allocation, forward planning and changes in policy to ensure that HIV/AIDS patients receive optimal care in Malawi. Poverty reduction efforts, which are obviously hampered by HIV/AIDS, must be enhanced in order to prevent the spread of the virus.

Conclusion

HIV/AIDS has probably surpassed all other health conditions that have affected Malawi and the sub Saharan Africa region. Prevention and control efforts must be multi-pronged. The availability of HAART to a major section of the affected communities will add to the armamentarium of prevention efforts[24].

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References

1. Centers for Disease Control. Pneumocystis pneumonia-Los Angeles. MMWR Morb WklY Rep 1981, 30:250-2
2. Delay P. AIDS in Malawi. Malawi Med J 1990, 6(1):2-4
3. Ratsma E, Manjolo EP, Simon J. Voices from the Epidemic. Malawi Med J 1992, 8(2):60-64
4. Clark S. HIV/AIDS in Africa. The Lancet 2002, 359:1960
5. Buve A, Bishikwabo-Nsarhaza K, Mutangadura G. The spread and effect of HIV-1 infection in sub-Saharan Africa. The Lancet 2002, 359:2011-17
6. Ministry of Health and Population. Malawi National HIV/AIDS Strategy Framework 2000-2004. The Strategy Planning Unit, National AIDS Control Programme, Ministry of Health and Population, Lilongwe, Malawi
7. Republic of Malawi. Report of the Budget and Finance Committee to the National Assembly Pre-Budget Report. National Assembly, June 2001
8. Kryut ML, Kryut ND, Boeree MJ, Harries AD, Salaniponi FM, Van Noord PA. True status of smear-positive pulmonary tuberculosis defaulters in Malawi. Bulletin of the World Health Organisation 1999, 77(5): 386-391
9. Maher D. Smear-positive pulmonary TB: a good management is good public health. Africa Health 1999, 21:6-9
10. Vernazza PL, Kashuba ADM, Cohen MS. Biological correlates of sexual transmission of HIV: practical consequences and potential targets for public health. Reviews in Medical Microbiology 2001, 12(3):131-42
11. Bozon M. Reaching adult sexuality: first intercourse and its implications. In Bozon M & Leridon H (Eds). Sexuality and the Social Sciences, Aldershop, Dartmouth, England, pp143-173,
12. Lawson A. Adultery: An analysis of love and betrayal. Basic Books, New York, 1988
13. Treas J, Grisen D. Sexual infidelity among married and cohabiting Americans. Journal of Marriage and the Family 2000, 16:48-60
14. Smith TW. Adult sexual behaviour in 1989: Number of partners, frequency of inter course and risk of AIDS. Family Planning Perspectives 1991, 23:102-07
15. Anonymous. Sexually transmitted diseases. Medical Quarterly 1986, 3(2):29-30
16. Lule GS, Moses A, Bandawe C. Characteristics and sexual behaviour of individuals attending the Sexually Transmitted Diseases Clinic at Queen Elizabeth Central Hospital, Blantyre, Malawi. Central Afr J Med 1997, 43(1):6-11
17. Odala R, Lalanje A, Kachepa G. Chithunzi cha Chishango sicholaula. The Weekend Nation, Zakukhosi 2002, 6-7 July: 7
18. Karim J. We prefer the shield and spear to the naked thigh. Generation Malawi News July 6-12:4
19. Muula AS. Even an HIV vaccine may not mean the end of AIDS. Bulletin of the World Health Organisation 2001, 79(3): 79
20. Nunn P, Harries A, Godfrey-Faussett P, Gupta R, Maher D, Raviglione M. The research agenda for improving health policy. Systems performance, and service delivery for tuberculosis control: a WHO perspective. Bulletin of the World Health Organisation 2002, 80(6):471-475
21. Malawi Government. Economic Report 2001. National Economic Council, Lilongwe, Malawi, 2002
22. Mzembe D. Free meningitis drugs available. The Nation 2002, 9(126):1
23. Republic of Malawi. Malawi Poverty Reduction Strategy Paper. Ministry of Finance and Economic Planning, Lilongwe, Malawi
24. Harries AD, Hargreaves NJ, Chimzizi R, Salaniponi FM. Highly active antiretroviral therapy and tuberculosis control in Africa: synergies and potential. Bulletin of the World Health Organisation 2002, 80(6):464-68

Revisiting human behaviour in relation to HIV/AIDS

Chiwoza R Bandawe

Abstract

It is widely recognised that human behaviour change is a key element in the fight against HIV/AIDS. The reality of the situation however is that the current approaches to instigating sexual behaviour change appear to have borne little fruit. This paper shall argue that in the fight against HIV/AIDS, a fundamental error is made in the numerous outreach programmes that exist within Malawi and elsewhere. This error is grounded in the assumptions that are made about how persons respond to the messages garnered to the control of the disease. Until this mistaken assumption is addressed, it is argued that no serious headway shall be made in the control of this disease, which threatens the very fabric of the Malawi nation.

Introduction

The most baffling thing about the impact of HIV/AIDS is that whilst there is so much awareness of it, there is so little accompanying behaviour change[1] . It can therefore be argued that somewhere along the line interventions are "missing" it. This brief discourse suggests an alternative approach that might shed brighter light in forging a more effective response to this dreaded disease.

Current approaches

The current messages aimed at controlling the disease work on the assumption that people change their behaviour after they receive information [2]. It is assumed that they then process the information cognitively and hence subsequently translate the message they have received into behaviour change. The messages therefore are targeted at the cognitive structures inherent within people. Such structures include information provision, leading to attitude changes, which it is assumed, would subsequently affect behaviour [3]. As a result of this assumption, numerous campaigns seek to provide information through posters, drama, music and lectures. These methods do clearly have their place and are pivotal in providing information leading to awareness. Information provision is always a first stepping stone.

However, awareness is not the main determining factor that results in behavioural change in Malawi. Green & Kreuter assert that an increase in knowledge by itself does not lead to behaviour change[4] . They do point out however that knowledge serves the function of a precursor to behaviour change. If there is present a sufficient amount of knowledge, when a powerful enough cue trigger is presented, a person shall then be motivated to act on the knowledge. Knowledge therefore is more a base for action. The premise of this argument is that behaviour change operates on the principle of combinations of factors. It is the bringing together of various combinations that will ultimately influence behaviour. Whilst behaviour may not change immediately due to knowledge, Green & Kreuter argue that the knowledge that is available impacts the prevailing beliefs, attitudes, intentions and perceived control leading to behaviour[5].

There are many causes of a health behaviour. There is therefore need for multi-dimensional approaches that will lead to behaviour change. No disease occurs in isolation, there are always mediating factors. Desjarlais et al. argue that behaviour "is so

rooted in social contexts, so inflected by social differences, and so at the mercy of social resources that behaviours must be thought of as primarily social. They are subject to individual variations at the margins only"[6]. There are therefore more insidious and powerful determinants of behaviour and unless these are addressed, the disease shall ravage on endlessly.

Social-oriented approaches

These determining or critical factors that are often unrecognised are what can be termed the normative influence. In other words, the social influence people receive from those around them. The factor that shall determine the control of the spread of AIDS in Malawi is not the numerous well intended messages aimed at the individual, but the peer influences that exist within Malawi. What determines whether a Malawian youth shall engage in sexual activity or not, is not his or her individual logic and deduction about the consequences of the action, but the images and symbols held in the minds of persons who engage in the activity. Hence, if it is believed that men who are sexually active are the ones to be held in high regard because they are capable of demonstrating their sexual prowess, then a young man is more likely to engage in sexual activity in order to demonstrate his own sexual prowess.

Furthermore, if it is perceived that the peers and role models are engaged in sexual activity and "boast" about it, then a young man is more likely to engage in sexual activity, regardless of the awareness he holds about the biological consequences of his action. It is the social consequences that carry the day. Such consequences may be that one is seen as "letting the side down" if not sexually active or is not normal, after all, normality is viewed among the peers as being sexually active. What shall therefore change the sexual behaviour is not messages targeted at awareness but change aimed at impacting a whole institution and culture. The change needs to be located within the prevailing unwritten expectations held within each social group.

Until the social leaders and other models that the young look up to, change their own behaviour, the youth shall not change either. However, the social leaders themselves are living what is "expected" of them by their own peers. Unfortunately, from an AIDS prevention perspective, it is expected for a man or woman to be sexually active with a wide range of different partners. People, regardless of their age, therefore tend to do what others around them are doing.

In Malawi this was particularly pronounced in my recent doctoral research. I found that the health behaviours of Malawian children were more influenced by what their friends were doing than the health messages alone[7]. In order to effectively fight the disease and not "miss" where the real influence takes place, there is need to target the image or symbol held of a sexually active person. What does it actually mean to be sexually active? How is sexual prowess viewed by one's peers? What images or representations do being sexually active hold for a person? The sustenance of the images or symbols held in people's minds occurs in the day to day conversations that persons have with each other[8]. It is here that the determining factor of whether people shall change their behaviours or not is made. By not gaining insights into the conversations that people have, the underlying and unwritten rules regarding what is expected of them, we miss the main determinant of a person's behaviour.

Conclusion

AIDS prevention needs to refocus itself. It needs to understand the networks of interaction among peers, the dynamics and meanings held by persons in relation to "image" held of people engaging in certain behaviours. Having understood this, then interventionists would be in a better place to position themselves strategically to effect the necessary behaviour change.

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References

[1]Desjarlais, R., Eisenberg, L., Good, B., & Kleinman, A. (1995). World Mental Health: Problems and Priorities in Low-Income Countries. New York: Oxford University Press.

[2]Stetson, V. & Davis, R. (1999). Health education in primary health care projects: A critical review of the various approaches. Washington: CORE Group.

[3]Abraham, C., Sheeran, P., & Orbell, S. (1998). Can social cognitive models contribute to the effectiveness of HIV-preventive behavioral interventions? A brief review of the literature and a reply to Joffe (1996; 1997) and Fife-Schaw (1997). British Journal of Medical Psychology, 71, 297-310.

[4]Green, L.W & Kreuter, M.W. (1991). Health Promotion Planning: An Educational and Environmental Approach, (2nd ed.). Mountain View: Mayfield.

[5]Green & Kreuter (1991).

[6]Desjarlais and colleagues (1995) World Mental Health Report, p.229.

[7]Bandawe, C.R. (2000). A schistosomiasis health education intervention among rural Malawian school Children: Lessons Learned. University of Cape Town, PhD thesis.

[8]Sindima, H.J. (1995). Africa's Agenda: The Legacy of Liberalism and Colonialism in the Crisis of African Values. Westport, Connecticut: Greenwood Press.