

## **Uncovering barriers to bilharzia prevention communication in Ugu district, South Africa: Lessons learned through participatory communication**

### *ABSTRACT*

Female Genital Schistosomiasis (FGS), commonly referred to as Female Bilharzia (FB), is a prevalent yet socially obscure disease. Caused by a waterborne parasite, it affects millions of people all over the world. Although it is a global health concern, FB is more pervasive in Sub-Saharan Africa. Motivated by the rapid response to treatment as demonstrated by rural Zimbabwean women, an organisation known as the FB Project conducted research exclusively with this group. Based in KwaZulu-Natal's Ugu District (Port Shepstone), the FB Project sought to raise an awareness of, to treat and ultimately eradicate the FB threat. This study investigated the most appropriate communication tools for achieving these goals. In 2012, in-depth semi-structured interviews were conducted with a sample of 20 female teenagers from both rural and urban areas across the Ugu District. Their perceptions of this issue highlighted various socio-cultural, economic and logistical constraints to effective FB communication. This paper explores these barriers and the implications they have for realising the project's goals. The opinions that are voiced by the participants underscore the value of adopting a participatory communication approach to addressing a health problem. The researcher's observations are also integrated into the discussion. The responses gathered from the participants were considered as recommendations that could support the design of a contextually-sensitive FB awareness campaign.

*Dr Lauren Dyll-Myklebust is a lecturer in the Centre for Communication, Media and Society (CCMS) at the University of KwaZulu-Natal (Howard Colleges), teaching graduate modules in development and public health communication from a participatory and culture-centred perspective. Ms Duduzile Zwane is an interdisciplinary lecturer whose health communication expertise is shared between CCMS and the Psychology department.*

## INTRODUCTION

Female Genital Schistosomiasis (FGS), known in layman's terms as Female Bilharzia (FB), is a highly widespread disease, yet the general public knows very little about it. The burden of FB is approximated to be 33% to 75% in Sub-Saharan Africa (Hotez, Fenwick & Kjetland, 2009). In the Ugu District (Port Shepstone), KwaZulu-Natal (KZN), where the Female Bilharzia (FB) project is based, 30% of the population was believed to be infected with it (Kjetland, Leutscher & Ndlovu, 2012). FB has long been suspected as being responsible for many seemingly minor illnesses that 'disappear' without treatment. However, it is only over the past two decades that its severity has been revealed (Hotez *et al.*, 2009). FB is caused by a freshwater parasite known as the *S. haematobium*, which enters the bloodstream via the skin. Symptoms include stomach cramps, unusual vaginal discharges and blood-stained urine (Helling-Giese *et al.*, 1996; Kjetland, 2014). If left untreated for a long time, FB creates chronic genital lesions which increase women's susceptibility to sexually transmitted diseases (STDs) and may lead to infertility (Kjetland, Hegertun, Baay, Onsrud & Ndhlovu, 2014). Treatment for FB is relatively simple and requires a patient to ingest a specific dose of Praziquantel, a drug approved by the World Health Organisation (WHO); (WHO, 2011, Kjetland *et al.*, 2012). However, Praziquantel is not considered as a permanent solution to FB, as it does not heal the genital lesions created by the parasite (Kjetland *et al.*, 2012). In this way, patients remain vulnerable to the disease with repeat exposure to water infested with *S. haematobium* (Kjetland *et al.*, 2012). Currently, a possible association between FB and an increased vulnerability to HIV is being investigated (Kjetland *et al.*, 2014).

This paper examines the insights gained from young women in the Ugu District's perceptions of FB. It highlights how communication can be a powerful tool for revealing a recipient community's beliefs about a health issue, and the barriers that prevent them from acquiring correct information about it. Furthermore, it explores how participatory forms of communication can be utilised to encourage their active participation in creating sustained change (Singhal & Rogers, 1999; Quarry & Ramirez, 2009; Dutta, 2008). The suggestions gathered from the young women are discussed as feasible recommendations that can be integrated into a future FB awareness campaign. In so doing, young women's voices can be heard and they have the opportunity to be at the helm of a health campaign developed by them, for them (Servaes, 1996; 1999; Dutta 2008). Since the overarching theme of the study is empowerment and participation, the theoretical section is underpinned by proponents of the participatory communication and the culture-centred approaches (Freire, 1985; 1972; Dutta 2008; Servaes, 1996; 1999; Melkote & Steeves, 2001).

### 1. CONTEXTUALISATION

In 2009, the FB Project was launched by several international organisations who had identified a need for treatment and awareness of FB in the Ugu District<sup>1</sup>. In order to highlight the fact that

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<sup>1</sup> These organisations are tertiary institutions, some of which specialise in medical research. They then collaborated with various local schools, clinics and the municipality to establish the FB Project.

Bilharzia can severely compromise an individual's health, the FB Project, together with its affiliates, supplied free treatment to both males and females at many schools in the area. This granted the FB Project access to a pool of young women who met the Project's research criteria. The decision to focus specifically on researching the impact of FB on young women was motivated by the positive response to treatment which had been exhibited during tentative work with a group of older rural women while the Project was based in Zimbabwe (Kjetland *et al.*, 2006). It was hoped that by focusing exclusively on younger women, FB could be curbed before it caused long-term health complications (Kjetland *et al.*, 2014). Furthermore, it would be an opportunity to establish the correlation between FB and the Human Immunodeficiency Virus (HIV). As an exogenous organisation that was embedded in the community for a substantial period of time, it became evident to the FB Project that there was a need for a revised communication strategy. Whilst notable milestones with regard to the provision of FB treatment were achieved, the communication gap between the Project and the community needed to be bridged. The researcher was involved as a communications researcher in this project. Her function was to facilitate dialogue between the participants, gather their recommendations and then examine how these could be integrated into a communications campaign.

### **1.1 Common health intervention challenges**

Literature on the successes and trials encountered by external health intervention programmes indicate that socio-cultural barriers are amongst the hardest to overcome (Kincaid & Figueroa 2009; Servaes 1996; 1999). In conservative communities, for instance, subject matter such as sexual and reproductive health needs to be approached with added caution (Hindin & Fatusi, 2009). While the FB Project's main concern was detecting and treating FB, the purpose ultimately was to encourage women to make responsible sexual health choices. However, creating a dialogue about this was a difficult undertaking, which is the norm in the developing world (Hindin & Fatusi 2009). This socio-cultural constraint is discussed alongside other challenges often encountered by health programmes.

#### ***Taboo nature of sexual and reproductive health***

Generally, in the developing world, openly discussing matters pertaining to sexual and reproductive health is considered a taboo (Hindin & Fatusi, 2009:58). Parents neglect to impart correct information to their children, because doing so would violate an unspoken social code of propriety (Aggleton & Campbell 2000; Kirby, 2002). Additionally, candid sexual health talk is perceived as condoning promiscuity amongst the youth:

Effective programs include activities that some parents and communities oppose because they fear that they will sanction and encourage sexual activity... many teachers and school districts do not realize that some sex-and-HIV-education programs have strong evidence for their success (Kirby, 2002:288).

Essentially, organisations such as the FB Project which seek to empower young people with accurate information on this subject struggle to gain support from parents, despite evidence

that the Project is effective. Peter Aggleton and Cathy Campbell (2000) indicate that often the youth are considered too immature to comprehend this kind of educational information. The general consensus within most conservative communities is that young people are too “hormonal” and “irrational” to understand such matters, because they lack “adult logic” (Aggleton & Campbell, 2000:285).

### ***Limited media coverage***

Studies also revealed that typically, media dominant diseases such as HIV/AIDS overshadow other health issues which affect young people (Hindin & Fatusi, 2009). FB is no exception to this trend. Drawing attention to its detrimental effects on young women’s health against the pre-eminence of the more ‘popular’ HIV/AIDS, was a constant challenge for the project (Zwane 2012). It can be inferred that with the media coverage consistently being dominated by information about a fatal disease such as HIV/AIDS, one with lesser known consequences such as FB is easier to dismiss. Faced with these barriers, it becomes even more imperative to find a communication vehicle that can pierce them successfully.

### ***1.2 Theoretical influences***

The theories which framed the study were popularised by advocates of beneficiary empowerment through equal participation and agency. All these scholars support instilling an attitude of self-reliance amongst aid recipients and respecting their capacity to reason for themselves (Servaes, 1996; 1999; Freire, 1990). Albert Bandura’s social cognitive theory (1995; 2004) and Kim Witte’s (1992) Extended Parallel Process Model (EPPM) also informed the study’s theoretical underpinning.

### ***Attributes of participation***

The participatory paradigm was implemented as a reaction to earlier dictatorial approaches to development communication such as the modernisation (Lerner, 1958) and dependency paradigms (Gunder-Frank, 1967). The latter notions of development had been criticised for failing to include the “beneficiary communities” in their attempts to address developmental needs (Dyll-Myklebust, 2011:10). The significance of their cultures and traditions was disregarded and dismissed as “backwardness and superstition” (Dyll-Myklebust, 2011:10). In contrast to this, the participatory paradigm emphasised inculcating a mind-set of empowerment and encouraged heeding community members’ voices (Melkote & Steeves, 2001; Dutta, 2008). In terms of health, the participatory paradigm is a “strategy that emphasizes the role of the community members in planning and managing their own health care” (Melkote & Steeves, 2001:208). Developing young women’s autonomy to manage their reproductive health by making responsible decisions was a long-term aspiration of the FB Project. Therefore, the core values of this paradigm were an appropriate framework for analysing whether its existing communication approach equipped them with the skills to do this.

### ***Developing critical consciousness and self-efficacy***

An important characteristic of the participatory approach is its capacity to trigger an empowered form of reasoning known as “critical consciousness” (Freire, 1990:47). The phrase has been used to denote people’s ability to reflect upon their realities and to effect positive changes. It was introduced by scholar and educator Paulo Freire after having witnessed the outcome of adopting a repressive and prescriptive form of engagement with learners. Being an educator, Freire (1990:49) realised that an authoritarian approach to teaching, which he termed the “banking method”, did not facilitate learning that stimulates transformative action. Instead, it teaches learners to be complacent conformists. According to Servaes (1996:80), Freire believed in “problem-posing education” which encourages “conscientization” and results in people gaining an understanding of their situation [and] confidence in their ability to change that situation”. Freire’s (1985; 1990) work highlighted the style of teaching that was most likely to help young women grasp FB facts and demonstrate the agency to adopt positive behaviours.

Bandura’s (1995; 2004) social learning theory was also instrumental in the researcher’s unpacking of participants’ responses. It is a framework for explaining how people acquire and maintain certain behaviours and it has become a popular tool for developing health communication campaigns (Bandura, 1995; 2004). Central to this theory are the concepts of role modelling and self-efficacy. The former refers to people learning and adopting behaviours displayed by positive role models, whilst the latter refers to the belief that one can exert control over events in one’s life (Bandura, 1995; 2004). It was important to determine whether or not the study’s participants had role models whose behaviour towards managing FB could be emulated. To this end, enlisting the help of a popular figure to champion this cause was considered for the communication campaign. Determining participants’ self-efficacy beliefs was also critical to the success of the programme, because the beliefs affect “the health goals that people set for themselves and the concrete plans and strategies for realising them” (Bandura, 2004:144). Further, the FB Project envisioned the communication campaign as an undertaking that would activate a sense of collective efficacy. In this way, participants would rally together and resolve to eradicate the FB threat. It was hoped that their determination to combat this condition would eventually filter down to their communities.

### ***Action inducing fear***

Utilising fear to raise public awareness is a well-documented but controversial practice (Ewoldsen-Roskos *et al.*, 2004). The logic behind fear-based health campaigns is that instilling fear in an audience will motivate the members to change undesirable behaviour. Generally, fearful reactions are achieved through the use of extremely graphic imagery. Critics of fear-based health campaigns have opposed these on moral grounds, while others have labelled them “amateurish [and] misguided” (Green & Witte 2006:245). In response to this, Kim Witte (1992) introduced a fear-based model which enhances audience efficacy beliefs. Witte’s (1992) EPPM is a revision of earlier fear models which frightened viewers,

without suggesting alternative action they could take to rectify their irresponsible behaviours. The EPPM operates on the premise that a “perceived threat (causing fear arousal) motivates action and perceived efficacy (causing hope) determines the nature of that action” (Green & Witte 2006:245). In summary, if individuals are made aware of a threat to their health, they will be afraid. However, if they are informed of steps they can take in order to avoid the threat, they will believe in themselves enough to do so (Green & Witte, 2006; Brug, Verplanken, Kok & Ruiter, 2001). Effectively, message-framing that highlights actions that help avoid a threat, determine whether or not a fear-based message is heeded (Brug *et al.*, 2001). Merely evoking fear does not stimulate the adoption of positive behaviour.

## **2. METHODOLOGICAL APPROACH**

A qualitative approach was employed in order to gain an appreciation of the nuances in the participants’ responses. To this end, the study was informed by two distinct, yet closely related, qualitative research paradigms. The first was the interpretative paradigm which, according to one of its key proponents Max Weber, allows researchers to analyse how individuals receive and make sense of messages (Weber, 1864 in Neuman, 2011; Teer-Tomaselli, 2008). It was important to assess this, because the FB Project spent a substantial amount of time and resources on disseminating FB information. Further, this paradigm challenges the notion of a passive audience by accommodating their “subjective human interpretation of...meaning” (Teer-Tomaselli, 2008:39; Weber, 1864 in Neuman, 2011). In so doing, it facilitates the design of messages that resonate instantly with the target audience. The second paradigm that informed this study was the radical humanist approach which “exposes power relations in terms of class, race and gender” (Teer-Tomaselli, 2008:39). It allowed the researcher to understand how participants from diverse social settings, with limited media exposure, interpret messages.

### **2.1 Sampling and ethical considerations**

A predetermined (quota) sample of 20 young women between 16 and 19 years of age were included in the study. From this number, 10 participants were selected from rural schools, while the remainder were from peri-urban schools across the Ugu district. In order to qualify for inclusion the participants had to meet specific criteria: they needed to have visited the project previously and consented to a gynaecological examination. Semi-structured interviews were conducted at the FB Project’s premises. In order to supplement their responses, the researcher’s personal observations during the interviews and various interactions at the schools were recorded as field notes. Prior to the interviews all participants were furnished with informed consent letters, which detailed the purpose and voluntary nature of the study. Participants were also informed that their responses would be recorded and transcribed at a later stage. Ethical clearance was obtained before the research process commenced.

### **2.2 Limitations**

This study included a relatively small number of participants and as a result, their subjective responses cannot be generalised. However, their insight is still valuable because it details the

main challenges to effective relations between the FB Project and its participants. Furthermore, the recommendations gleaned from their responses are worth further exploration, and could potentially become a blueprint to a successful awareness campaign.

### **3. FINDINGS**

#### **3.1 Apathy versus fear**

The interactions with participants revealed that, despite the project having been embedded in the area for over a year, there was a general lack of accurate understanding of FB information. Many of the responses received were vague and insubstantial, with barely a fraction of them demonstrating full comprehension of FB, indicating that there still was a great need for education on FB. Statements such as the one below demonstrate that the participants' understanding of FB was founded on misguided social beliefs:

Ya [laughs], I didn't know that you got it by crossing rivers. I just thought that you got it by jumping over a fire and then you would see that you had it by urinating blood. I didn't know you could get it by crossing a river at all. (Interviewee, 4 September 2012).

This substantiates Bandura's (1995) assertions about the influence of the social environment in shaping people's attitudes, beliefs and subsequent actions. The fact that young women chose to hold on to their misguided yet staunch convictions about FB, despite the Project regularly furnishing them with correct information, illustrates the conditioning power the social environment has on individuals. It also indicates that positive social change through communication is not an overnight occurrence, but a gradual process (Cornwall, 2008).

Furthermore, in order to be convinced of its severity, participants expected an outward manifestation of FB and an extensive course of treatment drugs. The absence of a visible symptom, such as an aggressive skin condition, and the single dose of Praziquantel tablets did little to convey the seriousness of the FB threat. This lack of fear of FB – after frequent visits by the project to the schools where young women were supplied with educational pamphlets – further conveys the need for a communication strategy that communicates susceptibility, severity and efficacious alternatives (Witte, 1992; Green & Witte, 2006).

While the majority of the participants were dismissive of FB, there were a few who were fearful, yet misinformed. Several factors prevented them from seeking correct information. The biggest stumbling block was the perception of FB as a social class disease (Schall, 1995). Due to FB being contracted after fresh water contact, and the majority of people reliant on such water sources for domestic purposes being from low income areas, it created a stigma of poverty (Kjetland *et al.*, 2014). This association of FB with poverty is a further indication that educational and communication efforts need to be intensified, as even affluent people are vulnerable to it if, for example, they engage in recreational water activities (Kjetland *et al.*, 2014).

The researcher observed that the project’s reading material was a contributing factor to the pervasive misinformation about FB. Staff were dependent on pamphlets (and, later on, posters depicting the FB cycle) to supplement the talks they delivered. However, the material apparently did not have the intended effect, because South Africa is not a strong reading nation (Pretorius, 2002). Instead of further enhancing their FB knowledge, the pamphlets widened the “knowledge gap” (Kincaid & Figueroa, 2009:1321) with a possible pro-literacy bias<sup>2</sup>. While the participants were all high school learners and could presumably read, for many of them it was their first encounter with scientific jargon such as “schistosomiasis”. This was a definite limitation on the project’s overall communication approach.

### 3.2 Rural versus urban voices

The researcher’s observations indicated that the authoritative style of teaching practiced by local teachers, and the (initially) public nature of the recruitment process, affected participants’ reception of information and their willingness to participate. The table below indicates the steps followed by the Project. It depicts how project personnel initiated school visits after liaising with parents and teachers, introduced FB, and then persuaded young women to participate.

**Table 1: Stages of the FB Project’s participation process**

1. Contact School	Visits are arranged. Arrangements for parents meetings at schools are made
2. Project team visits school	Talks are conducted and the following are explained: FB, the Project’s study. An invitation to participate is extended.
3. FB Project arranges a second visit	Permission to speak to participants regarding the following: Individual informed consent forms (ICs) and interviews.
4. Project transports consenting participants to its clinic	The following are explained: the personal interview, biological samples (urine, blood), examination (height, weight and the gynaecological examination undertaken by a female doctor).
5. Samples are tested and participants receive treatment	Young women are provided with the following health services: STD treatment, contraception services to those who request it, HIV testing (before and after counselling). Those participants whose health needs are greater than the Project’s resources are referred to the local hospital. Afterwards light refreshments are provided.

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<sup>2</sup> “The tendency of a communication source to encode messages in terms of symbols, either written, printed or verbal, which imply literacy and numerical skills on the part of the receivers, even when they are known to lack both skills” (Melkote & Steeves, 2001:233).



After observing this pattern numerous times, the researcher discovered that in some instances, a participant's agency regarding participation was compromised (Bandura, 1995; 2004). This trend was particularly prevalent at many of the rural schools where respect for adults is still a strictly upheld value. Often, well-meaning teachers pressurised young girls to participate. In this way, instead of making a decision based on a genuine willingness and being well-informed, the fear of disappointing authority figures became the motivation. This exemplifies what Freire (1990:48) referred to as "pseudo-participation [and not] committed involvement." In such instances it was difficult to ascertain whether genuine learning about FB had occurred. It is important to reiterate that the project *always emphasised* that participation should be voluntary. This trend supports Freire's (1990) statement that authoritarian teachers can hinder effective learning.

In contrast, at the peri-urban schools where problem-posing education was practiced, the learners were assertive (Freire, 1990). With encouragement from their teachers, they actively engaged with Project staff and asked thought-provoking questions. Interaction with them were dialogues that facilitated mutual learning, and the choice to participate in the Project's study was undoubtedly their own.

### **3.3 Social perceptions of gynaecological examinations**

Diagnosing FB requires a gynaecological examination. Although this procedure may be invasive, it is often a young woman's first introduction to the importance of maintaining a clean bill of reproductive and sexual health. However, conversations with the participants revealed several challenges that were deterrents to the procedure.

Despite the FB Project approaching the examination with professionalism and sensitivity, participants who consented to it were still subjected to mockery from their peers. This was partly due to the fact that in the area it is uncommon for young girls to undergo such an examination, as it is not a socially sanctioned practice (Taylor, Dlamini, Sathiparsad, Jinabhai & De Vries, 2007). In the Western world, a gynaecological examination is considered to be routine medical practice. However, in a conservative Zulu social setting, it engenders negative connotations which can undermine even the most confident young woman's efficacy beliefs (Bandura, 2004).

Further, the initially public manner in which participants that would undergo the examination were chosen, inadvertently confirmed to their curious peers that they had FB. The respondents reported feeling embarrassed at bearing the stigma of what is viewed as a poor man's disease (Schall, 1995). Additionally, because the examination is typically performed on women who have had sexual intercourse, participants were subjected to speculation about their virginity. In a social setting that reveres virginity, having it speculated about publicly can be distressing (Lerclec-Madlala, 2003). Once again, these misinformed yet socially prevalent beliefs indicate that the information it disseminated was not received as well as anticipated. Additionally, the interviewees revealed that the lack of specific details about the gynaecological

examination added to their reservations. The bulk of their anxiety was fuelled by not fully understanding what their consent to the procedure would entail:

I was very scared, shame. When I went they were returning to pick up girls for the fifth time, so it had spread across the whole school that this thing was painful, they stick things inside of you...so when I got there, I asked first (Interview 31 May 2012).

While Project personnel made mention of the examination during the school visits and emphasised that it was voluntary, they did not discuss it explicitly. As a result of this, participants expected “things” to be inserted into them when they arrived at the Project clinic. Responses such as the one above highlight the need for transparent communication that shatters myths and alleviates fears.

#### **4. DISCUSSION AND RECOMMENDATIONS**

The findings revealed several communication shortcomings that needed to be overcome in order for the Project to increase the FB knowledge of participants, enabling them to make responsible health choices. Below are various theory-driven recommendations, based on participants’ responses and the researcher’s observations:

##### **4.1 Integrating FB into the school syllabus**

Evidently, a major contributing factor to the FB indifference is the inability to conceive of it as a legitimate health threat. A suggestion on how to convey its severity, is to include it into the Ugu district school syllabus. Discussing it alongside other health issues during Life Orientation (LO) classes could enhance credibility. The LO class is a platform where all presumably ‘serious’ diseases are discussed and the facts about them imparted to the learners. In so doing, information on FB will be sustained, because subject matter discussed in health classes is repeated for years on end. This constant repetition of information accelerates the rate at which it is remembered (Bandura, 1995; 2004; Singhal & Rogers, 1999). Further, these lessons are facilitated by teachers who are influential authority figures, equipped to address questions and dispel misconceptions in order for learning to occur (Freire, 1985; 1990). Also, integrating FB into the syllabus would normalise it and possibly reduce the enveloping stigma (Schall, 1995).

Another suggestion for drawing attention to the gravity of FB is to enlist the help of former participants. They could be included in the project as ambassadors. Through testimonials of their experiences with the project and the positive health behaviours that they have adopted, they could alter negative perceptions of FB. This strategy could work, because, based on the pervasiveness of negative FB stereotypes, it can be concluded that word of mouth is a powerful means of perpetuating information. Therefore, its power could be harnessed for good via the former participants, and they could become “core agents of change” (Tufte, 2005:165). By word of mouth they could draw on their lived experiences in the discussion

of FB with their peers. Being considered as valued members of the project who have the responsibility of recruiting others, may enhance their efficacy beliefs as well as their sense of ownership of the project (Bandura; 2004; Kincaid & Figueroa, 2009).

Another reason former project participants could become powerful catalysts for positive change, is their capacity to be good role models (Bandura, 2004). Scholars have inferred that the most influential role models are those whose lives resemble those of the people observing them (Bandura, 2004; Singhal & Rogers, 1999). Unlike researchers, former participants originate from the community and are more aware of intricacies that researchers could be oblivious to (Servaes, 1999). Their intimate knowledge of the community and its members can guide researchers during the design of the communication campaign.

#### **4.2 Gaining public support for the FB cause**

In addition to working with former participants to legitimise FB communication, participants recommended involving the community to rally behind the cause. They believed that FB needed more visibility in order to foster dialogue that enhances people's understanding. Exchanges between the Project and the community could facilitate the development of a sense of shared responsibility in the quest to effectively treat FB (Kincaid & Figueroa, 2009). To this end, participants suggested implanting an extension of the FB Project, in the form of a mobile clinic, in the community. In this way, locals could have unrestricted access to a structure that alleviates their concerns by supplying them with correct information. Also, the clinic would be a concrete, dependable part of their lives. It would no longer be viewed as a facility established by a foreign organisation. Instead, people could embrace it as an organisation that *collaborates* with them to reduce the FB burden (Kincaid & Figueroa, 2009). However, because of the staffing and maintenance cost of such a venture, participants were in agreement that this could be explored further in the future.

#### **4.3 Integrating entertainment education**

Many of the young women indicated that the communication mediums they gravitated to most are those that require minimal exertion from them. For instance, they demonstrated an aversion to reading material and social media, because they were regarded as time-consuming, and required a certain level of effort from them. Based on their comments, the researcher suggests that entertainment education (EE) could be a suitable strategy that could facilitate effective engagement, without taxing participants too much. Substantiation for this suggestion is ascertained from statements such as:

Well I think maybe if they had a show that can explain – something like a drama you know? Something like that (Interview 06 June 2012).

EE is a popular approach that has attained success in many health communication interventions, because it comprises educational and entertainment components. "It

combines the attraction of entertainment with educational messages to help educate, inform and encourage behaviour change to achieve development and social progress” (Servaes, 2008:207). Essentially, it achieves results because the entertainment component makes the audience more receptive to educational messages that are strategically inserted into EE activities. Thus, it ideally enhances efficacy beliefs and gradually inspires positive changes (Bandura, 2004). Another characteristic which makes it a viable option for communication with the FB audience is that it transcends socio-economic conditions and geographical boundaries to promote “healthy choices, practices and lifestyles” (Durden & Nduhura, 2005:3). EE is accessible even in communities where young people lack the means to follow global trends such as social networking. In such settings “we find songs, drama and storytelling” (Durden & Nduhura, 2005:3).

Further, EE facilitates the absorption of seemingly complicated information by establishing an emotional connection with the audience. This occurs via a personalised form of engagement where an individual has the opportunity to live vicariously through a character or play (Singhal & Rogers 1999). Vicarious learning is more likely to lead to sustained behaviour changes because the audience “sees for themselves the consequences” of misguided actions (Durden & Nduhura 2005: 3). Another strength of EE as a communication tool lies in its flexibility. There are no rigid rules regarding how it should be performed (Singhal & Rogers 1999) and is thus adjustable to specific audience needs.

#### ***4.4 Minimising the stigma***

The relationship between the participants and the Project was mutually beneficial in that the latter rendered free health care services, while the former consented to being subjects of their study. While the Project made efforts to protect participants from “unintentional adverse effects” that could be triggered by their involvement, there was still room for improvement in this area (Guttman & Salmon, 2004:534). Drawing from relevant scholarly literature, observations and participant interviews, this article argues that context-relevant, participatory communication could be utilised to address many of these effects. Thus far, many of the challenges that were highlighted stemmed mainly from the socio-cultural environment. Issues such as stigma and misconceptions all originate from the social norms of the Ugu community environment. In some instances, however, these issues were exacerbated by problems internal to the Project that could be easily rectified.

An example of this was the scheduling conflicts between the Project and the schools. Often, the lack of synchronisation would force staff to make the best of any resources that had been hurriedly arranged. If they arrived at a school and no classroom was available, interviews would be conducted in open spaces, under the curious gaze of learners and teachers. Subjecting participants to such public – albeit unintentional – scrutiny, was fertile ground for breeding peer mockery and stigma. Privacy is always essential in order for the fundamental aspects of the Project’s work to be explained, for the young women to make enquiries and eventually make an informed decision (Cornwall, 2008). Where there is a lack of supportive

structures that can “nurture [an individual’s] voice”, the quality of the interaction deteriorates and “effective participation” does not occur (Cornwall, 2008:275). Stricter management of schedules and co-ordinated internal communication could greatly enhance engagement between the project and its participants.

## **5. CONCLUSION**

The findings in this article have demonstrated that the FB Project was in need of a communication strategy that could penetrate socio-cultural, economic and geographical barriers to trigger positive behaviour changes. Importantly, the discussion has illustrated that these challenges could be addressed if more participatory and emancipatory communication were practiced. Overall, the following can be surmised:

The bulk of the Project’s participants were not cognisant of their susceptibility to FB. A new strategy needs to not only incite fear in them, but provide efficacy-enhancing recommendations as well (Witte, 1992; Green & Witte, 2006).

Evidently the FB issue requires stronger local support, because the Project is still perceived to be an external organisation. This can be remedied by inviting former participants to join, because they wield considerable influence over their peers and wider body of community members. Getting them to ‘endorse’ the Project’s work, while emphasising that they are integral to the Project’s success, will inculcate a sense of pride and ownership in them (Kincaid & Figueroa, 2009). Also, by practising this empowering style of communication, the positive health behaviour they learned from the Project can be sustained for longer (Servaes, 1996; 1999).

Information is received differently within different social settings. In the rural areas, the banking, passive style of learning is practiced, which often blurs the lines of voluntary participation (Freire, 1985; 1990). In peri-urban areas problem-posing teaching that facilitates authentic learning is vigorously encouraged (Freire, 1985; 1990). A revised communication strategy that transcends these social differences and stimulates critical awareness could resolve this.

The detection of FB via a gynaecological examination needs to be preceded by public communication that protects participants from unintentional adverse effects such as ridicule and stigma (Guttman & Salmon, 2004). This negativity could be minimised by incorporating a participatory communication method such as EE in order to help the broader community understand the specifics of the examination (Singhal & Rogers, 1999; Durden & Nduhura, 2005). This could ensure that after the examination was performed, the participants could return to a supportive environment. The discussion highlighted how EE is a useful strategy for targeting a large audience and persuading them to change negative behaviour without necessarily experiencing its consequences. Not only does it stimulate vicarious learning, it can also be tailored to meet the unique needs of an audience.

The discussion also highlighted how important it is to be mindful of the socio-cultural differences of the community in which it is embedded, because what may be the norm in one part of the

world may be received poorly in another. This is borne out by the fact that a blanket approach to FB communication did not resonate as effectively as anticipated, because of these differences. For example, incorporating social media into the project, (which is a globally popular, almost standard practice) would have been premature in the Ugu District, because participants do not have access to social media. Another example of the importance of the social environment is the scientific jargon that was favoured by the project. While it may have made sense to the Project's medical staff, it did not make an impression on the participants. Instead, they alluded to the fact that less taxing, but more engaging forms of communication could have a better chance of helping them retain information.

The over-reliance on printed material was also highlighted in this article. Due to reading not being a strong habit within the South African context, it may have been unwise to depend heavily on pamphlets and posters (Pretorius, 2002). It is evident from participant's comments that a more interactive and culturally relevant form of communication would have yielded better results.

Most importantly, while the weaknesses in the FB Project's existing communication approach cannot be ignored, its redeeming attribute is that it attempted to restore control to its participants (Melkote & Steeves, 2001; Servaes, 1996; 1999). It recognised that a top-down approach to communication defeated its long-term goals of conscientizing young women to the hazardous impact FB could have on their health (Freire, 1985; 1990). Many health interventions often lack the foresight to see that a dictatorial communication approach does not lead to sustained change in behaviour. Only a socially relevant communication strategy that includes the voices and belief of their audience or beneficiaries can achieve this.

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