

Social Tract

Module on

Prevention of HIV

LEARNING OUTCOMES FOR ALL TEAM MEMBERS

After completion of this module the learner should:

- Understand the role of prevention as part of the continuum of care, management and treatment
- Understand prevention and behaviour change theory

1. PREVENTION AS PART OF A CONTINUUM OF CARE, TREATMENT AND MANAGEMENT IN SOUTH AFRICA

The advent of treatment in South Africa and other parts of the world is bringing hope to millions of people, but this expanded response to HIV and AIDS must be matched equally with universal access to prevention services. Prevention cannot be sacrificed at the expense of treatment. Twenty percent of the people worldwide have access to prevention services and only seven percent of the people in developing countries have access to antiretroviral treatment.

The International Guidelines on HIV and AIDS and Human Rights, as published by the UN, describes access to prevention as part of an effective and comprehensive response to HIV and AIDS. A comprehensive response includes, but is not necessarily limited to: accessible AIDS education, behaviour change programmes for the youth and other vulnerable and sometimes marginalised groups at higher risk of HIV exposure, promotion of female and male condoms; along with abstinence programmes and reducing risk through fidelity (where appropriate) to an uninfected partner and the reduction of sexual partners. Further by promoting confidential voluntary counselling and testing (VCT), prevention of mother to child transmission (PMTCT), preventing and treating sexually transmitted infections (STIs), blood safety, prevention of transmission in health care settings, community education and changes in laws and policies to counter stigma; vulnerability reduction through social, legal and economic change; and harm reduction programmes for injecting drug users.

1.1. HIV/AIDS/STD Strategic Plan 2000 – 2005

The National Department of Health's *HIV/AIDS/STD Strategic Plan 2000-2005* identifies prevention as one of the priority areas of the plan and is based on the following guiding principles:

- People with HIV and AIDS shall be involved in all prevention, intervention and care strategies;
- People with HIV and AIDS, their partners, families and friends shall not suffer from any form of discrimination;
- The vulnerable position of women in society shall be addressed to ensure that they do not suffer discrimination, nor remain unable to take effective measures to prevent infection;
- Confidentiality and informed consent with regard to HIV testing and test results shall be protected;
- Education, counselling and health care shall be sensitive to the culture, language and social circumstances of all people at all times;
- The government has a crucial responsibility with regard to the provision of education, care and welfare of all people of South Africa;
- Full community participation in prevention and care shall be developed and fostered;
- All intervention and care strategies shall be subject to critical evaluation and assessment;
- All sectors of government and other stakeholders in civil society shall be involved in the fight against HIV and AIDS;
- A holistic approach to education and care shall be developed and sustained;
- Capacity building will be emphasised to accelerate HIV and AIDS prevention and control measures; and
- STD prevention and control are central elements in the response to HIV/AIDS.

The primary goals of the strategic plan are to:

- Reduce the number of new HIV infections (especially among youth); and,
- Reduce the impact of HIV and AIDS on individuals, families and communities.

The following general strategies are stressed in the plan:

- An effective and culturally appropriate information, education and communications (IEC) strategy;
- Increase access and acceptability to Voluntary HIV Counselling and Testing;
- Improve STD management and the treatment of opportunistic infections and promote increased condom use to reduce STD and HIV transmission; and
- Improve the care and treatment of HIV positive persons and persons living with HIV/AIDS to promote a better quality of life and limit the need for hospital care.

The Strategic Plan is structured according to the following four areas:

- Prevention;
- Treatment, care and support;
- Human and legal rights; and
- Monitoring, research and surveillance.

Under priority area one, prevention, the following goals were formulated:

- Goal 1: Promote safe and healthy sexual behaviour
- Goal 2: Improve the management and control of STDs
- Goal 3: Reduce mother-to-child transmission (MTCT)
- Goal 4: Address issues relating to blood transfusion and HIV
- Goal 5: Provide appropriate post-exposure services
- Goal 6: Improve access to Voluntary HIV Counselling and Testing (VCT)

The strategic plan further broadly identifies youth as a priority population group, especially for prevention efforts.

1.2 Tracking progress: The Strategic Plan

In March 2003 the National Department of Health (NDOH) published a progress report on the Strategic Plan, here are some of the highlights for priority area one, prevention (this section refers to the situation up to March 2003, and can now be different):

Promote safe and healthy sexual behaviour

- Systematically improving the financial allocations for the purchase and distribution of both male and female condoms. Male condom distribution increased from 250 million in 2000 to 350 million in 2002, and this number will increase to 400 million in the 2003/4 financial year. Also, access to the female condom increased from 27 sites in 2000 to just over 200 sites in 2002.
- The Minister of Public Service and Administration has amended the public service regulations to the effect that all national and provincial government departments must implement HIV/AIDS workplace programmes in the civil service. All government departments already provide access to condoms and information, and the intention with the public service regulations is to broaden these programmes to include other Employee Assistance Programme elements, such as counselling.

- Implementation guidelines have been developed. The Department of Health supports the implementation of these regulations in national government departments through the Interdepartmental Committee on HIV/AIDS (IDC). To support the integration of HIV and AIDS at local government level, the Department of Health trained 120 master trainers who in turn trained 429 Local Government Councillors and officials. A Local Government support programme is currently in preparation in the Department of Health.
- Education, awareness and prevention are addressed through a variety of methods, including the mass communication efforts of both the Department of Health and GCIS, and the life skills education programme in the Department of Education. It is projected that the full rollout of life skills and HIV and AIDS education programme in primary and secondary schools will be concluded by the end of 2003.
- In addition to the school based life skills programme that is funded through a conditional grant, the Department of Education's HIV/AIDS programme has expanded to include the following:
 - Guidelines and tool kits to assist School Governing Bodies and School Management Teams to develop and manage comprehensive HIV/AIDS responses that include parents and communities.
 - A workplace policy has been developed and communicated to staff.
 - A workplace programme with a counselling service is available for staff.
 - Higher Education: This programme focuses on providing support to all 35 Higher Education Institutions and their leadership to put in place comprehensive responses to HIV and AIDS. The programme is based on the core business of Higher Education of providing leadership, teaching and facilitating research.
 - Early childhood development: HIV and AIDS curricula and an HIV-positive Muppet have been developed for inclusion in the children's series, Takalani Sesame. Early childhood Development practitioners are being trained to integrate life skills and HIV and AIDS into teaching. The main objective of this is to address HIV and AIDS related knowledge, skills and attitudes for children.
 - Work is underway to develop programmes for Further Education and Training Colleges and Adult Basic Education.
- The Department of Education held a major conference on HIV and AIDS and the Education sector in 2002. This Conference acknowledged the primary function of education in addressing HIV and AIDS, and thus agreed to put education at the heart of the national response to HIV and AIDS. It also developed a plan of action for the education sector that includes participation from traditional and religious leaders.
- Since 2002 the government has increased awareness on HIV, AIDS, STIs and TB. This has happened mainly through the Khomanani campaign, as well as the life skills and HIV and AIDS education programme in schools. Recent studies, including the HSRC study released in late November 2002, indicated a high awareness among the South African population. The broad aim of the Khomanani communication campaign is to move the nation to act, so that individuals see themselves as part of a caring community, proactively addressing the HIV, AIDS and TB epidemics. The campaign is conducted according to the best evidence available, as well as based on a sound behaviour change theoretical understanding. Prior to developing the strategy a national baseline survey of 2500 participants were conducted and 6 sentinel sites were established around South Africa to evaluate the effectiveness of the campaigns.

- The SABC already has a strong partnership with the Department of Health to provide sponsored airtime and media space. In November 2001, the SABC Corporate AIDS Desk announced that it was partnering with the Department of Health and we had a beneficial partnership through its airtime support for our Public Service Announcement (PSAs), with 100% value add of total above-the-line spend on TV and 50% value add of total above-the-line spend on radio.
- Funding is available in 2003/4 for these activities, including R50 million for campaigns; R115 million for male and female condoms; and R120 million for the life skills programme (in the Department of Education budget).
- The high transmission area project of the trucking industry was launched in 2000. The Trucking against AIDS initiative is an example of a partnership between the private sector, labour, national government departments, provincial government departments, local government and non-governmental organisations. The six roadside STI clinics provide access to condoms and treatment after hours. The policy for the road freight industry was developed and adopted by the Bargaining Council of the Road Freight Industry and has been distributed to all the participating organisations of the Road Freight Association.
- The focus of the Trade Union AIDS Programme is to build capacity of trade union members to mitigate the impact of HIV and AIDS in the workplace. Training in HIV/AIDS/STI/TB issues has been done with members of the three federations, namely COSATU, FEDUSA and NACTU, throughout the country. The labour sector is capacitating health professionals from trade unions, health professional associations, NGOs and health professionals on HIV/AIDS/STI/TB fundamentals and clinical guidelines.
- A Commuters AIDS Project has been established to provide commuters with HIV and AIDS information, basic counselling, a referral service and access to condoms and leaflets at 35 kiosks situated at the main taxi ranks throughout South Africa. At each kiosk two NAPWA members act as NAPWA Commuter Educators (NCEs), utilising training and an educational curriculum. The training and curriculum in turn is based on extensive baseline research.
- Activities performed by NCEs include the provision of information through answering questions, engaging in group discussions, one-to-one lay counselling, facilitating referrals, and distribution of leaflets and condoms. NCEs also spend a few hours each week in contact with organisations active in the area, such as local clinics and hospitals, AIDS Training and Information Centres, NAPWA branches and local support groups. In 2003 a project will be launched to address the vulnerability of migrant and other agricultural workers to HIV infection and human rights in farming communities in South Africa (three year project).

Improve the management and control of STDs

This goal focuses on improving the management and control of STIs in both the public and the private sector. This involves strengthening the skills of health workers in STI management, working with traditional healers in the management of STIs, and improving services to youth friendly health services.

Progress in this regard include:

- At least 80% of public health facilities have health workers trained in STIs National STI Guidelines revision and reviewing process to be completed by June 2003.

- Update of train of trainers (TOT) on the comprehensive approach (HIV/AIDS, STI and TB) completed. Provincial trainers have started implementing the new approach when training within the provinces.
- Expansion on the use of District STI Quality of Care Assessment (DISCA) as monitoring and evaluation tool. This is now being implemented in about 30% of districts, with further expansion in 2003.
- Funding has been made available in 2003 for STI Surveillance in all provinces.
- National STI Baseline Assessment conducted and results to be released by May 2003.
- Appointment of two Traditional Healers trainers in Health to strengthen the provincial traditional healer programme.
- National Traditional Healer rapid appraisal conducted to inform the traditional healer programme.

Reduce mother-to-child transmission (MTCT)

This goal focuses on integrating VCT into maternal and child health care services, improving family planning services to known HIV positive women, identify HIV positive women in order to improve their health seeking behaviour, and implement clinical guidelines to reduce the transmission of HIV from parent to child. (Some of the VCT issues will be addressed under goal 6).

In early 2001 the Department launched a limited programme on PMTCT to serve as research sites that would inform a broader implementation strategy. This schedule was challenged in the judicial system, resulting in a Constitutional Court judgement that saw a much more rapid rollout of the PMTCT programme.

To date approximately 600 facilities are offering VCT and the PMTCT programme that includes the provision of Nevirapine to mother and infant, and formula feed to women who choose to exclusively formula feed.

As indicated above, the Constitutional Court ruling dictated that the rollout process proceeds at a rapid rate. Presently all provinces have embarked on rollout, and it is expected that full national rollout will be achieved by the end of March 2003. To facilitate this process, significant additional resources have been made available for this programme.

Address issues relating to blood transfusion and HIV

South African maintains very high standards as it relates to blood safety. Blood donated to blood banks are routinely testing (using antibodies and P24 antigen testing), and this screening adheres to international standards.

Provide appropriate post-exposure services

The guidelines for needlestick injuries and occupational exposure have been available since 2000. The relevant protocols and drugs are available in the public sector for this intervention. Universal precautions are also in place in health facilities to reduce the risk of occupational exposure.

In terms of non-occupational post-exposure prophylaxis, the Department released guidelines and the protocol in May 2002 to ensure that survivors of sexual assault have access to an appropriate intervention. Implementation started in 2002, and

additional funds have been made available in the 2003/4 budget through the conditional grant system.

Improve access to Voluntary HIV Counselling and Testing (VCT)

Ensuring access to confidential and voluntary HIV counselling and testing is one of the essential elements of the Strategic Plan, as it provides an important entry into other health interventions, e.g. TB and STI treatment. This goal focuses on expanding access to VCT in both the private and public sector.

By the end of 2002 VCT is available in 982 sites throughout the country. This includes the sites where PMTCT is available. Through the expansion plans for both VCT and PMTCT, it is aimed to have VCT services available in 80% of public health facilities by the end of the 2003/4 financial year. To this end the conditional grant for HIV/AIDS to the provinces, including expanding VCT and PMTCT, has increased significantly (from R210 million in 2002/3 to R334 million in 2003/4).

The new tender for rapid test kits has been awarded for a 2-year period. This will ensure that new retraining on the test kits is only required in 2004. Through the expansion programme new counsellors will be recruited in 2003.

A tender has been awarded to the University of Natal to assist provinces to roll out the mentorship programme for the VCT programme. The tender ends in December 2003.

Through collaboration with the Development Bank of South Africa (DBSA) and a German donor, the Department aims to address the infrastructure issues relating to the provision of VCT. As many facilities do not have sufficient space to provide VCT, the R90 million grant (routed through the DBSA) will allow for construction of additional rooms to existing facilities.

Encouraging people to go for voluntary HIV counselling and testing will be an important advocacy focus in 2003. With approximately 1000 facilities now able to provide this service, it is the opportune time to create greater awareness around the benefits of knowing one's HIV status.

Some government departments are already investigating the establishment of VCT services. These departments include the Office of the Public Service Commission, Public Service and Administration, and the SA Management Development Institute.

2. OPTIONS FOR PREVENTION AND BEHAVIOUR CHANGE

South Africa – what is needed?

“Eluding South Africa still is an answer to these questions: What might be an effective response that is, in discursive terms, as complex as AIDS in a country as divided, as wracked by contradictions and stereotypes, and as filled with silences as ours? Exactly what interventions should practically constitute that response? How can the disease be decoded in terms that prompt people to act in accordance with such a response?”

Shaping AIDS in the public consciousness since its “arrival” in South Africa in the early 1980s has been a succession of chauvinistic clichés, starting with a focus on the sexual orientation of the ailing airline steward who allegedly transported the

disease onto our shores. But also shadowing the disease was an almost millennial (and, therefore, desperate) optimism, rooted in the modernist faith in science. Reason would triumph and medical science, it was believed, would conjure up a vaccine or a cure. Society was a patient waiting to be wheeled into the operating theatre” (MARAIS, To the edge: AIDS Review 2000).

The pursuit of an AIDS vaccine remains a critical international goal and increasingly funds have been and are being made available for this purpose. Clinical trials of vaccine candidates are presently underway. Until we have an effective vaccine, efforts to achieve social mobilisation toward healthier and safer sexual behaviour should be increased significantly and sustained. Data shows continuing high rates of HIV infection in the sexually active population. This indicates high-risk behaviour, which has been confirmed by various behavioural surveys. UNAIDS reported in July 2004 that in 2003 the highest number of new infections occurred in one year since the start of the epidemic in the 1980's.

Until we have a successful vaccine, our only hope is a social vaccine – behaviour change. The greatest barriers to achieving HIV prevention and behaviour change are fear, denial and ignorance. HIV prevention efforts have been plagued above all by silence brought on by the denial and stigmatisation that is associated with the disease. In one study of home-based care schemes in southern Africa, fewer than one in ten people who were caring for an HIV-infected patient at home acknowledged that their relative was suffering from AIDS. Patients themselves were only slightly more likely to acknowledge their status.

There is also the danger that concerted calls for the large-scale provision of anti-retroviral drugs could undermine prevention efforts. There is already a dangerous pessimism that prevention efforts do not work, despite convincing scientific evidence from other highly affected, poorly resourced countries of plummeting rates of infection as a result of sustained and well targeted prevention efforts. This pessimism could be compounded if at-risk populations perceive anti-retroviral drugs as a curative solution to HIV infection. Scarce resources for HIV prevention efforts may also be diverted to the provision of these drugs. Achieving sexual behaviour change is a complex task, requiring integrated inter-sectoral approaches implemented at all levels of society and sustained over a considerable number of years. Prevention initiatives need to succeed in creating a social consciousness and environment that facilitate appropriate personal action.

Back to the drawing board: behavioural theory

HIV transmission is fuelled by unsafe sexual behaviours many theories have been developed to try to alter human behaviour and most prevention programmes worldwide are based on these theories. Most of these theories were developed in the West and have been implemented around the world with varied results. Only one of these psychosocial models, the AIDS risk model, have been developed specifically for AIDS.

Model	Description
1. Health belief model	The Health belief model, developed in the 1950s holds that health behaviour is a function of individual's socio-demographic characteristics, knowledge and attitudes. According to this model, a person must hold the following beliefs in order to be able to change behaviour:

	<ul style="list-style-type: none"> • perceived susceptibility to a particular health problem (“am I at risk for HIV?”) • perceived seriousness of the condition (“ how serious is AIDS; how hard would my life be if I got it?”) • belief in effectiveness of the new behaviour (“condoms are effective against HIV transmission”) • cues to action (“ witnessing the death or illness of a close friend or relative due to AIDS”) • perceived benefits of preventive action (“ if I start using condoms, I can avoid HIV infection”) • barriers to taking action (“ I don’t like using condoms”). <p>In this model, promoting action to change behaviour includes changing individual personal beliefs. Individuals weigh the benefits against the perceived costs and barriers to change. For change to occur, benefits must outweigh costs. With respect to HIV, interventions often target perception of risk, beliefs in severity of AIDS (“ there is no cure”), beliefs in effectiveness of condom use and benefits of condom use or delaying onset of sexual relations.</p>
2. Social learning theory	<p>The premise of the social cognitive or social learning theory (SCT) states that new behaviours are learned either by modelling the behaviour of others or by direct experience. Social learning theory focuses on the important roles played by vicarious, symbolic, and self-regulatory processes in psychological functioning and looks at human behaviour as a continuous interaction between cognitive, behavioural and environmental determinants.</p> <p>Programmes built on SCT integrate information and attitudinal change to enhance motivation and reinforcement of risk reduction skills and self-efficacy. Specifically, activities focus on the experience people have in talking to their partners about sex and condom use, the positive and negative beliefs about adopting condom use, and the types of environmental barriers to risk reduction. A meta analysis of HIV risk-reduction interventions that used SCT in controlled experimental trials found that 12 published interventions with mostly uninfected individuals all obtained positive changes in risk behaviour, with a medium effect size meeting or exceeding effects of other theory-based behavioural change interventions.</p>
3. Theory of reasoned action	<p>The theory of reasoned action, developed in the mid-1960s, is based on the assumptions that human beings are usually quite rational and make systematic use of the information available to them.</p> <p>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, and that most actions of social relevance are under volitional control. The theory of reasoned action is conceptually similar to the health belief model but</p>

	<p>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 a behaviour will occur.</p> <p>A person's intention is a function of two basic determinants:</p> <ul style="list-style-type: none"> • attitude (toward the behaviour), and • 'subjective norms', i.e. social influence. <p>'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.</p>
4. Stages of change model	<p>This model, developed early in the 1990s specifically for smoking cessation, talks about six stages that individuals or groups pass through when changing behaviour: pre-contemplation, contemplation, preparation, action, maintenance and relapse.</p> <p>With respect to condom use, the stages could be described as:</p> <ul style="list-style-type: none"> • has not considered using condoms (pre-contemplation) • recognizes the need to use condoms (contemplation) • thinking about using condoms in the next months (preparation) • using condoms consistently for less than 6 months (action) • using condoms consistently for 6 months or more (maintenance) • slipping-up with respect to condom use (relapse) <p>In order for an intervention to be successful, it must target the appropriate stage of the individual or group. For example, awareness raising between stage one and two.</p>
5. AIDS risk reduction model	<p>The AIDS risk reduction model, developed in 1990, uses constructs from the health belief model, the social cognitive theory and the diffusion of innovation theory (a social model described below), to describe the process individuals (or groups) pass through while changing behaviour regarding HIV risk. The model identifies 3 stages involved in reducing risk for HIV transmission, including:</p> <ul style="list-style-type: none"> • behaviour labelling • commitment to change • taking action. <p>In the first stage, knowledge about HIV transmission, perceived HIV susceptibility, as well as aversive emotions influence how people perceive AIDS. The commitment stage is shaped by four factors: perceptions of enjoyment, self-efficacy, social norms and aversive emotions. Again, in the</p>

	<p>last stage, aversive emotions, sexual communication, help-seeking behaviour and social factors affect people's decision-making process</p> <p>Programmes that use the AIDS risk reduction model focus on:</p> <ul style="list-style-type: none"> • clients' risk assessment • influencing the decision to reduce risk through perceptions of enjoyment or self-efficacy • clients' support to enact the change (access to condoms, social support).
6. Diffusion of innovation theory	<p>The diffusion of innovation theory describes the process of how an idea is disseminated throughout a community. According to the theory, there are four essential elements: the innovation, its communication, the social system and time. People's exposure to a new idea, which takes place within a social network or through the media, will determine the rate at which various people adopt a new behaviour. The theory posits that people are most likely to adopt new behaviours based on favourable evaluations of the idea communicated to them by other members whom they respect. Kelly explains that when the diffusion theory is applied to HIV risk reduction, normative and risk behavioural changes can be initiated when enough key opinion leaders adopt and endorse behavioural changes, influence others to do the same and eventually diffuse the new norm widely within peer networks. When beneficial prevention beliefs are instilled and widely held within one's immediate social network, individuals' behaviour is more likely to be consistent with the perceived social norms.</p> <p>Interventions using this theory generally investigate the best method to disperse messages within a community and who are the leaders able to act as role models to change community norms.</p>
7. Social influence model	<p>This educational model is based on the concept that young people engage in behaviours including early sexual activity partly because of general societal influences, but more specifically from their peers. The model suggests exposing young people to social pressures while teaching them to examine and develop skills to deal with these pressures. The model often relies on role models such as teenagers slightly older than programme participants to present factual information, identify pressures, role-play responses to pressures, teach assertiveness skills and discuss problem situations. Social influence model has been used to reduce smoking among young people as well.</p>
8. Social network theory	<p>The social network theory looks at social behaviour not as an individual phenomenon but through relationships, and appreciates that HIV risk behaviour, unlike many other health behaviours, directly involves 2 people. With respect to sexual relationships, social networks focus on both the impact of selective mixing (i.e. how different people choose who they</p>

	<p>mix with), and the variations in partnership patterns (length of partnership and overlap). Although the intricacies of relations and communication within the couple, the smallest unit of the social network, is critical to the understanding of HIV transmission in this model, the scope and character of one's broader social network, those who serve as reference people, and who sanction behaviour, are key to comprehending individual risk behaviour. In other words, social norms are best understood at the level of social networks.</p> <p>Although few network-based interventions have been tried, the concept has proven complementary to individual-based theories for the design of prevention programmes by focusing on the partnership as well as the larger social group. Analysis of network mixing provides the means to see efficiency of transmission and effective points of intervention.</p>
<p>9. Theory of gender and power</p>	<p>Unlike the psychosocial theories which are essentially gender-blind, the theory of gender and power is a social structural theory addressing the wider social and environmental issues surrounding women, such as distribution of power and authority, affective influences, and gender-specific norms within heterosexual relationships. Using this theory to guide intervention development with women in heterosexual relationships can help investigate how a woman's commitment to a relationship and lack of power can influence her risk reduction choices.</p> <p>Programmes using the theory of gender and power would assess the impact of structurally determined gender differences on interpersonal sexual relationships (perceptions of socially prescribed gender relations).</p>
<p>10. Theory of individual and social change model</p>	<p>This theory asserts that social change happens through dialogue to build up a critical perception of the social, cultural, political and economic forces that structure reality and by taking action against forces that are oppressive. In other words, empowerment should increase problem solving in a participatory fashion, and should enable participants to understand the personal, social, economic and political forces in their lives in order to take action to improve their situations. Werner (1997) states that, "empowerment is the process by which disadvantaged people work together to take control of the factors that determine their health and their lives". For this to happen he explains that feelings of powerlessness, which can come from lack of skills and confidence, have to be cast off. Although empowerment can only come from the group itself, enabling empowerment is possible by facilitating its determinants. The common struggle against gender or ethnic oppression, economic exploitation, political repression or foreign intervention is what builds necessary confidence.</p> <p>A distinction is made between personal, organizational and community empowerment. Personal empowerment has to do with the psychological processes and is similar to self-efficacy</p>

	<p>and self esteem. Organizational empowerment encompasses both the processes that enable individuals to increase their control within the organization and the organization to influence policies and decisions in the community. An empowered community uses the skills and resources of individuals and organizations to meet respective needs.</p> <p>Interventions using empowerment approaches must consider key concepts such as beliefs and practices that are linked to interpersonal, organizational and community change. Intervention activities can address issues at the community and organizational level such as central needs the community identifies, and any history community organizing among community members. The theory would prescribe including participants in the planning and implementation of activities.</p>
<p>11. Social ecological model for health promotion</p>	<p>According to this model, patterned behaviour is the outcome of interest and behaviour is viewed as being determined by the following:</p> <ul style="list-style-type: none"> • intrapersonal factors – characteristics of the individual such as knowledge, attitudes, behaviour, self-concept, skills • interpersonal processes and primary groups formal and informal social network and social support systems, including the family, work group and friendships • institutional factors – social institutions with organizational characteristics and formal and informal rules and regulations for operation • community factors – relationships among organizations, institutions and informal networks within defined boundaries public policy – local, state and national laws and policies <p>Intervention strategies range from skills development at the intra-personal level to mass media and regulatory changes at other levels. The theory acknowledges the importance of the interplay between the individual and the environment, and considers multi-level influences on unhealthy behaviour. In this manner, the importance of the individual is de-emphasized in the process of behavioural change.</p>

Group discussion

- What is the role of behavioural theory in HIV and AIDS prevention programmes in South Africa?
- How do we utilise these behavioural models in our own programmes?
- Can you identify any of these models in prevention programmes in South Africa?
- How do myths in communities hamper our prevention initiatives and how can we curb them?