

Behavioural Change vis-à-vis Hiv/Aids Knowledge Mismatch among Adolescents: The Case of Some Selected Schools in Zomba

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ABSTRACT

Most researchers on adolescent reproductive health and related susceptibility to contracting HIV/AIDS have highlighted the ironical mismatch preponderant between adolescent knowledge of HIV/AIDS transmission dynamics and behavioural change exemplified in part by abstinence but also condom use. The paradox is compounded by the fact that survey data seems to depict heightened knowledge of the dynamics per se. Empirical data has previously posited variables as peer pressure and other psychosocial factors as the crisis at adolescence as explaining the anomaly. Results in the current study however unveil the culture of silence; the disdain towards AIDS messages and retrogressive cultural practices as alternative explanation. The results were obtained through survey data from adolescent students in selected schools in Zomba, a district in southern Malawi, and are discussed within the larger context of the applicability of cognitive dissonance theory to the AIDS pandemic.

Keywords: behavioural change, cognitive dissonance, culture of silence, HIV/AIDS, risk-reduction, susceptibility.

1. INTRODUCTION

Empirical findings on adolescent sexuality vis-à-vis the HIV/AIDS pandemic have highlighted a gap often prevalent between adolescents' attitudes, beliefs, knowledge or intentions pertaining sexuality and their actual sexual behaviour (Caldwell, 2001; Szekeres, 2000; Aggleton and Rivers, 2001; Gulure, 2003). There is however a dearth in explaining underlying variables relative to this gap in previous studies. This paucity of information is compounded by the fact that adolescents' sexual lives are often not easy to modify. To investigate the mismatch between adolescents' knowledge of HIV/AIDS transmission dynamics and behavioural change in Zomba [Southern Malawi], the current study applied the theory of cognitive dissonance. The theory proposes that there is often an inconsistency between people's attitudes, beliefs or intentions and their actual behaviour. The study acknowledges the fact that a myriad of behavioural interventions have been designed to promote safer sexual behaviours among adolescents yet relatively few have proven effective. One such intervention is Behavioural change communication [BCC]. Relative to the study, the paradox emanating from BCC is however that, while adolescents'

awareness of HIV transmission dynamics is generally high [a factor that can be attributed to intensive BCC campaigns] behavioural change relative to the HIV/AIDS pandemic in the study area has been limited. The crux of the problem has been to unveil factors and variables to explain this gap or anomaly.

There is enough empirical evidence supporting the contention that there tends to be sufficient knowledge of AIDS in most communities, and the limited success of intervention programmes in controlling the pandemic cannot be ascribed to limited knowledge (Caldwell, 2001; Szekeres, 2000; Aggleton and Rivers, 2001). As already highlighted the sole objective of the study was to assess the reasons as to why there is a pronounced mismatch between knowledge of HIV/AIDS transmission dynamics and subsequent change in behaviour. The assumption being that of an anticipated correlation between knowledge of dynamics and change in behaviour with perceived vulnerability to a disease such as HIV/AIDS being a major casual factor for compliance with a health regimen (Becker and Rosenstock, 1974). It is ironical that knowledge is not really being translated into substantial behavioural change relative to HIV/AIDS in Malawi in general and Zomba in particular.

At first it was thought possible to explain lack of behavioural change relative to the AIDS pandemic in terms of inadequate information and seek to overcome the problem through better and more intensive informational and educational programmes. Overtime, this explanation has become ever less tenable. Kirby (1994) notes that AIDS prevention entails behavioural change, which is difficult to achieve when the social environment is not conducive. Cochran and Mays (2004) and Osborn (1986) also emphasize the central place of behavioural change to AIDS prevention.

Behavioural change is very important when it is realized that AIDS even though a physical or biological disease depends for its transmission and spread mainly on the volitional behaviour of people. Obstacles to behavioural change were identified in the current study as the adherence to the present sexual culture; the refusal of leaders to recognize and come to terms with the situation; the sanguine acceptance and stoicism towards death; the silence about the epidemic and the reasons for this; and the limited number of relationships in which condoms are acceptable. As stipulated by Cochran and Replan (1989), in Gross (2001) perception of being at risk, especially among youth is a factor in change of attitude towards the virus.

In William's (2002) perspective, what has been neglected amidst the current AIDS epidemic are health practitioners who are being sent into various African countries to actualize behavioural change amid their own and client's homophobia, distrust, suspicion and misconception with little or no preparation in family life and sex education. These people lack understanding and appreciation of the sensitive and cultural impact of the Africans. Regan et al. (2001), asserts that dissemination of information about behavioural change, the traditional forte of health education, will be ineffective if barriers, misunderstanding, and fear exist between health professionals and clients. They maintain that,

“Even if well-informed specialists successfully transfer information, (to the individual, at risk) a positive behavioral change may not result because other variables, also motivate behaviour.”

Generally, heterosexual intercourse is the primary mode of HIV/AIDS transmission in Africa where it accounts for 70-80% of all cases (Hayward, 1990). The sexually active members of the population usually undertake heterosexual relations. In this case, youth are more involved in heterosexual relations than other members of the population. Hence, this group becomes the ideal target of any AIDS prevention programmes and one setting where this target group of youth can be located is in secondary schools. In view of the active sex lives of adolescents, AIDS prevention programmes may go a long way in reducing the spread of the virus if they are informed by knowledge of AIDS related perceptions of such a target group, with behavioural change being the final goal of the programmes.

In any case however, behavioral change is a slow process. Before launching an AIDS educational program, a situational analysis to determine possible areas of circumstances that might put people at risk and also to discover and understand the reasons behind people's actions or motives must be conducted. Primary strategies for encouraging behavioral change may include as first step analyzing the life-style and traditions to determine the risk behaviours that might enhance the spread of the AIDS virus. The second step should be an explanation of the facts of HIV/AIDS, that is; what it is, how it is spread, how it may be controlled, the most vulnerable groups, and so on. This is necessary to clear up some of the misconceptions that may have arisen over the years.

2. COGNITIVE DISSONANCE VIS-À-VIS RISK-REDUCTION/AVERSION IN HIV/AIDS

The paradox imbuing the mismatch between risk-reduction and subsequent behavioural change, has been grappled with from several dimensions but one stance that the study tried to delve into is the controversial theoretical application of Cognitive dissonance theory (Festinger, 1957; Gross, 2001). According to the theory, whenever persons simultaneously hold two cognitions or perceptions that are psychologically inconsistent, they experience dissonance. Dissonance is a negative drive or state of 'psychological discomfort or tension', which motivates people to reduce it by achieving consonance. Attitude change is a major way of reducing dissonance. Under certain circumstances, we may re-evaluate our attitudes so as to make them more consistent (less 'dissonant') with our present or past behaviour. Cognitions are the traits a person knows about himself, and about his surroundings. Any two cognitions can be consonant (A implies B), dissonant (A implies not B), or irrelevant to each other.

The cognition, ‘I am promiscuous or I engage in multiple sexual affairs’ is psychologically inconsistent with the cognition that ‘promiscuity or engaging in multiple sexual affairs may result in contracting HIV/AIDS’ (assuming that persons don’t wish to contract HIV/AIDS anyway). Perhaps the most efficient and healthiest way to reduce dissonance would be to stop indulging in promiscuity or sexual risky-behaviours but people, adolescents inclusive, will work on other cognitions for example, they might:

- First, belittle the evidence about HIV/AIDS (e.g., the human data is only correlational).
- Second, they may associate with other people indulging in promiscuity or sexual risk-behaviours (e.g., if so and so does it, then it can’t be very dangerous or detrimental).
- Third, they may date younger girls with the assumption that these are not yet infected.
- Last, they may convince themselves that promiscuity or sexual risk-behaviours exemplified by multiple sexual relationships are highly pleasurable activities (e.g., after all it’s worthy the consequences)

These analogies illustrate how dissonance theory regards human beings not as rational but as rationalizing creatures, attempting to appear rational, both to others and to themselves yet with occasionally devastating consequences (Gross, 2001). Suffice to say there is some wealth of evidence that unless individuals feel vulnerable to a threat they are unlikely to form the intention to act on the recommendations in any message tailored at abating the threat per se.

3. THE RESEARCH SETTING

The study was conducted in Zomba a municipality town in southern Malawi. Most of the student respondents who participated in the study come from the same Zomba district with the majority of the populace being Yao in ethnicity. Like any other ethnic grouping the Yao have their own cultural practices among which are *jando* and *msondo* initiation ceremonies. These ceremonies are basically rites of passage geared at preparing adolescent boys and girls for adult roles and responsibilities as well as a smooth transition into adulthood. As was expected most of the respondents had undergone the ceremonial rites which as portrayed by empirical research conducted by several authorities including National AIDS Commission (NAC) (2004) instil traditional knowledge that sometime breeds cognitive inconsistency within the adolescents and as well contradict with AIDS messages and information that the youth may have, thus encouraging them to indulge in promiscuity and sexual risk –taking behaviours. Needless to say research has also shown that some of the knowledge gained in these rites of passage and some proclivities like male circumcision may help negate to some extent the transmission of HIV (Anaffi 1999; Bongaarts and

Reining 1989). Bearing in mind that a researcher needs to carry out an investigation with respect and concern for the dignity and welfare of respondents, consent and permission were sought from the respondents in the questionnaires administered to report the findings.

4. MATERIALS AND METHODS

The study applied both the quantitative and qualitative paradigms in a triangulative approach in order to come up with tangible data that would explore as many dimensions as there were in the topic of concern yet without preempting and militating against future research possibilities in the area of adolescent sexuality in Malawi. The respondents who participated in the study were secondary school adolescents, drawn from three schools considered the accessible population respectively. The research sites chosen basically on grounds of proximity to the researcher as well as to cater for the gender disparity and selected purposively were;

- Mulunguzi co-educational Secondary School
- Zomba Catholic's boys Secondary School
- St Mary's girls Secondary School

Of the three secondary schools, all are conventional secondary schools with Zomba Catholic being a national secondary school for boys within the town periphery enrolling a cross section of students from several districts. Mulunguzi secondary school is more urban oriented with most students being enrolled from primary schools within Zomba and a few from the surrounding rural primary schools. St Mary's girls is a secondary school within the urban milieu enrolling students from several districts, like Zomba Catholic. The gender aspect was considered as a criterion for sampling with two of the schools being single sex schools (Zomba Catholic enrolling boys and St Mary's enrolling girls) with Mulunguzi being a co-educational school.

The students' sample consisted of 180 students with 60 coming from each school and systematic randomly selected from 3 and 4 forms. Thirty students were girls and the other thirty boys at Mulunguzi secondary school. This was done so as to have an overall equal number of boys and girls in the study. Systematic random sampling not only reduced bias and other extraneous variables that were apt to affect the research process but also made the findings representative of the targeted population of adolescents in Zomba.

In terms of instrumentation diverse areas concerning HIV/AIDS were assessed in the students' questionnaires. Some of the items were solicited from a standardized Knowledge, Attitude, and Behaviour (KAB) model referred to in Maluwa Banda (1999) with others being modified Likert items adopted from the Protection Motivation Model as utilized by Abraham (1994) in a study conducted in the United States. The KAB model in HIV/AIDS research is aimed

at soliciting respondents' awareness of transmission dynamics relative to the pandemic as well as their affective ideals. Not only that, finding out about respondents' perception of risk and the subsequent intention or non-intention to change behaviour remains within the scope of the model. Protection Motivation Models on the other hand utilize constructs adopted from Health Belief Models with the aim of evaluating respondents' susceptibility to disease regimen.

The questionnaire was divided into four sections with part A seeking to solicit data on students' socio-demographic characteristics. Questions concerning age, gender, religion, number of siblings in the family, parental existence and form of family were advanced. Questions in part B sought to gather data on the knowledge and attitude consistency domains of the KAB model. The items sought to solicit information about modes of HIV transmission, prevention, as well as attitude vis-à-vis behaviour consistency and ranged from item 8 through to item 15.

Part C items were designed to gather data on the students' attitudes towards HIV/AIDS with most of these items having been adopted from the Protection Motivation Model as applied by Abraham (1994). The response items sought to appraise self-efficacy, response efficacy as well as adaptive and maladaptive cognition relative to the HIV/AIDS pandemic. In all 9 items were advanced in this section with response items ranging from item 16 through item 24. The last part with questions ranging from item 25 through to item 38 sought to gather data on students' risky sexual behaviours. More of the skein issues unravelled in this section ranged from aspects of sexual experience across the continuum to condom use, modes of HIV/AIDS transmission, as well as behavioural change initiatives. The uniqueness of this section can be deduced in part from its consideration of structured items but above all else unstructured, open-ended objective items geared at soliciting more sensitive issues on adolescent sexual risky behaviours.

A focus group discussion was also conducted to compliment and consolidate the other device in a bid to foster a triangulative approach. Its major strength was that it helped in soliciting more personalized sentiments in an open and free atmosphere. Questions discussed ranged from those grappling with the attitudes that adolescents hold about HIV/AIDS through modes of behavioral change relative to the HIV/AIDS pandemic. Also considered were factors that adolescents consider as explaining the mismatch between adolescents' unequivocal knowledge of HIV/AIDS transmission dynamics and change in high risk-sexual behaviours, as portrayed by empirical findings.

5. RESULTS AND DISCUSSION

5.1 CULTURE OF SILENCE

Research findings in the current study have aptly revealed stoicism towards death and the culture of silence as prominent reasons for the mismatch between

risk-reduction or change in behaviour and unprecedented knowledge of the dynamics of HIV/AIDS transmission as well as prevention with the overall score on knowledge items being 7 (SD=2.4) or 87.5%. An exponential response by respondents (65%) that 'death is inevitable and one can even die from an accident or any other disease hence no need to fear AIDS' qualifies the brave but detrimental attitude towards death and HIV/AIDS. This qualifies the research assumption that given the dissonance between indulgence in risky sexual debuts and non-promiscuous proclivities the majority of respondents choose to rationalize and uphold the former. Apart from justification basing on the inevitability of death (55%) of the respondents belittled the evidence about the existence of HIV/AIDS claiming that 'AIDS is just a Eurocentric endeavour to discourage sexual intercourse'. This augurs well with findings documented by research (Caldwell, 1992; Ngugi, 2000; Abraham, 1994; Gulure, 2003; McAuliffe, 1994), that a combination of adequate knowledge and continual high-risk behaviour as well as stoicism towards death and AIDS appears unequivocal.

The silence posited owes something as portrayed in the focus group discussion in the current study to fear of being shunned and isolated, and something to those religious figures who preach that the epidemic is a punishment for sexual sin. This is also consistent with Caldwell (1994) who argues that stigmatization does not warrant an absolute appraisal of the misfit per se. He substantiated that the silence in relation to the HIV/AIDS pandemic among Africans owes a great deal to suspicions that AIDS is more than an ordinary disease, that it has supernatural elements or that it is caused or manipulated by witchcraft. Consequently, individuals including adolescents in many African cultures seem not to demand more from government because of a sense of guilt, a feeling that they may have brought the calamity upon themselves, compounded in many by a feeling that the deaths were inevitable.

This is also consistent with findings by Ngugi et al (2000) in studies conducted in Ghana and other West African Countries, that beliefs intact or vestigial in African Cultures that death causation is multiple and does not rest on a single mechanism (e.g., viral infection would have no effect unless witchcraft or other machinations were determined it would take hold), that the timing of death is predetermined, and that the most certain way of becoming sick was to worry about the possibility of death and change one's way of life, especially an extroverted pattern of sexual activity; affecting ways in which Africans in general respond towards the pandemic.

This stubbornness towards death is thus a fundamental factor in explaining the continuing high level of new HIV-infection not only among adolescents but the entire populace (Caldwell, 1992; Mays and Cochran, 2004; Williams et al 2002). It is argued that this stoic attitude is not a characteristic that would induce the early curtailment of epidemics. Reducing the risk of death has never been the sole aim of mankind. Risk-taking in sport and for thrills or just the determination to live a fairly carefree life have always been alternatives and have weighted the scales a little more towards death.

Studies also document that it is possible that those exposed longest to the world's religions are more focused on the significance of death. In the current study for instance a sentiment highlighted in the focus group discussion that *'after all if I were to die I would go to heaven'* seems to tally with this aspect of religiosity. Awusabo-Asare (1997) argues in the same scenario that in Ghana older beliefs in predestination are now being reinforced by the rise of Christian fundamentalism. Indeed, it is possible to argue that African belief in an afterlife may justify risk-taking, no wonder why the exponential percentile towards the wishful thinking item response (*God will protect me from contracting HIV/AIDS*) was also evident in the current study.

5.2 CULTURAL PRACTICES

Possibly yet another reason for the mismatch between knowledge of HIV/AIDS transmission and prevention dynamics and subsequent risk reduction as revealed by the current study are cultural practices. Respondents (95%) posited that there appeared to be a grave inconsistency between their own beliefs and values and cultural expectations. Following the focus group discussion, an inquiry into adolescent risk-behaviours exacerbating susceptibility to contracting HIV/AIDS and reasons why girls and boys indulge in premarital sexual encounters, revealed that of the prominent factors at stake was the perpetrating of counterproductive cultural practices among societies in the study site. Most of the respondents emanate from the Yao ethnicity which is predominant in the study area. Among the cultural practices of the Yao are the jando and msondo initiation ceremonies. The practices per se as highlighted at all research sites also encompass rituals of 'fisi', 'kusasa fumbi' 'kulowa kufa' and 'chokolo'. These are practices which encourage and promote sexual debuts between the patrons of the cultural rites. After being initiated at either jando or msondo which are rituals for boys and girls who have respectively become of age (adolescents), the initiates are strictly encouraged to go out and cleanse themselves. This cleansing ceremony requires them to indulge in unprotected sexual intercourse with an experienced person of the opposite sex. It is quite evident that the experienced person who is known as 'fisi' in female cleansing may as well be HIV positive bearing in mind that he takes cleansing as an obligation each and every initiation season. It is also quite unequivocal that both male and female initiates are at risk of contracting HIV/AIDS since they may not know the sero-status of the persons they have intercourse with. Above all else the respondents substantiated that to avoid cleansing connotes heralding unforeseen repercussions which all initiates are threatened with and fear confronting.

This is consistent with Ngugi (2004) that all societies seem to understand the relationship between early sexual debuts, increased risk of Sexually Transmitted Diseases (STDs) and reduced fertility yet maintain risky sexual cultural

practices e.g. early age of sexual initiation, multiple partners, polygamy and extra-marital sexual affairs. Also consistent with the findings, Bauman and Siegel's (1987) study of farming and foraging groups in the Ituri ethnic group of Cameroon ask:

“Why people in the group perish in their promiscuous attitudes and behaviour even in the face of such a perilous epidemic and by extension, in their own sense of social and psychological wellbeing,”

Further the belief, logical in a polygynous society, that males are biologically programmed to need sexual relations with more than one woman; even parallel relationships must also be construed as perpetrating the misfit per se. That this belief is widespread, perhaps almost universal across all sub-Saharan African cultures and is held almost as strongly by women, as men, was reported in Orubuloye, and Varga (2003). This seems concomitant as well with the findings of the current study relative to the dilemma why most adolescents prefer having multiple sexual partners, that:

“Having several sexual partners is seen as a sign of masculinity or machismo – the boy becomes a champion among his peers.”

This is also consistent with Varga (2003), that indeed, the boys are often most motivated by the desire to boast to their male peers about the number of their sexual conquests.

5.3 RESPONSE TO AIDS MESSAGES

Possibly yet another reason for the dichotomy between knowledge of HIV/AIDS transmission and preventive dynamics and risk-aversion with subsequent behavioral change as unveiled by the current study is the fact that AIDS messages are wholly or partly disbelieved. The messages like cultural practices also appear inconsistent with the attitudes and beliefs of the respondents. In the focus group discussion it was highlighted for instance by the majority of adolescent respondents (87%) that the urge for them to abstain is there but sexual desires seem to outweigh the desire to abstain in the final analysis. There is also some scepticism about the aptly construed foreign messages often regarded as wholly wrong or hysterically based on fiction. One respondent in the focus group discussion actually asserted that ‘AIDS is not real’. Other respondents claimed that there are already cures while some argued that for those just infected there will be by the time they will be symptomatic. The most intriguing argument posited in the focus group discussions was that there is a tendency by the western media to exaggerate the dangers and implications of HIV/AIDS. These fear appeals tend to create aversion toward the AIDS messages and more often than not the target groups respond contrary to these messages.

6. CONCLUSION

As reflected in the current study, adolescent vulnerability to contracting HIV/AIDS though explored from compounded risk perception, egocentrism and other psychosocial factors in various empirical domains has been shown to be complicated by cultural practices, stoicism towards death and misconstruing of AIDS messages. These factors have been discussed with reference to how they foster a mismatch between knowledge of HIV/AIDS and subsequent behavioural change. It has been noted that perception of being at risk of contracting HIV/AIDS and knowledge of transmission dynamics has not necessarily translated into change in behaviour relative to the pandemic. Behaviour communication programmes therefore need to capture some of these socio-cultural and psychosocial complexities that may be proximate barriers to change. Above all else, given such attitudes future HIV/AIDS prevention programmes for the study area, Malawi and Africa must be innovative, anticipating the myriad social and historical; ontological as well as epistemological inconsistencies that may act as barriers to effective intervention efforts, and must involve the community members and leaders in program development from the earliest planning stages. Those expatriate informers geared at steering change in behaviour in a bid to at least mitigate and stem the incidence of the pandemic must also be extremely conversant with such diverse barriers as have been portrayed by the current findings. Retrogressive cultural beliefs perpetrating inconsistencies within and among adolescents should be revisited.

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