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Theories, models and strategies in developing an effective HIV/AIDS campaign in South Africa

ABSTRACT

There is no doubt that the impact of media messages and campaigns has helped to inform, sustain and shape attitudes on a health issue such as HIV/AIDS. They have been heralded as the most important tools in raising awareness but little is known about how much impact they have had in changing people's behaviour. The purpose of HIV/AIDS health communication and campaigns is to educate by improving health, reducing the risks of HIV infections and promoting the well-being of individuals and communities. Most HIV/AIDS campaigns have been unsuccessful in achieving this goal because of poor conceptualisation and narrow strategic approaches. In fact, the media has been blamed for perpetuating confusions around the disease. Another problem may be that most health programme interventions have not been based on theories and models. Theories play a pivotal role in planning and implementing campaign strategies. Theories and models can be used to help campaign developers understand the nature of the targeted behaviour, suitable programmes for the targeted people, the methods that can be used to accomplish change, and the outcomes for the evaluation. Media messages and campaigns, if designed properly, can have a major impact on behavioural change. In this paper, I shall look at media messages and campaigns on HIV/AIDS, and address the application of health communication theories in influencing health behaviour. Finally, I shall look at how theories can be used to develop effective health campaigns targeting the people of South Africa.

1. INTRODUCTION

Media institutions are important in society especially in promoting a health issue such as HIV/AIDS because they legitimise an issue so that it is seen as relevant. They also raise awareness and provide frameworks of meaning (Bracht, 1999). Although the media has this powerful role, it has a long way to go in terms of depicting sexual behaviour as responsible and safe. In the study that Truglio (1998:7) conducted, she found that young viewers are exposed to approximately 1 400 sexual acts per year on prime time television. In the entertainment media, “sex between unmarried people outnumbered sex between married people at a ratio 3:1” (Neuendorf, 1990:125). The Planned Parenthood study has found that there is an average of 27 sex behaviours per hour of prime time television, with only a tiny proportion presented in the context of consequences and responsibilities (Neuendorf, 1990:125-126). Risky behaviours are not associated with unprotected sex on television. In almost all the programmes researched, there was a glaring absence of the portrayal of controversial issues such as Sexually Transmitted Illnesses (STIs), AIDS and homosexuality. “Where AIDS is used, the majority of people who have it are children and the most common transmission was through blood transfusion”. (Truglio, 1998:18.) Most television and newspaper stories rarely mention how HIV is transmitted. Some young people who were recently surveyed admitted that they did not know how the virus was transmitted. This is a worrying factor considering that about 60 per cent of South African young people between 12 and 17 years are sexually experienced (Lovelife, 2001).

Although most of the articles in Gauteng newspapers that were analysed by Qakisa (2001) focused on transmission from a pregnant mother to her child; HIV/AIDS and violence against women, they were not necessarily negative. Their accuracy as expected in every news story cannot be questioned, but the main problem is that they omitted a lot of information that is critical in the general understanding of the epidemic as it affects people. In covering the issues surrounding HIV/AIDS, most reporters were inclined to discuss the government policy on the subject rather than focus on the survival mechanisms of people living with the virus. By omitting critical information, journalists were therefore allocating blame to women, hence ignoring them completely in their reporting and focusing on them only as transmitters of the virus or victims. While stories about HIV-positive women dominated the newspapers, they were largely portrayed as individuals who were destitute, wasted, comatose, cachectic and desperate. The print media gave prominence to the “grotesque” issues about HIV/AIDS to the detriment of the HIV sufferers. The misunderstanding was further exacerbated by the fact that AIDS sufferers were victimised and sidelined. “It means a lot to a person with AIDS to be understood, respected and given space to be human again,” according to Florence Ngobeni, an AIDS counsellor at the Chris Hani Baragwanath Hospital in Soweto. “When not portrayed as wayward and sexually available and thus deserving of the disease, we

are often seen as victims who are helpless and unable to make sound decisions.” (Gender-Aids, 2000.)

2. MEDIA MESSAGES

The problem with the reporting of AIDS is based on several factors including people's distrust of the media, and how the AIDS epidemic was reported. All these factors contributed to people's perception about the AIDS epidemic. The public's perception about the media is that it is sensational and untrustworthy, and dwells on the negative information. This perception is not far from the truth if we look at how the media has reported the issue of AIDS, especially with regard to women. For the better part of the decade, the media's response to AIDS has been that the media has stigmatised people with HIV, and distinguished between innocent and guilty victims. The media is also guilty of promoting homophobia around the disease. Because the AIDS stories in South Africa dealt exclusively with medical or legislative issues, the media depended heavily on official medical and political sources. This emerged from media values of sensationalism and irresponsibility.

Almost all the articles analysed by Qakisa (2001) used an expert opinion or government official as the source of information. There is not even one single article that talked about women's feelings with regard to the drug that would stop transmission from mother to child. Most HIV/AIDS articles were largely medical, political or legislative, “as if we could police sexual transmission, or judge who was or who was not responsible” (Jaffe, 1999:18). The source of information is very critical in any story. In fact, when AIDS first surfaced in this country, black people saw it as a white man's disease. They viewed it as some type of holocaust, stopping black people from procreating. This belief made the condom campaign ineffective. White people on the other hand saw it as a disease for black people and homosexuals. Family planning in general was and is still looked at with suspicion in the black community. Therefore, any message that borders on the prevention of having children was a problem in most black communities. This may be one of the reasons why the AIDS campaign was very slow to pick up in South Africa. In fact, it started picking up when people started dying of the disease. Even in predominantly black areas, people still believe that those who are dying are either bewitched or cursed or have contracted some “nasty” disease from prostitutes or widows.

Right from the beginning of the epidemic, the AIDS story was never told by a sufferer. It is only recently that one has found an HIV-positive AIDS activist talking about the disease. Because of a lack of the image of a sufferer in most AIDS stories, people could not identify with the stories as they related to real people. Media articles mentioned statistics and government policies, but these did not mean much for a person who was

at risk of the disease. However, the media did educate people by providing facts, and figures, and familiarised them with vocabulary such as condoms, safe sex, body fluids, etc.

3. CAMPAIGN MESSAGES

Conflicting messages about safe sex in the media and in the broader culture make it difficult for people to take the safe sex message seriously. Campaigns on HIV/AIDS focus exclusively on messages of safe sex and the use of condoms to stop transmission. Although many young people are aware and know that condoms are the only contraceptive method that protects against STI and HIV infection, many of them still do not use condoms. "Resistance to safer sex goes beyond representation and understanding of the facts into the depths of people's social exchanges, their experiences of their sexuality and actual power". (Kitzinger, 1998:202). Although the majority of campaigns on HIV/AIDS focus on condom use, some studies have shown that men and women uniformly said that the use of condoms symbolised distrust between partners (Heise & Elias, 1995:936). Many women are afraid of raising the subject of condom use because they may be accused of infidelity. In some instances, women do not support condom use because it will prevent them from having children. Given this background, preventive methods as they are and the messages that they are sending to women are not effective.

Research conducted in sub-Saharan Africa has revealed that 15-19-year-old unmarried women who reported using condoms in their most recent sexual encounter ranged from 2% to 18% in different countries (Kiragu, 2001:12). This means that more than 80% of young women in sub-Saharan Africa do not use condoms. It is difficult for a young woman to negotiate condom use because she is supposed to be less knowledgeable about sexual matters. Women are taught not to question their sexual partner's behaviours, but to accept everything that they do. A recent survey has shown that 70% of rural women thought that men had a right to have multiple sexual partners and refuse to use condoms. Women are taught not to question their partner's behaviours, but to accept everything that they say and do (Jaffe, 1999:18). To question may be to admit to sexual activity and experience. Even young people who know about HIV and how to protect themselves often lack the courage to do so. Young women often hesitate to challenge any information regarding sex lest they appear to be knowledgeable about sex.

Most people will say that they do understand the intended message but still consider it irrelevant in their case. The negotiation of condom use was also seen to involve making a clear statement about sexual intentions. Women worried that this would make them look easy and expose them to abuse. A woman would not present a man with a condom or help him put it on especially if she thought that she was not at risk. The men on the

other hand felt that condoms interfered with pleasure (like eating a bar of chocolate with a wrapper on). Transforming sexual attitudes is a mammoth task, and education and information alone is not enough. Most media messages are not culture sensitive and therefore they further alienate the same people they are trying to reach. The AIDS campaign has many limitations partly because of its history as well as the political, economic, social and cultural baggage that it brings.

Much of the early coverage of HIV/AIDS implied that people who are at risk of contracting the disease are prostitutes, homosexuals, drug abusers or people who have multiple sexual partners. This initial association of the disease with these so-called high risk people resulted in the “them versus us” attitude which excluded many people who did not fall into this category. Even though the media went out of its way to correct this perception, most coverage continues to categorise people this way. Some of the articles in South African newspapers analysed in the study by Qakisa (2001) focused on the women as victims of violence and as transmitters of the disease. Another problem that may have influenced the way in which the AIDS story is reported is the issue of language and presentation.

“When you talk about a disease such as AIDS,” says a TV news science correspondent, “and you can’t show actual injections, you can’t show blood and you can’t talk about anal intercourse, then it does cause problems. I’m sure that it is one of the reasons that it is very hard to convince people what the hell is happening with AIDS, because you couldn’t use the terms, you couldn’t use the words and you couldn’t use the pictures”. (Williams & Miller, 1998:160.)

Although most people are knowledgeable about the cause, transmission and prevention of AIDS, they ignore preventative messages. They dismiss preventative messages as irrelevant. In addition, “campaigns geared towards young people have offered only a simplistic, short-term assistance that leaves them seeking effective solutions to difficult problems” (Austin: 1995:114). A common mistake in campaign design, according to Austin (1995:116), is the assumption that portraying the behaviour as deadly will cause young people to reject it.

4. THEORETICAL FOUNDATION

Theories can play a pivotal role in planning and implementing campaign strategies. Health behaviour theorists have developed different theories and models to help campaign developers understand the nature of the targeted behaviour. They believe that health programmes can be successful only if they are based on a clear understanding of a targeted behaviour. This is why they have suggested ways in which those behaviours

could be achieved. Most health behaviour theorists have based their theories on two approaches. The first approach is based on the theories that describe factors that influence behaviour and the second approach focuses on theories that guide the development of health promotion intervention. Health intervention programs should be based on models and theories for them to be successful.

4.1 Health belief theory

Early theorists of health behaviours focused on what motivates people to take action. Central to the health belief model is the belief that people “will take action to prevent or to control ill-health conditions if they regard themselves as susceptible to the condition” (Janz, *et al.*, 2002:47). This model is based on the concepts of perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues of action, and self-efficacy. An individual must believe that the benefits of preventive action outweigh the perceived barrier. Some studies have found that although people are aware of being at risk of contracting HIV/AIDS, they are less inclined to take preventive measures seriously because they feel as though death and disease happen to older people or other people but themselves. In fact, some studies have shown that sex workers are more likely to negotiate condom use than other women who do not see themselves susceptible to the risk of contracting the virus.

The Health Belief Model was developed to help explain health-related behaviours. The main purpose was to help campaign designers with messages that are likely to persuade people to make health decisions. According to the Health Belief Model hypothesis, AIDS protective behaviours become “largely a function of perceptions of benefits minus perceived barriers to behavioural change” (Janz, *et al.*, 2002:49). According to this model, a young woman who is at risk of contracting the virus should first perceive herself as vulnerable to HIV. She should also recognise that if she does not insist that her partner uses a condom every time they engage in sexual activity, she may contract the deadly virus. It is only when she has associated her behaviour of engaging in unprotected sex with contracting HIV that she will be able to take action to reduce the risk of contracting the virus. According to this model, this perceived benefit produces a force leading to a specific behaviour. If perceived HIV/AIDS threats are high and perceived benefits outweigh perceived barriers, the model predicts that the individual can be prompted to act and adopt AIDS preventive behaviour, such as using a condom. Although many young people are knowledgeable about the benefits of using a condom, their perceived benefits are usually not based on AIDS-protective behaviour. In fact, the Janz, *et al.* (2002:51) study revealed that their perceived benefits “are based on the benefits of pleasing one partner, not contracting the virus”.

4.2 The theory of reasoned action and the theory of planned behaviour

The Theory of Reasoned Action and the Theory of Planned Behaviour are the most widely used theories because they say behavioural change is based on an individual's intentions. These theories assume that the most important direct determinant of behaviour is a person's motivation or intention. The motivation is based on their attitude towards performing their behaviour and the values and norms associated with that behaviour. The attitude of a person is based on the individual's beliefs about the outcomes of performing the behaviour (Montano & Kazprysk, 2002). A study conducted by Lifeline in sub-Saharan countries found that about 80 per cent of young women have engaged in unprotected sex. The purpose of using this theory in the campaign would be to encourage these young people to use condoms when engaging in sexual activities. The behaviour that the campaign planner wants to achieve is to persuade young people to use condoms in order to reduce the HIV infection. First, according to this theory, a young person must be motivated to use a condom. His or her attitude towards changing his or her behaviour must be based on values and norms associated with the behaviour. The person's perception of control over behavioural performance, together with intention, is expected to have a direct effect on behaviour. These theories focus on cognitive factors such as values and beliefs as determinants of intentions and motivation to change a particular behaviour. They "provide a rationale for identifying and measuring behavioural and normative beliefs and for testing their association with intentions and behaviours" (Montano & Kazprysk, 2002:93). These theories assume that an individual has the ability to control his or her behaviour.

Although these theories may be helpful in focusing attention on how to identify factors that influence behaviour, targeting a few beliefs may not be effective. "An intervention communication may change one belief in the desired direction, but could adversely affect other important beliefs" (Montano & Kazprysk, 2002:94). These theories are based on what motivates people to perform certain behaviour and how much control they have in controlling the behaviour. If we look at the condom use campaign, the motivation may be protecting oneself from contracting the virus. These theories may work best in conditions where the targeted audience have control over their lives. They posit that attitudes and beliefs about a health behaviour are affected by one's social and normative beliefs (Teenet, 2002). It has been found that low-income and poorly educated people are frequently at higher risk of contracting HIV/AIDS and yet these groups usually emerge as less exposed, less knowledgeable, and less likely to change their behaviour (Freimuth, 1990). Most researchers who have looked at the knowledge gap hypothesis concluded that knowledge can be attained only through education and involvement. One of the major barriers of knowledge is the level of processing and cognitive skills. "The disadvantaged are not as likely as the rest of society to change

the undesirable conditions of their lives, or to see information as the instrument of their salvation” (Freimuth, 1990:177). In fact, they see their present conditions as worse off than contracting a disease. These attitudes, according to the theories, ultimately affect a person’s intention to engage in certain behaviours, that is, practising safe sex.

4.3 Transtheoretical model and the stages of change

Prochaska and DiClemente (1984) took the theory of reasoned action a step further by introducing a Transtheoretical model and the stages of change. These theorists believe that behavioural change is a process, which is why they came up with five stages of behavioural change. For a person to change a behaviour, Prochaska and DiClemente (1984) said, that he or she must begin at the pre-contemplation stage, where a person is not interested in changing a risky behaviour, or is unaware of having a problem. If the campaign is aimed at encouraging people to use a condom, messages should be aimed at informing people about the risks of contracting HIV and how they could protect themselves. It is only when a person is aware of the problem that he or she will begin to contemplate or consider changing the behaviour that puts him or her at risk. It is at this stage that a person may begin to consider using a condom. Once people have identified the need to change, they move to a preparation stage, where an individual plans a behavioural change strategy. The preparation stage is followed by an action stage where a person implements the behaviour. After people have implemented the behaviour, they strive to maintain it. These theorists believe that messages should be specific to each stage. If the purpose of media messages deals with condom use, the messages would be constructed in such a way that they encourage a person who has already started using a condom or persuade a person to use it. The problem with prevention campaign messages, according to Atkins (2001:55), is that they “focus primarily on the harmful consequences of the unhealthy behaviour practice rather than promoting a positive alternative to compete with it”.

The ideal situation is that people should move from pre-contemplation to contemplation to preparation to action and finally to maintenance, according to these theorists. Messages on the pre-contemplation stage may focus on the risk factors while being aware that people at this stage are actively resisting change. Fear appeal messages that emphasise harmful physical consequences may be used at this stage. Messages at this stage should actively raise awareness. On the contemplation stage, messages may focus on encouraging a person to change a behaviour. If a person is encouraged to use condoms, for example, he or she must see himself or herself as a person capable of changing his or her behaviour. This type of campaign message, if aimed at men who play a dominant role in sexual relationships with young women could be extremely effective. A message in this instance should identify how a certain behaviour can

effectively overcome a perceived barrier to change. At the action stage, messages should focus on encouraging a behaviour and building people's self-esteem. The most difficult stage of all is maintenance. Once people have moved through different stages, they are concerned with relapses. It is at this stage that people have to be encouraged. Researchers of these stages believe that behavioural change is influenced by personal and environmental factors (Prochaska & DiClemente, 1984).

4.4 Social cognitive theory

Changing people's behaviour is extremely difficult. Many theorists who have analysed behavioural change communication admit that knowledge on its own does not and cannot lead to behavioural change; people need cognitive, behavioural and social skills. These skills need to be identified early and modelled accordingly. Theoretical frameworks such as the social learning theory support the view that television and other media have an effect on socialisation. According to Bandura's (1997) Social Cognitive Theory, an individual notices something external and after repetition, he or she begins to internalise and copy it. And if he or she is rewarded for that behaviour, learning is internalised. This means that when a person is exposed to an AIDS message, be it in the form of entertainment or news from television, newspapers and other media, the information received is internalised through his or her frame of reference. The awareness that we bring to messages is a precondition for making sense of what we read, hear and see, and that awareness is often tinted by our frame of reference based on what we have experienced before.

Society and the media convey many contradictory messages about sex. On the one hand, casual sex, especially in the media, is glorified. On the other hand, young unmarried women are expected to be virgins and sexually inexperienced. And therefore they are afraid of asking for information about sex and how to protect themselves lest they be labelled sexually experienced. In many African cultures, women and girls do not have power to negotiate sex - let alone safe sex, because of their lower social and economic status. And yet most preventative messages focus on abstinence, faithfulness and condom use. The Social Cognitive Theory focuses on the cognitive response that the receiver generates while processing messages. According to this theory, a person must feel confident in his or her ability to change. This means that the person can only change if he or she has the skills and the abilities to perform the behaviour. According to this theory, change occurs when a person can be empowered with the necessary skills in order to effect change. The condom use preventive message assumes that women have the ability to negotiate condom use with their partners. In most African cultures, women who talk about sex are considered to be "loose". "Good" women are not expected to be knowledgeable about sex. In some instances, women do not support condom use

because it will prevent them from having children. The problem with this theory is that it fails to look at the social and cultural norms that influence behavioural change.

The Social Cognitive Theory, like other theories, emphasises individual-based determinants that are rooted in Eurocentric perspective. "Such individual centred models are too mechanistic and fail to adequately account for the environment determinants such as stress, poverty, low availability of education and health facilities. These may be more influential than individual motivation". (Resnicow *et al.*, 2002:497.) Social, cultural and environmental norms play a pivotal role in behavioural change. Knowing how a culture registers at various dimensions would be useful in order to understand how a particular culture's belief and value system is manifested in the behaviour of the people in that culture. The social, psychological and cognitive formulation of the audience has often been overlooked in designing health campaigns.

Most of the theories and models are individual centred; hence their emphasis on the individual's ability to control and change an undesirable behaviour (Bandura, 1997); an individual's behavioural intention (Montano, *et al.*, 2002); and a person's ability to take action if they regard themselves as susceptible (Janz, *et al.*, 2002). Almost all these theories focus on an individual as the unit of change. Are these theories relevant in the African context? Can they be used in developing health campaign messages aimed at behavioural change in the South African context?

4.5 Media advocacy theory

Before we can answer these questions, we need to look at the role of the media theories, since most of the campaigns rely heavily on media. Most studies in health communication research have focused specifically on the effects of communication in interpersonal and mass media. The idea was to look at how messages shape the political and social values of the recipients. Theorists who looked into media theories were concerned with the effect of the media on people. These studies were designed to measure the effect of media messages in relation to shaping political, cultural, social and health behaviours. These studies were critical because media messages have a powerful effect on people's attitudes in particular because they supply a means to vital information about AIDS. Media messages are responsible for providing factual information about AIDS. On the other hand, the media is blamed for perpetuating confusions and superstitions around the disease. The impact of media messages has helped to inform, sustain and shape the attitudes to the epidemic. "Popular media channels have the potential to provide essential information almost instantaneously to millions of people listening, viewing and reading". (Kalbfleisch & Bonnel, 1996:279.) It is therefore important that in designing health campaigns, there should be a thorough situation analysis.

The initial step, according to Atkin (2001:50), “is to analyse the behavioural aspects of the health problem such as AIDS to determine which actions should be performed by which people”. The media AIDS campaigns have many limitations partly because they often ignore the political, economic, social and cultural contexts of the people they are addressing. This is why the media advocacy theory proposes that social conditions should be the target of intervention. Central to this theory is that campaigns should respond to HIV/AIDS as a social issue rather than a personal issue. Media advocacy approaches health not as a personal issue but as a matter of social justice (Waisbord, 2001). According to this theory, campaigns are not the panaceas because they ignore the social causes of unhealthy behaviour.

Proponents of this theory believe that external conditions are responsible for health. Therefore, campaign strategies should target those conditions instead of focusing on lifestyle behaviour. “Promoting individual health habits in developing countries without advocating for clean water supplies under plays the factors responsible for disease”. (Waisbord, 2001.) That is why media advocacy theorists suggest that “change policy must be integrated into public health interventions” (Wallack & Dorfman, 2001:398). The media advocacy theory suggests that the media, given its power, can set the agenda by deciding what people should hear and see about the HIV story. They can also shape the debate and advance policy. This theory advocates the participatory approach that “emphasises the need of communities to gain control and power to transform their environments” (Waisbord, 2001). In South Africa, the HIV/AIDS advocacy groups have used the media to pressurise policymakers, the government and legislators to roll out drugs for HIV positive people. “Common to media advocacy campaigns is the focus on policies that change the environment in which people live and make their health decisions”. (Wallack & Dorfman, 2001:397). The media advocacy theory is not necessarily concerned with behaviour but with transforming social conditions. However, it can play a very important role in designing messages that can change people’s behaviour if they are in control of their destiny. The empowerment of women, according to Gupta (2000:8), is one of the major elements that could contribute towards fighting HIV/AIDS. This can be only achieved if the media plays an advocacy role.

5. TAILORING THEORY TO CULTURE

Prior to the development messages aimed at behavioural change, it is important to look at the cultural and environmental characteristics of the audience. In this way, a campaign developer will be able to address the needs specific to the target audience. Every campaign should start with a goal, that is, the aim of this campaign is to prevent the threat of HIV infection by promoting a certain specific behaviour. If the behaviour is to encourage abstinence or persuade people to use condoms, it should focus on one

purpose, not both. It is important for the messages that communicate a behaviour that is advocated to be simple and consistent. The second step of a campaign, is to clearly define and identify who is the target audience. By identifying this group, the campaign developer should determine who should consume the message about HIV/AIDS. The third step should focus on how and when to inform or persuade the public. The last step will be to evaluate the campaign. The campaign should be aimed at how best it can reach people at high risk. The ultimate goal is to move people from a certain behaviour to a desired response. This could be done by raising awareness by providing information about HIV/AIDS; giving instructions on how people can protect themselves or persuading a person to change his or her behaviour.

The desirable theories in health campaigns and programmes in South Africa should be communal based and culturally sensitive. Using community norms and social change would increase a further understanding of the impact of HIV/AIDS. The most fundamental principle of health communication and campaign should start with where people are. "Developing a health behaviour change programme that is culturally sensitive and appropriate for a particular population should begin with the analysis of the social environment; disease and behaviour risk factors". (Resnicow, et al., 2002:498). Resnicow et al. identified two structures that deal with culturally sensitive campaign material. According to their structures, the former, which they call surface structure, focuses on the intervention campaign material, whereas the latter, which they call deep structure, addresses the cultural dimensions of the target audience. Surface structure deals with matching intervention material with, and messages to, observable social and behavioural characteristics of a target population. This also addresses the channels used, and the settings that are most appropriate to deliver a message and the programmes. It examines the extent to which intervention fits in with the culture, experience and behavioural patterns of the audience. Surface structure increases the receptivity and comprehension of the acceptance of the messages (Resnicow, et al., 2002).

The second dimension focused on deep structure, which reflects on how cultural, psychological, environmental and historical factors influence health behavioural differences across racial groups or populations. This "contributes to the program impact because it conveys salience" (Resnicow, et al., 2002:495). Before the development of a health message or an HIV/AIDS message, it is important to determine for whom we are developing the message. "Culture and environment preferences are used to develop cues (and to determine) the audience". (Witte, 1995:149.) This will assist in the production of messages, that is, who are the people whom we want to hear about safer sex? Therefore, culture, that is, demographics, psycho-graphics and the environment should be considered in the development of a message aimed at reaching its audience. Campaign developers agree that "messages must be culturally, demographically,

geographically appropriate if they are to influence the audience as intended” (Witte, 1995:146; Freimuth, 1990:173). According to Witte (1995), persuasive health messages should contain a threat message, an efficacy message, and various cues, and they should be targeted towards a specific audience. The threat aspect of a message in this case, especially when dealing with young people, is risky behaviour that may lead to HIV infection. Before we develop that message, it is important to identify who we want to hear about risky behaviour that may lead to HIV infection.

It is in this regard that audience analysis is developed from the cultural and environmental information. Culture has often been overlooked in the development of health messages. Hofstede (1986:302) defines culture as "the collective programming of the mind which distinguishes the members of one human group from another". It is important to note that culture deals with how people interact with one another. Human beings carry mental programmes that are inherited biologically or developed or reinforced socially via family, peers, the media and culture. This is where different values and norms are developed among people of a specific culture. "The know-how that led to the wealth of industrialised countries is not necessarily the same that will bring wealth to poorer countries". (Hofstede, 1986:304.) In most cases the underlying assumption is that Africans learn in the same way that Americans and other Westerners do (Sawadogo 1995:282). This is why media campaign messages developed in a Western way, with a Western understanding, fail to reach African people.

If the communicator of the message comes from different cultural backgrounds to the audience, it is likely that the audience will interpret the message differently from the initiator or producer of the message. Since most messages are developed by adults who are of Western origin, there are differences in the profiles of cognitive abilities between the populations of the communicator and the audience drawn. The processing of information of people from developing countries is different from that of developed countries; the campaign styles will be different as well. It is clear that messages about HIV/AIDS must be tailored to the specific cognitive, social and behavioural conditions for them to be relevant.

6. HEALTH INFORMATION PROCESSING PARADIGM

Studies conducted in the United States have revealed that people from different cultures respond differently to health messages. The studies regarding cancer screening found that “African American women perceive different barriers and experience increased levels of cancer fatalism” (Janz, et al., 2002:59). The study on Hispanic women on prenatal care found that several barriers such as embarrassment with the physical examinations and lack of time spent in the doctor-patient encounter contribute to their

reluctance in attending prenatal clinics. Another study of Chinese and Asian American women found that barriers to access and familiarity with Western health care was more of a problem than the perceived benefit of cancer-screening practices (Janz, et al., 2002). These studies revealed that these perceived barriers outweighed the perceived benefits. Other studies on the health belief model constructs in other cultures have found that the value placed on health and illness is consistent with the cultural beliefs in the target populations.

These studies and experiments have shown that different societies process information differently. In China, for example, the nature of information processing is based on pattern recognition. "Culture influences cognitive styles through socialisation, ecological adaptation, language". (Shade, 1997:82.) The primary mode of socialisation is an important factor in information processing. In oral societies, learning is situational and contextually based, rather than categorical and abstract, as in literate societies. It is necessary to examine the ways in which Africans perceive, encode, represent and analyse information. The process of perception on how people select, organise and interpret information is based on their frame of reference developed from sociological, psychological, physical, emotional and environmental factors.

The information processing paradigm is based on how people of different cultures process information. In every culture, children are tuned into responding to certain types of information and filtering out other information. If the child is filled with a great deal of body contact and touching, this child is more likely to refocus his or her attention to people stimuli rather than object stimuli. These children get to know about the world through kinetic and tactile senses, through the keen observation of human scene and through verbal descriptions (Shade, 1997). These perceptions manifest themselves in the modality preference, cue selection and pictorial selection. African children, because of the way they are brought up, are "more people oriented than object oriented" (Shade, 1997:79). In African cultures, information is processed through a social process. A person feels the need to interact with other people. Group interaction is central to learning since a person is defined in terms of his community. In these communities, people owe their selfhood to others. In this culture, channels of communication are predominantly auditory and tactile rather than visual and literate. It is therefore important that campaign messages consider the factors identified.

Table 1 below illustrates the differences between individualism (Western) cultures and collectivism (African, Asian, South American) cultures.

Individualism	Collectivism
Emphasis is placed on the individual outcome	Emphasis could be placed on social outcome expectations related to communal benefits
Self-efficacy	Community efficacy
Intrapersonal motivation	Interpersonal motivation
Individual goals	Collective goals
Personal independence	High level of personal interdependence
Competitiveness	Conformity
Rewarding individual achievement	Rewarding group achievement
Separating intellectual, emotional and physical responses	Involving social, emotional, physical and intellectual responses

7. PUTTING A CAMPAIGN TOGETHER

People's social behaviour is best understood by examining their beliefs in a social context and their social perception representation (Rutter & Quine, 2002:391). To be successful, campaigns should be linked to a broader community action. Some cultures, especially African cultures, place greater importance on social harmony, interdependence, and a holistic view of health. The use of oral communication and stories on spiritual themes convey messages that should be considered when developing health behavioural change programmes. This is why it is important to look at the cultural and environmental characteristics of the audience. In this way, a campaign developer will be able to address the needs specific to the target audience. Every campaign should start with a goal, such as, the aim of this campaign is to prevent the threat of HIV infection in young people by promoting a certain specific behaviour. If the behaviour is to encourage abstinence or condom use, it should focus on one or the other, not both. It is important that the messages communicating the desired behaviour are simple and consistent. Behavioural change in HIV/AIDS awareness and prevention reflects individuals' sense of empowerment, deeply embedded in social and cultural norms. These norms also play a more significant role in behavioural change. This is why theorists who developed the model for Communication for Social Change identified three psychological processes in campaigns. The cognitive structure focuses on the knowledge, the affective structure is influenced by an individual motivation and the third structure focuses on an action, that is, a behaviour that a person takes. According to this model, behavioural skills are necessary prerequisites for the establishment of healthful habits. People need to be informed about how to protect themselves against HIV/AIDS and be persuaded to use a condom. These skills can only be achieved through observation and guided practice (Figueroa, et al., 2002).

Central to the Communication for Social Change model is the “process of understanding people’s situation and influences, developing messages that respond to the concerns within those responses” (Gray-Felder, 1999). This model seeks to empower individuals and communities by engaging people in decision-making processes. In explaining the differences between traditional campaigns and the proposed participatory communication for social change, Dragon (2001) emphasises some of the issues of participatory communication, which the model espouses.

Table 2 below indicates the distinction between the traditional campaigns and participatory communication for social change as described by Dragon (2001).

Traditional campaigns	Participatory communication
People are viewed as passive receivers of information and behavioural instructions	People as dynamic actors participating in the process of social change
Top-down campaigns help to raise awareness but they fail to build capacity to respond to needs of change	People are central to planning communication activities and they are charting their future
Short-term planning	Long-term process that needs time to be appropriated by the people
Targeted on behavioural change for an individual	Communities acting collectively in the interest of the majority
Using the same techniques, same media and the same messages in diverse cultural settings	Communication is adapted for each community and social group in terms of culture, content, language and media
Communication processes are owned by individuals	Communication processes are owned by the people and the community
Persuasion for short-term behavioural changes	Raising consciousness and a deep understanding of social realities

Campaigns of an important issue such as HIV/AIDS should approach health behaviour intervention in an integrative manner. The integrative theory of behavioural change is based on the premise that changing behaviour is primarily accomplished by changing beliefs and subject norms. This theory suggests that the key to changing behaviour is to target beliefs and norms that are high in the target population. This implies that positive and negative consequences that are associated with the behaviour should be targeted in order to change beliefs, attitudes, social norms and efficacy (Capella, et al., 2001). Behaviour is affected by several factors, including psychological, sociological, cultural, communal and public. An interactive approach should combine behavioural

and environmental issues. It does not help to provide poor people with information about HIV/AIDS without giving them information about where they should go for help. In developing countries such as South Africa, information about HIV/AIDS should be comprehensive and include issues such medical care, housing, drug abuse treatment, education, job training and legal services.

Reaching poor people is a challenge because their immediate conditions of daily life are so adverse that they outweigh concerns of contracting HIV/AIDS. "Campaign needs to combat not exacerbate, cultural stereotypes that contribute to their feelings of failure and (hopelessness)". (Austin, 1995:122.) However, campaign developers should still try to develop messages that are going to address them in their environment. One of the major limitations of campaign strategies in South Africa is that they have been exclusively media based. Although the mass media is important in disseminating information, social networks such as peer communication are responsible for the diffusion of ideas (Rogers & Kincaid, 1981). It is only when people discuss and talk about an issue that it begins to make an impact on people's lives. Interpersonal communication accounts for much of the success of the projects and programmes. Nothing can replace community involvement and education in the effective dissemination of information. Informal HIV/AIDS education efforts are a most effective means of relating information because people tend to be more receptive to other people like themselves. Credibility of sources is extremely important in illiterate communities where they do not see printed press and pictures as a source of information. Several programmes in other countries have hired HIV-positive people to talk to people. Some programmes have used peer group education and already trusted adults. The credibility of sources is extremely important in these communities.

Austin (1995) believes that communication about HIV/AIDS and sexuality should begin early. Children respond best when involved in making decisions about their lives. This is why Austin (1995) asserts that health campaigns must target young children. This will help in delaying or preventing sexual experimentation if the safe sex campaign begins before children become sexually active. At early adolescence, that is children between the ages of 10-13 years, people still turn to family and educational institutions for information. Although the media plays a critical role in educating young people, it is important that the educational institutions and parents discuss the programmes that their children watch on television. It is only when these credible sources are involved that the media plays a meaningful role towards educating and informing young people. "Media messages about HIV for this age group should focus on disproving myths and teaching facts as well as advocating moderation". (Austin, 1995:123.)

8. CONCLUSION

Most theories are based on the understanding that the communication in behavioural change is to change the behaviours of individuals. This approach has been problematic in South Africa because people from individualistic cultures process information differently from those from collective cultures. For many years, campaigns had focused on the outcome rather than the process of communication. Proponents of the Communication for Social Change model define this model as a process where “people define who they are, what they want and how they can get it” (Gray-Felder, 1999). Given the differences between individualistic cultures and collective cultures, it is clear that theories that address change in collective cultures should focus on communities as units of change. Mass media can be effective in stimulating attitude and behavioural change, especially if they are used in conjunction with interpersonal and community structures. The media can be extremely effective if campaigns engage in planning and focus on a specific behaviour that needs to be changed in the community.

Given the need to educate the public or influence the public’s perception on HIV/AIDS, what should be done? How could the media and other forms of communication help to shape knowledge that affects change in attitude? While theories can assist in developing campaign messages, South African media and health campaign researchers must come up with theories that are relevant to their environment in order to develop and design messages with which their audience will identify. HIV/AIDS messages must be culturally, socially, demographically and geographically appropriate if they are to influence the audience. The message should therefore be framed in such a way that it promotes and protects the cultural values of the audience. It is in this regard that a fundamental change is required in the development of campaign messages and the reporting of HIV/AIDS.

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