

## Chapter 21

### **Obstacles and challenges to sexual behaviour change**

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#### **Abstract**

**This chapter discusses three of the general issues that have emerged from the continuing discussion on AIDS in sub-Saharan Africa and Asia: whether African and Asian countries can share experiences in their responses to the epidemic; the observed obstacles or resistance to sexual behaviour change; and the concept of community as used in intervention programs. The aim is to explore these issues in the context of the varying patterns of spread and responses to the epidemic.**

#### **Responses to HIV and AIDS: can Asia and Africa share experiences?<sup>1</sup>**

The outbreak of AIDS has challenged some of the perceptions about our own societies. Until recently, there was an idealized picture of African society with built-in social morality and interfamilial as well as intrafamilial support. Similarly, in India, the outbreak of the epidemic has shattered the belief that 'India's deep-seated family traditions, social conservatism and spirituality would protect it from the ravages of the global AIDS epidemic' (McDonald 1992:28). The pattern of infection and the reactions to the epidemic have reinforced the universality of human behaviour.

Responses to AIDS in Africa and Asia seem to follow a similar pattern. There has been the initial denial followed by the blaming of foreigners. The next stage, which now seems to appear in the literature and to be reflected in the types of intervention, is the identification and the targeting of 'risk groups': sex workers, long-distance truck drivers, intravenous drug users (see Marck this volume Chapter 8; Singh and Malaviya 1994; Podhisita *et al.* 1996; Mukodzani, Mupembo and Marck 1999; Orubuloye and Oguntimehin 1999). The third stage is the recognition of cross-over of the virus from the risk groups to the general population. In the final stage, the epidemic becomes a major public health problem as is happening in parts of Eastern and Southern Africa. While some countries in sub-Saharan Africa have gone through the full cycle with disastrous consequences, other areas are in the second or third phases (see Figure 1).

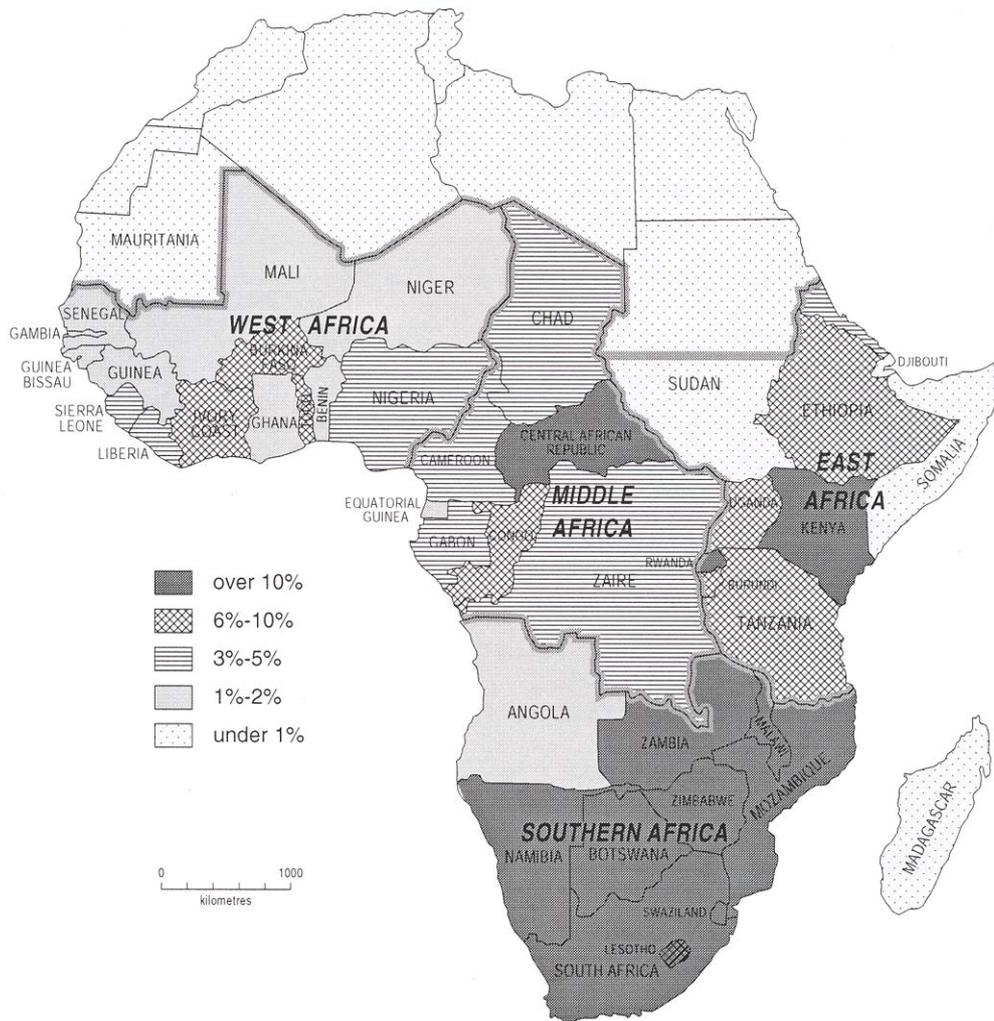
Asian countries are in a position to learn from sub-Saharan Africa. One thing to be learnt is that concentrating on risk groups diverts attention from aspects such as the infection of partners by clients of people in the risk category. Secondly, what is important is not so much the number of sexual partners, but the number of risky exposures in any sexual encounter. Although one of the initial responses to the epidemic in Southeast Asia was to identify and target risk groups, some countries have established public education campaigns to avert some of the extreme negative effects of the epidemic. For instance, the high mortality in

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<sup>1</sup> See Caldwell and Caldwell (1988) for a similar discussion on the applicability of the Asian model of family planning delivery to Africa.

Figure 1

ADULT HIV/AIDS, June 1998



the sexually active age groups in some parts of sub-Saharan Africa made the Indian Government speed up its anti-AIDS program in the early 1990s (McDonald 1992).

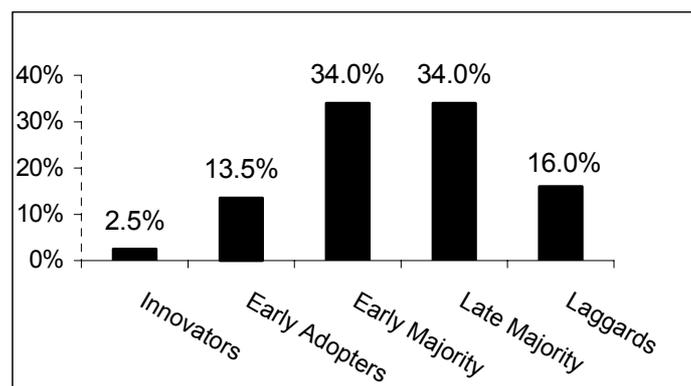
The Asian countries, on the other hand, have demonstrated that it is possible to achieve sexual behaviour change among some target populations within a very short time (see, for instance, Jenkins, this volume Chapter 18; Im-em 1998). The rapid decline in the incidence of STDs and HIV among military recruits in Thailand shows that it pays to confront the epidemic in a forthright manner. For African countries now in their second phase of the epidemic, the 'Asian' approach to the epidemic can help to avoid the disasters that have occurred in Southern and Eastern Africa.

### Diffusion of innovation

At the initial stages of the epidemic, governments and individuals provided information and education on HIV/AIDS in the hope that individuals would modify their behaviour in the light of the available information (see Caldwell and Caldwell 1987). The operative philosophy was that people should not die out of ignorance. Inherent in the approach was the acceptance of the diffusion model as originally postulated by Hagerstrand (1968).

According to the model, a person or a small group of people, innovators, who, in theory account for about 2.5 per cent of the population, always introduce new ideas, or ways of life. With time, the innovation spreads through the population, first among the most receptive group, early adopters (13.5%), followed by the early majority. When an innovation diffuses into the early majority, it brings the total adopters to 50 per cent of the population. The late majority, the next category, accounts for another 34 per cent of the total. If that group also adopts the innovation, bringing the total to 84 per cent, the spread is considered to have reached the theoretical saturation point (Figure 2). The last group, accounting for 16 per cent, comprises those individuals who resist change in the face of available evidence; they are referred to as 'laggards.' Thus, there is a group that is always expected to resist change.

Figure 2



The rate of diffusion of any innovation depends on factors such as the item to be diffused, the path for the change, the origin, destination, the environment and the time period. The item to be diffused in this case is the information about HIV/AIDS geared towards behavioural change. The paths are the channels for disseminating information for change such as the mass media, and group and person-to-person contacts (de Souza 1993). Originating the information or the innovation are the various agencies, individuals and groups, both governmental and non-governmental, involved in the dissemination of information for behavioural change. These sources or agents should be seen to be credible. The destination is the target group or the final consumer of the innovation. People may or may not adopt an innovation for a variety of reasons including whether the path chosen is culturally sensitive and whether the disseminators seem credible.

The environment as defined in the diffusion-of-innovation model includes the physical, political and socio-economic environments. The physical environment, for instance, can impede the pace of the diffusion of information or innovation. Similarly, the socio-economic and the political situations could either impede or enhance the adoption of innovative behaviour. Thus, individuals may be willing to change their behaviour but may be confronted by barriers that make this difficult. Some of these barriers may be personal, socio-cultural, economic and institutional factors. As pointed out by Jenkins (this volume Chapter 18), institutional factors as represented by religion, the law enforcement agencies and the social structures are some of the barriers that obstruct behavioural change among sex workers in Bangladesh.

Time is one major element in the diffusion process. The adoption of innovation could be over a short or a long period depending upon the other five features of the diffusion process: item, path, origin, destination and the environment. As experience with the adoption of modern contraceptive methods has shown, behavioural change involving intimate aspects of human life takes time. For instance, over three decades after the introduction of modern contraceptive methods in Ghana, only 10 per cent of women in the reproductive age group, and their partners, are using these methods (Ghana 1994). Programs to achieve sexual behaviour change have been in existence for an even shorter period. It might be thought that behavioural change associated with survival would occur faster than that associated with fertility, but it appears that the dynamics are the same, and the fact that sexual behaviour has not changed rapidly enough in some parts of sub-Saharan Africa could be a function of time, the socio-cultural and political environment, the agents for the change and the nature of the messages.

Resistance to change implies that individuals or groups are aware of the existing situation that needs to be changed, accept that there should be a change, have the necessary capacity and skills but are unwilling to effect change. However, in the area of sexual behaviour change relating to HIV/AIDS, barriers to change involve cultural dimensions, and political and economical factors. Gender and ethnic differences in HIV/AIDS infection, for instance, reflect socio-cultural aspects as well as the economics and politics of development and survival (Auerbach *et al.* 1994). Secondly, a number of the IEC strategies aimed at behavioural change in sub-Saharan Africa have been impersonal, modelled on some of the successful experiences from more developed countries which have a large reading public. People in sub-Saharan Africa are more listeners than readers: the majority, especially the females, are illiterate. Thirdly, political commitment is important for behavioural change, as demonstrated in Uganda, but not in a number of African countries, some of which are still at the denial stage. These are some of the issues that need to guide interventions for generating behavioural change. Perhaps we should discuss still-existing barriers to change rather than resistance to change.

## Concept of community

Although the public health response to the AIDS epidemic has been to target 'communities' for information and services, there has not been any attempt to define a 'community', particularly in view of the various types of community described in the literature. Two broad categories of community can be identified: the vertical community and the horizontal community (James 1994). The former refers to the groups with a common interest that they defend, such as the 'homosexual community', and religious and ethnic-based groups. The horizontal community is the group of people within a geographically defined area. Their binding factor is that they occupy a definable space in relation to other areas. They may or may not have common interests beyond those associated with proximity.

Historically, horizontal communities have been the focus of public health programs since outbreaks of epidemics have occurred in geographic areas. Epidemics such as cholera, influenza and measles have always been identified among some people in defined areas (Cliff *et al.* 1986). However, the HIV/AIDS epidemic has been different, with outbreaks observed among both vertical and horizontal communities.

Available evidence suggests that vertical communities, with their shared identity and commitment, have been able to develop programs that have changed behaviour. Some of the homosexual communities in Australia and the United States have been able to achieve behavioural changes which stopped the spread of HIV among their members (see Kippax 1999; Dowsett, this volume Chapter 19). In sub-Saharan Africa, the concept of 'community' as used for interventions is less clear. A number of the intervention programs described as 'community-based' have targeted high-risk groups such as sex workers, their clients and long-distance truck drivers. In most cases, the individuals do not have the shared identity that characterizes vertical communities, and the programs as designed do not involve the horizontal community within which the people live. Hence programs have been sporadic and not diffused into the general population. The next generation of programs in sub-Saharan Africa should recognize the differences in types of communities and the dynamics involved.

## Conclusion

AIDS will continue to challenge people's ways of life, the philosophies underlying approaches to public health delivery and the intervention strategies targeting sexual behaviour. The varying experiences and the responses from different parts of the world provide us with paradigms that could help to generate behavioural change. Both the successful experiences and the unsuccessful ones should be able to inform some of the strategies that could be adopted. For sub-Saharan Africa, the socio-cultural, political and economic barriers need to be removed before 'resistances' to change can be identified.

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