowledgeable" and "empowered" to sustain such awareness and translate it to behavioural change and eventually sustain such change. Hence, this requires much more than simple information dissemination, but rather, it requires offering individuals positive and realistic alternatives, helping them to build the skills or empowering them with necessary skills for change. (UNAIDS, 2006). This paper shall examine four theories commonly used for behaviour change interventions.

1. Persuasion Theory

The origin of this theory dates back to the work of Aristotle in the 4th century B.C. According to McGuire, (1973 and 1989) the theory grew out of psychological research in the late 1930s to 1950s on attitude and behaviour change. Persuasion theory focuses on psychological characteristics that affect a person's perception of and response to messages, including:

- Knowledge and skills;
- Attitudes towards behavioural and social issues;
- Predispositions or preferences;
- Beliefs and concerns about the behaviour and its consequences; and
- Attitudes towards the source of the message.

Many of these are related to demographic characteristics, such as; age, gender, ethnic group, income, and level of education. An understanding of them can help the design team to determine the type of messages and the type of story that are most likely to prove effective with their chosen audience. Persuasion theory also draws attention to the importance of message factors and source factors in influencing an audience

(Petty and Cacioppo, 1981). Message factors are the characteristics of a message that make it appropriate and effective for a particular audience: how long or complex it should be, what language or vocabulary is best, in what order the messages should be presented, whether one side or both sides of an issue should be presented, how much repetition is needed to get the message across, and whether the message should use fear, humour, or logic to make its point. Different audiences will have different preferences for message style. Source factors are the characteristics of a message's source that make it interesting, relevant, and persuasive for a particular audience member.

Persuasion theory can help the communicator make accurate determinations about the needs of the audience. It describes how audience members move toward acceptance and advocacy of a new behaviour at an appropriate speed and in a natural manner. The communicator can then include information (based on formative research) about the chosen audience's current attitudes toward the desired behaviour change and how to move them forward. For example, research may indicate that, while the audience is very much aware of and knowledgeable about family planning, many people do not consider adopting a contraceptive method because of traditional beliefs favouring large families. Based on this information, the communicator can determine that, the focus of the message, from the outset, should be on motivating the audience to a change of attitude. (De Fossard, Baptiste, Corrales and Bosch, 1993).

2. Theory of Reasoned Action

The Theory of Reasoned Action, by Ajzen and Fishbein (1980), is based on the assumptions that, human beings are usually quite rational and make systematic use of the information available to them. People consider the implications of their actions in a given context at a given time before they decide to

engage or not engage in a given behaviour. The theory is conceptually similar to the health belief model but adds the construct of behavioural intention as a determinant of health behaviour. Both theories focus on perceived susceptibility, perceived benefits and constraints to changing behaviour. The Theory of Reasoned Action specifically focuses on the role of personal intention in determining whether behaviour will occur. A person's intention is a function of two basic determinants:

1. Attitude (towards the behaviour), and
2. Social influence.

Normative beliefs play a central role in the theory, and generally focus on what an individual believes other people, especially influential people, would expect him/her to do. For example, for a person to start using condoms, his/her attitude might be: "having sex with condoms is just as good as having sex without condoms", and the subjective norms (or the normative belief) could be: "most of my peers are using condoms; they would expect me to do so as well." Interventions using this theory to guide activities focus on attitudes about risk-reduction, response to social norms, and intentions to change risky behaviors. Later, incarnations of the theory also explicitly take into account whether a person has control over a behaviour. This theory was adopted as an AIDS Risk Reduction Model for various HIV and AIDS interventions. The AIDS Risk Reduction Model (ARRM) posits that, change is a process, and that, individuals move from one step to the next as a result of a given stimulus. This involves: risk assessment, commitment to change, enactment or help-seeking (Fishbein M. 1990).

3. Social Learning Theory

This theory draws attention to the social rather than the individual aspects of communication and behavior, although

it is still largely concerned with how individual people make sense of the social environment and decide what to do. Social learning or Social Cognitive theory (Bandura, 1986) says that, people learn by:

- Observing what other people do;
- Considering the consequences experienced by those people;
- Rehearsing what might happen in their own lives if they followed the other peoples' behaviour;
- Taking action by trying the behaviour themselves;
- Comparing their experiences with what happened to the other people;
- Confirming their belief in the new behaviour.

Social Cognitive Theory (SCT) which evolves from research on Social Learning Theory describes a dynamic, ongoing process in which personal factors, environmental factors, and human behavior exert influence upon each other.

According to Social Cognitive Theory, three main factors affect the likelihood that a person will change a health behaviour: (1) self-efficacy, (2) goals, and (3) outcome expectancies. If individuals have a sense of personal agency or self-efficacy, they can change behaviors even when faced with obstacles. If they do not feel that they can exercise control over their health behaviour, they are not motivated to act, or to persist through challenges. As a person adopts new behaviours, this causes changes in both the environment and in the person. Behaviour is not simply a product of the environment and the person, and environment is not simply a product of the person and behaviour.

Hence, in support of Social Learning Theory (SLT), the Social Cognitive Theory asserts that, people learn not only from their own experiences, but by observing the actions of others and the benefits of those actions. Bandura updated SLT, adding the construct of self-efficacy and renaming it SCT. (Though SCT is the dominant version in current practice, it is still sometimes called SLT.) SCT integrates concepts and

processes from cognitive, behaviourist, and emotional models of behaviour change, so it includes many constructs. It has been used successfully as the underlying theory for behaviour change in areas ranging from dietary change to pain control (Baranowski et al,1993). Hence, the theory in relation to HIV prevention asserts that, providing information alone is not sufficient to change behaviour, rather, sustained behaviour change requires skills to engage in the behaviour and the ability to use these skills consistently and under difficult circumstances. It posits that, behaviour change requires four components:

1. An informational component to increase awareness and knowledge of health risk and to convince people that they can change their behaviour (i.e. educating people about HIV/ADS and showing them they can change)
2. A component to develop the self-control and risk-reduction skills needed to prevent the behaviour (showing people what their risks are and how they can change them)
3. A component to increase an individual's self-efficacy in implementing these behaviours (specific efforts to show people how to use condoms, how to negotiate safer sex, how to say "no").
4. A component to build social support for the individual as she or he engages in the new behaviour (support groups).

4. Diffusion Theory

Diffusion of Innovation's Theory addresses how ideas, products, and social practices that are perceived as "new" spread throughout a society or from one society to another. According to Rogers, (1995) diffusion of innovations is the process by which an innovation is communicated through certain channels over time among the members of a social system. Diffusion Theory has been used to study the adoption of a wide range of health behaviours and programmes, including condom use,

smoking cessation, and use of new tests and technologies by health practitioners.

Diffusion theory (Rogers, 1995) places the strongest emphasis on a person's social environment out of the four communication theories discussed. It was developed to explain how a new idea or behaviour spreads through a social system (usually a group or community) over time. Mass media can introduce information to a community, but it is social networks and interpersonal communication that spread information further within the community, help people evaluate it, and determine whether people act on it. Research shows that, information and influence spread through a series of interpersonal interactions among people who share similar characteristics (such as social status or experiences) or who are frequently in contact (such as friends, family members, and work mates).

Diffusion of innovations that prevent disease and promote health require a multilevel change process that usually takes place in diverse settings, through different strategies. At the individual level, adopting a health behaviour innovation usually involves lifestyle change. At the organizational level, it may entail starting programmes, changing regulations, or altering personnel roles. At a community level, diffusion can include using the media, advancing policies, or starting initiatives. According to Rogers, a number of factors determine how quickly, and to what extent, an innovation will be adopted and diffused. By considering the benefits of innovation, practitioners can position it effectively, thereby maximizing its appeal. According to diffusion theory, these social networks help people judge a new behaviour against the following criteria:

1. Compatibility—Is the new behaviour compatible with current behaviours, beliefs, and values?
2. Complexity—How difficult is it to perform?

3. Trialability—Can it be tried without too much risk before making a decision?
4. Observability—Are there opportunities to see what happens to others who adopt this behaviour?
5. Comparative advantage—Does the new behaviour offer any advantage over current behaviour?

Effective diffusion requires practitioners to use both informal and formal communications channels and a spectrum of strategies for different settings. Disseminating an innovation in a variety of ways increases the likelihood that it will be adopted and *institutionalized*.

HIV and AIDS interventions using this theory take into account four elements: the innovation, the communication channel, the social system, and time. If enough key leaders adopt the desired behaviour—such as remaining faithful to a spouse—a new norm can be established in the community and can thus be disseminated widely through the social networks and thereby have a better chance of being adopted by the community.

Steps to Behaviour Change

Research has shown that behaviour change rarely happens immediately upon exposure to a message. Usually, people must pass through a series of steps, quickly for some people, more slowly for others, that leads to the desired behaviour change. The most effective messages begin with an understanding of where the audience is located on the steps to behaviour change. They then employ the most appropriate form of communication to move the audience on to the next steps. Five steps to behaviour change appear in some form in all commonly used models of communication effects: knowledge, approval, intention, practice, and advocacy (Family Health International, 2001).

1. **Knowledge:**This refers to being aware of and knowing how to perform behaviours promoted by a social development

project. For example, the knowledge needed to put on a condom correctly is fairly simple, but the knowledge required to negotiate condom use with a sexual partner is far more complicated.

2. **Approval:** This refers to favourable attitudes towards the behaviour being promoted. People who approve of a behaviour talk about it with others and tend to think that, other people approve of it as well. Approval can occur at several levels: Listeners may approve of a new behaviour for people in general, for friends and family, and/or for themselves personally. Some listeners may approve of the behaviour for others, but not for themselves. Behaviour change strategies should present role-model characters who depict public approval of a behaviour, express positive emotional reactions toward a behaviour, or show how personal attitudes respond to public approval.

3. **Intention to Act:** The more strongly people approve of a behaviour, the more likely it is that they will form an intention to act. Intention is the stage just prior to action; recognizing that the behaviour fills a personal need, the person has decided to try it, but not yet changed his or her behaviour. Intention does not mean that the behaviour will occur always or immediately. There are degrees of intention (definitely, probably, maybe), and, intention can be conditional ("I won't take her today, but if her fever doesn't go down by tomorrow, I will definitely take her to the doctor then"). The design team must identify the personal needs of the listeners that are likely to motivate their intentions to act and the conditions that make such intentions more likely.

4. **Practice:** It is the actual performance of a behaviour. People with a high degree of intention are the most likely actually to perform a behaviour. Practice need not imply confirmed or consistent behaviour, however. Some people try

a behaviour and then reject it. Others start, stop, and start again. People who perform a behaviour intermittently may have experienced unexpected or unpleasant consequences or may require support or reinforcement for their behaviour. There should be recognition, also, of the likely pattern of adoption. Do members of the audience generally stick with a behaviour once they try it, or do they tend to start and stop a lot before practicing a new behaviour consistently?

5. **Advocacy:** the final step to behaviour change, is a vital part of the process, because, it represents a level of commitment that goes beyond the mere practice of a new behaviour. Advocates tell other people about the behaviour they have adopted and encourage them to adopt it too. At the same time, talking to others can strengthen the advocate's own resolve to continue with a difficult behaviour. Advocacy also allows people to express community support for a social change of programmes.

Such public expressions of support for a behaviour can move people through the steps to behaviour change, making them aware of a behaviour (knowledge), increasing their perception of public support for a behaviour (approval), motivating them to make a decision to act (intention), and encouraging them to implement that decision (practice).

Barriers to Behaviour change and HIV/AIDS Intervention

HIV/AIDS was initially seen as a health problem rather than as a development problem. However, there is now a general agreement that, the relationship between HIV and economic development is like the relationship between health and wealth. The spread of HIV has a trenchant effect on the economy, while the economy in turn affects the level and spread of HIV. There is now a growing body of studies showing the working of this complex relationship mostly in high sero-

prevalence countries in Africa (Botchwey, 2000). The effect of HIV/AIDS on the economy of most countries has led to various barriers to behavior change interventions among the people(Webb, D. 1997).

1. Economic Barriers

Poverty contributes to HIV transmission throughout Africa and serves as a barrier to sexual behavioural change (Parker, Easton and Klein, 2000 in UNAIDS, 2006). Economic pressure forces many women and young girls into sex work. Some impoverished parents enlist their adolescent daughters into sex work to earn money for the family. In many African countries, sex work is episodic and casual, and therefore, difficult for public health officials to monitor. Women who periodically receive money for sex do not necessarily identify themselves as commercial sex workers (CSWs), nor do their casual partners necessarily categorize them as such. Despite the potentials for behavioural change among people who engage in commercial sex work, the poverty level in Africa often necessitates this source of income.

Initiatives for behavioural change are also hindered by the economic pressures that force many people to travel looking for work. Throughout Sub-Saharan Africa, there is a long standing tradition of male migration to cities, mines, and other industry sites in search of work. Migrant workers typically stay in dormitories and endure harsh working conditions while earning money to support their families (Campbell and Williams, 1999 in UNAIDS, 2006). Male migrant workers, separated from their wives may turn to relationships with CSWs or "second wives". Wives left at home may also have extramarital relationships, sometimes to earn money. When male migrants return home, they may shun the use of condoms-which will suggest unfaithfulness-and thus increase the risk of spreading HIV and other infections to their partners. Migration and family separation have also occurred in some areas of Africa because

of famine and political conflicts. Migration is a major contributing factor to the spread of HIV infection across the socioeconomic spectrum and to rural areas in many African countries(Cohen, D. 1999)

2. Political Factors

Political factors play a significant role in facilitating or hindering behavioural change in individuals and communities. Perhaps the single most important factor related to national success in those developing countries where HIV incidence has declined, has been strong commitment to HIV prevention from the highest political levels (Ainsworth and Over, 1994). In some African countries, weak or unstable government, armed conflict, or health crises, such as famine and malaria or cholera outbreaks temporarily force HIV prevention to the bottom of the political agenda. In a resource-poor environment, funds devoted to HIV prevention inevitably mean fewer resources allocated for others, more popular programmes. Additionally, widespread misinformation, denial and the stigma of AIDS contribute to ambivalence about developing an HIV prevention policy.

In many countries, specific policies and laws such as those barring the distribution of needles and injection to drug users, are also barriers to behavioural change. Broad policy changes that are more difficult to accomplish include alleviating poverty, increasing access to education, raising hope for the future, and motivating health-seeking behaviour. However, there are signs of increasing awareness and political motivation at high level in many African countries, such as the completion of a 5-year national strategic control plan in Malawi (National AIDS Control Programme, 1999), the hosting of the 13th International AIDS Conference in South Africa and the National Agency for the Control of AIDS (NACA) in Nigeria.

3. Social and Cultural Barriers

HIV and AIDS have long been associated with stigma and denial worldwide. (Goldin, 1994 in UNAIDS, 2006). In Africa, these negative attitudes continue to be highly resistant to change except in very few countries, such as Uganda. Inaccurate information, including widespread rumour about the transmission of HIV, contribute to unfounded fears of casual, nonsexual contact with people living with HIV or AIDS, and further reinforces the stigma. Failure to recognize personal risk, fear of open discussion of high-risk behaviour or prevention methods, reluctance to learn or disclose HIV status, and familial concealment of HIV status and AIDS related deaths are examples of behaviours that are perpetuated by stigma and denial.

In most African countries, open discussion of sexuality is also discouraged, especially between adults and youth, except during traditional rites of passage conducted by non-parental adults. In some areas, especially in towns, traditional initiation rites have nearly disappeared or have been supplanted by church-based ceremonies. Where the initiation ceremonies do continue, they rarely address HIV prevention. Some parents fear that, these ceremonies may actually promote early sexual activity among youths (Kamlongera, 1997 in UNAIDS, 2006). It is often difficult for parents to educate their children about the risk of HIV transmission because discussion of sex is a taboo. Moreover, when parents reject sex education in schools, HIV prevention education is either minimal or unavailable to the vulnerable young population. Likewise, cultural taboos discourage partners from discussing sex and high-risk behaviours openly with one another.

4. Organisational Barriers

In many African countries, the ability to establish and maintain nationwide programmes for behavioural change is limited, in part, due to the many economic, political and

sociocultural factors previously mentioned. Collaborative network of both governmental and nongovernmental organizations must be strengthened and expanded, and larger groups of personnel need opportunities for training and professional growth (Ainsworth and Over, 1994).

At present, competition over scarce resources, including educating personnel, remains a barrier to collaboration at every level. Additionally, although many behavioural change interventions have been evaluated, their comparative efficacy and the cost-effectiveness of their components are not well understood. Strategies for the expansion and cost-effective adaptation of existing interventions to new settings also require further study (UNAIDS, 2006). The important role of designing various communication strategies to empower people to reduce high-risk behaviour and encourage a healthy behaviour change among them becomes highly expedient in view of increased number of people living with HIV.

Conclusion

As HIV continues to spread in many countries, prevention efforts are increasing to promote the changes in behaviour mentioned above. Every country needs information to guide the design of appropriate prevention programmes and to monitor whether these efforts are successful. Hence, the behaviour that puts individuals at risk of HIV infection and identifying ways to change these behaviour, are important strategies to help halt the spread of HIV in Africa and other developing countries. A major concern however is that, a limited number of such interventions exist on a scale capable of curtaiing the epidemic. The "ABCs" (Abstinence, Being Faithful and Condom use) are widely recognized as key behaviours that reduce the risks of HIV transmission. "Abstinence" includes the delay of first sexual experience for adolescents. "Being faithful", which can apply to a monogamous or polygamous union. "Condom" use for maximum effectiveness, male or

female condoms must be used correctly and consistently. Experts generally agree that, these three behaviours are effective ways to slow the spread of HIV.

However, condom promotion continues to be debated in many African countries(Population Report 2001). Many religious leaders, as well as some politicians and citizens, believe that abstinence and faithfulness are the only morally acceptable solutions. Some also argue that, promoting condom use encourages individuals to engage in high-risk sexual behaviour or that using condoms does not effectively protect against HIV(Ratzon, S.C. 2000). In contrast, others believe that promotion of condom use is an important component of behavioural change programmes. However, successful HIV prevention depends on changing risk behaviors. This includes increasing condom use and reducing the number of sex partners among sexually active people, reducing needle-sharing behaviour among injecting drug users, and delaying the onset of first intercourse among young people; to name only a few.(Family Health International, 2000).

The evidence on behaviour change HIV prevention cannot be overstated, but it also must not be overlooked. The central problem in HIV prevention is not lack of evidence but failure to bring to scale programming that addresses the major drivers of HIV infection in specific national settings. (UNAIDS and WHO. 2007) Studies have shown that, to change behaviour requires individual effort in relation to individual believe within a social environment. Hence, behaviour change initiatives on HIV and AIDS should be designed to target people at their various levels of cultural, social, educational economic, political and organizational development.

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