SEX NEWS
AIDS Education Media Development in South Africa

by

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Dissertation submitted in fulfilment of the requirements of Master of Arts Degree in Media Studies at the University of Natal, Durban, South Africa. November 1997
DECLARATION

I, Elaine Epstein, do hereby declare that the work presented in this dissertation is my own.
Any work done by other persons has been duly acknowledged.
Centre for Culture and Media Studies, University of Natal, Durban. November 1997.

Elaine Epstein  November 1997
ABSTRACT

This thesis explores various theoretical approaches to health education in an attempt to identify a model appropriate for developing a STD education media campaign in Hlabisa, KwaZulu Natal, South Africa. In so doing, it demonstrates the limitations of both psycho-social and semiotic models of health education media development and the need for rearticulation and further development of these models.

Chapter One contextualises HIV/AIDS in terms of the South African experience and describes the strategies used to try and prevent the spread of the disease. The use and effectiveness of media as a prevention strategy, is discussed in detail.

Chapter Two reviews the current theoretical approaches to HIV/AIDS intervention development. In identifying the limitations of existing models of media campaign development, it demonstrates how one such model, the communication planning matrix, can be enhanced by reframing it in terms of semiotic communication theory. The appropriateness of this rearticulated model is demonstrated in Chapters Three and Four by its practical application to the development of the Hlabisa STD education mass media campaign.

Chapter Three discusses the development of the Hlabisa STD education campaign, focusing particularly on the formative phase of the development process. Chapter Four discusses the practical application of the rearticulated communication planning matrix to the development of media materials in the Hlabisa STD education campaign. It describes the process of media selection, message construction and pretesting of pilot materials.

Chapter Five demonstrates the appropriateness of the theoretical approach used to develop the Hlabisa media campaign. Analysis of the pretest results, in terms of the campaign’s effect on and receptivity by the target audience, is used to validate the effectiveness of this approach. Based on the lessons learned from the Hlabisa STD education campaign, a list of criteria necessary for the development of mass media campaigns aimed at changing attitudes and behaviour about STDs and HIV/AIDS is suggested.
ACKNOWLEDGMENTS

The financial assistance of The National HIV/AIDS and STD Directorate, The Department of Health and The Centre for Epidemiological Studies in South Africa (CERSA), Medical Research Council towards this research is hereby acknowledged. Opinions expressed in this work, or conclusions arrived at, are those of the author and are not attributed to The National HIV/AIDS and STD Directorate or CERSA.

I would like to thank the following people for their important contributions at various stages of this research:

Dr. Slim Abdool Karim, Director of CERSA, MRC, for giving me the freedom to pursue my own ideas and for his invaluable insights and support.

Ms. Nellie Ntuli, Ms. Masula Msweli and Ms. Petti Pathekile, for collecting the data for this project and providing valuable input throughout the development of the campaign.

My supervisor, Professor Ruth Teer-Tomaselli, for her incisive input and her continual encouragement, support and patience.

Andy Mason and the team at Art Works for doing such a great job of translating theoretical ideas into innovative media products.

Julie Fredrickse, Madoda Ncayiyana and the team at Vuleka Radio for their hard work in producing the radio scripts and their commitment to developing entertaining, educational media

The members of KwaZulu Natal NACOSA, for their input and ideas.

My father, for invaluable advice, constructive criticism, for rounds of proofreading and for teaching me a thing or two in the process.

My mother, for her support and encouragement.
# TABLE OF CONTENTS

## CHAPTER ONE
- HIV/AIDS: The South African Context ............................................. 4
- South Africa's Response to the HIV/AIDS Epidemic .......................... 6
- Counseling ...................................................................................... 7
- Welfare ......................................................................................... 8
- Health Care .................................................................................. 8
- Law Reform and Human Rights ...................................................... 9
- STD Management and Control ...................................................... 10
- Prevention and Education .............................................................. 11
- Can Media Make A Difference? ...................................................... 12
- Mass Media and Health Education ................................................ 14
- Mass Media Smoking Prevention and Cessation Campaigns .......... 15
- Using Mass Media for AIDS Education .......................................... 16
- Soul City: A South African Success Story ...................................... 17

## CHAPTER TWO
- Theoretical Foundations of Public Health Media Campaigns ........... 20
- The Health Belief Model ................................................................. 23
- The Theory of Reasoned Action .................................................... 23
- The Communication/Persuasion Model .......................................... 25
- Shannon and Weaver's Model ....................................................... 27
- Semiotics: An Alternative Approach ............................................. 29
- Ideology ......................................................................................... 34
- First Order Signification ............................................................... 34
- Second Order Signification ......................................................... 35
- Myth ............................................................................................. 35
- Ideology and Signification ............................................................. 36
- Semiotics and Media Messages .................................................... 37
- Codes ............................................................................................ 40
- Genres .......................................................................................... 41
- Intertextuality .............................................................................. 42
- The Use Of Semiotics In Health Promotion ................................... 43
- The Culture Debate ...................................................................... 45
- The Communication Planning Matrix .......................................... 50
- Health Education Variables ......................................................... 52
- Reception ....................................................................................... 52
- Encoding ....................................................................................... 53
- Communication Variables ........................................................... 55
- Receiver ......................................................................................... 55
- Message ......................................................................................... 56
- Source ........................................................................................... 57
- Channel ......................................................................................... 58

## CHAPTER 3
- The Hlabisa Sexually Transmitted Disease Control Project ............. 60
- Background .................................................................................. 60
- The Development of the Hlabisa Media Campaign .......................... 62
- Research and Methodology ......................................................... 62
- Formative Research ...................................................................... 62
- Study One: Attitudes and beliefs about STDs among STD clinic attenders at a Durban City Council STD clinic ............................................. 64
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>African National Congress</td>
</tr>
<tr>
<td>CBO</td>
<td>Community based organisation</td>
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<tr>
<td>CERSA</td>
<td>Centre for Epidemiological Studies in South Africa</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>MRC</td>
<td>Medical Research Council of South Africa</td>
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<td>NACOSA</td>
<td>National AIDS Convention of South Africa</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organisation</td>
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<td>PSA</td>
<td>Public service announcement</td>
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<td>RAPS</td>
<td>Regional Planning Sub-group</td>
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<td>RDP</td>
<td>Reconstruction and development programme</td>
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<td>STD</td>
<td>Sexually Transmitted Disease</td>
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<td>VD</td>
<td>Veneral Disease</td>
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CHAPTER ONE

This thesis explores various theoretical approaches to health education media in an attempt to identify a model appropriate for Sexually Transmitted Disease (STD) education media development in South Africa. Impetus for the programme arose out of lack of effective Acquired Immune Deficiency Syndrome (AIDS) and STD education in South Africa despite a substantial and rapidly growing epidemic. This lack of effective media is due in part to the countries limited experience in developing health education media and their over-reliance on Western based models which are often inappropriate to the South African context. This is apparent from one of South Africa's initial AIDS education campaigns which was conducted in 1987. The governments limited understanding of health promotion, particularly AIDS awareness programmes, resulted in a costly yet ineffective advertising campaign which was conducted in 1987 (Zwi & Bachmayer, 1991). More than R1-million was spent on the campaign. The media targeted at the black population employed fear tactics and featured a coffin and a funeral, whilst the campaign targeted at white youth, featured graffiti on a wall that supposedly symbolised promiscuous (heterosexual) relationships. Research after the campaign indicated that most white people saw AIDS as a black disease. Research examining knowledge, attitudes and practices amongst black patients attending an STD clinic indicated that there had been no increase in awareness or change in practices resulting from this campaign. With no signs of the epidemic abating there is an urgency to identify and/or develop effective ways of communicating about AIDS in a manner which people can understand and integrate into their lifestyle.

HIV/AIDS: The South African Context

Gay men were the first to be affected by Human Immunodeficiency Virus (HIV) in South Africa, through spread from America and Europe. While the number of reported AIDS cases amongst this group reached its peak in the late nineteen-eighties - 10%-15% of gay men in Johannesburg were estimated to be HIV positive (Sher, 1989) -these figures have steadily declined since (Department of National Health and Population Development, Epidemiological Comments, 1992). In contrast, heterosexual cases increased, and an estimated 200 000 to 500 000 people
were infected with the virus at the end of 1992 (Department of National Health and Population Development, Epidemiological Comments, 1993).

A series of national HIV surveys in women attending antenatal clinics has provided the most relevant descriptive epidemiology to date with national prevalence figures showing an increase from 0.76% in 1990 to 7.57% in 1994. Although HIV prevalence in South Africa is still lower than that in central and east African countries (Nkowane, 1991), it is instructive to note that HIV was first diagnosed in Zimbabwe in 1983 yet by 1990, 16.5% on antenatal women and 40.6% of sexually transmitted disease patients tested in multisite sentinel surveillance were HIV positive (National AIDS Control Programme and Health Information Unit, Zimbabwe Ministry of Health, 1990).

HIV infection in South Africa is transmitted predominantly through heterosexual contact. Persons infected with other sexually transmitted diseases (STDs) are among those who are at particularly high risk of becoming infected with HIV. Since the presence of an STD increases a person's susceptibility to and risk of transmitting HIV (Wasserheit, 1992), the longer an individual with an STD remains untreated, the more opportunity he or she will have of transmitting the infection to others. This takes on a greater significance in light of the fact that STDs are one of the most common presenting complaints to primary health care services in South Africa. The annual incidence of STDs (excluding HIV) was recently estimated by the World Bank to be approximately 11% in South African adults. The current rate of STDs in the greater Durban area has remained on the increase for several years. The KwaZulu Health Department reported a 50% increase in the number of STD clinic attenders between 1990 and 1991. The implications for the spread of HIV is apparent from the fact that it is estimated that roughly 10% of the 60 000 annual attenders at the Durban City health Department's STD clinic are now HIV positive. Control and prevention of STDs; including, the early diagnosis and effective treatment of STDs, has been identified as a major strategy in the prevention of HIV infection and ultimately AIDS.

There are also marked geographical, racial and age-group differences in prevalence. At 9.6%, KwaZulu-Natal is the worst region affected by the epidemic (Department of National Health and Population Development, Epidemiological Comments, 1993). The black population suffer much higher infection rates than any other group, and women between the age of 20-24 years are most
affected (8.94% nationally in 1994). According to Schneider et al (1993), reasons for this marked difference in prevalence include the following:

HIV rates conform to the gradient of privilege in South African society. AIDS is fundamentally a disease of social disadvantage. A powerful context for the spread of HIV is created when factors such as poverty, low intensity wars, a high degree of population movement, migrant labour, and the low socio economic status of women are combined.

Women have a greater susceptibility to HIV infection than men. This may be related to physiological factors but other possible mechanisms may also be important, such as the practice of ‘dry sex’, and a higher rate in women of silent (asymptomatic) STDs which increase the transmission of HIV.

South Africa’s Response to the HIV/AIDS Epidemic
The rapid increase in HIV in KwaZulu Natal highlighted the need for a provincial plan of action to coordinate and mobilise resources within the province. In February 1992, the Regional Planning Sub-group (RAPS) was formed to draft a provincial strategy based on wide consultation and participation by all stakeholders. This process was facilitated through consultative workshops and culminated in the development of a strategic plan that covered the following areas: Education and Prevention, Counselling and Care, Welfare, Condoms, Research, and Human Rights and Law reform.

In tandem with this provincial initiative the National AIDS Convention of South Africa (NACOSA) was launched. From the outset NACOSA’s aim was to unite different groups through the common objective of combatting HIV/AIDS. To this end a steering committee, including members from the then government, business, labour, religious institutions and The African National Congress (ANC), was set up. This was a significant move because previously AIDS work had been characterised by violent distrust between non-governmental organisations (NGOs) and the State. AIDS work in South Africa, early on in the epidemic, was in fact often characterised by a culture of infighting and distrust among all the AIDS organisations. This effectively blocked the

1 ‘Dry sex’ refers to the practice of using herbs and other agents to dry sexual secretions in women before or during sexual intercourse. This is discussed in more detail in Chapter Three.
development of good and effective AIDS education materials, programmes and media, as well as co-operation between many diverse groups.

During the ten years prior to the establishment of NACOSA, an established pattern of infection had developed in South Africa and during this period few if any significant interventions on a national scale had taken place. While there were some good regionally based centres and programmes, there was no unity of purpose or direction. According to Mary Crewe, director of the Johannesburg Community AIDS Centre, “Sadly, the history of AIDS prevention was as divisive and vindictive as the political history of the country. NACOSA was a refreshing break from this pattern” (AIDS Bulletin, vol 3, no 2, 1994).

Once established, NACOSA set out to formulate a National AIDS policy. The inclusion of people with a wide range of expertise in the NGOs and community based organisations (CBO’s), from the public sector as well as the private sector allowed a range of experience and a wealth of understanding to be tapped and transformed into creative policies and recommendations. This led to the development of the National AIDS Plan which according to Crewe is

the creation of people who have had daily to confront the reality of the epidemic in their professional and personal lives. It is the work of people who have had to develop AIDS programmes and policies and who understand both that which is ideal and that which is possible. (AIDS Bulletin, vol 3, no2)

A National Implementation Plan was developed based on the priorities identified in the National Strategy. The development of the National AIDS Policy through NACOSA was a unique process as in most other countries the National AIDS Plan was developed by the government department responsible for AIDS education and care whereas in South Africa the lack of government response to AIDS led to the establishment of NACOSA and consequently a process which allowed a large constituency to be drawn into the development of a National AIDS Policy. The key areas and strategies identified in the plan include the following:

- **Counselling:**
  The counselling component of the NACOSA plan provides a thorough overview of how HIV/AIDS counselling services should be conceived and developed. The priorities
identified include, all people undergoing a test for HIV to receive pre- and post-test counselling, the development of an extensive network of trained counsellors in both the health care setting and in the community, all counselling must be accessible and culturally sensitive, that confidentiality and support is recognised and that counselling be integrated into other services.

Counselling also has a preventative function/role in that it aims to prevent the transmission of HIV through the facilitation of sustainable behaviour change and modification. Furthermore, it allows for support for people with HIV or AIDS and their partners and families to be developed.

- **Welfare:**
The main consideration in the Welfare component of the National Plan is to find ways in which the effect of HIV/AIDS on communities can be reduced and ways in which the existing services can be developed to cope with the demands of the epidemic. The welfare aims of the NACOSA plan must be viewed in the context of a generally weak welfare service in South Africa. As a result the aims laid down in the plan emphasise those HIV/AIDS aspects which can be developed while the welfare services are generally being restructured.

- **Health Care:**
The current fragmentation of health services and the inadequate development of primary health care services are issues that need to be urgently addressed by the new government if the health services are to cope with the scale of the HIV/AIDS epidemic. Despite the demise of legislated apartheid, and the entrenchment of a new political order committed to a more equitable distribution of resources, many of the features of the apartheid system will remain entrenched for some time. Considerable commitment has however been made in the restructuring of the health care system as well as in the prioritisation of sexual health and AIDS. Item 2.12.8 of the Reconstruction and Development Programme (RDP) states:

A programme to combat the spread of sexually transmitted diseases and AIDS must
include the active and early treatment of these diseases at all health facilities, plus mass education programmes which involve the mass media, schools and community organisations.

Counselling, home care and palliative care are particular challenges arising from the epidemic. Ideally there should be a continuum of care between home, primary care centre and hospital. The home care function of the health services may be met in several ways: health care worker visits to the home; involvement of community health workers; training and organisation of volunteers; and cooperation with community volunteers and non-governmental organisations (NGOs).

Community acceptance is the key to care in the community. Discrimination prevents infected people and their families from functioning in the community and receiving community support. Community acceptance requires extensive awareness and education programmes linked to prevention strategies. Specific groups should also be recognised for the unique roles they can play. These include, traditional healers, religious healers, organisations of infected people and their families, other community organisations. These groups require support, that is, they should have access to training and discussion forums and allocation of resources, for example, materials, basic drugs, subsidies for services provided. These groups should also be integrally involved in planning and coordination of care.

- **Law Reform and Human Rights:**

The priorities of the law reform and human rights strategy include the following:

1. To combat all discriminatory practices in employment, health care, HIV testing, insurance and medical aid. Discrimination against HIV infected persons is recognised internationally as contributing to the spread of disease by encouraging denial and risk behaviour and discouraging voluntary testing. Discrimination in jobs, insurance, social attitudes and facilities means that those who have been exposed to infection are reluctant to come forward for counselling, testing, behaviour modification and treatment. The need to combat all forms of discriminations is therefore one of the main challenges to the development of a National AIDS Strategy.
2. To insure that the rights of persons with or affected by HIV/AIDS are respected. There should be equality between AIDS and other life threatening illnesses with regard to the provision of care facilities. Patients must also be informed of their rights within the health care system and health care workers need appropriate training.

3. To ensure that through respect for their autonomy and human rights, women are able to take protective action against infection. Poor socio-economic conditions, unequal gender relations and lack of access to health care and education all increase the vulnerability of women to HIV infection. Public health and social policy must ensure that women are treated with dignity and with due regard for their human rights. This is particularly urgent with regard to HIV and other reproductive issues, in general, all legislation which inhibits the autonomy of women should be amended.

4. To enable women to terminate pregnancy on the ground of HIV infection.

5. To abolish criminal penalties against same sex conduct and commercial sex work in that such measures stigmatise those groups and inhibit HIV prevention efforts.

6. To ensure compliance with ethical guidelines for testing of experimental drugs.

7. To ensure adequate provision of monitoring and enforcing human rights.

STD Management and Control:
Current levels of STDs in the general population are unacceptably high. Given that STDs are an important co-factor in the transmission of HIV it is essential that there is improved management and early detection of STDs. This will impact substantially on the course of the HIV epidemic.
Strategies laid out in the plan to improve the management and early detection of STDs include:

1. Improving the accessibility and the effectiveness of treatment for STDs.
2. Setting up mechanisms to monitor common STDs and supporting research to ascertain the impact of improved STD management and control on HIV rates.
3. Providing information and education on STD services. This involves developing and producing educational materials on STDs, distributing information on STDs to particular target groups and to the general population through the mass media and educating and counselling women on STDs to encourage early detection and treatment.
4. Developing and implementing programmes at health centres that provide STD treatment, encouraging all index STD cases to inform partner(s) to seek treatment and to facilitate this process through partner notification cards.
5. Distributing condoms at STD treatment centres and providing training of Primary Health Care workers in STD management, treatment and counselling.

- Prevention and Education:

The prevention and education strategy plan is based on the following underlying principles:

1. Everyone has the right to accurate information about HIV/AIDS.
2. Target specific information, education and communication campaigns shall involve the target audience at all stages of planning and implementation.
3. Prevention strategies shall be incorporated into other existing training programmes and shall at all times complement such programmes.
4. Educators, teachers and trainers shall be equipped with the knowledge and skills to provide HIV/AIDS education.
5. Sustained behaviour change involves more than simple information transfer and programmes shall recognise this.
6. Innovative teaching methods shall be employed and the power of the mass media shall be understood and harnessed.

The prevention strategy targets three methods of spread, namely, sexual contact, blood
spread and mother to unborn child. Sexual transmission is the most important, accounting for 80% of transmission. Strategies for preventing sexual spread are closely interlinked and include: promoting public awareness of STDs and HIV/AIDS; health education to promote safer sex; developing a cultural environment that supports behaviour change in the community and action on socio-economic issues which promote the spread of HIV. Two additional strategies which are also important in supporting appropriate behaviour change are, first, condom promotion and supply through multiple sources: health services, commercial outlets and the informal sector, and secondly, the effective and accessible treatment of STDs combined with education that promotes behaviour change.

Sexuality education was identified as a priority and after much debate about the style and content of this education it was agreed that sexuality education requires a context of values and must include ‘life-skills’. With respect to information and education on safer sex methods for reducing exposure to HIV infection, people should be provided with a range of options from which they can make informed choices. These options, which range from abstinence, a single safe partner, to condom usage and reducing the number of sexual partners, should include information on each of their relative risks. The NACOSA plan advocates that these strategies should reach everyone in society as people have the right to comprehensive education on STDs and HIV/AIDS. It recommends the use of mass media in order to reach a number of target audiences.

**Can Media Make A Difference?**

While the use of mass media to combat the spread of HIV/AIDS is highlighted in the NACOSA plan, the effectiveness of media in changing behaviour has long been debated. During the inter-war period there was - to a remarkable extent - broad consensus that the mass media wielded a powerful and persuasive influence. This promoted a relatively uncomplicated view of the media as "all-powerful propaganda agencies brainwashing a susceptible and defenceless public." (Curren, Gurvitch and Woollacott, 1982) . The prevalent image of the mass media at this time was that of a hypodermic needle or bullet penetrating public consciousness. Media effects were measured in terms of the depth and size of this penetration through modern scientific techniques. This strong-effects view, that skilled media strategists can profoundly sway
impressionable mass audiences at will, was so overstated that it contributed to the reassessment of mass media impact during the late 1940s, 1950s and 1960s. This reassessment gave rise to a new academic orthodoxy- that the mass media have only limited influence. As a result of scientific studies of media impact in the 1940s, such as the apparent minimal influence of political persuasion in presidential campaigns (Lazarsfeld et al, 1948, Berelson et al , 1954), a pessimistic outlook developed regarding the likely effectiveness of information campaigns. A ‘null effects’ perspective became dominant in the 1950s academic circles, especially among sociologists and psychologists who contended that audience members are often highly resistant to mediated messages because of apathy, attitudinal defensiveness, and cognitive ineptness. Underlying this new orthodoxy was a reassessment of man’s susceptibility to influence. It was argued that people manipulated rather than were manipulated by the mass media. Furthermore it was felt that interpersonal influences outweigh and overcame mass media inputs(Lazarsfeld and Merton, 1948; Klapper, 1960; Bauer, 1964). Article titles such as "Some Reasons Why Information Campaigns Fail " and "The Obstinate Audience" reflect this pessimism. That outlook stands in contrast to the perspective that media campaigns can be successfully used to achieve important effects.

During the late 1960s and the 1970s, the ‘new orthodoxy’ was challenged from two opposed directions. Those working within the empirical effects tradition initiated the ‘new look’ in mass communications research. This has consisted partly of a detailed relook at pioneering studies into media effects obscured by the often polemically worded dismissals of media influence that are regularly cited in summary overviews of the literature. Leading media researchers like Katz, Lazarsfeld and Klapper, while disputing the conventional view of the all powerful media were careful to qualify what they said by allowing a number of cases when the media may or has been persuasive: when audience attention is casual, when information rather than attitude or opinion is involved, when the media source is prestigious, trusted or liked, when monopoly conditions are more complete, when the issue at stake is remote from the receiver’s experience or concern, when personal contacts are not opposed to the direction of the message or when the recipient of the message is cross pressured.

The limited model of media influence was also attacked by scholars in the Marxist and neo-Marxist critical tradition that gained increasing influence on mass communication research in the
1970s. Many Marxist and critical writers\textsuperscript{2} initial response to empirical communications research was to dismiss it entirely. They opposed the idea of media having no influence and argued, that the media were ideological agencies that played a central role in maintaining class domination.

While the two research traditions are opposed irreconcilably in many ways, ironically there is no inconsistency between the two approaches at an empirical level. Marxist and critical commentators argued that the mass media play a strategic role in reinforcing dominant social norms and values that legitimise the social system. The classical empirical studies, which started during the 1920s with the Payne Fund studies (a large scale programme investigating the influence of motion pictures on children), also revealed the central role of the media in consolidating and fortifying the values and attitudes of audience members. This however tended to be presented in a negative way only because the preceding orthodoxy they were attacking had defined the influence of omnipotent media in terms of changing attitudes and beliefs. The absence of media conversion consequently tended to be equated with the absence of influence.

The conventional characterization of liberal and Marxist traditions in mass communication research as constituting two opposed schools tends to obscure both the internal differences within each of these traditions and the reciprocal influence which each has exerted upon the other. The shift from a perception of the media as omnipotent to a more cautious assessment in which dominant meaning systems are moulded and relayed by the media, are adapted by audiences and integrated into class based or ‘situated’ meaning systems is characteristic of a significant shift within Marxist research that has been influenced, in part, by empirical communication studies. At the same time Marxist critiques have contributed to a growing recognition within empirical communications research, that more attention needs to be paid to the influence of the media on ideological categories and frames of reference through which people understand the world. Evolving from the relatively limited conception of media ‘agenda setting’ in election studies, a new interest has developed in the wider ‘cognitive effects’ of the media that reflects a nearly universal dissatisfaction among researchers with the narrow conceptualization of media influence afforded by the classic effects studies (Curren, Gurevitch and Woollacott, 1982).

\textsuperscript{2}The group of media scholars, sometimes called ‘Critical Theorists’, attribute more power to the media than do selective influence theories, although the power is said to be long range and indirect. They point out that using communications to shape the meanings people share is a very effective strategy for gaining and maintaining social, political and/or economic control.

*Sex News: AIDS Education Media Development in South Africa*
Mass Media and Health Education

Today, mass media commonly is promoted as a mechanism for increasing knowledge and influencing attitudes and behaviour. While some contemporary work on mass-mediated health campaigns has been discouraging (Festinger, 1975; Wallack, 1981), other early research attempting to define the conditions under which communication campaigns were successful (Mendelsohn, 1973) and recent studies and reviews have supported the use of mass media for health attitude and behaviour change (Atkin, 1981). A review of studies conducted on the influence of media on smoking behaviour provides a case in point.

Mass Media Smoking Prevention and Cessation Campaigns

A review of 40 evaluations of mass media programmes/campaigns designed to influence cigarette smoking found that these programmes generally produced changes in awareness, knowledge and attitudes (Flay, 1987). Extensive national campaigns also produced meaningful behavioural change. Programmes designed to elicit some specific smoking related response, such as requesting of smoking cessation kits for home use or enrolment in smoking cessation programmes at clinics or community agencies, produced mixed results, depending in largely on the type of promotion involved.

One of these campaigns, the USA counteradvertising public service announcement (PSA) campaign, broadcast during 1967 - 1970, demonstrated that an intensive and extensive counteradvertising campaign can influence smoking related beliefs of a substantial portion of the general population (Hamilton, 1972; Warner, 1981 in Flay, 1987). More importantly, the campaign was found to influence the smoking behaviour of a relatively small percentage but numerically substantial number of smokers. The USA counteradvertising campaign demonstrated that intensive television and radio programming of high frequency, extended reach, and long duration can produce behavioural effects. It is important to note however that most PSA campaigns do not produce behavioural effects (Capalaces and Star, 1973; Flay, 1981, Flay, DiTecco, Schlegel, 1980), mainly because they consist of a small number of spots, sometimes of questionable quality, that are shown infrequently at odd (non prime time) hours and therefore are not of sufficient reach, frequency, and duration to be effective.

Elaine Epstein
According to Flay (1987), the most promising use of mass media for smoking control during the past decade has consisted of the broadcast of smoking cessation 'self help clinics'. With these campaigns, the target audience is encouraged to quit smoking with the aid of a televised "self help clinic" which is often accompanied by written 'self help' materials or social support in the form of group discussions. A review of studies evaluating media smoking cessation 'self help' clinics (Flay, 1987) found that a combination of media and social support were more effective than a combination of television programming and printed materials. Both of these combinations were however more effective than viewing a smoking cessation television programme on its own. This finding is supported by Mc Allister(1981), who stresses the importance of interpersonal support for mediated communications. Mass media communication may effectively inform, persuade and train their audiences but lasting change will not be achieved in the absence of a supportive social environment.

Using Mass Media for AIDS Education

In the United States, the broadcast media has emerged as one of the principal vehicles for conveying HIV/AIDS education messages because of their capacity for transmitting artful and potent messages and their efficiency in reaching vast audiences (Warner, 1987). A survey conducted in the US in 1988 found that 86% of all American adults reported having seen public service announcements on television, and 48% had heard them on the radio (Dawson, 1989). Resulting from a combination of television and radio public awareness campaigns, news media coverage, print advertising and television entertainment programming, most American adolescents and adults are now relatively well informed about the AIDS threat, modes of transmission and available prevention measures.

Unfortunately, these gains in factual knowledge do not often lead to health protective changes in sexual behaviour and myths and misunderstandings about specific facts still persist. One possible explanation for this limited effect is that targeted messages are required for different audiences and risk behaviours. However, because the US broadcast media seek to avoid alienating large segments of their mass media audience and the political or economic pressures that would ensue, they cannot be readily mobilized to communicate the specific information that is necessary for motivating safer sexual behaviour, even among heterosexuals (DeJong and

Carol Levine, Director of the Citizens Commission on AIDS for New York City and Northern New Jersey, in commenting on HIV/AIDS education, notes that

*Just as there is no therapeutic 'magic bullet', there is no educational panacea. Early optimism, even naïveté, which saw prevention as a simple matter of telling people to stop risk sexual and drug-using behaviours, has given way to a sober recognition of the complexities of changing human behaviour. ...Prevention is a complex problem that calls for changes in deeply rooted attitudes and behaviour by individuals, partners in sexual and drug-using relationships, and by society in general. Nothing less than a shift in basic social attitudes is required.* (Levine, 1991)

While it is necessary to acknowledge the difficulties in AIDS prevention education, it is just as important to acknowledge that several studies have established that long-term mass media campaigns can have a meaningful impact on health-related behaviours and lifestyle (DeJong and Winsten, 1990). The goal of preventing HIV transmission can be furthered through education directed at the general public, at communities and small groups, and at individuals and their sexual partners. Well researched mass media campaigns that are entertaining as well as informative have also been shown to have an impact (Hornik, 1989 in Rice). A mass media campaign to encourage people to attend family planning clinics in Nigeria was partly responsible for a 13 fold increase in clinic attendance over a three year period. The campaign consisted of entertaining spot announcements and the incorporation of family planning messages into existing popular radio shows (Piotrow et al, 1990). An assessment of the impact of a multifaceted television programme ("VD Blues") aimed at informing sexually active persons about venereal disease revealed that the programme attracted a wide audience and increased their perceived seriousness of the problem (Greenberg & Gantz, 1976). Not only did viewers of the programme have higher knowledge levels particularly with respect to modes of VD transmission and the most effective treatment, but there was also a massive increase in the number of people visiting VD clinics in the days following the broadcast of the programme. The success of the programme can be partly attributed to the fact that it used a highly entertaining style to present straight facts from credible sources in understandable language.

*Elaine Epstein*
Soul City: A South African Success Story

*Soul City*, a multimedia health promotion campaign in South Africa also had an identifiable impact (Case, 1994). The campaign which ran between August and October 1994, and which concentrated on eight maternal and child health topics also had an HIV/AIDS awareness sub-theme that ran through the entire series. The primary target audience was young women in the lower income groups. The evaluation of *Soul City* was carried out by using a sample of 800 black South African adults over the age of 15. Findings showed that the multimedia campaign reached 8.1 million people. The media materials also proved to be highly successful in reaching the primary target audience, young adult women in lower income groups, in both the rural and urban areas. The evaluation revealed that people exposed to the campaign showed significantly greater knowledge levels on the health care issues covered compared to people not exposed to the campaign. Moreover, many people who were reached by the campaign reported that the knowledge imparted was new to them. People exposed to the campaign, reported significant changes in attitudes towards the health issues covered. More importantly, the evaluation showed that the campaign did have an influence on behaviour change. Sixty percent of those who reported using the health knowledge they gained from the campaign also reported having changed their behaviour as a result of this knowledge. Reported behaviours specific to HIV prevention included, visiting a clinic and using condoms (Case, 1994).

The effectiveness of *Soul City* resulted from its combination of health education and drama. This combination was found to make the series more attractive to the audience then either component separately. This was illustrated by the fact that audience ratings for the series outstripped those of more conventional health education programmes and also compared favourably with established popular dramas on the electronic media.

While the debate about the extent of mass media’s effectiveness for HIV prevention continues, it is generally accepted that AIDS information campaigns can be moderately successful under certain conditions; the key conditions include - defining criteria for success, distinguishing various types of effects and identifying and maximising conditions for impact (Mendelsohn, 1973 and Atkin, 1979). Short-term public communication campaigns should not be expected to produce sweeping changes in behaviour. Commitment to a long-term effort is usually necessary (Roberts & Maccoby, 1985). as often the behaviours that public health advocates seek to change
are ingrained habits or have taken on a cultural meaning or personal significance that makes them resistant to change (Robertson & Worzel, 1977). This is especially true in the case of HIV prevention where the behaviour to be changed is sexual behaviour. Rather than focusing on immediate behaviour change in the short term, it is often more realistic and appropriate for a campaign to concentrate on achieving objectives that set the stage for behaviour change in the long term. In this regard, mass media campaigns can accomplish the following:

1. increase awareness of a health problem and establish it as a priority concern;
2. increase knowledge and change beliefs that impede the adoption of health-promoting attitudes and behaviour;
3. stimulate additional information-seeking through hotline or other mechanisms;
4. motivate change by demonstrating the personal and social benefits that the desired behaviour can bring;
5. teach new behavioural skills;
6. link the performance of new acquired behaviours to cues in the physical and social environment;
7. demonstrate how various barriers to behaviour change can be overcome;
8. teach self management techniques for sustaining changes in behaviour; and
9. provide supports for maintaining the behaviour, both directly and by stimulating interpersonal communication and the support of opinion leaders, spouses and peers.

McAllister (1981) succinctly summarises media's capability in changing health behaviour when he suggests that, while media offer economy and uniformity in mass distribution which make them attractive options for communicators wishing to effect widespread behaviour change, if one relies solely on mass media to influence behaviour change the effects will be disappointing. This is due in part to the fact that the effectiveness of mediated messages depends on the social environment in which they are received. If their advice is supported by interpersonal communication and direct social reinforcement it will be much more likely to be followed. Mass media efforts are therefore not a replacement for interpersonal communication or other forms of AIDS prevention. Instead they are a much needed partner in encouraging healthier, safer behaviour. While the review conducted by Flay (1987) on smoking behaviour, supports this view it also concludes that mass media health promotion programmes can be more effective than many academics thought possible. However the knowledge necessary to ensure such success is seriously lacking. Questions concerning the criteria for effective media campaign development still remain and the successful use of mass media for AIDS prevention is a challenge that many health educators face in the 1990s.
CHAPTER TWO

Theoretical Foundations of Public Health Media Campaigns

The research literature examining information campaigns has given little attention to the components that govern the degree of effectiveness (Atkin, 1981). As a result, much of the basis for suggested strategies is borrowed from the more extensive evidence generated by social psychologists, advertisers and mass communication researchers. The most common approach to designing communication strategies involves breaking down the communication process into source, message, channel and receiver variables to determine the role of each factor. In the typical campaign situation the strategist has control over the first three elements; however, the optimum manipulation of these elements depends on a thorough understanding of the receivers in the target audience. The majority of health promotion media campaigns, investigate receiver variables in terms of psycho-social explanatory models of behaviour and behaviour change. These variables include amount of prior knowledge, attitudes, level of salience, value systems, degree of motivation, and capacity for learning information. The campaigns typically begin with a study of the behavioural determinants of the particular health behaviour being targeted. These interventions therefore take as their starting point medical discourses of disease, such as public health or psychological models of behaviour change. Based on individual-cognitive models of health behaviour, these behavioural interventions generally rest on the assumption that individuals given objective information will respond by making rational choices that will result in the desired behaviour change, regardless of the specific media employed, or the particular groups being targeted (Parker, 1992).

An increasing number of health professionals agree that this individualistic focus limits programme effectiveness (Freudenberg, 1981; Becker 1986). Despite increasing moves to address these concerns under the auspices of health promotion efforts the most widely researched and widely applied social psychological models of health behaviour are largely cognitive in orientation. Based on the expectancy value theory they emphasize the beliefs, values, and attitudes of individuals as they exist apart from the social world (Rosenstock, 1974). The
limitations of these models are highlighted by examining some of the main social psychology models of behaviour change.

**The Health Belief Model**

The Health Belief Model (Becker, 1974) has been used extensively to predict a variety of health behaviours. Studies using the health belief model have been reviewed extensively (in Mullen, Hersey, Iverson, 1987) and used in planning programmes and retrospective studies of immunization programmes, private preventive action, patient adherence to therapeutic regimens and the habits of everyday living such as smoking. According to this model, personal perceptions of susceptibility, severity, benefits, and barriers are thought to determine the likelihood of taking a preventive measure in the presence of a ‘cue to action’.

The model affirms that readiness to take action for health stems from a perceived threat of disease, coming from an individual's perception of his or her susceptibility to the disease and its potential severity. The cue for action can be triggered by an individual's private perception or by reading about health matters. Behaviour is evaluated from an estimate of the potential benefits of health seeking action to reduce susceptibility or severity. The benefits are then weighed against perceptions of perceptions of physical, psychological, financial, and other costs or barriers inherent in the health-finding effort. Demographic, social, structural, and personality factors are included in some versions of the model as modifying factors since in theory they indirectly influence actual behaviour (Rosenstock, 1974; Becker, Drachman, and Kirscht, 1972)

The basic components of the health belief model are derived from a well-established body of psychological and behavioural theory whose various models hypothesize that behaviour depends on mainly on two variables: 1) the value placed by an individual on a particular goal; and 2) the individuals estimate that of the likelihood that a given action will achieve that goal (Maiman, Becker, 1974). When these variables were conceptualised in the context of health-related behaviour, the correspondences were: 1) the desire to avoid illness; and 2) the belief that a specific health action will prevent (or ameliorate) illness.

Specifically, the Health Belief Model consists of the following dimensions:

*Perceived susceptibility: Individuals vary widely in their feelings of personal vulnerability*
to a condition (in the case of medically-established illness, this dimension has been reformulated to include such questions as estimates of susceptibility, belief in diagnosis, and susceptibility to illness in general). This dimension, therefore refers to one’s subjective perception of the risk of contracting a condition.

Perceived severity: Feeling concerning the seriousness of contracting an illness (or of leaving it untreated) also vary from person to person. This dimension includes evaluation of both medical/clinical consequences (e.g., death, disability, and pain) and possible social consequences (e.g., effects of the conditions on work, family life, and social relations).

Perceived benefits: While acceptance of personal susceptibility to a condition also believed to be serious was held to produce a force leading to behaviour, it did not define the particular course of action that was likely to be taken; this was hypothesized to depend upon beliefs regarding the effectiveness of the various actions available in reducing the disease threat. Thus, a “sufficiently threatened” individual would not be expected to accept the recommended health action unless it was perceived as feasible and efficacious.

Perceived barriers: The potential negative aspects of a particular health action may act as impediments to undertaking the recommended behaviour. A kind of cost-benefit analysis is thought to occur wherein the individual weighs the action’s effectiveness against perceptions that it may be expensive, dangerous (e.g., side effects, iatrogenic outcomes), unpleasant (e.g., painful, difficult, upsetting), inconvenient, time consuming and so forth. (Janz and Becker, 1984)

According to Rosenstock (1974), the combined levels of susceptibility and severity provide the energy or force to act and the perception of benefits (less barriers) provides the preferred path of action. A stimulus to trigger the decision making process is however also necessary. This so called ‘cue-to-action’ might be internal (i.e., symptoms) or external (e.g. mass media communications or interpersonal interactions).
In emphasising the individuals motivation and predispositions to adopt a particular set of behaviours, the model assumes a degree of intentionality and tends to ignore the fact that non-compliance may be unintentional (Svarstad, 1979). Socii-psychological domains, which are conceptualised as personality variables, social class, and reference group pressures, are relegated to secondary importance in that they are seen as exerting only an indirect effect on behaviour. The way in which they are operationalised reflects their status within the model - they usually consist of a simple list of demographic characteristics such as age, sex, soci-economic status. The Health Belief Model also falls short in its account of interpersonal or group influences. In view of the ‘social nature’ of sexual intercourse and the influence of other factors such as the individual’s beliefs, intentions, comprehension, and memory recall, this is an important omission in the context of STD and HIV/AIDS prevention.

The Theory of Reasoned Action

In Fishbein and Ajzen’s reasoned action model (Ajzen and Fishbein, 1970, 1980; Fishbein and Ajzen, 1975), behaviour is largely determined by intentions. It is similar to the Health Belief Model in that it takes into account the attitudes the individuals have towards the behaviour, their beliefs about the outcomes of the behaviour and their evaluation of these outcomes. Fishbein and Ajzen (1975) have however included a social norms component in their model. Cultural, religious, peer and family attitudes would seem to be an important inclusion in any model which is to be applied to behaviours because attitudes and values change across time and context.

Fishbein and Ajzen's theory of reasoned action posits that volitional behaviour is predicted by one's intention to perform the behaviour. Behavioural intention is predicted by two components, the Attitude Toward the Act and Subjective Norm. The Subjective Norm consists of beliefs about other's expectations regarding the performance of the specific behaviour (Normative Beliefs) multiplied by one's motivation to comply with those expectations (Motivation to Comply). According to the theory, whether or not one will engage in a particular health behaviour is determined at least partly by the expected social consequences of the behaviour and the value that person places on those consequences.

According to this theory, changes in behaviour are seen first in individual beliefs, attitudes and norms. Behavioural intention is pivotal, as a necessary but not sufficient immediate cause of
behaviour. As with the Health Belief Model, demography, personality, and other social psychological variables are expected to influence intention only through the other components of the model. Unlike the Health Belief Model, the theory of reasoned action is almost entirely rational and does not provide explicitly for emotional fear-arousal elements such as perceived susceptibility to illness (Salt, Boyle and Ives, 1990). By defining attitude and organising other variables as casual processes that affect behaviour in an attitude behaviour relationship, this model has strongly influenced attitude-behaviour research in the past decade. It has been applied in numerous ways to a variety of health related concerns, including, among others, family planning, substance abuse, weight loss and exercise.

These and other field studies found that behavioural intention often does predict behaviour particularly when the time frame is short and the intent is clearly specified. From this it seems that intention is a better predictor of behaviour than attitude, but attitudes effect on behaviour is not completely mediated by intent, perhaps because intention is less stable in a longer time frame. Behavioural intention takes into account barriers and other moderating variables to the extent that the respondent is aware of them. Furthermore, the more specifically attitudes and behaviour are defined, the stronger the correspondence between them, e.g. general attitudes toward safer sex are a weaker predictors of intent and behaviour than attitudes towards using condoms (Mullen, Hersey and Iverson, 1987) This model is problematic because there is an implicit assumption that the individual has arrived at a reasoned and rational solution to a complex equation of beliefs, attitudes, perceptions of outcomes and social norms.

De Vries, Dijkstra and Kuhlman (1988) critique Fishbein and Ajzen's theory of reasoned action by raising the question of whether attitudes and subjective norms are indeed the only significant factors that play a role in explaining behaviour. They posit that Bandura's theory on the role of personal efficacy expectations will significantly increase the prediction of behavioural intentions. According to Bandura (1977, 1986) behaviour and behaviour change depend on both outcome expectations and personal efficacy. Outcome expectations consist of beliefs about whether a particular behaviour will lead to particular consequences. They are beliefs about consequences of an act and correspond highly with Fishbein and Ajzen's conception of beliefs. Self efficacy refers to a persons expectation regarding his capability to realise a desired behaviour. It does not reflect a person's skill but rather one's judgements of what one can do with whatever skills one
possess. DeVries, Dijkstra and Kuhlman (1988), argue that models for behaviour change and health education programmes have to pay attention to increasing personal efficacy expectations as well attitudes and subjective norms. They demonstrate the importance of self efficacy in a study conducted with Dutch pupils on the intention (not) to smoke (DeVries, Dijkstra and Kuhlman, 1988). Results of the study indicated that while attitudes and subjective norms are significant predictors of the intention to smoke or not to smoke, self efficacy expectations add significantly to the prediction of intention. This study also supports the results of Ajzen and Madden (1986) who indicated that perceived behavioural control expectations increased the predictions of behavioural intentions.

The theory of reasoned action is limited not just by its omission of a significant predictor of behavioural intentions, but also by its inadequate conceptual development of the societal processes that underlie the emergence and maintenance of norms. As such, the model deals only with the social world as it is perceived by the individual, and interventions incorporating this component seem to be limited to changing dysfunctional beliefs about expectations of others. We are left with the impression that little can be done if, as is so often the case, the norms themselves are dysfunctional. It is not that the expectancy-value paradigm proscribes variables related to social influence. In fact, careful scrutiny of these models by Bruvold and Rundall (1988) reveals that social factors are critical in that they confirm expectancy beliefs; desirable social outcomes, as expected, follow from the performance of certain behaviours. In their analysis, the social world is important because it not only provides reinforcers, but also because social factors can be viewed as a source of information about non-social consequences (the beliefs about outcomes) and of evaluations of these consequences. Despite the potential for an expanded role for social elements in these models, they have received limited attentions.

The Communication/Persuasion Model

A psycho-social behaviour change model that places greater emphasis on communication variables is McGuire’s (1985) Communication/Persuasion matrix. According to McGuire, (public communication campaigns) the basic theories about the structure and motivation of the person can be used to design public communication campaigns that are effective in ‘persuading people’ to change their beliefs, feelings and behaviours. The most popular theory of how this ‘persuasive communication’ operates is illustrated by means of an input/output matrix.

Elaine Epstein
<table>
<thead>
<tr>
<th>Source</th>
<th>Message</th>
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<th>Channel</th>
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<table>
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<tr>
<th>OUTPUT, Developmental Step (Reception, Persuasion)</th>
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<tr>
<td>1. Exposure to the communication</td>
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<td>2. Attending to it</td>
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<tr>
<td>3. Liking, becoming interested in it</td>
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<tr>
<td>4. Comprehending it (learning what)</td>
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<td>5. Skill acquisition (learning how)</td>
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<td>6. Yielding to it (attitude change)</td>
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<tr>
<td>7. Memory storage of content and/or agreement</td>
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<tr>
<td>8. Information search and retrieval</td>
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<td>9. Deciding on basis of retrieval</td>
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<tr>
<td>10. Behaving in accord with decision</td>
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<tr>
<td>11. Reinforcement of desired act</td>
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<tr>
<td>12. Post-behavioural consolidating</td>
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**Figure 1.** The Communication/Persuasion Model as an Input/Output Matrix (McGuire, 1985:45)

The output steps consist of successive information processing behavioural substeps that the communication must evoke in the target person for the persuasive impact to occur. First, if the communication is to have any impact, the intended recipient needs to be in a position where he or she is exposed to the message(s). Given that exposure occurs, the second necessary step is that the message gains the person’s attention. A third step is that the person becomes sufficiently engaged by the message so that the subsequent steps can occur and be rewarded. It is only when interest in the message has been aroused that the fourth step, absorbing the information in the message, becomes possible. The fifth step involves generating and retrieving the related cognitive content already processed and the sixth step of skill acquisition is involved when the persuasive impact requires not only learning what, but learning how. Subsequent steps in the process include, the receivers agreeing with the supportive information evoked by the message, retention of the message if long term impact is the objective, search and retrieval of the convincing
arguments, actually utilising this retrieved material in decision making and lastly, behaving in accord with this decision.

McGuire (1985) acknowledges that in actual persuasive situations some steps may be omitted or may occur in sequences other than the one laid down in the matrix. Mass media adverts, for example, may affect attitudes or behaviour with very little comprehension and a message may continue to produce attitude change after its interest value has waned. He argues, however, that this overly detailed analysis of the output provides an 'as if' checklist useful in calling attention to numerous mediating response steps through which a communication's impact can be predicted or enhanced (Bagozzi, 1982) Utilisation of this matrix ensures that commonly made errors in the development of public communication campaigns are avoided.

A more fundamental problem, identified by McGuire and others, is that early output steps often have low correlations with later steps. Information assimilation can be a poor predictor of attitudinal change, just as attitude change poorly predicts behaviour change. McGuire concedes that it seems that the linear information-processing depiction of output will be drastically revised during the coming 'systems' era of attitude research.

The input steps of the communication/persuasion model include the various components out of which one can construct the communication to change attitudes and actions. The input factors in a public communication campaign are the independent variables. They are the persuasive message options that can be manipulated and/or the components for constructing the persuasive communication. A commonly used analysis starts with Laswell's (1948) interrogative formulation of communication as a matter of who says what, via what medium, to whom, directed at what kind of target. Laswell's model (1948), which is specific to mass communication, views communication simply, as the transmission of messages and which measures message generation and feedback in a linear way. This model is a verbal version of an earlier model proposed by Shannon and Weaver.

Shannon and Weaver's model (1949; Weaver, 1949b)
Shannon and Weaver's "Mathematical Theory of Communication" (1949) presents communication as a simple linear process. A clear example of the process school, it regards
communication as the transfer of messages and emphasises the effectiveness of message transfer from communicator to receiver.

![Diagram of communication model](image)

**Figure 2.** Shannon and Weaver's model of communication (Fiske, 1982, p.7)

The information source produces a message to be communicated out of a set of possible messages. The message may consist of spoken or written words, music, pictures or anything else. The transmitter converts the message to a signal suitable for the channel to be used. The channel is the medium that transmits the signal from the transmitter to the receiver. According to Shannon and Weaver, the meaning is contained in the message, thus improving the encoding will increase the semantic accuracy. The model, which is mechanistic in its operation and sender-oriented in nature, ignores cultural factors that are also at work and thereby gives an oversimplified account of what communication is. It also falls short in its visualization of the essential characteristics of communication. Communication is a dynamic process of interpreting ideas. Ideas are never transmitted in isolation but always within a network of other ideas and meanings. For example, a poster that encourages breast-feeding has a slogan, is illustrated by a picture, has a certain type of lettering, uses a number of colours, is a particular size and is displayed in a particular place. All these characteristics carry meaning and will therefore influence the interpretation of a message. Similarly, a simple sentence can be interpreted in a number of ways depending on the way in which it is said, the context in which in which it is used and the experience of the receiver.

Despite their conceptual contributions, the theoretical models discussed above are limited in their ability to predict sexual risk behaviour for two main reasons. First, these models are based
on the assumption that sexual encounters are regulated by self formulated plans of action, and that individuals are acting in an intentional and volitional manner when engaging in sexual activity. However, sexual behaviour is often impulsive and, at least in part, physiologically motivated. A well formulated plan of action that is the careful weighing of potential harms and benefits can be dismissed in the context of a passionate sexual encounter when competing proximal goals (i.e., sexual gratification) offset well informed intentions (i.e., to use a condom). Second, these theoretical models of behaviour do not easily accommodate contextual personal and socio-cultural variable such as gender and racial/ethnic culture. Gender roles and cultural values and norms influence the behaviour of women and men and the nature of the relationships in which sexual activity occurs. Unsafe sexual practices often are not the result of a deficit in knowledge, motivation, or skill, but instead have meaning within a given personal and socio-cultural context. A case in point, is the initial prevention responses aimed at the gay community in the United States. This illustrates how the medical construction of HIV distorts efforts at prevention. The medicalization of sexual intercourse as a health conduct prompted the use in prevention interventions of models that were inapplicable because they stripped intercourse of its social, cultural, and psychological meanings and motivations. Human behaviour emerges out of a complex gamut of psychological, socio-cultural and physical precipitates and therefore strategies for bringing about behavioural change have to take cognisance of these precipitates. Current theoretical models of HIV risk behaviour do not easily accommodate contextual personal and socio-cultural variables.

Communication is a complex process that works within an elaborate/intricate network of intentions, interpretations, social relationships, power structures, standards and values. For health education campaigns to be effective, the complex social context in which individuals make choices regarding their health related activities needs acknowledgment. The paradigm within which much health promotion theory is generated needs a shift from an emphasis on social psychological models of behaviour and toward the application of socio-cultural theory in understanding health related knowledge and practices.

**Semiotics: An Alternative Approach**

Semiotic Communication Theory acknowledges both the context and the interrelationship of social forces. In so doing it positions communication integrally within human society and ensures that "analyses of the communication process are coloured with the same brush as that of the context within which they take place (Parker, 1995). The central concern of semiotics is the sign."
According to Fiske (1990) semiotics has three main areas of study:

1. The sign itself. This consists of the study of different varieties of signs, of the different ways they have of conveying meaning, and of the way they relate to people who use them. Signs are human constructs and can only be understood in terms of the uses people put to them.

2. The codes or systems into which the signs are organized. This study covers the way that a variety of codes have developed in order to meet the needs of a society or culture, or to exploit the channels of communication available for their transmission.

3. The culture within which these codes and signs operate. This in turn is dependent upon the use of these codes and signs for its own existence and form.

Modern semiotic analysis can be said to have begun with two men - Swiss linguist, Ferdinand Saussure, with whose work the term semiology is associated, and American philosopher Charles Sanders Pierce, who coined the term semiotics. Although Saussurean semiotics remains the dominant tradition, Peircean semiotics is increasingly informing recent theory development.

The Peircian sign points in two directions: on the one hand towards the person to whom it is addressed and in whose mind it creates an idea or secondary sign, called the interpretant, and on the other towards that which it stands for, called the object. According to Pierce, a sign 
is something which stands to somebody for something in some respect or capacity. It addresses somebody, that is, it creates in the mind of that person an equivalent sign, or perhaps a more developed sign. The sign which it creates I call the interpretant of the first sign. The sign stands for something, its object (In Zeman, 1977).

Peirce viewed the relationship between these elements as three points of a triangle. Each is closely related to the other two, and can be understood only in terms of the others. The interpretant becomes the meaning or the content of a sign and the interpretant resides in the mind of the person; it is not embedded in the sign itself. The concept of interpretant places responsibility for signification with the audience. According to Jensen (1995), Pierce's
interprets are the signs by which people orient themselves toward and interact with reality of diverse things, events and discourses. The interpretant is neither identical with the interpretive agent, nor an essence representing the content of that person's thoughts. Being a sign the interpretant itself calls up another interpretant, and so on ad infinitum. Interpretation, is therefore a continuous process of human interaction with reality, rather than one act which, once and for all, internalizes external phenomena through the medium of signs.

Pierce produced three categories of sign, each of which showed a different relationship between the sign and its object or that to which it refers. Peirce divided signs into three types, index, icon, and symbol.

- Every sign is determined by its object, either first, by partaking in the character of the object, when I call the sign an icon; secondly, by being really and in its individual existence connected with the individual object, when I call the sign an index; and thirdly, by more or less approximate certainty that it will be interpreted as denoting the object in consequence of a habit...when I call the sign a symbol. (In Zeman, 1977, in Fiske)

Saussure's work, although similar to that of Pierce, is more closely concerned with the relationship between the sign and the mental concepts that the sign evokes. For Saussure, the sign itself can be perceived as a physical object with a meaning. He divided the sign into two components, the signifier, or sound-image, and the signified, or concept. His suggestions that the relationship between the signifier and the signified is arbitrary were of crucial importance for the development of semiotics.

Saussure's analysis of the sign relegates 'signification', the relationship of the signified to reality or of Peirce's sign to object, to second place. However, the similarities between Saussure's signifier and Pierce's sign, and Saussure's signified and Pierce's interpretant are immediately noticeable. Saussure, however, offers a crucial insight about the nature of signs - that signs have meaning because of relations and the basic relationship is oppositional. "Concepts are purely differential and defined not by their positive content but negatively by their relations with the other terms of the system" (Saussure, 1966). It is not the 'concept' that determines meaning, but 'relations' in some kind of a system. The "most precise characteristic" of these concepts "is in being what others are not" (Saussure, 1966: 117). Thus the meaning of the sign "man" is
determined by how it is differentiated from other signs. "Man", in this respect, can mean not animal, or not boy or not master.

According to this model of meaning, the signifieds are the mental concepts we use to divide reality up and categorise it so that we can understand it. The relationship between the signifier and signified is arbitrary, unmotivated and un-natural as there is no logical connection, for example, between a word and a concept. Signifieds are made by people and determined by the culture or subculture to which they belong. They are part of the linguistic or semiotic system that members of that culture use to communicate with each other. The area of reality or experience, to which any one signified refers, that is the signification of the sign, is therefore determined by the boundaries of the related signified in the system, and not by the nature of that reality or experience (Fiske, 1990). Meanings are therefore better defined by the relationships of one sign to another than by the relationship of that sign to an external reality. This relationship of the sign to others in its system is what Sassure calls value and which for him is what primarily determines meaning (Fiske, 1990).

The problem with Saussurean semiology in communication studies has been a tendency to give much attention to signs as such, less to society, and hardly any to the `life' of signs in social practices (Jensen, 1995). According to Jensen (1995), the relative neglect of semiosis as practice in the humanities is matched by the neglect in much social-scientific communication research, of mass media as sources of meaning. Social scientist have been to busy trying to answer the questions posed by linear models of communication to address the more fundamental question of how communication and its 'effects' are mediated in discourse. While these disciplinary blindness have long been recognised, substantial interdisciplinary convergence remains to be accomplished. One area, where important interdisciplinary dialogue has occurred, is in the area of reception studies where mass communication is simultaneously examined as a social-material and semiotic-discursive phenomenon. A new conception of the reception, social uses and impact of mass media has emerged out of both the theoretical and empirical work during the eighties and early nineties. The classic question of effects has been reformulated to state broader issues concerning the role of mass media in the production and circulation of meaning in society and significantly, the activity of audiences in that process (Jensen, 1995).
Reception encompasses several directions of study, however Holub (1984) in his book "Reception Theory: A Critical Introduction" delineates it as the general shift in concern from the author and the work to the text and the reader. This shift has been appropriated by some semioticians, for example Fiske (1982), into semiotics. This is evidenced by semioticians replacement of the term receiver which implies passive reception of messages with the term reader which implies a greater degree of activity. Reading is something we learn to do and is therefore determined by the cultural experience of the reader. The reader helps to create the meaning of the text by bringing to it his or her experience, attitudes and emotions (Fiske, 1990). The emphasis here is not on stages in the process: but on the text and its interaction with its producing/receiving culture: the focus is on the role of communication in establishing and maintaining values and on how those values enable communication to have meaning (Fiske, 1990).

Attempts have also been made to integrate ideology with audience research. Parkin (1972) for instance has offered three general meaning systems (which in essence, can be seen as ideological stances toward texts) based on an orientation to the political system: (1) acceptance of the dominant system, (2) accommodation with the dominant system, and (3) opposition to the dominant system. Hall (1980) and Fiske and Hartley (1978) have adopted Parkin’s typology to account for the depth of an audience member’s interaction with media texts. Both Hall and Fiske and Hartley have implied that an audience member’s ideology influences what will be looked for in a text and what conclusions will be drawn regarding the meaning of a text.

Meaning production is a dynamic act in which both elements, the text and the audience, contribute equally (Fiske, 1982). When the text and the audience are members of a tightly knit culture or subculture, the interaction is smooth and effortless: the connotations and myths upon which the text draws fit closely, if not exactly, with those of the audience members. While the preferred reading may come easily to some, for others it may be the cause of stress or disagreement. They may decode it by oppositional or negotiated codes, not by the dominant 'easy' one. In other words, their myths by which they understand the world around them are different from those the text/author assumes to be held by the majority of its readers. Semioticians would in fact argue that the text is not merely assuming that its readers share these second order meanings but actively invites the reader to conform with the text position in order to be able to
decode it according to the dominant codes or be able to arrive at the meanings that the text itself prefers. The reader and the text together produce the preferred meaning, and in this collaboration the reader is constituted as someone with a particular set of relationships to the dominant value system and to the rest of society. This is ideology at work.

**Ideology**

Articulating fully a semiotic approach requires addressing the issue of ideology. Saussure's crucial distinction between language and speech\(^2\) provides two spheres which can be transposed to express two levels of any discourse or system of signs, the manifest content and the latent content. While the manifest content is analogous to speech, the latent content represents the underlying structure of the discourse. According to Larrain (1979),

*the assumption can be made that this latent structure is equivalent to ideology; that is ideology constitutes a sort of hidden structure in every discourse which is conveyed and received wrapped up in an external and opaque form. Hence this ideological structure cannot be consciously noticed by addresses.*

Barthes (1973), characterises this hidden second level as the level of connotation. The ideological analysis of a message, therefore seeks to grasp the system of second meanings; it tries to decodify the denotative reading to reveal a connotative world, a mythical level.

Barthes, following Sassure set up a systematic model by which this negotiating, interactive idea of meaning could be analysed. At the centre of Barthes theory is the idea of two orders of signification.

**First Order Signification**

First order signification, or denotation as Barthes refers to it, describes the relationship between the signifier and signified within the sign. It also describes the relationship between the sign and its referent in external reality. Tomaselli (1994) refers to "icons" as an example to explain denotation as they have a physical correspondence to the 'reality' referred.

\(^2\)Saussure's distinction between language and speech allowed him to define language as a formal system of oppositions which underlies speech (Larrain, 1979).
Second Order Signification

When a sign carries cultural meanings rather than merely representational ones, it has moved into the second order of signification. In this movement the sign changes its role; the sign becomes the signifier of the cultural values embodied in the sign. According to Barthes (1973), signs in the second order of signification operate in two distinct ways, namely, as myth makers and as connotative agents.

Connotation describes the interaction that occurs when the sign meets the feelings or emotions of the users and the values of their culture. Barthes (1977) argues that in photography the denoted meaning is conveyed solely through the mechanical process of reproduction, while connotation is the result of human intervention in the process. Connotation is expressive, involving subjective rather than objective experience, and is essentially the way in which the encoder transmits his feelings or judgement about the subject of the message.

According to Hall (1984), the analytic distinctions between denotation and connotation must not be confused with distinctions in the real world. There will be very few instances where in which signs organized in a discourse signify only their 'literal' meaning. In most discourse signs will combine both the denotative and the connotative aspects. Hall (1984) points out that this leads us to raise the question, why we retain the distinction at all. His answer lies in the analytic value of this distinction. Signs appear to acquire their full ideological value - appear to be open to articulation with ideological discourses and meanings - at the level of their associative meanings (that is, at the connotative level) - for here the meanings are not apparently fixed in natural perception and their fluidity of meaning and association can be more fully exploited and transformed. So it is at the connotative level of the sign that situational ideologies alter and transform signification. This does not mean that the denotative or literal meaning is outside ideology Rather, its ideological value strongly fixed - because it has become so fully universal or 'natural'.

Myth

According to Barthes, myths are another way signs operate in the second order of signification. Barthes thinks of myth, which is in essence the second order meaning of the signified, as a chain of related concepts. The signified activates a chain of existing cultural concepts that constitute
the myth. He argues that the main way myths work is to naturalize history. This points to the fact that myths are actually the product of a social class that has achieved dominance by a particular history: the meanings that its myths circulate must carry this history with them, but their operation as myths makes them try to deny it and present their meanings as material, not historical or social. Myths mystify or obscure their origins and thus their political and social position.

According to Levi-Strauss, myth is a story that is a specific and local transformation of a deep structure of binary opposed concepts that are important to the culture within which the myth circulates. The most powerful and significant myths act as anxiety reducers in that they deal with the contradictions inherent in any structures of binary oppositions and although they do not resolve them (for such contradictions are often finally irreconcilable) they do provide an imaginary way of living with them, and coping with them so that they do not become disruptive and do not produce too much cultural anxiety (Fiske, 1982).

Ideology and Signification
The only way the commonality of connoted values and myths common members of a culture can be established and maintained is by their frequent use in communication. Every time a sign is used it reinforces the life of its second order meanings both in the culture and in the user. This can be illustrated in a triangular model of interrelationships. The interrelationships indicated by the double-ended arrows all depend upon frequent use for their existence and development. The user of the sign keeps it in currency by using it, and maintains the myths and connoted values of the culture only by responding to their use in communication. The relationship between the sign and its myths and connotations, on the one hand and the user on the other, is an ideological one. Signs give myths and values concrete form and in so doing both endorse them and make them public. In using the signs we maintain and give life to the ideology, but we are also formed by that ideology, and by response to ideological signs. When signs make myths and values public, they enable them to perform their function of cultural identification, that is, they enable members of a culture to identify their membership of that culture through acceptance of common, shared myths and values.

The myths which operate as organising structures within the area of cultural intersubjectivity cannot themselves be discrete and unorganised, for that would negate their prime function
(which is to organise meaning): they are themselves organised into a coherence that we can call ideology.

Semiotics and Media Messages
Clarifying the relationship between media discourses, audience decodings and social uses of mass mediated signs is facilitated by Peirce's concept of a multidimensional interpretant (Jensen, 1995). Pierce identified three levels of the interpretant: the immediate, the dynamic, and the final. The immediate interpretant is defined as a signs intrinsic uniqueness, or put in another fashion, the full and unique range of potential interpretants which a sign can engender. An immediate interpretant corresponds to the matrix of potential meanings inherent in any text. According to Fry and Fry (1986) this construct has limited analytic application since it would be impractical, if not impossible, to compile a fully developed matrix of possible interpretants implied by the immediate interpretant of each relevant sign. Heuristically, the immediate interpretant anchors the multidimensional nature of signs and allows for the real and present potentiality for aberrant decoding because the construct presupposes the text's capacity to produce multiple meanings.

Peirce's two other interpretants - the dynamic and the final - are constituent parts of a signs full potential and emerge from the immediate interpretant. Though any sign has the capacity to produce a range of possible effects, the actual interpretant that is brought to mind of an audience member by a sign or sign system is the dynamic interpretant. While media texts are constructed to direct an audience's attention in ways that increase the likelihood that a specific dynamic interpretant will result, audiences are capable of responding in aberrant ways. There is little guarantee that all audience members will conjure up identical dynamic interprents when confronting the same sign.

At the same time regularities do prevail. Peirce (1931-1934) has coined the term final interpretant to explain the effect the Sign would produce upon any mind upon which circumstances should permit it to work out its full effects" (1958:413). This stage of interpretation reemphasizes semiosis as interminable process which unfolds over time and in varying contexts. This enables media discourses to be reactivated outside the immediate context of reception as performative meaning that reorients the cognition and action of audience publics in everyday contexts. Peirce
sometimes conceived the Final Interpretant as the last link of an interpretive chain which might lead the interpreter to act.

Eco has extended Peirce’s somewhat mentalistic notion of the final interpretant to encompass a more cultural or social interpretation. Eco implies that the final interpretant is the consensual interpretant of a social, linguistic, or cultural group. This concept allows for the possibility of regularities in signification across members of an audience, and is the basis for the conventional correlations that codes generate between specific expression and content planes. For some audience members, then, the dynamic interpretant - the actual impact of the text on the individual - may be isomorphic with the final interpretant - that is, meanings commonly shared by most other audience members. However aberrant decodings are feasible. Thus, though the final interpretant may be isomorphic with the dynamic interpretant for a particular audience member, this is not necessarily the case.

For Peirce, the dynamic interpretant is a multidimensional construct that includes three subdivisions: the emotional the energetic, and the logical interpretant. Peirce’s disinterest in their utility as analytic categories resulted in failure to organise them clearly and categorically. Elaboration of Peirce’s scheme of interpretants will therefore follow Fry and Fry’s analysis which more clearly categorises and classifies them, while at the same time, following Eco, shift them from the wholly mentalistic form in which Peirce conceived them to a more culturally grounded notion.

The possibility of the same sign engendering different dynamic interpretants, together with the possibility that the same audience members will encounter a given sign on different levels of experience, Peirce calls the emotional, the energetic and the logical levels of the dynamic interpretant.

The emotional interpretant is an audience member’s initial and primary recognition of a sign or sign system, a in a text, and usually takes place as an immediate recognition or comprehension of the sign’s probable intended meaning. Pierce recognises both the passive mentalistic acknowledgment of a sign and the physical response, or motor activity produced by a sign. Peirce classified emotional reactions like disgust, fear, envy and so forth as energetic
interpreters in order to convey the importance of the expenditure of physical energy associated with emotional responses.

The energetic interpretant encompasses both mental and/or physical responses to signs and therefore is closer to what researchers have treated as behaviour or an effect. The energetic interpretant becomes a behaviourial response to the emotional interpetant. The emotional interpretant, is not an emotional reaction per se, but rather an initial recognition or signification of a sign. The relationship between the emotional and the energetic interpretants provides a theoretical grounding for Hall’s (1980) contention that meaning must precede effect or use. Emotional interpretants are the initial meanings; audience behaviour is a reaction to the emotional interpretant. Thus behaviour is a less direct reaction to a media text than it is a response to the interpretant that a text elicited initially.

The logical interpretant exists in the realm of the intellect and includes such things as the rationalization of meanings. It is what allows for regularities of interpretation (similar signs engendering similar interpretants over time), and allows for the possibility that audience members may perceive multiple meanings in a specific text. Logical interpretants can be seen as analytic extensions of the emotional and energetic interpretants, extensions that are guided by the earlier initial significations.

Peirce’s constructs provide the potential for quite complex patterns of signification as a series of interpretant scenarios are possible. First, a media text can evoke an emotional interpretant that is consistent with the intent of the encoder of the message, or the text can evoke an aberrant emotional interpretant that is other than the intent of the encoder. Second, a series of physical and/or cognitive reactions to the sign can occur. These may be reactions intended by the encoder or they may be aberrant. Third, a series of analytic reactions can occur. At this level the decoder may extend the implications of the textual sign, question the validity of the text, or perhaps, assume any number of analytic reactions.

In such instances, an interpretant generated by a message may itself become a sign which evokes other interpretants. The three subdivisions of the dynamic interpretant can be related to Eco’s use of denotation and connotation. The connection cannot be made explicitly, however it seems
apparent that the emotional interpretant is quite similar to denotation. The energetic interpretant is the behavioural manifestation of the denotation and the logical interpretant is the end result or effect of the process of connotation.

**Codes**

The way we interpret signs and symbols found in the media and the way we live is affected by the highly complex patterns of associations we all learn in a given society and culture. These patterns or codes, are in fact, systems into which signs are organised, and can be considered as a collection of rules that tells us what to do in all conceivable situations. We carry over our rules and understanding of life to media productions, or "mass mediated culture" (Berger, 1991).

Codes are difficult to see because of their characteristics - they are all-pervasive, specific, and clear cut, which makes them almost invisible. Most codes are dynamic systems, continually evolving to meet the changing needs and practices of their users. This dynamism implies a constant tension between tradition and innovation or between convention and originality. It is the conventional or traditional aspect of the code that enables it to communicate and convey meaning.

Codes and conventions constitute the shared centre of any cultures experience. They enable us to understand our social existence and to locate ourselves within our culture. It is through the use of common codes that we feel and express our membership of our culture. By using codes, whether as a audience or source, we are inserting ourselves into our culture and maintaining that cultures vitality and existence. Convention relies on redundancy: it makes for easy decoding, it expresses cultural membership, it relies on similarity of experience and is reassuring. It can also produce conformity.

Guirard (1975) terms the way norms or conventions are established, codification. Codification of the sign is a constant process. The frequent use of a sign makes it more conventional, and increases the probability that it will decoded similarly by different receivers. The codes which we acquire are specific to our social class, geographical location, ethnic group and so on. It is for this reason that misunderstandings arise between the producers of media and those who consume these media products. Umberto Eco, in his essay "Towards a Semiotic Enquiry into the
Television Message" (1972) suggests that this "misunderstanding" or "aberrant decoding", as he terms it, "is the rule in mass media". This is because people bring different codes to a given message and thus interpret it in different ways. As Eco (1972:115) puts it;

*Codes and subcodes are applied to the message in the light of a general framework of cultural references, which constitutes the receiver's patrimony of knowledge: his ideological, ethical, religious standpoints, his psychological attitudes, his tastes, his value systems, etc.*

The transmitter of messages, because of their social class, educational level, political ideologies, world view, ethos, and so on, do not share the same codes as their audiences, who differ from the message transmitters in some or even most of the respects and who interpret the messages they receive from their own perspectives.

Aberrant decoding therefore takes place when the codes that people use to interpret messages differ from the codes in which the messages were originally cast. According to Eco, with the development of mass media, aberrant decoding became the norm. This is because of the wide gaps that exist between those who create and generate the material carried in the media and those who receive this material. It is useful to extend this concept to aberrant encoding, that is, encoding which fails to recognise that people of different cultural or subcultural experience will read the message differently.

**Genres**

As links codes result in the generation of genres which are ways of structuring messages into instantly recognizable forms, for example closed texts such as love stories, dramas, thrillers, and so on (Tomaselli, 1994). As far as conventional genres are concerned, there is usually a significant fit between a genre's implicit semiotic instruction on how to read the text and the general message usually inferred by the reader. Not only do media genres follow codes, which are commonly known as formulas, but so do the media in general. Medium carries various genres. The category of genre incorporates both discursive and performance aspects of communication. As argued by Williams (1977), genres must be defined not merely by their formal composition, as in aesthetics and literary theory, but equally by the type of subject matter or social sphere referred to, and, most important, by their mode of address. Genres invite
audiences to take particular stances that imply their social roles as actors in the possible world being represented. Being vehicles of representation, expression, ritual, as well as transmission (Carey, 1989), genres offer a promising avenue for studying mass communication as a cultural practice (Jensen, 1995).

**Intertextuality**

Codes, as links between producers, film and videos, and audiences, are agents of intertextuality. The concept of intertextuality emphasises that no text is an island: it refers to the complex structure of interrelations that exist between single literary works or media products. Text cannot therefore be examined on its own but must also be examined in terms of our cultural experience, that is, its reading is affected by readings of other similar texts. The meanings generated by any one text are determined partly by the meanings of other texts to which it appears similar. Jensen (1995) defines intertextuality as the process in which elements of discourse communicate specific meanings to audiences by implicit reference to other, familiar discourses, themes, genres, or media, which may also be present or implied by the context of reception. Intertextuality is perhaps an especially prominent feature of mass communication, because the media feed on each other as part of the simultaneously economic and cultural dynamic that shapes the contemporary integrated media environments.

Two aspects of intertextuality can be analytically distinguished, namely structural and thematic intertextuality. Structural intertextuality has not been traditionally emphasised however it contributes crucially to the configuration of media texts as part of an institutionalised communicative purpose which goes beyond so called 'primary', secondary' and tertiary texts. More relevant to this thesis is the notion of thematic intertextuality which refers to the incorporation of discursive elements from one text, genre or medium into other texts. An illustrative example is the adoption by a number of commercial advertisements of formats from other genres, particularly game shows, sitcoms and news.

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The Use Of Semiotics In Health Promotion

Very few health promotion campaigns have taken semiotics as their starting point. A notable exception is Parker's (1995) development of community based AIDS education. Parker employs a methodology that emphasises the incorporation of intended readers of texts in the development of communication messages. Further emphasis is placed on the relevance of symbolic or iconic signs which promote interpretive responses in readers and which can be used to generate intellectual and emotional responses. The main aim of Parker's study was to generate target group or rather 'reader' derived media products to facilitate HIV education and prevention and to assess this 'reader' centric educational media production. The approach employed moved beyond the more common retrospective application of semiotic theory and instead applied semiotic theory proactively by using a methodology whereby the process of message generation incorporated the perspectives of the intended readers. The process of researching and shaping the media products utilised participatory action research and small group methodologies. A sequence of focus sessions was held which culminated in the development of indigenous signs that were deeply relevant to the readers' own context and to the problem at hand, AIDS education. Early sessions focused on level of knowledge among participants and subsequent sessions focused on media and included assessments of previously produced posters. The groups then explored possible images and slogans for posters that would be applicable within their context. A range of creative ideas, closely tied to the perspectives of the focus groups emerged, and a number were subsequently developed into posters. These included a depiction of the national flag on a condom with the slogan "Viva Condoms", multi-hued hands with the slogan "Let's unite and fight AIDS, not each other" and a condom holding as steering wheel with the slogan "Ride safely".

The process of promoting 'indigenous signmaking' enables participants to incorporate their own lived experience and consciousness into perspectives of the task at hand - that of HIV/AIDS awareness. This is evidenced by the slogan "Let's unite and fight against AIDS, not each other", which reflects participants' experience of internecine violence which has long been a feature of South African township. Parker argues that this methodology allows for the development of images and slogans that were unlikely to have emerged utilising conventional (top down) approaches to health media development. Parker uses his findings in the form of the nature of the images and slogans that were generated to indicate that dominant assumptions regarding the "professional" components of information production need to be questioned. Within dominant
models of information production where, in the case of health promotion for example, health professionals and media professionals jointly conceptualise media products and messages, the perspectives of target audiences are seldom directly assessed. Such professional producers are likely to occupy considerably different class (social, economic and cultural) positions and this contributes to lesser awareness of grass roots issues and thus undermines the possibility of intertextual perceptions.

While the application of this methodology to AIDS education media development results in ‘culturally sensitive’ media it is interesting to note that none of the messages emerging from this process critically examine or address the prevailing barriers to condom use or the cultural values underlying these barriers. For example, the poster Viva Condoms which presents the new South African flag in the shape of a condom does not in any way address myriad of cultural barriers to condom use, including among others, gender inequalities in sexual negotiation and the value placed on procreation and the transfer of sperms during the sexual act.\(^5\)

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\(^5\) If the male partner is using a condom it is seen as a sign that he is not serious about his female partner as he is not trying to make her pregnant.
This suggests a significant limitation of this approach to AIDS education media development, namely that the critique of existing and/or culturally determined beliefs and behaviours does not emerge from members of the target audience. As a result, media products developed in this way, do not stimulate the target audience to critically examine the cultural values underlying their risk behaviour.

The role of culture or rather 'cultural sensitivity' in the development of AIDS education media therefore requires critical consideration.

The Culture Debate
In recent years health educators have become more aware of the impact of culture on the success of health education programmes. Growing awareness of the impact of cultural issues in health education has prompted educators to experiment with the use of cultural elements in HIV education and prevention efforts.

"Culture" writes Raymond Williams (1976:87), "is one of the two or three most complicated words in the English language". Culture has been defined in various ways. Muller (1980) defines culture as "a storehouse of ways in which we create a meaningful world". Thus culture is concerned with meaning, the practices that generate that meaning and the representational forms in which that meaning is encoded (Tomaselli, 1988).

The Contemporary Cultural Studies Unit of the university of Natal has defined culture as follows, *Culture is an ensemble of meaningful practices and 'uniformities of behaviour' through which self defined groups within or across social classes express themselves in a unique way or locate themselves within an identifiable 'field of significations'. It is the process which informs the way meanings and definitions are socially constructed and historically transformed by the social actors themselves. Cultures are distinguished in terms of differing responses to the same social, material and environmental conditions. Culture is not static or even necessarily a completely coherent phenomenon: it is subject to change, fragmentation, reformulation. It is both adaptive, offering ways of coping and making sense* (Tomaselli, 1988).
Despite the multiplicity of definitions of culture most definitions agree on some core conceptual elements. Culture is a body of learned beliefs, traditions, principles and guides that are shared among members of a particular group. Elements of culture such as values, language, rituals and traditions evolve or change slowly over time and some elements take on new shapes or meanings among subgroups of people who share a neighbourhood, religious tradition, sexual orientation, geographic origin, class or other characteristics. It is repeatedly stated and accepted that for AIDS prevention programmes to be effective they should be culturally sensitive. Bayer (1994:895), in examining the validity of this assertion in part refutes it. He states that "the call for cultural sensitivity entails a number of perspectives, some of which are obvious and uncontroversial, some of which are not so obvious, and some of which are simply false".

Bayer (1994), in looking at what is meant by the concept, cultural sensitivity, distinguishes three different ways in which the concept is used: the semantic, the instrumental and the principled. The first two uses are rooted in the pragmatic argument, - AIDS prevention efforts that are not culturally sensitive will be ineffective. They will fail because they will not reach their intended audience, will not be understood by those who are reached, and will not be accepted by those who understand.

The semantic conception of cultural sensitivity underscores the importance of conveying AIDS prevention messages in a form that makes the content understandable, that uses linguistic and stylistic characteristics of those to whom the message is addressed. Walters et al (1994) term this cultural responsiveness. Educational materials which are culturally responsive use language, symbols and visual images in a way that effectively portrays the values and lifestyles of particular cultural groups. Failure to understand the complex ways in which language and culture filter prevention messages is a recipe for failure in AIDS prevention. Cultural sensitivity, applied in this way - although vital to the success of health education campaigns - is often omitted or applied incorrectly. For example, DeJong and Winsten's (1990) summation of the elements necessary for an effective media campaign fails to mention the importance of cultural and communication contexts in educational media development. According to them, mass media communication is most successful at changing behaviour when it:

1. Is designed to reach a specific audience.
2. Extensively uses formative research (e.g. focus groups and in-depth interviews) to
understand the target audience and to pretest campaign materials.

3. Provides messages that build from the audience's current levels of knowledge and skill.

4. Comes from a source - person or group - that the audience likes, understands and believes.

5. Comes through familiar communication media.

6. Provides a message that is engaging, personally relevant, and novel

7. Tells the audience what to do and how to do it.

8. Uses a media plan guaranteeing that the target audience is exposed to the campaign.

9. Is coordinated with locally available supplies and services.

For media interventions to be effective they must take as their starting point the way people make sense of their world, that is they must ultimately be based on an understanding of experiences as rooted in cultural meanings and social systems and respond to nuances of cultural specificity and detail. While many AIDS education materials demonstrate an appreciation of culture and utilize relevant aspects of it in educational materials, many materials display problematic uses of cultural elements or make errors in language, images and symbols.

Culturally responsive (Boyajian, 1992) HIV/AIDS educational material should identify relevant aspects of a particular culture in order to communicate with members of that cultural group. According to Walters et al (1994) the most effective materials will:

1. Use accurate information about a cultural group, including the appropriate use of cultural images, language, and depiction of values, activities, and people;

2. Appreciate and utilize culture in a manner which accomplishes its primary health goals.

Common mistakes relevant to the portrayal of cultural elements in educational material include the following:

1. Lack of community participation in materials development.
2. Use of an inappropriate reading level.
3. Design that detracts from easy comprehension of the message.
4. Poor organisation of information.
5. Too many words or too many concepts.
6. Use of jargon or technical terms.
7. Inappropriate translations from English vernacular into other languages.
8. Homogenization: does not recognise differences between cultural groups.
9. Universalization: applies certain values, behaviours, or activities to all members of a cultural group.

Pedagogy across cultures involves more than translating prescriptions of behaviour change into different languages. Inevitably we need to know more about the meaning of given practices and conceptions, their place in a community's social and cultural life, the political economy that frames them, and the contingencies that sustain or discourage them (Treichler, 1992). This brings us to what Bayer describes as the instrumental conception of cultural sensitivity. This conception underscores the importance of understanding the cultural context of sexual, drug-using, and procreative behaviour in order to facilitate the transformations of those behavioural norms that foster the transmission of HIV infection. This conception of cultural sensitivity finds repeated expression in the literature on women and ethnic minorities. The instrumental conception of cultural sensitivity seeks to advance the goals of public health with a solid grounding in cultural studies and analysis.

The importance of the instrumental concept of culture in addressing the problem of both STDs and AIDS is evidenced in the accepted definition of risk to these diseases which reveals examples of how culture is implicitly "hidden" in the categories and assumptions of epidemiology. For example, while the seemingly simple question "Who is the subject's sexual partner?" (Parker, Herdt & Carballo, 1991) may seem obvious it varies across cultures and is probably the source of significant error in research design. Consequently any interventions that are developed on the basis of those results are likely to fail. Whether a partnership is sexual and/or social, culturally approved or disapproved, voluntary or coercive is of real import in survey and fieldwork studies. If a community places a value on marriage and monogamy respondents may be unwilling to discuss adultery, especially with an outsider unknown to them. In Africa, for instance, this issue
of extramarital relations and predominantly male promiscuity is a key to understanding the transmission of HIV (Obbo, 1990). Cultures vary substantially in how they approve of sexuality outside of the context of marriage and reproduction. When sex is exchanged for money, gifts or other favours; it is necessary to understand how the definition of sexual partner may support or violate normative community standards in order to both sample the range of sexual practices and develop interventions to reduce the sexual spread of disease within that population.

More importantly, culture shapes our response to disease. According to Gilman (1988), some diseases are interpreted through existing cultural categories. Gilman refers to these interpretations as myths and points out that myth making about disease in German literature, for example, differs from myth making elsewhere. Beliefs about health and illness do not arise necessarily from either ignorance or wilful misinterpretation of mainstream medical knowledge. They may be actively constructed in an effort to make sense of frequently confusing and contradictory experiences people have. Myths are constituted through complex cultural processes involving active interplay between dominant and dominated `systems of meaning'. In this respect people's beliefs about health relate closely to the social strategies that they conventionally use to negotiate contradictions associated with social position (Warwick, Aggelton & Homans, 1988).

The principled conception of cultural sensitivity represents a radical departure from the others since it would prohibit those interventions that violate the cultural norms of those to whom they are directed. This concept of cultural sensitivity is rooted in the ethical and political argument. The basic principle of ethics that individuals should be treated with respect and that their dignity should not be violated is by extension applied to cultures. Cultural sensitivity is thus required of us by the ethics of pluralism. A failure to respect the cultural integrity of others is almost always characterised as an imposition of the values of the dominant and powerful on the subordinant marginal.

The foundations for the principled conception of cultural sensitivity are therefore respect for the cultural integrity of those whom the public health efforts are directed and the moral claims of pluralism. It is in this strong sense of cultural sensitivity that a profound clash between the goals of public health and the demand that interventions respect groups cultural integrity becomes clear. The clash is inherent in the broadly understood ends of AIDS prevention, which require
fundamental changes in sexual and drug using behaviour and the norms that inform and structure such a behaviour.

According to Bayer (1994), no strategy for effective AIDS prevention can be limited by the demand that cultural barriers to behavioural change always be respected. Acceding to the demands of cultural sensitivity in the principled sense of the term, not only is not a prerequisite for effective public health practice but would be inimical to the goals of AIDS prevention. It is accepted that it is necessary to recognise cultural differences as prevention efforts are fashioned, to recognise that communities are not monolithic and that cultural conflicts may occur within them. It is also essential to understand the cultural barriers to AIDS prevention. “In the face of such barriers it is desirable to reach for understanding, to persuade even to hector” (Bayer, 1994).

The normative environment is best conceptualised in terms of culturally distinct groups, each with its own set of behavioural norms that express the collective values and beliefs of group members. The process of changing the norms of the group in order to affect the behaviours of its members is what Gladis et al (1992) call ‘cultural change’. If health behaviour is deemed to be regulated by cultural influences then the goal of health promotion would be to change the culture from one that supports health risk behaviours to one that is conducive to health. Here the group is viewed as the target for intervention rather than the originator of messages.

While the dominant theoretical models of behaviour do not place sufficient emphasis on contextual personal and socio-cultural variables that influence risk behaviour, models based on reader centric, approaches, by nature of their underlying premise, do not address ‘cultural change often necessary to effect behaviour change. Reluctance to confront damaging cultural beliefs and practices has led educators to avoid issues that are critical to behaviour change rather than attempting to confront these issues.

The Communication Planning Matrix

A model that allows the incorporation of the strengths of both psycho-social and semiotic approaches would be ideal. Regrettably, after extensive review of the literature I was unable to find a model that specifically met this criteria. In the course of my review I did however find a planning matrix based primarily on McGuire’s Communication/Persuasion model, which
although not ideal was sufficiently flexible to rearticulate in terms of semiotic communication theory. This communication planning matrix simplifies McGuire’s framework and extends it into the following seven phases (Kok, Hospers, den Boer & de Vries (1996): successful communication (attention and comprehension); changes in behavioural determinants (attitude, social influence, self efficacy) and behaviour; and maintenance of behaviour change. Interventions may be different for each step. The planning matrix facilitates identification of the major issues for programme development and planning and due to its flexibility allows the application of a variety of theories. While these theories may cover only (parts of) specific steps in the process of behaviour change, they can be helpful when developing behaviour change programmes.

<table>
<thead>
<tr>
<th>Reception</th>
<th>Receiver</th>
<th>Message</th>
<th>Channel</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attention</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Comprehension</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Encoding</td>
<td>9</td>
<td>10</td>
<td>11</td>
<td>12</td>
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<td>(intention)</td>
<td>13</td>
<td>14</td>
<td>15</td>
<td>16</td>
</tr>
<tr>
<td>Social Influence</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>20</td>
</tr>
<tr>
<td>Self-Efficacy</td>
<td>21</td>
<td>22</td>
<td>23</td>
<td>24</td>
</tr>
<tr>
<td>Behaviour</td>
<td>25</td>
<td>26</td>
<td>27</td>
<td>28</td>
</tr>
</tbody>
</table>

**Figure 5. The Communication/Planning Matrix**

The matrix identifies 24 different cells. For each cell one an formulate specific questions. For example, for cell one it is important to know which characteristics of the target group may positively or negatively influence the reception of information. It is also important to identify which messages may enhance reception and which channels and sources are needed (cells 2-4). For the encoding phase (cells 9-20) the questions would include: which characteristics of the target group are important with respect to attitude (cell 9), which messages (cell 10), channels (cell 11) and sources (cell 12) may be utilized to enhance a positive attitude towards the desired behaviour. Similar questions can be raised with respect to the other cells. Completion of the questions for all cells identifies the relevant characteristics and issues that need attention in a particular programme.
In summary, the matrix, combines health education goals, namely reception, (attention and comprehension), encoding (attitude, social influence and self efficacy) and behaviour with four communication variables, namely receiver, message, channel and source. The matrix does however have a number of limitations. These limitations are revealed when analysing the structure of the matrix and the definitions of the variables used in the model. In many instances these limitations can be overcome by adding a semiotic dimension or by re-examining these variables in terms of semiotic communication theory.

Health Education Variables

1. Reception

Attention: Attention is the factor that serves as the connecting rod between a medium and the intended audience. Attention is a selective process in that people selectively filter the stream of stimuli from the world around us, actively seeking certain perceptual cues and ignoring others. What we select, either consciously or unconsciously, is largely dependent on needs, interests and circumstances. Family attitudes, schools, religion, economic status, individual cultural identity, political power, and present workloads are some of the forces that determine which information we attend to. Such factors determine the nature of the barriers and filters that individual audience members use to select relevant information and to exclude information that would be dissonant with their worldviews and thus disturb their cognitive equilibrium. We use cultural models to simplify, organise, and interpret our perception of reality. Each group of people sees something other groups fail to see, and each ignores something others notice. As a result, different people may see, know and believe quite different things, even after having been exposed to virtually identical sets of stimuli (Casmir, 1991).

Comprehension: Audience attention does not necessarily imply that the audience understands what the message is trying to communicate. Comprehension, as used in this model, is concerned with how precisely the transmitted symbols convey the desired meaning. Barriers to comprehension include noise - anything that is added to the signal between its transmission and reception that is not intended by the source and entropy - a message that is completely unexpected or that is opposite of what is expected (Fiske, 1990). According to this model, both of these factors may cause miscomprehension of the message. This model however does not take
into account the fact that audience members bring their past experiences and present expectations to each communication transaction and may interpret or misinterpret communication in terms of their previous experiences. The different life experiences of the producers and audiences may therefore cause them to decode the messages differently. Messages, particularly those constructed in terms of linear models of communication, will not necessarily be interpreted or understood in terms of the intentions of those who arranged them. Sometimes as oppositional decoding occurs, confusion results and often the message is simply rejected. The production of messages using shared codes will greatly reduce the amount of aberrant decoding by limiting the range of meanings negotiated by the audience members.

2. Encoding

**Attitudes:** Attitudes, which can be defined as the opinions of an individual about a particular behaviour, are formed by weighing up all the advantages and disadvantages of performing that behaviour. Health is only one of the possible considerations and is often a relatively unimportant one. According to Kok, de Vries, et al. (1991), when health is considered to be part of an attitude, we suppose that the motivation to act in a manner conducive to good health is a combination of the perceived severity of the health risk, the perceived susceptibility of the health risk and the effectiveness of the preventive behaviour. Unfortunately, health considerations rarely dominate and other considerations such as status, costs, likes and dislikes predominate. Knowledge about health risks is therefore insufficient to change behaviour.

**Social Influences:** Social influence is the perceived or encountered support for a healthy behaviour and the encountered pressure for an unhealthy behaviour, and includes social norms. Social norms have been shown to be important determinants of health behaviours (Fischer, 1988; Friedman, Desjarlais, Soberan, Garber, Cohen & Smith, 1987). Perceived support of key reference groups for labeling oneself as susceptible to HIV/AIDS is likely to determine personal susceptibility ratings. Furthermore, referent group attitudes towards safer sex has shown to influence intentions regarding safer sex acts.

Social Comparison Theory assumes that people tend to conform to the attitudes and behaviour of similar others, partly because those others provide information about social reality, and partly because conformity may be socially rewarding (Suls and Wills, 1991) Kelman() proposes three...
processes of social influence: (1) compliance which occurs when an individual accepts influence from another person or from a group because he hopes to achieve a favourable reaction from the other; (2) identification, which occurs when an individual adopts behaviour derived from another person or group because this behaviour is associated with a satisfying self-defining relationship to this person or group; and (3) internalization, which occurs when an individual accepts influence because the induced behaviour is congruent with his value system.

The social aspects of this process vary considerably. In the case of compliance, the relationship is less social than instrumental. The receiver of communication realises that the other person can supply or withhold the means required by him to realise his goals. Thus he will publicly express opinions in which he does not believe when in the company of the influencing agent. Identification is more deeply rooted in social relations because it is based on the attractiveness of another person or group to an individual. So long as this attractiveness exists the individual seeks to maintain his relationship by meeting the expectations of the influencing agent. In the case of internalization, the role of the influencing agent is defined by his credibility as a source of information.

Source credibility can have at least two bases. The first, is respect for the communicator’s expertness about a specific subject, which leads to a belief in what he says. The second basis of source credibility is trustworthiness. A communicator who is considered trustworthy by one group may appear otherwise to another. Generally, a communicator is trusted if he is seen by the audience as belonging to their group or class, or in someway upholds the interests of the groups.

Self Efficacy: Self efficacy is an estimation of ability to cope with possible barriers inside or outside the person. Examples of inside barriers are: not enough knowledge, not enough abilities, and not enough endurance. Outside barriers include: resistance from others, time and money not available, and conflicting lifestyle. Self efficacy is the perception of the ability to perform the behaviour. Barriers are the real problems people face, sometimes unexpectedly, in actually behaving. According to de Vries, Dijkstra and Kuhlman (1988) self efficacy is shaped by experiences with barriers, experiences with successes, vicarious learning, verbal persuasion and physiological information.
There is a logical relation between perceived efficacy and real barriers, but there is also an important relation between efficacy and success in performing the behaviour. People with higher efficacy have a higher chance of succeeding, independently of real barriers. Ideally, health educators should try to motivate people to perform the preventive behaviour while at the same time helping people to overcome real barriers.

Communication Variables

1. Receiver
The receiver in this model is viewed as a passive receiver of media messages. Audience composition is typically described in terms of demographic variables such as age, sex, marital status, education, occupation, religion, place of residence, and ethnic and racial background. However, what we register, an essential determinant of communication, is governed by our knowledge and experience. Through learning and experience we are able to give meaning to what we perceive. The strong relationship that exists between knowledge and experience on the one hand and our capacities to interpret information on the other, has important implications for the process of communication and the introduction of new ideas. (Boeren, 1994). In viewing the receiver or rather in semiotic terms the ‘reader’ in this light we restore agency to the audience by acknowledging that the reader helps to create meaning of the text by bringing to it his or her experience, attitudes and emotions. By also acknowledging the creative agency possessed by the reader in creating their personae in everyday life this approach rejects the unified self in favour of viewing individuals as having multiple, changeable, and highly contextualised identities (Lupton, 1994). Social relations are embedded in the culture of a particular group. This culture defines the rules of conduct in particular contexts and for particular roles. A person plays numerous roles during the day, for example, mother, daughter, lover, sister, employer or employee and friend. Different communication styles are associated with each of these contexts and roles. These styles differ in tone, jargon, content and communication rules. Using communication styles out of context is a sensitive issue and may often be offensive.

An important communication context factor with respect to the reader is timing, which has two dimensions: 1) the availability of the receiver, and 2) the appropriateness of the moment. The first
dimension refers to the readers time availability to pay attention to the communication. The second dimension of timing refers to the appropriateness of the moment of communication. Boeren (1994) discusses this in terms of the importance of synchronizing the communication with the needs and circumstances of the moment.

2. **Message**

As in Shannon and Weaver's model, this model assumes that the meaning is contained entirely in the message, thus to increase the semantic accuracy it is necessary to improve the encoding. Communication within this context, is purposive and can be assessed in terms of how closely this matches the intention of the source. What the model does not specify is that there are also cultural factors at work here, that is, the meaning is at least as much part of the culture as in the message (Fiske, 1990). Communication here is concerned with the generation of meaning and for communication to take place, a message has to be created out of signs. These signs stimulate one to create a meaning that relates in some way to the meaning generated in the original message. Thus, the more we share the same codes and the more we use the same sign system the closer the two meanings of the message will approximate each other. According to Hall, "before a message can have an 'effect' (however defined), satisfy a need or be put to a 'use', it must first be appropriated as a meaningful discourse and be meaningfully decoded" (1980, quoted by Fry and Fry 1986: 443). A media message is made up of signs which convey numerous intertwined meanings. A media text is therefore not simply a transmitter of a particular meaning from source to receiver, but rather a text capable of producing multiple levels of meaning. A text is a resource or a matrix of possible meanings (Eco, 1976:57). An audience drawing from textual and nontextual sources, reduces the range of potential meanings by selecting definitive interpretations from the matrix.

The relationship of 'message' to the other communication variables is an important one, and is not highlighted in this model. It fails to take into account the fact that within a single medium the signs used to generate messages can vary according the context or genre in which it is used. Signs are altered by a change of genre within the medium, in the same way as it is by a change in the medium itself. This is discussed in more detail in the analysis of the 'channel' variable, but points to the limitation of considering variables in isolation during the process of media development.
3. Source

The source in this model is seen as the decision maker in that the source decides which message to send or rather selects one out of a set of possible messages. A source is a person or object/entity that conveys an idea. According to Boeren (1994), the three foremost characteristics that a source should have are authority, credibility and appeal.

Authority, in this context can be taken to mean weight of opinion or influence over opinion. Depending on its origin, authority can either be ascribed or achieved. Ascribed authority is linked to the position one holds in society, for example, the head of the family, a leader or chief. Achieved authority, on the other hand, is based on knowledge and skills an individual has acquired and on his success in life, for example a medical practitioner. The two types of authority are not necessarily mutually exclusive and may overlap.

A source is considered to be credible when it is believable or when we regard the source as sincere and trustworthy. Credibility partly overlaps with achieved authority, however not necessarily with ascribed authority. People in high positions are not necessarily perceived to be credible sources of information.

Appeal may be based on physical presence, personality or an intriguing nature. Appeal helps to attract and captivate an audience and it influences our feelings of sympathy, not only towards the source itself but also towards the message.

A source never stands alone, the person or object is always entangled in a network of meaningful entities. These entities or signs, when carefully selected may strengthen the appeal, credibility and authority of the source.

Physical attributes, actions and presentation all add to source acceptance and approval. Perceived authority of the source is enhanced when objects are used which more or less directly point at the expertise of the source. Signs which surround the source or qualities that are inherent in the source may also however negatively influence source authority, credibility and appeal.
The same principles of authority, credibility and appeal apply to media. Media, especially mass media, are generally regarded as sources with high levels of authority, primarily ascribed authority, and credibility. Authority and credibility also vary according to the type of media. For example, daily newspapers and radio and television documentaries are more credible than comic books.6

4. Channel

In the context of this model the channel is viewed in technical, transportation terms as an avenue over which messages reach an audience. The power of the medium to attract an audience is a primary consideration in the choice of channel and therefore the communicator is chiefly interested in two questions: (1) What proportion of the population do different medium reach? (2) What kind of people are attracted to which media? Furthermore, selection of an appropriate channel is determined by which channel can deliver the message effectively to the receiver without spoilage. In this sense, the media should ideally function as passive conduits for the message. According to Hovland's analysis, attention is the factor that serves as the connecting rod between a medium and the intended audience.

Marshall McLuhan rejects this distinction between the medium and message as according to him "the medium is the message". It is not what is said that counts but rather medium through which it is said. "The medium becomes master over the content". McLuhan however overstates his case to gain recognition for the active role played by the media. A more reasonable interpretation of his assertion is that the media interact with messages to shape the experience of the audience. Essentially, signs will mean slightly different things, or convey different kinds of meaning depending on the medium through which they are channeled. This points to the importance of considering communication variables in relation to each other and in so doing highlights a fundamental limitation of this model, that is, it views each communication variable in isolation from the others. This can however be overcome through alternative interpretations of the constituent variables, for example, in this case considering channel issues in the message column

6 While comic books in Western countries have limited credibility, experiences with comic books in developing countries initially showed a different picture. Comic books were used as credible sources of information for neo-literate adults. Current research, however is beginning to show a decline in the perceived credibility of certain types of comic books. Comic books that use fantasy characters are not seen as credible while those reflect a more accurate picture of reality, through use of photographs and photo-realistic drawings are more effective.
or vice versa.

The strength of this communication/planning matrix lies in its flexibility. While it is based predominantly on the process school of communication and psychosocial theories of behaviour change its' flexibility allows for rearticulation of its' constituent variables. The appropriateness of this rearticulated model is demonstrated in the following chapters by its practical application to the development of a STD education media campaign in Hlabisa, a rural area in Northern KwaZulu Natal.
CHAPTER 3

The Hlabisa Sexually Transmitted Disease Control Project

Background
The Hlabisa Health District of KwaZulu Natal is a newly formed amalgamation of the ex-KwaZulu and ex-Natal Provincial Administration (NPA) districts. It has a well staffed district hospital, 8 village clinics and 22 mobile clinic points. The population served is about 200 000 and is largely black African; most of the district is traditional and rural but a sizeable township exists and many people live in shacks on sugar farms and timber plantations. The male population in particular is very mobile, migrating to work.

In 1992 HIV prevalence in Hlabisa was 4.2%, in 1993 it was 7.9% and in 1995 it had increased to 14%. HIV prevalence among adults diagnosed with tuberculosis (TB)\(^7\) in Hlabisa increased from 35% in 1993 to 58% in early 1995 (Wilkinson & Abdoel Karim, 1996). In addition there has been a threefold increase in the number of patients admitted with TB to Hlabisa hospital, and much of this is attributable to HIV.

While the prevalence of HIV in STD patients is not well documented in this area, an indication is given by figures from a small rural hospital neighbouring Hlabisa, where 20% of 77 consecutive patients tested in December 1993 were HIV positive.

STD patients attend three groups of practitioners in Hlabisa: public sector clinics, private sector general practitioners (GPs) and traditional healers. Public sector clinics treat a large number of patients and are well supplied with appropriate drugs. These clinics however are often very busy and understaffed. Private sector GPs also treat large numbers of patients, but often do not use the appropriate drugs. Few, if any, practitioners provide syndromic management in full, i.e. provision

\[^7\]The association between HIV and tuberculosis (TB) is well recognised.
and promotion of condoms, counseling and health education, and voluntary contact treatment, in addition to the standardised syndromic drug therapy. Large numbers of traditional healers operate throughout the district and patients consult these healers prior to bio-medical health services.

The district health system is at present not well coordinated. In particular, the public and private sectors have little interaction and despite the recent political and policy changes the two public services are not well coordinated. This fragmentation of services is illustrated by the different approaches to STD care, and even the different drugs used to treat STDs.

The Hlabisa Health District is the site for extensive STD/HIV research. Community-based studies to determine the prevalence and the incidence rates of several STDs are underway as are studies relating to STD health seeking-behaviour. An integrated, community based STD prevention and treatment programme is currently being developed to control the spread of STDs and significantly decrease the incidence of HIV infection. The programme focuses on four particular strategies:

1. Improvement of the management of STDs at public sector clinics by emphasising syndromic management and improving the training and motivation of clinic staff.

2. Improvement of the quality of care in the private sector by developing an understanding of the constraints to effective STD management and by developing strategies to overcome them.

3. The development and testing of a novel syndromic treatment packet for use by GP's and public sector clinics; each packet will contain drugs appropriate to the syndrome being managed, condoms, voluntary contact tracing card, and simple health education messages.

4. The development of a STD education media campaign to increase community awareness of STDs and to increase symptom recognition and early, appropriate treatment seeking behaviour for STDs.
The effectiveness of this programme is dependent on a multifaceted approach - each intervention is reliant on the other for its success. In order for the other interventions to be maximally successful the level of awareness of STDs as an important health issue needs to be heightened in the community through the use of media campaigns. In addition, people who contract STDs need to be encouraged to attend for appropriate treatment as soon as possible after the onset of symptoms. By the same token, media messages need to be comprehensively integrated with the infrastructure changes required for the achievement of goals. Given the media focus of this thesis, further discussion about the Hlabisa programme will be limited to the media development as the other components, while crucial, fall outside of the scope of this paper.

The Development of the Hlabisa Media Campaign:

Research and Methodology
The effectiveness of an intervention has been shown to be determined by the quality of the planning (Green and Lewis, 1986). The development of the Hlabisa campaign was guided, at each stage, by the Communication/Planning matrix which was interpreted where possible in terms of semiotic communication theory. Semiotic theory was primarily utilised to frame the development of questions in each cell of the planning matrix so that greater emphasis was placed on cultural, socio-economic and communication contexts.

Formative research, framed by the matrix questions, was conducted in order to determine behavioural determinants, such as attitudes and beliefs as well as socio-cultural factors, associated with STDs and myths and discourses surrounding STDs. Information generated during this phase of the project was then analysed in terms of the matrix to plan the development of media materials. The matrix was also used as a basis for pretesting the media materials.

Formative Research
A workshop was held with fieldworkers who had been working in Hlabisa for a number of months on the broader Hlabisa study. The aim of the workshop was to: identify the primary target audience, to gather preliminary information on the target audience and their use of media and to formulate a discussion guide for focus groups which were to be held with the target audience.
The primary target audience selected included all those between the age of 16 and 25 years living in the Hlabisa area. The secondary target population included all those between the age of 25 and 35 years living in the Hlabisa area.  

The discussion with fieldworkers also provided valuable information about the target audiences use of media. According to the fieldworkers, the majority of people living in Hlabisa own a radio and listen to Radio Zulu. Magazines and newspapers were also widely read. At this point of the project media producers were selected and brought on board. A radio script writing team, Vuleka Radio and a print media company, Artworks were appointed. Both of these organisations have extensive experience in developing educational media campaigns in a variety of different languages. The appointment of a Zulu scriptwriter was an essential factor. For the campaign to be effective it needed to be developed in Zulu as too much nuance is lost in the translation.

Two research initiatives, based on the planning matrix, formed the basis of the media development. The first which was conducted at the Durban City Council STD clinic examined, among other things, clinic attenders' understanding of STDs. The Durban City Council STD clinic, is attended by patients from throughout KwaZulu Natal. As a result, the study, which was conducted prior to the initiation of this project provided valuable in-depth information on the attitudes and beliefs about STD prevalent in KwaZulu Natal and other factors.

The second research initiative involved workshops with both men and women between the ages of 16 and 25 years, living in the Hlabisa area. The aim of the workshops was to determine the primary target audience's knowledge about and attitudes towards STDs and to assess whether these attitudes and beliefs were the same as in other parts of KwaZulu Natal. The workshops were also aimed at identifying language and terminology used by the target audience in reference to STDs and to determine their current media use patterns, including use of specific media vehicles and attention to various types of media content.

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8 Preliminary data collected in Hlabisa in February 1996 showed that > 50% of STD patients were between the age of 15 and 24 years.
Study One: Attitudes and beliefs about STDs among STD clinic attenders at a Durban City Council STD clinic.

The study was conducted in the Durban City Council STD clinic which attends to the majority of STD patients in the region. Data was collected using qualitative research methods in the form of focus groups. Interviews and group discussions were initially conducted with the staff working in the clinic. The purpose of this was: to draw the staff into the project at the outset, obtain information that would assist in the development of focus group discussion guides for the remaining groups consisting of patients and elicit their assistance in setting up and organising the remaining groups. Staff generally reacted very positively to the study and they also contributed by raising questions which where possible were incorporated into the study.

From data obtained from discussions with staff it became apparent that they had a good understanding of how patients perceived STDs and the difficulties patients experienced in trying to put their suggested prevention strategies into practice. This is illustrated further on in the paper by means of comparison of staff and patients perceptions. In addition, information gathered from the staff in some instances enhanced understanding of patients views. A pilot study consisting of two focus groups, one with male and one with female patients was then conducted in order to determine the acceptability and effectiveness of the discussion guide and to identify gaps and priority areas that needed further exploration. It was noted during this phase that questions about the relationship between STDs and AIDS made a number of patients uncomfortable given the fact that they were STD infected. As a result these questions were moved to the end of the discussion guide in order to reduce their effect on the group rapport.

Seven focus group discussions, three male and four female groups, were then conducted with clinic attenders. Participants consent was obtained before the discussions commenced and they were reassured of the confidentiality and anonymity of their responses. Participants were required to complete a short questionnaire after the discussion in order to obtain the following demographic data: age, sex, marital status, level of education and employment status. Although it was intended that groups be stratified according to age and previous clinic attendance this proved to be extremely difficult to implement. The main reasons for this being the fact that given the high level of activity in the clinic waiting room patients could only be screened after they had
entered the room set aside for the group discussions. This resulted in the selection of participants before they could be screened according to age and previous clinic attendance. In addition, the staff who assisted in the selection process often chose participants from patients who were waiting for test results as this reduced interference in their work with other patients. During the course of the discussions it became apparent that many ostensibly first time clinic attenders had in fact attended the clinic previously, although this was contrary to their responses in the questionnaire completed by them. This could have been due to the stigma attached to STDs and their reluctance to acknowledge having previously attended the clinic. Despite the difficulties encountered it was possible to divide the groups into predominantly older or younger participants. It was also to some extent possible to differentiate between older and younger participants from the responses given in the group discussions.

Interviews were conducted in the participants home language and given the sensitive nature of the topic, moderators/interviewers of the discussions were of the same race, language and gender as the participants. Although an interview schedule was used as a guide for conducting the groups facilitators had the freedom to improvise where necessary. Feedback discussions with interviewers were conducted immediately after each group to discuss problems, findings and emerging issues. This enabled the researcher to clarify issues that were still unclear with the remaining groups. This often occurred with Zulu cultural concepts, for example in regard to the use of traditional medicines, which while clear to the moderators, given their cultural commonality with participants, remained unclear to the researcher. While moderators were able to elaborate on these concepts and provide explanations the researcher felt that it was also important to explore these concepts further from the participants perspective.

Discussions were tape recorded and later transcribed and translated. In some cases however it was impossible to block out outside noises making it difficult to transcribe certain of the tapes. In addition, a lot of nuance was lost in the translation from Zulu to English. This was offset to some extent by leaving the Zulu words or terms in the transcripts next to the English translations. During analysis a number of Zulu linguists were consulted on both the meaning and nuance of these terms in order to obtain some form of uniformity. This however was not always successful, for example the researcher was not able to obtain consensus on the meaning of the term "Ukhubjwa" used by participants in reference to STDs. This together with the fact that there are
few written references made it extremely difficult to expand on some of the concepts raised in
the course of the study.

Information about sexually transmitted diseases was provided to all participants at the end of the
discussions and misconceptions were corrected and queries answered. The majority of questions
that were raised by participants focused on the facts about AIDS. This shows that there is still
uncertainty and confusion regarding the basic facts about AIDS, such as transmission.

Forty eight participants, 27 female and 21 male participants (including those in the pilot study)
participated in the study. The average age of the female participants was 25 years with the oldest
female participant being 41 years and the youngest 16 years old. The average age of the male
participants was 27 years with the oldest male participant being 51 years and the youngest 20
years old. Of the female participants only 1 was married and only 4 were employed. In
comparison, 7 of the male participants were married and 11 were employed. The average level
of education for males and females was Std.8 and Std.7 respectively.

Terms Used to Describe STDs
The most common term used to describe STDs was "Ukubhajwa" (trapped). Other, less common
words used included "Ukuqhumu" (bursting), "Iqhhumile" (blasted), and "Ukusha" (burned).
Generally however "Ukubhajwa" was the most familiar term. This name had different
implications for men and women. The majority of female participants acknowledged that they
acquired their STD through sexual intercourse, and considered themselves as being "trapped" by
the disease.

"there is nothing you can do once you have this problem. You can't move. You have to
pay all your attention to it, you can't even continue sleeping with your partner"

For a number of male participants however the term "Ukubhajwa" (trapped) was synonymous
with an infection caused by bewitchment, usually by ones' sexual rivals. Zulu cultural customs
reserve the right for a husband to use medicines to harm his wife's lover who after having
intercourse with her develops a condition referred to in Ngubane (1977) as "Iqondo".

some men bewitch their partners to prevent them from sleeping with anyone else. They
do this without the females knowledge. After another man has slept with that female he
finds himself with an STD.
Another form of bewitchment which was believed to cause STDs was described by a male participant as follows,

*you can be bewitched, for example, while walking on a path you might walk over muti that was put there for you by your rival and then you get infected.*

This form of bewitchment is referred to as "umeqo".

Zulu beliefs include the notion that human being when in motion absorb certain elements from their immediate surroundings. This creates opportunities for sorcery whereby a sorcerer is able to deliberately place harmful substances in places where they will harm particular people. This is said to be the most common sorcery technique used mainly because it is the easiest. "Whatever is discarded from the system through the use of certain types of medicines is deposited at a particular point where a person is likely to pass by. If that person is not sufficiently immunized or strengthened he may fall sick" (Ngubane, 1977). According to Ngubane (1977), in many instances men have the right to use techniques of sorcery while women are not expected to use such methods. This view was supported by a participant in one of the male groups when he claimed that,

*most females...don’t use the medicines <mentioned above>, it is very rare.*

The use of laxatives and "Imbiza" for cleaning out one’s system, as well as the use of solutions such as Alum and Dettol for douching were also thought to cause/induce STDs. According to participants, this could occur in two ways. The first, was through the direct use of tablets or mixtures.

*I felt that I should clean myself and I brought a mixture from the market. I used it for enema and as a tonic. The following day I became infected (male participant).*

The second was from sleeping with a partner who was using or had recently used one of the above preparations.

*Take for instance laxatives, if your female sexual partner has taken these tablets you might find yourself developing STDs (male participant).*

According to one female participant males may be using this "belief" as a way of avoiding confrontation with partners by "shifting the blame to the tablets". Tablets and mixtures were also described as being used to avoid STDs however these methods protected only the person using...
for instance when your partner sleeps with a women who uses 'Izigezo', that women would not be infected but your partner would carry the infection to you if you are using nothing (female participant).

The rationale for this form of transmission lies in the fact that if your sexual partner is in the process of cleaning out his or her system and has sexual intercourse before the process is complete then the dirt would be passed on to the other partner. All participants agreed unequivocally that it was necessary to "wait at least three to four days to make sure there was no traces of tablets in the bloodstream" before engaging in sexual intercourse to ensure that infection did not occur. There was a close association between dirt and STDs which in turn were related to issues concerning cleanliness and pollution.

STDs are caused by dirtiness. Some males do not wash after sleeping with other women and they carry the dirt to you and it will cause an infection (female participant).

In the Zulu culture 'pollution' is considered to be a 'mystical force' more often associated with women as it is closely related to female reproductive functions and birth. For example, a menstruating women is considered to be polluted which may harm her male partners virility if she has sexual intercourse with him. This may explain the belief among some men that women are responsible for the spread of STDs. It seems likely that the belief that STDs result from the female use of contraceptives is closely associated with this.

*If a women has used <contraceptives> for a long time, for example three to four years that created some problems in the women then if a man sleeps with that women he will get an STD*

Another male participant claimed that,

*he would be "very happy if these tablets <contraceptives> were properly checked because most of the time their partner get infection by using them*

A male participant claimed that he did not like sleeping with women who have excessive natural lubrication which he believed to be caused by the use of contraceptive tablets. Women are aware of their male partners preference for "tight" sex and as a result they use a number of methods to try and achieve this, some of which are believed to produce infection.

*sometimes females use things to make themselves good, when they are with their*
boyfriend. Such things are snuff, Alum and Piong Tong.

Some other girls use newspapers...they tear a small piece and rub it like a cotton wool swab..dampen it in water and put it into the vagina...this newspaper will be kept in the vagina and removed at bed time before she sleeps with her partner..this can cause infection.

This finding corresponds with that of a study examining the use and physical effects of intravaginal substances in Zairian women. (Brown, Brown & Ayowa, 1993) The study showed that Kananga men and women prefer that the vagina be "tight" or "dry" during intercourse. Consequently, Kananga women sometimes insert substances into the vagina that will produce the desired sensation. While the main aim of these practices among Kananga men and women was to heighten sexual pleasure, participants in this study also used these substances to prevent male partners from finding out that they have other partners:

They also use ice cubes, especially if she has been sleeping with another man and hoping to sleep with another one...ice cubes do not cause infection.

As there are very few published studies investigating the use of intravaginal substances it was necessary to obtain further elaboration of participants responses by discussions on this issue with a number of Zulu women, including the female moderator and other colleagues. From these discussions it would appear that the use by women of intravaginal substances was encouraged by the fact that males often warn their partners that they could tell when having sexual intercourse if she has been unfaithful. "Wetness" and subsequent lack of "tightness" were perceived as being a sign of infidelity. According to the female moderator, men expected their female partners to be "dry" before and at the start of intercourse as they believe that they should be the ones to "seduce" or "arouse" their partner. If the woman was already aroused before penetration she was considered to be unfaithful, the rationale being that she could only have been aroused by another man. Furthermore, if penetration was easy it was seen as a sign of promiscuity as it implied that the women had slept with many partners. Tightness is associated with newness and therefore innocence. As a result many women use mixtures that are believed to remove any natural lubrication and cause the vagina to contract:

the snuff tightens the vagina. If you have been sleeping with someone else you can use snuff so that your straight <steady> partner doesn't feel the difference.
According to Parker (1992) sexual behaviour norms are often moulded by contradictory, cultural discourses. The very classification of certain practices as acceptable or admissible and others as prohibited or forbidden however, simultaneously opens up the possibility of some form of transgression in which the values and regulations that "structure conduct" can be called into question, undercut or even overturned. Thus while culturally it is unacceptable for women to have more than one partner they do not necessarily conform with these cultural rules but instead resist these norms and use methods to hide the fact that they are doing so.

Some use perfume roll on...they do this to make themselves good, as if they behave themselves.

Recognition of Symptoms and Action Taken

While the majority of participants realised that they were ill when they started experiencing physical symptoms, some were not aware that they were suffering from a STD.

I noticed this two weeks after I had seen my female partner. I first noticed it at work when I found that I had small cuts. I first thought that it's friction caused by vaginal hair...These cuts became painful. When I looked at myself I noticed small sores....these became worse. I went to a private doctor who injected me. So Tuesday, Wednesday and Friday I was using doctors treatment. I never knew about this place <the STD clinic>. A friend I am staying with told me. I didn't even know this problem until he explained to me and directed me to this clinic.

While the example given above was expressed by a male participant this scenario was more predominant among female participants. This is illustrated by a female participant, who on experiencing a STD for the first time informed her sister of her physical symptoms as she was unable to give a name to her condition and therefore was not aware of what action to take in order to deal with the problem.

I told my sister that I have a problem...that when I urinate, urine burns me, after that it becomes very itchy and I felt like scratching with toilet paper. After scratching I then realised there is some blood...I think from scratching. After a few days, thick dirty mucus came out of my vagina. It had some blood. After some time, some pus like substance started coming out of my vagina...I then told my sister <again> who then advised me to come here.
Other participants who failed to recognise their symptoms as being a STD, responded according to what they thought their symptoms to be.

*I first thought I had inyongo*<sup>9</sup> *and I took the tablets called Supertabs <laxatives>. There was no change, instead it became worse.*

From participants responses, when describing symptoms, it was clear that they continued to have sexual intercourse with partners even after detection of symptoms. For example, a male participant claimed that when he experienced STD symptoms his

*penis becomes easily tired and doesn’t want to be erect for a long time. I then find it hard having sex with my partner with a tired penis.*

According to a female participant,

*I had pains both in the abdomen and in the vagina when passing urine. I also had these pains when making love. I told my partner first. I thought he knew about this problem, maybe he was just afraid to approach me.*

This behaviour has serious implications for both the spread of STDs as well as increased risk for HIV transmission.

While some participants, who recognised their symptoms as being indicative of a STD claimed that they sought help as soon as they started experiencing symptoms the majority delayed seeking immediate treatment. This was mainly due to the fact that patients waited to see if the symptoms would clear up on their own accord or used their own remedies in an attempt to treat the problem. A number of female participants reported having used disinfectants in an attempt to relieve symptoms, however some women did not distinguish between medicinal and potentially harmful household disinfectants.

*My whole body was always tired. I then had a itching discharge. I first used Dettol <medicinal> and Jayes Fluid <household> to wash for a week. When I saw that there was no improvement I came straight here <to the clinic>.*

Only when the symptoms worsened, did they seek help. For the majority of participants this involved discussion of the problem with a friend, relative or partner. It appears that for many of

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<sup>9</sup> Excess bile caused by overindulgence particularly of alcohol, sugar or salt.

Elaine Epstein
the participants, particularly male participants, discussing STDs with friends was easier than discussing it with partners.

*when we are together as friends you find that quite a lot have had this problem. It then becomes easy to talk with them.*

According to a male participant, STDs are associated by some members of the community with AIDS and as a result "it is not easy to tell just everyone because once you have such a problem people tend to shun you. They also tell others that you have AIDS." Nevertheless, discussions with friends were helpful in that they could often can advise on necessary action to take to deal with the problem, despite the fact that this advise was not always the most appropriate.

*When one becomes infected, one does not go quickly to doctors, instead one informs one's friends first. Friends will then advise him to go to certain 'inyangas' first who are said to have helped others (male participant).*

While a number of women lacked the confidence to approach their male partners because they feared their responses, generally women were more likely than men discuss their STDs with their partners before attending the clinic. This conforms with cultural norms as culturally women are not the decision makers and therefore rarely make decisions on their own. They would rather consult their male partners for advice and guidance before reaching a decision. Moreover, it appears that while male partners are often aware of their STDs they do not inform their female partners until she broached the subject and only then might they admit to experiencing symptoms or inform their partner to attend the clinic. The following responses from female participants illustrates this point.

*I told my boyfriend that when I urinate the urine burns me and my private parts become itchy. I asked him whether he has any problem or not and he then said he has small boils on his private parts. We then both came here <to the clinic>.*

*I developed wounds inside my vagina. I told my boyfriend and he told me he also has small wounds on his penis. He came here <to the clinic> and was helped. I then had a discharge and I have now decided to come here to get some help.*

The ease of interaction/exchange with male partners which emerges from the above responses
is not the norm and often admission to partners about the problem experienced was met with
denial and blame.

_the thing is that a male a partner cannot tell you he has a problem. ...when you tell him
that you have a problem he will stand there and deny that he has a problem too and start
blaming you._

This view was supported by a male participant when he claimed that

_They ask us where we got this infection and we tend to accuse them even when we know
very well that they are not responsible. Then quarrels start._

Another difficulty expressed by female participants in informing their partners about their STD
or symptoms was that on doing so their partners either told them to ignore the problem or tried
to persuade them not to attend the clinic.

_It started last year when I was involved with a taxi driver. I had a problem when I had sex
with him. A lot of water would come out of my vagina. I told him and he said that I
should not worry, it would stop._

This could be due to the fact that males, in acknowledging their partners STDs tacitly
acknowledge that they may be responsible. The suggestion that their partners ignore their
symptoms may in fact be a projection of their own denial of responsibility. Moreover, if the
female partner attends the clinic she may be made aware of his possible responsibility. This
assumption is supported by the fact that those participants, both female and male, who claimed
to have more than one partner were afraid to discuss STDs with their partners as it might expose
their own unfaithfulness. Furthermore, discussion of STDs with sexual partners could be
perceived by these partners as being accusatory.

_females feel we are accusing them when we talk to them about this problem._

Overall, the main problem faced by both male and female participants when disclosing their STD
to their partners was that this frequently led to accusations of blame often resulting in disputes
and possibly even the end of the relationship.

Actual treatment seeking behaviour also depended to a large extent on belief of disease
causation. For example, according to a male participant

_Elaine Epstein_
we normally tell ourselves that STDs are caused by witchcraft...that is why we start with herbalists <traditional healers> first because they are the ones responsible for traditional Zulu ailments, not doctors. When the herbalists fail we then go to doctors.

Perceptions of the type of STD also influenced decisions about where to seek treatment. Some participants viewed the clinic as appropriate for the treatment of some symptoms of STDs, "clinics are specialists when it comes to drop" but not others,

I have a problem with the clinic because they don't know how to treat pig lice..but Inyangas are able to treat them.

This also appears to be related to perceptions of disease causation as "pig lice" was considered to be transmitted by both sexual contact as well as by means of bewitchment.

a problem with pig lice is that you can't be infected by a women only. One can also be bewitched and get them from walking along paths.

It is significant to note that none of the female participants reported consulting a traditional healer before attending the clinic. Women however appear to adhere more to the "dirt" theory of STD transmission than bewitchment and as a result often resorted to the use of disinfectants before visiting the clinic which they obtained from pharmacies. When they used "solutions" from traditional healers, these were obtained for them by their male partners.

Partner Notification

According to one of the nurses education around partner notification is more effective with female clinic attenders and more women than men notify their partners to attend the clinic. Her reasoning for this was that females blame their partners for their STD and this makes it easier for them to approach their partners. The main difficulty however is that male partners refuse to attend the clinic and deny having a problem. This is aggravated by the unequal role of genders in sexual relationships which makes it difficult for women to insist that their partners attend the clinic.

Some of the clinic staff felt that it was easier for males to notify their partners given the gender inequality of the relationship as they could "act like the boss" and simply demand that their partners attend the clinic. Despite this however it was generally agreed that it is also difficult for males to inform their partners to attend the clinic as the stigma attached to females attending the clinic made it difficult for men to persuade their partners to attend the clinic.

they <female partners> don't want to listen and if you tell them to go to the clinic they
tell you straight that they will never go to the clinic because they don't want to disgrace themselves (male participant).

The main difficulty for both men and women in notifying their partners to attend the clinic was that it necessitated disclosure of their STD to their partners. Given that STDs are associated with promiscuity this was seen as synonymous with admitting to being unfaithful. According to a male participant, "you won't tell her that you are from the clinic if you know that she is not the one who infected you" as this often has serious implications for the relationship.

The relationship ends the moment we tell them

This is aggravated by the fact that partners may not necessarily be suffering from any physical symptoms and therefore do not perceive themselves as being at risk of having an STD. This is often used to implicate the symptomatic partner as being the unfaithful one and also indicates that there is a lack of knowledge about asymptomatic infection. As a result these partners see no need to attend the clinic and often simply refuse.

Other reasons mentioned by the clinic staff for the failure of patients to notify their partners included the casual nature of many relationships in which there was no exchange of even the most basic personal details between partners.

I have got a problem to tell my Roll-on because I do not know where she lives. I only slept with her once on the day we met.

This was further illustrated by a male participant who claimed that the relationships he had with his sexual partners were casual to the extent that he did not even know their names. He confessed to the fact that he referred to his partners by their actions or appearance.

if she is fat I call her 'scuella' but if she is slender I call her 'slender'.

From the data obtained from participants it would appear that casual relationships of this nature were more common among younger participants than their older counterparts.

It is very difficult for us students because we tend to sleep with females and never see them again. This makes it difficult to track them down in order to talk with them (male participant).

Other difficulties in notifying partners particular to this group included lack of sufficient money to pay for partners to attend the clinic and restrictions placed on partners by parents.
It is a problem because as pupils we use stolen time with our girlfriends. They have strict parents. I don’t think they will have time to come to the clinic (male participant).

Similar concerns were expressed by male participants with young girlfriends

As a person who sleeps with young girls, I find it hard to bring them here because they might be seen by their neighbours or relatives getting in here with me and their parents might be told by these people (male participant).

Partner notification may also be hampered by the fact that partners may not be living together, or in close proximity and may live a considerable distance away from each other only seeing each other on brief occasions.

I haven’t told anyone because the person I should be telling is not here, she has gone <back> to Port Shepstone.

Despite the fact that a number of participants acknowledged the importance of notifying all their partners, their responses suggest that this rarely occurs in practice. Participants were more inclined to notify their "steady" partner if they did notify a partner at all, the reasoning being that it is easier to discuss these matters with a person who is close to you. This view was supported by one of the clinic staff when he explained that if patients do notify their partners to attend the clinic it will often be those they feel will be the most understanding. More often than not this is their "straight". In addition, patients were usually more concerned about their steady partners than any casual contacts.

For some patients, particularly female patients, it was easier to tell their casual partners because "at least he knows about my permanent partner. A permanent partner would ask a lot of questions" This also applied to "Sugar Daddies". Participants felt that it was particularly important to notify "Sugar Daddies".

Sugar Daddy has to be told too because we know very well that sugar daddies have lots of girlfriends including the wife and he sleeps with all these people.

It is evident from the responses of some participants that they do not understand the need to notify all their partners.

I only tell the one who is special to me, the other one who is a roll-on, I do not bother to tell because I do not sleep with her as often (male participant).
I would tell only my straight so that we both get help and then avoid any sexual involvement with my roll-on.

It was clear that some participants had no intention of informing their partners about their STD and thus had no intention of referring them to the clinic. A number of participants, both male and female claimed that they were only concerned with getting treatment for themselves.

*my case is different because I have more than one partner...I will just concentrate on getting treatment for myself.*

**Perceptions of AIDS**

It is significant to note that not one participant raised AIDS as a health problem at the beginning of the discussions. Moreover, none of the participants spontaneously referred to the relationship between STDs and AIDS. As mentioned before it is likely that participants did not want to raise the issue of AIDS given the fact that they were STD infected. The fact that questions about AIDS elicited feelings of discomfort and fear among participants supports this assumption. While this was not patently evident from participants responses according to the moderators it distinctly showed in their expressions and tone of voice. This may also account for the fact that a number of participants in acknowledging risk to AIDS did not acknowledge their specific risk as a result of their STD but rather suggested that they were at no greater risk than people in general.

*STDs and AIDS cannot be associated. Anyone can get AIDS (male participant).*

The majority of participants were quite adamant that there was no relationship between AIDS and STDs. This distinction was made on the basis of STDs being curable while AIDS was not, the time it took for each to manifest itself, and the lack of visible symptoms during the HIV positive stage of AIDS.

A number of patients while acknowledging their risk to HIV did not want to find out whether or not they were HIV positive.

*If they take my blood and ask me to come back later for the results, I will never dare come back. I don't want to know that I have AIDS if I have it (female participant).*

This was mainly due to the stigma attached to AIDS and resultant alienation from community and friends and the fear of suffering from the disease.

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*Elaine Epstein*
Study Two: Attitudes and beliefs about STDs in Hlabisa, a rural area in Northern Casual Natal.

Workshops were conducted with men and women living in Hlabisa, between the ages of 16 and 25 years. The workshops were run over two days and were attended by the script writing team. This gave them the opportunity to gather information first hand and expose them to the language and terminology specific to Hlabisa that could be used in the campaign.

Approximately 10 women participated in the discussion on the first day and 10 men on the second day. The discussions were very animated and participants expressed their views openly and eagerly. Both discussions were conducted in Zulu by a trained focus group facilitator. A member of the scriptwriting team co-facilitated the discussions.

The discussions were opened with an explanation of the purpose of the discussion and introductions of all those participating. Thereafter participants were played a number of music soundtracks to assess what type of music they liked. They were also asked what music they felt would be suitable for use in STD information adverts.

After the discussions around the music selections, three women and three men were selected from the groups to participate in a more intimate in-depth discussion. These groups were conducted in English by myself and a member of the scriptwriting team.

The results of the workshops are presented in summary form as they do not vary significantly from the findings of the clinic study. New information generated by this study is presented more detail.

Thirty one participants, 16 female and 15 male participants participated in the second study. The average age of the female participants was 23 years and the average age of the male participants was 25 years. Of the female participants 72.7% reported having children. In comparison, 16.6% of the male participants reported having children. The average level of education for males and females was Std.8 and Std.9 respectively. All of the male participants and 82% of the female participants owned a radio.
Perception of Risk

Participants did not perceive themselves to be at risk of STDs but rather viewed STDs as only affecting "others". This became increasingly evident when participants were asked "What types of people get STDs?". Participants responses indicated further their perception that STDs only happen to others. "Others" in this instance included the wealthy described as "people who have cars", such as "policemen, Sugar Daddies and teachers". "Others" also included "those who do not care about their lives". For some male participants, "otherness" was perceived in terms of gender and as a result those identified as getting STDs were "girls who change partners".

Terms Used To Refer To STDs

Participants were asked to list the terms they were familiar with to describe or name STDs. The terminology used in Hlabisa to describe STDs and the meanings ascribed to these terms were the same as those used by attenders at the Durban City Council STD clinic. As found in the clinic study, the most common term used by both male and female participants to refer to STDs was "Ukubhajwa". This is significant in that it illustrates cultural consensus in STD terminology across various communities in Casual Natal. Other terms used by the women when discussing STDs with friends included: Ugcusula (Gonorhea); Cauliflower (often used to describe genital warts); Isifo Samadoda (a disease for men); Drop; and Ukucushwa (setting a trap). Other terms used by the men when discussing STDs with friends included: Ukuqhumu (burst); Ibhemile (slang in Zulu meaning something went wrong); Ilugwayi; and Ibhakabhaka.

Participants did not view all the terms they used to discuss STDs with friends as acceptable for use on the radio. While it was viewed acceptable to use slang with friends they preferred the more correct medical terms to be used on the radio. Terms viewed as being acceptable for use on the radio included: Sexually Transmitted Disease (STD), Ungcusula (Goonorhea) and Umashayabhuqe (a deadly disease).

What is a STD?

Participants exhibited a good knowledge of the symptoms of STDs however they had many misconceptions about STD causation and the consequences of STDs. None of the participants mentioned infertility as one of the adverse consequences of STDs and the effect STDs can have
on unborn children. According to one woman, STDs are only "dangerous if the child conceived is a male". Knowledge about the relationship between STDs and HIV was limited and none of the participants mentioned STDs as increasing the risk of contracting HIV. Women with STDs were blamed for causing the death of their partners.

Myths around STD causation were prevalent in this group and included explanatory beliefs about STDs arising from the use of tablets such as laxatives and use of intravaginal substances such as snuff and newspaper. Female participants also believed that STDs are caused by washing with Alum or Vicks after sexual intercourse. This group also stated that you could get a STD from sleeping with a partner who has slept with a women who is using intravaginal substances. Other causes of STDs mentioned by participants included bewitchment or Utkucupha (setting a trap), oral sex and sexual intercourse with animals. Despite all the myths and misconceptions, both men and women acknowledged that multiple partners and promiscuity also lead to STDs.

Self Treatment
Self treatment was reported to be used by both men and women. According to female participants self treatment occurs frequently and includes the use of the following: Nsukumbili and Msuzwasa (herbs from the Traditional healers), painkillers, Dettol and Savlon (medicinal disinfectants which are not harmful if used in diluted form however they are usually used undiluted) and Jeyes Fluid, a household disinfectant, used to clean the affected area and for enemas. Male participants also reported drinking Jeyes Fluid, in an attempt to treat STDS and also using the following substances: Imbiza (herbal solution for enema), Potassium Permanganate, Indian medicine and pain killers.

Discussion with Partners
Women were more likely than men to discuss STDs with their sexual partners. This conforms with cultural norms as culturally women rarely make decisions on their own. This is likely to be more evident in the rural areas where women have less exposure to information and are therefore more dependent on their male partners for advice and guidance. Often this approach for advice is met with denial or blame. According to female participants men will either change the subject, refuse to listen or do not believe what they are saying. Attempts to discuss STDs with male partners was often met with verbal and physical threats. A female participant’s claim that men
"threaten to take you home" if you mention STDs underscores women's dependence on their male partners.

Both men and women admitted that it was easier to discuss STDs with a friend or relative than discussing STDs with partners. Overall, the main problem faced by both male and female participants when discussing STDs with partners was that this immediately implied that the initiator of the discussion was suffering from a STD. According to a male participant in this group, if a female partner raises the issue of STDs it immediately implies that she has got one. These findings are comparable with the findings from the clinic group which also indicates that discussion about STDs with partners is not the norm and rarely occurs.

The Traditional Healer Versus the Clinic

A number of participants had faith in the traditional healers ability to cure STDs and felt that the traditional healers treatment was more effective then the clinics treatment. This however was not the only reason why some participants maintained that they would choose to see a traditional healer rather than going to the clinic for treatment. Traditional healers were described as being more understanding and sympathetic then clinic staff and there was more privacy when seeing a traditional healer. According to traditional healers (Interview with traditional healers, STD Photo Novella, Balisa Educational Comics: Progress Report, 1995), people have more respect for the traditional healers because of the nature of the way the process works. a patient arrives and the healer uses her or his psychic powers to "read" what the clients problems are. The traditional healer then tells the client about her/his life and/or symptoms. In this way the confidence of the client secured. When patients go the clinics they expect the doctor to "know" what is wrong with them without performing invasive, clinical procedures (which traditional healers do not have to do). Lack of privacy and the judgmental attitudes of the clinic staff were also mentioned as being reasons why participants disliked going to the clinic.

According to one woman, she "believes in going to the clinic but older people at home believe in the traditional healer and they influence younger people to go there for treatment".
Prevention
Participants mentioned two strategies to reduce the risk of contracting STDs. These included having one faithful partner at a time and using condoms. Despite the inclusion of condom use, a number of participants claimed that they would not use condoms as they decrease pleasure and are difficult to use. A male participant in reference to condoms claimed that "It is not nice to eat a sweet in a paper".

Media
All of the music selections, tested with the participants, were based on traditional Zulu music as it was assumed that these would receive a positive response from a rural target audience. Music selections however were not liked by the participants and many felt that the selections were inappropriate for the nature of the advert. Traditional Zulu music is often played or sung at what they termed "cultural events" which included weddings, twenty first birthdays and other celebrations. This music was therefore not deemed suitable for use in an advert. Traditional Zulu music was also viewed as being more appropriate for and well liked by the older generation. Participants in the group showed a strong preference for more upbeat music produced both locally and abroad. A number of participants, both men and women stated that they enjoyed gospel music and they felt that this type of music should be used in the advert. It was noted that gospel music was not liked specifically for its religious messages but rather for the type of music that accompanied the lyrics.

A male participant confirmed this finding when he claimed that people do not necessarily listen to the lyrics of gospel but rather just enjoy the music. He added that youth often view the messages of gospel music in the context of preaching how to behave. A number of youth took exception to this aspect of gospel music. Therefore, while gospel was popular among many of the participants the team viewed its association with preaching as problematic for use in this campaign and counterproductive to achieving a non-didactic tone.

The research revealed that radio is the most popular medium, Radio Zulu the most popular station and drama and news programmes the most popular radio formats. The most popular
listening times are shown in the table below:

<table>
<thead>
<tr>
<th>LISTENING TIMES</th>
<th>NUMBER OF PARTICIPANTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MALE</td>
</tr>
<tr>
<td>05:00 - 0:600</td>
<td>2</td>
</tr>
<tr>
<td>06:00 - 08:30</td>
<td>4</td>
</tr>
<tr>
<td>08:30 - 12:00</td>
<td>0</td>
</tr>
<tr>
<td>12:00 - 14:00</td>
<td>1</td>
</tr>
<tr>
<td>14:00 - 16:00</td>
<td>4</td>
</tr>
<tr>
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<td>1</td>
</tr>
<tr>
<td>18:30 - 21:30</td>
<td>9</td>
</tr>
<tr>
<td>21:30 - 24:00</td>
<td>2</td>
</tr>
<tr>
<td>24:00 - 05:00</td>
<td>0</td>
</tr>
</tbody>
</table>

A range of other media were also mentioned and these included: television, magazines and newspapers. Participants indicated that information is highly valued in their community as those that are "in the know" are respected. As a result newspapers, news programmes on radio and television and magazines with news and information are popular. Participants claimed that they read magazines regularly, the most popular magazines being "Drum", "Pace" and "Bona". Their favourite type of articles include: Agony Aunt columns, "Sex and Your Life", in "Drum" magazine, star signs and stories and articles about famous people. Women mentioned that they consult magazines particularly for "life skills" information. Participants stated that they get their health information predominantly from the following sources: the mass media, magazines, from clinics in the area, community health workers and nurses, schools and pamphlets.

The information that was generated during this formative research phase was used to develop the media materials that formed the Hlabisa STD education mass media project. The development of these media materials is discussed in detail in the following chapter.
CHAPTER 4

The Development of the Hlabisa Media Campaign:

Messages and Media Materials
The Hlabisa STD education media campaign was developed by means of the semiotic application of the communication/planning matrix. Messages were based on the information generated in the formative phase of the project. In-depth information about the target group obtained during this phase of the project has been covered in detail in chapter three, however a summary of the pertinent issues and their implications for the development of a STD education media campaign are presented below.

Formative research revealed that STD patients are confronted with a multitude of competing and often more immediate life concerns than those relating to their illness. These concerns which include, widespread poverty, poor living conditions, and lack of resources play an integral role in the spread of STD and HIV infection. Those not STD infected did not consider themselves or their communities to be at risk of contracting a STD. They rather viewed STDs as something that only happens to others. STD media education programmes therefore need to increase awareness of STDs as a

| Reception                  | - low involvement with issue
|----------------------------| - distinct cultural beliefs
| Attention                  | - desire to be "in the know"
| Comprehension/Decoding     | - interest in information about sex and the body
|                            | - previous exposure to media
|                            | - lower end of socio-economic scale
|                            | - one radio per family
| Encoding                   | - low to moderate education
| Attitude                   | - low to moderate literacy rates
|                            | - socio-cultural influences
| Social Influence           | - existing myths and misconceptions
|                            | - oppositional cultural attitudes and beliefs
| Self-Efficacy              | - strong peer influence
|                            | - influence of parents and elders
|                            | - lack of knowledge and skills

Figure 6. Matrix Summary

Sex News: AIDS Education Media Development in South Africa
community problem and personalise the risk of infection. Media campaigns also need to heighten awareness of the consequences of untreated STDs, to give STDs greater import for those already infected, for example, the risk of contracting HIV and infertility.

For this information to be relevant to and accepted by the target audience it must take as its starting point the way people make sense of their world, that is - it must ultimately be based on the target audiences understanding of and beliefs about STDs. This is particularly significant in light of the fact that the formative research indicates that beliefs about STDs impact on a variety of factors related to STDs, including prevention, treatment and partner notification practices, which in turn impact on risk of infection. For example, culturally influenced ‘prevention practices’ such as the use of laxative tablets and disinfectants are in fact ineffectual in protecting patients from STD and HIV infection. Cultural beliefs also often lead to harmful treatment practices which not only delay effective treatment but also extend the time period over which spread of the disease can occur. This is particularly significant because the data obtained indicates that patients continue to be sexually active during this extended period. Cultural beliefs and norms dictate that patients seek alternative treatment options to those offered by the clinic. This includes seeking treatment from traditional healers and the use of supposed alternative treatment remedies such as disinfectants and laxatives. Both of these delay effective treatment.

While participants in Hlabisa were well conversant with STD symptoms, a number of participants, particularly women in the clinic study, were unaware that the symptoms they were experiencing were STD symptoms. Only after they had consulted a friend, relative or partner did they seek treatment and this was often inappropriate treatment. This indicates the need for community education programmes that result in early recognition of symptoms and appropriate treatment seeking behaviour. The fact that treatment seeking behaviour may be facilitated or inhibited by advice obtained from peers, relatives and partners makes it imperative that the entire community is targeted.

Gender inequalities impact both on risk of STDs and treatment seeking behaviour. Women face a series of obstacles in attempting to protect themselves from STDs and hence HIV. Women’s social, economic and cultural dependency on men makes it difficult for them to persuade their male partners to adopt practices that will reduce both partners risk of infection. The stigma
attached to having an STD, particularly for women, also influences prevention and treatment seeking behaviour. Media messages therefore need to encourage open discussion about STDs in the community while at the same time providing information about STD symptoms, the risks of leaving STDs untreated and the risks of repeated STD infections. An attempt should also be made to reinforce positive group norms with respect to STD prevention and treatment seeking behaviour, particularly among women.

Provision of information is however insufficient as culturally determined attitudes and behaviour patterns which increase the risk of STD and HIV infection also need to change as do the myths supporting these attitudes and behaviours. While this is a formidable task it is not beyond the realm of possibility as myths are dynamic, they change and can change rapidly in order to meet the changing needs and values of the culture of which they are part. Media messages therefore need to create or trigger new myths, particularly, gender myths, that take into account the required changes in behaviour to reduce risk of STD and HIV infection.

Partner Notification
At present there is no specific partner notification card and the patient's card is used to notify partners. The format of this card, requires the patient to explain to his/her partner the purpose of the card and what to do with it. Many patients find it difficult to initiate this discussion as partner notification necessitates disclosure of STDs which is in turn synonymous with admitting to being unfaithful. This system also encourages selective notification as patients with more than one partner must use the same card for each. This means retrieving the card from one partner to give to the next. This also has implications for delayed treatment seeking behaviour.

The implementation of a partner notification card is in itself insufficient to address these barriers however it can make an impact on partner notification practices. For example, if patients are given a number of cards they can more easily distribute these to their partners within a short period of time. Lack of information on the card is a missed opportunity for education, particularly around asymptomatic infection which leads many people to deny their risk of infection and the need to seek treatment. The card could also be used to facilitate discussion between partners by being self explanatory. Pilot intervention programmes including the development of an alternative partner notification card, improved education around partner notification and the
availability of alternative sites for treatment, such as family planning clinics and possibly traditional healers need to be implemented and evaluated. Furthermore, investigation should be given to the use of the card for educational purposes by including information about STDs on the card.

Condom Promotion

Condom promotion and distribution also needs to be given serious consideration. Although some argue that condoms conflict with African cultural values and practices condom use can be motivated in terms of both Western and traditional beliefs around STD causation. Moreover, where dry sex is preferred for reasons relating to increased pleasure, the promotion of un lubricated condoms as a means of achieving this desired sensation should be explored. Moreover, as long as people perceive condoms to be associated with promiscuity and lack of trust and love in a relationship they will not use condoms to any large extent. Common misconceptions about condoms also need to be addressed and condoms need to be popularised. Condom adverts of the past have only served to reinforce the public’s negative image of condoms by exploiting public fears of sexually transmitted diseases and of AIDS in particular. Those aspects of a condom that have been emphasized are those that suggest its performance as a protective device. By focusing on disease prevention and technical aspects of the products quality this advertising also inadvertently portrays the condom as a device to be tolerated. Promotion efforts need to suggest that condoms need not interfere with sexual pleasure and might even enhance it if approached in a sexually appealing way. Media messages therefore need to clear up common misconceptions and misinformation about condoms while at the same time reposition both condoms and the people that use them in the minds of the target audience. Media campaigns need to promote condoms as something that is used in the context of a caring, loving relationship. Condom users need to be seen as people who are sexy and popular and who at the same time are involved in caring, trusting, loving relationships.

Campaign Objectives

A number of the issues identified in the formative research cannot be addressed by media campaigns alone. As noted earlier, it is important that media messages be integrated into a broader intervention programme. Given the limitations of media education programmes, the following action was agreed upon by the project team. Objectives were prioritised and those that
were considered to be outside the scope of the project were dropped from the campaign. The remaining objectives were placed into one of two categories, namely major objectives and underlying objectives. A major objective was defined as a main message point and an underlying objective was defined as a theme which runs throughout the campaign or that supports a major objective.

The following objectives were identified as being the major objectives of the campaign:

To 'demystify' myths through explanation and provision of appropriate information on:

1. STD symptoms and the importance of early treatment of STDs at a clinic.
2. The importance of informing partners to go for treatment at a clinic.
3. The consequences of untreated STDs.
4. The relationship between STDs and HIV/AIDS.
5. The importance of practising abstinence or condom use until treatment of STDs is complete.
6. The promotion of condom use for the prevention of STDs.

The following objectives were identified as underlying objectives as they could either be linked to a major objective or be achieved through characterisation, the nature of the dialogue and the media format.

1. Increase awareness of STDs as a community problem.
2. Increase personal perception of risk
4. Present the advantages of prevention.
5. Enhance Self Efficacy Expectations:
Medium and Messages
At the outset of the project, mass media, such as radio and print, were earmarked as a potential means of reaching the target audience as they have the ability to reach both the women living in Hlabisa as well as their migrant worker partners who are often away from home. Mass media's ability in reaching a wide audience is also significant as the entire community needs to be exposed to STD information if it is to impact on STD treatment seeking behaviour. This is due to the fact that STD treatment seeking behaviour is influenced by advice from friends and family. Learning from mass media, however, requires familiarity with the formats and codes that characterise these media. Familiarity with mass media codes is dependent on prior or existing consumption of mass media. The widespread consumption of mass media by both men and women living in Hlabisa therefore strengthened the argument for the use of mass media in this campaign. Formative research revealed that radio is the most popular medium. Print media, such as newspapers and magazines were also found to be popular, with magazines being particularly popular among women.

It was decided, on the basis of this information, to place the emphasis on of the project on the development of a radio campaign and to back this up with a variety of print materials. The advantage of using a multi media strategy, i.e. radio, magazines and posters, is that each medium can be viewed as a language, a context and a set of uses which engages people in different ways to create meaning. Moreover, some materials can be designed to promote a simple message, while others can provide greater depth. Further advantages of using radio and print for the campaign are presented below.

Radio
Radio is often perceived as an authoritative source, and therefore is often effective in addressing attitudes and beliefs as people are more likely to believe what they hear on the radio. Radio provides opportunities to introduce positive role models and demonstrate constructive dialogues about STDs and safer sex. It also has the ability to stimulate the imagination which allows the individual to construct the scene around the messages. In this way the medium has an intimate relationship with each listener. The flexibility of radio is a major advantage in that it allows the listener to perform other activities while listening to programmes.

Elaine Epstein
Print
This group consists of a wide variety of media that includes, posters, newspapers, pamphlets, books, charts, comic books among others. The function and strengths of each of these mediums varies. Posters for example are explicitly aimed at attracting attention and by doing so either inform, seduce or intrigue people. They are useful for publicizing forthcoming events, for reinforcing messages that have been received through other media and for stimulating the process of reflection on a particular topic. Small booklets, leaflets or pamphlets, on the other hand, can be taken home, consulted and kept as constant reminders. They can convey more information than is possible on a poster and can include a number of detailed drawings or photographs. The advantages common to all print media can be summarised as follows:

*Printed media can combine words, pictures and diagrams to convey accurate and clear information. Their great advantage is that they can be looked at or read for as long as the viewer or reader wishes, and can be referred to time and time again. Printed materials are relatively cheap, simple and easy to produce.* (Boeren, 1994:154)

Capturing The Audience’s Attention
In the sea of available information, health information rarely stands out from the rest and is not necessarily information people actively seek out. Moreover, STDs are not a high priority with the target audience. To capture and hold the audience's attention it is therefore necessary to present the information in a way that is:

1. Popular with the target audience.
3. Not didactic.
4. Entertaining while at the same educative.
In order to meet the criteria listed above, the project team decided to appropriate popular radio and print genre's for STD education. It is not uncommon for media programmes and commercials to appropriate conventional media genres to reach their target audiences. This technique is particularly effective because it creates additional mechanism of identification. It enables the target audience to identify not only as an audience but also as consumers of popular culture. Furthermore, it allows the familiarity of the genre to ease the audience into the message. Due to the popularity of radio dramas it was decided to utilise a series of one minute, mini-dramatic, radio adverts to capture the audiences attention while at the same time conveying information about STDs. Music was another important factor in capturing attention and the original idea of using traditional Zulu music was abandoned in favour of more current, upbeat music. "Ding Dong", an extremely popular song with the target audience, recorded by Joe Nina, a young, well known, up and coming singer, was selected for the radio adverts.

Seven radio PSA (public service advert) scripts were developed on the basis of the information generated in the formative phase of the project. Each spot was constructed as a mini-episode in a series, however each spot was also meaningful independent of the series. The use of drama had a number of other advantages which these comments express:

*In no other medium *<than radio drama> *could we have as effectively portrayed people facing problems to those of the target group and then solving them successfully. By carefully structuring the script, one can reveal the complex psychological meanings of behaviour, indirectly address the very same anxieties many in the audience are experiencing and present acceptable ways to handle conflict, embarrassment, and stress - and one can do so in an entertaining way without moralising.*

(Solomon and Dejong, 1986)
Drama, unlike any other medium, have the potential of "draging" the audience into the story by means of the "true to life" character of the performance. It also has the ability to stimulate audiences to reflect on their own situation and to consider critically the core of the problem, including the cultural values, underlying their existing behaviour.
(Solomon and Dejong, 1986)

With respect to the print media, a magazine format was utilised rather then the traditional health education pamphlet or leaflet, which often are written in restricted codes, only intelligible to those in the medical profession. Sex News, an attractive, colourful, magazine incorporating STD education messages was developed by the Medical Research Council and Artworks. The use of text, in the form of a magazine, enabled the presentation of longer stories which allowed an in-depth treatment of complex issues. The magazine format also enabled a variety of communication styles and presentation to be used, a method commonly used to increase the target audiences attention span when they have limited interest in the topic under discussion.

Intertextuality, that is, the meanings generated by any one text are determined partly by the meanings of other texts to which it appears similar, is significant in the comprehension or decoding of messages. Magazines are often seen as a credible source with respect to how to become successful in society. Magazines however usually promote commodities as a means of achieving this success. Their target audiences' bodies and lives are constructed as a set of
problems for which there are commodities to provide solutions. Magazines present themselves as showing concern for the interests of its readers while constructing those interests as ones that can be met by appropriate commodities, itself included. Readers are led to construct its interests as theirs in much the same way. Sex News therefore appropriates this popular genre while at the same time subverting it by discouraging the use of these same commodities.

While the magazine is targeted at the more literate sector of the population it also has value for those who are less literate. This is achieved by presenting messages in the magazine in two ways. Important information is presented in short text bites that are either in large print, in bold and/or highlighted in colour. The reader does not therefore have to review the entire magazine to get the most important message points. It also enables the less literate reader to acquire the information without having to read large amounts of text. Pictures are included where possible to convey messages. The combination of pictures and texts has been found to succeed in attracting English second language readers and readers of low literacy.

Magazines also allow information to be presented in a number of ways, in a number of particular genres. This enabled different meanings of the same message to be emphasised in different places in the magazine. For example, while the information presented in the "Agony Aunt" column appears elsewhere in the magazine, its inclusion in this particular genre carries a particular connotation, namely that the issues expressed are experienced as problems by others in the community. The same information, presented in the article "Doctors Warn" carries the connotation of accuracy and seriousness as it is an experts opinion.

Constructing The Message
Through the explanation and provision of appropriate information, messages attempt to "demystify" myths that increase the risk of STD and/or HIV infection. In order to facilitate the acceptance of these new myths it was essential that media messages did not reject the old myths entirely, but rather dropped some concepts from their chains and added others. If media materials
are to be perceived as credible, they need to acknowledge the beliefs, values and experiences of the target audience. In both the radio and print campaigns, messages are personalised by basing the stories, articles and contextual situations on the target audiences actual experiences and problems with respect to STDs. Furthermore, prevailing myths associated with STDs were woven into the articles and stories so as to place the factual information in a meaningful and recognisable context. More importantly, these myths were actively engaged by means of acknowledging and exploring their complexities. In "Bongani's Story", for example, Bongani acknowledges cultural norms when he says, "In our tradition men do not usually discuss sex with their wives". This norm however is challenged in the story through Bongani's realisation that this norm is no longer appropriate in current times. The challenge is presented in a nonprescriptive way - rather than someone outside prescribing the correct behaviour, the challenge emanates from a member of the cultural group. This is important in light of the fact that impositions from above can provoke resistance that is counter productive to the goals of the campaign. While messages are constructed in such a way as to present both the short and long term personal advantages of the desired behaviours (e.g. early appropriate treatment seeking) and the personal disadvantages of risk behaviours (e.g. multiple partners), short term advantages and disadvantages are emphasised because they are more salient (McGuire, 1985).

Campaign messages were structured in such a way as to provide a number of behavioural solutions thereby enabling the reader to select the most appropriate solution to their own lifestyle. In Sex News, for example, the article, "When To Use A Condom: A Sex News Guide", discusses condom use within the context of a range of possible sexual relationships.

Campaign messages are also integrated into the broader Hlabisa project and other ongoing
projects by advertising the services provided by these projects and reinforcing their messages. Sex News advertises the newly introduced availability of STD treatment and free condoms at all local clinics and the implementation of the new partner notification card.

**Source and Characters**
A main objective of the adverts was to facilitate target audience identification with characters portrayed in the adverts so as to enhance the salience of messages. The traditional expert to viewer method was downplayed in favour of other more innovative approaches. Through dramatic soap opera techniques used in the radio adverts, an attempt was made to create a strong identification between viewers and characters, who face similar problems to those faced by the viewers themselves. The use of a magazine format and dramatic radio adverts to convey STD information was an attempt to move away from the conventional health education concept of doctors being the only credible authority source. Rather, media materials made use of non-traditional experts, for example, Mildred, the Agony Aunt and modelled people like the target audience, i.e. the audience peer group, adopting the desired behaviour, in a way that the audience can identify with.

**Social Influence**
The campaign attempts to influence normative beliefs about the prevalence of STDs in the community, appropriate treatment seeking behaviour and condom use through the presentation of messages by peer "experts" (members of the peer group who have experienced an STD and who have managed it successfully by seeking out appropriate treatment and by using condoms to prevent further infections). In the radio campaign, for example, Dululu, based on her own experience, advises her friend Fikele to attend the clinic for treatment of her STD. Perceptions of peer norms has been shown to influence behaviour change.
Believing that significant referents see a particular behaviour as being important, impacts on individual behaviour. Positive social influence resulting in positive outcomes are also portrayed. In the radio campaign, for example, Dululu persuades her friend Fikele to go to the clinic for treatment of her STD. When she finally goes she is rewarded with effective treatment. On the other hand, negative social influence, for example advice from peers to self treat STDs resulted in negative consequences and negative reinforcement from close friends.

FIKILE: (SIGHS) Hey, things are bad, Dululu.

DULULU: Your STD still hasn't gone away? So you've run away to your uncle's place because you didn't want to hear what I was telling you about the clinic?

FIKILE: But people have told me that I can treat it myself.

DULULU: What? Treat it yourself? That could be dangerous!

FIKILE: I've tried sheep dip, Dettol, laxatives - you name it. There's nothing I didn't try, but (IDIOMATIC) everything failed.

DULULU: But you didn't try the easiest way - and the one that's most reliable. (PAUSE) Have you been to the clinic?

FIKILE: The clinic? No. I know you've always been telling me about the clinic, and I haven't heeded your advice.

DULULU: Look, I'm helping you, as a friend - from my own experience.

FIKILE: Your own experience?

DULULU: Yes. Sipho and I were in the same situation as you. He also was stubborn in the beginning and didn't want to go. But after he'd been to the clinic he regretted the time he had wasted. (PAUSE, MOVING OFF MIC) OK, my friend, I have spoken to you and now I'm going.

Radio Campaign: Script Two (English)

Self Efficacy

Self efficacy is addressed through the provision of information and role modelling of behaviours. Many people, for example, fail to attend the clinic for treatment of a STD due to the fact that they possess insufficient information to confidently make appropriate treatment seeking decisions. Others, however simply do not feel that they can successfully negotiate the clinic situation. Clinics are perceived as unfriendly, lacking privacy and clinic nurses are perceived as being punitive. Unfortunately in many clinics this is in fact the case. Given that some clinics are not
going to change dramatically in the short term, the project team decided to address this issue in
two ways. Firstly, negative perceptions of clinics are challenged and secondly, people's sense of
rights with respect to treatment are reinforced. This is illustrated in the following excerpt from the
radio campaign:

FIKILE: Hey, Sipho, why are you standing out the clinic? Why don't you go in? Have
you forgotten that we arranged to meet inside so we can get treated?

SIPHO: I'm still undecided. I don't want to be troubled by those scandalmongers
(SLANG) inside there. I've heard that there are people who have a big
mouth, that there's no privacy when you go to the clinic for STD treatment.

FIKILE: Don't worry - it's your right as a patient to be treated at the clinic, and to be
welcomed there without feeling embarrassed.

SIPHO: By the way, how did it go with you, since you came from there? How did
those scandalmongers respond?

FIKILE: I found that we are not the only ones who are suffering from STD. There are
lots of others. Those who are coming for their final treatment couldn't stop
talking about how quickly they got better.

Radio Campaign: Script Four (English)

Comprehension
In order to limit 'misinterpretation' of campaign materials, messages were developed using
expressions that are commonly accented in the target audience. This was achieved by using
conversational language, replete with idiomatic expressions and culturally based proverbs to
convey information and sensitive issues.

Illustrations and photographs were used to further aid comprehension of important message
points. Photographs are excellent for portraying situations and objects in detail and for showing
constructions and internal structures of bodies and machines. In one single visual impression they
can clarify things that cannot be explained easily in words. While the style of the photographs,
close ups of worst case scenario STDs immediately connotes something to be feared and
avoided, we did not want their inclusion to raise people's anxiety about STDs. The preferred
reading of the photographs were simply showing examples of different STDs and their symptoms
thereby enabling STD symptom recognition. These potentially 'fear' arousing photographs were

Elaine Epstein
therefore balanced with constructive suggestions for purposeful action in order to reduce stress. People are more likely to deny the validity of a message, dismiss its applicability to themselves, or adopt a fatalistic attitude if they are not presented with concrete steps they can take on their own behalf (Mewborn & Rogers, 1979). The photographs are therefore headed by a caption which explains that they portray STDs which are at an advanced stage because they were not treated immediately. Each photograph is also accompanied by an explanatory paragraph which describes the nature of the STD and its symptoms while also providing positive action one can take to get them treated. Barthes (1964) terms this use of words with visual images, anchorage. Visual images, he argues, are polysemous, "they imply a floating chain of signifieds, the reader able to choose some and ignore others'. "Words help `fix' the floating chain of signifieds in such a way as to counter the terror of uncertain signs." (Fiske, 1990) The paragraphs forms another anchorage function in that they explain the photograph and in so doing helps us to locate it accurately within our experience of the world, thereby anchoring its meaning¹⁰ (Barthes, 1964).

Pretesting
To reduce the amount of aberrant decoding informal pretesting was conducted at various stages during the production process. This enabled the early identification of problem areas. Initially, an informal pretesting was conducted on a draft of copy of Sex News. The copy was produced to resemble as closely as possible the intended final version of the publication. The copy was printed in colour and bound together in a magazine format. Two indepth discussions were conducted with female participants. The first participant was a single, 19 year old, school student who had a 3 year old child. The second participant was a 22 year old school student.

Sex News: Pretest Results
After reading the magazine, participants claimed that there was nothing in the magazine that they particularly disliked or found offensive. They both viewed the magazine as "talking about things that really happen". They also claimed that they would feel comfortable taking the magazine home to read. The name of the magazine, Sex News, was well liked by both participants.

¹⁰ Barthes terms this function of anchorage, denotation. (Barthes, 1964)
According to the first participant, "the name captures your attention because it is about sex". The second participant added that, it "is the right name as many young people are sexually active and they will want to see what is inside the magazine". Both participants objected to the "Adults only" sign. The first participant felt that because of this "warning sign" distributors or sellers may not want to give the magazine to younger people. The second participant objected to the sign because she felt that it would deter younger people from reading the magazine as even though "younger people are also sexually active and they will think that the magazine is not for them". She added that, because of the sign, younger people will feel uncomfortable reading the magazine and will have to do so clandestinely. 

The first participant thought the picture on the front cover was inappropriate as it "does not talk about sex and therefore does not reflect the name of the magazine". Both participants claimed that the picture is not believable as it is culturally inaccurate and does not reflect reality. It is not the norm that a man will bring his wife tea in bed, particularly if he has a STD. According to one of the participants, males are, "difficult when they have a STD and they tend to blame the female partner. Males will fight you saying you brought the STD". Both participants liked the second picture. According to the first participant, the second picture captures your attention and makes you want to read that part of the story. The second participant claimed that the picture and the caption below, "Now that Bongani has been honest with his wife, it is easier for them to discuss sexual matters. And their sex life has improved" is believable.

The "Sex Quiz" created some confusion among the participants. The concepts and language used in some of the questions were not understood. For example, the first participant did not understand the concepts used in the true or false statement "Men can lose their virility if they have sex with a woman while she is menstruating". She did however feel that the statement
about the use of laxatives was important as myths about the causal relationship between laxatives and STDs is common. She claimed that she had heard from her peers (particularly male peers) that it is not safe to sleep with a person who has taken a laxative.

The first participant had not heard about the use of Jeyes Fluid or Dettol to treat for STDs and therefore the article on self treatment had little relevance to her. She vaguely recalled hearing about the use of Vicks and Snuff however she did not know exactly how or why they were used. The second participant had heard about the use of Detol and Snuff from her male peers. According to her these male peers claimed that "women insert these so that men cannot tell how many partners a woman has had." This participant stated that after reading the magazine she now knew that "Jeyes Fluid and Dettol are not the right stuff to use— it is better to go to the clinic."

Changes were made to Sex News on the basis of this information and a limited pilot edition of the magazine was printed for further pretesting. (Appendix B). Results of the pretesting are discussed in the following chapter.

Radio Scripts: Pretest Results

Rough cuts of five of the seven radio scripts were recorded on audio cassette and tested with the target audience. Each radio script was tested with two groups, a male group and a female group, consisting of three participants each. Altogether, fifteen males and fifteen females participated in the pretest study. The average age of the male participants was 24 years and the average age of the female participants was 21 years.

Overall, the adverts were well received by the participants and they easily identified the main messages in each of the respective adverts. Participants did however raise a number of issues which needed to be addressed in order to improve the radio adverts and increase their acceptability. For example, participants were not familiar with the term "cauliflower" used in the first advert to refer to genital warts and as a result the term was dropped from the advert. Participants also felt that the tone of voice used in advert two did not reflect the fact that the character, Fikele is sick. "In the advert they laugh as if it is not a serious thing they are discussing. The tone of her voice should show that she is feeling depressed or anxious". Participants also
disliked the adverts explicit description of how substances are used for self treatment, for example, the use of enemas and Jayes Fluid to induce vomiting in order to treat STDs. The project team decided that because the objective of the advert was to discourage self treatment of STDs, particularly among those who are already self treating, it was unnecessary to describe in detail how these substances are used. The advert was changed to reflect this decision.

A number of participants commented that the radio adverts should emphasize the fact that condoms are obtainable free of charge from the clinics. They also felt that it should be stressed that condoms should be used by everyone and not just those suffering from STDs. Both comments were acknowledged in the rewriting of the scripts and an entire advert was devoted to the general promotion of condom use (see advert 6, Appendix C). Some participants stated that while they found the beginning of the advert one confusing, as the advert progressed it became clearer and was easily understood. The project team decided not to change the beginning of the advert as its' obscurity caught participants attention compelling them to listen to the advert to find out what it was about.

Generally, the majority of participants found the content of the adverts and the language used in the adverts acceptable - "They don't mention things in a bad way" - however a few of the participants felt that they would feel uncomfortable listening to the adverts in the company of adults. They also felt that their parents and grandparents may prevent them from listening to the adverts. Given the fact that families listen to the radio together this poses an obstacle to youth being exposed to the messages.

The project team decided that to water down the language and content of the adverts in order to solve this problem would be counterproductive to encouraging open dialogue about STDs among the target audience and would diminish the impact of the messages. After much debate it was decided that the main solution lay in the broadcast timing. Where possible, broadcast slots were selected at times when youth are more likely to listen to the radio in the company of their peers. Programmes targeted predominantly at the youth market, such as youth magazines and music shows were selected as being the most appropriate broadcast times. Out of the range of programmes identified, the Radio Zulu "Top Twenty" was selected as the most ideal broadcast time to capture the youth market on their own. This decision was supported by data obtained from the All Media and Products Survey (AMPS).
CHAPTER FIVE

This chapter attempts to demonstrate the appropriateness of the theoretical approach used to develop the Hlabisa media campaign for the development of STD and HIV/AIDS education media in South Africa. While it is recognised that evaluation of the success of media materials in reaching their planned objectives is essential, long term evaluation of this campaign falls beyond the scope of this paper. Analysis of the pretest results, in terms of the campaign's effect on and assessment by the target audience, does however go some way in providing an indication of the appropriateness and effectiveness of this approach.

Sex News (pilot edition): Pretest Results

A limited pilot edition of Sex News was printed in both English and Zulu and tested with the target audience by means of in-depth individual interviews. Participants were given a copy of Sex News, in the language of their choice, to read and were then asked to complete a questionnaire (Appendix D). Six men and six women participated in the second pretest with the average age of the men being 23 years and the women being 20.5 years.

Reader response to:

1. The name Sex News

There was an overwhelmingly favourable response to the name of the magazine Sex News. The name was successful in capturing the audiences attention and stimulating further interest in the contents of the magazine.

The name is good. When I first saw it I was interested to read what is being said inside I became interested to read what was being said inside, so the name encourages people to read the magazine
The name is very interesting because everybody would like to hear what is being said about sex. <just> as I wanted to see what was said inside

Only one participant responded negatively to the name.

I dislike the name because I can think this magazine is discussing things about people who are lovers and what they are doing during their lovemaking

2. The Messages

Participants easily identified the main messages of the magazine however they emphasised different messages as being the main objective of the publication. For example, while some participants stated that the magazine "teaches us about STDs" others stated that the "the main message or idea is safer sex, people should practice safer sex". Some participants commented that the magazine "warns people that if they get an STD there is bigger chance of getting AIDS". The project team viewed this as a positive finding as it suggests that participants focused on the information that was most relevant to themselves.

Participants commented that they found the information in the magazine believable and relevant. They also stated that the appropriate use of language in the magazine made it "easy to understand" and "easy to follow". Participants engaged with different parts of the magazines, some particularly liked the story, others mentioned the questions and answers and others mentioned the examples of STDs as being the reason for liking the magazine. Contrary to the project teams expectations, the most popular article in the magazine was "Some examples of STDs" which included graphic photographs of STDs. A female participant claimed that she found the examples of different sexually transmitted diseases useful "because they have been clearly indicated to us in pictures". Other responses to the photographs included,

They are good, you get to understand the condition better when you see it unlike when a person is describing it to you.

I liked the photographs because I have heard about some sexually transmitted diseases but I have never seen them. So when I read about the condition and see the picture then I understand and I know those conditions now.
The following quote from a male participant indicates that the inclusion of explanatory headings and text with the photographs successfully reduced the amount of aberrant decoding.

*At first I thought that what I was seeing was not good to be shown on paper but as I read through I was interested and I got a clear understanding.*

3. **Bongani's Story**

Both male and female participants claimed that they found Bongani's story interesting and informative. While a number of participants viewed Bongani's story as a prevention message or "warning" for others to change their behaviour,

*The story is a warning for people who like changing their partners, they should be very careful and think before they make love.*

others identified more closely with Bongani's predicament. According to one participant, "this is the real thing that is happening. It is a big problem to tell your partner that you have a STD". Participants did not reject the challenges made to cultural norms in the story but rather viewed Bongani's actions as possible strategies and solutions in their own lives.

*When I am in the same position as Bongani, I would do as Bongani did, that is buy a present.*

*The story has helped me to find a way of discussing STDs with a partner - like buying something for my partner.*

It was interesting to note that female participants identified not only with the female character in the story but also with Bongani and his predicament. According to a female participant

*The story gives us ways of telling our partners when we have a STD, like buying a present or doing anything good for him.*

This highlights the importance of moving beyond the simple provision of information to including practical behavioural solutions that the audience can adopt.

4. **Sex News Answers Ten Questions About STDs**

Participants found the article, "Sex News answers ten questions about STDs" particularly informative and relevant because it raised and answered the questions that were foremost on their
minds. Participants responses to this article included the following:

The questions are interesting because I also had some questions in mind but they have been answered in this <magazine>.

Some of the questions that were worrying us have been answered.

The questions are relevant to what is happening today.

The articles success in raising the readers pertinent questions highlights the importance of basing media development on extensive formative research. The following quote from a male participant also highlights the fact that messages which conflict with existing harmful cultural beliefs will not necessarily be rejected by the target audience if presented in an appropriate way,

The questions that have been asked are good questions. At times I usually tell myself that I am always right but when these questions were answered I could see where I was wrong.

5. Discussing Sex News With Friends

All participants claimed that they would feel comfortable sharing the information in Sex News with both friends and peers.

I would feel good about discussing <Sex News> with friends as they have a lot of girlfriends and would be interested in knowing about safer sex.

More importantly, they articulated the need for this information among their peer group.

I would feel comfortable and happy as I know that my friends need this knowledge as desperately as I do.

This is partly due to the fact that information about STDs is not forthcoming from their parents.

Our parents are scared to tell us the real facts so as a peer group we must discuss these issues together.

6. Personal Relevance of Sex News

While the majority of participants claimed that Sex News was relevant for "everyone", and particularly those in sexual relationships, others felt that it was only relevant for certain
individuals or groups. These individuals and groups included the following:

a person who is not yet married but who is still looking for a partner.
for people who like sleeping around and who have different sexual partners.

it is good for people who do not look after themselves, like women who have different partners.

It appears however that the selection of these individuals and groups for whom the magazine relevant was not a form of 'othering' but rather an acknowledgment of their own behaviour and risk. This is inferred from the fact that when participants were asked if the magazine was personally relevant, all but two participants, claimed that they viewed Sex News as being relevant to themselves. Those that did not view the magazine as having any relevance, did so for the following reasons:

the magazine is not useful to me because I am married.

no it is not for me as I do not sleep around.

Overall, the majority of participants claimed that they learned something new from the magazine. Participants listed the following information as being new information they had learnt as a result of reading Sex News:

It is not right to treat yourself only, the partner should also be treated.
When you have a STD and are undergoing treatment you should use condoms until the course of treatment is finished.
Examples of different STDs.
Do not sleep with every new women you meet, you must know her first.
About the different types of STDs.
I have learnt that when I see an abnormal vaginal discharge I should go to the clinic or doctor.
I hadn't seen some of the different infections before but now I have seen them.
How to prevent STDs - I have learnt also what STDs are, what they do and how to prevent them.
Target Audience Response To The Radio Campaign

As mentioned above, rough cuts of five of the seven radio scripts were recorded on audio cassette and tested with the target audience. Participants in each group were required to listen to the radio spots and then respond to a questionnaire administered by a group facilitator (Appendix E).

Participants liked the adverts and their attention was immediately captured by the opening music. They claimed that the music was appropriate for their peers and themselves. It was also noted by many of the participants that the music complimented the issues being discussed in the advert, namely sexual relations and STDs. Participants responses are included below:

The advert was produced in a good way because of this music which is more liked by the youth

I liked the music ..it makes one continue listening, even when one is busy doing something one just stops because of the music

I liked it ..even the message it (the song) has. I know what it means - he explains about a person who he is in love with and how much she loves him and it is relevant to the conversation in the advert

The music is relevant as it is about lovers when they are together and maybe discussing some of these things

Only one negative response was made about the choice of music.

The music is fine but it makes the problem worse because the music is used more when there is party time" (when it is more likely for sexual encounters to take place)

A main objective of the adverts was to facilitate target audience identification with the characters portrayed in the adverts so as to enhance the salience of the messages. Through careful scripting and character development this was successfully achieved and is illustrated by participants responses.

Characters are good and we can hear that they are still young, you can hear that "the characters are our age.

They make you develop an interest in listening to them.
Participants identified the overall campaign objective as being the provision of information about the signs and symptoms of STDs and the importance of both them and their partners attending the clinic for treatment if they experience any of these signs or symptoms. Participants were also able to relay the main messages in each of the respective adverts.

*if my boyfriend is having an STD it means that I also have the same problem - <there is> no need to run away from him only to go with him to the clinic so that we will both be treated.*

*it teach <es> us that once one is having signs of STD you must go with your partner to the clinic.*

*it teaches even those who do not know about STDs on how it starts.*

Participants also claimed that they liked the idea of getting information on the radio as it enabled them to act without having to first ask others for advice.

**Conclusion**

This paper demonstrates the limitations of existing models of STD and HIV/AIDS education media development and, in the absence of an appropriate model, demonstrates the need for rearticulation and further development of these models.

As mentioned above, current psycho-social models of behaviour change are individualistic in their focus and cognitive in their orientation. These models give little credence to the importance societal processes that underlie the emergence and maintenance of norms. Moreover, these models do not take into account the complexity of communication, a process that operates within elaborate networks of intentions, interpretations, social relationships, power structures, standards and values. *Semiotic Communication Theory,* on the other hand, acknowledges both the context and the interrelationships of societal and cultural forces. Nevertheless the use of semiotics as a starting point for HIV/AIDS education media development is also problematic. While the application of Semiotic Communication Theory to HIV/AIDS media development results in the production of 'culturally sensitive' media, it fails to generate messages that critically examine or
address the prevailing barriers to behaviour change or the cultural values underlying these barriers. Media products developed on the basis of Semiotic Communication Theory alone are therefore ineffective in stimulating the target audience to critically examine the cultural values underlying their risk behaviour.

The absence of an appropriate theoretical model for the development of the Hlabisa mass media campaign was fortuitous in that it led to the selection of a communication planning matrix, which though not ideal, when rearticulated in terms of Semiotic Communication Theory yielded new insights into HIV/AIDS education development. While rearticulation of the planning matrix exposed a number of limitations, the process of attempting to overcome these limitations generated a number of creative solutions. These are discussed in detail in chapters two and four, however a summary of the pertinent issues and their implications for the Hlabisa campaign and STD and HIV/AIDS education media development are presented below.

By viewing the target audience as passive receivers of media messages the communication planning matrix fails to acknowledge that the 'reader' helps to create meaning of a text by bringing to it his or her experience, attitudes and emotions. This impacts on the development process from formative research through to final production of media materials. Information about the 'receiver', in this model, is limited to the collection of demographic information and the capacity for multiple, changeable and highly contextualised identities is ignored. HIV/AIDS interventions occur in contexts and settings where ideas about health, disease, illness and risk often differ from those generated by modern biomedicine. Rather, biomedical ideas may often coexist with traditional/popular beliefs, with individuals switching between them to suit their circumstances.

By rearticulating the 'receiver' variable in terms of Semiotic Communication Theory, acknowledgment is made of the strong relationship that exists between knowledge and experience and the capacity to interpret information. The use of semiotic theory to frame the development of questions in the formative research phase of the campaign development leads to greater emphasis being placed on cultural, socio-economic and communication contexts. In depth formative research and pretesting of materials reduces the likelihood that campaign developers (particularly those with different cultural norms from the reader) will make common
assumptions about the target audience. The value of this approach was well made by the overwhelmingly popular response to the magazine name Sex News which was initially assumed by many of the project team to be inappropriate for a rural audience. This also reflects a tendency in South Africa to assume that rural audiences have a very low level of media literacy although these audiences are often exposed to the same media influences as urban audiences. This exposure is primarily due to the fact that members of these communities often migrate between rural and urban areas for work, education or other purposes. Furthermore, rural communities in South Africa often attempt to emulate an urban type lifestyle and urban lifestyle trappings, which include sophisticated media products, are highly valued in these communities. Media which emanates from an urban source, and which is associated with an urban lifestyle, is therefore accorded high credibility by these communities and considered to be authoritative. Very little research has been conducted on media literacy among rural audiences. Given the significance of media literacy, particularly in regard to the reception of STD and HIV/AIDS education messages, this is an area which requires further in depth exploration and research.

The communication/planning matrix narrowly defines comprehension in terms of how precisely the transmitted symbols convey the desired meaning. The influence of socio-cultural factors on comprehension of messages is therefore ignored. For the development of the Hlabisa STD and HIV/AIDS education campaign this variable was extended to take into account the impact of the ‘readers’ past experience, present expectations and current socio-economic, political and cultural context. Of particular importance to the comprehension of messages was the ‘readers’ prior consumption of mass media. Learning from mass media requires familiarity with formats and codes that characterise these media. Given that the Hlabisa media campaign was developed for rural audience particular attention was paid to media literacy and its impact on comprehension. A strategy employed to facilitate comprehension of messages in the Hlabisa campaign that I feel deserves special mention was the utilisation of existing popular genres for message delivery. Through the use of popular genres aberrant decoding is reduced as implicit semiotic instruction as to how to read the text is provided. Moreover it enables the developer of the message to influence the context of reception. The use of magazine and radio drama genres enables messages to be presented in a non-didactic way by providing an alternative to the traditional health promotion context in which messages are usually received. Use of existing popular genres was also found to be highly successful in facilitating the acceptance of messages that challenged
harmful cultural norms. Not only did it ease the audience into the message but also provided the 'reader' with an additional point of identification, that is, as both an audience and a consumer of popular culture. The utilisation of familiar genres offers a promising avenue for development of future STD and HIV/AIDS campaigns and should be explored further.

Another limitation of the communication planning matrix is that the media channel is viewed as a passive conduit for the delivery of messages. Media however interact with messages to shape the experience of the audience. Signs will mean slightly different things or convey different kinds of meaning depending on the medium through which they are channeled. Moreover, within a single medium the sign used to generate messages can vary according to the context or genre in which it is used. As stated above, this exposes what is probably the most fundamental limitation of the model, that is, that it views each communication variable in isolation from the others. To develop effective media messages it is essential to consider communication variables in relation to each other. By rearticulating the constituent variables of the planning matrix in terms of Semiotic Communication Theory this limitation can somewhat be removed.

Based on the Dejong and Winsten's summation of the elements necessary for an effective media campaign and the lessons learned from developing the Hlabisa STD and HIV/AIDS education campaign I would like to put forward a list of criteria necessary for the development of mass media communication aimed at changing attitudes and behaviour.

Media campaigns should:

1. Be developed in an environment that allows programme needs to dictate the appropriate theoretical basis and approach.

2. Be developed within a paradigm that shifts the emphasis away from rigid psychosocial models of behaviour change and towards the application of socio-cultural theory.

3. Be designed to reach a specific audience while at the same time acknowledging that even narrowly defined audiences are not homogeneous. Messages should therefore be presented in a variety of formats and genres allowing different aspects of the message to be emphasised in different places.
4. View the reader as both the target for intervention and a partner in the development of messages. Ideally media development should be a partnership between the audience and an external project team, each with their own set of inputs.

5. Use formative research to obtain input from the target audience and to facilitate the use of local understandings about STDs and HIV/AIDS as a starting point for health promotion and education.

6. Be developed from the outset in the language of the target audience as too much nuance and meaning is lost in translation.

7. Include an alternative set of social representations and behaviour in an attempt to create a new terrain on which people operate, new identities and new interpretations of the world.

8. Explore the use existing popular genres to capture the target audience's attention, create additional points of identification, and ease the audience into the message.

9. Extend the concept of source to include the medium used for message delivery, that is, messages need to come from a person or group that the audience likes, understands and believes and be presented in a medium that is familiar, appealing and credible.

10. Acknowledge the relationship that exists between communication variables and develop messages and materials accordingly.

11. Provide the audience with a number of behavioural solutions from which to choose as well (practical) information about ways of integrating these solutions into their lives.

12. Be part of a multifaceted approach, i.e., media messages need to be comprehensively integrated into broader intervention programmes.
Finally, I would like to suggest that in South Africa, media messages need to strive for personal relevance as part of an effort of social change. HIV/AIDS risk behaviours are deeply rooted in the social, cultural and economic and as a result these cannot be bracketed out. South Africa, in light of it's post apartheid transformation and reconstruction, has a unique opportunity to introduce new knowledge, perceptions and language into current discourses. STD and HIV/AIDS education has the potential to utilise this opportunity to challenge harmful cultural norms and practices that place people at risk of infection.
References


"Let the sky be the limit: Soul City Evaluation Report" Community Agency For Social Enquiry, Guateng. (1994)


Muller, J. (1980) "An approach to the study of culture and society in Southern Africa." CCSU Seminar paper No 1 University of Natal Durban


Vries, H. de. Primary Prevention of Cancers: The need for Health Education and Intersectoral Health Promotion. Paper 3.2


How do you tell your partner that you've got an STD?

What would you do if you discovered that you had a sexually transmitted disease (STD)? How would you tell your partner about it? Here is Bongani’s story...

“One day I noticed sores on my private parts. I waited for a few days for them to go away, but they got worse. I didn’t want my wife to see them, because then she would know I had been sleeping with another woman.

“I went to the STD clinic for treatment. The nurses were very kind and helpful to me. They told me to notify my wife and my girlfriend that I had an STD. I should advise them to go to the clinic as soon as possible so they could also receive treatment. Otherwise, I would become infected again.

A DIFFICULT THING TO DO

“It was quite easy to tell my girlfriend, because she did not expect me to be faithful to her. But how was I going to tell my wife? It was the most difficult thing that I have ever had to do!”

“I couldn’t sleep. I lay awake all night. What would I say to her? How would I explain that I still loved her but I had been unfaithful.

The next morning I got up early and made some tea. I took it to her in bed. She was most surprised.

‘Why are you bringing me tea?’ she asked. ‘Is there something wrong?’

If you have an STD, you must tell your sexual partners so they can get treatment.

Why are you bringing me tea? Is there something wrong?

IN THIS ISSUE

- All about STDs
- Do you use condoms?
- Sex Quiz
- Can laxatives cure STDs?

WARNING

“HOW I CONFESSION TO MY WIFE” Page 3
Welcome to the first issue of our magazine about sexual problems and how you can solve them.

These days, it is necessary for people to talk more openly about sex. In the old days, most men refused to discuss these matters with their wives or girlfriends. But today, women are more liberated, and they want to share information about sex with their men.

Also, sex has become dangerous if you are not careful. We have all heard of AIDS. This killer disease is spreading all over Africa.

Now, doctors have discovered that people who have other kinds of sexually transmitted diseases (e.g. syphilis, gonorrhea drop etc) are at great risk of being infected by the AIDS virus.

This issue of SEX NEWS looks at the problems caused by STDs and how to solve them. We talk about how to notify your partner or partners that they might be infected and should seek treatment.

We explain what STDs are and how they can be cured. And we talk about why you should be using condoms.

We hope you enjoy reading SEX NEWS.
The Editors

STOP PRESS

All clinics to offer treatment for STDs

Now there is good news for STD patients. All clinics will be offering STD treatment. So now you can go to your normal clinic for treatment if you think you may have an STD.

New Partner Notification Card will make it easier for STD patients

It is very difficult to tell your partner that you have an STD and that he or she may be infected too. Now a new Partner Notification Card will make it easier for STD patients to notify their partners that they may have an STD and should go immediately to a clinic for treatment.

FREE CONDOMS

Do you need some condoms? The government's health programme has 97 million condoms to give away. You can get them from your local clinic. You should ask for as many as you need, and you can go back for more as often as you want.
“How I confessed to my wife...”

‘My dear wife,’ I said, ‘I have to confess something to you.’

‘What? Do you have a girlfriend and you want to leave me for her?’

‘No, no. I do not want to leave you. I have made a great mistake and now I wish to ask for your forgiveness.’

‘How can I forgive you if I don’t know what you have done? Tell me, don’t keep me in suspense!’

“I realised that I would have to tell her the truth”

“So I told her that I had slept with another woman and that I had caught a sexual disease from her. I told her about the clinic and what the nurse had said. At first she was very angry with me, and then she started to cry. I tried to comfort her and I said I was very sorry, many times. She asked me who my girlfriend was. At first I pretended that I did not know the woman’s name, but my wife became angry and threatened to divorce me. I realised that I would have to tell her the truth. After I had told her the truth, I felt much better. I promised to stop seeing my girlfriend.

“It was very difficult for me to talk to my wife about these things. We had never talked much about sex before. Most of the men that I know have girlfriends. They do not talk to their wives about such things. It is not common in our culture for a man to discuss sex with his wife.

“But do you know something? I feel much better now. We have both been treated at the clinic and our STDs have gone away. Now that both of us are cured, we won’t infect each other again, unless one of us is unfaithful. Since this has happened I feel much closer to my wife. I have realised that I do not want to lose her, she is the mother of my children.”

Now that Bongani has been honest with his wife, it is easier for them to discuss sexual matters. And their sex life has improved.

“It helps you to understand more about how your partner feels.”

It is easier now for us to discuss sexual matters. I never gave much thought to these things before. But when you discuss sex with your wife it helps you to understand more about how a woman feels.

“And do you know something else? Our sex life has improved. I am enjoying sex with her much more these days. I don’t think I need to sleep with other women any more. Especially with so many STDs and AIDS around these days. It is so easy to become infected. These days, I would rather be a one-woman man than a dead man.”
TELLING YOUR PARTNER

New Partner Notification Card will make it easier for STD patients to tell their partner they have an STD

It is very difficult to tell your partner that you have an STD and that he or she may be infected too. Now a new Partner Notification Card developed by the Medical Research Council will make it easier for STD patients to notify their partners that they may have an STD and should go immediately to a clinic for treatment.

According to nurses at the Durban STD clinic, very few patients notify all of their partners as requested by the clinic. Most men will bring their steady ("straight") girlfriend or wife to the clinic, but they will not bother to notify casual partners ("roll-ons").

In many cases, STD patients do not want to see casual sex partners again, especially where they have only slept with that person once.

The new card makes it possible for STD patients to notify casual sex partners without having to talk to them. The card contains a message which reads:

"Your partner has recently received treatment for a sexual infection. This means that you may also have an infection even if you have no symptoms.

It is very important that you go to a clinic for treatment soon. You can go to any clinic at any time during the week."

The card also contains some important information about STDs.

If you have an STD but do not feel able to talk to your casual sex partner about it, you can put the card in an envelope and send it to him or her.

DOCTORS WARN: 

Recent studies undertaken by AIDS researchers have found that men and women with genital ulcers are more likely to become infected with the AIDS virus.

ULCERS

Some STDs cause ulcers or sores on the genitals. These sores provide an open passage for the AIDS virus to pass into the bloodstream. Other STDs that cause discharge rather than ulcers are also dangerous.

Scientists have also found that where there is already an STD, the AIDS virus can work more efficiently to destroy the body's immune system.

For these reasons, people with STDs should under no circumstances have unprotected sex. By doing so, they are playing a dangerous game with their own lives, as well as putting their partners at risk.

NO SYMPTOMS

The danger is even worse for people, especially women, who have an "asymptomatic" STD. This means that they have an STD, but because there are no visible symptoms, they do not know they are infected.
What are STDs?

Sexually Transmitted Diseases (STDs) are infections of the sexual organs. You can catch these diseases through sexual contact with someone who is already infected with an STD.

**TREATMENT**
The most common STDs are Gonorrhoea, Syphilis, Genital Herpes and AIDS. Most STDs can be easily treated using powerful antibiotics. But AIDS is different. AIDS is the most frightening of all the STDs because there is no known cure for the disease.

**SYMPTOMS**
Some of these diseases cause sores on the sexual organs or discharge of fluids. But some of them can live in your body without you knowing about it. You can look and feel healthy but still have an STD. AIDS can live in your body for up to 7 years before you suffer any symptoms.

**STDs AND AIDS**
Medical researchers have proved that people who have STDs are far more likely to get AIDS than people who don’t. If you think you have an STD you must seek treatment immediately. The sooner you get treated, the less the danger of you getting AIDS. If you find that you have an STD, you should stop having sex until you are properly cured.

Below are photographs and brief descriptions of some of the more common STDs and their symptoms. If you find any of these symptoms on yourself, get to a clinic as soon as you can.

<table>
<thead>
<tr>
<th>Some common symptoms of STDs</th>
</tr>
</thead>
<tbody>
<tr>
<td>A discharge or unusual smell from the vagina or penis</td>
</tr>
</tbody>
</table>

**STD FACTS**
- Anyone who has sex can get an STD.
- You can get an STD from having sex just once.
- You can have more than one STD at a time.
- Untreated STDs can make you unable to have children.
- Untreated STDs can harm unborn babies.
- The more people people you or your partner have sex with, the more chance you have of getting an STD.
- If you get treatment but your partner does not, you will get infected again.
- Birth control methods like the Pill or the Loop will not protect you from STDs.
- You can get free condoms from all clinics.
QUESTION: Many people think that by cleaning out their bowells using laxatives or "imbiza" (traditional medicine) they can cure sexually transmitted diseases (STDs). Is this true?

SEX NEWS: No. Laxatives cannot cure STDs. Some people think that STDs are caused by impurities or "dirt" in their bodies. This is true, but the STD germs are not in the stomach or digestive system, so the laxative will not help.

QUESTION: Some people say that if a man sleeps with a woman after she has taken laxatives, he can catch an STD. Is this true?

SEX NEWS: No. People think that if they have sex with their partner while the "dirt" is still being passed from their partner’s system, they might become infected. This is not true. Emptying your stomach and bowells has got nothing to do with sex or STDs.

QUESTION: How do sexual infections (STDs) get into your body?

SEX NEWS: STDs are caused by infections (viruses or bacteria) which are passed from an infected person to another person during sex. The infection is carried in the sperm of the man, or in the moisture in a woman’s vagina. If your partner has an STD, this is passed into your body during sex. Once the infection gets into your body, it can get into your blood, and can make you sick.

QUESTION: How do you know if your partner has an STD?

SEX NEWS: There are many different kinds of STDs. (See page ...) If a man has an STD, there will usually be symptoms (signs). These may be discharge from the penis (the drop) or sores (ulcers), or small cuts on the penis. If a woman has an STD, there may be sores on or inside her vagina. But some STDs are invisible. Many women carry an STDs inside their sexual organs without knowing about them. AIDS is the most dangerous STD of all. Your partner may have it in his or her bloodstream for years without knowing about it. And you can become infected by that person without knowing about it.

QUESTION: Do many people have STDs?

SEX NEWS: Yes, many people are infected. Many do not even know. People who have more than one sexual partner are most likely to have STDs. If you sleep with more than one person, you are taking a risk. If your partner has slept with someone else, you are also at risk.

DON’T TRY TO TREAT

These are some of the substances people use to try and treat themselves for STDs. This is very dangerous because these substances can cause irritation to sensitive skin and make the problem worse.
YOUR QUESTIONS

The best way to avoid risks is to be faithful to your partner and make sure that your partner is faithful to you.

**QUESTION:** What must you do if you want to have sex with a person that you do not know very well. You don’t know who they have slept with before.

**SEX NEWS:** Then you must use a condom. If your partner is infected, the condoms will prevent the infection from getting into your body, if the condom is used correctly every time.

**QUESTION:** If you have an STD, how can it be cured?

**SEX NEWS:** The only way to cure STDs is to go to a doctor or clinic for treatment. You will be given a course of tablets (pills) to take. These tablets are antibiotics. They will kill the infection. You must finish all the tablets, or they will not work properly. Remember that some STDs, AIDS and Herpes, cannot be cured.

**QUESTION:** My friend offered me some tablets which he was given at the clinic. Can I use them?

**SEX NEWS:** No. You must go to the clinic and get your own tablets. Do not use other people’s tablets.

**QUESTION:** Can you have sex after you have had an STD?

**SEX NEWS:** Sure, but only once you have finished all your tablets and the STD is cured. But you must make sure that your partner is also cured, otherwise you will become infected each other again. It is very important to not have sex until you are sure that both of you are cured. If you are not sure whether both of you are cured, you must use a condom.

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**YOURSELF!**

Some people are scared to go to an STD clinic because they fear they will see someone there that they know. And so they try to treat themselves for STDs.

Powerful antibiotics are needed to kill STD germs. These can only be administered at an STD clinic or by a qualified doctor.

Washing with Dettol or Jeyes Fluid will not cure your STD.

Sometimes women insert snuff or other substances into their vaginas. This is very dangerous and can lead to infection.

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**SEX QUIZ**

How much do you know about sex? Answer TRUE or FALSE to the following questions. Then check the answers on page... to find out just how much you really know about sex.

1. It is not safe to sleep with someone if he or she has just taken a laxative.
2. Men can lose their virility if they have sex with a woman while she is menstruating.
3. Some men claim that witchcraft is the cause of their STD because they do not want to admit that they have been unfaithful.
4. People who indulge in anal sex are most in danger of being infected by the AIDS virus.
5. You can catch AIDS from sitting on a public toilet after someone who has AIDS has sat there.
6. Using condoms can help men to make sexual intercourse last longer.
7. If a woman uses contraceptives such as the pill for a long time, this can cause her partner to get an STD.
8. If a woman is "wet" before sex, it means that she is being unfaithful to her partner.
9. Washing with undiluted Dettol or Jeyes Fluid can cure sores on the penis or vagina.
10. Women may carry sexual diseases even if there are no symptoms.
DO YOU USE CONDOMS?

**NO MORE WORRIES**

"Me? I used to think that condoms were a joke. My friends used to say that AIDS is just rubbish. They said that it's just the white man's way of trying to destroy our African culture. Myself, I have made love to many young girls. I never thought that I could get sick from sex. Then one day I noticed that I had sores on my private parts. I asked my friend about them. He told me to be careful. He said that if you have sores, it makes it very easy for you to catch AIDS. I started to get worried. I kept wondering whether the girl I was with might have AIDS. If she had AIDS, it could get through my sores into my blood. I went to the clinic for treatment. And I began to use condoms. Now my sores are gone and I still have lots of girls. But now I have learnt how to use condoms, and I don't worry anymore."

*I never thought that I could get sick from sex.*

**SIPHO "KWIKSTIX" ISOKA, OFFICE WORKER

**STAYING OUT OF TROUBLE**

"I always insist that my boyfriend uses condoms when we make love. Not only is it much cleaner and safer, it also protects me against getting pregnant. You see, my parents do not know that we sleep together. If they were to find out... oh dear! I would be in terrible trouble. My boyfriend doesn't mind. At first he didn't want to use them because he said it's like eating sweets with the wrapper on. But I told him that he could choose between condoms or no sex. Although it took time to get used to it, now it's just the same as it was before."

*I always insist that my boyfriend uses condoms.*

**VISHNI RAMSAMY, SHOP ASSISTANT

**LIVE FAST, LIVE LONG**

"Girls just love me, man. When I win a big race, they're all over me! I can take my pick. But one thing I can tell you, is that I always use condoms. I always keep a few in my wallet, just in case. You never know when a beautiful woman might give you the eye. Most times, I don't know who they've been with. I'm scared of this AIDS thing, man! People say it's invisible. The person you sleep with can be infected with AIDS and you'll never know. A couple of years later, you get sick and die. Just for one night of pleasure? No thank you. For me, condoms are the answer. I keep clean, I live fast, but I'm not going to die young!"

*I'm not going to die young!*

**JOHNNY REV MANN, MOTORBIKE RACER

**EVEN GOOD GIRLS MUST BE CAREFUL**

"Tell you about my sex life! I'm not the kind of woman who sleeps around. The only trouble is, these men of today, they expect you to have sex with them. Otherwise they will look for another girlfriend. And most of the time, they do not tell you the truth. They will say that you're their only one, then you'll walk into a shebeen and see them in some other woman's arms. Well, I know all about AIDS. I read the newspapers. And there was someone, a soccer player, who lived near us who died suddenly. The"
family said it was TB, but we all know it was AIDS. Since when does a top soccer player suddenly fall over and die from TB? He played the price for sleeping around. I don’t take chances. If I’m going out with a man, I hide some condoms in my bag. Even good girls must be careful.”

A GOOD MAN IS HARD TO FIND

“...the kind of woman who sleeps around.

VICKIE JACOBS, BEAUTICIAN

WHEN TO USE CONDOMS:

A SEX NEWS GUIDE

When is the right time to use condoms? This SEX NEWS guide will help you choose when to use condoms.

ONE FAITHFUL LONG STEADY RELATIONSHIP

If you have only one sexual partner and you have been with that person for a long time, and neither of you has an STD, you do not need to use condoms. But remember that some STDs, especially the AIDS virus (HIV), can live hidden in your body for years. You or your partner may be carrying AIDS or an STD from a previous partner long ago. You and your partner should have an AIDS test just to make sure neither of you is infected.

ONE LONG STEADY RELATIONSHIP WITH OTHER PARTNERS FROM TIME TO TIME

If you have been in a long steady relationship with a person you know is not infected with AIDS or other STDs, but you have other partners from time to time, you must protect yourself. Other partners put you at great risk of infection. You must use condoms with your other partners, even if you do not use condoms with your steady partner. Remember that casual sex places both you and your steady partner at risk from STDs and AIDS. If you get an infection, your steady partner will get it too.

IF YOU CHANGE STEADY PARTNERS

If you change steady partners, then you must use condoms with your new partner. When you get a new partner, you should both go for an AIDS test. When you are sure that neither of you are infected with AIDS or other STDs, then you and your partner should discuss not using condoms. But be sure that your partner does not have another partner. If you are not sure of your partner, use condoms.

TAKING CARE TO BE SAFE

I had a steady girlfriend, but I broke up with her when I found out she was unfaithful to me. We always used condoms, and now I am glad we did, because I found out that I couldn’t trust her. She could have become infected from her other partner. Then I would have become infected too. Now I am looking for someone new. I am studying to be an accountant. I want the best out of life, and I want a woman to share it with. When I meet the girl of my dreams and marry her, I will stop using condoms and start having children. Until then I am sure I have found my one true love, I’ll use condoms. I am a careful person. I want to live long and enjoy my life, so I don’t take risks.

I don’t take risks.

GULAM SAYED, STUDENT
How do you tell your partner that you’ve got an STD?

If you discover that you have a sexually transmitted disease (STD), you must tell your partner about it so he or she can also get treatment. This is a very difficult thing to do. Here is the story of Bongani and how he told his wife about his STD.

BONGANI’S STORY

“One day I noticed sores on my private parts. I waited for a few days for them to go away, but they got worse. I realised that I had a sexually transmitted disease.

I didn’t want my wife to see that I had sores, because then she would know I had been sleeping with another woman. I went to the STD clinic for treatment. The nurses were very kind and helpful to me. They gave me some pills. They said I must not have sex again until my STD was cured. They told me to tell my girlfriend to go to the clinic as soon as possible.

A DIFFICULT THING TO DO

But they also told me to tell my wife, because she might be infected too. They told me about the danger of re-infection. This means getting infected again. Unless we were both cured, we would continue to re-infect each other. So the nurses said I must tell her to go to the clinic for treatment too.

I told my girlfriend first. She agreed to go to the clinic for treatment. The nurses told her to notify her other partners too. I began to see how easy it is for STDs to spread through the community.

Now I had to tell my wife. It was the most difficult thing that I have ever had to do!

I couldn’t sleep. I lay awake all night. What would I say to her? I didn’t want to tell her, but I knew I had to.

I decided to give her a gift to show her that I still loved her. I would tell her that I had made a mistake and ask her to forgive me.

“HOW I CONFISSED TO MY WIFE” Please turn to Page 3
Welcome to the first issue of our magazine about sexual problems and how you can solve them.

These days, it is necessary for people to talk more openly about sex. In the old days, most men refused to discuss these matters with their wives or girlfriends. But today, women are more liberated, and they want to share information about sex with their men.

Also, sex has become dangerous if you are not careful. We have all heard of AIDS. This killer disease is spreading all over Africa.

Now, doctors have discovered that people who have other kinds of sexually transmitted diseases (e.g. syphilis, gonorrhea, discharge etc.) are at great risk of being infected with the AIDS germ.

This issue of SEX NEWS looks at the problems caused by STDs and how to solve them. We talk about how to notify (tell) your partner or partners that they might be infected and should seek treatment.

We explain what STDs are and how they can be cured. And we talk about why you should be using condoms.

We hope you enjoy reading SEX NEWS.

The Editors

Published by the Medical Research Council (MRC) in association with the AIDS Training, Information and Counselling Centre (ATICC), Pietermaritzburg.

Thanks to the staff of the Durban City Council STD Clinic for their valuable contribution to this publication.

Edited and designed by Artworks, the Desktop Publishing Agency.

This Pilot Issue of SEX NEWS is being used for research purposes. The publishers seek responses, comments and suggestions from interested members of the public and the medical and nursing professions to the material contained herein.

Please write to the Editors, SEX NEWS, P.O. Box 17120, Cwanga 4013.
AN UNEXPECTED GIFT
The next evening I got home from work early. I gave her the gift. She was very surprised. “Why are you giving me this gift?” she asked.
“To show you I care for you,” I said.
But she became suspicious. “This is very strange,” she said. “Have you done something wrong?”
“My dear wife,” I answered, “I have to confess something to you.”
“What? Do you have a girlfriend and do you want to leave me for her?”
“No, no. I do not want to leave you. I have made a great mistake and now I wish to ask for your forgiveness.”
“How can I forgive you if I don’t know what you have done? Tell me what you have done!”

A BIG FIGHT
So I told her a lie. I said that I had got drunk at a party one night and slept with another woman, but only once. I said I had caught an STD from this woman.
At first she was very angry with me, and then she started to cry. I said I was very sorry. She asked me who my girlfriend was. I said that I did not know the woman’s name. But my wife did not believe me. She became angry again and began to shout at me. I became angry too and began to shout at her. We had a big fight. I walked out of the house, slamming the door behind me. I went to the shebeen to have a drink with my friends, but I could not enjoy myself.

TALKING ABOUT SEX
My mind was confused. In our tradition men do not usually discuss sex with their wives. It is said that a woman should never ask her husband where he has slept. But things are different these days. There are too many diseases around. There is AIDS. Sex is not what it used to be. It has become dangerous to sleep around.
I sat there for a long time, thinking. I realised that my wife was the most important woman in my life. I decided to go home and tell her the truth. It was very difficult, but I did it. She was angry and upset. But she was also glad that I had told her the truth.
And do you know something? After I told her about my STD, it became easier for us to talk about sex. I never thought much about her feelings before. But when you discuss sex with your wife it helps you to understand more about how your partner feels.

Talking about sex helps you to understand more about how your partner feels

If you have an STD, all your sexual partners must be treated or you will become infected again.

Now that Bongani has been honest with his wife, it is easier for them to discuss sexual matters. And their sex life has improved.

A BETTER LIFE
We have both been treated at the clinic and our STDs have gone away. And do you know something else? Our sex life has improved. I am enjoying sex with her much more these days. I decided to stop seeing my girlfriend. I don’t want to sleep with other women any more. With so many STDs and AIDS around these days, it is too easy to become infected.
These days, I would rather be a one-woman man than a dead man!
A BURNING FEELING

Dear Mildred,
I first noticed this problem a week ago when I went to the toilet. I had a burning feeling. Later it became itchy and I developed a discharge. A friend gave me a muti that she got from the market to make it go away. I have been using it for a week now but it is only getting worse. What should I do?
Jane, Stanger

Dear Jane,
You have a sexually transmitted disease (STD). You should go to your nearest clinic for treatment as soon as possible. The clinic has qualified staff and proper medicines that are very effective in treating the problem you have described. Be careful of using muti’s or other mixtures bought on the street - they will probably not work and may make the problem worse. Don’t wait for your symptoms to get worse. Go to the clinic now and your problem will soon be cured.

MY PARTNERS WILL BE ANGRY

Dear Mildred,
I was recently treated at the clinic for a sexually transmitted disease. The nurse at the clinic told me to bring in all my sexual partners for treatment. I have more than one girlfriend and they do not know about each other. How am I going to take them all to the clinic? There will be a big argument and they will be very angry with me. Surely it is all right if I just take my steady partner?
Worried, Durban

Dear Worried,
No, it is not all right if you just bring your steady partner, you must bring them all. You have managed to keep your partners apart all this time, surely you can arrange for them to go to the clinic at different times?

It is very important that all of your partners get treatment, otherwise they will continue to infect other people. Even if you do not sleep with your other partners again, the same STD can always find its way through other people, back to you again.

By helping to get rid of these STDs, you will be doing your bit to make sex safer for us all.

PAINFUL SEX

Dear Mildred,
I love my boyfriend very much and enjoy being with him. We have always had a good relationship. Lately however every time we have sex it is really painful and sore. I have started to avoid him as I don’t know how to tell him about this problem. I have examined myself and can’t find anything wrong. I have never had this problem before. Will I ever enjoy sex again?
Thembi, KwaNdegezi

Dear Thembi,
It sounds like you have an STD. You cannot always see the signs of an STD as they may be hidden inside you. It is very important that you and your boyfriend stop having sex until both of you have been to the clinic and completed a course of treatment. To avoid this problem in the future use condoms every time you have sex. Knowing you are safe and protected makes sex much more pleasurable.

IN LOVE WITH AN OLDER MAN

Dear Mildred,
I am 16 and in love with an older man of 34. The problem is that my boyfriend wants me to have sex with him but I am afraid of falling pregnant. He says that if we have sex only once I cannot fall pregnant. I feel bad saying no as he is always buying me new clothes and taking me out. I am scared that if I do not have sex with my boyfriend, I will lose him.
Schoolgirl, Groutville

Dear Schoolgirl,
You must not have sex until you feel you are ready for it, no matter how much pressure your boyfriend tries to put on you. He is giving you wrong information - of course you can fall pregnant even if you only have sex once. And, I assure you, he will not be satisfied with only having sex once.

The only way to be 100% sure of not falling pregnant is by not having sex. If you do at a later stage decide to have sex you should first visit a family planning clinic so that you can avoid an unwanted pregnancy. You should also get your boyfriend to wear a condom every time you have sex, to make sure that you don’t get a sexually transmitted disease.

Remember that no matter what your boyfriend does for you - you have the right to say no!
DOCTORS WARN:
People with STDs are more at risk of AIDS

Recent studies by AIDS researchers have found that men and women with sores on the sexual organs or discharge ("drop") are in greater danger of getting the AIDS germ.

The AIDS germ (HIV) needs to get into your body to infect you. If a man is infected, the AIDS germ is carried in his semen. If a woman is infected, the AIDS germ is in the moisture (wetness) inside her vagina.

OPEN DOORS
If you have sores on your sexual organs, it is very easy for the AIDS germ to pass through these sores into your body. The sores caused by STDs are like open doors into your body. The AIDS germ can easily get through these open doors into your blood.

If you have discharge ("drop"), it means you have an infection inside your penis or vagina. This infection is also like an open door for the AIDS germ.

This is the kind of ulcer (sore) you can get if you have an STD. These sores are like open doors for the AIDS germ to pass through.

Once the AIDS germ is in a person’s blood, it waits there for a long time. The person usually does not know that it is there. But once the person is infected with the AIDS germ, they can infect other people by having sex with them. A person who is infected with the AIDS germ may infect other people without even knowing about it. Pregnant women with AIDS can also pass the infection on to their unborn children. This is how AIDS is spread through the community.

DEFENCE AGAINST AIDS
Our best defence against AIDS is to have only one partner. But if you have more than one partner, then you must use condoms.

All people who have sex without condoms are putting themselves at risk from AIDS. But people with STDs who have sex without condoms are placing themselves and their partners in very great danger.

WHY YOU SHOULD USE CONDOMS

Condoms prevent the man’s sperm from going into the woman’s vagina. They also prevent the man’s penis from touching the inside of the woman’s vagina. This is how condoms protect you from STDs and AIDS.

You should use a condom every time you have sex. You should make sure that you know how to use condoms properly and you should never use a condom more than once. You should also make sure that you always have enough condoms for your needs. This is easy, because the clinic will give you as many as you need.

Using condoms correctly every time is the only way to make sure that the AIDS germ does not get into your body.
What are STDs?

Sexually transmitted diseases (STDs) are infections of the sexual organs. You can catch these diseases by having sex with someone who is already infected with an STD. You can catch an STD from an infected person even if you have sex only once. You can also have more than one STD at a time. Most STDs can be cured. But AIDS cannot be cured. The best way to avoid STDs is to limit your number of sexual partners and to use condoms.

The most common STDs are Gonorrhoea, Syphilis, Warts, Genital Herpes and AIDS. Most STDs can be cured at the clinic. Herpes cannot be cured, but it can be treated. AIDS, the killer disease, cannot be cured.

SYMPTOMS
If you have any of these symptoms, you may have an STD. Go immediately to the clinic for a check up.

- sores, blisters, rashes, swelling or warts ("cauliflowerers") around the vagina or penis. These may or may not hurt.
- a discharge or unusual smell from the vagina or penis
- itching, burning feeling or pain around the vagina or penis
- burning feeling or pain while urinating

Some STDs also cause swollen glands, pain in the abdomen, as well as other symptoms.

Not all STDs are easy to see. Women often have ulcers or warts inside the vagina. Women should use a mirror to examine themselves for STD symptoms.

You must always check your own sex organs carefully to make sure that there are no symptoms of STDs. If you have any of these symptoms, you should go immediately to the clinic.

AIDS
In most cases you will know if you have an STD, because you will have symptoms. But AIDS is different. You can look and feel healthy but still be infected with the AIDS germ (HIV). The AIDS germ does not kill you straight away. It can live in your body for many years before you have any symptoms.

People who have STDs are in great danger from AIDS. STDs make it easy for the AIDS germ to get into your body. That is why you must get all STDs treated immediately. The sooner you get treated, the less the danger of you getting AIDS.

If STDs are not treated, they can get much worse and make you very sick. If you are pregnant, they can be passed to your unborn child. They can make you unable to have children. Therefore it is very important to get treatment as soon as possible.

TREATMENT
If you have an STD, go immediately to the clinic for treatment. Do not try to treat yourself. This can be dangerous and can make the problem worse.

Both you and your partner must be treated. If you get treatment but your partner does not, you will become infected again. If you have more than one partner, you must tell them all to go to the clinic.

You can now get treatment for STDs at any clinic. If you have an STD, you should stop having sex. You should not have sex again until the treatment is complete. If you do, you must always use condoms. You must take all the medicines that the clinic gives you, otherwise they may not work properly. You must never share your medicines with anyone else.
Some examples of STDs

Here are some pictures showing STDs. Some of these STDs are very bad. This is because they were not treated immediately.
Do not allow your STD to get worse. If you think you have an STD, go straight to the clinic for treatment. Remember, the longer you delay treatment, the worse your STD will become and there will be a greater chance of getting AIDS.

**DISCHARGE ("Drop")**
This picture shows discharge from the penis. Women can also have discharge from the vagina. If there is an unpleasant smell coming from your vagina, this may mean that you have discharge. Discharge is one of the most common symptoms of STDs. If you have discharge, go to the clinic immediately. Do not have sex until the discharge is cured. Your partner must be treated too.

**GENITAL WARTS ("Cauliflowers")**
This picture shows genital warts, also known as "cauliflowers".
These can be on the penis or vagina, or on the skin around the sexual organs. They may or may not hurt. Genital warts are easy to cure as long as they are treated as soon as they appear. The longer you leave them, the worse they will get, so go for treatment now!

**A SERIOUS CASE OF "CAULIFLOWERS"**
This picture shows what can happen if you do not get treatment for genital warts. This woman's vagina is completely covered in "cauliflowers". When they get as bad as this, they have to be surgically removed. Don't make the mistake that this person made. If you have a "cauliflower", no matter how small, go to the clinic immediately!

**GENITAL HERPES**
This picture shows genital herpes. This rash can be found on the penis or vagina. It can get much worse than this. Genital herpes cannot be cured. Once you have it, it will stay with you for life. But if it is properly treated, it can be kept under control. If you or your partner have this rash, be careful. Always use condoms. Herpes can also be transmitted to the mouth, so avoid oral sex.

**GENITAL ULCERS (sores) (WOMEN)**
This picture shows the most common kind of ulcer or sore that women get on, around or inside their vaginas. The ulcer may be hidden in the folds of the vagina, so always check your vagina carefully for any sores. Use a mirror to help check yourself carefully. There may be one or more of these sores. Sometimes they may be painful, sometimes not.

**MEATY SORES**
This picture shows lesions (sores) which are a result of an STD not being treated. These sores started out as a small sore, but now they have spread and are much more difficult to cure. Don't let this happen to you! If you see any kind of sore, blister, or rash on your sexual organs, go to the clinic immediately for treatment.

**GENITAL ULCERS (Sores) (MEN)**
This picture shows the most common kind of ulcer or sore that men get on their penises. The ulcer may be hidden under the foreskin, so always check under the foreskin. There may be one or more of these sores. Sometimes they may be painful, sometimes not. Notice also that this man has a swelling in the gland above the penis.

**SWOLLEN GLAND**
Sometimes STDs can cause a painful swelling in the glands above the sexual organs, in both men and women. This man has a large swelling in his gland. If this swelling is not treated, it can burst. Once it bursts, it will take longer to heal. If you have a swollen gland, this may mean that you have an STD. Go immediately to the clinic for treatment.
EX NEWS ANSWERS  TEN QUESTIONS

These are the ten questions people most often ask about STDs.

QUESTION 1: How do sexual actions (STDs) get into your body?

SEX NEWS: STDs are caused by actions (germs) which are shed from an infected person to other person during sex. The action is carried in the semen of a man, or in the moisture in a woman's vagina. If your partner has an STD, this is passed into your body during sex. Once the action gets into your body, it can make you sick.

QUESTION 2: Do many people have STDs?

SEX NEWS: Yes, many people are infected. Many do not even know. People who have more than one sexual partner are most likely to have STDs. If you sleep with more than one person, you are taking a risk. If your partner has slept with someone else, you are also at risk. The best way to avoid risks is to be faithful to your partner and make sure that your partner is faithful to you.

QUESTION 3: How do you know if you have an STD?

SEX NEWS: There are many different kinds of STDs. (See page 7) If a man has an STD, there will usually be symptoms (signs). These may be discharge from the penis (the drop) or sores (ulcers), or swollen glands above the sexual organs. If a woman has an STD, there may be sores on or inside her vagina. But some STDs are not easy to see. Many women carry STDs inside their sexual organs without knowing about them.

QUESTION 4: How do you know if your partner has AIDS?

SEX NEWS: You cannot know by looking at someone whether they have AIDS. AIDS is the most dangerous STD of all. Your partner may have the AIDS germ in his or her bloodstream for years without knowing about it. And you can become infected by that person without knowing about it. The only way to be sure you do not have AIDS is to have an AIDS test.

QUESTION 5: If you have an STD, how can it be cured?

SEX NEWS: The only way to cure STDs is to go to a doctor or clinic for treatment. You will be given a course of tablets (pills) to take. These tablets are antibiotics. They will kill the infection. You must finish all the tablets, or they will not work properly. Remember that some STDs such as AIDS and Herpes, cannot be cured.

QUESTION 6: If a friend offers you some tablets which he or she was given at the clinic, can you use them?

SEX NEWS: No. You must go to the clinic and get your own tablets. Do not use other people's tablets.

DON'T TRY TO TREAT

Some people try to make their STDs go away by putting Dettol, Jeyes Fluid, muti from traditional healers or other substances on their sores. This can be dangerous because it can cause damage to the sensitive skin, and can lead to other infections.

If you find you have an STD, you must go immediately to
ABOUT STDs
Here are the answers.

**QUESTION 7:** Can you have sex after you have had an STD?

**SEX NEWS:** Sure, but only once you have finished all your tablets and the STD is cured. But you must make sure that your partner is also cured, otherwise you will infect each other again. It is very important not to have sex until you are sure that both of you are cured. If you are not sure whether both of you are cured, you must use a condom.

**QUESTION 8:** What must you do if you want to have sex with a person that you do not know very well?

**SEX NEWS:** If you don’t know who your partner has slept with before, then you must use a condom. If your partner has an STD, condoms will prevent the infection from getting into your body, if the condom is used correctly every time.

**QUESTION 9:** Many people think that by cleaning out their stomach using laxatives or “imbiza” (traditional medicine) they can cure STDs. Is this true?

**SEX NEWS:** No. Laxatives cannot cure STDs. Some people think that STDs are caused by impurities or “dirt” in their stomach or digestive system. This is not true. STD germs are not in the stomach or digestive system, so the laxative will not help.

**QUESTION 10:** Some people say that if a man sleeps with a woman after she has taken laxatives, he can catch an STD. Is this true?

**SEX NEWS:** No. People think that if they have sex with their partner while the “dirt” is still being passed from their partner’s system, they might become infected. This is not true. Emptying your stomach and bowels has got nothing to do with sex or STDs.
DO YOU USE
CONDOMS?

NO MORE WORRIES

"Me? I used to think that condoms were a joke. I used to make love to many young girls. I thought that I could never get sick from sex. Then one day I noticed that I had sores on my private parts. I asked my friend about them. He told me to be careful. He said that if you have sores, it makes it very easy for you to catch AIDS. I started to get worried. I kept wondering whether the girl I was with might have AIDS. If she had AIDS, it could get through my sores into my blood. I went to the clinic for treatment. Now my infection is gone. These days, it is not safe to have too many girlfriends. I always use condoms now and I am more careful about who I go to bed with. I don't worry so much anymore, and because I don't worry, I enjoy myself more."

SIPHO ISOKA,
OFFICE WORKER

I never thought that I could get sick from sex.

STAYING OUT OF TROUBLE

"I am on the Pill, because I don't want to get pregnant, but I always insist that my boyfriend uses condoms when we make love. It's much cleaner and safer, if you use them properly. You mustn't try to use them more than once, because then they don't work. In the beginning my boyfriend complained, but I told him that he could choose between condoms or no sex. He chose condoms. Now, we both enjoy sex much more, because we both know that we are protected."

VISHNI RAMSAMY,
SHOP ASSISTANT

I always insist that my boyfriend uses condoms.

EVEN GOOD GIRLS MUST BE CAREFUL

"Tell you about my sex life? I'm not the kind of woman who sleeps around. The only trouble is, these men of today, they expect you to have sex with them. Otherwise they will look for another girlfriend. And most of the time, they do not tell you the truth. They will say that you're their only one, then you'll walk into a shebeen and see them in some other woman's arms. Well, I know all about AIDS. I read the newspapers. And there are people in our community who have AIDS. There was a woman who lived near us who died of AIDS. And her baby died too. It was very sad, especially a child dying like that.

I am scared of AIDS, so I don't take chances. If I'm going out with a man, I carry some condoms in my bag. Even good girls must be careful."

JOHNNY REVRENN,
MOTORBIKE RACER

I'm not going to die young.

ZANDILE MKHIZE,
SECRETARY

I'm not the kind of woman who sleeps around.
A GOOD MAN IS HARD TO FIND

"The thing I want most of all in life is a good man. I want a nice home and children and a man who comes home every night. But such men are not easy to find. Most of them only want sex. Like my last boyfriend. He told me he loved me. He told me that he wanted to marry me. He said that we were going to be together forever. He wanted sex. He didn’t want to wait until we got married. So I had sex with him. Then he left me or a new girlfriend, and I discovered that he had given me a sexual disease. He left me with nothing but a disease! Now I insist on condoms. One day, when I marry the man of my dreams, we can have sex without condoms. Until then, no sex without condoms. I may not be able to protect myself from disappointment, but I can protect myself from disease!"

TAKING CARE TO BE SAFE

'I had a steady girlfriend, but I broke up with her when I found out she was unfaithful to me. We always used condoms, and now I'm glad we did, because I found out that I couldn't trust her. She could have become infected with an STD or AIDS from her other partner. Then I would have become infected too. Now I'm looking for someone new. I am studying to be an accountant. I want the best out of life, and I want a woman to share it with. When I meet the girl of my dreams and marry her, I'll stop using condoms and start having children. Until I am sure I have found my one true love, I'll use condoms. I am a careful person. I want to live long and enjoy my life, so I don't take risks."

WHEN TO USE CONDOMS:

A SEX NEWS GUIDE

When is the right time to use condoms?
This SEX NEWS guide will help you choose when to use condoms.

ONE FAITHFUL, LONG, STEADY RELATIONSHIP
If you and your partner are faithful to each other and you have been with that person for a long time, and neither of you has an STD, you do not need to use condoms. But remember that some STDs, especially the AIDS germ (HIV), can lie hidden in your body for years. You or your partner may be carrying AIDS or an STD from a previous partner long ago. You and your partner should have an AIDS test just to make sure neither of you is infected.

ONE STEADY RELATIONSHIP BUT WITH OTHER PARTNERS FROM TIME TO TIME
If you have been in a long, steady relationship with a person you know is not infected with AIDS or other STDs, but you have other partners from time to time, you must protect yourself and all your partners. You must use condoms with your other partners, even if you do not use condoms with your steady partner. Remember that casual sex places you and all of your partners at risk from STDs and AIDS. If you get an infection, your steady partner will get it too.

IF YOU CHANGE STEADY PARTNERS
If you change steady partners, then you must use condoms with your new partner. When you get a new partner, you should both get an AIDS test. When you are sure that neither of you are infected with AIDS or other STDs, then you and your partner should discuss not using condoms. But be sure that your partner does not have another partner. If you are not sure of your partner, use condoms.

IF YOU HAVE TWO OR MORE PARTNERS OR CASUAL PARTNERS
If you do not have a steady relationship, and have sex with a number of partners, use a condom every time you have sex. Always have enough condoms with you. If you think that a person may have an STD, do not have sex with that person. Be aware that you are at great risk of catching STDs and AIDS.
FIKILE: Uyazi 'o' ave nginenkinga. Intombazana yami inezilonda.

DULULU: Ayibo musukungibhedela wena-la uqale nini ukuba nengane wena?

FIKILE: Awukahle ukuzenza isilima 'o' uyazi ngiqonde ukuthini.

DULULU: Oooh, usho...

FIKILE: Uyazi ngisho ngichama umchamo uyangishisa, kanti nezimbilaphu zithi ngila.

DULULU: Yisifo socans'i leso esikuphethe 'o', kanti futhi siyalapheka eclinic.

FIKILE: (CYNICALLY) Waze wawumpetha-bo!

DULULU: Akuwena wedwa baningi nabanye abangaziqondi izimpawu zesifo socansi. Kanti-ke uma ushitsha wumchamo, kunezilonda, noma kuphuma okukwasansumpa ngaphambili, kubuhlungu noma kungebuhlungu, noma ikanjani "usuqhumile".

FIKILE: Uluthathaphi lonke lolulwazi olungaka ngezifoso socansi.

DULULU: Uthini-lo, kwamina sesake sangibamba.

FIKILE: Wena wasizwa yini, pho?

Script 2: English

Characters: 2 women, Dululu and Fikile

DULULU: Hey, my friend, I've been knocking at the door for ages - what's the problem?

FIKILE: (SIGHS) Hey, things are bad, Dululu.

DULULU: Your STD still hasn't gone away? So you've run away to your uncle's place because you didn't want to hear what I was telling you about the clinic?

FIKILE: But people have told me that I can treat it myself.

DULULU: What? Treat it yourself? That could be dangerous!

FIKILE: I've tried sheep dip, Dettol, laxatives - you name it. There's nothing I didn't try, but (IDIOMATIC) everything failed.

DULULU: But you didn't try the easiest way - and the one that's most reliable. (PAUSE) Have you been to the clinic?

FIKILE: The clinic? No, I know you've always been telling me about the clinic, and I haven't heeded your advice.

DULULU: Look, I'm helping you, as a friend - from my own experience.

FIKILE: Your own experience?

DULULU: Yes, Sipho and I were in the same situation as you. He also was stubborn in the beginning and didn't want to go. But after he'd been to the clinic he regretted the time he had wasted. (PAUSE, MOVING OFF MIC) OK, my friend, I have spoken to you and now I'm going.

FIKILE: No, wait - I'll walk with you so that I can hear more about it.

DULULU: That's a wise move. Another important thing is that you must not leave your boyfriend behind so he doesn't re-infect you while you are getting treated - and he can get treated too.
DULULU: Mngani wami ulele kade ngingqonqoqoza. Kwenzenjani?

FIKILE: (SIGHING) I shuuu... Kubi Dululu.


FIKILE: Phela abantu bathi ngingazilapha ngokwami.


FIKILE: Sengizame osheep-dip, odetholizihlanziso, wena maphilisi okukhipha, akukho la ngingazamanga khona, kodwa kwahlungazisaimukomoya.

DULULU: Engathi uyeke yonandlela elitula, nethembeke ukwedu-lula zonke. (PAUSE) Usuke waya-nje eclinic?


DULULU: Kufanele ngikusize mngani wami, kwengikwazelayo.

FIKILE: Okwazelayo?

DULULU: Phela mina noSipho sasisenkingeni efana ngwa neyakho, naye waqale wangabaza njengawe, kodwa sesilashiwe eclinic, wakhalela isikhathi ayesimosile. (PAUSE, MOVING OFF MIC) Kulungile mngane wami sengikutshelile, manje sengiyahamba.

FIKILE: Ungabe usangishiya, khona ngizozwa kahle.

Characters: 2 men, Themba and Sipho

THEMB: Eita Sipho, my broe! I hear that you and Fikile are getting married.

SIPHO: No, my brother, she has changed her mind.

THEMB: Hey, what's happening, man?

SIPHO: She says if she marries me she might get children who are not well - who are born dead or die immediately after they are born.

THEMB: Hey, such bad luck! Are you two related?

SIPHO: No. That's not it.

THEMB: So maybe she doesn't smack you any more.

SIPHO: No, we smack each other blindly (IDIOMATIC: a lot). It's just that I have some sores - here, in front. I'm bust (IDIOMATIC: I've been caught by STD).

THEMB: Hey, you have an STD! Then why don't you go to the clinic? They can destroy that disease.

SIPHO: I thought maybe it would eventually go away.

THEMB: Even if it looks like the STD has gone away, if you haven't had treatment you must know that it could still be doing a lot of damage inside you, and could affect your fertility.

SIPHO: Don't say any more! I didn't know that Fikile was right. (MOVING OFF MIC) Hey, hey, hey, hey...

THEMB: It's true. Also it can happen that you have children who are born blind, or have cancer.
SIPHO: Oh, no! I don't want to hear more.

THEMBA: (CALLING OUT) Hey, Sipho, where are you going now?

SIPHO: (OFF MIC) Don't ask any more questions. I'm going to look for Pikile so that we can go to the clinic. When we get well, then it's wedding time. I'm not going to take a chance with my fertility!
Script Three: Zulu

THEMBA: Elfa, Sipho my bro, ngizwa ukuthi nizimisele ukutrowa noFikile?

SIPHO: Useyagxuma mfowethu.

THEMBA: Yini zishaphi manje?

SIPHO: Uthi uma eshada nami ngingase ngimtholise abantwana abangasile kahle, abazalwa sebeshonile noma bashone besanda kuzalwa.

THEMBA: Amashobolo anje? Niyizihlobo yini?

SIPHO: Lutho.

THEMBA: Akasakuncanywa mthaka.

SIPHO: Sincanywana blind, ukuthi-nje nginezilonda ngaphambili - ngiqhumile.

THEMBA: Habe yisifo socansi leso! Pho, awuyingani eclinic? Basishaya basibhuqe lesosifo?

SIPHO: Bengithi mahlayeni sizoziphelela.

THEMBA: Kanti-ke uma ubona engathi siphelile isifo socansi ube ungayanga eclinic, noma ungaqeledanga ukwelashwa, ubokwazi ukuthi styaqhubeka ngaphakathi. Kanti futhi singawenza nononakalo esizalweni sakho.

SIPHO: Ungabe usaqhubeka! Kanti uqinisile uFikile! (MOVING OFF MIC) Hawu, hawu, hawu!

THEMBA: (CALLING OUT) Hey! Sipho uyaphi manje?

Script Four: English

Characters: 1 man, 1 woman: Sipho and Fikile

FIKILE: Hey, Sipho, why are you standing out the clinic? Why don't you go in? Have you forgotten that we arranged to meet inside so we can get treated?

SIPHO: I'm still undecided. I don't want to be troubled by those scandalmongers (SLANG) inside there. I've heard that there are people who have a big mouth, that there's no privacy when you go to the clinic for STD treatment.

FIKILE: Don't worry - it's your right as a patient to be treated at the clinic, and to be welcomed there without feeling embarrassed.

SIPHO: By the way, how did it go with you, since you come from there? How did those scandalmongers respond?

FIKILE: I found that we are not the only ones who are suffering from STD. There are lots of others. Those who were coming for their final treatment couldn't stop talking about how quickly they got better.

SIPHO: Don't tell me it's true, that there are really others (like me)?

FIKILE: Listen as I tell you. (IDIOMATIC) Believe me, it's true. Come, I'll keep you company. Let's go inside the clinic. You'll see yourself that it's not only us.

SIPHO: Keep me company? Who says I'm scared of the people (at the clinic)? (GRADUALLY MOVING OFF MIC) I'm not shy. I was just standing around for fun. I'm going into the clinic now. Check you later.

FIKILE: (LAUGHING) Hey, you!
FIKILE: Hawu weSipho umeleni ngaphandle kweclinic awungeni ngani? Engathi sivumelane ngokuthi sizohlangana ngaphakathi sizolashwa.

SIPHO: Ngimamqikanqika, ngingena ukunakwa ocheckers langaphakathi. Ngizwe kuthiwa kunabantu abanesipepe abashawodanayo uma uzolapha isifo socansi kuleli clinic.

FIKILE: Kanti-ke ungesabi, kuyilungelo lakho njengesiguli ukwelashwa, futhi uzizwe wamkelekile e-clinic, unahlambalazwa.

SIPHO: Kambe kuhambwe kanjani kuwe njengoba usuphuma khona. Banjani ocheckers?

FIKILE: Ngithole ukuthi akuthina sodwa esiphethwe yisifo socansi, bakhona nabanye. Abesebezoqedela ukwelashwa bebebabaza ukuthi bayashesha ukwelulama.

SIPHO: Awuthi istru' kanti bakhona nabanye?


FIKILE: (LAUGHING) Eyi wena!
Script Five: English

Characters: 1 man, 1 woman: Sipho and Fikile

SIPHO: Hey, I never believed that the clinic could cure STD's like this. You really helped me.

FIKILE: I'll only be glad when you're completely cured and those swollen glands are gone.

SIPHO: The fact is that I am much better than before.

FIKILE: (CLEARLY SENSING HIS INTENTION) Well, Sipho, my darling - sleep well. I'm going home now.

SIPHO: But I thought we were going to sleep together today. I'm telling the truth - I'm really much better now! It's true!

FIKILE: No, no, no! Sipho, my darling, this disease will not get cured if we sleep together before we have completed our treatment.

SIPHO: Fiki, my darling, don't be stubborn (IDIOMATIC: act like a stone). How can you just leave me like this?

FIKILE: I thought you were the kind of guy who doesn't like to use condoms.

SIPHO: That was a long time ago. Can you believe it. I actually took the free condoms that they had at the clinic.

FIKILE: (IN DISBELIEF) You? The Sipho I know - collecting a condom?

SIPHO: No, I didn't collect a condom - I collected some condoms. So, are you staying or leaving?

FIKILE: (JOKINGLY) Don't be so cheeky, Sipho!
Script Five: Zulu

SIPHO: Hey! Bengingazi ukuthi eclinic banosizo olungaka ngezifo zocansi.

FIKILE: Mina ngothokoza usuphila nalezimbilaphi zakho seziphelele.

SIPHO: Iqiniso wukuthi-nje sengingcono kakhu kuNaklua.

FIKILE: (CLEARLY SENSING HIS INTENTION) Hayi ke! Sipho mtakwethu uzolala kahle, sengiyagoduka manje.

SIPHO: Hawu, bengithi uyalala namhlane - ngiqinisile sengingcono ngempela! Stru’!

FIKILE: Cha, cha, cha! Phela Sipho mtakwethu ngeke saphela isifo uma sihlengana ngokobuhlili singakaqedi ukwelashwa.

SIPHO: Hawu awukahle ukuzenza (Ey! awe uyi) isitini Fikile mtakwethu. Uqinisile nonesi ungitshelele lokho, kodwa wasethi uma kwenzeka kungcono sisebenzise icondom.

FIKILE: Engathi wena uyiloluhlobo oluthi aluyingeni eyamacondoms/eyejazi lomkhwenyana.

SIPHO: Mhlawumbe wangigcina kudala, Kulokhu ngizithathele minca atholakala mahhala eclinic.

FIKILE: (IN DISBELIEF) Wena Sipho, wathatha icondom?

SIPHO: Angithathanga icondom, ngithi ngithathe amacondom. So, uyalala noma uyahamba?

FIKILE: *(JOKINGLY)* Awukahle ukungicinela, wena Sipho.

SIPHO: Ey! awe uyi sitini Fikile mtakwethu. Kodwa uqinisile, nonesi ungitshelele lokho, kodwa wasethi uma kwenzeka kungcono sisebenzise icondom.

FIKILE: *(JOKINGLY)* Uyangipaqela. Awuthiicoathanger ngilengise izimpahla zami.
Script Six: English

Characters: 1 man, 1 woman: Manqofela and Dululu

MANQOKOFELA: So, my sweetheart, have you also started going around with "bodyguards" in your pockets and your handbag, like the rest of the in-crowd?

DULULU: "Bodyguards"? What do you mean?

MANQOKOFELA: Come closer. Let me tell you before anyone hears that you don't know...

DULULU: Ja?

MANQOKOFELA: "Bodyguards" - it means condoms!

DULULU: Don't play around. How must I know all these new words that you make up all the time? Anyway, how could I not arm myself with condoms when I know I'll be going out with you?

MANQOKOFELA: Don't imitate everything that others are doing. Condoms are for people who are suffering from STD.

DULULU: Even if you're not suffering condoms can protect you from AIDS. But I see why you call them bodyguards.

MANQOKOFELA: Ja, well, even if they do protect us, I don't have money to buy them every day.

DULULU: No, you can get them free from every clinic in the country! (SUSPICIOUSLY) But what would you do with them every day? Hmmm... By the way, we cherries (women) have a nickname for a condom that tells how powerful it is.

MANQOKOFELA: What do you call it?
DULULU: "Bullet-proof!"

MANQOKOFELA: (LAUGHS) So, there's no danger in having fun - as long as you use a...?

DULULU: Bodyguard!

MANQOKOFELA: Which is bullet-proof!

DULULU: Whatever you call it - it means...

MANQOKOFELA and DULULU: A condom! (LAUGHING TOGETHER)
Script Six: Zulu

MANQOKOFELA:  
Ek se sweetheart, kambe nce sesikugenile lesitayela sokuhlaie uhamba nama-bodyguards emaphaketheni noma ku-handbag yakho?

DULULU:  
Yini amabody...?

MANQOKOFELA:  
Sondela-la ngikuhlebele bangaze bakuhleke abaningi.

DULULU:  
Ja?

MANQOKOFELA:  
Phela ama-bodyguards ama-condom.

DULULU:  
Musudlala-la wena, kodwa ngingawazi ngani wonke lamagama ohlale uwoqamba? Kanti-ke ucabanga ukuthi bengayeka ukuhloma ngamacondom ngibe ngazi ukuthi ngizovakasha nawe?

MANQOKOFELA:  
Ungabolingisa into ongayazi. Yinto yabantu abaphethwe yisifo socansi leyo.

DULULU:  
Ngisho ngabe awuphethwe yilutho, amacondom yiwo akuphephisa ngishe nakungculaza imbala. Ngingacishe ngikuvumele uma uwabiza ngama-bodyguards.

MANQOKOFELA:  
Yize ephephisa, mina angisoze ngaba nemali yokuthenga amacondom zonke izinsuku.

DULULU:  
Atholakala mahhala kuwomonke ama-clinic akuleli. (SUSPICIOUSLY) Kazi ungabe uwenzani, nobantu ke zonke izinsuku dade? Hmmm... Thina ma-cherrie sinesiteketsiso segama elichaza amandla estivikela ngayo i-condom.

MANQOKOFELA:  
Nithi yini nina?

DULULU:  
Thina sitihi yi: "Bullet-proof".

MANQOKOFELA:  
(LAUGHS) Oh, kusobala ukuthi akunankinga ukuzidumisa, kuphela-ije uma usebenzisa i...?
DULULU: Bodyguard!

MANQOKOFELA: Ekuyi bullet-proof!

DULULU: Noma i...

MANQOFELA and DULULU: I-condom! (LAUGHING TOGETHER)
Script Seven: English

Characters: 2 women: Nok'thula, Fikile, and 2 men: Sipho, Bongani

NOK'THULA: Tell us, Fikile and Sipho, how true is it that since Bongani and I are suffering from STD we're now in danger of getting HIV/AIDS?

FIKILE: Nok'thula, it's quite true. It's because the AIDS virus likes to go into open spaces.

BONGANI: What do you mean?

SIPHO: Bongani, you know how with STD you can get some sores?

BONGANI: You mean the ones that are exposed?

FIKILE: There are also ones that you can't see, but whether you can see them or not, those sores are like doors. And HIV is like a ruthless murderer who enters into any of those doors that are waiting - wide open - for the HIV killer to enter.

SIPHO: We protected ourselves by using a door that has such resistance that whatever tries to pass through finds no way to enter (IDIOMATIC: until it becomes a waste). A condom.

BONGANI: You mean that you also were once suffering from STD?

SIPHO: Well, it's true that the people who have experience are the people who are able to give information. (A BIT NERVOUSLY) Fikile and I had STD and we were helped (saved) by the clinic. But that is our secret.

NOK'THULA: Relax, I knew already. Fikile told me that you two have visited the clinic - that's why I told Bongani that we should talk to you.
NOKTHULA: Ake nisitshele Fikile nawe Sipho, kuyiqiniso kangakanani ukuthi sinoBongani njengobaiphethwe yisifo socansi sisengozini yokuba nengculazi.

FIKILE: Iqiniso Nok'thula, wukuthi, igciwane lengculazi liyayithanda indawo evulekile.

BONGANI: Usho ukuthini?

SIPHO: Bongani, angithi kuyenzeka ophehthe yisifo socansi, abenezilonda?

BONGANI: Eh-hhe, ziba sobala.


SIPHO: Thina sazivikela ngokusebenzisa umnyango ovimba into eyoziyolahlwa: Ijazi lomkhwenyana/ Icondom

BONGANI: Kanti nani sesake saniphatha yini isifo socansi?


NOKTHULA: Ungahlupheki, mina bese ngivele ngazi, uFikile wangitshele kudala, yingakho size kunina.
APPENDIX D: Sex News Pretest Questionnaire

Explain to participant(s) that you want them to read Sex News which was developed by the Medical Research Council and then answer some questions about the magazine. Do not explain what the magazine is about as this may bias responses. Explain to participants that they must feel free to express their opinions when answering the questions, that we want to hear what they think despite whether it is good or bad.

Ask the participant if they would like to read the magazine in English or Zulu. Give the participant a copy of Sex News in the language they requested and give them sufficient time to read it (+/- 30min) before answering the questionnaire.

1.1 What do you think of the magazine you have just read?

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

1.2 Is there anything you like about it?

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

1.3 Is there anything you dislike about it?

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
1.4 Is there anything in the magazine that your friends and family would be offended by?

Yes____ No____

1.5 If yes, what is offensive and why?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

1.6 How would you feel about discussing this magazine with your friends?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

(Probe: Would you feel comfortable/embarrassed etc.)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

1.7 What do you think of the following parts in the magazine?

(Probe: like/dislike, interesting/uninteresting, informative, appropriate, relevant, offensive etc)

a) The name of the magazine "Sex News"

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

b) The story on page one and three, "Bongani's story", including the pictures?

________________________________________________________________________
________________________________________________________________________

(pictures)________________________________________________________________________
c) The photographs on page seven, "Some examples of STDs"?


d) "Sex News answers ten questions about STDs" on page eight and nine?


2. Comprehension of the main idea/message

2.1 What do you think are the main ideas/messages that the magazine is trying to put across?


Anything else?


2.2 Are the messages in the magazine easy to understand or hard to follow?
2.3 Was there anything that you found confusing in the magazine?
Yes: ___________________________________________________________
No: ___________________________________________________________

2.4 If yes, what was confusing?
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

2.5 Were there any parts (words) that your friends would have difficulty in understanding?
Yes: ___________________________________________________________
No: ___________________________________________________________

2.6 Which parts/words?
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

2.7 Is the language used in the magazine the same language as that which you would use when discussing this with friends?
Yes: ___________________________________________________________
No: ___________________________________________________________

2.8 If not, what language would you use?
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

2.9 Which words would you change?
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
3. Credibility

3.1 Do you believe the information presented in the magazine?
Yes: __________________________________________
No: __________________________________________

3.2 Is there anything you did not believe?
__________________________________________
__________________________________________
__________________________________________

3.3 For what kind of person would the magazine be most useful?
__________________________________________
__________________________________________
__________________________________________

3.4 Was there anything in the magazine that would be useful to someone like you?
__________________________________________
__________________________________________
__________________________________________

3.5 Did you learn anything new from this magazine?
__________________________________________
__________________________________________

3.6 What did you learn?
 __________________________________________
__________________________________________
__________________________________________

3.7 What other information would you like the magazine to give you?
__________________________________________
__________________________________________
__________________________________________

Elaine Epstein
3.8 Do you have any suggestions you would like to make on how to improve it?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

3.9 What changes would you like to make to make it more

* understandable:
________________________________________________________________________

________________________________________________________________________

* believable
________________________________________________________________________

________________________________________________________________________

* useful
________________________________________________________________________

________________________________________________________________________

* relevant to you
________________________________________________________________________

________________________________________________________________________

4. Demographics

4.1 Gender: Male: _____ Female: _____

4.2 Age: _____ (yrs)

4.3 Married: Yes: _____ No: _____
4.4 Children:  Yes:  ____ No:  ____

4.5 If yes, number of children:  __________

4.6 Do you listen to the radio? Yes:  ____ No:  ______

4.7 If yes, what is/are your favourite programme(s)?
APPENDIX E: Radio Campaign Pretest Questionnaire

Advert Number: ___

1. Observation

Explain to participant(s) that you want them to listen to a radio advert that was developed by the Medical Research Council and then answer some questions about the advert. Do not explain what the radio advert is about as this may bias responses. Explain to participants that they must feel free to express their opinions when answering the questions, that we want to hear what they think despite whether it is good or bad.

Ask participants if they are ready.

Turn on the tape recorder.

Make sure that the advert you are listening to corresponds with that marked on the top of the questionnaire.

Observe the participant while they are listening to the radio advert and try and assess the following:

Turn over the page and complete the next section while participant is listening to the advert
1.1 Did the participant/audience listen to the message the entire time

Yes ____ No ____

1.2 Did the participant/audience appear to be interested in the message

Yes ____ No ____

1.3 Did the participant/audience appear to be confused, distracted or bored

Yes ____ No ____

Changes in expression (Observe for laughter/empathy etc.)

1.4 Comments:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

STOP THE TAPE AFTER YOU HAVE PLAYED THE ADVERT TO BE TESTED

2. Questions after exposure

2.1 What do you think of the advert you have just heard?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

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2.2 Is there anything you like about it?

________________________________________________________________________

________________________________________________________________________

Probe:

music___________________________________________

characters_________________________________________

dialogue__________________________________________

2.3 Is there anything you dislike about it?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Probe:

music___________________________________________

characters_________________________________________

dialogue__________________________________________

2.4 Is there anything that your friends and family would be offended by?

Yes____ No____

2.5 What is offensive?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
2.6 Why is it offensive?


2.7 How would you feel about discussing this advert with your friends?


(Probe: Would you feel comfortable/embarrassed etc.)


3. Comprehension of the main idea/message

3.1 What do you think is the main idea/message that the radio advert is trying to put across?


Anything else?


Elaine Epstein
3.2 Does the advert want you to do anything in particular?


3.3 What does it want you to do?


3.4 Would you do it if you were in the similar or same position as the character in the advert?


3.5 Why/Why not?


3.6 Is the message easy to understand or hard to follow?


3.7 Was there anything confusing about the message?
Yes: ___________________________
No: ___________________________
3.8 If yes, what was confusing?

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

3.9 Were there any parts (words) that your friends would have difficulty in understanding?
Yes: ______________________
No: ______________________

3.10 Which parts/words?
(NB! Give participant a copy of the script to look at or offer to play the tape again)

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

3.11 Is the language used in the advert the same language as that which you would use when discussing this with friends?
Yes: ______________________
No: ______________________

3.12 Why/Why not?

_______________________________________________________________

3.13 If not, what language would you use?

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

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3.14 Which words would you change?

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

4. Credibility

4.1 Do you believe the information presented in the message?
Yes: _________________________________________________________________
No: _________________________________________________________________

4.2 Is there anything you did not believe?
Yes: _________________________________________________________________
No: _________________________________________________________________

4.3 What?
____________________________________________________________________

4.4 Are the characters who presented the information in the message believable?
Yes: _________________________________________________________________
____________________________________________________________________
No: _________________________________________________________________

4.5 For what kind of person would the message be most useful?
____________________________________________________________________

____________________________________________________________________
4.6 Was there anything in the message that would be useful to someone like you?


4.7 Did you learn anything new from this message?


4.8 What did you learn?


4.9 What other information would you like the advert to give you?


4.10 Do you have any suggestions you would like to make on how to improve it?


4.11 What changes would you like to make to make it more

* understandable:


* believable


Elaine Epstein
5. Demographics

5.1 Gender: Male: ____ Female: ____

5.2 Age: _____(yrs)

5.3 Married: Yes: ____ No: ____

5.4 Children: Yes: ____ No: ____

5.5 If yes, number of children: __________

5.6 Do you listen to the radio? Yes: ____ No: ______

5.7 If yes, what is/are your favourite programme(s)?