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The efficacy of integrative model of behavioural prediction in guiding communication in the male circumcision campaign among the traditionally non-circumcising Luo of Kenya: A review

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Abstract: Theoretical constructs provide a basis for developing behaviour change communication. However, there is limited direct evidence on the efficacy of behaviour change communication theories in predicting behaviour of those targeted in the voluntary medical male circumcision (VMMC) programme for the prevention of HIV/AIDS in Kenya. This paper evaluates the efficacy of the Integrative Model of Behavioral Prediction (IMBP) as a guide to developing communication strategies for male circumcision among the traditionally non-circumcising Luo of Kenya. It arises from the challenges to the presumed universality of Western-based behaviour change theories, which predominantly target the individual in change messages, yet most culture-related behaviours in closely-knit cultures of Africa reside not in the individual but in the community. With IMBP as the focus of analysis, I review extant literature on behaviour change communication theories and practice, discussing the place and influence of the Luo culture, and the community's cultural standpoint regarding male circumcision, in the VMMC campaign. I argue that the Luo are a culturally cohesive ethnic group, with non-circumcision as their collective mark of cultural identity, and, thus, a communication strategy targeting individuals' self-efficacy risks failing due to the collectivistic location of circumcision. The paper concludes that IMBP is inadequate to the extent that it targets the individual in a behaviour that is community-centred.

Keywords – Behaviour change communication, Luo Community, Male circumcision, Theories and models

1. INTRODUCTION

Kenya is one of the countries in Africa with the highest HIV burden, with more than 1.4 million individuals living with HIV (NSDCC, 2024). The epidemic exhibits geographical diversity, with prevalence rates of 14.5% in Kisumu County, 15.5% in Siaya County, 14.3% in Homa Bay County, and 13.3% in Migori County, all located in the Nyanza region. In contrast, the rates are significantly lower in Kenya's northeastern region, with 0.8% in Garissa County, 0.2% in Mandera County, and 0.1% in Wajir County (NSDCC, 2024). One of the key demographic distinctions between the two regions is the prevalence of male circumcision, with Nyanza having the lowest prevalence at 45.7% prior to the start of the national medical male circumcision programme in 2008, while the north eastern region led at 99.7% around the same time. Nyanza region's most numerically dominant ethnic community is the Luo, who occupy

four of the six counties and 16 out of the total 34 sub-counties therein. Given the substantial evidence that male circumcision markedly decreases a man's risk of acquiring HIV during sexual activity (Grey, Kigozi, Serwadda, Makumbi, Watya, & Nalugoda, 2007), Kenya initiated the voluntary medical male circumcision programme in 2008 to mitigate the spread and effects of HIV and AIDS.

Communication plays a crucial role in any action aimed at minimising health risks (Corcoran, 2007). It is central to HIV/AIDS response strategies that seek to transform behaviour (Airhihenbuwa, Makinwa & Obregon, 2000). Yet despite many years of HIV/AIDS communication programmes in developing nations, progress in the efforts to reduce infection in many countries remains average at best. For success to be realised, efforts in response to HIV/AIDS require an effective communication strategy grounded in a sound theory that gives birth to a flexible framework that guarantees application in different regional and cultural contexts (Airhihenbuwa & Obregon, 2000). Since the emergence of HIV/AIDS, a number of psycho-social theories and models have been applied, with varying success rates, to the development of communication strategies for prevention and care.

Questions have, however, arisen regarding the effectiveness of some theories commonly used to guide the development of communication strategies in response to HIV/AIDS, particularly in Africa, Latin America, Asia, and the Caribbean as well as their diaspora (Airhihenbuwa, 1995; Dutta-Bergman, 2005). Of concern is the theories' efficacy in contexts different from those where they were developed and tested (Airhihenbuwa & Obregon, 2000). A common factor in this conversation is the place of community and culture, and whether they are taken into account in the planning, implementation, and evaluation of health communication programmes in general and HIV/AIDS response in particular (Dutta-Bergman, 2005; Corcoran, 2007).

More often than not, theories and models designed to facilitate the execution of health projects in a population are not evaluated for their relevance (Airhihenbuwa *et al*, 2000). Besides, those using the BCC theories for HIV/AIDS response often try to fit the execution processes into the rules of a dominant theory in social psychology rather than allow the field experience to shape its own framework. And in trying to align the programme to the theory—what Airhihenbuwa *et al.* (2000) call focus on theories for intervention rather than theories of interventions—the role of cultural context in the implementation is often omitted, despite abounding evidence that culture is important in shaping health behaviour and decision (Ho & Sharf, 2021).

2. LITERATURE SURVEY

2.1. Male circumcision as a religious and cultural requisite

Male circumcision has a historical precedent among ancient Semitic populations, including Egyptians and Jews. The earliest documentation of this practice is found in Egyptian temple and wall paintings, which date back to approximately 2300 BC (Sudhe, Gumo & Iteyo, 2021). In Judaism, male infants undergo circumcision on the eighth day of life, barring any medical contraindications. The Torah provides justification for the covenant established between Abraham and God, with circumcision serving as the outward sign for all Jewish males. The Torah states: "This is my covenant, which ye shall keep, between you and thy seed after thee: every male among you shall be circumcised " (Genesis 17:10). Male circumcision continues to be almost universally practiced among Jewish people.

Islam represents the largest religious demographic that engages in the practice of male circumcision. Islam, as an Abrahamic faith, incorporates circumcision as a manifestation of the adherents' covenant with Allah, referred to as 'tahera', which translates to purification. The global propagation of Islam from the 7th century AD resulted in the widespread adoption of male circumcision among populations that had not previously practiced the procedure. Circumcision in Islam does not have a specified age. However, Prophet Muhammad advised that it should occur at an early age and is said to have circumcised his sons on the seventh day after their birth. Numerous Muslims observe the rite on this day; however, circumcision may occur at any age from birth to puberty. The Coptic Christians in Egypt and the Ethiopian Orthodox Christians, two of the oldest surviving branches of Christianity, preserve numerous characteristics of early Christianity, such as the practice of male circumcision.

While many contemporary Christian groups view circumcision as a religious practice, it is not mandated in all branches of Christianity. In the New Testament, St. Paul states: "in Christ Jesus neither circumcision nor non-circumcision count for anything" (Galatians 5:6). Additionally, a Papal Bull issued in 1442 by the Roman Catholic Church declared male circumcision unnecessary: “Therefore it strictly orders all who glory in the name of Christian, not to practise circumcision either before or after baptism, since whether they place their hope in it, it cannot be observed without loss of eternal salvation.” In most of sub-Saharan Africa today, there is no consensus on whether male circumcision is compatible with Christian beliefs. Some Christian churches in South Africa oppose the practice, viewing it as a pagan ritual, while others require circumcision as a mark of authenticity of a member (Sudhe *et al*, 2015).

The Nomiya church is of particular interest to this study, because the denomination is predominantly domiciled in the Luo community and has practised circumcision as a religious ritual since it was founded in 1912 in Asembo Location of Siaya (in Luoland) by Prophet Johanna Owalo, a Luo patriarch, who, had decamped from the Anglican Church (Sudhe et al., 2015).

Circumcision has been a cultural practice for millennia in sub-Saharan Africa and among various ethnic groups globally, including Aboriginal Australians, the Aztecs and Mayans in the Americas, and populations in the Philippines, Eastern Indonesia, and several Pacific Islands such as Fiji and the Polynesian islands. In many cultures, circumcision serves as a crucial rite of passage to manhood, although it may have initially functioned as a test of bravery and endurance. It is linked to factors such as masculinity, social cohesion among peers, self-identity, and spirituality (UNAIDS, 2007).

Ethnographer Arnold Van Gennep (1960), in his work 'The Rites of Passage,' outlines various initiation rites found in numerous circumcision rituals. The process consists of three stages: separation from conventional society, a transformative period for the neophyte and subsequent reintegration into society with a new social role. This classification is important to the present review, as it contradicts arguments by some scholars (for instance, K’Aoko, 1986) that the Luo practiced male circumcision.

Numerous rituals ascribe particular significance to circumcision, thereby legitimising its role within this context. Certain ethnic groups, such as the Dogon and Dowayo of West Africa, as well as the Xhosa of South Africa, perceive the foreskin as the feminine aspect of the penis. The removal of the foreskin, along with the completion of specific tests, is thus seen as a rite of passage into manhood for the child. In numerous African ethnic groups, the imperative for circumcision is rooted in the preservation of tradition. In certain contexts where circumcision is prevalent, non-circumcised men may experience discrimination. In Zambia, the Lunda and Luvale tribes, as well as the Bagisu in Uganda, consider remaining uncircumcised unacceptable, leading to the prevalence of forced circumcisions among old “boys.” In South Africa, among the Xhosa, uncircumcised men may face severe penalties, such as bullying and physical violence.

2.2. Male circumcision as a health practice

The UNAIDS (2007) estimates that only approximately 30% of all males across the world—representing a total of approximately 670 million men—are circumcised. With the recent findings that male circumcision significantly reduces a man’s risk of acquiring (Auvert, Taljaard, Lagarde, Sobngwi-Tambekou, Sitta, Puren, et al., 2005; Bailey, Moses, Parker, Agot, Maclean, Krieger et al., 2007; Gray, Kigozi, Serwadda, Nalugoda, 2007; Watya et al., 2007), the practice is receiving renewed interest as the world seeks to incorporate VMMC into the broader spectrum of HIV/AIDS prevention and management. Long-term follow-up of the participants of this study has shown that the protective efficacy of male circumcision increases with time from surgery (Tobian & Gray, 2013; Tobian, Gray & Quinn, 2010).

While VMMC has largely been marketed as primarily a male issue, at least in Kenya, research has also reported derivative benefits for female partners of circumcised men; the risk of HR-HPV for female partners was reduced by 28%, the risk of bacterial vaginosis was reduced by 40%, and the risk of trichomoniasis was reduced by 48% (Waweru,

et al, 2011). Besides the prevention of HIV, male circumcision has been shown to reduce the risk of other heterosexually acquired sexually transmitted infections (STIs). Two trials demonstrated that male circumcision reduces the risk of acquiring genital herpes by 28% to 34%, and the risk of developing genital ulceration by 47% (Tobian et al., 2010). Additionally, the trials found that male circumcision reduces the risk of oncogenic high-risk human papillomavirus (HR-HPV) by 32% to 35% (Tobian et al., 2010).

Launched in 2008 by Kenya's Ministry of Health, the voluntary medical male circumcision programme mainly targeted the traditionally non-circumcising communities, including the Luo, Turkana, Teso, and a pocket of Luhya subtribes, namely Samia (NASCOP, 2008). Within five years of its launch, the programme had been declared a major success story (Galbraith et al., 2014). The proportion of men who reported being circumcised increased significantly from 85.0% in 2007 to 91.2% in 2012. Despite this success, early reports indicated that the uptake was still lowest among the Luo, and Turkana, [with Galbraith et al. (2014:1), and Macintyre et al. reporting that VMMC was lowest among the Luo and Turkana,]delete two of the main traditionally non-circumcising communities in Kenya, with Galbraith et al. (2014:1), saying: "Despite this accomplishment, the Nyanza region (where the Luos live) remains below the target to circumcise 80% of all eligible men aged 15–49 years between 2009 and 2013. In both instances, culture was cited as one of the main reasons for the low uptake of VMMC. In their study on the barriers to interpersonal communication in the VMMC implementation programmes in Siaya county of Kenya, Otteng, Kiptoo & Wenje (2020) cited culture as a hindrance to the acceptance of VMMC among the Luo people of Siaya. Up to 68.5 percent of the respondent thought that the VMMC implementers' failure to appreciate the local culture was a major barrier to the success, while a large majority (71.7%) agreed that the Luo community's cultural beliefs regarding male circumcision presented a problem in the VMMC campaign.

2.3. The Luo, their collectivistic system, and their non-circumcising tradition

The Luo, as a distinct cultural group, are found in South Sudan, Ethiopia, Kenya, Uganda, Tanzania, and the Democratic Republic of Congo (Ojwang, 2005). The Luo of Kenya speak Dholuo, and live along the shores of Lake Victoria, spilling into North Mara in Tanzania. In Kenya, the Luo are the fourth largest ethnic community, totalling 4,663,910, according to the last national census in 2019 (KNBS, 2020). They are found in the diaspora in all major towns in East Africa and major cities of the world.

The Luo of Kenya settled in their present localities between the 17th and 18th centuries (Ndeda, 2004). By 1900, the Luo settlements were complete, with their politico-religious and socio-economic systems intact. *Dala* (homestead) is the basic unit of society, both politically, socially and economically. Thus, the structure of the Luo society is dictated by the grouping of a man, his wife or wives, and children, as well as the type of economic production pursued by the household (Schiller 1982). The owner of the homestead, the man, is the primary authority therein. In a polygamous homestead, the husband is the head of many households. Co-wives live in separate houses within the homestead (Ocholla-Ayayo 1980). Each co-wife is, therefore, *wuon ot*, (the owner of house) and the leader of its domestic and economic activities. Under her are her children who grow up with the idea of *odwa* (our household), thus planting the concept of collective ownership or belonging. Each household (*ot*) is charged with all the activities required for the maintenance and needs of its members, including production, deployment, and use of labour power and the determination of economic objectives.

Land is allocated to the household and not the individual. The land of a mother is shared by her sons as they marry, and it immediately becomes communally owned. A mother will usually give her son a part of her farms and his wife retains usufructuary rights. The land is referred to henceforth as *puoth nya'kumanyien,* literally meaning the farm of the women from the foreign place (her place of birth), or *puoth nya' ng'ane* (the farm of the daughter of so and so), and this becomes the inalienable property of her sons. If the woman, however, deserts before bearing a male child, the farms revert to the man (Wilson 1965). If she has a male child before desertion, her farms become her son's future inheritance (upon his return), no matter how long he remains with his mother elsewhere. Polygamy is accepted among the Luo, although the advent of the Christian faith, which the Luo, like other African peoples, embraced at

the turn of the 19th century, frowned upon it, leading to a significant decline in the practice. Politically, the Luo nation is headed by the Council of Elders under the leadership of *Ker.*

The most notable rite of passage among the Luos is the removal of six lower teeth by both boys and girls as they reach puberty. However, this has since been discarded, except among the faithful of the Legio Maria, an African-initiated Christian church mainly found in Luoland. The sect's adherents extract six lower anterior teeth as a religious rite of passage.

Male circumcision as a rite of passage is alien to the Luo. It is only practiced as a religious rite among members of the Nomiya Church, a small denomination introduced in the Nyanza around 1912 by a Luo convert, Prophet Johanna Owalo (Sudhe, Gumo, & Iteyo, 2015). The Nomiya Church was the first of the myriad independent African Christian churches established by Africans, apparently to countermand Western culture embedded in the missionary theology (Taylor, 2001). However, it is noteworthy that the Nomiya Church congregation constitutes a negligible fraction, accounting for slightly below one-eighth of the Luo population, and its presence in their midst has not influenced any significant move towards male circumcision except among its adherents.

K'Aoko's (1986) characterisation of Luo men's cutting of the connective tissue that joins the foreskin to the male genital as circumcision has been disputed by many scholars and commentators on two fronts. Firstly, the original strict narrow dictionary definition of circumcision as the "cutting off of the loose skin covering the end of the male sex organ, they argue, precludes the act of merely disconnecting a small portion of the under-skin from the rest of the genital. Secondly, they observe that circumcision, whether for cultural or religious reasons, has been performed in a ceremonial fashion and involves an entire group and not an individual self-administered operation, as done by the Luo boys as they get into puberty. Furthermore, they cite Gennep's (1960) three-stage process found in all circumcision undertakings, namely separation from normal society; a period during which the neophyte undergoes transformation; and, finally, reintegration into society in a new social role. This process is lacking in the case of Luo "circumcision," where the boys self-administer the act using various methods like the *okoko* (soldier ant method), *wino* (the fly whisk method), or the *opila* method (sugarcane rind method), among others (K'Aoko, 1986). This review does not venture into the merits or demerits of either side of this debate, as that is outside its scope.

Thus, the non-practice of male circumcision, as conventionally known among the Luo, is considered a traditional norm rather than a cultural omission, and while the traditionally circumcising communities have held non-circumcision as a factor of ridicule for the Luo men (Sifuna, 2021), the community largely sees nothing wrong. This reality is manifested in their disdain for circumcised men, whom they refer to disparagingly as *rayuom* - the circumcised (Obure, Nyambedha & Oindo, 2011).

The introduction in 2008 of the voluntary medical male circumcision as a measure to check the spread of HIV/AIDS in the community presented a dilemma where individuals had to choose between their own survival and the survival of the tradition. Thus, to a segment of the Luo community, circumcision came as a relief to the ridicule and condescension that they say the community has long endured from the country's traditionally circumcising communities (Sifuna, 2021). To another large segment of the community, however, this new practice comes as an affront on the community's cultural identity, cultural integrity, ethnic identity, and even traditional customary law (Obure, Nyambedha, & Oindo, 2011). *Ker* (Luo supreme cultural leader) Riaga Ogall Luo captured this dilemma aptly thus: "That we do not practise circumcision has been used to despise us, make us feel like we are not worthy of national leadership…so when the doctors came here, we asked them: Are you trying to make us lose our pride in being Luo…?'" (*Daily Nation*, May 20, 2016).

2.4. The Integrative Model of Behavioral Prediction

The integrative model of behavioral prediction (IMBP) is the most recent development in behavioral prediction theory using the reasoned action approach (Fishbein, 2000; Yzer, 2012). Fishbein first introduced the IMBP in the 4th International AIDS Impact Conference in 1999 (Dai, 2018) and later published the IMBP in AIDS Care (Fishbein, 2000). The model offers an integrative view of behavioral prediction based on the theory of reasoned action (Fishbein

& Ajzen, 1975), and the theory of planned action (TRA) states that attitudes and subjective norms predict one's intention to perform a behaviour, and such intention then predicts the behaviour. Attitudes are positive or negative evaluations of behaviour, and they stem from outcome expectancies associated with that behaviour (e.g., voluntary medical male circumcision can prevent HIV infection). Perceived subjective norms are the perceived social pressure to perform or not to perform the behaviour in question (Dai,2018). The TPB extended the TRA by introducing perceived behavioral control as a new predictor of behavioral intention. Perceived control beliefs, or self-efficacy, refer to a person's perceptions of his/her ability to engage in a behaviour (e.g., I think I can be circumcised). Attitudes, subjective norms, and perceived behavioral control together predict behavioral intention in TPB, and then the intention subsequently predicts behaviour.

Fishbein (2000) created the IMBP by expanding the main framework of the TBP, itself a modification of the TRA, by first adding to the IMBP background variables as the distal predictors with impacts on attitudes, normative beliefs, and perceived behavioral control (Dai, 2018). Beliefs are subjective probabilities, and include observational, informational, and inferential beliefs (Fishbein & Ajzen, 2010). Background variables contribute to the individual differences in behavioral beliefs. Second, Fishbein further specified two categories of subjective norms: injunctive and descriptive. Injunctive norms refer to one's perceptions of what other important people (important others) think about the behaviour (e.g., my girlfriend thinks I should be circumcised), and descriptive norms refer to one's perceptions of what other important people do (e.g., my boyfriend is circumcised) regarding a behaviour.

Different scholars have used different ways to measure the three behavioral beliefs, namely attitudes, normative beliefs, and perceived behavioral control. For example, one of the differences in operationalization is the choice of direct versus indirect measures of the behavioral beliefs. Direct measures refer to the general and broad assessment of attitude, norms, and perceived behavioral control, while indirect measures mean "the distal indices of the salient behavioral beliefs that inform those broader constructs" (Dai, Wombacher, Matig, & Harrington, 2017: 3). Indirect measures assess both the evaluations of beliefs and the strength with which people hold them. Third, Fishbein added actual control variables to the theory. Specifically, in some cases, the intention-behaviour relationship can be moderated by what Fishbein and Ajzen (2010) call "actual control" variables, or the individual skills and environmental factors that influence eventual behaviour. The duo emphasizes the importance of these actual control variables, stating that a behaviour is possible when:

- **i.** the person has formed a strong positive intention (or made a commitment) to perform the behavior,
- **ii.** there are no environmental constraints that make it impossible for the behavior to occur, and
- **iii.** the person has the skills necessary to perform the behavior. (p. 19)

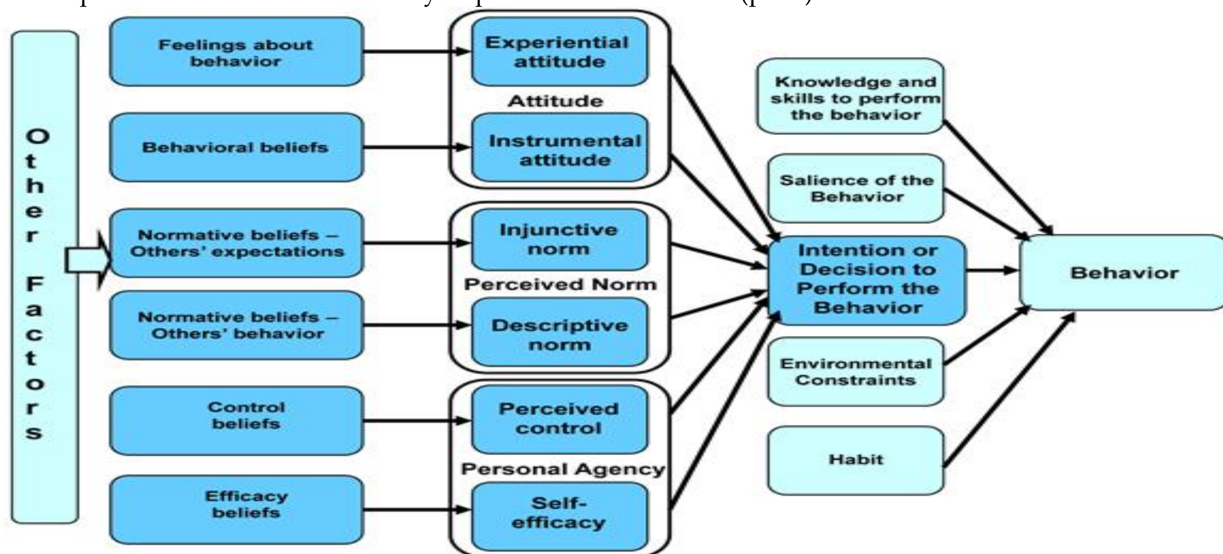

Figure 1: IMBP (Source: Fishbein, 2000)

The Integrative Model of Behaviour Prediction (IMBP) posits that altering the beliefs that underlie a behaviour's intention eventually causes the intention to change. According to the model, a behaviour is more likely to occur if the individual has a strong intention to engage in it, if they possess the skills and talents needed to do so, and if there are no external factors that prohibit them from doing so. (Fishbein & Capella, 2006). If a man has developed a strong intent for circumcision, and possesses the requisite skills and abilities to be circumcised, and if there are no environmental constraints to prevent the taking of the cut, there is a high probability that he will be circumcised (Fishbein, 2000; Fishbein et al., 2002).

This suggests that different kinds of behaviour change messages will be required for individuals who have made a decision but are unable to follow through, as opposed to those who have little or no intention to follow the suggested course of action. Therefore, in certain situations, the behaviour might not be carried out because people have not yet made up their minds to do so, while in other situations, the issue might be a lack of abilities or the existence of environmental limitations. This means that those engaged in developing communication strategies will have to be conscious of the factors that will influence action or inertia in each case. A communication intervention will focus on either skill development or reducing (or assisting individuals in overcoming) environmental restrictions if people have formed the desired intention but are not acting on it.

Conversely, in the absence of strong intentions to carry out the behaviour in question, the model identifies three key factors that will determine intention: self-efficacy regarding carrying out the behaviour, perceived norms regarding carrying out the behaviour, and attitude towards carrying out the behaviour (Fishbein & Ajzen, 2010). The behaviour and the population being studied will determine how significant these three psycho-social factors are as predictors of intention. For example, considerations of self-efficacy may impact one behaviour, whereas attitudinal factors may lead to another particular behaviour. Likewise, an action that is motivated by norms in one group may be motivated by attitudes in another. Therefore, it is necessary to ascertain the extent to which an intention is controlled by normative, attitudinal, or self-efficacy factors in the population prior to formulating and developing a communication campaign to impact or alter intentions.

IMBP also acknowledges that attitudes, perceived norms, and self-efficacy are all products of underlying beliefs about the benefits of carrying out the suggested behaviour, the normative proscriptions (injunctions) of particular referents, and particular obstacles to (or enablers of) behavioural performance (Yzer, 2012). In the case of VMMC, for instance, the more convinced a man is that being circumcised prevents HIV infection, the more positive his attitude should be to circumcision. In the same vein, the higher the conviction that the “important others” want or do not want him circumcised, and the higher his motivation to follow those important others, the stronger the subjective norm will be to perform or not accept the behaviour. Finally, the stronger the man’s perception that he has the requisite skills and capacities to take the “cut”, the greater will his self-efficacy be regarding the procedure.

The integrative model of behaviour prediction is significant in the communication campaign to engender attitude change in respect of male circumcision, which is seen as a major tool in the response to the HIV/AIDS menace among the traditionally non-circumcising communities in Kenya. This is because, as one of the most recently developed behaviour change communication theories, IMBP has the key ingredient necessary for the modification of behaviour.

2.5. The Luo culture versus IMBP assumptions in the context of the VMMC campaign

Health campaign theories and models originate from social psychology traditions. They primarily focus on the individual (Wallack, 1989). In IMBP, a particular facet of an individual's attitude, belief, or cognition is identified as the focus for a communication strategy aimed at altering behaviour. The individual functions as the subject of theoretical application and directs the health communication methodology, the decision-making role is allocated to the individual (Dutta-Bergman, 2005). While IMBP acknowledges the targeted individual’s assessment of significant others within the interpersonal network, it fails to adequately address the intricate social dynamics that influence certain health behaviours, such as circumcision. In complex behaviours, social influence extends beyond a limited number of significant individuals to encompass the wider socio-cultural context of the community (Dutta-Bergman,

2005). This is especially true in a culturally cohesive society like the Luo community (Ndeda, 2005). The Luo are the most culturally distinct of the three main non-circumcising communities in Kenya (the rest being the Turkana and Teso), their key distinguishing aspect being non-circumcising culture (Sifuna, 2021). Thus, when dealing with a culturally sensitive practice, like circumcision, in a setting, where getting circumcised means embarking on a path to identity loss, the individual could find himself under pressure to cast his net wider beyond the "important others", which, in the definition of Fishbein and Capella (2006) is confined to the narrow circle of family and friends. The individual may be compelled to engage in a behaviour due to its inherent nature within a collectivistic context, rather than solely being motivated by the influence of significant others in their immediate family (Dutta-Bergman, 2009).

At the launch of VMMC, the government appeared to recognise this fact and, instead of targeting the individual Luo men, sought the consensus of the wider community leadership, particularly the traditional segment (Rosenberg et al., 2012). The then Prime Minister, Raila Odinga, a Luo, met with about 500 influential Luo, seeking to secure their buy-in. These included members of the Luo Council of Elders, scholars, politicians, and health experts. Raila pleaded: "I know circumcision will raise a lot of eyebrows, but there is evidence that it reduces infection by as much as 60%. We should not just say that this is not our culture" (*Daily Nation,* Tuesday, September 23, 2008).

Notably, even amid the pleas by top political leadership (the late Mr. Odinga was largely considered the Luo community's undisputed political supreme leader), the Council of Elders, the designated custodians of the Luo culture and traditions, was largely unconvinced that this was not an assault on the community's cultural order. Their chairman said: "Aids is killing us, we are going to kill it. But do not kill our integrity. Do not kill what makes us Luos" *(Daily Nation,* September 23, 2008). The pre-eminence of culture and collective rather than individual efficacy was expressed in the incorporation of members of the Luo Council of Elders in the 13 district-circumcision steering committees that coordinated the VMMC exercise, an action that the government acknowledged as having played a pivotal role in soaring up the uptake of the programme (*Daily Nation,* April 6, 2006). The strong negative community attitude to circumcision is thus bound to affect the perception of the individual who, relying on the injunctive, will be constrained to reject the proactive (Dai, 2018; Dutta-Bergman, 2005).

In their study on psychosocial factors influencing promotion of male circumcision for HIV prevention in a non-circumcising community, Obure, Nyambedha, Oindo and Kodero (2009: 671) list culture and community-think as the first in line of the most frequently mentioned obstacles to promoting male circumcision, coming before pain, healing complications, and costs. They also mention as an inhibition the stigma emanating from the disdain with which the community treats circumcised men. The labels associated with circumcised men or those with shortened prepuces, like *rayuom* and (circumcised) or *apum* (incomplete) or *mwache* (non-Luos), are pejorative terms often used to refer to men who are circumcised, or whose prepuces are shortened, and "circumcised or had congenitally shortened prepuces, were embarrassed and experienced isolation".

The foregoing may explain the finding by Galbraith *et al.* (2014*)* that although there is high intention by the people, the Luo people's Nyanza region has the lowest uptake of VMMC "despite high intention." IMBP prescribes that where intention to perform an act or change behaviour is high, messaging should be geared towards addressing the individual's skills and abilities, and environmental factors (Fishbein 2000). However, this prescription may be constrained by the fact that the problem is not an individual's lack of skills and ability, and environmental constraints (availability of non-availability of health facilities, and many more). Thus, even if the individual has the intention to perform the prescribed intervention, the power to act resides outside of him. While, as a Luo, a man may have the intention, the ability, and a conducive environment to undergo circumcision, he will still feel constrained not to do so because the intervention runs counter to the collectivistic norm.

Moreover, even if the environment were to include the community, as envisaged in the IMBP, studies show the propensity to focus on the individual skills at the expense of the environment and other extraneous factors, a fact that is attributable to the Western orientation, where the individualistic approach towers over the collectivistic (Dutta-Bergman, 2005). In their examination of sexually transmitted infections testing behaviours among vocational students in the Netherlands, Wolfers et al. (2010) measured skills by examining STI knowledge but left out the

environment, which can be interpreted to mean the location of behaviour change in the individual efficacy rather than the collective control. It is further noteworthy that the environment as perceived in the IMBP and related Western-based theories does not include the people in the individual's life; rather, it is the space in physical space in which health transactions take place, like the health facilities (Dai, 2018).

Like the two preceding behavioural theories (TRA and TPB), which place the individual at the centre of decision-making, IMBP assigns little latitude to the wider culture, which, nonetheless, straddles the entire universe of the Luo ethnic structure. Even in the narrow sense, the function of the important others in behaviour change communication (Fishbein & Ajzen, 1975) is worth putting in a proper cultural context, particularly when the intervention in question touches on sexually, a fairly emotive issue, which demands consensus building in the couple. However, the scope of the "important others" as envisioned by Fishbein et al. (2000) falls short of what, according to the Luo culture, would encompass important others when it comes to circumcising male children (Mboya, 1975). Moreover, even where there are all indications that the important others will play a significant role, the theory does not provide a clear guideline on how to involve them in the communication strategy. In their study on the importance of livelihood support programmes to aid health communication campaign to soar up the uptake of voluntary medical male circumcision in resource poor communities of Kenya, Otteng, Kiptoo, and Wenje (2020) found that the was no meaningful involvement of important others as women reported that the implementers of the project did not make any attempts to rope them into the project.

The distinct social and cultural difference between the non-Western societies in general and the Luo community in particular, where communication experts are applying the model to foster communication to increase the uptake of VMMC, raises questions as to the level of success. In their look into the interpersonal influences in the scale-up of male circumcision services in the Luo community, Obure, Nyambedha and Oindo (2011: 6) show that cultural inhibitions slow the uptake of VMMC. They quote a 31- year of Luo man as saying: "We have our elders and leaders, who are like the cultural watchmen… This circumcision touches on our culture, and there is a need to talk to the Luo Council of Elders so that they give it a green light. If they oppose it, projects promoting it will have it very difficult…There is a need to begin with and get the blessings of elders…"

Brown (2000) presents the example of cultures like the Philippines and Thailand, where young men frequent brothels as a rite of passage. He asserts that in these cases, attitudes and beliefs about brothel visits are not situated within the individual or significant others. The broader community emerges as the source of influence, transferring behavioural control from the individual to the collective. The above examples are in sync with the Luo practice of widow inheritance, a cultural practice which has been associated with the spread of HIV in the community (Perry et al, 2014), which has largely persisted despite concerted advocacy against it (Oluoch, 2013). This suggests that culture is collectivistic in nature and resides in the collective mores of the community. Individual decision-making is thus merely an expression of the cultural norms and rituals. Dutta-Bergman (2005) cites the research on HIV/AIDS in India, which shows that attitudes and beliefs about extramarital sex are embedded in the culture of the community. Thus, advocating abandoning the practice requires appealing to the collective action rather than an individualistic approach.

The Luo community traditionally does not engage in male circumcision, a practice derisively referred to as alien (Ndeda 2003). It is therefore worth bearing in mind that a Luo man remains uncircumcised not out of choice but because he is Luo. Dholuo terms *rayuon* and *apum,* meaning a circumcised one and one with an incomplete prepuce, respectively, are, by and large, unhonourable (Obure et al., 2009). Consequently, an individual Luo man may view the decision to perform male circumcision as one that transcends personal choice, opting instead to defer the matter to the broader community network rather than solely to a select few, such as his wife. In such a situation, the individualistic behaviour change messages derived from the IMBP framework may fundamentally contradict collectivistic value considerations (Dutta-Bergman, 2009). Consequently, while IMBP-based messaging may generate significant threat and response efficacy regarding circumcision, the likelihood of adopting male circumcision will remain minimal due to its dissonance with the prevailing cultural norms of traditional Luo society.

Airhihenbuwa and Oregon (2000) assessed the Social Learning Theory and Theory of Reasoned Action, arguing that while these theories have been deemed useful in HIV/AIDS communication campaigns in the United States of America, questions persist regarding their relevance in cultures where individual decisions are influenced by group norms, making individualism counterproductive.

The subjective norm, as explained in the IMBP, is largely applicable in the Western relationship culture where the individual is only "answerable" to a small circle of close relations (Dutta-Bergman, 2003), who thus become his important others. The African idea of important others in the entire community. As Obure and others (2011) found, to convince a Luo man to take the cut requires involving the entire clan and beyond. Most young men interviewed in their research agreed that: "We should have our elders involved in this...if they are made to be part of this thing, then we will start seeing it as normal... but if they continue criticizing male circumcision for cultural and political reasons, then these projects cannot go anywhere" (p. 6). As Ogutu (2001) says of the Luo system of marriage, "the woman, upon marriage "became invariably "*chi chuore*" (wife of her husband), "*chi ot*" (wife of the household), "*chi pacho*" (wife of the homestead), and "*chi oganda*" (wife of the clan)", so it is with all members of the community, more so the men and boys who are targeted for VMMC. Their belongingness resides in *oganda* Luo (the Luo nation), and this militates against the narrow Western concept of important others.

The foregoing conduct of the Luo community cannot be said to be idiosyncratic to the community, but an Africa-wide phenomenon. Michael (2020) avers that African communalism emphasizes the will of the community over and above every individual. Mentiki (quoted in Michael, 2020) says that community rather than qualities such as rationality, will or memory is the defining element of a person in Africa, while John Mbiti (1970: 141), in his seminal book *African Religions and Philosophies*, captures this communalistic attitude thus, "I am because we are, and since we are therefore I am." Michael (2020: 138) says:

> It is the community, understood as the society that decides what is right or wrong, good or bad. People rather than the individual or a person are recognized and acknowledged. No uniqueness of an individual, no difference among people, sameness is upheld. In Africa, a person is modelled and behaves according to the dictates of the community.

In their study on barriers to interpersonal communication in the VMMC campaign in Siaya county of Kenya, the same focus of this review, Otteng, Wenje and Kiptoo (2020) identified the Luo culture as a major factor in decision-making with regard to male circumcision, where family relations and sexuality-related protocols must be taken into account. The study found, for instance, that the decision to circumcise a boy, particularly in the rural setting, did not lie with the parents alone; his paternal grandmother had to give her consent since, traditionally speaking, the boy is her "husband," and thus her consent is needed for VMMC to take place. It is likely that if understood from the fairly narrow meaning of "important others" and personal agency envisaged in the IMBP, this only extends to a boy's parents and none beyond. Hence, Fishbein and Capella's (2006) theoretical standpoint advises the spreading of health decisions beyond the significant others. In advocating what they call "cultural competency" and "cultural humility," Ho and Fart (2021: 280) advise health service providers to recognize and appropriately address gender and cultural biases in themselves and in the process of health care delivery.

Acknowledging the limitations of individual psychological theories and models. Yoder, Hornick, and Chirwa (1996) have advocated for an emphasis on collective efficacy. Scholars, such as Bandura (1995), have introduced the concept of collective efficacy to highlight its significance in health behaviour, particularly in the context of health campaigns. The authors introduce the concept of collective efficacy, defined by Bandura (1995) as "people's beliefs in their joint capabilities to forge divergent self-interests into a shared agenda, to enlist supporters and resources for collective action, to devise effective strategies and to execute them successfully, and to withstand forcible opposition and discouraging setbacks" (Bandura, 1995: 33).

In culturally sensitive practices such as VMMC within non-circumcising communities like the Luo, individuals may feel more secure in collective decision-making rather than in individual choices. This, consequently, fosters collective efficacy (Bandura, 1995; Lupton, 1994; Wallack, 1989). This analysis focuses on a collectivistic culture that

prioritises collective identity, with barriers to the practice of male circumcision situated within this context (Dutta Bergman, 2003; Triandis, 1994).

Male circumcision is situated within the attributes of the collective, becoming an integral aspect of the cultural identity of the Luo community. This points to the possibility of failure if communication programmes are targeted at individuals, as advocated by IMBP, in the male circumcision campaign among the Luo. The implication of this is that the communication programme emanating from the assumption of IMBP and related theories may run counter to the norms of the targeted beneficiaries of health interventions. There is therefore a need to rethink the theoretical standpoint of African health campaigns, especially for interventions based in rural African populations with little influence from Western ways of thinking.

3. PROBLEM STATEMENT

Communication experts use social and behaviour change communication (SBCC) theories to design communication programs that address health problems. However, contestations have been advanced against assuming the universality of behaviour change theories with the argument that many of them focus on the individual as the unit of analysis. Yet most behaviour change in closely-knit cultures of Africa requires casting the SBCC net beyond the individual to the wider community of the targeted individual. The integrative model of behavioral prediction (IMBP) is the most recent development in behavioral prediction theory; an improvement of the two earlier theories, the reasoned action approach and the theory of planned behaviour. Although it is considered viable, there is limited evidence of efficacy in informing the development of communication programmes for HIV/AIDS interventions in Kenya. This paper evaluates the efficacy of IMBP in guiding communication in the male circumcision campaign to prevent HIV/AIDS among the traditionally non-circumcising Luo of Kenya. It traces the interplay between individualistic and collectivistic efficacy in the decision by a Luo man to accept circumcision, and examines the model's efficacy in guiding message development for an intervention that requires community-wide approval when the model's thrust is the individual as the unit of analysis. This study finds its relevance in the need to come up with theoretical frameworks that resonate with the populations under study and not the popular trends where populations are expected to fit with the theoretical frameworks.

4. RESEARCH METHODOLOGY

This paper examines the effectiveness of the integrative model of behaviour prediction (IMBP) as a theoretical framework for formulating communication strategies to promote the campaign for male circumcision among the Luo community in Kenya. It builds upon my previous research regarding the function of interpersonal communication in promoting voluntary medical male circumcision to prevent HIV infections in Siaya County, Kenya (Otteng, 2021), where my theoretical framework was based on IMBP.

Pitching my discussion on the experiences gathered from the above study, this paper asks whether IMBP suffices as a theoretical basis for developing a communication strategy to engender the individual acceptance of a behaviour like male circumcision in a community where non-conformity is deeply rooted as a communal norm, where the non-practice is significantly not individual but stems from collective ethnic mores and norms. Using the extant literature on IMBP as the focus of analysis, it critically evaluates the available literature on behaviour change communication theories. I also reviewed the place of culture and community in behaviour change campaigns. Further, I broadened the review to cover literature on the Luo people's cultural beliefs and practices that relate to circumcision, family and clan relationships, and their bearing on individual decision making. Besides the academic works on these areas, I reviewed past media reports on cultural beliefs and practices of the Luo community as related to male circumcision, and HIV and AIDS. The introduction of the VMMC in 2008 elicited robust debate, especially among members of the Luo community, with opinions ranging from support as a viable health intervention to outright rejection as "an alien practice brought here to erode our identity" (Daily Nation 2009). Thus, the question high on the mind of the government and its implementing partners was how they were going to navigate the cultural web to optimise the

intervention within a community that was already agitated by decades of ridicule due to their non-circumcising culture, a culture which, at the same time their source of pride and bedrock of their identity.

5. RESEARCH IMPLICATIONS

This study underscores the need to critically reassess the applicability of Western-based behaviour change theories in African cultural contexts. By examining the Integrative Model of Behavioral Prediction (IMBP), it highlights the limitations of individual-focused models in addressing behaviours that are rooted in collective cultural identity. The findings suggest that communication strategies for voluntary medical male circumcision (VMMC) must extend beyond individual self-efficacy to consider communal values, traditions, and identity markers. For the Luo community, where non-circumcision is a shared cultural symbol, interventions that ignore the community dimension risk rejection or ineffectiveness. This implies that culturally adaptive frameworks are essential in designing impactful health communication campaigns. Researchers are therefore encouraged to integrate sociocultural dynamics when applying or developing behaviour change models in African contexts. The study also opens space for rethinking how behavioural theories can be modified or hybridized to address collective practices. Moreover, it highlights the importance of engaging communities in co-creating messages that align with their values while addressing public health goals. Ultimately, the research challenges the universality of existing models and calls for new paradigms that harmonize individual behaviour change with community identity. This has broader implications for public health interventions beyond VMMC, particularly in culturally cohesive societies.

6. CONTRIBUTIONS TO SCIENTIFIC COMMUNITY AND FUTURE RESEARCH

This review contributes to the scientific community by critically assessing the applicability of the Integrative Model of Behavioral Prediction (IMBP) in a culturally specific African context. It advances scholarship by questioning the assumed universality of Western-based behaviour change communication theories, particularly in relation to HIV/AIDS prevention programmes. By foregrounding the Luo cultural identity and the collective significance of non-circumcision, the paper highlights the cultural embeddedness of health-related behaviours. This work contributes theoretically by demonstrating the limitations of individual-centered models when applied to community-centered practices. It enriches interdisciplinary debates across communication, public health, and cultural studies by integrating behavioural theory with anthropological insights.

Future research should explore alternative or hybrid theoretical models that better account for collectivistic cultures and communal decision-making. Empirical studies are needed to test communication strategies that shift the focus from individual self-efficacy to community-based efficacy. Thereviews provokes behaviour change communication scholars to carry out comparative research across different African ethnic groups, which would provide broader evidence on how culture mediates the reception of health interventions. Longitudinal studies could assess whether culturally adapted communication strategies influence not just behavioural intentions but also sustained behaviour change. Finally, it prods scholars to engage in research that incorporates participatory approaches with local communities, which would be valuable in co-creating communication models that align more closely with cultural realities.

7. CONCLUSION

This paper sought to establish the suitability of the integrative model of behavioral prediction in guiding communication in the male circumcision campaign targeting the traditionally non-circumcising Luo of Kenya in response to the HIV/AIDS pandemic, a campaign that has been hailed as the African continent's success story in the WHO-led voluntary medical male circumcision in HIV/AIDS burdened countries (Agot, Onyango, Ochillo, & Odoyo-June, 2022; *Daily Nation*, April 6, 2010). It focused mainly on Fishbein's (2000) treatment of key constructs of attitude, perceived norms, and personal agency, all of which revolve around the individual, and how these components can

help in developing communication messages targeting a behaviour that is largely community-driven. Based on the literature reviewed, this paper concludes and suggests as follows:

i. IMBP is particularly important in the way it pinpoints specific factors which influence behaviour acceptance or rejection, namely attitudes, norms, and self-efficacy. However, the model has serious weaknesses when it comes to developing communication programmes for culture-laden matters such as male circumcision among the non-circumcising Luo people. This is because IMBP is heavily preoccupied with the individual, while the Luo community exhibits a cohesive nature glued together by its non-circumcising culture. This calls for rethinking the model to cast its net wider beyond the individual if it is to be considered fit to guide the development of communication strategies.

ii. Fishbein's characterization of the two categories of subjective norms – injunctive and descriptive – is too narrow in the context of male circumcision among the Luo. A communication strategy for circumcision Luo me should necessarily cast the "important others" net far beyond the targeted men's sex partners (wives or girlfriends) to the wider family, the community, and its various facets of leadership.

iii. The culture of an individual has a profound effect on the way they deal with health and illness, considering that culture encompasses a people's total way of life; their way of thinking, doing things, and of being. This review suggests that IMBP does not provide adequate latitude for those developing communication strategies to take into account the role of culture in a culturally determined behaviour like circumcision among the Luo. There is therefore a need to see health and diseases as a cultural construct that requires communication theory and practice that attempts to deal with them, rooted in the cultural codes of a community.

iv. The fact that the VMMC programme is implemented by a mixed contingent of medical and paramedical practitioners, and logistical staff from a demographic diversity that includes people of varying age groups and cultures, creates a recipe for cultural discordance, hence slowing down the male circumcision uptake. This calls for the creation of cultural competence within the implementation team.

In a nutshell, this review brings to the fore the need to critically reassess the applicability of Western-based behaviour change theories in general and IMBP in particular in African cultural contexts. Itbsuggests the necessity of expanding behaviour change communication strategies beyond individual self-efficacy to consider communal values, traditions, and identity markers. It calls for culturally adaptive frameworks in designing impactful health communication campaigns. I recommens the rethinking how behavioural theories can be modified or hybridized to address collective practices. I believe the view that it is important to engage communities in co-creating messages that align with their values while addressing issues that transcend the realm of healthto touch on deep-rooted cultural practices, thereby developing new paradigms that harmonize individual behaviour change with community identity.

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