HIV/AIDS COMMUNICATION AND YOUTH BEHAVIOUR IN SOUTH AFRICA: A STUDY OF FEMALE HIGH SCHOOL STUDENTS IN THE EASTERN CAPE PROVINCE

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DECLARATION

I, Mpofu Nkosinothando, do hereby declare that except for references indicated as such in the text, and any other help as I have acknowledged, this dissertation is wholly a product of my own research, opinion, analysis and industry and has not been submitted in fulfilment of the requirements for degree purposes or academic examination towards any qualification at any University.

Signed: ----------

NKOSINOTHANDO MPOFU

Date:

DEDICATION

I DEDICATE THIS WORK TO MY FAMILY (TAPIWA, HAZEL AND ASHLEY) AND MY DEAREST MOTHER, MRS MPOFU. YOU ARE MY SOURCE OF INSPIRATION.

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ABSTRACT

Human Immuno-Deficiency Virus and Acquired Immune-Deficiency Syndrome communication remains one of the most significant tools in the fight against HIV/AIDS given the absence of the cure to fight the growth and spread of the global pandemic. Through the use of information, HIV/AIDS communication seeks to empower recipients or societies with skills that will help reduce their risk of infection. South Africa has seen a high visibility of HIV/AIDS communication programmes or campaigns aimed at empowering different audiences, whilst paying particular emphasis on the most vulnerable. Young people, in particular young women, have a higher prevalence of HIV/AIDS in South Africa. This has prompted the development of many youth focused communication campaigns which have sought to address factors that increase young people`s vulnerability to HIV infection. However, despite the high visibility of HIV/AIDS communication campaigns targeting young people, high risk behaviours are still being seen among young women. Important to note are the high teenage pregnancy rates, growing abuse of substances and even the premature engagement of sexual activities among female youths. This, therefore, raises questions on the effect of HIV/AIDS communication programmes in encouraging protective behaviour against risky behavioural practices amongst young women. Using both quantitative and qualitative research approaches to this study, an investigation was conducted into whether current HIV/AIDS communication campaigns have been limited (in terms of effectiveness) when it comes to communicating with young women on issues relating to HIV/AIDS. Awareness of HIV/AIDS and HIV/AIDS communication programmes, relevance of HIV/AIDS communication programmes, the factors that influence the use and understanding of HIV/AIDS messages and the impact of HIV/AIDS communication on attitude and behaviour change amongst female youths is measured. A total of 350 questionnaire copies were self-administered to 350 participants, with a 100 percent response rate. From the 350 participants, seventy five took part in focus group discussions. Data obtained was analysed using SPSS (for descriptive statistics), and the grounded theory. The results of the study indicate that all participants were aware of HIV/AIDS with at least 60% of the participants aware of at least three HIV/AIDS communication campaigns. When measuring the relevance of HIV/AIDS communication campaigns, participants (58%) indicate that issues discussed in most HIV/AIDS communication campaigns increased the relevance of HIV/AIDS messages to

young women although such relevance was, for some respondents, affected by limited access to communication campaigns. Results also show that levels of knowledge and understanding of factors that expose young women to HIV infections differed amongst participants in as much as the factors that hinder the use of advice contained in HIV/AIDS messages also differed. Sixty-nine percent of the participants have knowledge and a better understanding of factors that expose young females to HIV infections. Twenty-five percent of the participants identified peer pressure, whilst 23% identified limited access to HIV/AIDS communication campaigns and another 18% identified a disregard of HIV/AIDS messages as significant factors that limit the ability of individuals to implement advice contained in HIV/AIDS messages. The results also indicate that although HIV/AIDS communication campaigns seem to have played a role in empowering some participants, there is still a significant minority whom communication has not effectively communicated with. Based on these findings, the study suggests, amongst other things, the need to intensify current HIV/AIDS communication campaigns through the provision of consistent messages on appropriate condom use, the identification of easily accessible communication channels and the development of thought provoking and attention grabbing campaigns as well as the need to continue to directly involve young women in the processes of their own development.

Key Words: HIV/AIDS, HIV/AIDS Communication, Female youths, Behaviour, Eastern Cape Province

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

CHAPTER ONE

INTRODUCTION

1.1 INTRODUCTION

HIV/AIDS communication is regarded as a critical component in the fight against HIV/AIDS. The unavailability of an HIV/AIDS cure has contributed to the significance of prevention efforts as the best method of mitigating the spread of the epidemic, and curbing its effect on society. As such, a number of HIV/AIDS communication campaigns have been developed to empower societies on appropriate behaviour with regard to the deadly epidemic. In countries like South Africa, there has been tremendous growth in the use of HIV/AIDS communication campaigns since the first case of HIV/AIDS was recorded. Different communication campaigns have been developed for different audiences to address a number of concerns regarding HIV/AIDS. Despite the presence of such communication, South Africa retains a high prevalence of HIV/AIDS in comparison to other countries in the world; this is a development which qualifies it as one of the countries worst hit by the epidemic. Tragically, not only is prevalence high in the country, it has also affected a significant percentage of young people, especially female youths (Shisana, Rehle, Simbayi, Zuma, Jooste, Pillay-van-Wyk, Mbelle, Van Zyl, Parker, Zungu, Pezi & SABSSM, 2009). Based on the statistics provided by UNICEF (2011), a decline in HIV infection among young women has also been recorded in some cases, however, the decline is not yet significant enough to declare victory over the epidemic.

Studies have been conducted on the impact of HIV/AIDS communication prevention efforts amongst the youth (both male and female) with results indicating some change their perceptions of HIV/AIDS and their willingness to adopt more protective behaviour against

HIV/AIDS. Results have also shown varying trends in the success of HIV/AIDS communication efforts, with some studies indicating success in certain variables and failure in others that are considered critical in mitigating the spread of the epidemic. Although studies indicate some level of change amongst the youth, in terms of perception and behaviour, it is clear that what is presented on paper is, to some extent, different from what transpires in action when it comes to HIV/AIDS and female youths in South Africa. According to Karim (2011), it is of great concern that the HIV/AIDS prevalence amongst 15-24 year old South African female youths is not showing a decline. Karim (2011) states further that there is a high incidence of HIV, driven by the age-sex difference amongst young women in South Africa, with many young women currently acquiring HIV around their sexual debut, at 14 or 15 years of age. Shisana et al. (2009) also maintain that the infection rate of female youths is twice that of males in the same age group in South Africa. Figures also indicate that of the 5.4 million youths living with HIV/AIDS worldwide, over 3 million constitute female youths (UNAIDS, 2007).

In a bid to understand this prevailing scenario amidst the large volumes of HIV/AIDS communication, which have sought to address the various factors known to exacerbate the spread of infections amongst young women, a legitimate question arises: could the effectiveness of the communication campaigns have been limited in certain aspects when it comes to communicating with female youths? Or, is the impact of such communication different on males and females, to an extent that requires different communication strategies and campaigns to be employed for different groups?

In light of the concerns raised above, this study attempts to investigate the possible limitations of current HIV/AIDS communication campaigns, in South Africa, concerning communicating with female youths. The purpose of this chapter is to locate the study in its

proper context. Firstly, the chapter provides a discussion of the background to the study, followed by a discussion of the problem statement of the study. Discussions on youth behaviour and HIV/AIDS, the research questions as well as the objectives of the study are also provided in this chapter. In addition, this chapter focuses on the location of the research, the scope and limitations of the study whilst also providing the justification for this study. Finally, this chapter provides a definition of the key terms used in this study.

1.2. BACKGROUND TO THE STUDY

HIV/AIDS is still a serious threat in most states, affecting not only the health of individuals but also the socio-economic state of any country. An approximate 34 million people worldwide were living with HIV/AIDS in 2011; a clear indicator of the unprecedented levels of the HIV/AIDS epidemic in the world (UNAIDS, 2012). According to UNAIDS (2008), South Africa has the highest infection rate in the world. In 2009, South Africa had a prevalence estimate of 6 million people living with HIV/AIDS, with over 1000 people being infected with the deadly epidemic daily (UNAIDS, 2010). Soul City Institute further states that, since 2004, HIV/AIDS has been claiming an approximated total of 300, 000 people per year in South Africa. Such prevalence of HIV infections clearly shows that there is more to be done when it comes to mitigating the disease, especially when the disease seems to be affecting the active population in the society.

Of the total infected population, globally, 45% are youths under the age of 25 (UNAIDS, 2008). Thus, young people between the ages of 15 and 25 are more vulnerable to HIV/AIDS infections. In addition, 3500 new HIV infections were recorded daily, in 2008, amongst 15-24 year old youths worldwide (UNAIDS 2009). This global trend is also prevalent in South Africa where 9.6% of youths were infected with HIV in 2008 (Setswe,

2009*)*. Of the youths living with HIV/AIDS, studies have shown that the female youths constitute a greater percentage than male youths (Shisana et al., 2009).

According to UNICEF (2011), there were approximately 5 million youths living with HIV/AIDS globally in 2010, and over 3 million of this number are female youths. In Sub-Saharan Africa alone, young women accounted for 70 percent of all new infections in 2009, among young people, whilst South Africa had an approximate estimate of 14 percent of female youths infected with HIV/AIDS in 2010 (UNAIDS, 2010; UNICEF, 2011). In addition, Shisana, et al. (2009) state that the prevalence of HIV/AIDS among female youths in South Africa is twice that of the males within the same age group. Although HIV/AIDS figures seem to vary from one study to another, they all point to an exceptional need to deal with the pandemic that is posing a serious threat to young people in societies.

A number of factors have been identified as responsible for increasing the vulnerability of young women to HIV infection. Research has shown that the biological make-up of women contributes to the easy transmission of infections from one person to the other (UNFPA, 2005). However, there are other critical factors (which an individual could have control over) that have been identified as playing a role in the spread of HIV/AIDS, and these are briefly discussed below.

The early onset of sexual activity amongst youths, which is rarely followed by a return to abstinence, has significantly contributed to the rise in HIV infections amongst the youth, with females losing their virginity early in comparison to their male counterparts (Lioeanjie, 1996). Such early onset of sexual activity can put female youths at greater risk of acquiring any sexually transmitted disease. Moreover, as a result of early engagement in sexual activities, an increased number of teenage pregnancies have been recorded in South Africa. One in three girls has had a baby by the age of 20, with 16% of pregnant women

under the age of 20 testing positive for HIV (Harrison, as cited by IRIN, 2007). According to Van Dyk (1999), high numbers of teenage pregnancies clearly indicate a significant percentage of adolescents practising unsafe sex, despite knowledge of sexual matters. Pettifor, Maesham, Rees & Padian (2004), further state that teenage pregnancy in South Africa is a strong predictor of HIV/AIDS infections amongst female youths. It is clear that female youths are continuously exposed to HIV infections as a result of unsafe sexual activities which are pursued, despite the many HIV/AIDS communication programmes advocating safer sexual practices.

Female youths also remain at the greatest risk of acquiring HIV as the number of females who have partners who are five or more years older than themselves has increased substantially from 18,5 percent in 2005 to 27,6 percent in 2008 (Katz & Low-Beer, 2008). According to Katz and Low-Beer (2008), this is seen as an important factor that has also contributed to the spread of HIV amongst females as their ability to negotiate for protective sexual behaviour is compromised due to the existing power dynamics between the parties involved. Furthermore, Dworkin & Blankenship (2009) state that young women fail to negotiate for safer sexual practices, like condom use, because of the existing gender inequalities and, as such, remain at a high risk of being infected. Related to this is the issue of multiple concurrent partners (MCP). MCP is a critical factor that fuels the spread and growth of HIV as infections are easily passed on to more than one partner as a result of engaging in sexual activities with more than one person at a time (Parker, Makhubele, Ntlabathi & Connolly, 2007).

Economic instability is another factor that continues to expose young females to infections. According to UNFPA (2009), economic instability or poverty usually leads to

relationships where sex is exchanged for material goods. Such practices tend to exacerbate the spread of HIV/AIDS, particularly for women (Dworkin & Blankenship, 2009).

Drug abuse is also another factor that has increasingly become of concern among women as the use of drugs is gradually increasing amongst females and has contributed to the many unfortunate cases of HIV/AIDS infections (Zhusupov, 2000). Fisher, Williams, Austin, Camargo & Colditz (2007) maintain that there is a strong link between substance use and risky sexual behaviour. Substance abuse strengthens one`s vulnerability to HIV infections (Zhusupov, 2000).

The use of contraceptives has also contributed to high HIV infections among female youths as they believe that the contraceptive methods will protect them against HIV/AIDS in the same way that it prevents pregnancy (Van Dyk, 1999). Such misconceptions have led to the practice and adoption of unsafe sexual practices which expose individuals to HIV infection.

In the absence of a clear-cut cure for HIV/AIDS, health communication has continued to play a pivotal role in controlling the spread of the pandemic. As such, effective HIV/AIDS communication must build skills that will help protect individuals from contracting the disease and motivate them to adopt protective behaviour against HIV/AIDS (Deane 2007). This means that the development and design of such communication campaigns will contribute significantly to the kind of influence the message has on society.

The first HIV/AIDS communication strategies and campaigns to be developed were individualistic in nature, as an individual was regarded as having the ability to make decisions without any external influence when it comes to HIV/AIDS issues (Airhihenbuwa, Makinwa & Obregon, 2000). Such communication did not yield the expected outcomes as a

number of limitations were identified from the communication campaigns. Notably, communication failed to acknowledge the social, cultural and even environmental factors which exert much influence on the manner in which individual decisions regarding issues concerning HIV/AIDS are taken. It is such concerns that led to the development of HIV/AIDS communication strategies and campaigns which sought to address the context in which an individual existed. In this instance, environmental factors or societal influences were seen as critical factors towards individual decision making (Airhihenbuwa, et al., 2000). As a result of this change in focus, current HIV/AIDS communication strategies and campaigns use an integrated approach that allows communication efforts to address various influences which are critical in the spread or reduction of HIV infections in societies.

With such a shift in the focus of current HIV/AIDS communication, why is the outcome not as good as expected? Effective communication must support a change in attitude towards HIV/AIDS and eventually lead to behaviour change. However, this is what communication campaigns have struggled to achieve since their inception. Could this suggest a need for another shift in the focus of HIV/AIDS communication in order for communication to motivate people to adopt protective behaviour against HIV/AIDS? Could there be any limitations in the HIV/AIDS communication currently used in South Africa, concerning communicating with female youths?

The study pays particular attention to five selected HIV/AIDS communication brands in South Africa, with the aim of examining how they have and are communicating with young people and whether there are limitations to those campaigns. The communication brands include the *Khomanani campaign, Scrutinize campaign, Soul City campaign, Love Life campaign* and the *Siyayinqoba Beat It! campaign*. These have been discussed at length in chapter three.

1.2.1 ADOLESCENCE, RISK BEHAVIOUR AND HIV/AIDS

Human behaviour has contributed immensely to the spread and growth of HIV around the world. As such, it has become the main focus of many HIV/AIDS intervention programmes as behaviour change remains an important factor in the reduction of HIV infections globally. Risk behaviour, in particular, has increased the chances of infections amongst individuals and it describes the chance or possibility of a bad consequence resulting from a certain act (Nikolova, Carignan, Moscovitz & Demers, 2004). Nikolova et al. (2004) continue by asserting that risk behaviour denotes behaviour that includes concepts of dangerous, aggressive and problematic behaviours which, in relation to health, can expose an individual to adverse health outcomes (Boyer & Keggles, 1991). Risk behaviour includes dangerous lifestyle aspects like smoking, alcoholism, drug abuse and risky sexual activities (Richter, as cited by Nikolova et al., 2004). Such activities can increase the incidence of HIV/AIDS.

Young people, on the other hand, have been associated quite strongly with risk behaviour. Adolescence is a stage in one's life where there is greater exploration, opportunity and even risk (Boyer & Keggles, 1991). Adolescents basically have the drive to want to experiment with a lot of "things", barring the consequences of whatever behaviour they engage in. According to Boyer & Keggles (1991), experimenting with tobacco, alcohol, sex and drugs are rites of passage for many adolescents. These lifestyle aspects which have become common among youths expose their health to danger.

Sexual risk behaviours, which are also prevalent among adolescents, can result in unintended health outcomes for these youths. Risky sexual behaviours such as inconsistent condom use and sexual intercourse with multiple partners are relatively common among adolescents in South Africa (David et al., 2006:259). Such risk behaviour places young people at risk of HIV infection, sexually transmitted diseases and even unwanted pregnancies

(which have become rampant among female adolescents). It can therefore be inferred that there is a strong relationship between high risk behaviour and the spread of HIV infections.

The recognition of the role of behaviour in the spread and in reduction of the growth of the epidemic, largely amongst the youth, has prompted the development of communication campaigns which discourage risky behaviour whilst advocating for the adoption of protective behaviour. Such communication campaigns are expected to go a long way in empowering the youth against HIV/AIDS, hence the need for constant evaluation of HIV/AIDS communication programmes in order for communication to achieve its intended results. The following section offers a discussion of the problem statement of the study and a justification of the need to conduct such a study.

1.3 PROBLEM STATEMENT

As a result of the increased commitment from government and other health organisations in the fight against HIV/AIDS, South Africa has experienced a high visibility of public campaigns and a large number of communication programs that hope to reduce the spread of HIV/AIDS. However, with all these communication efforts, HIV/AIDS remains a significant threat to the health of South Africans, especially female youths (Swanepoel, 2005). According to Karim (2011), it is of great concern that HIV/AIDS prevalence amongst 15-24 year old female youths in South Africa is not showing a decline. Despite the visible campaigns, the prevalence of HIV amongst female youths remains at levels that are of concern and, thus, poses a great challenge to the society. According to a study by Statistics SA, no fewer than 160, 754 school girls fell pregnant between July 2008 and July 2010 (Govender, 2012). Mclea (2011) states further that an alarming number of teenagers in South Africa are having unprotected sex, resulting in thousands of unplanned pregnancies which, according to Pettifor et al. (2004), are a strong predictor of HIV infections. In Gauteng, 1,756

teenage girls gave birth between April and December 2010 whilst another 203 had abortions during the same period (Mclea, 2011). This damming picture also prevails in the Eastern Cape where Ellis (2012) contends that one teenage abortion takes place on average every 10 minutes at clinics in the province, with the Eastern Cape recording the third highest number of teenage pregnancies in 2009. For some young women, abortion is now seen as a way of preventing pregnancy instead of using contraceptives or condoms which are advocated in HIV/AIDS communication. According to Ellis (2012), not even the risks of contracting HIV/AIDS or other sexually transmitted diseases deter the province`s teenagers from becoming pregnant.

Condoms, both male and female, are a widely available contraceptive choice that can reduce the transmission of STI as well as unwanted pregnancies. However, the percentage of South African youths who used a condom in their last sexual encounter ranges from only 44 to 48 percent of young women, and approximately 53 to 57 percent of young men (MacPhail, Pettifor, Pascoe & Rees, 2007). Recent studies show an increase in the use of condoms amongst young people, but this is clearly not enough to prevent the transmission of STDs and unwanted pregnancies, as indicated by the current high numbers of teenage pregnancy in South Africa.

Pregnancy is not the only indicator of the adoption of high risk behaviour amongst teenagers. Substance use is spiralling out of control amongst young people in South Africa, with a growing number of female teenagers consuming alcohol (Reddy, Panday, Swart, Jinabhai, Amosun & James, 2003). Teenagers and alcohol are two words which are commonly put into the same sentence. According to Reddy, Panday, Swart, Jinabhai, Amosun & James (2003), studies have shown an increase in alcohol consumption amongst adolescents, where binge drinking was reported amongst one in four high school students.

Binge drinking is most commonly known as five drinks for males and four drinks for females in one sitting (Reddy et al., 2003). The relationship between alcohol or substance use and the spread of HIV is significant, with some infections having occurred when people were under the influence of alcohol or drugs. Studies have also shown that this understanding is limited to some teenagers.

The age-sex difference has also contributed to many young women acquiring HIV around the time of their sexual debut. According to Katz & Low-Beer (2008), the number of South African young women involved in intergenerational sex is growing and this increases their risk of HIV infection. The tendency, in such relationships, is that power dynamics come into play and the health of young women may be compromised. With older partners, young women are usually not in a position to negotiate for safe sex and this increases their vulnerability to HIV/AIDS. In support of the above, Karim (2011) contends that the age-sex difference has significantly contributed to the high HIV incidence among young women in South Africa.

In another study conducted by Katz and Low-Beer (2008), to understand the stabilization of HIV/AIDS prevalence amongst young people (15-24 years) in South Africa and why prevalence has not declined, results indicated some level of behaviour change and moderate risk behaviour amongst young people. This is despite the fact that prevalence still remains high when compared to that of their counterparts in countries like Uganda. The same study also noted an inconsistent use of condoms and an extended age distribution of risk together with age and partner mixing. These increase the risk of infection amongst young people. Based on its findings, the study suggested the need for comprehensive HIV prevention in South Africa that needs to be intensified to clearly promote consistent condom

use and a reduction in sexual partners as well as a focus on the transmission dynamics which include older age groups (Katz & Low-Beer, 2008).

A number of studies have been conducted to evaluate the impact of different HIV/AIDS communication campaigns on different audiences (Bertrand & Anhang, 2006). With reference to young people and HIV/AIDS, impact data from both male and female youths has been used to indicate a change in perception among them (Katz & Low-Beer, 2008). Much of the existing literature provides information on the impact of HIV/AIDS communication from a combination of female and male perspectives. Although research has focused much on the impact of communication, few or limited studies have been conducted to investigate why a significant decline in terms of HIV/AIDS figures among young people has not been recorded despite literature showing a change of attitude among young people. In particular limited research exists to explain why, despite the visible HIV/AIDS communication campaigns, young women are still engaging in high risk behaviours. It is from this point of view that this study seeks to investigate why high risk behaviours are still prevalent among young women in the Eastern Cape despite the many HIV/AIDS communication campaigns they are exposed to.

If HIV/AIDS communication is effective, why are such high risk tendencies still prevalent amongst female youths? Could it be that current HIV/AIDS communication may still have limitations when it comes to effectively communicating with female youths towards the adoption of protective behaviour against HIV/AIDS? Or, could the continued adoption of high risk behaviour among female youths suggest the existence of new factors that are not being addressed by the current HIV/AIDS communication campaigns? Finally, are there factors or other influences affecting the translation of HIV/AIDS messages into protective behaviour?

It is from this point of view that this study attempts to investigate the possible limitations, if any, of HIV/AIDS communication on female youths in South Africa. The study focuses specifically on High School female youths in the Eastern Cape, between the ages of 15 to 19, as representative of other female youths at risk of HIV infection. In order to engage in this investigation, the study is informed by the research objectives discussed below.

1.4 RESEARCH OBJECTIVES

The main aim of the study is to investigate the possible limitations, if any, of the current HIV/AIDS communication campaigns on female youths in South Africa. The specific objectives of the study are as follows:

1. To investigate the extent to which female high school students in the Eastern Cape are aware of HIV/AIDS, the factors that can expose them to HIV infection and the sources of HIV/AIDS information.

2. To investigate the relevance of HIV/AIDS messages, in terms of the issues addressed, digestibility and accessibility, to female high school students in the Eastern Cape.

3. To investigate and examine factors that influence the understanding and use of advice contained in HIV/AIDS communication campaigns amongst female high school students in the Eastern Cape.

4. To determine the extent to which HIV/AIDS communication campaigns have been effective in influencing attitude and behaviour change, regarding HIV/AIDS, amongst female high school students in the Eastern Cape.

1.5 RESEARCH QUESTIONS

Based on the objectives of the study, this research attempts to answer the following research questions:

1. To what extent are female high school students in the Eastern Cape aware of HIV/AIDS, the factors that can expose them to HIV infection and the different sources of HIV/AIDS information?

2. To what extent are HIV/AIDS messages relevant, in terms of the issues addressed, digestible and accessible to female high school students in the Eastern Cape?

3. What are the factors that influence the understanding and use of advice contained in HIV/AIDS communication amongst female youths in the Eastern Cape?

4. To what extent have the HIV/AIDS communication campaigns been effective in influencing attitude and behaviour change regarding HIV/AIDS, amongst female youths in the Eastern Cape?

1.6 RESEARCH CONTEXT

This study is located in the Eastern Cape Province of South Africa. This province, according to DEDEA (2008), is marked by widespread and deep poverty; racial, class and geographic inequality and backlogs in public services. High unemployment is seen as one of the contributors to the deep poverty characterising the province. As a result, this has increased the number of people, and their level of dependence, on government social grants (DEDEA, 2008). In a survey conducted by the provincial government in 2006, 64.4 percent of households in the Eastern Cape depended on social grants like the old age pension, child care grants and even disability grants (DEDEA, 2008); this is a clear depiction of the nature of poverty in the province.

Young people, and women especially, in the rural Eastern Cape are the most affected by unemployment, poverty and disease. Poverty, high unemployment rates, backlog in public services, especially health services, as well as geographic inequalities are seen by many scholars as the major contributors in the spread of diseases. This statement may serve to explain the current trends of HIV/AIDS and other infectious diseases in the province. Such factors limit access to health care services and even health information which can lead to the making of uninformed decisions. For poor women, poverty creates economic dependence on those who are economically stable. In such relationships, the power to negotiate for safe sexual practices is lessened whilst increasing the risk of infection for women.

In terms of HIV and AIDS, the Eastern Cape Province is one of the worst hit in the country; where life expectancy is below 50 years and unspecified HIV-related diseases account for the highest number of deaths (EC Annual Report, 2006). According to the 2008 HRSC survey, there was an estimated prevalence of HIV/AIDS of 15.2 percent amongst 15 to 49 year olds in general. Based on the estimated HIV prevalence amongst antenatal attendees, between the ages of 15 to 49 in the Eastern Cape, it is evident that the prevalence of HIV has continued to grow amongst these women. In 2008, 27.6 percent were infected whilst 2010 saw an estimated 29.9 percent of pregnant women being infected (Avert, 2011). In addition, prevalence also increased amongst the 15-19 year old antenatal attendees. As of 2008, there were 14.1 percent of infected young women, with this number decreasing to 13.7 percent in 2009 and later increasing again to 14.0 percent in 2010 (UNICEF, 2011). The Eastern Cape is also amongst the top three provinces that have recorded high teenage pregnancy rates in the country. According to Ellis (2012), the annual surveys for Ordinary Schools for 2009-2010 report revealed that of the 45,276 pregnancies of pupils, 8,420 were from the Eastern Cape Province. This is despite the widespread health communication programmes advocating for

safer lifestyles. The increasing number of teenage pregnancies is cause for concern, as these have contributed to the increasing number of HIV infections amongst young women.

Clearly, the Eastern Cape Province is one of the provinces that require an increased presence of health communication programmes. An increase in health communication programmes will also increase exposure to HIV/AIDS messages that will empower people to look after themselves and live healthier lifestyles, regardless of the prevailing circumstances which are likely to increase their chances of infection. Particular attention must be given to the most vulnerable of the society in order to equip them against the epidemic. In this case young people, in particular young women, are seen as one group most affected by the epidemic in the province. The high prevalence of teenage pregnancy and the adoption of other high risk behaviours have thus compelled the investigation of this study in the direction of ascertaining whether there are any limitations to current HIV/AIDS communications targeting the youth, or whether there has been a development of other mediating factors in the behaviour of female youths towards HIV/AIDS.

1.7 SCOPE OF THE STUDY

- This study focuses on high school female students between the ages of 15 and 19 in the Amathole District of the Eastern Cape, as representatives of young women, in general, who are vulnerable to HIV/AIDS infections in the province. The study focuses on the Eastern Cape given that the province has been listed among the most affected by HIV as shown by, amongst other things, the high teenage pregnancy rates in the province accompanied by the high prevalence of HIV/AIDS amongst young women between the ages of 15 and 19 who are attending antenatal classes.
- The study involves schools from both rural and urban settings for a balance of views from the participants.

- The study specifically focuses on understanding why young women still continue to adopt high risk behaviours which can increase their chances of being infected by HIV, despite the many HIV/AIDS communication campaigns in South Africa. The study therefore investigates whether there are any limitations to current HIV/AIDS communication campaigns in terms of communicating with young people, in particular young women, regarding HIV/AIDS issues.
- The study provides a detailed description of the selected five common HIV/AIDS communication campaigns in South Africa to discuss the various themes addressed by these campaigns. This is done in a bid to try to understand whether there are issues still not addressed by the communication currently available, which could help protect young people from infection.

1.8 LIMITATIONS TO THE STUDY

- High school female students in the Amathole District of the Eastern Cape might not necessarily be representative of all female youths who are vulnerable to HIV infections in the Eastern Cape Province.
- Information collected for this study is largely from individual self reports which could influence the outcome of the study.
- Students participating in the study have different socio-economic and education backgrounds which have an influence on the results of the study.

1.9 JUSTIFICATION FOR THE STUDY

South Africa is one of the countries with the most HIV infections in the world, with young people representing a significant percentage of people living with HIV/AIDS (UNAIDS, 2008). South African female youths between the ages of 15-24 have an even higher prevalence of HIV, as it is estimated that the HIV/AIDS prevalence amongst female

youths is twice that of their male counterparts. Not only has South Africa recorded high HIV infections amongst female youths, it has also recorded a high rate of teenage pregnancy within the global context (Harrison, 2007). Teenage pregnancy is seen as a strong predictor of HIV infections as it indicates the extent to which teenagers are engaging in unsafe sexual activities (Pettifor et al., 2004). The high prevalence of teenage pregnancy amongst female youths is simultaneous with the growing use of substances like alcohol as well as the age and partner mixing amongst this group, which increases their vulnerability to HIV infection. Therefore, with such a prevalence of HIV/AIDS, the growing number of teenage pregnancies and the increasing use of alcohol amongst female youths, an investigation into the impact of HIV/AIDS communication campaigns becomes important in order to examine whether there are factors that hinder the translation of knowledge into protective behaviour amongst female youths.

A number of studies which focus on evaluating the impact of HIV/AIDS communication on youths have been conducted on a general scale: i.e. impact data has been collected from both male and female youths using the same evaluation questions. This study will, however, attempt to gather the impact data of HIV/AIDS communication from the perspective of female youths. It will do so by exploring and examining participants' views regarding the effectiveness of current communication campaigns concerning communicating with female youths in South Africa. According to Airhihenbuwa (2000), the quality and effectiveness of interventions designed to reduce HIV/AIDS transmission is as critical as ever, making it significant to investigate any limitations to the current communication strategy. If no limitations are identified, such impact data will provide insights into the causes of a continued involvement in risky behaviour amongst female youths.

The study is therefore relevant in the South African context where there is an urgent need to reverse the transmission rate of HIV infection amongst young people. The insights obtained through this study will possibly help in the improvement and the possible identification of new communication strategies that will assist in the achievement of the goal of changing attitudes and behaviours amongst the most affected groups. In addition, the findings of the study will hopefully help service providers to place more focus on programmes geared towards encouraging the sexually active to engage in safer sexual activities that will reduce their exposure to HIV infection. The study basically seeks to extend, and possibly add to, the knowledge base that already exists on the impact of HIV/AIDS communication strategies on the targeted audiences, in particular, female teenagers.

The study focuses on Eastern Cape high school females as representative of female youths affected by the pandemic. The study further explores the five identified communication brands to assess their strengths and abilities to foster behaviour change amongst the youth, by addressing circumstances that could fuel the spread of the pandemic. Basically, the study hopes to unveil whether there are any limitations to the current HIV/AIDS communication strategy in order for communication to improve and be able to foster behaviour change with regards to HIV/AIDS.

1.10 DEFINITION OF KEY TERMS

HIV/AIDS COMMUNICATION: can be described as the dissemination of HIV and AIDS information to target groups, towards encouraging protective behaviour against HIV. It is communication that tackles beliefs, attitudes and social norms that fuel risky behaviour within societies. As such, it can be regarded as communication that seeks to instil the proper

and correct perceptions, knowledge and information of HIV/AIDS, enabling recipients to make informed decisions on protective behaviour against HIV/AIDS.

YOUTH BEHAVIOUR: can be described as the actions or reactions of a person in response to external or internal stimuli (Johnson et al., 2002). In the context of this study, it refers to the reactions of youths in response to HIV/AIDS communication advocating for a change of negative attitudes to positive attitudes which will support the adoption of protective behaviour against HIV/AIDS.

HIGH SCHOOL FEMALE STUDENTS: this refers to female teenagers between 15-19 years of age, currently registered in High Schools of the Eastern Cape Province.

LIMITATIONS: the shortcomings or weaknesses of intervention programmes in their implementation and achievement of their intended results or goals. This could include whether recipients have a clear understanding of the HIV/AIDS messages and are able to implement the advice contained in HIV/AIDS communication strategies.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

Thirty years since the first case of HIV was discovered, the struggle against the epidemic seems far from over. New infections are recorded daily whilst the death toll increases as a result of HIV/AIDS related diseases. The prevention and control of the spread of the HIV/AIDS pandemic remains a top priority especially in countries that have the highest prevalence. So far, HIV/AIDS communication, besides antiretroviral drugs, remains the most significant tool in mitigating the spread of HIV. It (HIV/AIDS communication) seeks to ensure that people, particularly those who are vulnerable, have adequate skills and knowledge to help protect themselves from HIV infections through the provision of accurate and relevant HIV/AIDS information. However, with much efforts put in HIV/AIDS communication, the expected outcome, mainly change of sexual behaviour, has not yet been fully realised. There seems to be a gap between knowledge acquisition and the translation of knowledge into positive behaviour change regarding HIV/AIDS. It is for this reason that this study attempts to investigate whether there are still limitations to current HIV/AIDS communications targeting the youth, female youths in particular, in South Africa, so that they inhibit a change of behaviour amongst this group.

To gain a clearer understanding of the issues relevant to HIV/AIDS, HIV/AIDS communication and its impact, a number of issues related to HIV/AIDS and HIV/AIDS communication are discussed in this chapter. The chapter provides a general historical background of HIV and a brief overview about the development and role of Health and HIV/AIDS communication. The chapter also provides a discussion into obstacles or factors

that exacerbate the spread of HIV/AIDS amongst young women as well as the challenges to and of HIV/AIDS communication. The chapter concludes with a discussion of the empirical framework of the study.

2.2 DEFINING HIV AND AIDS

The Human Immuno-Deficiency Virus (HIV) is the virus that causes the Acquired Immune-Deficiency Syndrome (AIDS) (Kalichman, 2003:17). The virus directly affects the immune system which the body uses to protect it from infections and it is passed on from one person to another through bodily fluids (Avert, 2010). According to UNAIDS (2006), the epidemic comes in successive waves, with the first being HIV infection and then followed several years later by a wave of opportunistic diseases. This is followed by the wave of AIDS and, eventually, death. At this stage the defence system of the body has been completely attacked by the virus (UNAIDS, 2006). Behaviour, in particular sexual behaviour, plays a critical role in the spread of HIV and AIDS within communities, hence the need for preventive measures that advocate for safer and protective behaviour thereby reducing the spread of the disease.

2.2.1 HIV/AIDS BACKGROUND

HIV/AIDS is unquestionably still a serious cause of concern for many nations. Since the virus was first discovered in the 1980s, it continues to grow in many nations (Singhal & Everett, 2003). Although success stories have been recorded in some countries, the general and prevailing picture globally is that of an epidemic which continues to grow and end the lives of many infected people. Therefore, to offer a general background into HIV/AIDS, global and South African contexts are discussed here. This section also considers the extent to which the youth, especially female youths, are affected by the epidemic.

2.2.2 HIV/AIDS GLOBAL CONTEXT

According to UNAIDS (2012), an estimated 34 million people around the world were living with HIV/AIDS in 2011. This figure has increased from 33.4 million in 2009, indicating the continued growth of the pandemic globally. The epidemic is seen as one of the leading causes of death worldwide, with over 1.8 million people having died of HIV and AIDS in 2010 whilst 2. 7 million new infections were recorded in the same year, at a rate of 6 800 persons per day (UNAIDS, 2010). Of the total figure of people living with HIV/AIDS around the world, sub-Saharan Africa constitutes a greater percentage. Far more infections have been recorded in sub-Saharan Africa than in any part of the world; with the epidemic being described as the worst epidemic in the world. At the end of 2010, an estimated 22.9 million people were living with HIV/AIDS in sub-Saharan Africa (UNAIDS, 2011). According to UNAIDS (2006), seventy two percent of all AIDS related deaths are in sub-Saharan Africa and only in sub-Saharan Africa can you find over eighty five percent of HIV pregnant women (WHO, 2007). On a global scale, HIV/AIDS has taken a particularly devastating toll. Many people are infected while some are affected by the problems associated with HIV/AIDS.

Amongst those affected by the epidemic are the youth. Young people are disproportionately affected by the epidemic worldwide. Young people in the 15-25 age group accounted for 40 percent of all new infections in 2008, whilst 3000 new infections were recorded daily amongst the youth worldwide (UNAIDS, 2009). According to UNICEF (2011), an estimated 5 million young people between the ages of 15-24 were living with HIV/AIDS in 2010, with a third of all new infections occurring within this age group. Statistics further show that more than 180 million, out of the global total of 340 million sexually transmitted diseases other than HIV/AIDS, occur among young people aged 15 to 24

(WHO, 2007). Such a trend of infection amongst the youth is a serious cause for concern and, where possible, must be met with strict measures that will help reduce the transmission rate amongst this age group.

Sub-Saharan Africa again constitutes a greater percentage of the youths infected by the epidemic. There were approximately 2.7 million infected youths in sub-Saharan Africa at the end of 2009 (UNICEF, 2010); clearly indicating that sub-Saharan Africa is the hardest hit worldwide. Although young people are vulnerable to HIV/AIDS, young women remain the most vulnerable and the urgency of addressing their vulnerability cannot be overstated. Of the estimated 5 million young people living with HIV/AIDS, over 3 million represent female youths. Young women are more vulnerable to HIV infection and, as such, account for a greater proportion of the infected young people (UNICEF, 2010). In sub- Saharan Africa alone, young women accounted for an estimated 70% of all infections in young people at the end of 2009 (UNICEF, 2010). UNAIDS (2006) further maintains that young women between 15 and 24, worldwide, are 1.6 times as likely as young men to be HIV positive. It is thus obvious that although HIV/AIDS is taking a devastating toll on society, it has done so amongst female youths at a greater magnitude. In particular, most infections seem to be occurring between 15 to 24 year olds, which indicates a need to pay particular attention to this group (Pettifor, et al., 2004) Prevention, treatment and care for this age group must be considered a matter of extreme urgency. Having provided a picture of HIV/AIDS globally, I now turn to a discussion of HIV/AIDS in the South African context.

2.2.3 HIV/AIDS IN THE SOUTH AFRICAN CONTEXT

South Africa is still in the grips of a devastating epidemic. Whilst other countries report significant decreases or reduced transmission rates, the epidemic continues to grow in South Africa. According to MacGregor (2001), South Africa has the highest number of

people living with HIV and the fastest growing epidemic in the world. An estimated 5.6 million people were living with HIV/AIDS in 2009 (UNAIDS, 2010). The magnitude of the epidemic is so intense such that over 1000 new infections are recorded daily, with an estimated 310 000 South Africans having died of HIV and AIDS in 2009 alone (UNAIDS, 2010). According to UNAIDS (2008), the national prevalence of HIV/AIDS has since increased from 16.2 percent in 2005 to 16.9 percent in 2008.

The prevalence estimates and the total number of people living with HIV/AIDS in South Africa vary from one study to another. However, what seems apparent, regardless of the variances, is that South Africa has been hard hit by the HIV/AIDS epidemic which many have described as the worst ever in the world.

Similar to other countries is the manner in which HIV/AIDS has taken its toll on the youth. Young people, particularly those between the ages of 15 and 24, represent a significant portion of people living with HIV/AIDS in South Africa. In 2005, the prevalence of HIV amongst the youth was at 10.3 percent, although this figure has since declined, according to current surveys (Shisana et al., 2005). Setswe (2009) places the prevalence of HIV/AIDS amongst 15 to 24 year olds at 9.6 percent for the year 2008. What has been a cause for concern regarding HIV and young people is that the HIV trend among them (15-24 year olds) does not show a desired or significant decline, even in instances were declines have been recorded. The situation is worsened even by the new infections recorded amongst the youth.

HIV prevalence amongst the youth is particularly high among young women, especially in the 15-24 year old category in South Africa. Young women in South Africa are five to six times more likely to be infected by HIV than their male counterparts in the same age group (Shisana et al., 2005). According to Shisana et al (2005) South Africa continues to have high infection rates amongst 15-24 year old females. This rise in infection rates has been

attributed to numerous factors, besides the biology of young women, and these will be discussed later in this chapter. Given that the study focuses on female youths in the Eastern Cape, more statistics are provided below to portray the contextual realities of HIV/AIDS and young women.

Characterised by poverty and high unemployment rates, the state of HIV/AIDS in the province cannot be any different. UNAIDS maintains that the Eastern Cape Province is one of three in South Africa where life expectancy is below 50 years and unspecified HIV diseases account for the highest number of deaths (EC Annual Report, 2006). According to UNAIDS/WHO (2006), the prevalence rate of HIV in the Eastern Cape was at 29.5 percent in 2005 compared to 23.6 percent in 2002; a clear indicator of an increase in HIV prevalence. Using the estimated HIV prevalence amongst antenatal attendees between the ages of 15 and 49 in the Eastern Cape, the prevalence of HIV has continued to grow amongst these women. In 2008, 27.6 percent were infected whilst 2010 saw an estimated 29.9 percent of pregnant women being infected (Avert, 2011). In addition, prevalence also increased among the 15 to 19 year old antenatal attendees. As of 2008, there were 14.1 percent of young women infected with HIV, with this number decreasing to 13.7 percent in 2009 and later increasing again to 14.0 percent in 2010 (UNICEF, 2011). Teenage pregnancy rates in the Eastern Cape are a matter of concern, as they have contributed to the increasing number of HIV infections. According to Pettifor et al. (2004), pregnancy is seen as a strong predictor of HIV infections.

Conclusively, one can argue that young women present a group of young people who are highly vulnerable to HIV infections owing to a number of factors which will be discussed later in this chapter. Prevalence continues to rise despite the many communication efforts that seek to equip recipients against HIV/AIDS. Could this, therefore, suggest that there could be limitations to current communication or have other mediating factors fuelling the spread of

HIV infections amongst young people in South Africa emerged? Below are tables that provide a comparison of HIV trends amongst 15-24 year olds in South Africa over the years.

2.3 TREND COMPARISON OVER THE YEARS

This section basically attempts to compare and discuss the HIV figures of female youths from different time periods. Such a comparison will help to provide an understanding into the prevalence of HIV/AIDS amongst the female youths and the extent to which young women have engaged in activities that could increase their vulnerability to HIV infection. The focus here is on young women aged between 15 and 24 years.

Table 1: HIV Prevalence Trend amongst 15-19 year old Females Attending Antenatal Clinic in South Africa from 2008-2010

Age	2008	2009	2010
15-19	14.1%	13.7%	14.0%

Adapted from National Antenatal Sentinel HIV & Syphilis Prevalence Survey, 2010

The figures in the diagram indicate that there was a decline in the HIV prevalence amongst the female youths between 2008 and 2009. However, the figures increased to 14.0% in 2010. This suggests that there is a fluctuating HIV/AIDS trend amongst young women, with statistically insignificant declines being recorded. Considering that there are cases that have not been recorded, or individuals that have not been tested, it seems apparent that HIV prevalence amongst young women remains a cause concern.

Table 2: Sexual Debut amongst 15-24 year old females in South Africa (2002, 2005, 2008)

Year	**Percentage**
2002	5.3 %
2005	5.1 %
2008	5.9%*

Adapted from Setswe (2009).

* The table shows that early sexual debut is on the rise amongst 15 to 24 year olds. Young women are seemingly engaging in sexual activities earlier than expected. In a study conducted by Lioeanjie (1996) it was discovered that female teenagers lost their virginity earlier than their male counterparts in the same age group. The main problem with an early sexual debut is that it can increase the incidence of HIV amongst young women.

Table 3: Intergenerational Sex among 15-19 year old Female in South Africa (2005, 2008)

Year	Within 5 years of own age %	Partner is 5+ years older %
2005	81.4	18.5
2008	72.4*	27.6*

Adapted from Setswe (2009)

*The statistics in Table 3 above show a decline in sexual activity with partners who are within one's age group, whilst showing an increase in sexual activity with partners who are five or more years older than young women. The trend in such encounters is that power dynamics come into play and the health of young women may be compromised. With older partners, young women are usually not in a position to negotiate for safe sex and this could increase their vulnerability to HIV/AIDS.

Table 4: HIV knowledge amongst 15-24 year old females (2005, 2008)

Year	Percentage
2005	44.7
2008	27*

Adapted from Setswe (2009)

*This figure indicates a decline in the percentage of female youths with the appropriate and accurate knowledge of HIV; this is a matter of concern given the vast amount of HIV/AIDS communication available before and after 2008. UNICEF (2010) also maintains that in 2009,

only 26 percent of young women in sub-Saharan Africa had a comprehensive knowledge of HIV/AIDS.

The statistics displayed in the above tables simply show that much still needs to be done to achieve even more significant reversed transmission rates amongst the most vulnerable in South Africa. Comprehensive and strategic communication programmes are a necessity in order to provide target populations with the correct and relevant information and skills that will empower them against the pandemic.

With this discussion on the state of HIV/AIDS globally and in South Africa, it is worth noting that although differences may exist in terms of HIV/AIDS statistics, it is clear that HIV/AIDS has had a devastating impact on the lives of young women. The susceptibility of young women to the epidemic is exacerbated, beyond biology, by the interplay of a number of social factors (Fuller, 2008), which shall be discussed later in this chapter. It is also important to note, at this point, that this growth or trend in HIV infections amongst young women occurs despite their exposure to HIV/AIDS communication. It is this communication that endeavours to empower and equip recipients with skills that will help protect them from being infected. More so, with the changing nature of the epidemic, HIV/AIDS communication has also evolved to address all possible factors contributing to the spread of the disease. It is on this premise that this study investigates whether current communication has any limitations that could or are contributing to the failure of female youths to translate knowledge and attitudes into positive behaviour.

2.4 AN OVERVIEW OF HEALTH AND HIV/AIDS COMMUNICATION

Information is a key weapon in the battle against any disease. Technology alone and other hospital services cannot help to fully address the concerns that arise as a result of a disease (Jackson & Diffy, 1998). As such, the significance of communication was noted and led to the development of health communication. Although health communication has been present in the 1960s and 1970s, primarily as family planning, it only developed as a field in the 1980s (Obregon & Mosquera, 2005). According to Query and Bonaguro (cited in Jackson & Diffy, 1998), health communication developed over the last twenty-five years as a vibrant field of study concerned with the powerful roles performed by human and mediated communication in health care and promotion. Health communication thus emerged to enhance health promotion through the provision of health information (Jackson & Diffy, 1998). In this case, health information was regarded as an important resource in health promotion; of which communication becomes the central social process in the promotion of health (Jackson & Diffy, 1998).

According to Obregon and Mosquera (2005), health communication is recognized as a necessary element in the efforts to improve personal and public health as it contributes to all aspects of disease prevention; this includes physician-patient communication, adherence to treatment and the design, implementation and evaluation of public health communication.

As a way of definition, health communication is regarded as:

> A multi-faceted and multidisciplinary approach to reach different audiences and share health related information with the goal of influencing, engaging, and supporting individuals, communities, health professionals, special groups, policy makers and the public to champion, introduce, adopt or sustain a behaviour, practice or policy that

will ultimately improve health outcomes" (Health People, 2010 in U.S Department of Health and Human Services, 2005).

Health communication is generally conceived as a strategic process aimed at achieving a rational use of health services and improving the efficiency and effectiveness of programs directed towards disease prevention and health promotion (DrumBeat, 2005). The integral element to this strategic process is communication which, in turn, must be designed in such a manner that it will influence social norms or change the behaviour of individuals and communities against any disease. According to DrumBeat (2005), the primary objective of health communication is usually health related behaviour. Health communication must bring about improvements in health related practices and, in turn, health status (Graeff et al, 2003:13). For example, health communication on family planning must lead to an increase in the use of contraceptive methods. However, to achieve the intended behaviour, health communication must be able to address the human and environmental factors that directly or indirectly impact on one`s health (Graeff et al., 2003:19). By so doing, individuals or communities are motivated to adopt and sustain healthy behaviours.

Basically health communication, according to Obregon &Mosquera (2005), must therefore:

- Bring health to the forefront of the public agenda
- Reinforce a sanitary message
- Stimulate people to seek more and better information and
- Lead towards healthier lifestyles.

Only health communication that identifies and prioritizes key behaviours, segments audiences, designs messages based on scientific evidence and research, and reaches audiences through key channels whilst mobilizing communities to become involved in this process will be able to achieve the intended goals (Piotrow et al., 1997; Freimuth, 1992).

2.4.1 HISTORICAL PERSPECTIVE

There has been a significant shift in health communication over the past decades. Health communication was earlier characterised by high technology and hospital based concepts of health care which were largely concerned with the effects rather than the inclusion of audiences in their own development (Obregon & Mosquera, 2005). Such an approach follows the principles of the modernization paradigm of development which views communication as a one-way process of passing messages from one point to many others (Servaes, 1991). According to Salawu (2001), this paradigm conceived communication as having an all-powerful effect, akin to the discredited bullet (hypodermic needle) theory. This paradigm further maintains that for change to happen there must be a high degree of individual empathy and an attitude ready to abandon traditional beliefs and embrace change (Lerner, 1958). It further considers development as a linear, cumulative, evolutionary and unidirectional process through which "experts' disseminate information they regard as necessary towards the development of communities (Servaes, 1991). As a result, when using this approach, health communication followed a top-down fashion of communication, where communication and media were regarded as primary instruments of change. A one-way linear communication flow, with a sender passing a message to a receiver through a selected channel, characterised early health communication. Overwhelming influence was attributed to the media with the receiver being seen as a passive entity (Salawu, 2001).

This approach, as maintained by the modernization paradigm, does not support development to the desired levels. The same can be said of health communication that has adopted this approach. Hence, there was a shift conceptually and practically in health communication. The Declaration of Alma Ata (1978) was an important conceptual shift from previous health care and prevention (McDonald & Bunton, 2004). According to McDonald &

Bunton (2004), the spirit of Alma Ata`s declaration was mainly underpinned by communitarian values which aimed to enhance the democratic distribution of power in decision making. The community development movement emphasized the importance of involving people in their own development and the significance of such involvement was in its ability to transform people from passive recipients into active agents of development (Sanchez, 1994 in Obregon & Mosquera, 2005; Mefalopaulos, 2002). This included understanding the needs and social realities of the people and mobilising them towards the development goals (Salawu, 2001).

Ascroft and Masilela (1994:282) maintain that:

> if people do not control or share control in the processes of their own development, there can be no guarantee that it is in their best interest.

Community involvement thus creates individual responsibility for self care and allows health communication to be informed by the drawbacks and limitations inhibiting the translation of knowledge into action (Obregon &Mosquera, 2005). More so, community involvement supports a dialogue which is at the heart of communication, participation and even empowerment (Freire, 1997). This dialogue will allow for a clearer understanding of the environment surrounding people, how it directly or indirectly influences them towards certain behaviours as well as how to best counteract the threat to healthy life styles in communities (Freire, 1997).

Therefore, health communication in this context (participatory approach) has centred not only on exclusively achieving a change in behaviour but also in achieving effective communication by producing adequate, persuasive messages that respond to the symbolic universe of the target groups (Obregon & Mosquera, 2005). Such an achievement comes as a

result of dialogue and the horizontal flow of communication. Communication, in this case, loses its top-down connotations, as noted in the modernization paradigm, and becomes instead a tool of empowerment (Freire, 1997).

Following this discussion on health communication in general, the next section provides a discussion of HIV/AIDS communication, in particular the nature and role of HIV/AIDS communication in the fight against the epidemic.

2.5 HIV/AIDS COMMUNICATION

Unlike any other disease where communication is used alongside the available medication in combating the disease, a different scenario is presented with HIV/AIDS. Communication, as a preventive measure against the epidemic, remains a very significant tool in curbing the effects and spread of HIV. It remains a central aspect for almost all HIV/AIDS interventions.

Since HIV/AIDS was first discovered, a cure for the epidemic has not been found, arguably due to the changing nature of the epidemic. In response to the absence of a cure, HIV/AIDS communication was developed in a bid to mitigate the spread of the disease. HIV/AIDS communication sought to provide a broad based set of communication activities that seek to promote accurate knowledge about all aspects of HIV transmission as well as knowledge on risk reduction and prevention (Airhihenbuwa et al., 2000). Rather than the provision of services and treatment, communication remains the primary output of all HIV/AIDS communication activities. If effective, it is this communication that will generate knowledge amongst individuals, about services and commodities that reduce the risk of HIV infection.

Given the pivotal role of communication in controlling the spread of HIV infections, it thus suggests that HIV/AIDS communication must go beyond simply raising awareness about the epidemic. It must be designed in such a manner that it can transform individual and normative behaviour in a society (Airhihenbuwa et al., 2000). Although awareness is a prerequisite to change, it is not sufficient to minimize the spread of the epidemic (Singhal, 2000). With reference to the latter, one can therefore maintain that the role of HIV/AIDS communication in mitigating the spread of the disease is to deliver messages that:

- Go beyond raising and increasing awareness of the disease amongst target groups
- Change individual and community attitudes towards HIV/AIDS
- Build skills in an individual or community to protect themselves from infection
- Motivate and lead individuals or communities to adopt protective behaviour against HIV infection
- Allow and support the sustenance of adopted positive health behaviours.

HIV/AIDS communication therefore remains an essential tool in the reduction of high risk behaviour as well as the acceptance and reinforcement of positive and protective behaviour amongst target populations.

As previously stated, the development of HIV/AIDS communication arose as a result of the absence of a cure and the urgent need to reverse the spread of the disease. According to Airhihenbuwa et al. (2000), the development of this type of communication has largely been informed by the social psychology theories and models of behaviour that are believed to be effective in guiding behaviour-changing communication. These models and theories were central to the planning, implementation and evaluation of communication programs (Airhihenbuwa et al., 2000). As a result, these models determined the nature of communication interventions.

The early forms of communication supporting preventive healthy behaviours were informed by individual level theories and models. In other words, communication assumed an individualistic approach. Some of the theories behind individualistic communication include the Health Belief Model (HBM), Theory of Reasoned Action (TRA), Stages of Change, Hierarchy of Effects Model and the Social Cognitive Theory (SCT). The Theory of Reasoned Action, developed by Ajzen and Fishbein (1980), states that the primary predictor of behaviour is an intention to engage in that behaviour. This behavioural intention is influenced by a person`s attitude towards the behaviour under consideration and his or her appraisal of relevant social norms (Wright et al., 2008). The theory further assumes that individuals are rational in their decision making; an assumption that Michal-Johnson & Bowen (1992) consider as not entirely relevant for HIV/AIDS related behaviours that are heavily influenced by emotions.

The Health Belief Model is another individual level theory that was developed by Becker (1974) to predict individual responses to, and utilization of, screening and other preventive health services. The theory focuses on an individual`s perceived threat of illness and their behavioural response to that threat (Wright et al., 2008:238). The theory further maintains that individuals assess threats to their health against the costs and benefits of changing their behaviours (Wright et al., 208:238). Another individual level theory is the Social Learning/Cognitive Theory. This theory was developed by Bandura (1986) and it maintains that health related behaviours are ultimately the result of a combination of an individual's thought processes and environmental events. The cognitive processes of an individual, like beliefs and attitudes, influence various health related behaviours. According to Airhihenbuwa et al. (2000), the primary domains of the theory widely used in HIV/AIDS programs are modelling and self-efficacy. Although this theory is said to have worked in

other contexts, its relevance is questioned in contexts where individual decisions are the result of a group's social norms (Airhihenbuwa et al., 2000).

Although these theories have largely informed the development of most health communication programs, and even HIV/AIDS communication; a number of limitations have been noted as having minimised their effectiveness in terms of changing and sustaining behaviours. The limitations of these theories lie in the assumption held by these theories. According to Singhal & Everett (2003:213), theories like the HBM, TRA, HEM and SCT maintain that all individuals:

- **are capable of controlling the elements and structure of their context**: a desired action is often impacted upon by cultural, economic, social and political factors over which an individual may exercise little control.
- **are on an even playing field**: women and those of a low socio-economic status are more vulnerable to HIV/AIDS.
- **take decisions of their own free will**: protection is often determined by another partner who may or may not wish to use a condom in a sexual relationship.
- **take preventive health decisions rationally**: emotions also play a role in triggering the practice of preventive behaviour. For example, the death of a close friend from AIDS can serve as a more powerful trigger to adopting preventive behaviour than rationally structured media messages promoting condom use.

It is clear that these theories have attributed behaviour change to individual characteristics whilst ignoring the properties of relationships between and within units (Wasserman & Faust, 1994). This particular focus on individual capacity to adopt a change in behaviour has undermined the overall capacity to understand the complexity of disease transmission and the crucial determinants of behaviour (AfriComNet). In addition, Kelly (2008) maintains that

many people, or individuals, confront an exceptionally elevated risk of infection not primarily as a result of their own behaviour but rather because of the behavioural characteristics of their partners, or the particular structure and functioning of the social network to which they belong (AfriComNet). This failure to explain and analyze how structural properties affect behaviour beyond the effects of individual attributes has largely led to the limited success of HIV/AIDS communication campaigns in the fight against HIV (Wasserman & Faust, 1994).

As a result, the new UNAIDS communication framework advocated for a change in approach, i.e. to ascertain the role of socio-cultural influences and environmental influences in shaping behaviour (Singhal, 2000). In essence, there has been a shift from communication informed by individual level theories to more multilevel, cultural and contextual interventions and explanations (McKinlay & Marceau, 1999). Such interventions have sought to appreciate that individual behaviour is embedded in their social and cultural contexts; with five domains identified as crucial to the effectiveness of HIV/AIDS communication programs since they permeate and affect decision making in the context of HIV/AIDS (Airhihenbuwa et al., 2000). The focus on these five domains will help to create a flexible culture-based holistic strategy by which interventions are located in the social patterns of relationships amongst individuals (Singhal, 2000).

The five domains under consideration are: government and policy, gender equality, culture, spirituality and socio-economic status. Government policy plays a critical role in programs aimed at controlling the spread of HIV/AIDS (World Bank, 1997). Policies in general will speak volumes about the stance of any government in the fight against HIV/AIDS. Enacting laws or legislations that support and create a conducive environment for health organisations, HIV organisations in particular, to operate will go a long way in combating the spread of the epidemic. Government policy exerts the most influence on social

change, having the power to transform social and environmental forces for the benefit of individual health outcomes, even when individuals have no intention to change (World Bank, 1997).

Socio-economic status (SES) also has a significant impact on the success or failure of many public health interventions (Airhihenbuwa et al., 2000). Individuals and communities with a lowered socio-economic status are the most vulnerable to HIV/AIDS. These individuals have limited access to health care and they are least able to afford medical services (Airhihenbuwa et al., 2000). They also have less access to health information, hence becoming more vulnerable to HIV/AIDS. The effects of a lower economic status go beyond the inability to access health services as many are pushed into high risk activities that increase their chances of HIV infection. Put simply, the economic status of an individual or community can support or hinder the spread of HIV/AIDS.

Culture is also important in understanding the context of preventive health behaviours. Culture informs and shapes an individual's understanding of health concepts. Most people involved in HIV/AIDS communication have recognized the importance of culturally appropriate communication (Becker et al. 2004). The goal is to assess the negative and positive aspects of a culture rather than concentrating solely on the negative (Krenn and Limaye, 2004). An understanding of the different cultures in society will help in the development of communication strategies and campaigns that are culture sensitive whilst at the same time supporting the provision of relevant and accurate HIV/AIDS information.

Gender relations must also play a role in the development of HIV/AIDS communication. Gender analyses should address both male and female dynamics as they relate to HIV/AIDS communication (Mendoza, 1997). Notions of power and equality come into play at this level as they affect the negotiating powers of partners for safe sexual

activities (Becker et al. 2004). Gender defines how programs respond to the needs of both males and females (Mendoza, 1997). This means creating supportive environments that would allow males and females to have adequate means of protection against the disease as well as care and support when infected. Communication must avoid interventions that stereotype or undermine either gender.

There is also evidence to suggest that there is a relationship between spirituality and HIV/AIDS (Gray, 1997). Spirituality is defined or seen as encompassing aspects of hope, faith, self transcendence, a will or desire to live, the identification of meaning, purpose and fulfilment in life as well as the maintenance of interpersonal and intrapersonal relationships (Relv, 1997). Spirituality encompasses beliefs and value systems that range from organised religion to individual or collective values, or both, wherein a belief represents a guiding principle on which meanings are based (Relv, 1997). Aspects of spirituality include questions regarding what is considered right or wrong and what constitutes fairness and unfairness. There is a relationship between spirituality and both negative and positive attitudes towards HIV/AIDS. For example, religion or spirituality can discourage the use of condoms whilst, it can advocate for a delay in sexual activity and fidelity in relationships; the latter of which could support the reduction of the spread of the epidemic (Gray, 1997).

This framework, as discussed above, serves as a guide for the development of effective HIV/AIDS communication that will hopefully see a reversal in the transmission rate of HIV infections. The framework thus acknowledges and emphasises the importance of a contextual response to HIV rather than a focus on individuality. The sole purpose of this discussion was to highlight the nature of HIV/AIDS communication; how it started and how it has since evolved. Clearly, the quality of HIV/AIDS communication cannot be overstated;

it necessitates the constant evaluation of communication strategies and campaigns in order to redefine or strengthen communication approaches towards achieving their intended goals.

As mentioned briefly earlier, young women become even more vulnerable to HIV infections as a result of various factors. These factors have exacerbated the spread of HIV/AIDS and, as such, must be addressed. The purpose of the next section of this chapter is to dwell upon these factors exposing young women to HIV infections. The discussion provides different arguments which consider how such factors can fuel the spread of HIV infections amongst young women.

2.6 VULNERABILITIES OF YOUNG WOMEN TO HIV/AIDS

According to Fuller (2008:9), HIV/AIDS can be seen as a disease that has drastically affected the lives of women, and African women in particular. The epidemic has changed and taken the lives of many women, both young and old. Fuller (2008) continues to state that African females are the worst hit by HIV/AIDS and the most vulnerable to the disease for a number of reasons. Women, in general, are said to be more vulnerable to HIV than males as a result of their biological make up. Parker (2007:25) argues that:

> although this difference in susceptibility to HIV between males and females can be accounted for biologically, it is also clear that female vulnerability to HIV is also socially driven.

It is for this reason that this part of the chapter attempts to discuss the social factors that have fuelled, and continue to do so, the spread of HIV/AIDS among women and, in particular, female youths.

Poverty or a low socio-economic status is one of the main drivers of the growing HIV infections amongst females. As Dworkin & Blankenship (2009) argue, poverty is one of the

main structural determinants of HIV/AIDS, particularly for women. Poverty disempowers women and creates an economic dependence of females on their male counterparts. According to Medrano (2008), situations of economic dependence can cause women to find themselves in vulnerable situations where they can become victims of domestic abuse, or sexual abuse, if they refuse the sexual advances of their partners. Economic dependence may also limit the negotiating powers of females for safe sexual practices, hence their increased vulnerability to HIV infection, or any other infectious disease. Poverty does not only cause economic dependence but it also limits an individual`s access to health care services (Airhihenbuwa et al., 2000). The lack of access to health care services may also mean a lack of access to health information and treatment, both of which are critical in the fight against HIV/AIDS.

Prostitution has also been established as one of the reasons for the increased vulnerability to HIV infections amongst young women. Prostitution emerged as a result of a number of factors, chief among which is poverty. The dire need for financial stability has led women to practise prostitution: an act that allows them to be paid for their sexual services (Krenn & Limaye, 2004). More often than not, women in this situation are even more vulnerable to HIV due to multiple sexual partners, frequency of sexual acts and low bargaining power in condom use with clients (Krenn & Limaye, 2004). The picture portrayed here is that of the serious consequences of poverty which, if not addressed, will continue to marginalize women, increasing their chances of being infected. According to Blankenship et al. (2006), a more appropriate response to poverty and its effects, particularly for women, is the economic empowerment of women through microfinance projects. The provision of income sources for women promotes their empowerment and may promote the prevention of HIV/AIDS (Ehrhardt 2007, cited by Dworkin & Blankenship, 2009).

Cross-generational or intergenerational sex is another factor that increases the susceptibility of young women to HIV/AIDS. According to Setswe (2009), there has been an increase in the number of young women (15-19 years) who engage in sexual relationships with partners who are five or more years older than they are. This makes young women vulnerable to HIV infections for a number of reasons, as shall be discussed here. Firstly, Montgomery & Brocato (2004) argue that older men, or partners, are more likely to have or have had other partners including spouses and are therefore more likely to have been exposed to HIV. Multiple partners, regardless of frequency, will always increase the possibility of HIV in an individual. Secondly, the power imbalance in these sexual relationships leaves young women unable to negotiate for safer practices, like condom use (Montgomery & Brocato, 2004). A power imbalance tends to affect the nature of communication, respect and mutuality in the relationship.

According to Fuller (2008:102), the economic transfer of money, or gifts, contributes significantly to the involvement of young women with older partners. Young women perceive the older men to be more economically stable and in a position to provide for them (UNGASS, 2002). These perceptions, held by young women, have led to sexual activities that have caused the incidence of HIV/AIDS to spike amongst this group (UNGASS, 2002).

Another factor that continues to expose young women, or women in general, to HIV/AIDS is gender inequality. Fuller (2008) maintains that the vulnerability of women and girls to HIV/AIDS is directly related to the relations between women and men. Gender inequality has led to gender violence that is associated with HIV/AIDS. Gender violence associated with HIV/AIDS manifests itself in terms of sexual coercion, lack of negotiation - especially relative to condom use, and the disclosure of one's HIV status (Fuller 2008). Global statistics reveal that women have been victims of rape or sexual abuse (Luciano,

2007). According to Luciano (2007), the effects of sexual abuse or violence go beyond physical harm but extend to the psychological harm of an individual. Luciano (2007) continues to state that sexual abuse distorts one's self image and esteem and, when this happens, it increases the chances of adoption of high risk behaviour. High risk behaviour might include drug and alcohol abuse, as well as unprotected sexual activities. These clearly can increase the incidence of HIV/AIDS amongst young women. Therefore, there is a correlation between gender violence and the increasing incidence of HIV/AIDS amongst young women.

Culture, although important in guiding a society, has to some extent also contributed to the spread of HIV/AIDS. Culture informs and shapes the opinions of community members who will then behave within the confines of the prevailing norms and values of the culture to which they subscribe (Wright et al. 2008). According to Wright et al. (2008: 101), culture permeates all aspects of life and it influences our perceptions and experiences of life events, including health related situations. As such, expectations of culture from women have made them even more vulnerable to HIV. According to Amaro & Raj (2000), the rigidity of the feminine role places women at a significant disadvantage to be able to negotiate lower risk sexual relations and refuse demands for unwanted sexual activities. This kind of repression, which occurs as a result of the rigidity of gender roles, increases the risk of women in regards to acquiring HIV (UNGASS, 2000). In addition, studies have shown that the purchase of condoms, by virtue of tradition, remains a male prerogative; with women having limited opportunities to influence their behaviours (Zhusupov, 2000). The situation is made worse by the perceptions held by some cultures which maintain that condoms are only used with prostitutes and, as such, causes women to fear judgment and mistreatment should they insist on the use of condoms with their sexual partners (UNGASS, 2000).

Substance abuse can also exacerbate the spread of HIV amongst young women as there is now a growing trend in women using drugs and alcohol. It was unusual to see a women drink or smoke but this has since changed, with some women even consuming more of these substances than their male counterparts. Alcohol and drug abuse can be categorised under high risk behaviour and Luciano (2000) asserts that there is a relationship between high risk behaviour, (like drug and alcohol abuse, as well as unprotected sexual behaviour) and the high incidence of HIV. Substance abuse strengthens the degree of vulnerability with respect to HIV infections (Zhusupov, 2000). For women, there are reported cases of sexual abuse when they were under the influence of drugs and alcohol, which exposes them to HIV /AIDS infections. For some, the onset of sexual activities has taken place under the influence of alcohol. Basically, alcohol and drug abuse can increase the vulnerability of young women to HIV infections.

Social network norms, values and systems have also contributed to the behaviour of many teenagers. The need to identify and belong has had a detrimental effect upon many adolescents as their behaviour, even sexual behaviour, has been the result of detects within their social network **(**DasGupta, 2008**).** For example, young people have engaged in early sexual activities as a result of their societal standards of what constitutes womanhood. Childbirth is seen as a sign of womanhood whereas those without children are regarded as barren (McLea, 2012)**.** This, on its own, has compelled some to "prove" their fertility in their communities, increasing their chances of HIV infections as a result of unprotected sexual activities. Social network values can, if unguarded, increase young women`s susceptibility to HIV infections.

Last, but not least, the effect of some government policies has presented setbacks in the fight against HIV/AIDS. Policies can reduce or increase the spread of HIV in societies.

Government policies supporting HIV/AIDS communication will help in fighting HIV yet some policies, although developed with good intentions, can support the spread of HIV amongst young women. For example, government policies in South Africa have advocated for the need of young women, as early as 12 years, to have access to contraceptive methods and, in cases of pregnancy, young women can perform abortions even without the consent of parents. Most contraceptive methods will address the problem of unwanted pregnancies yet, at the same time, these would expose young women to the risk of HIV infection. Van Dyk (1999) states that some female youths believe that contraceptive methods will protect them against HIV/AIDS in the same way it prevents pregnancy and, as such, they believe that they can engage in unprotected sexual activities. Unprotected sexual activities will still increase the incidence of HIV regardless of the use of contraceptives. In cases where contraceptives were not used and pregnancy occurs, abortion policies have been put in place to allow young women to terminate their pregnancies. Again, although this might solve the problem of unwanted pregnancies, it has also contributed to the increasing incidence of HIV amongst female youths. With the knowledge of legal abortion services, young women now engage in unprotected sexual activities which increase their chances of being infected with HIV.

Furthermore, government policies on social grants have also, in some way, fuelled the spread of HIV amongst young women. The need for a social grant, in some cases, has made young women to wilfully engage in unprotected sexual activities neglecting the consequences of such acts. There could be many other factors supporting the spread of HIV amongst young women but, on a general scale and in the South African context, the above mentioned factors have significantly contributed to the increasing susceptibility of young women to HIV/AIDS and demand attention in order to reverse their impact.

According to Zhusupov (2000), it is important to establish and understand the structural determinants of HIV in order to design and develop effective interventions. Since HIV was first discovered, a number of different communication strategies and campaigns have been employed to fight against the disease. Strategies have changed with time to address the different concerns that arise as a result of the disease. Despite the many years of HIV/AIDS communication programs, infection rates continue to rise in South Africa and globally. Ross and Carson (cited by Salawu, 2004) acknowledge that most HIV/AIDS information is obtained from mass media, yet the precise impact of these messages, on reducing AIDS risk behaviour, continues to be a subject of debate. There are countries that have reported success stories, like Uganda, Tanzania and Senegal. For example, the prevalence among the 15-24 year old age groups in Tanzania dropped by more than 50 percent over a six year period (Salawu, 2004). In South Africa, reported declines, particularly amongst the youth, are still statistically insignificant and more commitment at all levels is needed to keep the rate of infection relatively low. As such, one may infer that in countries like South Africa, HIV/AIDS communication has not fully realised its goals when it comes to addressing the spread of HIV/AIDS, particularly amongst young women. The following section of this chapter will attempt to discuss the challenges to and of HIV/AIDS communication.

2.7 CHALLENGES FOR HIV/AIDS COMMUNICATION

The impact of HIV/AIDS communication has been undermined largely by the nature of HIV/AIDS. According Singhal (2000) and Svenkerud et al. (1998), there are four probable categories in which to classify factors that minimise the impact of HIV/AIDS communication on recipients. These four categories as mentioned by Singhal (2000) are discussed below.

1. Nature of HIV/AIDS

HIV/AIDS is invisible, silent and non-debilitating for several years. The fact that the impact of HIV is not felt at the point of infection has led people to continue in the adoption of high risk behaviour. A person can live for more than ten to twenty years before HIV develops into full blown AIDS. This on its own creates an impression that one is not likely to be infected by the disease and the fact that one does not feel ill becomes even more reason for not testing to know one's status. As such, there is little regard for HIV/AIDS messages supporting protective sexual behaviours because it usually takes long for one to become seriously ill as a result of the disease.

2. HIV/AIDS deals with human behaviours that:

- **Often involve interactions between unequal parties.** Power dynamics in interactions will determine the nature of the relationship. An older man in a relationship with a teenager is likely to decide on unprotected sexual behaviour and the teenage girl may not have the power to object. In other words, inequalities between partners affect the negotiating powers of the weaker partner for safer sexual practices. What this means is that even when there is communication for safer practices, its impact is undermined by the power dynamics in relationships.
- **Are shaped by deep-rooted socio-cultural traditions such as, for example, patriarchy.** It has proven rather difficult for HIV/AIDS communication to convince people to change their cultures. Cultures which can increase the incidence of HIV include the dominance of men in relationships to such an extent that women have no negotiating power for protective sexual behaviour; the ability of men to marry as many women as they can; and cultures which compel young women to be married, without their consent, by older men. All these practices increase the incidence of HIV

infection amongst women and pose challenges to HIV/AIDS communication as many are adamant to uphold their cultures in the face of this deadly epidemic.

- **Are considered taboo by society and therefore not easily discussed.** Sexual issues are still considered a taboo by some, and it is regarded as unacceptable for them to be discussed at family or public platforms. When communication endeavours to bring to light how certain sexual practices can put one at risk, some societies still consider it improper to talk about sex and HIV/AIDS, rendering it a challenge to HIV/AIDS communication. When societies talk about sex and HIV/AIDS it can help them to adopt protective behaviour against the disease. However, when it is still considered taboo to discuss such issues, one can expect the incidence of HIV infections to be on the rise, despite the many communication programs.

3. An efficacious response to HIV/AIDS involves the adoption of behaviours that:

- **Are dependent on compliance of more than one party**. A partner in a relationship may be willing to use a condom whilst the other party might not be willing. When it comes to understanding sexual behaviours, the actors and their actions are seen as interdependent. This means that a party involved can influence another towards the adoption or neglect of protective behaviour against HIV/AIDS. The expected response to HIV/AIDS communication is to have people adopting protective behaviour, however, this is dependant not only on one party in the relationship.
- **Are dependent on the availability of products and services.** Most HIV/AIDS communication encourages people to use condoms and visit testing centres in order to know their HIV status. The availability of such products and services may enable an individual or community to adopt protective behaviour. However, in the absence of the products and services being communicated about, the adoption of protective

behaviour becomes impossible. For this not to pose a challenge to HIV/AIDS communication, recipients must have easy access to condoms and testing centres.

- **Are preventive in nature**. In light of HIV/AIDS, most preventive behaviours are those that people seem reluctant to pursue, for example, not having multiple concurrent partners and using condoms. The fact that people do not want to adopt preventive behaviours poses challenges to HIV/AIDS communication.
- **Involve foregoing and reducing pleasure or adventure**. The expected response to HIV/AIDS communication, in this regard, will see people or individuals foregoing and reducing pleasure or adventure. This, again, is not typical of many people who, most often, would seek pleasure and adventure. Even in terms of sexual behaviour, people have engaged in sexual activities to satisfy their physical, psychological and socio-affinitive needs.

4. HIV/AIDS seemingly affects populations that are often hard ***to reach by conventional media channels and who are mostly of a lower socio-economic status****.*

- The effect of this communication is not fully realised, given the inability of communication to reach some people who, in turn, cannot access health information and services as a result of their economic status. In most instances, such people of a lower economic status also tend to be **the most marginalised, vulnerable and powerless**. In instances where communication may reach them, the prevailing circumstances around them may not support the adoption of protective behaviour against HIV/AIDS.

The above shows some of the challenges confronting HIV/AIDS communication. The expected responses to HIV/AIDS communication by individuals and societies are undermined by the prevailing situations or circumstances around or within societies. It is

clear that the adoption of protective behaviour is determined by a number of reasons, as alluded to above.

2.7.1 AUDIENCE RECEPTION OF MEDIA MESSAGES

Audience reception of messages, communicated largely through mass media, describes how audiences make sense of and interact with media content or messages. The meanings and interpretations attached to media messages, in particular, health messages tend to vary from one individual to another. Thus Corner (2000) states that when constructing meanings, individuals draw on personal and social frameworks of understanding and judgement in making sense and attributing significance to media messages. Corner (2000) continues to say that in interpreting messages, audiences are able to consistently apply a "self conscious scepticism" that can significantly modify and even reject that which does not fit with situated experiences and values. Hall (1980) also argues that the degree of understanding or misunderstanding in the communicative experience exchange depends on the degree of shared cultural, social or political codes between the receiver and the sender. Thus health communication, in particular, can be met with various challenges that can lessen its effect in persuading people towards protective behaviour against any disease.

To further provide an understanding into how audiences interpret and attach meaning to media messages, Hall (1980) in his Encoding and Decoding model, maintains that audiences do not blindly accept encoded meaning but can:

1) accept the preferred meaning of a message. This involves the audience's interpretation of the text which may reflect the assumptions and intentions of the producers (Corner 2000). According to Hall (1980) the reader or audiences can take the dominant hegemonic position and decode the message in terms of the reference code in which it has been decoded. If

preferred meaning is accepted, then the message can be seen as instrumental in influencing the audience.

2) undertake a negotiated reading or interpretation of the message. This means audiences may accept some preferred meaning of the message while rejecting others. Hall (1980) contends that in undertaking negotiated reading, audiences acknowledge what has been dominantly defined but operate within exception to the rule by making a more negotiated application to suit individual conditions.

3) engage in oppositional reading in which they are able to understand the preferred meaning of the message but rejects it. Hall (1980) and Corner (2000) state that a reader who makes an oppositional meaning has a perfect understanding of both the literal and connotative codes but decodes the message in a globally contrary way.

There are a number of models that have been applied in the understanding of how audiences construct and attach meaning to media messages. The encoding and decoding model has been discussed in this section to show how audiences interpret health messages as well as how such interpretations of messages can impact on the effectiveness of health messages. Based on this model it is clear that HIV/AIDS communication, in its effort to communicate with audiences, is met with several challenges that hinder its success. Messages can be understood and accepted whilst in some instances can be partially accepted. In the worst cases, some HIV/AIDS messages are completely disregarded although audiences might have a profound understanding of such messages. In light of the above, it can be said that the manner in which HIV/AIDS messages are interpreted and given meaning, poses a challenge to HIV/AIDS communication as ways of constructing meaning have a potential to minimize the effect of HIV/AIDS communication on audiences.

2.7.2 CHALLENGES TO HIV/AIDS COMMUNICATION

There is a possibility that HIV/AIDS communication may have problems or limitations that may inhibit the adoption of protective behaviour amongst recipients. In this instance, it could be the design or message contained in the different communication campaigns that pose challenges when attempting to empower people to adopt preventive behaviour.

2.7.3 PORTRAYAL OF HEALTH SITUATIONS IN HIV CAMPAIGNS

Communication technologies remain one of the most significant channels to employ in the fight against HIV/AIDS. This is as a result of their ability to reach masses and provide information resources that can enable individuals to make appropriate decisions regarding their behaviours against any disease. According to Bahk (2001, cited by Wright, Sparks & O`Hair, 2008:184), health occupies an essential part of human living and, as such, the use of dramatic media presentations to depict health related situations becomes significant. According to Piotrow, Kincaid, Rimon & Rinehart (1997), drama seeks to capitalise on the appeal of popular media to show individuals how they can live safer and healthier lives. However, these dramatic presentations have come with their own limitations, thereby impacting on the strength of HIV/AIDS communication to influence positive behaviour.

According to Bahk (as cited by Wright et al., 2008), the portrayal of health situations in mass media is often unrealistic, with some communication promoting unhealthy perceptions of health and health behaviours amongst media consumers. Kline (as cited by Wright et al., 2008) further asserts that the media characters are the most attractive to media consumers as they often serve as role models for a variety of health behaviours but, unfortunately, many of the health behaviours they engage in are negative. Bandura (1986) also maintains that people learn from observing behaviour and then modelling it. In most

instances, when unhealthy behaviours are portrayed in a campaign, the purpose will not be to support that negative behaviour but to eventually show the effects of such behaviour. Unfortunately, communication in this regard seems to do exactly what it does not intend to do. If a role model is used in that behaviour, those looking up to him/her may copy that behaviour. Kline (in Wright et al., 2008) states that it makes little difference whether media roles are real or fictitious, people look up to role models and mimic their behaviours.

To further explain this concept, the one performing negative behaviour in portrayed situations is often depicted as a hero for the greater part of the presentation, with the consequences of that negative behaviour only being represented later (Wright et al., 2008). This has led on-lookers to overlook the later consequences and enjoy the pleasures of pursuing such behaviour. Wright et al. (2008) also argue that individuals associate actors with the behaviours which they see them perform; when actors engage in certain behaviours, it sends audiences an indirect message that these behaviours are desirable since they are associated with actors to whom people are attracted. Positive aspects of healthcare situations are thus often offset by unhealthy role models in health related entertainment.

2.7.4 PORTRAYAL OF WOMEN IN HIV/AIDS COMMUNICATION PROGRAMMES

The depiction of people in any intervention initiative plays a significant role in determining the manner in which such people will respond to the disseminated messages. The depiction of women and young women in some HIV/AIDS communication programmes has played a role in the perpetuating of certain negative stereotypes against women (Chitando, 2011). It is these stereotypes that have, to some extent, lessened the ability of women to perform certain behaviours as they are regarded as weak and not in control of their circumstances. According to McFadden (1992) some media messages have played an active

role in the construction and perpetuation of negatives stereotypes against women, particularly in the era of HIV/AIDS. In some HIV/AIDS programmes women have been portrayed as dangerous, weak and dependent upon men. They also have been depicted as vectors in the spread of HIV, thus perpetuating sexist ideologies (Chitando, 2011). The ways in which women are depicted affects the way in which communication is understood and even its impact on intended recipients.

To give an example of what has been discussed above, there is a soap opera which was developed by Soul City under the theme of One-love. The Soap Opera "*umtshado"* has a story line that shows how an infected young woman hides her status from her boyfriend who she later infects with the virus. Another case is an advert that encourages young people to 'love themselves'. In this advert, a young woman is depicted as having failed to resist the demands of her boyfriend who wants to have unprotected sex with her. When the girl first refuses the demands made to her, the boyfriend stands up to leave her and she immediately gives in to unprotected sexual activities. The end of the advert shows the young women regretting the incident, although she is later shown attending HIV counselling and testing with her boyfriend at the end. Although the aim of the advert is to encourage young women to take care of themselves and test for HIV/AIDS, the manner in which some scenes depict young women can have a detrimental effect on their perceived ability to manage and overcome certain situations.

To portray young women in such negative ways, even though a lesson is being put forth, can lessen the capability of young women to control certain behaviours. Young women will believe they have no power to perform certain behaviours as indicated by media and as such can continue to engage in high risk behaviour. The purpose of this discussion was to show

how portrayal of young women in HIV/AIDS can present challenges on the impact of some HIV/AIDS communication strategies.

2.7.5 USE OF LANGAUGE IN HIV/AIDS COMMUNICATION CAMPAIGNS

Language is another challenge of HIV/AIDS communication campaigns. Language construction can be very powerful in altering perceptions about health concerns (Wright et al., 2008:115). According to Bearth, Cisse, Singy & Singo (2012), language interfaces are critical loci of heightened risk of distortion, misinterpretation or even rejection of HIV/AIDS prevention messages. As such, the importance of using the appropriate language in conveying health messages cannot be overstated. Language which is not simple to understand, in terms of the words used, and language that is not culture sensitive will cause communication campaigns to have a minimal impact. Considering that African societies are linguistically fragmented, it becomes critical to communicate in a language that will be understood by the different members of different societies. In addition, Bearth et al. (2012) state that multilingualism which is insufficiently compensated by individual bi-or plurilingualism constitutes a formidable barrier to efficient transmission of key messages carried by HIV/AIDS communication.

Therefore, the question to ask when talking about language is whether language in communication campaigns has been constructed in such a manner that even the uneducated can understand the message clearly. Is the language used in these campaigns culture sensitive and is the campaign available in the people`s native languages? A failure to address these questions in the design and development of HIV/AIDS communication may lead to limited success in their objectives.

2.7.6 CLASH OF CONCEPTS IN COMMUNICATION PROGRAMMES

Another probable challenge of HIV/AIDS communication is the "clash" that might exist between HIV/AIDS communication campaigns and the prevailing social and cultural environment. Communication that challenges the culture or norms of a society is bound to be met with resistance. For example, HIV/AIDS communication that advocates for discussions on sexual issues, the use of condoms and having only one partner, would achieve limited success in cultures where talking about sex is taboo and the use of condoms is associated with promiscuity, and having many partners is a sign of manhood. This is a critical challenge for HIV/AIDS communication as it calls for health communicators to design their messages in such a manner that the contributory factors, as mentioned earlier, to the spread of HIV are tackled without offending the greater community.

Basically, what this chapter maintains is that the information provided through different media channels could play a particularly significant role in influencing people's perceptions of a subject like HIV/AIDS. As such, communication must refrain from stereotypes of any nature. These include stereotypes against gender, culture, the vulnerable and the marginalised as they will act as obstacles to people`s ability to translate knowledge of HIV/AIDS into behaviour. For HIV/AIDS communication to yield positive results, it must therefore be sensitive to issues that may directly or indirectly limit their impact. Communication must not leave room for recipients to suggest what is meant, instead, health messages must be clear and precise for them to instil a desire for behaviour change, where needed, amongst recipients.

2.8 EMPIRICAL FRAMEWORK

Mass media has played a pivotal role in the provision of HIV/AIDS communication to different masses. The main purpose has been to increase knowledge and awareness of the

pandemic, and change attitudes towards HIV/AIDS, which will eventually lead to the adoption of desired protective action against HIV/AIDS. However, since the inception of HIV/AIDS communication, the precise impact of this communication in reducing the prevalence of HIV/AIDS has remained a subject of debate. There are strategies and campaigns that have yielded positive outcomes in changing variables like awareness, attitude and behaviour. Most campaigns have, however, succeeded in only increasing awareness with little or no success in changing behaviour. This section will discuss a selection of previous studies that have been conducted to evaluate the impact of HIV/AIDS communication amongst the youth globally, and in South Africa.

A study was conducted by Cury & Rossi (2008) to investigate the patterns of sexual activity amongst teenagers from a private clinic in Brazil. According to Cury & Rossi (2008), the results of the study showed that teenagers had engaged in their first sexual encounter at the age of 15 and had an average number of sexual partners of 1.5. Results from this study also showed that these teenagers tended to use less or no contraceptives in their first sexual encounter. This pattern of sexual activity amongst these teenagers, as Cury and Rossi (2008) argue, exists despite the widespread knowledge of contraception and the delay of the onset of sexual activities. Most HIV/AIDS communication campaigns targeting youths have paid particular attention to messages that discourage the early onset of sexual activity and messages that advocate for protective behaviour like the use of condoms and contraceptives to prevent unwanted pregnancies and any sexually transmitted infections.

Based on the study by Cury & Rossi (2008), one can argue that HIV/AIDS communication has not fully achieved its goal in this regard. Patterns of sexual activity amongst these teenagers reflect the failure, or even reluctance, amongst these youths to use the advice contained in HIV/AIDS communication.

Ragnarsson, Onya & Aaro (2009) also carried out a study in order to understand young people`s interpretations of HIV/AIDS and Sexually Transmitted Diseases (STDs) in South Africa. The results of the study showed that participants had a limited understanding and knowledge of HIV/AIDS, from a biomedical perspective (Ragnarsson et al., 2009). Their understanding and interpretation of HIV, AIDS and STDs was informed largely by their traditional beliefs. Ragnarsson et al. (2009) further state that, because of their nature of interpretation, participants expressed distrust towards the medical health system as they believed that local traditional healers were the only people who could cure several STDs. For young people to hold such perceptions, despite visible HIV/AIDS campaigns, is cause for concern with regards to HIV/AIDS communication. Clearly, the ways of understanding HIV/AIDS weakens the efforts of health education which is based solely on a medical notion of the disease (Ragnarsson et al., 2009).

HIV/AIDS communication therefore needs to address the conceptions of HIV/AIDS as understood by different cultures in order to provide a comprehensive understanding of the epidemic. By so doing, the appropriate protective behaviour will be adopted. In instances were medical help is not trusted; communication will serve to instil the correct knowledge and understanding for the need of medical treatment in suppressing the effect of the disease. Behaviour change, like the use of condoms, can also be supported if communication reaches and addresses the different meanings attached to the epidemic by different societies.

Another study was conducted to evaluate the impact of a multimedia campaign in Nigeria (Salawu, 2004). According to Yahaya (as cited by Salawu, 2004), this campaign was all embracing and encompassing; drama sketches and folk musicals were employed in this campaign. The purpose of the campaign was to sensitise target populations about protective sexual lifestyles, the dangers of unwanted pregnancies, HIV/AIDS and other sexually

transmitted diseases. The results of this study revealed that awareness of the HIV/AIDS epidemic rose to 100%. In other words, the nature of the campaigns employed induced awareness about HIV/AIDS, with little being said about attitude and behaviour change. According to Salawu (2004), positive change in attitude and behaviour in light of the epidemic is more desired than a simple increase in awareness, and this is rarely recorded by the HIV/AIDS communication campaigns.

Maharaj (2006) also conducted a study to understand the reasons for condom use among young people in KwaZulu-Natal. This study, according to Maharaj (2006), was conducted amongst sexually active youth to analyse or assess their reasons for condom use, as well as their levels and determinants of use. Although results showed that young people used condoms in their last sexual encounter; they used condoms for different reasons. According to Maharaj (2006), young people (both sexes) who would consider pregnancy as highly problematic were more likely to use condoms than their counterparts who would view pregnancy as unproblematic. The results of the study also revealed that both young men and women who perceived of themselves as having a medium to high risk of HIV infection were less likely to use condoms than their counterparts who perceived themselves as being at no risk (Maharaj, 2006). Clearly, the results of the study show that although young people use condoms, they have no clear understanding of the role condoms can play in protecting them against both unwanted pregnancies and HIV infections. It is worth noting that young people do not understand the twin risks of pregnancy and infection leading to their reluctance in the use of condoms in some instances. Does this mean that prevention programmes have addressed these two issues separately or have not completely shown the risks of, and relationship between, pregnancy and HIV infection?

Another study was also conducted to assess the strength of selected mass media interventions on HIV/AIDS among young people in developing countries. This was done by evaluating the results of studies that have been conducted to assess the strength of three types of mass media HIV/AIDS interventions. The purpose was to determine whether those interventions reached the threshold of evidence needed to recommend their widespread implementation (Bertrand & Anhang, 2006). According to Bertrand & Anhang (2006), data supported the effectiveness of mass media interventions to increase the knowledge of HIV transmission, improve self-efficacy to condom use and influence "some" norms. Although this is the case, results further showed that the evaluated studies did not show significant effects with regard to creating awareness that healthy looking people may have HIV/AIDS or improving self-efficacy in terms of abstinence (Bertrand & Anhang, 2006). Furthermore, the evaluated studies did not show significant effects in terms of increasing the proportion of adolescents who delay their first sexual encounter or decreasing the number of sexual partners (Bertrand & Anhang, 2006). Based on this, it is clear that the success of HIV/AIDS interventions, in terms of behaviour change, has limited success.

Katz & Low-Beer (2008) also conducted another study in a bid to understand why HIV stabilized in South Africa, yet did not decline further amongst the youth. The age and sexual behaviour patterns amongst youths were measured with results indicating some level of change in behaviour and that youths have moderate risk behaviour. Despite the fact that there seems to be some behaviour change observed, HIV prevalence amongst the South African youth is twice that of their counterparts in countries like Uganda. The study further observed an inconsistent use of condoms and an extended age distribution of risk together with age and partner mixing (Katz & Low-Beer, 2008). These behaviours, according to Katz and Low-Beer (2008), increase the cumulative risk beyond indicators which are based on

sexual behaviour in the last year and condom use during the most recent sexual act. As such, the recommendations based on the study findings suggest the need for comprehensive HIV prevention programmes that will clearly promote consistent condom use and reduction in sexual partners.

Numerous studies have been conducted to evaluate the impact of HIV/AIDS communication campaigns and what is apparent is that results from these studies show a similar pattern. Comprehensive campaigns have been valuable in influencing positive HIV related outcomes amongst young people, although not on every variable or in every campaign. Clearly, most have managed to increase awareness of HIV/AIDS yet with limited success in going beyond increasing awareness. It is on this basis that this study seeks to investigate whether current HIV/AIDS communication campaigns in South Africa have limitations that have hindered the translation of knowledge into action amongst female youths, such that they persist with the adoption of high risk behaviours.

2.9 CONCLUSION

The role of HIV/AIDS communication cannot be undermined in this continuing battle against HIV/AIDS. As such, the quality and effectiveness of HIV/AIDS communication must always be moderated in order to redefine or develop new communication strategies and campaigns that will yield positive outcomes. This highlights the importance of studies that seek to periodically evaluate the strength of existing communication campaigns. This chapter has therefore offered a discussion of the background to HIV/AIDS, the development of health and HIV/AIDS communication as well as the vulnerabilities of young women to HIV/AIDS. The chapter has also offered a discussion of the challenges to and of HIV/AIDS that could limit the positive effects of HIV/AIDS messages amongst recipients. Lastly, the empirical framework of the study was also provided for in this chapter.

CHAPTER THREE

AN OVERVIEW OF HIV/AIDS COMMUNICATION IN SOUTH AFRICA

3.1 INTRODUCTION

Prevention of HIV infections, in particular new HIV infections, still remains a major health priority for many countries especially those with high infection rates. Because health communication plays a critical role in curbing the spread of HIV/AIDS, its importance in the fight against the epidemic remains unquestionable. As highlighted in the previous chapter, effective or comprehensive HIV/AIDS communication initiatives contribute immensely in the fight against the disease; implying that the nature of HIV/AIDS communication can either support or inhibit the development of the desired protective behaviour against HIV/AIDS. More often than not, the nature of HIV/AIDS intervention programmes, in many countries, is largely influenced by existing policies regarding their response to the epidemic. This chapter, thus, seeks to discuss or provide an overview of the development of HIV/AIDS communication campaigns in South Africa. This development has played a pivotal role in determining the nature and effect of prevention intervention programmes in South Africa.

This chapter offers a discussion of the historical development responses to HIV/AIDS in South Africa, which have ultimately led to the development of many prevention intervention programmes. Because of the vast number of current communication campaigns, the study identified five HIV/AIDS communication campaigns to focus on, and a discussion on these is provided in the chapter. The prevalent themes in the communication campaigns and the approaches to communication are also discussed in this chapter. Concluding remarks on this subject are also provided in the last section of the chapter.

3.2 DEVELOPMENT OF HIV/AIDS COMMUNICATION PROGRAMMES AND ACTIVITIES IN SOUTH AFRICA

As a result of the recognition of the devastating impact of HIV/AIDS on the health of individuals and the economic development of the country, South Africa developed and introduced policies that would work towards the eradication of the epidemic and its impact on society. This development was not without challenges as AIDS denial, which could impact the nature of a government`s response to HIV/AIDS, was noted amongst the most influential in the South African community (Caesar-Kasenga, 2007). Prior to 1994, the South African government`s response to the epidemic was restricted to limited condom distribution, with intensified training and awareness campaigns (Erasmus & Nkau, 2009). This strategy was not very successful as there were problems with the distribution and accessing of condoms. Realizing the insufficiency of this strategy, the commitment of the government increased to more comprehensive strategies as indicated by the growth in the budgets for HIV/AIDS (Erasmus & Nkau, 2009). The increased commitment of the government, according to Erasmus & Nkau (2009), also led to the establishment of the Inter-Ministerial Committee (IMC) on HIV/AIDS in 1998 to craft a more comprehensive government response to HIV/AIDS. This committee was instrumental in broadening the response to HIV/AIDS, focusing on aspects which included Partnership Support, Youth Programmes and Integrating HIV and TB.

In order to solidify the effectiveness of the government's response, there was later (in 1999) a realization for the need of government and civil society to be brought together in a single structure that would enhance the coordination and integration of HIV/AIDS activities and programmes (Erasmus & Nkau, 2009). Civil society, in the form of Non-Governmental Organisations (NGOs) and Community Based Organisations (CBO), plays a critical role in

the development of societies as these organisations are largely involved at grassroots levels with communities. As such, the importance of their collaboration with government's response to HIV/AIDS lies in their committed ability to ensure that people have access to HIV/AIDS services, thereby complementing the work of government (Erasmus & Nkau, 2009). This move indicates the realization by the government and the health sector that the engagement of communities towards their own development was also critical for the implementation of policies and services aimed at eradicating the spread and effects of the disease.

As a result of the intense threat of HIV/AIDS in South Africa, the government further introduced two HIV/AIDS policies in 2000. These policies are the HIV, AIDS and STD Strategic Plan for South Africa (2000) which set out the basis for the country`s response to the growing challenge of HIV infection and the Comprehensive HIV/AIDS Prevention, Care, Management and Treatment Plan for South Africa (2003) (DoH, 2007). These policies were again reviewed and replaced with the South African National AIDS Council HIV/AIDS and STI Strategic Plan for South Africa 2007-2011 (DoH, 2007). This plan sought to represent the South African comprehensive multi-sectoral response to the challenges of HIV/AIDS, with its primary activities being that of:

- Implementing an effective and culturally appropriate information, education, and communication strategy;
- Increasing access to and acceptance of voluntary counselling and testing;
- Improving the management of sexually transmitted infection and treatment for opportunistic infections, promotion of condom use to reduce transmission of HIV and sexually transmitted infections; and
- Improving the care and treatment of persons living with HIV and AIDS to promote a better quality of life and limit their need for hospital care (DoH, 2007).

The continued review of HIV/AIDS policies was mandated by the need for the development of holistic communication and prevention programmes that will aid in the decline of the spread of HIV epidemic. According to Erasmus & Nkau (2009), the completion of the national policy review necessitated the identification of key prevention interventions which, upon approval, became the focus of many HIV/AIDS communication advocacy interventions. These prevention interventions included, amongst others, HIV prevention programmes, youth friendly sexual and reproductive health services, unwanted pregnancy prevention and positive prevention programmes. The identification of specific prevention programmes was of paramount importance in order to enable the development and provision of relevant services and products to different target populations.

Below is a historical timeline for the HIV/AIDS programme activities from 1990-2007. As depicted in Table 5, the development of HIV/AIDS communication programmes and activities in South Africa has been guided by prevailing governmental policies which have also contributed to the very nature of current HIV/AIDS communication activities. HIV/AIDS policies, basically, provide a broad framework that guides institutions in their development of initiatives that work towards the fight against the pandemic. With the government support, a number of prevention intervention programmes in South Africa have been developed to address the main contributory causes of the increasing HIV infections amongst various groups of people in the country.

TABLE 5: Historical Timeline of HIV and AIDS programme activities in South Africa, 1990-2007

Year	Intervention, Legislation, Policy or Declaration
1990	First annual Antenatal HIV Sero-Prevalence Survey conducted
1991	National AIDS Helpline established
1992	National AIDS Co-ordinating Committee of South Africa (NACOSA) established
1994	Rendering of Free Health Services Notice; Soul City established
1996	Constitution of the Republic of South Africa (Bill of Rights) promulgated
1998	Compulsory Community Service for Medical Doctors and Interns; Inter-ministerial Taskforce on HIV and AIDS established; Partnership Against AIDS Declaration launched; Essential Drug List (Revised or Second Edition); Introduction of Female Condom at Family Planning Service Points
1999	National Integrated Plan for HIV and AIDS (Social cluster) approved; National Policy for HIV Testing approved; LoveLife established
2000	Establishment of the South African National AIDS Council (SANAC); HIV and AIDS/STI Strategic Plan for South Africa (2000 – 2005); The Primary Healthcare Package for South Africa: A Set of Standards and Norms; Takalani Sesame children's programme is launched
2002	Khomanani communication campaign is launched
2003	Expanded Prevention of Mother-to-Child Transmission (PMTCT) of HIV; Plan for Comprehensive HIV and AIDS Care, Management & Treatment for South Africa developed; Essential Drug List (Revised or Second Edition); Tsha Tsha and Gazlam TV programmes launched
2004	Implementation of ARV Roll-out Programme; South African Social Security Agency Act, 2004 signed into law
2006	National conference on Orphans and Vulnerable Children (OVC) hosted by the DSD in Midrand; Reconfiguration of the South African National AIDS Council (SANAC) under the leadership of Deputy President Phumzile Mlambo-Ncuka; Preparation and consultations on the National Strategic Plan 2007-2011
2007	Cabinet approves the National Strategic Plan 2007-2011

Source: Adapted from Erasmus & Nkau, 2009. HIV and AIDS: Towards a 10 year Review of the Population Policy Implementation in South Africa (1998-2008).

It is imperative to note that the table does not suggest that, after 2007, there were no programme activities developed. It means that the 2007-2011 National Strategic Plan, which was approved in 2007, served as a framework for the development of programme activities in 2007 going forward.

Currently, there are a number of HIV/AIDS prevention intervention programmes in South Africa. Each programme seeks to empower people on a number of variables that could either expose or protect them from HIV/AIDS infections. Given that this study focuses on

the youth, five HIV/AIDS communication brands, which have components that focus on the youth, have been identified and a discussion of these communication campaigns is provided below.

3.3 HIV/AIDS COMMUNICATION CAMPAIGNS IN SOUTH AFRICA

Social and behavioural communication is important and required to reinforce and extend behaviour that contributes to HIV/AIDS prevention. This communication seeks to positively promote self-efficacy and personal behaviours that may reduce the risk of infection by addressing attitudes, beliefs and social norms that could fuel high risk behaviour in communities (Johnson, Kincaid, Chikwava, Delate & Mahlasela, 2010). Notably, HIV/AIDS communication is not only limited to the above, it also seeks to support and ensure the uptake of and adherence to essential care, support and treatment interventions. Five common HIV/AIDS communication brands that have a particular focus on young people are discussed below to reflect upon how they have sought to address the challenge of the epidemic amongst the youth. These communication brands are: Khomanani Campaign, Soul City Campaign, Love Life Campaign, Scrutinize Campaign and the Siyayinqoba Beat It Campaign.

3.3.1 KHOMANANI – CARING TOGETHER CAMPAIGN

The Khomanani campaign serves as a framework for South Africa's response to the major challenge of HIV and AIDS (Mseleku, 2007). It is an example of a comprehensive HIV and AIDS campaign that is based on a clear understanding of the priorities in HIV/AIDS prevention and care, and of the efficacy of mass communication. Khomanani is an intensive communication campaign that seeks to encourage positive sexual behaviour to prevent new HIV infections and mobilize access to care and support services for those who are infected and affected (Mseleku, 2007).

Khomanani has identified and developed a number of communication strategies that seek to reach out to different audiences facing different circumstances. Messages are based on research and, as such, involve target populations in the development of initiatives that will best address their unique circumstances which could potentially expose them to HIV/AIDS infection. Khomanani addresses a number of issues that expose different age groups and genders to HIV infections by providing information in a variety of ways which will empower target populations against HIV/AIDS.

Khomanani also recognizes the impact that different communication channels may have on audiences and, as such, its channels include a mix of conventional advertising, public service announcements, social mobilisation activities and unconventional advertising (Mseleku, 2007). An extensive range of small media has been developed to communicate with the masses. Because the study focuses on youth, attention will be given to communication that targets the youth. Three communication campaigns from the broader Khomanani campaign that seek to empower youths against HIV infections will be discussed below.

Campaign 1: Let's Take our Relationship to the Next Level

This campaign seeks to add a new dimension to safe sex and HIV prevention as it encourages young people to know their status through HIV testing. Many youths have assumed that their partners were negative, yet the opposite was true. The campaign seeks to reinforce the trust and commitment that young people say is a feature of "long-term" relationships. This trust and commitment to partners can only be reinforced by knowing each other`s HIV status and, as such, it must not be regarded as an insult when one partner suggests that both parties must take an HIV test. It is a sign that he or she values both lives equally.

This campaign is presented through the use of different scenarios that involve the youth. For example, there is a scene of a marriage proposal between loving couples who make the mutual decision to get tested before they take the next step. Knowing their status will help protect them from infections if negative, and it will empower them to live a positive life, if HIV positive.

Campaign 2: Zithande - Delayed Onset of Sexual Activities and Condom Use Campaign

This campaign seeks to promote a delay in the onset of sexual activities amongst youths. In cases where young people are already sexually active, safe sexual practices are advocated for. Safer sexual practices, in this context, will involve the use of condoms and mutual sexual fidelity. The campaign "Zithande", meaning "love yourself", places much emphasis on giving value to one`s life. To love yourself will imply that you will take care and protect yourself from HIV infection by delaying sexual activities, using condoms for protection as well as staying mutually faithful in a sexual relationship.

This campaign is illustrated through the use of situations that depict young people put under peer pressure when it comes to sexual matters. Friends "push" others into sexual activities but one who values his/her life is depicted as resisting the peer pressure by not engaging in such acts; thus, delaying the onset of sexual activity. Another scenario illustrates friends or partners reminding each other to use condoms in order to protect themselves from infections.

Campaign 3: Empowering the youth

This campaign basically seeks to expose young people to the opportunities and skills that will help protect them from getting infected. Economic dependence is seen as a critical determinant of HIV infections. As such, economic empowerment can help alleviate the

spread of HIV amongst young people. As the campaign shows, young people can start projects that will keep them occupied; for example, farming projects. Such projects will keep young people from peer influences on the streets and empower them in numerous ways, thus giving them a million reasons to protect themselves from HIV/AIDS infections.

THEMES

There a number of themes running through the Khomanani campaigns and these include:

- **Youth Prevention**: these campaigns pay particular attention to the youth, giving them advice on how to handle situations that could eventually lead to HIV/AIDS infections. Areas of focus include delayed sexual activity, economic empowerment, HIV testing, having one partner instead of multiple partners, substance abuse, use of condoms and contraceptives.
- **Support for Orphans and Vulnerable Children**: these campaigns focus on giving information that will help communities or individuals in providing care for HIV/AIDS orphans and children vulnerable to the epidemic.
- **Anti-discrimination and VCT**: these campaigns work towards removing the stigma associated with HIV/AIDS through the provision of accurate information about the epidemic and the state of people infected by the disease. Voluntary counselling and testing is also encouraged as a way in which people can help to reduce or stop the spread of the disease.
- **Promoting awareness and treatment of TB and STIs**: these campaigns focus on giving adequate information on the strong link between TB and STI/Ds. TB and STDs tend to increase the vulnerability of people to HIV infections. As such, the provision of timely and relevant information about the relationship between TB and HIV is necessary.

- **Motivating Health Workers to improve the care of People Living with AIDS**: these campaigns seek to provide Health workers with information that will enable them to provide adequate care for people PLWA.
- **Promoting the Government's ARV roll-out campaign:** such campaigns advocate for the consistent use of ARVs and increasing awareness of the advantages of using ARVs.

3.3.2 SCRUTINIZE CAMPAIGN

The Scrutinize campaign, created in partnership with United States Agency for International Development (USAID) and John Hopkins Health Education in South Africa (JHHESA), aims to encourage and equip young people to take responsibility to reduce their risk of HIV infection through a series of short animated commercials known as animerts (Scrutinize, 2009). The campaign targets 15-32 year olds, in South Africa, with the aim of equipping them with a new HIV fact or insight to help them examine (or scrutinise) their own risky behaviours and beliefs.

The Scrutinize campaign series makes use of animated township characters who illustrate daily life encounters that place young people at risk of HIV infection. The campaign uses township characters, slang, and symbology that South African youth can easily relate to (Scrutinize, 2009). The animated commercials are about 40-60 seconds long and are based on the everyday realities that place young South Africans at risk of HIV infection. The lead character is a taxi driver named Victor who is on a mission “to flip HIV to H-I-Victory”; the rest of the characters include a shebeen queen (a female owner of a small drinking establishment, usually in her home), a sugar daddy (an older man who dates young girls), a young girl, a businessman, and a teenage boy (Scrutinize, 2009).

In this campaign, HIV is personified as a ninja character which pops up in many different situations: alongside sugar daddies and mommas, hanging around when there is drunken sex in shebeens, never far away from the stigma and prejudice that help it grow stronger, and having multiple concurrent partners.

Basically, what the campaign shows is how fast and easily the ninja can attack an individual when they:

- are under the influence of alcohol,
- have multiple concurrent partners,
- do not use condoms in any sexual activity, and
- (girls) are involved with an older man who might have already been exposed to HIV infections.

The campaign also recognizes the effect of mass media in communicating with the masses. As such, the Scrutinize campaign has used television to strategically flight their campaign in order to reach those most affected. The series has also appeared in Health Clinics via Mindset Health Television. The campaign has also been taken to local communities, where the commercials were used as discussion starters for a series of planned youth conversations around HIV/AIDS (Scrutinize, 2009).

THEMES

The campaign seeks to address certain factors that seem to contribute to the spread of HIV/AIDS amongst the youth, these include:

- **perceptions of risk**: the campaign addresses the perceptions amongst the youth who tend not to regard certain situations as elevating their risk of infection.

- **multiple and concurrent partnerships**: the campaign discourages having multiple partners as it increases the spread of HIV/AIDS to many people, because one person with multiple partners can infect every person they come in contact with.
- **faithfulness:** the campaign encourages having one sexual partner and remaining faithful to one partner.
- **condom use and safety**: the campaign encourages the use of condoms and engaging in safer sex. The use of condoms is seen as important in reducing the risk of HIV/AIDS infections.
- **transactional intergenerational sex**: the campaign encourages young people, especially young women, not to have relationships (sexual relationships) with older people. Older people are likely to have had other partners before; which increases their risk of infection.
- **alcohol and sex:** the campaign shows the effect of alcohol or substance abuse on an individual`s sexual behaviour. Alcohol benumbs the cognitive processes which can lead people to actions which can increase their risk of HIV/AIDS infection.

3.3.3 SIYAYINQOBA – BEAT IT CAMPAIGN

Siyayinqoba Beat It! campaign is a television and video based project designed to provide reliable, scientifically-based information to people living with HIV/AIDS, as well as their partners, family, friends, care-givers, and health workers (TCI, 2008). The campaign was initiated by Community Health Media Trust (CHMT) based on the premise that treatment and prevention are interdependent processes and that prevention information is for everyone – HIV negative and positive people. The campaign includes the production of training materials and community outreach related to treatment literacy. This refers to the

provision of accurate information about the science behind the HIV/AIDS and its prevention and treatment (TCI, 2008).

Siyayinqoba Beat It! is comprised of a number of key programmes including the *SIYAYINQOBA BEAT IT! TELEVISION MAGAZINE PROGRAMME*. This programme is designed to promote positive living, treatment access, and the prevention of HIV infection both for the uninfected and those living with HIV. The show's format focuses on documentary inserts depicting different scenarios of HIV/AIDS related issues. The show also discusses different HIV/AIDS issues amongst members of an in-studio programme. People involved in these talk-shows could include support groups of people living with HIV or those most vulnerable to the disease.

In this instance, documentaries will portray the circumstances of people living with HIV and how they address their circumstances. Documentaries may also include experts who share information on recommended ways of dealing with HIV/AIDS. When it comes to studio discussions, there are moderator and programme members who tackle any relevant HIV/AIDS issue. These discussions, whether from experts or people affected by and infected with HIV/AIDS, seek to empower others in terms of positive living, treatment and the prevention of HIV/AIDS.

THEMES

The campaign seeks to highlight, in their shows and all other Siyayinqoba Beat It! programmes, communication that encourages:

- regular testing and starting anti-retroviral treatment at the right time;
- reporting sexual abuse and rape (a major contributing factor to the spread of the disease);

- alcohol abuse and its relation to risky sexual practices;
- partner reduction; and
- encouraging safer sex at all times.

3.3.4 SOUL CITY CAMPAIGNS

The Soul City Institute is an independent non-governmental organisation which has seen the development of a number of HIV/AIDS communication and disease prevention strategies in South Africa (Soul City, 2000). Soul City is commonly known for using edutainment as a tool for communicating about HIV/AIDS and other issues related to HIV/AIDS. According to the Soul City Institute, Soul City campaigns use plays or dramas to depict real life situations that expose individuals and communities to HIV infections. Basically, the campaigns seek to address the different circumstances that can and do expose different people to HIV/AIDS. These campaigns also highlight prevention measures and advocate HIV testing and adherence to HIV treatment (Soul City Institute). The campaigns focus on the general population, with programmes developed to address the concerns of the youth.

As already indicated, much of Soul City's communication is done through dramas in order to appeal to different audiences in various circumstances. As such, there are a number of plays or soap operas that Soul City has developed to address health concerns in society. I will concentrate on one Soul City campaign that focuses on "One-love", given the increasing number of people having multiple concurrent partners.

One-Love is a campaign that seeks to reduce the number multiple concurrent partners (MCP) in order to reduce new infections of HIV (Soul City, 2000). MCP is seen as a key driver of the HIV epidemic, hence, the need to shift such social norms and reinforce positive behaviours through advocating for one sexual partner. One-Love offers role models for safer

sexual behaviour, and challenges men and women to change their behaviour to live a safer and happier life. This campaign is aimed at both adults and younger people.

An example of the One-Love campaign is a TV drama about a young man and women in a relationship, who are about to get married. The young man is at the same time involved in a sexual relationship with another woman. This exposes the young man to HIV infection as the other woman is infected with HIV. When he eventually gets married to his fiancée, he is already infected and thus passes the disease to the wife. The drama sought to highlight the effects of having more than one partner. It not only affects the one involved, but the next person too. Hence, it offers the message that one needs to refrain from such behaviour. Soul City campaigns are communicated to the masses through a number of channels which include television and radio broadcasting, as well as the publication of newspapers and booklets.

THEMES

The dominant themes addressed by the Soul City campaigns include:

- campaigns on multiple concurrent partners
- issues of alcohol and drug abuse
- safe sexual activities (partner reduction and condom usage)
- HIV testing and counselling as well as HIV treatment
- Perceptions of HIV/AIDS

3.3.5 LOVE LIFE CAMPAIGNS

This is one of South Africa`s largest national HIV prevention programmes for young people, which aims to turn back the tide of the HIV/AIDS epidemic and associated epidemics amongst the youth (Parker, 2003). Love Life campaigns provide comprehensive, factual and

personalised sexual health and HIV education to empower young people in the fight against HIV/AIDS. The main purpose of having HIV/AIDS programmes targeting the youth is to support the growth of a generation that is creative, connected and has the tools to stay HIV/AIDS free (Parker, 2003). Love Life is seen as the most comprehensive effort that strives to positively influence adolescent lifestyles in South Africa (Parker, 2003).

Love Life has also employed a number of communication strategies that involve the youth in their own development. These campaigns use different media channels to reach the youth, with the most popular channels amongst the youth at the forefront. Recently, new platforms of communication, like cellular phones and the internet, have been engaged in disseminating information that will help in the fight against HIV amongst the youth (DasGupta, 2008).

An example of the Love Life programmes targeting the youth is the MYMsta.mobi (Make Your Move) initiative. This initiative can be accessed by young people on their web-enabled phones and computers (Seopa, 2008). The initiative is dedicated towards the empowerment and prevention of HIV/AIDS amongst young people in South Africa. MYMsta seeks to reach out to young people by giving them a platform on which they can discuss issues that are of concern and probably come up with solutions to the problems faced by young people today (DasGupta, 2008). The features of MYMsta have also been designed to build personal initiative and strengthen young people`s ability to negotiate day-to-day pressures with others. Its main purpose is to provide informational support to people belonging to a particular network (Seopa, 2008).

THEMES

Besides the MYMsta initiative, Love Life has other campaigns that address issues that are seen as structural determinants to HIV/AIDS infections amongst the youth. These issues include:

- Abstinence and delayed initiation of sexual activity,
- Reduction of sexual partners and condom use,
- HIV/AIDS counselling and testing,
- Ways of economic empowerment, and
- Reduction in alcohol and drug abuse.

The different identified communication strategies have been developed mainly to contribute significantly in the fight against HIV/AIDS. Identifying and understanding structural determinants is important for the development of effective HIV/AIDS communication for different situations and recipients.

3.4 APPROACHES TO HIV/AIDS COMMUNICATION ADOPTED WITHIN HIV/AIDS COMMUNICATION CAMPAIGNS

Different approaches to HIV/AIDS communication have been used by many intervention programmes in South Africa, to convey HIV/AIDS information that would work towards fostering social change or influencing the behaviour of targeted populations. Approach, in the context of this study, is defined as the different methods that intervention programmes adopt in their bid to convey information. Table 6 below presents the various approaches that intervention programmes have implemented in order to communicate with different audiences. Some of these approaches are discussed at length later in this chapter.

The complex nature of the epidemic, as well as the complex circumstances in which people engage with HIV/AIDS, compels the need for the development of a variety of strategies that will aid in mitigating the spread of the epidemic. One strategy clearly cannot be efficient and effective, hence the need for a multiple approach strategy in conveying HIV/AIDS information to target populations. As seen in the table below, messages are designed with a specific purpose and must be communicated through the appropriate channels in order to reach their audiences.

Table 6: Communication Approach in South Africa (*Adapted from Parker, 2003)*

ACTIVITY	COMMUNICATION COMPONENT	EXAMPLE
Purposive mass media- typically conducted by government and non-governmental organizations. (includes purposive activities of media formations)	Television, radio, print (newspaper, magazines), outdoor (billboards, mobile media)	Short duration advertisements/inserts, once-off programmes, talk shows, drama series and documentaries. News and feature articles
Non-purposive mass media	Television, radio, print	AIDS content within: -News programmes, once off shows, drama, documentary. News and feature articles, columns.
Purposive small media	Leaflets, posters, booklets, brochures, manuals, videos, exhibitions, signs, utility items	Typically print material but can extend to other approaches.
Events	Community gatherings, sports and entertainment events	Events such as AIDS Day, integration of HIV/AIDS into various social events
Dialogue and direct experience and personal action	Purposive support systems, health systems, religious and cultural systems, sexuality, gender, legal & rights framework. Extends to direct experience of HIV/AIDS	Dialogue include: structured and purposive dialogue. Telephones help-lines, VCT, interacting with health workers
Social Action and mobilisation	Involvement in HIV/AIDS activities	Meetings, protests and rallies, giving advice, caring for the ill/orphans

3.4.1 NATURE OF COMMUNICATION - ENTERTAINMENT EDUCATION APPROACH

The nature of communication generally describes the manner or format in which information is conveyed to a target population. Different ways have been used by many HIV/AIDS organisations in South Africa to communicate with target populations, although some have become more popular methods of HIV/AIDS communication. Entertainment education (EE) is one method of communicating about HIV/AIDS which has become popular both in the South African and global context. According to Singhal & Rogers (1999), entertainment education, which has its historical roots in the art of storytelling, can be defined as the:

> process of purposely designing and implementing a media message both to entertain and educate in order to increase audience members' knowledge about an educational issue, create favourable attitudes, and change overt behaviour. It seeks to capitalize on the appeal of popular media by combining entertainment and education so as to obtain certain advantages from each.

Using performance and dramatic arts to engage the attention, interest and curiosity of an audience, entertainment education involves presentations that purposefully seek to explain, demonstrate, define and/or compare the consequences of different life choices (UNFPA, 2002). In other words, entertainment education has the potential to reach large audiences and engage with them through memorable plots and appealing characters (Deborah, et al., 2002).Entertainment education does so by weaving health information into a short-term storyline within an ongoing commercial television or radio series. By adopting the narrative format, entertainment education makes it possible to demonstrate strategies for overcoming

barriers to a recommended behaviour and the consequences of either adopting or failing to adopt the recommended behaviour (Deborah, Nowak, Valente, Spasis & Martin, 2002).

Entertainment education comes in many forms including serial dramas which are broadcast on TV and radio, as well as cartoons, interactive "talk" shows and folk media (UNFPA, 2002). Framing messages in such a popular, entertaining format helps create an environment where people of all ages can take part in conversations about topics discussed in the latest episode of their favourite soap opera or cartoon (Colle, 2000). Also, EE is used to legitimize sensitive topics for public discussion, giving people the positive reinforcement they need to talk about certain issues with family and friends. Interpersonal communication becomes more feasible and acceptable, and positive learning and decision-making are more likely to follow.

In South Africa, campaigns within Khomanani, Soul City and many other HIV/AIDS communication advocates have used the entertainment education strategy to communicate with their target populations. For example, Soul City has developed a number of dramas and soap operas that target different audiences for the purpose of HIV/AIDS communication. Phuza Wise, Tsha Tsha, Soul Buddies are a few examples of dramas and soap operas that Soul City has used to convey HIV/AIDS information. These have used plots and characters to convey information about a health concern. According to Greenberg (as cited by Singhal, 2004:191), such plots show how a character progresses or has progressed through the symptoms, diagnosis, prognosis, treatment, complications and recovery associated with a specific illness. Table 7, below, presents an example of an entertainment education strategy and its effect on recipients.

Table 7: An Example of Soul City Entertainment Education Campaign.

Tsha Tsha is a gritty Xhosa-language educational drama with English subtitles. Set in a fictional rural town in South Africa, the drama focuses on the lives of four 20-somethings living on the dusty streets of this impoverished town. The setting includes a ballroom dance club, which provides a background for exploring relationships and intimacy. As they transition to adulthood, the main characters deal with HIV/AIDS, relationships, sex, and poverty. The series aims to deliver lessons that enhance young people's capacity to reflect on solutions and to see themselves as active agents who can shape their own lives.

The main objectives of the campaign are to:

- Encourage young people living with AIDS to seek HIV/AIDS-related services
- Increase the rate of voluntary counselling and testing among youth
- Increase condom use among youth engaged in high-risk sexual behaviour
- Decrease stigma associated with HIV/AIDS
- Encourage secondary abstinence among unmarried youth
- Increase self-efficacy of young people regarding positive decision-making and problem solving

Results

An evaluation of the first 26 episodes was conducted from 2003 to 2004 by means of a longitudinal sample survey of 960 youth aged 16 to 26 in three diverse provinces of South Africa: Gauteng, the Eastern Cape, and KwaZulu-Natal. Sixty-eight percent recalled seeing Tsha Tsha on television. Exposure to *Tsha Tsha* was found to be significantly related to a positive attitude toward living with HIV/AIDS (reversed stigma), the prevention practices of sexual abstinence, faithfulness to one partner, condom use to prevent HIV, and condom use at last sex. Exposure was also positively related to obtaining an HIV test to determine one's status. These findings were replicated in a national sample survey of 7,000 conducted in 2006 that included a sub-sample of 2,814 males and females aged 15 to 24 years. The survey demonstrated substantial exposure to the campaign and changes in behaviors among the Tsha Tsha viewers. Sixty-one percent of youth aged 15 to 24 surveyed had seen *Tsha Tsha*. Sexually active youth aged 15 to 24 were more likely to use a condom if they had seen *Tsha Tsha* than youth who were not exposed to the campaign.

Source: Adapted from USAID, 2009

Basically, entertainment education is a strategic process that has been used to design and implement a media communication message (incorporating participation from the target audience) with both education and entertainment elements to facilitate social change (Colle, 2000). The effectiveness of HIV/AIDS initiatives which have implemented the entertainment education strategy has been questioned, in some instances, as a number of criticisms have been leveled against some communication strategies.

For instance, Parker (2006) had this to say about the Love Life initiative:

> The Love Life intervention… positioned South African youth – as fundamentally driven by internal values of materialist consumption…. The notion of 12-17- year old South African youth as mono-cultural and unified by sexual desire and materialist consumption, directly contradicted obvious diversities of language, culture and access to disposable income amongst youth.

Clearly, there are challenges associated with the use of entertainment education in conveying messages and the following section of this chapter offers a discussion of some of the challenges which can weaken the effect of HIV/AIDS entertainment education programmes.

3.4.1.1 CHALLENGES TO ENTERTAINMENT EDUCATION HIV/AIDS COMMUNICATION CAMPAIGNS

Greenberg et al. (cited by Singhal 2004) have identified some challenges that could affect the strength of EE HIV/AIDS communication strategies. These include:

- The ratio issue: the primary goal of using EE is to use entertainment to enhance education and not the other way round. The important question to be asked is, in this regard, what proportion of entertainment is necessary and beneficial to achieve the desired outcome. Excessive entertainment may dilute the educational component whilst excessive information could result in bored receivers or the outright rejection of the message.
- The amount issue: this describes the nature of the relationship between the size or length of a message and its outcomes. Does carrying a theme focussed on a specific

health issue, throughout an entire episode, work more effectively than having a series of events presented over time.

- The order of presentation issue: this refers to the attention given to locating the strongest position of the entertainment component relative to that of the educational. Using entertainment, initially, might serve a dual purpose of generating interest and moving receivers to a less defensive posture whilst primacy advocates argue that the best option for behaviour change consists of first impressions. Therefore, the question to ask is: should entertainment lead or the reverse?
- The repetition issue: this refers to a general communication maxim which holds that repetition is good, at least to a certain point. The repetition of messages plays a pivotal role in enhancing the power of audience retention which could lead to attitude change. Some studies have found a positive association between the degree of exposure to health messages and behaviour change (Ferguson, 1999:173). Therefore, repetition can increase the understanding of the contents of the message and enhance the importance of the issue or problem (Hanan, 2003). Although repetition is good, how long can a message be repeated before tedium or even revulsion sets in? Too much repetition is likely to increase rejection or to have the audience "tune out" the message. Another problem also arises when greater emphasis is placed on one or a few aspects of prevention, as it causes a decline in the significance given to other factors in the transmission of epidemic (Ferguson, 1999:173).

As has previously alluded to, many HIV/AIDS interventions in South Africa have adopted this approach to convey HIV/AIDS information. Have these interventions yielded positive results or have they contributed to the disregard of such information amongst target populations?

3.4.2 USE OF ADVERTISEMENTS TO COMMUNICATE HIV/AIDS MESSAGES

Another approach to HIV/AIDS communication that is closely related to entertainment education is the use of advertisements. Advertisements, in terms of HIV/AIDS communication, can be described as short and theatrical series of messages designed to raise awareness on various aspects relating to HIV/AIDS (Utulu, 2011). These messages are packaged in ways that are easy to understand, appeal to people and hope to change the beliefs, attitudes and behaviour towards HIV/AIDS issues (Utulu, 2011). In most instances, HIV/AIDS information has been disseminated through the placement of advertisements on radio and television. The advantages of using advertisements for HIV/AIDS communication are that:

- The frequency of broadcasting advertisements is higher and as a result audiences are continuously exposed to HIV/AIDS communication. Studies have shown that there is significant relationship between increased exposure to HIV/AIDS messages and behaviour change

- Advertisements are short, concise and easy to understand. Longer programmes on any issue tend to affect the attention span of audiences when compared to short programmes. With concise programmes, audiences are still able to pay attention to messages and receive information on different aspects of HIV/AIDS.

- Advertisements easily appeal to audiences, who in turn find it easy to identify with advertisements. The nature of advertisements has been designed in such a manner that it draws attention and appeals to the masses. When audiences find it easy to identify with selected advertisements on HIV/AIDS, it also implies that the content of the

advert is vivid in their minds to raise more awareness of the different aspects of the epidemic.

In the South African context, the use of advertisements to communicate HIV/AIDS is common. Advertisements have been employed to address various issues related to HIV/AIDS. For example, HIV/AIDS communication adverts have focused on issues of HIV/AIDS and stigma, voluntary counselling and testing (VCT), use of condoms and family planning as well as issues relating to multiple concurrent partners. A common initiative that has produced a number of advertisements on HIV/AIDS is the *'it begins with you'* initiative. Through this initiative, the above stated issues have been addressed using short theatrical inserts in a bid to continue raising awareness of HIV/AIDS among target populations. *'Brother for life'* is also another initiative that has been employed the short theatrical inserts to communicate issues of having one partner and protecting that partner as well as issues of VCT. These are some of the examples of initiatives that have used adverts to communicate HIV/AIDS messages with different audience and mainly through the use of radio and television.

3.4.3 LANGUAGE USE IN HIV/AIDS COMMUNICATION CAMPAIGNS IN SOUTH AFRICA

Language consideration is of paramount importance in the development of HIV/AIDS communication as it can directly or indirectly affect the effectiveness of such interventions. Language construction can heighten the risk of distortion, misinterpretations and/or even cause the rejection of messages, especially in multilingual societies (Bearth, 2012). South Africa is a linguistically heterogeneous country with many different languages being used amongst its population. As such, it becomes imperative for any HIV/AIDS dissemination strategy to embrace and integrate the essential elements emanating from language diversity

and social ethnic complexity in order to effectively communicate with target populations. To consider societal language in the construction of health messages will help to:

- eliminate the alienation of the message, and
- make the message culturally, geographically and educationally more understandable and acceptable (UNESCO, 2005)

According to Namyalo (2005), societal multilingualism, if not sufficiently compensated for by individual, bi or plurilingualism will constitute a formidable barrier to the efficient transmission of key messages carried in intervention programmes. As such, the development, translation and adoption of HIV/AIDS related information complying with local cultural and linguistic norms is a necessity in order to facilitate effective message construction (Salmon & Atkin, 2003). The absence of culture-specific HIV communication, which would speak to the relevant, complex issues of the identity, community, and economics of the different ethnic groups in societies, can affect the enhancement of user-friendly HIV/AIDS materials (Namyalo, 2005). Therefore, messages or information material must be developed in official/regional/local and/or in national languages depending on the diversity of audience-spoken languages in the communication campaign's target area (Bearth, 2012).

In the South African context, HIV/AIDS communication strategies have largely employed English for most of their communication campaigns, although there are initiatives that have been translated to other languages within the country. South Africa has eleven official languages although English seems to be the official language for use in administration and in many communication activities like HIV/AIDS communication. Although there are strategies that provide HIV/AIDS information in local languages, more needs to be accomplished in this regard in order to provide timely and relevant messages. For

both print and electronic media, more local languages must be used for HIV/AIDS communication activities. Currently, there are soap operas or dramas that use both English and some local languages, and which strive to use simple language without medical terminology that may become a barrier to effective communication. Efforts have also been made to provide print material in native languages.

It is important for service providers to have an understanding of the needs of the different populations, rather than generalizing those needs. For example, some populations consist of people who are illiterate: some cannot read and write. Some populations also consist of people who are blind and deaf. A comprehensive knowledge of the audience should guide the development and use of appropriate language that would be understood by the relevant target populations. Simplicity in language, whilst remaining accurate, in HIV/AIDS communication is important so that even the illiterate can understand the message. Sign language, on the other hand, also has to be used in order to effectively communicate with the deaf. The importance of language in effectively communicating HIV/AIDS messages cannot be overstated. As such, care must be taken in the development and use of language in HIV/AIDS communication strategies.

In the South African context, more programmes, which use local languages, must be developed as well as programmes that cater for the needs of the deaf, as there are very limited numbers of programmes developed for the deaf and the blind.

3.4.4 CHANNELS OF COMMUNICATION USED IN HIV/AIDS COMMUNICATION CAMPAIGNS

The selection of the medium or channel of communication has played a crucial role in disseminating messages to the target audience. Mass media has largely been used as a way of conveying messages to the target audience and to convince them to change their behaviours.

The selection of appropriate communication channels is important for the success of communication programmes. According to Minja, Schellenberg, Mukasa & Nathan (2001) studies have shown that the use of relevant communication channels in supplying important health information has produced positive outcomes. Salmon & Atkin (2003) further state that no matter how persuasive one's campaign messages are, they cannot be effective without being placed in channels with great potential to reach the target audience. For instance, HIV/AIDS prevention awareness campaigns for Africa and Asia revealed that people living in remote areas did not have access to television (due to range and cost factors) or newspapers and magazines (due to the poor literacy rate) (Anarfi, 2005). While radio (because of remote access) and interpersonal communication (due to direct contact with an audience) were more effective techniques in spreading information that lead to behaviour change (Anarfi, 2005). This clearly indicates that the identification of relevant channels of communication is equally important as the development of HIV/AIDS messages.

Different communication mediums - electronic, billboards and print have been used in conveying HIV/AIDS information and they all have different requirements for message construction. Therefore, an understanding of the technical details of the various mediums of communication is important in order to effectively communicate with the target population. In South Africa, different interventions have used different channels of communication to reach their target audience. Besides television and radio, newspapers, magazines, billboards and mobile media (buses, taxis and trains) have also been employed to communicate about HIV/AIDS. In newspapers and magazines, news and feature articles as well as regular columns have been used to consistently provide information on HIV/AIDS (Parker, 2003). Leaflets, posters, booklets and brochures are also examples of print media that have been used to disseminate HIV/AIDS information in South Africa. The use of print media is

challenged by the low literacy levels of some members of community (Vaughan & Roger, 2000). This can result in the reduced use of such materials, thereby limiting the effect of communicated messages. To counter this set back, Minja et al. (2001) argues that the increased use of local language in print media can contribute to their increased use, rendering them important tools for development communication.

Regarding the use of mobile media, artistic paintings addressing certain aspects of HIV/AIDS have been put on buses, taxis and even trains. This strategy has the potential to expose many people to HIV/AIDS messages. New media technologies have also become a platform worth considering for HIV/AIDS communication, given the vast numbers of people using them. For example, AIDS.gov is now on Facebook and functions as a community for people with specific medical conditions or concerns; it also provides a space for users to share their experiences, find support and discuss their health concerns and treatment information with others (AIDS.gov, 2008). In South Africa, social platforms have been used to develop initiatives like MYMsta.mobi to communicate with young people about HIV/AIDS (DasGupta, 2008). Research is still being conducted to ascertain the appropriate ways of how social platforms can be effectively used for HIV/AIDS communication given the vast numbers of people using social platforms.

When it comes to the identification of channels to employ for communicating with audiences, the philosophy of "fish where the fish are" (Anderson, 2011) becomes relevant. For example, there has been a tremendous growth in the number of young people using the internet and some of its applications as platforms for communication. Young people now spend much of their time on their social networks which they have access to through their mobiles and computers. According to Rosen (2010), Facebook forms the largest 'country' in the world, with 80 percent of a teenager's time being spent on social networking. In South

Africa, social sites such as MXit draw approximately 14.5 million users, with most users accessing the site daily (ClubbersGuide 2010). This means that HIV/AIDS communication developers must consider the use of such channels to increase the exposure of young people to HIV/AIDS messages.

What is apparent, however, is that no one campaign transmitted via one channel can yield significant results but the synergy of campaign components is likely to increase exposure and may increase the impact of a campaign (Derzon & Lipsey, 2002). Conclusively, identifying the channels used by target populations and understanding their potential in HIV/AIDS communication can help in the identification of appropriate channels with which to communicate and reach the masses.

3.4.5 INTERPERSONAL COMMUNICATION

Mass media plays a crucial role in the dissemination of HIV/AIDS information. However, Simons-Morton et al. (1997) point out that a one-dimensional approach to health promotion, such as the reliance on mass media campaigns has been shown to be insufficient to achieve programme goals. Multi-dimensional interventions increase the success of health promotion interventions as programs are designed to reach diverse audiences about complex health concerns (Simons-Morton et al. 1997). Interpersonal communication is one important approach that can effectively complement mass media programmes.

Interpersonal communication is important in influencing the behaviour of an individual or a group of people. The strength of interpersonal communication lies in the fact that:

- messages can be delivered by a person who belongs to that particular group for whom the message is constructed. The opinion leader influence is significant in this regard.

- the content of the message is more harmonized with the local culture, tradition, norms and values.

- media campaigns are typically limited in duration (Hanan, 2003).

Interpersonal communication has been supported largely through community gatherings and events. HIV/AIDS issues are integrated into the various socio-cultural and even religious events. Such events have the potential to support dialogues and even allow for HIV/AIDS issues to be discussed in the context of the community members. Through the use of influential people in these gatherings, the possibility of message acceptance is high. Interpersonal communication therefore plays an important role in the dissemination of HIV/AIDS information to a target population; to effectively complement media campaigns.

3.5 CONCLUSION

The South African HIV/AIDS and communication environment is a complex one as it strives to address the diverse ways in which people engage with HIV/AIDS, particularly young people. What is clear from the literature on the matter is that there is no one method or communication activity that can solely address the complex nature of HIV/AIDS and lead to the desired social and behavioural change. However, the use of a multiple approach strategy can aid in the development of a holistic or comprehensive strategy that can help convey information which can positively influence the lifestyle of target populations. It is also clear that the nature of communication is largely influenced by the prevailing policies of a country. This chapter has, therefore, discussed the development of HIV/AIDS communication in South Africa, provided an overview into the five common HIV/AIDS communication brands in South Africa and, lastly, discussed the different approaches to HIV/AIDS communication.

CHAPTER FOUR

THEORETICAL FRAMEWORK

4.1 INTRODUCTION

This study uses the Theory of Reasoned Action and Planned Behaviour (TRA/PB) developed by Fishbein and Azjen (1975) and the Communication model for Development as proposed by Mersham, Rensburg & Skinner (1995) to provide the theoretical foundations of the study. The components of these models reflect the aims of the communication intervention programs to raise awareness, change attitudes and behaviour, whilst implementing behaviour and even sustaining changed behaviour against an epidemic. As such, the use of these models will help to provide a clear understanding on the effectiveness of HIV/AIDS communication amongst female youths by focusing on their use of such communication.

The purpose of this chapter is, therefore, to provide a discussion of the theoretical framework of this study. The chapter highlights the core assumptions of the Communication model for Development and the TRA/PB model as well as the development and application of the theories in other studies and in this study. The possible limitations of the theories relevant to this study are also discussed in this chapter.

4.2 THEORY OF REASONED ACTION/ PLANNED BEHAVIOUR

The Theory of Reasoned Action (TRA) was developed by Azjen and Fishbein in 1967 and underwent review in the 1970s. The model was developed to study human behaviour and aid in the development of appropriate intervention programmes. The model was developed at a time when there was a growing interest amongst social psychologists to understanding how attitude impacted behaviour (Azjen & Fishbein, 1980). Fishbein and Azjen were among

scholars who joined forces to explore ways that could predict behaviour and outcome, leading to the development of the TRA. However, in 1988, the planned behaviour construct was added as an extension to the TRA in order to address the inadequacies that had been identified when using the Theory of Reasoned Action (Azjen & Fishbein, 1980). Because the Theory of Reasoned Action and Planned Behaviour are conceptually linked, the study will adopt and use the term TRA/PB.

The TRA/PB model has a number of principles attached to it. These principles lie in the assumptions held by the model, and they include the facts that:

- human beings are rational and make systematic use of information available to them in order to develop reasonable behavioural intentions
- people consider the implications of their actions before they decide to engage or not engage in certain behaviors (Fishbein & Azjen, 1975).

Basically, what this theory sought to achieve was to develop a way in which to examine and explain human or individual behaviour by focusing on four aspects, namely: behavioural intention, attitudes, social norms and perceived behavioural control.

4.2.1 DEVELOPMENT OF THE THEORY OF REASONED ACTION/PLANNED BEHAVIOUR

The Theory of Reasoned Action and Planned Behaviour addresses the impact of cognitive components on behaviour. As such, in its development, TRA/PB identified antecedents to behaviour. TRA/PB began by looking at intention as being the immediate antecedent to behaviour. According to Malhotra & Galletta (1999), a person's performance of a specified behaviour is determined by his or her behavioural intention to perform the behaviour. Behavioural intent is seen as the most important determinant of a person`s behaviour and is defined, by Chen et al. (2009), as the motivational factors that capture how

hard people are willing to try and how much effort they are planning to exert in order to perform a behaviour. As such, in TRA/PB, behavioural intention occurs as a result of the person's attitude, normative beliefs and perceived behavioural control concerning the behaviour in question (Malhotra & Galletta, 1999). The assumption is that the stronger a person`s intention to perform a behaviour, the more successful they are expected to be in performing that behaviour.

Fishbein and Middlestadt (1989) summarize the relationship between behaviour and intention using the equation below:

$$\mathbf{B \approx I = f\ [\ w_1\ Ab + w_2\ SN]}$$

Where:

B=Behaviour

I= Intention to perform the behaviour

Ab= Attitude towards performing the behaviour

SN= Subjective norm with regard to the behaviour

w_1 = Weight (relative importance) of the attitude

w_2 = Weight (relative importance) of the normative component

The Theory of Reasoned Action and Planned Behaviour has various underlying concepts which include (1) behavioural criterion, behavioural category and outcome; and (2) behavioural elements of action, target, context and time (Azjen & Fishbein, 1980), and are discussed below.

1. Behavioural criterion, behavioural category and outcome:

- The central focus of the Theory of Reasoned Action is on single, directly observable behaviour under an individual's control. A distinction needs to be made between behaviours and occurrences that may be the outcome of those behaviours (Azjen & Fishbein, 1980). According to Fishbein & Middlestadt (1989), behaviour can take the form of an overt observable action for example a single act or behavioural criterion – which basically describes whether or not a certain act was performed. With regards to HIV prevention, behavioural criterion measures whether or not a person used a condom the last time they had sexual intercourse (Tlou, 2009). Behavioural category, on the other hand, describes behaviour that cannot be directly observed but one that can be inferred from single actions assumed to be instances of general behaviour (Fishbein & Middlestadt, 1989). For example, the behavioural category of safe sex can be inferred from single behaviours such as abstinence, avoidance of risky social interactions and using a condom when having sexual intercourse (Tlou, 2009). A behavioural outcome is different from the behavioural category and criterion in that it describes outcome that may result from the performance of one or more behaviours. For example, behavioural outcome measures the outcome of using condoms and abstinence (Fishbein & Middlestadt, 1989).

2. Behavioural elements of action, target, context and time:

- According to Fishbein & Middlestadt (1989) once behaviour of interest has been identified, the next step is to measure the behaviour; a measurement that requires consideration of the four behavioural elements of action, target, context and time. Every *action* is directed at a *target* in a given *context* at a given point in *time*. For example, a person going out at night (time) would use a condom when having sex

(action) with a casual sex partner at a club (context) in order to protect himself against HIV (target) (Fishbein & Middlestadt, 1989).

Figure 1: Theory of Reasoned Action

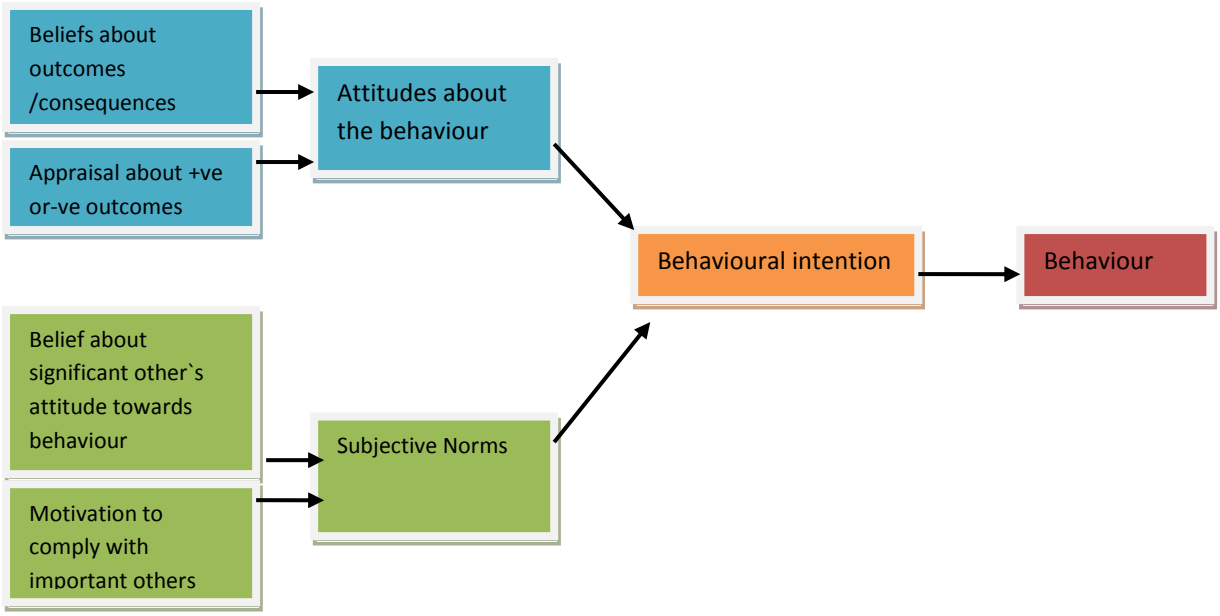


Figure 1: Theory of Reasoned Action (Azjen, 1991; Azjen & Fishbein, 1980)

4.2.2 DETERMINANTS OF BEHAVIOURAL INTENTIONS

The theory of reasoned action/planned behaviour identifies two variables as the main antecedents of behavioural intention. These are attitude towards behaviour and the effect of social norms towards behaviour.

4.2.3 ATTITUDE TOWARDS BEHAVIOUR

In order for behavioural intention to develop, TRA/PB identifies attitude as the first antecedent to behavioural intention. Attitude involves judgement whether the behaviour is good or bad and whether the actor is in favour of or against performing it (Leonard, et al, 2004). Attitude includes behavioural beliefs and evaluations of behavioural outcomes. The antecedents of attitude are corresponding beliefs reflecting the underlying cognitive structure (Azjen, 1991). Each behavioural belief links a given behaviour to a certain outcome or to

some attribute, such as the cost incurred in performing the behaviour (Armitage & Conner, 2001). Thus the attitude towards the behaviour is determined by the strength of these associations and even by the beliefs that are salient at the time (Armitage & Conner, 2001). Attitudes are thus determined by the individual's beliefs about the consequence of performing the behaviour weighted by his or her evaluation of those consequences (outcome evaluation) (Leonard, et al, 2004). Therefore a person who holds a belief that positively valued outcomes will result from performing a behaviour (for example, condom use) will have a more positive attitude towards the behaviour (condom use) than one who has a strong belief that negatively valued outcomes will result (Leonard et al. 2004). According to Fishbein and Middlestadt (1989), the expectancy-value relationship between attitude and behavioural beliefs is illustrated in the equation below:

$$\mathbf{Ab = f\ (\Sigma b_i\ e_i)}$$

Where:

Ab = Attitude towards performance of a behaviour (for example, use of a condom when having sex).

b = belief that performance of the behaviour will lead to outcome ***i*** (for example, using a condom will protect sexually transmitted diseases and pregnancy).

e = evaluation of outcome ***i*** (for example, how good or bad is the protection from sexually transmitted diseases as a result of using a condom?).

Attitudes towards any object are determined by beliefs about that object, which may be favourable or unfavourable, depending on the characteristics associated with the object (Tlou, 2009). Direct observation, indirectly accepting information from outside sources, or making inferences about an object can lead to the generation of beliefs a person holds towards an object (Azjen & Fishbein, 1980). According to Azjen (1991) although a person may hold many beliefs about any given object, it is only the salient beliefs that will serve as

the determinants of attitude. Therefore to understand a person's attitude towards an object, it is imperative to assess the person's salient beliefs about that object; which are usually the first few beliefs that a person reports in relation to a given object (Azjen & Fishbein, 1980). Azjen and Fishbein (1989) believe that there has to be a correspondence between beliefs and attitude, if attitudes towards behaviour are to be successfully predicted or understood. Ajzen and Fishbein (1989) further maintain that when eliciting salient beliefs that determine attitude towards behaviour, it is important to ensure correspondence to action, target, context and time elements. Salient beliefs are therefore elicited by asking respondents to list advantages and disadvantages of engaging in the behaviour. With the knowledge of a person`s salient beliefs about performing behaviour, it becomes possible to determine their attitude towards performing that behaviour.

After identifying salient beliefs, it becomes necessary to measure how confident a person is that performing a given behaviour will produce a desired outcome. This measure is described as the individual`s belief strength (Tlou, 2009). Belief strength is measured by asking a person to indicate the likelihood that performing a behaviour will result in a given outcome or that it is associated with some attribute (Azjen & Fishbein, 1980)

The Theory of Reasoned Action maintains that a person`s attitude towards a behaviour can be predicted by multiplying his/her evaluation of the consequences of each behaviour by the strength of his/her belief that performing the behaviour will have a particular outcome, and then summing the products for the total set of beliefs (Azjen & Fishbein, 1980). Therefore the expectancy-value model of attitude maintains that attitude towards behaviour corresponds to the favourability or unfavourability of the total set of consequences, each weighted by the strength of the person`s belief that performing the behaviour will lead to each of the consequences (Ajzen & Fishbein, 1980).

Beliefs, clearly, are an important factor in determining the attitude of people towards a given issue or object.

4.2.4 SUBJECTIVE NORMS

Subjective norms, which are also known as social norms, have also been identified as having an important role in predicting intentions towards behaviour. Social norms have similar origins in a combination of people`s perceptions that have important others think they should or should not perform the behaviour in question and their motivation to comply with others wishes (Spark, et al, 1995). This means that if other related person or people feel that adopting the behaviour is positive and the person is motivated to take these people`s point of view into consideration, then the effect of social norms is positive and the individual`s intention towards the behaviour will also be positive (Spark, et al, 1995).

Social norms are thus defined as the perceived social pressure to perform or not to perform the behaviour. Social norms include the normative beliefs and the motivation to comply. These norms are a function of beliefs that specific individuals approve or disapprove of performing the behaviour in question (Azjen & Fishbein, 1980). The Theory of Reasoned Action assumes a causal chain that links behavioural and normative beliefs to behavioural intention, and behaviour via attitude (towards behaviour) and subjective norm (Fishbein & Middlestadt, 1989). This means that people are likely to perform behaviour when they evaluate it positively and believe that significant others think they should perform it (Ajzen & Fishbein, 1980; Fishbein & Middlestadt, 1989; Montano & Kasprzyk, 2002). Fishbein and Middlestadt (1989) summarize the relationship between subjective norm and normative beliefs in the equation below:

$$\mathbf{SN = f\ (\Sigma b_j m_j)}$$

Where:

SN = Subjective norm (for example, the belief that significant others think that he/she should use a condom every time they have sex).

b = normative belief that referent ***j*** thinks "I should or should not perform" a behaviour (for example, using a condom every time they have sex).

m = motivation to comply with referent ***j*** (for example, when having sex, he/she will use a condom, as referent *j* thinks he/she should).

Therefore, as maintained by the Theory of Reasoned Action, subjective norms can determine whether or not a certain behaviour towards an object will or will not be performed. According to the Theory of Reasoned Action subjective norms are a function of normative beliefs (Azjen, 1991). Subjective norm is described as an individual's belief that most significant others think that he/she should or should not perform a specific behaviour. A *normative belief*, on the other hand, describes a belief about another person's behavioural prescriptions. According to Azjen & Fishbein (1980), normative beliefs differ from subjective norms in that they involve specific individuals or groups, rather than a generalised significant other. The Theory of Reasoned Action therefore suggests that individuals take the normative expectations of significant others in their environment into account when forming subjective norms (Azjen, 1991). This implies that an individual considers whether significant others think he/she should or should not perform the behaviour, and then uses the information to arrive at his/her subjective norm (Azjen, 1991).

In determining subjective norms, not every possible referent will be significant at a specific point in time or in a given context - only the most *salient* referents will influence a person's subjective norm (Azjen & Fishbein, 1980). To elicit the salient referents, the respondent in an investigation is asked to list all individuals or groups who would influence his/her decision to engage in a particular behaviour. Azjen and Fishbein (1980) state that

once a person's beliefs about specific referents are known, the next step is to assess his/her motivation to comply with each of the referents. The Theory of Reasoned Action further maintains that a person's subjective norm can be predicted from the index obtained by multiplying normative beliefs by motivation to comply, and then summing the products (Azjen & Fishbein, 1980). Normative beliefs and motivation to comply determine the social norms of an individual.

4.2.5 THEORY OF PLANNED BEHAVIOUR

The Theory of Planned Behaviour is an extension of the Theory of Reasoned Action, and attempts to understand behaviour when people cannot exercise full control over the internal and external factors that make it possible to engage in a given behaviour (Azjen, 1991; Azjen & Fishbein, 1980). The construct 'perceived behavioural control' was added in an attempt to deal with situations in which people may lack complete volitional control over the behaviour of interest (Azjen, 1991). The extension was based on the idea that behavioural performance is determined by motivation (intention) and ability (behavioural control) (Azjen, 1991)

Percieved behavioural control (PBC) describes the capability of an individual to perform behaviour (Azjen & Manstead, 2007). Percieved behavioural control refers to the degree to which an individual feels that performance or non-performance of the behaviour in question is under his or her volitional control (Azjen & Manstead, 2007). PBC is therefore determined by two factors, namely control beliefs and perceived power. People are not likely to form a strong intention to perform behaviour if they believe that they do not have resources or opportunities to do so even if they may hold positive attitudes toward the behaviour and believe that others would approve it (Azjen, 1991). Control beliefs refer to the perception of factors likely to facilitate or inhibit the performance of a behaviour (Azjen & Manstead,

2007). These factors include both internal factors (for example, information, personal deficiencies, skills, abilities and emotions) and external factors (for example, opportunities, dependence on others and barriers) (Azjen & Manstead, 2007). People who perceive that they have access to the necessary resources and that there are opportunities to perform a behaviour – that is, people who have positive control beliefs – will have a high degree of perceived behavioural control (Azjen, 1991).

Azjen (1991) summarizes on the subjective norms by stating that, each control belief (*c*) is multiplied by the perceived power (*p*) of the particular control factor to facilitate or inhibit the performance of a behaviour, and the resulting products are summed across *n* salient control beliefs to produce the perception of behavioural control (perceived behavioural control). The following equation by Azjen (1991) summarizes the above.

$$\mathbf{A} \propto \sum_{i=1}^{n} \boldsymbol{b}_i \boldsymbol{e}_i$$

According to Azjen (1985 the Theory of Planned Behaviour, suggests that intentions can only be expected to predict a person's *attempt* to perform a behaviour, not necessarily its actual performance. In trying to predict behaviour, one would have to not only assess intentions, but also obtain an estimate of the extent to which individuals are apt to exercise control over the behaviour in question (Azjen & Fishbein, 1980). The equation:

$$\mathbf{B} \propto \mathbf{B_t} \cdot \mathbf{C}$$

illustrates that the strength of a person's attempt to perform a behaviour (B_t) interacts with the degree of his/her control (C) to determine the likelihood of the actual performance of the

behaviour (B). This implies that the harder the person tries, and the greater his/her control over personal and external factors that may interfere, the greater the likelihood that he/she will achieve his/her behavioural goal (Azjen, 1991). According to Azjen (1991), performance of a behaviour is a function of both intentions and perceived behavioural control. For accurate prediction, Azjen (1991) identifies three conditions that have to be met and these are:

(a) Measures of intention and perceived behavioural control must correspond with the behaviour that is to be predicted. Intentions and perceived behavioural control must only be related to the behaviour in question, and the context must be the same as that in which the behaviour is to occur. For example, the behaviour could be "to use a condom every time I have sex", not "to prevent myself from getting AIDS";

(b) Intention and perceived behavioural control must remain stable in the interval between their assessment and observation of the behaviour. Intervening events must be minimised; and

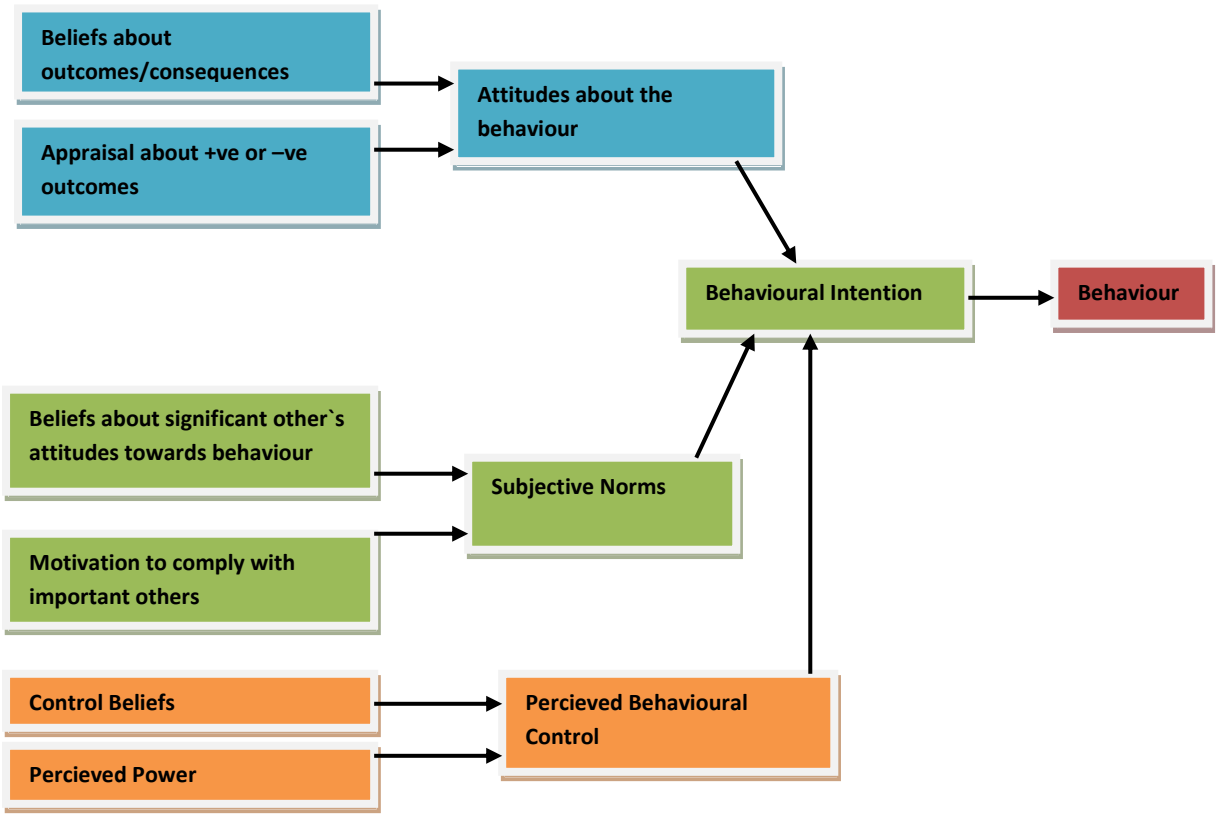
(c) Perceptions of behavioural control must realistically reflect actual behaviour.

According to Azjen (1985) the relative importance of intention and perceived behavioural control in predicting behaviour varies across situations and behaviours. When the behavioural situation is within a person`s control, intentions alone can predict behaviour. When control decreases, both intention and perception of control are needed (Azjen, 1985; 1991). Azjen (1991) also states that control beliefs are the antecedents of PBC and are concerned with the perceived power of specified factors to facilitate or inhibit the performance of the behaviour. Like other beliefs, the equation takes account of the relevance of the belief to the individual, in this case by taking a measure of the frequency of the occurrence of the promoting or inhibiting factor (Armitage & Conner, 2001). Therefore PBC

indicates that a person's motivation is influenced by how difficult the behaviours are perceived to be as well as the perception of how successfully the individual can or cannot perform the activity (Azjen and Fishbein, 1980). This perception can reflect on past experiences, anticipation of upcoming circumstances and the attitudes of the influential norms that surround the individual (McKenzie, 2000).

Basically the TRA/PB model explains individual behaviour by examining how attitudes, social norms and perceived behavioural control can influence behavioural intention which could eventually lead to the performance of a specified behaviour. The TRA/PB model has been used in various contexts as shall be demonstrated below and later demonstrated how applicable it is to this present study. Figure 2 below illustrate the Theory of Planned Behaviour.

Figure 2: Theory of Planned Behaviour (Azjen, 1985; 1991)



4.3 APPLICATION OF THE THEORY OF REASONED ACTION/PLANNED BEHAVIOUR MODEL

The theory of reasoned action and planned behaviour is very general and has been designed to explain virtually any human behaviour (Azjen & Fishbein, 1980). It has provided a theoretical foundation on which to investigate the individual's behaviour. As such, this model has been applied in various contexts and has been of great importance in research related to the reduction of social problems. TRA/PB thus has important implications for health education in examining health related behaviours and implementing and developing health prevention programs. It has therefore been used to:

- predict and understand healthy and unhealthy behaviour and the outcomes of such behaviour

- predict and understand intentions, behaviours and outcomes of health related behaviors (Romano & Netland, 2008).

Because of the nature of the TRA/PB model, it has been used to address various aspects of health-related behaviour. For example, in one study, the model was used to develop an HIV/AIDS prevention intervention for Latina adolescents from predominantly low-income communities in Los Angeles (Romano & Netland, 2008). By examining the attitudes, social norms and even perceived behavioural control of Latina women to HIV/AIDS behaviours, the model helped to determine the aspects of prevention that were especially relevant to Latina women (Romano & Netland, 2008). This model was also used by Hersey et al. (2003), to assess whether the tobacco counter-industry media campaign affected teens and young adults' attitudes about smoking cigarettes and their attitudes towards the tobacco industry in general. The study found that the counter-industry media campaign had a significant effect on the attitudes and behaviours of young people, with regard to cigarette smoking, and thus suggested that future research should focus on messages that most strongly influence smoking beliefs and attitudes (Hersey et al., 2003).

Generally, TRA/PB has been seen to be well suited to address individual risk and protective factors in prevention research, reducing risk variables while promoting variables that protect and enhance individual health (Romano & Netland, 2008). It is for this reason that TRA/PB has been applied to the prevention of HIV/AIDS, sexually transmitted diseases, teenage pregnancy and even illegal substance use (Albarracin et al., 2001). Based on these few examples in which TRA/PB has been applied, it is clear that TRA/PB has provided a theoretical framework for research on a number of health behaviours. Armitage & Conner (2001) maintain that TRA/PB has been most frequently used to guide prevention research in the health sciences, providing a theoretical framework for preventive behavioural and

systematic change interventions with diverse populations. Basically, TRA/PB can be employed to provide an explanation for the behaviour of different groups of people with regard to the behaviour in question. The next section of this chapter will focus on the relevance of and how TRA/PB has been applied to this present study.

4.3.1 APPLICATION OF THE THEORY OF REASONED ACTION/PLANNED BEHAVIOUR TO THE STUDY

This study seeks to investigate whether current HIV/AIDS communication strategies in South Africa - especially those targeting the youth - could still have limitations that have hindered or reduced the extent to which female youths translate HIV/AIDS information or knowledge into behaviour change. To understand this, the study attempts to understand why female youths seemingly still persist in the adoption of risk behaviour, as evident primarily in the rising teenage pregnancy rates and the increase in alcohol use (McLea, 2012); all of which continues despite the many visible HIV/AIDS communication campaigns. Because TRA/PB is general and designed to explain any human behaviour, it is thus appropriate to use it in this study in order to understand the HIV/AIDS communication usage behaviour amongst female youths. TRA/PB provides this study with a theoretical framework from which to understand how female youths use HIV/AIDS messages and to assess whether such communication has had any impact regarding the adoption of positive behaviour against HIV/AIDS. Basically, what the TRA/PB model will do, is to provide insight into why young women seem not to implement advice contained in HIV/AIDS communication strategies.

Using the TRA/PB model, the attitudes of young women to HIV/AIDS communication strategies will be measured, the effect of social pressure with regard to the use of communication will also be measured, as well as the influence of perceived behavioural control in the communication usage behaviour of young women. Attitude, in this

study, is defined as the user's evaluation of their desire to use communication. This pertains to whether an individual sees the behaviour as favourable or unfavourable to perform and is largely impacted upon by the consequences accompanying the behaviour. The study will measure young women's attitudes to HIV/AIDS communication and their attitudes towards the use of such communication. This will provide insight into the effect of HIV/AIDS communication on female youths.

Social norms in this study are defined as the user`s perception of social pressure, which may largely influence whether or not female youths will implement the advice contained in HIV/AIDS communication. In this regard, the influence of important others on the use of HIV/AIDS messages will also be evaluated. This will also provide an indication of the strength of current communications in fighting HIV/AIDS amongst the youth. Finally, perceived behavioural control, which for the purpose of this study is described as the perceived capability of an individual to perform behaviour, will also be measured. Within the context of this study, perceived behavioural control relates to the individual's perception of the accessibility of HIV/AIDS communication and the opportunities for its usage as well as an individual's self confidence in his or her ability to use HIV/AIDS messages effectively.

Basically, the TRA/PB model will provide a deeper understanding of the HIV/AIDS communication usage behaviour of young women. It will also provide insight into the effects of the communication campaigns in changing behaviour with regards to HIV/AIDS. In conclusion, the model will also provide insight into whether current communication strategies have limitations or not. If not, it will help explain the probable cause of the limited translation of knowledge into behaviour change amongst female youths. The assessment of individual and group assets and vulnerabilities are important in the development of successful prevention programs (Masten and Gerwirtz, 2006) and, as such, TRA/PB can help to assess

the strengths and limitations for behavioural change amongst members of the target population.

4.4 LIMITATIONS OF THE THEORY OF REASONED ACTION/PLANNED BEHAVIOUR MODEL

Although TRA/PB has been applied across disciplines, the model has conceptual limitations which can have an impact on the findings of the study. A number of conceptual limitations to this model have been identified and shall be discussed below.

- TRA/PB assumes that behaviors are solely influenced by intentions (Albarracin et al., 2001). However, a number of TRA/PB studies have shown past behaviour to be the best predictor of future behaviour (Sutton et al., 1999). This suggests that there are other stimuli that may habitually trigger a behavioural response, besides behavioural intention. The behaviours that were assessed using the TRA/PB model may be more reflective of past behaviour than that of current cognitions related to attitudes, social norms, PBC and behavioural intention.

- The relationship between long term goals (viewing aggregate behaviour in terms of a more distant goal) and current intention to perform specific behaviours can be overlooked in TRA/PB. Because the theory focuses on predicting a single behaviour, Abraham and Sheeran (2003) believe that the relationship between the behaviour and other actions one may take in pursuit of a supporting or competing goal may be obscured. Thus, the theory seems to neglect both the context and complexity of goals that bring about the behaviour in question.

- Weinstein (1993) further states that the model cannot predict the degree to which behaviour will change to avoid negative consequences; rather, it predicts only whether the behaviour will change.

- The theory is based on the assumption that human beings are rational and make systematic decisions based on available information. This may not be so, which implies that unconscious motives are not considered in this assumption.

- There is much ambiguity regarding how to define perceived behavioural control, which creates measurement problems. More so, the assumption that behavioural control predicts actual control may not always be accurate.

4.4.1 LIMITATIONS OF THE THEORY OF REASONED ACTION/PLANNED BEHAVIOUR MODEL IN RELATION TO THE STUDY

- Behaviour is not solely influenced by intentions, as maintained by TRA/PB. There are other triggers, like past and personal experiences, that can influence a behavioural response. In as much as HIV/AIDS communication can influence the development of an intention to adopt preventative behaviour, there are other salient factors that can trigger a behavioural response. It may not be an individual attitude, prevailing social norms and even perceived behavioural control that determines the adoption of protective behaviour; other factors may influence behaviour. Therefore, behaviour change may not be solely measured by intentions.

- Rational decisions, and the systematic use of available information, are not often made in all situations. In addition, decisions can even be influenced by emotions. In the presence of rationally structured HIV/AIDS media messages, it is still possible for individuals to adopt protective behaviour as a result of other stimuli that is not communication. For example, Singhal (2000) states that the death of a person can trigger behaviour; emotions in this instance play a role in triggering the practice of preventive behaviour.

- The model cannot predict the degree to which behaviour will change to avoid negative consequences; rather, it predicts only whether the behaviour will change. Although TRA/PB can be used to measure the success of health intervention programmes, it is limited when it comes to measuring the extent to which behaviour has been changed.

- People consider the implications of their actions before they decide to engage or not engage in certain behaviours (Fishbein & Azjen, 1975). The reality is that people do not always consider the implications of their actions before they decide to engage or not engage in certain behaviours.

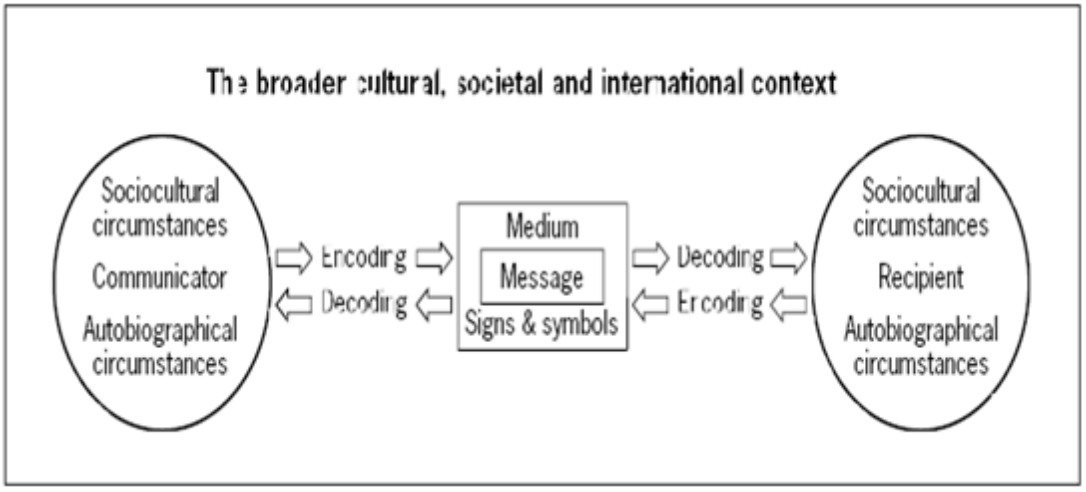
Although the TRA/PB model has some conceptual limitations, it has provided a theoretical basis for a number of health prevention studies. Through the use of this model, an understanding has been gained into the different attitudes of the target population and their impact on behaviour. The model has also been used to evaluate the impact of prevention strategies which target specific groups of people. It is on this basis that this study has adopted the TRA/PB model in order to try to gain an understanding of the use of HIV/AIDS communication amongst female youths and the impact of such communication on the behaviour of female youths in relation to HIV/AIDS.

4.5 COMMUNICATION MODEL FOR DEVELOPMENT

The communication model for development was proposed by Mersham et al. (1995) to allow for a heuristic approach to evaluating the different components of the communication process, with specific reference to the socio-cultural circumstances of communicators and recipients in the broader context of a society (Mersham, 1995). This model draws attention to the importance of the way in which the communicator manifests his or her ideas, and its importance to the success of the communication process. The

communication model analyses the message components, drawing attention to the codes and symbols of content as a vital area in the process of understanding.

FIGURE 3: A COMMUNICATION MODEL FOR DEVELOPMENT.



Source: Adapted from Mersham (1992b).

4.5.1 ASSUMPTIONS OF THE COMMUNICATION MODEL FOR DEVELOPMENT

Basically, the main elements of the model are that:

- The way in which the communicator manifests his or her ideas is vital to the success of the communication process (Mersham et al. 1995). In order to transfer thoughts, information, feelings and attitudes, Mersham et al. (1995) argues, that there is a need to consciously ensure that the form in which these ideas are manifest is 'decodable' by the partners in the communication process.
- The purpose of the communication must emanate from the stakeholder or recipients. Mersham et al. (1995) argues that the communicator exchanges roles and initially becomes a recipient or a ‘listening post’ for messages originating from stakeholders. According to the model, the context of the recipient and the communicator are

identical as recipients are also actively involved in the process of creating and sharing of a message (Huebsch 1986)

- There is a need to consciously monitor the interpretations attached to messages by partners in the communication process. Otherwise, they remain inner thoughts that communicators assume are shared with their communication partners. The recipient's active participation in the communication process must be encouraged and recognised. This process of interpretation (internalisation) can be vigorous enough to transform the message into the recipient's own message when it is reexpressed (externalisation) (Mersham et al. 1995). It is therefore important for the communicator to take active steps in encouraging the recipient to manifest his or her interpretation through the medium with which all the participant are comfortable. This makes it possible for the understanding or meaning attached to the original meaning to be evaluated. Communication does not end once communication has been encoded in the medium. The process is completed once the message has been received and interpreted (Mersham et al, 1995).
- The communicator must have skills in encoding messages in the mother-tongue of the communication partners and skills in the technology and techniques of the medium in question. All partners must have the requisite skills for decoding the mediated message.
- Signs and symbols in a message are devoid of meaning in themselves. They only receive meaning if the source gives them specific meaning and if the recipient sees a specific meaning in them (Mersham et al. 1995). The meaning of a sign depends not only on personal interpretation but also on collective agreement that may change across culture, space and time (Mersham et al. 1995).

- The model points to the importance of taking into account the broader societal circumstances in which the communication interaction takes place. Mersham et al. (1995) refers to this broader context as the cultural and autobiographical circumstance of individuals. Mersham believes that individual circumstance must be recognised (1995). He states that regardless of commonalities that link people is social structure, no two lives are the same in terms of individual experiences (Mersham et al. 1995). He therefore encircles the communicator and recipient with socio-cultural and autobiographical circumstances. The socio-cultural and autobiographical circumstances influence the perception and credibility of the communicators and their target messages (Mersham et al. 1995). The knowledge of these circumstances establishes a definite context for the communication process. Mersham et al. (1995) believes that the broader societal context is an important aspect of communication as it exposes people to far more stimuli and factors that can affect the way in which individuals interpret and re-express messages.

The model further maintains that in implementing programmes and campaigns, the skills of the communicator is of great significance. The communicator has to have sound knowledge and understanding of the community with whom he/she communicates. The following would assist in contributing towards communication with the various groups (Parker et al., 2000):

- Language: The communicator would have to identify and be able to understand the different languages that are spoken, (i.e. home, second language, etc.) in the communities. Such an understanding can assist in the formulation of strategies that are relevant to target populations.

- Socio-cultural factors: The communicator would require a knowledge and awareness of the different levels of HIV/AIDS infection. It would also be necessary that the communicator understands the internal and external awareness of myths, beliefs, and needs; as well as how the virus affects gender. This is in addition to the communicator's knowledge of other pertinent issues contributing to the internal and external environment of the target population.
- Health infrastructure: the communicator must have a clear understanding of the availability of health infrastructure in a community. How many clinics or health facilities are there in the communities? What drugs are available and what resources are made available to community members? An understanding into these factors will also support the development of relevant communication campaigns that will address the needs of community members.
- Communication: the communicator should understand the mediums that are available for the distribution of information e.g. radio, internet/intranet, multimedia approach, pamphlets, talks/trainings sessions. Identifying easily accessible communication channels and preferred communication channels will also assist in the development of communication programmes.
- Analysis of the Message(s), signs and symbols of the coding process: the communicator must ensure that messages are formulated in a manner that will be easily understood by recipients. An account must be taken of what the target audience understands about HIV/AIDS issues. The message must be kept appropriate to the medium, so as to ensure that the messages are conveyed effectively through the chosen medium. For example, detailed information is not good on a pamphlet but would read better in a policy document. Ideally, messages should be kept short and simple and avoid technical language.

- Interpretation and expression of messages: The form in which these messages are communicated to the recipients needs to be easily decoded; therefore messages must be expressed in a manner that is easily accepted by the recipient. Mersham (1992b) argues that signs and symbols are devoid of meaning in themselves. They can mean something to somebody only if the source gives them a specific meaning and if the recipient sees a specific meaning in them. The meaning of a sign depends not only on personal interpretation, but also on collective agreement that may vary across space, time and culture.

The Communication model for Development provides generally provides guidelines or principles that must be adhered to in order for the development of effective communication campaigns, in different contexts, to be made possible.

4.5.2 RELEVANCE OF THE COMMUNICATION MODEL FOR DEVELOPMENT TO THE STUDY

The communication model for development provides a way in which the success or failure of communication initiatives can be investigated. The policies or strategies implemented in the development of communication intervention programmes play a significant role in successfully communicating with the recipients. Because this study seeks to examine whether current HIV/AIDS communication targeting the youth - female youths in particular - could still have any limitations given the soaring figures of HIV cases and other sexually transmitted diseases amongst them. The Communication model for Development provides the basis for understanding this. The principles held by this model provide a way through which an understanding of the effect of communication campaigns can be achieved; making it imperative to use this model for this study. It is against the principles held by this model that the effect of HIV/AIDS communication on female youths will be measured.

The model maintains that the way in which the communicator manifests his or her ideas is vital to the success of the communication process. In other words, thoughts, information, feelings and attitudes must be manifest in a manner that is 'decodable' by all partners in the communication process. Communication must be in a form that would provide the intended meanings, primarily to the recipients of the message. In HIV/AIDS communication, providing messages that are correctly decoded by recipients is of paramount importance in the fight against the epidemic. The words, information and attitudes related to the epidemic must be appropriately constructed for them to be correctly understood and then applied by the recipients. This principle helps to assess whether current HIV/AIDS communication targeting youths has been transferred in a manner that is decodable by their recipients.

The model further states that there is need to consciously monitor the interpretations attached to messages by our partners in the communication process. The nature of communication can lead to a number of interpretations of the same message, hence the need to monitor these interpretations to ensure that only the correct and intended meanings have been received. Understanding the interpretations attached to HIV/AIDS messages is important if such communication is to yield positive results. The study evaluates the impact of HIV/AIDS communication by investigating whether messages have been received with clarity amongst female youths.

Another principle held by the communication model for development is that all partners must have the requisite skills to decode the mediated message. This could refer to those skills needed to operate technology used as a channel of communication or skills like reading and listening. The inability to use a given technology can hinder one from decoding a message. Channels of communication which are accessible to users in terms of their availability and the audience’s ability to use them are important for the success of

communication initiatives. Using this model, the study will gain insight into the channels of communication used for HIV/AIDS communication and their impact in empowering female youths against HIV/AIDS.

The use of language can also be a challenge in decoding messages. Local, national and even regional language must be employed for effective HIV/AIDS communication. Language could also mean the words used in mediated messages; these could either be a hindrance to understanding messages or provide a simple way to understand messages. The use of terms not familiar to recipients can be a limitation to effective communication. Therefore, to gain an understanding of the effect of HIV/AIDS communication, the study will measure the impact of language used in communication amongst female youths.

The Communication model for Development has, basically, been developed to measure the success of communication initiatives and help improve communication where necessary. Using its principles, the model provides a way in which to understand the effect of communication efforts. This model has been used to demonstrate how to effectively communicate about HIV/AIDS to a broad target population. Using its principles, the study attempts to measure the effect of current HIV/AIDS communication strategies on female youths in South Africa.

4.6 CONCLUSION

The Theory of Reasoned Action and Planned behaviour provides a way in which to understand and explain human behaviour. In health prevention cases, the model can help provide reasons for the behaviour that people adopt in support or against a recommended behaviour. The Communication model for Development provides a basis on which to evaluate the effect of any communication initiative, whilst at the same time providing guidelines of developing effective communication strategies. Both the TRA/PB and

communication model for development have provided a theoretical framework for this study, mainly to understand the behaviour of young women with regard to HIV/AIDS and their response to HIV/AIDS communication initiatives. This chapter has, therefore, discussed the core assumptions of the models, their development and application to the study and their possible limitations in providing a clear understanding for the phenomenon under study.

CHAPTER FIVE

METHODOLOGICAL FRAMEWORK

5.1 INTRODUCTION

The significance of health communication, and HIV/AIDS communication in particular, and its critical role in mitigating the spread of HIV has been discussed extensively in the previous chapters. However, the expected impact of such communication has not yet been fully realised. This study, therefore, intends to investigate whether current HIV/AIDS communication has limitations that could possibly inhibit the translation of HIV/AIDS knowledge into behaviour amongst female youths in South Africa. By exploring all related variables contributing to the effectiveness of HIV/AIDS communication, this study provided valuable insight into the impact of HIV/AIDS communication campaigns on female youths.

Using a survey and focus group approach, the study explores and probes into the possible limitations of current HIV/AIDS communication on female youths in South Africa. In light of this, this chapter offers a discussion of the research design adopted for the study, the research instruments used in the study and the study population and area. The chapter also outlines the sampling procedure, the approach to data collection and analysis as well as the research ethics considered for this study. Justification for all adopted research methods is also provided in this chapter.

5.2 RESEARCH DESIGN

This study adopts both quantitative and qualitative approaches to data collection, in which a survey and focus groups discussions are used for data collection. Quantitative methods allow for data which is obtained to explain how many people hold a certain opinion or behaviour in a certain manner (Robinson, 1999:910). The use of the survey research

method, in this study, has been informed by its ability to allow respondents to provide information that can describe their own opinions, attitudes and behaviours. Fourie (2009) points out that surveys are especially appropriate for measuring attitudes, beliefs, opinions, knowledge and awareness, as well as behaviour.

A qualitative approach explores how those opinions are constructed with regard to a particular issue (Robinson, 1999:910). The use of focus groups, in this study, is also informed by the ability of focus groups to emphasise the stated experiences of research participants and the stated meaning they attach to themselves, to other people and the environment around them (Coolican, 1994). To use only a quantitative approach in a study that seeks to explore and probe into a given phenomena may lead to insufficient and inaccurate results. Thus, the blending of both quantitative and qualitative research methods supports the development of insights that might not be attainable without such integration or in a single analysis (Burns, 2005). In other words, the combination of quantitative and qualitative approaches to data collection and analysis allows for the generation of valid and reliable results for this study.

According to Onwuegbuzie & Teddlie (2003), the use of both quantitative and qualitative approaches, also known as mixed research design, is classified in two major dimensions. These are: 1) time order and 2) paradigm emphasis. The time order describes whether research methods were used concurrently or sequentially whilst paradigm emphasis describes the status of the research methods, and whether they have a dominant or equal status.

For the purpose of this study, the mixed method design is as follows:

QUAN ⟶ **qual**

Where: **QUAN** represents the dominant status

qual represents the lower status and the

⟶ represents the sequence in which the research was conducted.

The study is primarily quantitative in nature and is complemented by a qualitative phase. A survey is the main instrument of data collection for this study, as it attempts to explore the impact of HIV/AIDS communication amongst female youths. Focus group discussions serve to complement the information obtained through the use of a questionnaire.

5.3 STUDY AREA AND POPULATION

The study area for this project is the Eastern Cape Province of South Africa. This province is characterised by poverty and high rates of unemployment (The Project People, 2006). The province has a total of 8 districts from which one selected district represents the secondary sampling unit (SSU). Culture still plays a significant role in the lives of many in this province. In relation to HIV/AIDS, the province is considered among the worst affected provinces by the epidemic. It has also registered high figures of HIV infections, in comparison to the rest of the country (South African Department of Health, 2005). Generally, some of the prevailing conditions in the Eastern Cape Province are regarded as major contributors to the spread of HIV/AIDS. These prevailing conditions legitimize the need for this study to focus on this province.

The study population comprises of Eastern Cape High School females aged between 15 to 20 years. According to Shisana et al. (2005) young people between the ages of 15 and 24 are the most affected by HIV, especially the female youths within this age group. Despite the many HIV/AIDS communication efforts, a number of risk behaviours which could increase infection levels amongst female youths are still being noted. Furthermore, Petiffor (2004) argues that most infections recorded in youths just above 25 years of age would have

occurred in adolescence, hence the need to pay particular attention to 15 to 20 year old teenagers in order to curb further increase in infections.

The Eastern Cape Province is one of the provinces in the country to record high teenage pregnancies. Teenage pregnancy is regarded, by Petiffor et al. (2004), as a very strong predictor of HIV infections. According to IRIN (2007), the Eastern Cape has also shown a high pregnancy rate amongst pupils; this is a phenomenon that has become common in some Eastern Cape Schools. In a survey conducted by the *Saturday Dispatch* in East London, 70 percent of grade 11 and 12 pupils are sexually active and do not practice safe sex (SAPA, 2012). Fifty one percent of those who participated in the study were sexually active and, of these participants, 72 percent practise unsafe sex (SAPA, 2012). Young women, in particular, engage in these activities to prove their fertility as those without kids are negatively labelled (SAPA, 2012). As a result, there is an increase in the number of teenage pregnancies, which can in turn increase the incidence of HIV infections, recorded amongst pupils in the Eastern Cape Province. Given this scenario, it is relevant to focus on high school females in the Eastern Cape Province as a means of investigating the effects of current HIV/AIDS communication on them. By so doing, the study seeks to understand whether or not there is 'something' lacking in current HIV/AIDS communication, to the extent that young people persist in adopting high risk behaviour despite numerous communication strategies being directed at them.

5.4 SAMPLING PROCEDURE

Based on the fact that the study focuses on a large population, a multistage sampling approach was used to allow for sufficient representation of the population. Multistage sampling allows the population to be divided into a number of groups from which the final sample is drawn (Strydom et al., 2005). In this case, the primary sampling unit (PSU) is

identified from the population and it is from this PSU that all other sampling units are selected until the final sample which represents the participants of the study is selected. For the purpose of this study, the Eastern Cape Province represents the primary sampling unit. From the PSU, the second stage unit is represented by the Amathole district which has been selected from the other districts within the province. This is followed by the selection of Education Districts within the Amathole district. From the identified Education Districts in the Amathole district, seven high schools are selected to participate in the study. From the selected schools, another sampling unit is selected to represent the female students, which is followed by the selection of the final sampling unit. The final sampling unit, in this case, is represented by high school female students between the ages of 15 and 20.

With the final sampling unit identified, the study acknowledges that it is not feasible for the study to involve all students within the required age group from all participating schools. Thus, an adequate sample size has to be identified. According to Reid & Smith (1981: 171, in Strydom et al., 2005), an appropriate sample size must also remain representative of the whole population. Different views exist regarding the identification of the appropriate size of a sample. For example, Seaberg (1988) and Grinnell & Williams (1990) state that, in most cases, a 10% sample should be sufficient for controlling sampling errors. Stoker (1985), however, offers a guiding table as an indication of what the size of a sample ought to be. According to Stoker (1985), the smaller the population, the greater the percentage of the sample size and the vice versa is true; the greater the population, the smaller the percentage. This study adopts Stokers principle to identify the sample size for this study.

According to Stoker`s table, when a target population has 1000 people, fourteen percent of the population will provide an adequate sample size and when the target

population has 10 000 people, 4,5 percent of the population will provide a representative sample. The total number of female students (within the required age group) at participating schools is an estimated 5000. Following Stoker`s principle, calculations were made to estimate the appropriate sample percentage for a population of approximately 5000 people. From the calculations, seven percent of the total population becomes the representative sample. In other words, 350 students represent the sample size for the study, thus offering sufficient representation of the population under study. Table 8 below shows the number of students at participating schools.

Given that the total sample size for the study is 350, it therefore means that a total of 50 students were selected from each participating school. This sample size was selected from female students within the required age range from each school. To get the sample, a probability sampling method was used. Systematic sampling was employed to obtain participants for this study. According to Van der Walt (1984 in Strydom et al., 2005:200), cases, when using systematic sampling methods, are selected according to a particular interval depending on the percentage sample needed. To use this method, a total number (N) of female high school students aged 15-20 were identified at all participating schools. From that total number, the expected sample size (n), which is 50, was selected from each participating school. This means that the sampling fraction would be 50 (n) divided by the total number of students (N) to give the interval size (k). This means that one can select an integer between 1 and K.

Basically, to get a sample using the systematic sampling approach, the following steps must be followed:

Systematic sampling: identify the number of units in the population (1 to N)

Select the sample size (n)

Get the interval size (k) which is k=N/n

And using the interval size, randomly select an integer between 1 to K

Using the formula for systematic sampling, the interval for selecting respondents from one participating school was identified. For example, in one participating school, there were an estimated total of 130 female students aged between 15 and 20 and only 50 respondents were required from the total population. To get the interval for selecting participants, the formula: K=N/n was used. This means that the total population (N=130) was divided by the required sample size (n=50) to get the interval (K= 2). Using this interval, every second case on the list of students was selected until a sample size of 50 was obtained.

Table 8: Sample Size for Participating Schools in the Amathole District

AMATHOLE DISTRICT

PARTICIPATING SCHOOLS	Number of female students
Jabavu Senior Secondary	**50**
Qonce High School	**50**
Kingsridge High School	**50**
Kama High School	**50**
St Christopher `s High School	**50**
Stirling High School	**50**
Kuyasa High School	**50**

In selecting the participating schools, urban, semi-urban and rural schools were selected in order to provide for a balance in the views regarding the exposure to and effects of HIV/AIDS communication strategies. As a result of the different backgrounds of participants, the extent to which participants are exposed to HIV/AIDS communication is also different. It is expected to have participants that have more exposure to HIV/AIDS communication whilst some have only a limited exposure to such communication. At the same time, it is highly possible that many who have unlimited exposure to this communication have fewer factors exposing them to HIV infections. In contrast, those with limited exposure to communication are confronted with a number of contributory factors to HIV infection. Cases such as these impact on the results of the study.

5.5 RESEARCH INSTRUMENTS

In order to clearly understand the phenomena under study, two research instruments were employed: a questionnaire and focus group discussions were used for this study.

5.5.1 QUESTIONNAIRE

The questionnaire is probably the most generally used instrument in research projects with a basic objective of obtaining facts and opinions about a phenomenon from people who are informed on a particular issue (Strydom et al., 2005:166). There are different types of questionnaires that can be used for different purposes. In this study, self-administered questionnaires were used. According to Strydom et al. (2005:168), in cases of self-administered questionnaires, the questionnaire is handed to the respondent who completes it on his or her own form; the researcher is available for consultation in case problems are experienced. When using self-administered questionnaires, the researcher`s contribution to the completion of the questionnaire is at its absolute minimum.

The structure and layout of the questionnaire contributes to its ability to accurately capture the responses to questions on the form. As such, questionnaires must be clear and easy to follow. Neuman (2003: 284) states that a professional appearance with high quality graphics, spaces between questions, together with a good layout, improves accuracy and completeness; this also helps the questionnaire to read more fluently. The structure of the questionnaire used in this study was informed by the objectives of the study. In other words, the questionnaire was divided into categories that had questions addressing the different objectives of the study.

The first section of the questionnaire asks questions about the socio-demographics of the respondents, with the respondent’s level of HIV/AIDS knowledge and awareness measured in this section. This section also asked questions regarding the awareness of

HIV/AIDS communication strategies as well as the different communication channels used by young people to access HIV/AIDS information. The second section of the questionnaire probed into the relevance of HIV/AIDS communication to young women. Relevance, in this case, was measured by questions which sought to understand whether factors exposing young women to HIV infections were addressed in communication strategies. Relevance was also measured by questions on whether messages where easy to understand and whether participants had easy access to different HIV/AIDS communication strategies.

The third section focussed on understanding the factors that influence the comprehension and use of advice contained in HIV/AIDS communication messages, amongst female youths. The fourth and final section of the questionnaire sought to gain an understanding into the impact or influence of HIV/AIDS communication in helping young people translate HIV/AIDS knowledge and attitudes to preventive behaviour. Basically, this section focused on the impact that HIV/AIDS communication has on the behaviour of young women, in relation to HIV/AIDS.

The structure of the questionnaire consists of close-ended questions. This means that participants were expected to respond to the questions asked by choosing from a set of pre-selected responses. As such, clear and precise instructions were given as to how to respond to the questions. Closed-ended questions allow respondents to choose from pre-selected answers and the main advantage of close-ended questions is that these questions can be answered within the same framework and responses are easier to code and analyze (Monette et al., 2002:163; Hulley & Cummings, 1988). Close-ended questions can be more specific and are thus more likely to communicate similar meanings.

The questionnaire was developed by reflecting on comparable surveys, both internationally and locally. Some of the questions in the questionnaire were borrowed from

surveys conducted in the same field with the hope that they will allow for the direct comparison of results, which would thus be more meaningful. The questionnaire was designed to contain a number of varied sections that seek to obtain different sets of information from participants. This allows for a sufficient understanding of each variable to be measured in this study. Thus, the questionnaire was designed to cover questions on: individual demographics, knowledge and awareness of current HIV/AIDS communication strategies, the relevance of HIV/AIDS communication to female youths, the factors that probably influence their understanding and use of HIV/AIDS messages as well as the impact of these messages in terms of knowledge, attitudes and behaviour change amongst female youths.

5.5.2 PILOT TESTING THE QUESTIONNAIRE

To employ the questionnaire without pilot-testing it might have unbearable consequences. As such, it was of paramount importance to test the data collection instrument before utilization. The questionnaire was pilot-tested before it was used in the main investigation. The pilot process involved the distribution of copies of the sample questionnaire to subjects who shared the same characteristics as those who participated in the study. The main purpose for the pilot-test was to minimize errors of any nature in the questionnaire, prior to the study, and allow for the questionnaire to be rectified immediately and at a low cost (Strydom, et al., 2005). This was also done to ascertain whether the instrument was able to adequately test what the study intends to test (Bless et al., 2006:117). The questionnaire was also submitted to the Supervisor for content approval before use. After pilot-testing and the approval of the Supervisor, the questionnaire was used to collect data for the study.

5.5.3 FOCUS GROUP DISCUSSIONS

Following the questionnaire, focus group discussions were also conducted. According to Mugari (2011), focus groups assist as a way of cross validating the findings based on the questionnaire. Focus groups are described by Robinson (1999:905) as in-depth open-ended group discussions that explore a specific set of issues on a predefined topic. Kitzinger and Barbour (1999:5 in Mwiturubani et al., 2009) further describe a focus group as any group discussion of people provided that the researcher is actively encouraging and attentive towards the group interaction. Focus groups are seen as a valuable method of obtaining a wide range of understandings, views, opinions and attitudes on a particular social issue. As such, focus group discussions become an efficient qualitative data generation technique in that participants tend to provide checks and balances on each other and weed out extreme views. The approach helps to assess how consistent the views of the participants are (Flick 1998:115). Removing those views and statements which are not shared socially increases the validity of the information.

According to Kitzinger (2003), focus groups have been used to examine public attitudes on illness and behaviour. Because the study seeks to understand HIV/AIDS communication and youth behaviour, the use of focus groups aids significantly in this regard. The nature of focus groups enables the complex dimensions - in terms of response - to be revealed, as these are not readily accessible by more traditional methods.

A focus group guide was used to collect data using focus group discussions. In this case, a set of questions for discussions were developed, although some emerged as the discussion progressed.

5.6 STUDY MEASURES

a. Demographics of the Participants

The study reports on the ages and educational levels of the participants. Self-reports on the participant's knowledge of HIV/AIDS, the factors that can expose them to HIV infection and awareness of current HIV/AIDS communication strategies in South Africa are examined. The study also examined the sources of HIV/AIDS information amongst female youths.

b. Relevance of HIV/AIDS communication strategies to female youths

The measure examined the relevance of HIV/AIDS communication to female youths. Specifically, the study measures the ability of communication to identify and effectively address issues or factors that exacerbate the spread of the epidemic amongst female youths. The nature of communication interventions in terms of design, language and channel used was examined so as to aid the assessment of the impact of HIV/AIDS communication on female youths.

c. Factors influencing the understanding and use of advice contained in HIV/AIDS messages

To further our understanding of the impact of HIV/AIDS communication on female youths, the study also examined factors that significantly influence the understanding and use of advice contained in HIV/AIDS messages, amongst female youths. Female youths, in this instance, were required to identify factors that influence their understanding and use of the advice contained in HIV/AIDS messages.

d. Impact of HIV/AIDS communication messages on female youths in terms of knowledge acquisition, attitude and behaviour change

The study measured the extent to which HIV/AIDS communication has impacted on female youths in terms of knowledge about HIV/AIDS, attitude change regarding HIV and an adoption of positive and protective behaviour. Participants indicated the level or extent to which HIV/AIDS communication has increased their knowledge of the epidemic, changed their attitudes and eventually changed their behaviour against HIV/AIDS.

5.7 DATA COLLECTION PROCEDURE

After getting permission from the Department of Education to conduct this study, an informed consent from parents (of minors) and participants was sought and the process of gathering data begun.

The Questionnaire

From each school, participating female students were assembled at one venue where copies of the questionnaire were given to them to complete. The administration of the questionnaire was supervised by the researcher in order to provide assistance with the completion of the form, when solicited. The completion of the questionnaire took approximately 15 to 20 minutes and, upon completion, the questionnaires were collected from the participants. After this process, the focus group discussions began.

Focus Group Discussions

Three schools participated in the focus group discussions. After the completion of the questionnaire, the twenty five students, drawn from those who responded to the questionnaire, were engaged in a discussion on a number of selected study variables. This means that a total of seventy five students were involved in these discussions. All the

responses which emerged as a result of these discussions were written down. Focus group discussions allowed participants to express themselves on the different issues raised.

5.8 APPROACHES TO DATA ANALYSIS AND PRESENTATION

Data for this study was analysed qualitatively and quantitatively using descriptive and interpretive techniques. The Statistical Package for Social Sciences (SPSS) computer programme was used to analyse quantitative data in which descriptive statistics were provided to indicate the frequency distribution of age, grade and other study variables. Results are shown graphically and complemented by a discussion on those findings.

To analyse qualitative data, Grounded Theory was employed. The grounded theory approach emerged in the mid-1960s and was the brainchild of Glaser and Strauss (1967). The theory was developed in order to generate theory from observations of real life as these were occurring. Thus, it was seen as a way of shifting research from being theory directed to theory generating by using observations of reality to construct both meaning and theories (Grbich, 2007:71). Grounded theory uses the inductive approach (which relies on observations to develop understandings, processes and protocols) and ultimately aims for the construction of substantive and formal theory (Grbich, 2007:71). The formal aims of grounded theory are to generate an analytic substantive schema through processes of theoretical sensitivity which, after comparison with other substantive areas, can become formal theory (ibid: 71).

Charmaz (1990; 2006) identifies a number of features that characterize the grounded theory. Charmaz states that the grounded theory allows for the:

1) simultaneous collection and analysis of data

2) creation of analytic codes and categories developed and not pre-existing conceptualisations
3) discovery of basic social processes in the data
4) inductive construction of abstract categories as well as the use of theoretical sampling to refine categories
5) integration of categories into theoretical frameworks.

Basically, the grounded theory describes the discovery of theory from data systematically obtained from social research (Glaser & Strauss, 1967).

To analyse data, the grounded theory identifies three processes that need to be implemented and they include, open coding, axial coding and selective coding. Open coding is described by Strauss and Corbin (1998) as a process through which concepts are identified and properties are discovered in data. Strauss (1987) buttresses this description by stating that open coding involves word-by-word, line-by-line analysis which questions the data in order to identify concepts and categories which can be dimensionalised. Thus open coding involves a process of breaking down, examining, comparing and conceptualizing and categorizing data (Strauss & Corbin, 1998). Open coding, as a process, consists of three phases namely labelling phenomena, discovering categories and developing categories, which aid towards data analysis.

Axial coding is another process that follows open coding. With axial coding, data is assembled in new ways after open coding by making connections between the categories (Charmaz, 2006). Axial coding describes the development and linking of concepts into conceptual frameworks. Axial coding is a process of relating codes (categories of properties) to each other via a combination of inductive and deductive thinking (Charmaz, 2006). In this case codes that emphasize causal relationships and fit things into a basic frame of generic

relationships are identified (Strauss, 1987). The aim of coding paradigm is to make explicit the connection between categories and sub-categories. It involves explaining and understanding relationships between categories in order to understand the phenomenon to which they relate (Strauss & Corbin, 1998).

Selective coding involves integrating and refining the theory by using categories and their associations with subcategories to create a type of a case study of a particular sub-phenomenon (Strauss & Corbin, 1998). It is the process of selecting a core category around which the final analysis will be based. This category must be associated with other categories. Selective coding is a process that eventually leads to the development of a theory from data. During the process of coding, a point of saturation is reached. To achieve saturation, grounded theory analysis requires re-evaluation of concepts, themes/categories at varying stages until no new information emerges (Charmaz, 1990). According to Charmaz (2006) saturation of concepts is the point at which data collection and analysis cycle can conclude and it also means that no additional data are being found to allow for the development of properties of the category. It is at this stage that theoretical constructs generated are categorised into themes which basically give a description of the findings of a study. Selective coding thus involves validating those relationships, refining and developing categories (Charmaz, 2006). Categories are integrated together and a grounded theory is arrived at.

This procedure described above was applied to the data gathered for this research project. By using information obtained through focus group interviews, numerous codes (open coding) were created. These codes assisted in the development of categories that allowed data with an 'almost' similar meaning to be put together. These categories were evaluated to measure the frequency, intensity of codes and the number of codes dropped to

attain categories that reflect more accurately on the views of the research participants regarding the phenomenon studied. After this process (open coding), axial coding was done in order to link concepts into conceptual frameworks. With axial coding, codes that show a causal relationship were identified to assist in generating an understanding for the phenomena studied. This process of locating themes that connected cause and effect led to selective coding where categories were refined into themes to assist with theory building.

The themes identified provided results on the relevance of HIV/AIDS messages to female youths, the factors influencing the understanding and use of advice contained in HIV/AIDS messages amongst female youths as well as the impact of HIV/AIDS messages on the knowledge, attitudes and behaviour change of female youths, in light of the epidemic.

5.9 ETHICAL CONSIDERATIONS FOR THE STUDY

The research protocol was reviewed by the Research Committee of the Eastern Cape Provincial Office of Education, the Social Sciences and Humanities Faculty Research & Ethics Committee (FREC) as well as the University of Fort Hare`s Research & Ethics Committee (UREC). These procedures were followed to ensure that the study adhered to all ethical principles of research in order to minimise or avoid infringement on the rights of the participants. As a way of approving the research protocol, research clearance letters were issued out by both the Provincial Department of Education and the UREC. The certificate reference number, as issued by UREC, is **SAL01 1SMPO 01** (See Appendices 3 and 4).

Permission to conduct the study was also sought from the schools selected to participate in the study. The researcher also informed the potential participants of the purpose of the study, and thereafter asked for their consent to participate in the study. Completion of the consent form (see Appendix 5) indicated the agreement of participants to voluntarily participate in the study. Confidentiality was assured to all participants and, as

such, they were requested not to provide personal information by which they could be identified; this would include names and so forth. Participants were also assured that their responses were to be kept by the principal researcher and used only for the purpose of this study and the publication of other academic writings.

Upon completion of the study, the researcher will provide feedback on the results of the study to all participating schools in the form of a written document. Basically, the study ensured the adherence to all ethical research principles at all stages of the research.

5.10 CONCLUSION

The use of an appropriate research design in any study contributes towards the acquisition of a sufficient and accurate understanding of the phenomenon being study. This study hopes to acquire a sufficient and accurate understanding of the impact of HIV/AIDS communication on the behaviour of female youths in the Eastern Cape. In this regard, the chapter has provided a discussion on the research methodology of the study, which would possibly aid in generating accurate information about the issue at stake. The research design, research instruments, study area and population, as well as the sampling procedure, have been discussed in this chapter. The chapter has also offers a discussion of the different variables to be measured in this study, as well as the methods of data analysis. The justification for using the selected research methods has been given in this chapter and, last but not the least; this chapter has provided a discussion of the ethical considerations of this study.

CHAPTER SIX

DATA PRESENTATION AND ANALYSIS

6.1 INTRODUCTION

To provide an understanding of the phenomenon under-study, this chapter presents the results of the study as obtained from data collected for the purpose of this research. This chapter presents descriptive statements which are graphically illustrated. Quantitative results are complemented by a qualitative analysis of data. Analysis of data is done in order to provide meaning for the observations and findings of the study. A discussion of the results is also offered in comparison to the findings made by other researchers in this field of study.

The presentation of the results in this chapter is guided by the specific research questions of the study. This implies that results describe the awareness levels of HIV/AIDS and HIV/AIDS communication programmes as well as the different sources of information on HIV/AIDS. The results also describe the relevance of HIV/AIDS messages in terms of issues addressed, the accessibility of the messages and the factors that influence the understanding and use of HIV/AIDS messages among female youths. The extent to which HIV/AIDS communication has been effective in influencing attitude and behaviour change amongst the female youths has also been discussed. Sub-conclusions are provided after the discussion of one measure (research question results), with a conclusive statement provided at the end of the chapter.

6.1.2 Demographics of Participants

Three hundred and fifty questionnaire copies were distributed to seven selected high school female students in the Eastern Cape. Because the copies were administered to the respondents by the researcher, all questionnaire copies were returned upon completion. This

means that there was a 100% response rate. Results on the characteristics of participants are shown graphically through the use of tables and charts.

As shown in Table 9 below, the ages of the respondents vary between 15 and 19. The majority of the respondents fall in the 17 to 18 age group, with each group recording twenty seven percent of respondents. Twenty two percent represent respondents in the sixteen year old age group whilst 16 percent are fifteen years old. The table also shows that only seven percent were nineteen years old and one percent of the respondents did not indicate their age. Table 9b further depicts the different grades of the respondents in this study. It emerged from the results that 38 percent of the respondents are in grade 10 whilst 28 percent of the respondents are in grade 12. Results further show that 12 percent of the respondents are in grade nine whilst the other 21 percent are in grade eleven. The use of female high school students was relevant to this study as they represented the age group of young women who are most vulnerable to HIV/AIDS.

Table 9: Characteristics of Participants

AGE	FREQUENCY	VALID PERCENTAGE
15	56	16
16	77	22
17	94	26.9
18	95	27.1
19	26	7.4
No Response	2	0.6

Table 9b: Characteristics of Participants

GRADE	FREQUENCY	VALID PERCENTAGE
9	42	12
10	132	38
11	74	21
12	98	28
No Response	4	1

6.2 Research Question 1:

To what extent are female high school students in the Eastern Cape aware of HIV/AIDS, the factors that can expose them to HIV infection and the different sources of HIV/AIDS information?

The awareness of HIV/AIDS amongst female youths was also measured. Awareness, in this case, was measured by the response of the respondents on whether they had heard about or knew about HIV/AIDS. Table 9c below clearly shows that 100 percent of the respondents had heard or known about HIV/AIDS. It is important at this point to note that these quantitative results on awareness are extensively complemented by results from focus group discussions, as shown in later discussions.

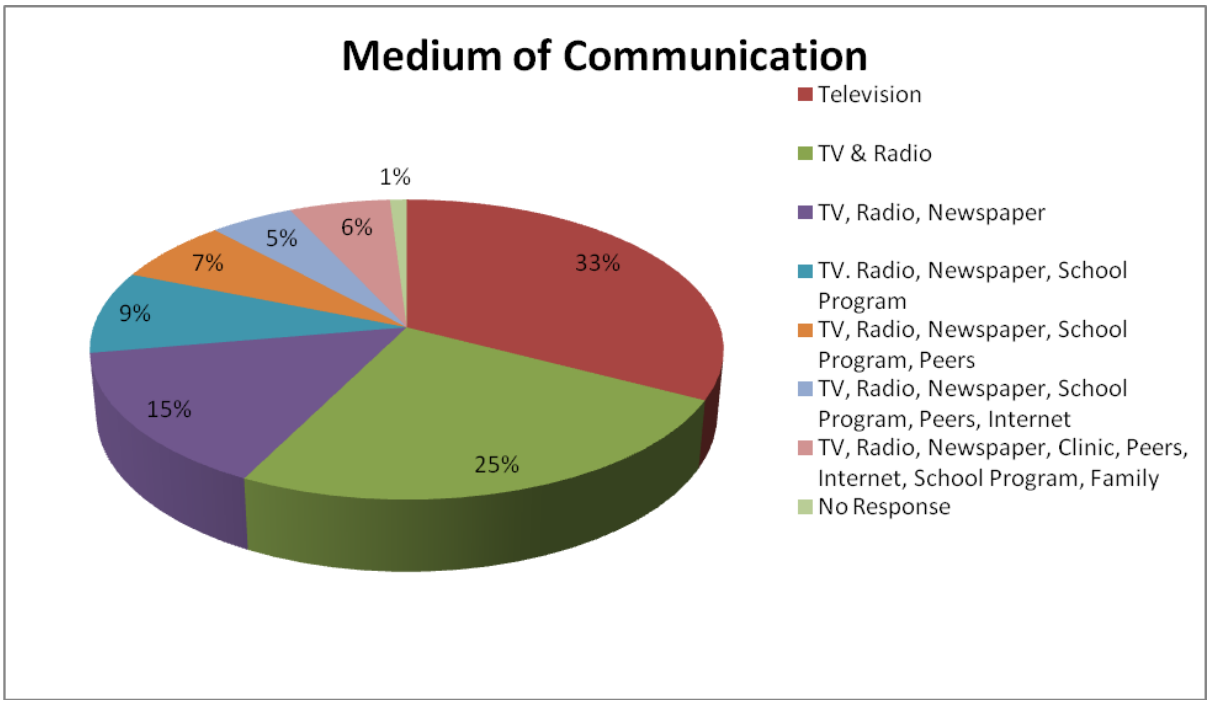
Table 9c: Awareness of HIV/AIDS among female youths

HIV/AIDS AWARENESS	FREQUENCY	VALID PERCENTAGE
YES	350	100
NO	-	-

The study further sought to investigate the channels through which female students came to know about HIV/AIDS and still use to access information on HIV/AIDS. As Figure 4 below shows, most respondents (33 percent) have received HIV/AIDS information through at least one channel. Twenty-five percent have heard about HIV/AIDS through at least two channels whilst fifteen percent have heard about the epidemic through at least three channels. The chart further shows that nine percent of the respondents have gained knowledge about HIV/AIDS through four channels, with another seven percent receiving information through five channels and five percent have received this information through six channels. Only six percent of the respondents have known about HIV/AIDS through at least seven channels and one percent of the respondents did not respond to the question.

The channels or media of communication through which respondents have received HIV/AIDS information or knowledge include radio, television, newspaper, peers, clinic, school programmes, internet and their families. From this list, respondents have either received HIV/AIDS information from all the channels or from one or a combination of selected channels.

Figure 4: Medium or Channel of Communication



6.2.1 Knowledge of HIV/AIDS Communication Methods

To measure the knowledge and awareness of HIV/AIDS communication methods amongst female youths, respondents were required to indicate whether they were aware of any HIV/AIDS communication methods. If so, they were to select from the pre-selected response and state the HIV/AIDS communication programmes they knew of, besides those provided by the questionnaire. It emerged from the results that 99 percent of the respondents were aware of at least one existing HIV/AIDS communication campaign in South Africa with only one percent of the respondents not answering the question. It also emanated from the study that respondents knew at least one of the five identified HIV/AIDS communication campaigns. Regarding knowledge of the communication campaigns, the results indicate that 14 percent of the respondents knew at least one HIV/AIDS communication program, while 10 percent of the respondents knew at least two communication campaigns. Sixty percent of the respondents knew at least three communication campaigns, whilst 8 percent of the

respondents knew at least four communication campaigns. Results also show that 5 percent of the respondents knew at least five HIV/AIDS communication campaigns whilst the remaining 3 percent of the respondents did not answer the question. Table 10, below, shows the different HIV/AIDS communication programmes known by the respondents.

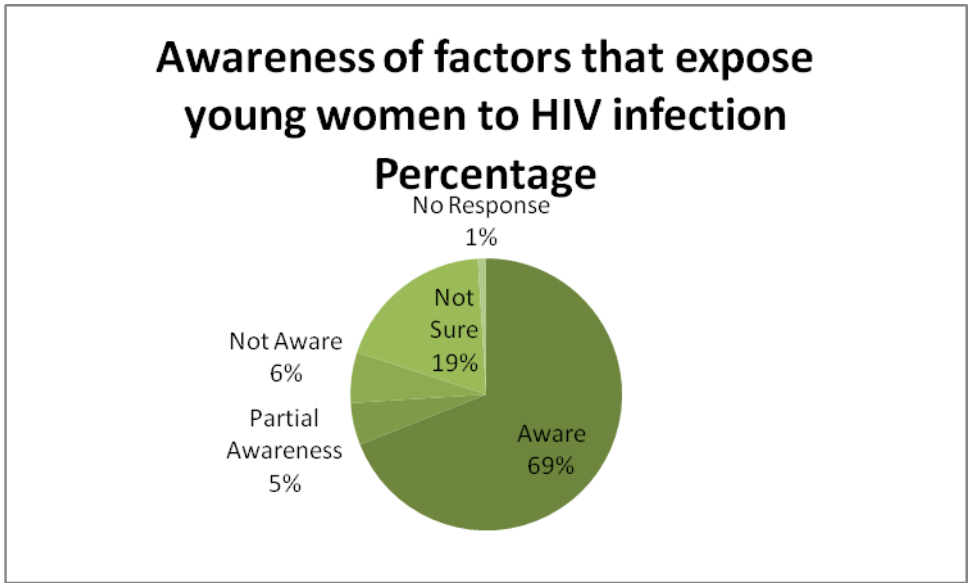
Table 10: Awareness of HIV/AIDS Communication Programmes

HIV/AIDS COMMUNICATION STRATEGIES	PERCENTAGE REPRESENTATION
Soul City	14
Love life & Soul City	10
Scrutinize, It begins with you & Love life	60
Soul City, Scrutinize, Love Life, Siyayinqoba	8
Soul City, Scrutinize, Love Life, Siyayinqoba, Khomanani	5
No Response	3

Respondents were also required to indicate or name other HIV/AIDS communication campaigns they knew about, besides those provided for them to select from. As the results indicate, 55 percent of the respondents know other HIV/AIDS communication programmes, namely: *Intersexions*, *Untold love stories* and *Soul buddies*. These campaigns are branches of some of the main communication strategies in South Africa. For example, *Soul buddies & Untold love stories* fall under the broad communication framework of Soul City. The findings also indicate that 8 percent of the respondents did not know of any other HIV/AIDS communication campaigns, whilst 37 percent of the respondents did not respond to the question.

The awareness of factors that can increase young women's vulnerability to HIV infection was also measured. The findings of the study indicate that 69 percent of respondents are aware of factors or problems that could expose them to HIV infections whilst 6 percent of the respondents are not aware of such factors. Another 5 percent of the respondents have a partial understanding of the factors that can expose them to HIV infection. Partial, in this case, means that respondents have a lesser knowledge of the factors that can expose them to HIV infection. The results also indicate that 19 percent of the respondents are not sure whether they are aware of factors that can increase their chances of being infected by HIV. Only one percent of the respondents did not respond to the question.

Figure 5: Awareness of factors that expose young women to HIV infection



The above descriptive statements show that high school female students are aware of HIV/AIDS, the factors that can expose them to HIV infection and the different HIV/AIDS communication campaigns in South Africa. To support these findings, focus group discussions also indicated the high awareness levels about HIV/AIDS and the different HIV/AIDS communication campaigns amongst the female youths. **"Information on**

HIV/AIDS is everywhere" is the main theme that best describes the views of respondents regarding their awareness of HIV/AIDS.

"Information on HIV/AIDS is everywhere, we can now easily find information on HIV/AIDS, it is everywhere"- Respondents.

Awareness of HIV/AIDS amongst the respondents has largely been raised through the different campaigns used to communicate about HIV/AIDS to different target populations. Although the many different HIV/AIDS communication campaigns have increased awareness of HIV/AIDS amongst the respondents, it emerged from the focus group discussions that the high numbers of HIV/AIDS communication campaigns have also led to an overload of information on HIV/AIDS amongst recipients.

"Everywhere you go, you hear about HIV, when I am watching TV, there is so much on HIV/AIDS. It is now boring"- Respondent.

Focus group discussions also provide results on the awareness of factors that expose young women to HIV infection. **In-depth and limited understanding of factors that expose young women to HIV infection** is also another theme that describes the opinions of respondents regarding awareness and understanding of factors that increase their vulnerability to HIV infection.

"There are obvious things like unprotected sex that can make one get HIV"- Respondents.

"We do not exactly understand how alcohol can make someone get HIV"- Respondents.

The focus group discussions indicated that respondents have a clear understanding and awareness of some of the factors (unprotected sexual activities) that could expose them to HIV infection at the same time having a limited understanding of how other factors (alcohol use) can expose them to HIV infection. To provide meaning to these observations and findings, a discussion and analysis of these results is provided below.

6.2.2 Discussion of Findings on the extent to which Eastern Cape High School female students are aware of HIV/AIDS, the factors that can expose them to HIV infection and HIV/AIDS communication strategies in South Africa

HIV/AIDS communication was developed to mitigate the spread of the disease through the provision of a broad based set of communication activities that seek to promote accurate knowledge about all aspects of HIV transmission, risk reduction and prevention (Airhihenbuwa et al., 2000). Awareness plays a significant role in promoting health reform. According to Singhal (2000), awareness is a prerequisite to change, although it is not sufficient to minimize the spread of the epidemic. Awareness according to behaviour modification proponents can be effective in increasing or decreasing the frequency of behaviours (Martin & Pear, 2007). Awareness, based on the assumptions of behaviour modification, can assist in altering an individual`s behaviours and reactions to stimuli (Martin & Pear, 2007). Awareness, therefore, may persuade people to take preventive action against HIV/AIDS. In another study conducted by Bertrand & Anhang (2006), to assess the strength of selected mass media interventions on HIV/AIDS amongst young people in developing countries, results showed that the selected media interventions had been successful in increasing the knowledge or awareness of HIV/AIDS amongst the youth.

Another study was also conducted to evaluate the impact of selected multimedia campaigns and the results showed that HIV/AIDS campaigns induced or increased awareness

of and about HIV/AIDS amongst the target population (Yahaya, cited by Salawu, 2004). Cury and Rossi (2008) further state that young people have a vast knowledge of the factors that could expose them to HIV infections; this means that young people are aware of HIV/AIDS and its related issues. The results of this study are not any different from those of previous studies as they depict a high level of awareness of HIV/AIDS amongst female youths. Although this is the case, it is imperative to state that in as much as awareness is a prerequisite to change; it cannot bring about the desired behavioural change on its own. The latter provides a possible reason for why young people, as shown by results of various studies, have engaged in high sexual risk behaviour despite the widespread knowledge of HIV/AIDS and its related issues.

It also emanated from the study that respondents are not only aware of HIV/AIDS but they are also aware of and exposed to HIV/AIDS communication campaigns which seek to empower them about the epidemic. Exposure to HIV/AIDS communication can increase positive individual attitudes towards HIV/AIDS, build skills in people that will help to protect themselves from infection, and it will provide support for the sustenance of positive behaviour. According to the Theory of Reasoned Action, attitude involves judgement on whether behaviour is good or bad or whether the actor is in favour of or against performing the behaviour (Leonard et al., 2004). The provision of accurate health information, through identified communication activities, can contribute to a positive attitude which can also increase the chances of individuals engaging in preventive behaviour against HIV/AIDS. A study conducted through the National Communication Survey (2009 in SAGI, 2009) concurs with the findings of this study. The results of the study showed a high awareness of HIV/AIDS communication campaigns amongst the youth, although it did not guarantee that the messages had also brought change to the behaviour of young people.

According to Avert (2010) more and more people have become aware of HIV/AIDS owing to their exposure to some HIV/AIDS communication campaigns. In a study conducted to examine the effectiveness of eleven South African HIV/AIDS communication campaigns, the results indicated that young people had a higher level of exposure to HIV/AIDS communication; as a result, they are more aware of the epidemic. Avert (2010) further states that the results of a major survey conducted to assess how HIV/AIDS communication campaigns are received by their target population showed that awareness campaigns were best received by 15-24 year olds; this is a probable reason for the extent to which female high school students are aware of HIV/AIDS.

The results of the study also revealed that respondents have had access to HIV/AIDS information through a number of different channels of communication. According to Salmon & Atkin (2003), channels of communication also play a pivotal role in spreading information that seeks to mitigate the spread of HIV/AIDS. Wellings et al. (1995) state that multi-dimensional approaches, and the consistent provision of messages to the youth, are effective in creating significant behaviour change concerning the prevention of HIV/AIDS. The more the channels are mobilized to reach young people; the higher the likelihood of a program's success. Young people are technologically innovative and will therefore not use one channel as their only source of information. This is even shown by the number of channels that have been employed by female youths to receive HIV/AIDS messages. In a study conducted by the Kasier Family Foundation (2007), on young South Africans, broadcast media and HIV/AIDS awareness, the results showed that young people used not only one channel of communication as their source of HIV/AIDS messages; this concurs with the findings of this study. The internet, television and radio were among the most frequently used channels of communication, by young people, to receive health information.

Although the many different HIV/AIDS communication campaigns have increased awareness of HIV/AIDS amongst the respondents, it emerged from the focus group discussions that the high numbers of HIV/AIDS communication campaigns have also led to an overload of information on HIV/AIDS. According to the respondents, too much information makes people lose interest in what is being discussed. People will no longer pay attention to the messages as they now assume that they have heard it all from many different communication campaigns or the same campaign that has been repeated several times. Greenberg et al. (in Singhal 2004) maintain that repetition is good, at least to a certain point. However, too much repetition is likely to increase rejection or to have the audience "tune out" the message.

One of the goals of HIV/AIDS communication campaigns is to raise and increase awareness of HIV/AIDS and its contributory factors amongst the target population. The findings from the study show that a significant number of respondents are aware of the factors that could expose them to HIV/AIDS. It is also noted, from the results, that the percentage of respondents who indicate not being fully aware of factors that can expose them to HIV infection is a cause of concern.

The findings of this study concur with those of the study conducted through the National Communication Survey on HIV/AIDS (2009) in (SAGI 2009) to examine the effectiveness of selected communication campaigns in South Africa. The results of this study show that young people have become much exposed to HIV/AIDS messages which have in turn improved their knowledge and understanding of factors that can expose them to HIV infection. However, although this is the case, another study which assessed how HIV/AIDS communication campaigns have been received revealed that, despite the widespread communication campaigns, accurate knowledge of HIV/AIDS and its contributory factors is

poor (Avert, 2010). The study further maintains that in some instance, accurate knowledge has significantly decreased in recent years. According to UNICEF (2010), fewer young women have a comprehensive knowledge of HIV/AIDS in Sub-Saharan Africa. The results of the study indicate that although awareness of HIV/AIDS is high amongst the respondents, not all of them have a comprehensive understanding of the epidemic, particularly with regard to the factors that lead individuals to HIV infection.

Besides issues of information overload, it is apparent, based on the results of the study, that respondents are aware of HIV/AIDS and its related issues. Respondents have also gained exposure to different HIV/AIDS communication campaigns which are communicated through different channels of communication. Obtaining an understanding of the levels of HIV/AIDS awareness amongst young people, their exposure to HIV/AIDS communication programmes as well as the channels of communication most frequently used provides this study with a basis on which to investigate the effects of current HIV/AIDS communication on young people.

6.3 Research Question 2:

To what extent are HIV/AIDS messages relevant, in terms of the issues addressed, digestible and accessible to female high school students in the Eastern Cape?

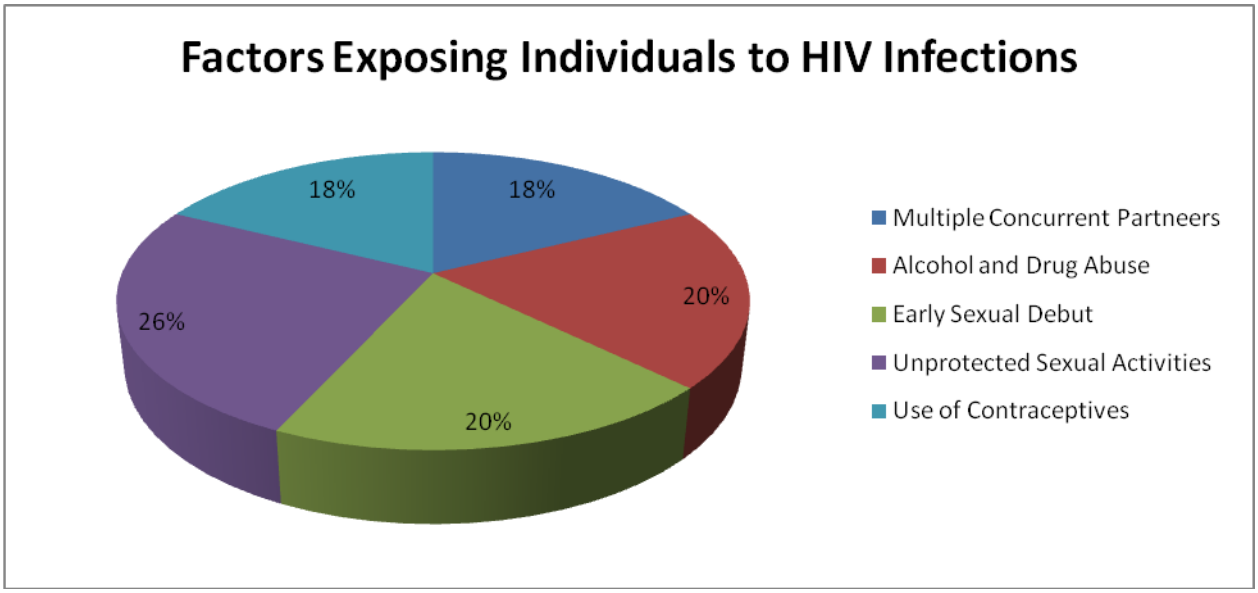
The relevance of HIV/AIDS communication campaigns to female high school students was also measured. This included measuring whether or not: 1) communication programmes have been successful in addressing factors that increase young women's vulnerability to HIV infections; 2) individual`s questions on or about HIV/AIDS have been answered by contemporary communication; 3) young women have a clear understanding of messages communicated; 4) the language used in communication make it easy to understand

messages contained in HIV/AIDS communication campaigns; and 5) young women have easy access to HIV/AIDS communication programmes.

6.3.1 Awareness of factors that expose young women to HIV infection

After establishing the extent to which respondents are aware of the factors that put them at risk of HIV infection, the study sought to understand whether young women could identify those factors and state the extent to which they believe those factors are significant in exposing them to infection. To answer this question, respondents ranked pre-selected factors according to their importance. It therefore emerged from the study, as shown in Figure 6 below, that:

Figure 6: Factors Exposing Individuals to HIV Infections



1) Twenty six percent of respondents viewed unprotected sexual activities as a very strong factor that can increase one`s vulnerability to HIV infection.

2) Eighteen percent of the respondents considered having multiple concurrent partners as quite strong in increasing one`s vulnerability to HIV infection.

3) Twenty percent of the respondents considered engaging in early sexual activities as a strong factor that can also expose an individual to HIV infection.

4) Twenty percent of the respondents considered the use of alcohol and drugs as a less important factor that can expose an individual to HIV infection, and

5) Sixteen percent of the respondents considered the use of contraceptives as a factor that is not important or that cannot expose them to HIV infection.

6.3.2 Success of HIV/AIDS communication campaigns in addressing problems or factors that increase young women's vulnerability to HIV infections.

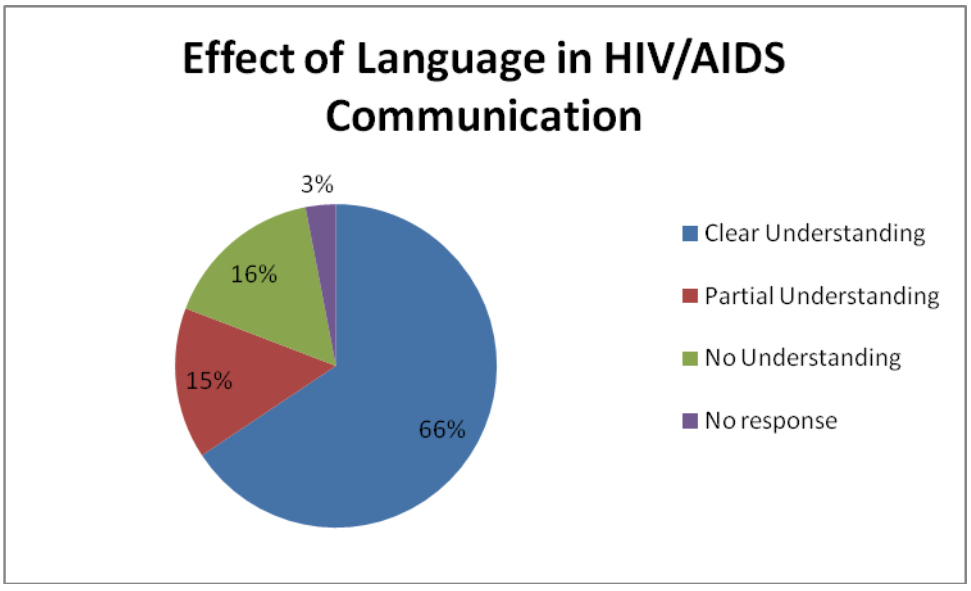
Using the views of female high school students, this measure sought to establish whether HIV/AIDS communication campaigns have been successful in addressing factors that increase their vulnerability to HIV infection. According to the results of the study, 58 percent of the respondents believe that HIV/AIDS communication campaigns have provided adequate information on factors that expose young women to HIV infection and the appropriate ways of reducing their risk of infection. Although this is the case, a significant 42 percent of the respondents are not fully convinced of the success of HIV/AIDS communication campaigns in addressing their concerns regarding HIV/AIDS. From this 42 percent, 14 percent of the respondents believe that HIV/AIDS communication campaigns have not addressed factors that expose them to HIV infections, whilst 12 percent of the respondents believe that HIV/AIDS communication campaigns have, to a lesser extent, addressed problems that increase their vulnerability to HIV infections. Fifteen percent of the respondents are not sure whether their concerns regarding HIV/AIDS have been addressed by HIV/AIDS communication campaigns with one percent of the respondents not responding to the question.

In relation to the above, the study also sought to establish whether female high school students thought that HIV/AIDS communication campaigns answered their individual questions on HIV/AIDS. Results show that 57 percent of the respondents believe that their individual questions on HIV/AIDS have been answered through HIV/AIDS communication while 17 percent believe that communication has partly, or to a lesser extent, answered their questions on HIV/AIDS. Thirteen percent of the respondents indicate that their questions on HIV/AIDS have not been answered by HIV/AIDS communication campaigns with the other 11 percent of the respondents not sure whether their individual questions on HIV/AIDS have been answered by current HIV/AIDS communication campaigns. The study went further to establish whether female high school students had a clear understanding of the messages communicated to them through HIV/AIDS communication activities. Using the general question on whether they understood messages or not, 60 percent of the respondents indicated that they had an understanding of the messages communicated whilst 20 percent of the respondents indicated that they have a partial understanding of the messages. Eleven percent of the respondents were not sure whether they have a clear understanding of the messages with 8 percent indicating that they have no understanding of the messages communicated through HIV/AIDS communication programmes. One percent of the respondents did not answer the question. In support of these findings, focus group discussions indicate that in some instances, individual questions on HIV/AIDS have not been adequately answered. **There is a limited understanding knowledge and understanding of factors that increase young people`s vulnerability to HIV infection.**

"Even when we are now HIV positive, we still do not know how to take care of ourselves"- Respondents.

To provide a more comprehensive understanding of whether respondents understood messages communicated to them through HIV/AIDS communication campaigns, the study investigated the extent to which the language used in these campaigns helped or hindered them from understanding HIV/AIDS messages. Language, in this regard, refers to whether local languages were used or not. As shown in Figure 7 below, 65 percent of the respondents indicated that they clearly understood the language used in HIV/AIDS communication whilst 16 percent of the respondents indicated that the language used in communication was difficult for them to understand. Another 15 percent of the respondents indicated that they understood, to some extent, the language used in HIV/AIDS communication and only 3 percent were not sure if they understood language used in HIV/AIDS communication s. One percent of the respondents did not respond to the question.

Figure 7: Effect of Language Used in HIV/AIDS Communication



6.3.3 Accessibility of HIV/AIDS communication programmes

The accessibility of HIV/AIDS communication programmes by the respondents was also measured. Accessibility, in this instance, refers to the extent to which HIV/AIDS

communication programmes are readily available to target populations. In other words, do target populations have adequate exposure to such communication? The findings show that 60 percent of the respondents have easy access to HIV/AIDS communication whilst 30 percent of the respondents indicated that they did not have easy access to HIV/AIDS communication programmes. Ten percent of the respondents did not answer the question. Focus group discussions also indicate that respondents have different access levels to HIV/AIDS communication. Results revealed that whilst some have unlimited access to communication programmes, some respondents have a limited access to such communication. **Identify more easily accessible communication channels to increase access for everyone** is also another theme describing the views of respondents regarding access to HIV/AIDS communication.

> *"access to information in societies must be increased. Some of us have more access to HIV/AIDS information whilst others have less"- Respondent.*

> *"I prefer watching the Mind Channel television, and it has no specific HIV/AIDS communication"- Respondents.*

Focus group discussions also indicate that some channels, preferred by some respondents, have little to no programmes on HIV/AIDS, in comparison to other channels. This according to respondents can limit their exposure to the different kinds of HIV/AIDS messages.

6.3.4 Discussion of Findings on the relevance of HIV/AIDS Communication messages -in terms of issues addressed - digestibility and accessibility of HIV/AIDS Communication Campaigns among Eastern Cape female High School students.

Using pre-selected responses regarding factors that can expose young women to HIV infection, the respondents were required to answer the question by selecting factors which,

according to their importance, could increase one's vulnerability to HIV. It emerged from the study that respondents consider engaging in unprotected sexual activities, multiple partners and early sexual activities as significant factors that can increase their exposure to HIV infection. Alcohol and drug abuse and the use of contraceptives were not seen as factors that can increase ones chance of getting infected. These findings indicate that communication programmes have increased knowledge on some factors whilst there are still low knowledge levels on how factors such as substance abuse can increase ones chance of being infected. This could suggest that many communication campaigns have focused heavily on preventing unprotected sexual activities, reducing sexual partners and even delaying sexual onset whilst giving little attention to critical factors like alcohol abuse. According to NCS (2009 in SAGI, 2009), there is a high correlation between substance abuse and risky sexual behaviour and, as a result, communication programmes need to highlight the linkages between alcohol, sex and HIV. It is clear that communication needs to place more emphasis on the relationship between substance abuse and HIV infections. This is important when one considers the increasing levels of substance use among female youths.

The study also sought to examine the success of communication campaigns in addressing problems or factors that expose young women to HIV infection. The findings from the study also show that some respondents feel that communication has addressed their concerns with regard to factors that can increase their vulnerability to the disease. Although this is the case, results also indicate that a significant number of respondents are either not sure or do not believe that communication has addressed their concerns with regard to HIV. Using information that emerged from the focus group discussions, the accessibility of communication and the language used in communication campaigns could be probable reasons why some respondents believe communication has addressed their problems whilst

others believe communication has not addressed their concerns. Accessibility, in this case, refers to the extent to which HIV/AIDS communication programmes are readily available to target populations.

The extent to which individuals have access or are exposed to HIV/AIDS communication can influence their knowledge and understanding of factors that increase a person's vulnerability to the infection. With more exposure or access to HIV/AIDS communication, the higher the chances of individuals obtaining more knowledge and understanding of contributory factors to HIV/AIDS. In contrast, limited or no exposure to HIV/AIDS communication can also mean a reduced knowledge and understanding of factors that expose individuals to HIV/AIDS. Access, according to Salmon & Atkin (2003), can increase awareness, knowledge and understanding of all aspects of the epidemic. According to Hanan (2003), knowing the channels used by the target population is crucial in the dissemination of HIV/AIDS messages. Anderson (2011) further contends that the philosophy of "fishing where the fish are" is crucial if messages are to be effectively communicated.

Furthermore, the language used in HIV/AIDS communication campaigns can contribute to knowledge and understanding of factors that can increase an individual's chance of being infected. Language can directly or indirectly affect the effectiveness of intervention activities as it can heighten the risk of distortion, misinterpretations and/or the rejection of messages, especially in multilingual societies (Bearth, 2012).

Using the information above, it is probable that respondents who indicate that communication has clearly addressed factors that can expose them to infection and answered individual questions on HIV/AIDS have more exposure and access to HIV/AIDS information whilst those who believe that individual questions have not been answered could have less exposure and access to HIV/AIDS communication activities. It can also be inferred, using the

findings of the study, that the language used in communication has also contributed to the extent to which individuals understand messages. If the language used in communication activities is not clearly understood by the campaign's recipients, it can reduce the levels of understanding and lead recipients to believe that communication has not addressed their concerns regarding HIV/AIDS.

Based on the results of the study, it is clear that the respondents who are aware of factors that can expose them to HIV/AIDS, believe that HIV/AIDS communication campaigns have clearly addressed these factors. These respondents also believe that individual questions on HIV/AIDS have been answered and they have an understanding of the language used to communicate with them. Although this is the case, a significant minority are not aware or not sure of factors that can expose them to HIV infection; these respondents believe that communication has not clearly addressed those factors and their individual questions on HIV/AIDS have not been fully answered.

6.4 Research Question 3

What factors influence the understanding and use of HIV/AIDS messages among Eastern Cape female high school students?

In order to gain clarity regarding the factors that influence the use and understanding of HIV/AIDS messages amongst respondents, questions were asked on the following areas of concern: whether respondents had found it difficult to understand messages in HIV/AIDS communication; failed to implement advice from any HIV/AIDS communication programmes, and whether they knew of any factors or obstacles to their understanding and use of advice contained in HIV/AIDS communication programmes. The results indicate that 70 percent of the respondents had no difficulties in understanding HIV/AIDS messages whilst 29 percent of the respondents indicated that they had difficulties in understanding messages

contained in HIV/AIDS communication programmes. One percent of the respondents did not respond to the question. The findings of the study also show that 35 percent of the respondents found it difficult or had failed to implement advice contained in HIV/AIDS communication programmes whilst 60 percent of the respondents indicated that they did not have difficulties in implementing the advice contained in HIV/AIDS communication programmes. Five percent did not answer the question.

Respondents were also asked to indicate whether they were aware of any factors that were obstacles to their understanding and use of advice in HIV/AIDS communication programmes. The results indicate that 66 percent of the respondents believe that there are obstacles or factors that have hindered their understanding and use of advice in HIV/AIDS communication programmes. Thirty percent of the respondents believe that there are no obstacles to their understanding and use of advice contained in HIV/AIDS communication programmes. Four percent of the respondents did not answer the question.

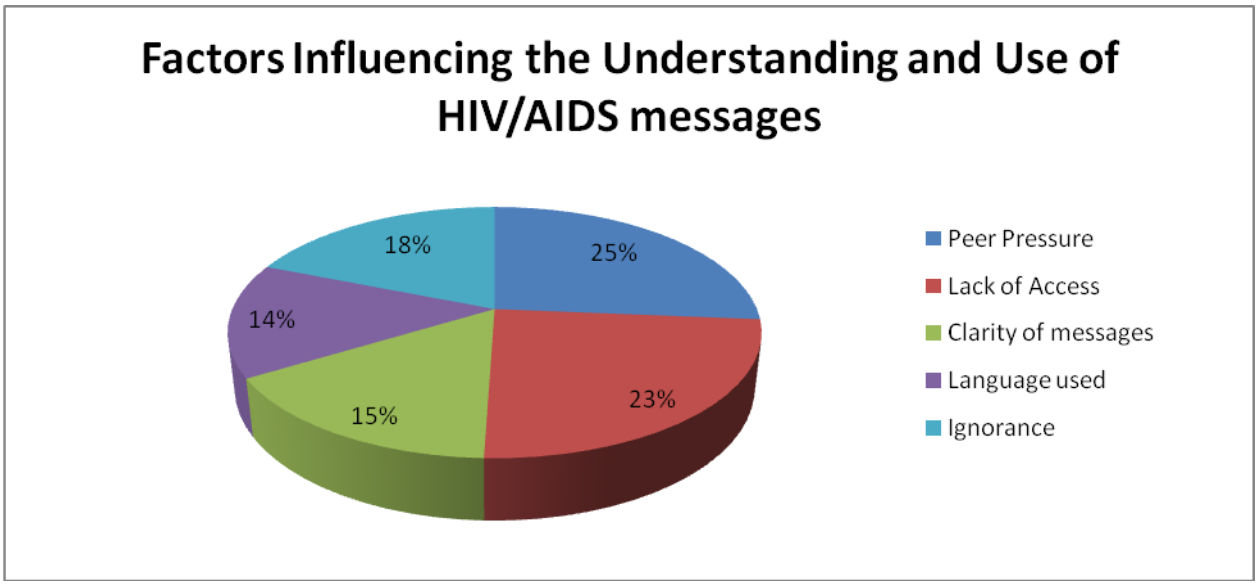
Table 11: Understanding and Implementation of HIV/AIDS messages

Understanding of HIV/AIDS Messages	Percent	Implementation of HIV/AIDS Advice	Percent	Obstacles to understanding and use of HIV/AIDS advice	Percent
Yes	**29**	**Yes**	**35**	**Yes**	**66**
No	**70**	**No**	**60**	**No**	**30**
No Response	**1**	**No Response**	**5**	**No Response**	**4**

6.4.1 Factors that Influence the understanding and use of advice contained in HIV/AIDS communication programmes

Although results indicate that some of the respondents believe that there were no obstacles to their understanding and use of advice in HIVAIDS communication programmes, the study asked respondents to indicate whether they knew of any factors that could possibly make it difficult for them to understand and use advice from HIV/AIDS communication activities. Their responses came from the pre-selected options on the questionnaire. In addition, the factors were to be ranked according to their importance or level of contribution to influencing the individual`s understanding and use of HIV/AIDS communication messages. It emerged from the study, as shown by Figure 8 below, that:

Figure 8: Factors Influencing the Understanding and Use of HIV/AIDS messages



1) Twenty five percent of the respondents viewed peer pressure as a significant or very important factor in influencing the understanding and use of advice in HIV/AIDS communication programmes.

2) Twenty three percent of the respondents viewed limited access to communication as an important factor in influencing the understanding and use of advice in HIV/AIDS communication programmes.

3) Fifteen percent of the respondents viewed the clarity of HIV/AIDS messages as an important factor in influencing the understanding and use of advice in HIV/AIDS communication programmes.

4) Fourteen percent of the respondents viewed the language used in HIV/AIDS communication programmes as a less important factor in influencing the understanding and use of advice in HIV/AIDS communication programmes, whilst

5) Eighteen percent of the respondents viewed ignorance of HIV/AIDS communication programmes as a factor that does not influence the understanding and use of advice in HIV/AIDS communication programmes.

Focus group discussions were also used to gain knowledge into factors that influence understanding and use of advice contained in HIV/AIDS campaigns. Focus group results indicate that the design of current communication strategies does not capture the attention and interests of young people. **There must be a change of the format or design of some HIV/AIDS communication campaigns.** This theme also describes the views of respondents regarding the nature and impact of HIV/AIDS communication. According to the respondents, communication must draw the attention of the target populations and keep them focused on it.

> *"We need dramas that capture our attention and raise our curiosity. We now know the sequences of most HIV dramas, how it will start and even come to an end. I will rather switch to another channel and watch something else"- Respondent.*

In relation to the design of HIV/AIDS communication campaigns, it emerged from the focus group discussions that the language used in these also contributed to the effectiveness of the communication.

> *"It is difficult for some of us to understand English, which is used in many communication activities. There are few HIV/AIDS communication strategies that use our home language that we can easily understand"- Respondent.*

Although not all respondents have problems with the language used in these campaigns, they do however agree that language can influence the understanding and use of HIV/AIDS messages. Language consideration is very important in the development of HIV/AIDS communication as it can directly or indirectly affect the effectiveness of such interventions.

6.4.2 Discussion of Findings on the factors that influence the understanding and use of advice in HIV/AIDS communication campaigns among Eastern Cape female High School students.

The results of the study indicate that a large percentage of the respondents had no difficulties in understanding HIV/AIDS messages whilst a significant minority indicated that they have had difficulties in understanding HIV/AIDS messages. Results further indicate that some respondents found it difficult or failed to implement advice in HIV/AIDS messages, whilst other respondents indicated that they were able to use or implement advice from HIV/AIDS communication programmes. The use of HIV/AIDS messages can be attributed to a number of factors, with understanding of the messages playing a critical role in the implementation of advice from HIV/AIDS communication campaigns. A study was conducted by Cury & Rossi (2008) to investigate the pattern of sexual activity amongst teenagers from a private clinic in Brazil. According to Cury & Rossi (2008), the results of the

study showed that teenagers had engaged in their first sexual encounter at the age of 15 and had an average number of sexual partners of 1.5. The results from this study also indicated that these teenagers tended to use less or no contraceptives in their first sexual encounter. This pattern of sexual activity amongst these teenagers, as Cury and Rossi (2008) argue, exists despite the widespread knowledge of contraception and the delay of onset of sexual activities. Most HIV/AIDS communication campaigns targeting the youth have paid particular attention to messages that discourage the early onset to sexual activity and have advocated for protective behaviour like the use of condoms and contraceptives to prevent unwanted pregnancies and any sexually transmitted infections. Clearly, the patterns of sexual activity amongst these teenagers reflect a failure or even reluctance amongst these youths to use the messages contained in HIV/AIDS communication.

To further investigate the factors that influence the understanding and use of advice contained in HIV/AIDS messages, the study measured the awareness of these factors and the significance of the selected factors in influencing the use of HIV/AIDS messages. The results show that respondents are aware of factors that largely influence their understanding and use of HIV/AIDS messages. Peer pressure was seen as a significant factor in the understanding and use of HIV/AIDS communication. This finding concurs with the principles held by the Theory of Reasoned Action that social norms will dictate to an individual whether or not to pursue certain behaviours. Social norms play an important role in predicting intentions towards behaviour, and they are defined as the perceived social pressure to perform or not to perform a behaviour. Social norms include normative beliefs and the motivation to comply. These norms are a function of beliefs that specific individuals approve or disapprove of performing the behaviour in question (Azjen & Fishbein, 1980). Therefore, subjective norms have an impact on the intention to perform behaviour.

Limited access to HIV/AIDS communication activities was also identified as an important factor in influencing the use and understanding of HIV/AIDS messages. Access increases exposure which will in turn increase awareness, knowledge, understanding and the eventual use of messages. According to Avert (2010), limited access to health and HIV/AIDS communication activities decreases exposure to accurate information which then increases the risk of infection. Another factor that has been identified as important in influencing the understanding and use of HIV/AIDS messages is the clarity of messages. Clarity of messages removes misconceptions about the epidemic by providing accurate and simple to understand messages for different target populations. For example, the misconception that the use of contraceptives will prevent the transmission of HIV infections in the same way that they prevent pregnancy would be easily avoidable if there was clear and concise communication on what contraceptives can and cannot do in terms of HIV/AIDS prevention. Although some respondents know that contraceptives cannot protect them from HIV infection, it was clear from discussions that the use of contraceptives solely to prevent pregnancy increases the chances of engaging in unprotected sexual behaviour, amongst young people. This observation is in line with findings of Van Dyk (1999) who states that some female youths believe that contraceptive methods will protect them against HIV/AIDS in the same way it prevents pregnancy and, as such, they feel that they can engage in unprotected sexual activities. The discussion thus indicated a misconception regarding the use of contraceptives amongst young people.

According to Avert (2010) although there has been an improved reach of awareness campaigns, it seems that, to a certain extent, poor knowledge of accurate information about HIV/AIDS continues to exist, especially amongst the younger population groups. According

to KFF (2007), a small but significant number of young people still hold misconceptions about some key aspects of the epidemic.

The findings of the study also indicate that respondents believe that the language used in communication activities and a complete disregard of HIV/AIDS messages has lessened the impact on their understanding and use of HIV/AIDS messages. This finding is consistent with the findings of other studies that have seen language use in communication, and the attitude of recipients to HIV/AIDS communication, as significant factors in the understanding and use of advice in HIV/AIDS communication. Language will determine the extent to which messages are understood whilst attitude contributes towards the performance of protective against HIV/AIDS.

6.5 Research Question 4

To what extent have HIV/AIDS communication campaigns been effective in influencing attitude and behaviour change regarding HIV/AIDS among the female High School students?

To measure the impact of HIV/AIDS communication on female youths, questions on whether communication campaigns had increased individual knowledge about HIV/AIDS, changed or influenced attitude change towards positive or protective behaviour and whether communication influenced the adoption of positive behaviour were asked. The importance of HIV/AIDS communication campaigns in the fight against HIV infection among young women was also investigated.

The findings show that 70 percent of the respondents indicate increased knowledge and awareness of HIV/AIDS and its related issues as a result of their exposure to HIV/AIDS communication campaigns whilst 25 percent of the respondents indicate that HIV/AIDS

communication programmes did not impact on their knowledge of HIV/AIDS. Five percent of the respondents did not answer the question. The respondents were further requested to indicate whether communication had an impact on their attitude towards HIV/AIDS. Results show that 55 percent of the respondents believe that HIV/AIDS communication influenced them towards positive attitude change with regards to HIV/AIDS whilst 40 percent of the respondents indicate that HIV/AIDS communication campaigns did not influence attitude towards HIV/AIDS. Five percent of the respondents did not respond to the question.

Focus group discussions also looked at the effect of HIV/AIDS communication on the attitude of individuals towards HIV/AIDS. Based on the discussions, **the disregard of HIV/AIDS messages** is also another theme that emerged to describe some of the respondent's views regarding the impact of HIV/AIDS programmes.

> *"People just want to experience certain things for themselves in order to learn from them. People still think that they cannot get HIV infected"- Respondent.*

It emanated from the focus group discussions that young people will engage in high risk behaviour only to experience certain things for themselves. The discussions also revealed that some individuals believe that they cannot get infected by HIV and as a result they are likely to engage in high risk activities.

Table 12: Impact of HIV/AIDS communication on female high school students

Knowledge Increase	Percent	Attitude Change	Percent	Adoption of Behaviour	Percent	Importance of HIV/AIDS Communication	Percent
Yes	70	Yes	55	Yes	60	Yes	80
No	25	No	40	No	37	No	12
No Response	5	No Response	5	No Response	3	No Response	8

Respondents were also requested to indicate whether HIV/AIDS communication campaigns had helped them to adopt positive behaviour against HIV/AIDS. It emerged from the study that 60 percent of the respondents agree that HIV/AIDS communication campaigns enabled them to adopt positive behaviour against HIV/AIDS whilst 37 percent of the respondents indicate that HIV/AIDS communication did not influence them towards the adoption of behaviour against HIV/AIDS. Three percent of the respondents did not answer the question.

The importance of HIV/AIDS communication in the fight against HIV/AIDS was also measured. The study shows that 80 percent of the respondents believe that HIV/AIDS communication strategies are important in the fight against HIV/AIDS while 12 percent of

the respondents do not attach any significance to HIV/AIDS communication in the fight against HIV/AIDS. Eight percent of the respondents did not indicate their views.

6.5.1 Discussion of findings on the impact of HIV/AIDS communication campaigns in influencing attitude and behaviour change towards HIV/AIDS among female High School students.

Results on the impact of HIV/AIDS communication are based on the general questions asked through the questionnaire and the information gathered through focus group discussions. It emanated from the study that HIV/AIDS communication campaigns have had a significant impact in supporting and increasing awareness of HIV/AIDS amongst young women. The majority of the respondents indicate that they have an increased awareness and knowledge of HIV/AIDS as a result of their exposure to HIV/AIDS communication. However, there are some respondents who indicate that HIV/AIDS communication programmes did not impact on their knowledge of HIV/AIDS. This could suggest that, for these respondents, HIV/AIDS communication has not provided any new information on the epidemic and their knowledge levels of and on HIV therefore remain the same. Another probable reason could be that respondents have had limited exposure to communication activities and, as a result, have no exposure to different communication campaigns that carry different messages on HIV/AIDS.

In a study conducted by KFF (2009), the results indicated that young people did not feel at risk of getting infected with HIV as they were careful with who they have or will have sex with and that they do not have enough sex to feel at risk of HIV infection. It is perceptions such as these that highlight that young people have some misconceptions regarding the nature of the epidemic thereby questioning the effect of the increased awareness and exposure to HIV/AIDS communication.

Basically, the results of the study indicate that HIV/AIDS communication campaigns have had a positive impact in increasing the awareness and knowledge of HIV/AIDS amongst young women. The findings are consistent with those of previous studies. According to South African Government Information (2009), young people have been exposed to at least one communication campaign in South Africa and this has contributed to the significant levels of HIV/AIDS awareness and knowledge amongst young people. Furthermore, Bertrand & Anhang (2006) state that results obtained from a study that sought to assess the strength of selected mass media interventions on HIV/AIDS, amongst young people in developing countries, showed that the selected media interventions had been successful in increasing knowledge or awareness of HIV/AIDS amongst the youth.

The study also shows that a significant percentage of respondents believe that HIV/AIDS communication messages have changed their attitudes towards HIV/AIDS while an equally significant number of respondents believe that HIV/AIDS communication has not changed their attitudes towards HIV/AIDS. Extensive exposure to HIV/AIDS communication messages could have lead to attitude change for some respondents whilst the same exposure has not brought about any attitude change to other respondents. This could be attributed to the failure of communication to effectively communicate with recipients or the existence of other factors like limited exposure to communication or a complete disregard of HIV/AIDS messages. In a study conducted by Bertrand & Anhang (2006), to assess the strength of selected mass media interventions on HIV/AIDS amongst young people in developing countries, the results suggested that HIV/AIDS communication campaigns can achieve success in certain variables, but not in all variables important in the fight against HIV/AIDS. In as much as some respondents allude to the fact that their attitude has been changed, the

representation of this change is not significantly different from those who believe HIV/AIDS communication has not changed their attitude towards HIV/AIDS.

The study also measured the impact of HIV/AIDS communication on the behaviour of respondents, regarding HIV/AIDS. The results reveal that some respondents indicated that communication had influenced their adoption of protective behaviour against HIV/AIDS, while a significant number of respondents also indicated that HIV/AIDS communication has not contributed towards any significant behaviour change against HIV/AIDS, on their part. The results suggest that the impact of HIV/AIDS messages on behaviour change amongst young people is different. For some, it has brought about a change in behaviour and for others it can mean that HIV/AIDS has not changed their behaviour. This suggests that some respondents have not been motivated to adopt positive behaviour change or it could mean that their behaviour has been changed but not as a result of HIV/AIDS communication programmes.

The importance of HIV/AIDS communication in mitigating the spread of HIV/AIDS amongst young people was also measured. The results indicate that although the effect of HIV/AIDS communication on the individual varies, almost all respondents consider HIV/AIDS communication campaigns to be important tools in the fight against HIV/AIDS, particularly amongst young people. A number of studies investigating the impact of HIV/AIDS communication also show that, although the impact varies owing to the different circumstances surrounding people, HIV/AIDS communication is regarded as an important mechanism in the fight against HIV.

6.7 CONCLUSION

Based on the findings of the study, it cannot be disputed that HIV/AIDS communication plays a critical role in empowering people, particularly young people. It is

also clear that HIV/AIDS communication has been successful in addressing certain critical variables that tend to expose people to HIV infection. However, what is also apparent from this study is that there is significant minority which has not been effectively reached by HIV/AIDS communication. It is arguably through this significant minority that the spread of HIV/AIDS will continue and it is therefore imperative that communication must work towards effectively reaching every member of the society, if we are to see a reversal in HIV transmission rates amongst the most vulnerable groups.

CHAPTER SEVEN

CONCLUSIONS AND RECOMMENDATIONS

7.1 INTRODUCTION

Having discussed, in the previous chapters, the various aspects of HIV/AIDS communication in the South African context and having examined the effect of HIV/AIDS communication on female high school students, this chapter offers a summary of the central findings of the study and reflects on the relevant issues that have emerged. Key questions are, therefore, raised and recommendations for further research are also proposed.

The conclusions of the study are guided by the research questions and objectives which were highlighted at the beginning of this work.

7.2 SUMMARY OF FINDINGS

AWARENESS OF HIV/AIDS AND HIV/AIDS COMMUNICATION CAMPAIGNS AMONG FEMALE HIGH SCHOOL STUDENTS.

As observed by other researchers in their different studies on young people and HIV/AIDS, this study found a very high level of HIV/AIDS awareness amongst female high school students in the Eastern Cape Province. In terms of awareness of HIV/AIDS communication campaigns, the study indicates that at least one to two HIV/AIDS communication campaigns have reached and communicated with young people. The mediums through which young people receive HIV/AIDS related information vary, although the study observed that television was the common channel through which many young people received HIV/AIDS communication. The study also indicated that there is a growth, among young people, in the use of the internet to access HIV/AIDS related information. The

high level of HIV/AIDS awareness clearly shows that, in some respects, the goal of HIV/AIDS communication is being met. With regard to the channels of communication, the internet and peers are also among the different channels through which information is received. The use of the internet to receive HIV/AIDS information clearly indicates the need for more extensive use of the internet and some of its applications to reach young people who are spending much of their time on the internet. Basically, the data in this study places particular emphasis on the high awareness levels of HIV/AIDS and the different methods through which information on HIV/AIDS is received.

RELEVANCE OF HIV/AIDS COMMUNICATION CAMPAIGNS TO FEMALE HIGH SCHOOL STUDENTS

The study shows a high awareness, amongst young people, of factors that could expose them to HIV infections. The study also revealed that, to some extent, HIV/AIDS communication has been able to provide young people with the necessary skills to reduce their risk of infection through the communication that they have access to and that they can understand given the manner in which messages are communicated. By the same token, a significant number of participants have no clear understanding of the factors that could expose them to HIV infections and know little about how to counter the effects of such factors. To these participants, HIV/AIDS communication messages are not easy to access and the language used in such communication, in some instances, is not easy to understand. Unprotected sexual activities are regarded as the most critical factor that can expose young women to HIV infection whilst having multiple concurrent partners is considered an insignificant factor in increasing the risk of infection.

Although HIV/AIDS communication seems to be successful, in some respects, it is clear that HIV infections will not decline significantly and new infections will continue to be

recorded as long as there are young people who still do not have equal access to HIV/AIDS information. The decline will also not become a reality while these young people have difficulties with clearly understanding the languages used in the different campaigns and, as a result, they have limited information on critical issues that can increase their risk of infection. Basically, the study places emphasis on the need to reach everyone with clear and accurate messages that will provide the skills necessary for reducing the risk of infections.

FACTORS INFLUENCING THE UNDERSTANDING AND USE OF ADVICE CONTAINED IN HIV/AIDS COMMUNICATION CAMPAIGNS

The data indicates which factors young people regard as having significant effects on their understanding and use of HIV/AIDS messages. As observed from the study, young people do have an understanding of HIV/AIDS messages, and have not failed to implement the advice contained in HIV/AIDS programmes although they believe that there are factors that can have an impact in their understanding and use of HIV/AIDS messages. At the same time, a significant minority indicate having difficulties in understanding the HIV/AIDS messages, and state that they have failed (in some instances) to implement the advice received from HIV/AIDS messages. These respondents also believe there are factors that have contributed to their situations.

Peer pressure, limited access to communication campaigns and a disregard of HIV messages are seen as the most significant factors in the understanding and use of advice contained in HIV/AIDS messages. The language used and clarity of messages delivered have also, in certain respects, contributed to the failure of young people in implementing the advice received from HIV programmes. From this, it can be inferred that HIV/AIDS communication has not extensively engaged with issues of peer pressure, nor has it adequately addressed issues of equal distribution of messages, and neither has it fought the

inclination to disregard the importance of such messages in the fight against HIV/AIDS. Clearly, issues of peer pressure and access to communication can have a significant impact on the ability of HIV/AIDS communication campaigns to empower target populations and must therefore be met with strict measures that will ensure an increase in exposure to communication and reduce the effect of peer pressure that sometimes supports unhealthy social norms.

THE EFFECTIVENESS OF HIV/AIDS COMMUNICATION CAMPAIGNS IN INFLUENCING ATTITUDE AND BEHAVIOUR CHANGE

The study indicates that young people believe that HIV/AIDS communication has increased their knowledge of HIV/AIDS and contributed to their attitude and behaviour change against HIV/AIDS. The representation difference between those who believe that communication has brought change to them and those who believe HIV/AIDS communication has not made any difference to them is not huge. A very significant number of young people indicate that HIV/AIDS communication has not increased their knowledge of HIV/AIDS, or changed their attitude and behaviour towards HIV/AIDS. This may not necessarily suggest that these young people are engaging in risky behaviour but it could suggest the existence of other factors, besides HIV/AIDS communication, that have contributed to the manner in which they respond to HIV/AIDS related issues. HIV/AIDS communication, in this regard, is seen as having been unable to effectively communicate and persuade some young people against the pandemic.

Although there are differences in terms of the impact of HIV/AIDS communication on young people, it is clear that most of these respondents still view the role of HIV/AIDS communication in the fight against HIV/AIDS as important.

7.3 GENERAL CONCLUSIONS

HIV/AIDS communication has been able to increase the awareness levels of young people in the Eastern Cape although the impact of such communication, in other related aspects of HIV prevention, has been manifest in different degrees to different individuals. It is also clear that awareness does not automatically mean a change in behaviour as there are other mediating factors, such as peer pressure, a disregard of health messages, which seem to be able to trigger behaviour change. The relevance of HIV/AIDS communication messages to target audiences is important for attitude and behaviour change against HIV/AIDS. The relevance of HIV/AIDS communication campaigns to target audiences may increase if messages are presented in languages that are easily understood by recipients and when access to different communication campaigns is increased. Factors like peer pressure, limited access to HIV/AIDS communication messages and a complete disregard of such messages have limited the success of HIV/AIDS communication campaigns amongst certain individuals.

The importance of HIV/AIDS communication in the fight against HIV/AIDS is undoubted, although it is clear, as observed from the study, that there could be other factors that have also contributed to the adoption of positive and protective behaviour against HIV/AIDS, besides HIV/AIDS communication amongst high school female students. Therefore, based on the findings of the study, one can infer that current HIV/AIDS communication campaigns in South Africa have put much effort into the fight against HIV/AIDS amongst young people, although there are still issues of concern that communication campaigns or service providers have to be cognisant of in order for communication to have a significant impact on the recipients. What is clear is that most of the strategies currently used need to be intensified in order to have an effect. For example, increasing the number of programmes that use local languages; identifying easily accessible communication channels for different audiences in order to increase their exposure to

HIV/AIDS messages; intensifying communication that supports the consistent use of condoms; as well as the development of more peer based strategies will go a long way in supporting attitude and behaviour change amongst young people.

Whilst some campaigns need to be intensified, new aspects or strategies also have to be implemented in order to improve the effectiveness of current communication. The following section of this chapter discusses the significance of the conclusions of this study.

7.4 SIGNIFICANCE OF CONCLUSIONS

The conclusions arrived at, based on the findings of the study, clearly indicate that although young women have a high awareness level of HIV/AIDS and the different existing communication campaigns, the degree to which such communication has had an impact on individuals varies. The significance of such findings lies in its ability to highlight the success or failure of HIV/AIDS communication campaigns in influencing change amongst recipients. Varying degrees of impact therefore suggests the need to re-evaluate current communication campaigns in order to implement changes, where necessary, that will contribute towards achieving the objectives of HIV/AIDS communication.

The conclusions of the study also provide additional data to the existing knowledge base on the effect of HIV/AIDS communication on target populations. Specifically, the study provides information on how female youths in the Eastern Cape Province of South Africa respond to HIV/AIDS communication. Some of the strategies (for example, nature of language used) in HIV/AIDS communication and even access to communication are seen as the major contributors to the lessened impact of communication on some female youths.

The conclusions also indicate that factors, like peer pressure, limited access to communication, message construction and a disregard of HIV/AIDS messages, have a huge

impact on the ability of an individual to translate HIV/AIDS messages into action. These findings substantiate significantly on the claims of the Theory of Reasoned Action and the Communication model for Development as they provide a basis from which to understand the behaviour of people with regards to behaviour in question. The Theory of Reasoned Action maintains that attitude and social norms governing an individual can determine the ability of an individual, whether to or not to perform a behaviour. Attitude, which could come in the form of a disregard of HIV/AIDS messages and social norms which could be influenced by peer pressure both determine the ability of an individual to perform behaviour. The Communication model for Development maintains, in one of its principles, that the construction of messages and the medium used to transfer information are critical for the success of any communication programme. As such it also, in its own way, has the ability to provide an understanding into how and why people respond to communication in the manner they do. Messages that are easy to decode, communicated in local languages and easily accessible can increase their impact on recipients.

Therefore the significance of conclusions lies in the ability of the findings to indicate the impact of communication on female youths and the implications thereof, to add to the current knowledge base on the effect of HIV/AIDS communication as well as validating the claims made by the theories used in the study.

7.5 RECOMMENDATIONS

Based on the findings of the study, the following recommendations are made:

1. HIV/AIDS communication campaigns must place equal emphasis on all factors contributing to HIV/AIDS amongst young people. The tendency to place more emphasis on certain factors over others lessens the importance of the more neglected factors which, in essence, can also heighten the incidence of HIV/AIDS amongst the target populations. For

example, much of the current HIV/AIDS communication in South Africa places emphasis on condom use and HIV testing with only a few programmes focusing on issues like substance abuse and multiple partners. This does not suggest the non-existence of communication campaigns that have sought to address issues of multiple concurrent partners and even substance use. The point, however, is that there is only a limited amount of emphasis placed on such factors; hence, the need to place the same amount of emphasis and importance on all factors as they can all expose individuals to HIV infections.

The causal effect chain therefore suggests that:

> **Equal emphasis on all contributory factors to HIV infections ⟶ will increase the importance of those factors and support the retention of messages ⟶ which will influence positive attitude change ⟶ and support behaviour change**

2. Service providers must increase the quantity of HIV/AIDS communication campaigns that use indigenous languages. The importance of language in HIV/AIDS communication cannot be overstated. The use of local languages in communication campaigns can increase the relevance of those campaigns to target populations. More campaigns that use local languages are needed, in addition to what is already available, in order to effectively communicate with relevant audiences. The use of local languages supports a clear understanding of messages and allows messages to deliver the intended meaning. According to Bearth et al. (2012), language interfaces are critical loci of a heightened risk of distortion, misinterpretation or even rejection of HIV/AIDS prevention messages. As such, the importance of the nature of the language used in HIV/AIDS communication cannot be undermined. The causal effect chain suggests that:

Increased use of indigenous language in communication campaigns ⟶ increases the relevance of messages through the provision of easy to understand messages ⟶ which will influence positive attitude change ⟶ and support behaviour change

3. More peer-based HIV/AIDS communication campaigns need to be developed. A number of studies, including this study, have shown the significant influence of peers on individual behaviour. Peer pressure has a tendency to undermine healthy social norms and HIV/AIDS prevention messages like delayed sexual on-set, abstinence and use of condoms. If peers can contribute to the disregard of health messages, it suggests that peers can also be used to uphold healthy social norms. As such, health service providers need further engagement with the matter of peer pressure, with the aim of changing unhealthy social norms to healthy ones. The development of more HIV/AIDS peer based communication campaigns can provide a mechanism through which peers can challenge cultures that support risky sexual behaviours, by modelling healthy social norms. Therefore, there is a need for more peer based campaigns in order to fight the spread of HIV amongst young people. The causal effect chain therefore suggests that:

Development of more peer- based HIV/AIDS communication campaigns ⟶ will capitalize on the social network influence to challenge unhealthy social norms to ⟶ influence attitude change ⟶ and support behaviour change

4. New formats and designs of entertainment education communication campaigns, that are thought-provoking and attention-grabbing, need to be developed. The design of communication campaigns, as observed from the study, has become monotonous because of continued use of similar ways of presenting HIV/AIDS information. Audiences can now predict what would happen in the programme. This has affected the attention of audiences

when watching the communicated messages. By so doing, audiences can miss out on important information regarding certain aspects of the epidemic. This, therefore, calls for the development of new designs of entertainment education campaigns that would raise the curiosity of audiences, grab their attention and provide relevant issues for public discourse. The causal effect chain therefore suggests that:

> **Change in format of HIV/AIDS entertainment education campaigns ⟶ will increase attention to messages whilst increasing the retention of the message and lead to the development of a constructive public discourse ⟶ which can influence attitude change ⟶ and support behaviour change**

5. There must be a balanced distribution of similar messages in different communication channels. Owing to a varied number of reasons, audiences or target populations will not have access to the same communication channels. As such, their exposure to HIV/AIDS communication will also vary. This means that certain individuals could be exposed to messages that others are not exposed to. Alternatively, individuals could have no access to messages that are available to others. It cannot be disputed that different communication campaigns will communicate differently and have varying influences on different audiences; this makes it crucial for HIV/AIDS communication campaigns to be distributed across all communication channels that have the potential of reaching target populations in order to increase their exposure to HIV/AIDS related issues. Therefore, striving to provide a balance in the distribution of similar messages over a number of communication channels has a greater potential to increase the awareness of HIV/AIDS and even lead to behaviour change.

The causal effect chain therefore suggests that:

A balanced distribution of similar messages in different channels ⟶ will increase exposure to all types of HIV/AIDS messages which can communicate different messages to different recipients ⟶ to influence attitude change and ⟶ support behaviour change

6. Services providers must identify more easily accessible channels of communication that can increase young people`s exposure to HIV/AIDS messages. The need for the identification and use of easily accessible communication channels amongst young people cannot be overstated. Easily accessible communication channels support an easy flow of information to the recipients. Relative accessibility of different types of media as the main sources of information differs by location as well as by population and gender groups. Therefore, the use of more channels, especially those easily accessible amongst young people, can increase their exposure to HIV/AIDS messages that have the potential to empower them against HIV/AIDS. The more channels that are mobilized to reach and communicate with young people, the better the chances of the programs' success. The causal effect chain therefore suggests that:

The use of easily accessible channels to different audiences' ⟶ increases exposure to HIV/AIDS communication campaigns ⟶ which can influence attitude change ⟶ and support behaviour change

7. Service providers must intensify communication that provides clarity on the use of contraceptives. Although contraceptives have been made available to young women, research has shown that there are misconceptions regarding the use of contraceptives. HIV/AIDS communication has largely advocated for the use of contraceptives as a way of

preventing pregnancy. Due to the prevailing misconceptions regarding the use of contraceptives, it is clear that HIV/AIDS communication, in its advocacy for the use of contraceptives to prevent unwanted pregnancies, must go beyond advocating for this. HIV/AIDS communication campaigns must also provide clarity on what contraceptives cannot do regarding the prevention of HIV infections. Misconceptions regarding the use of contraceptives have contributed, to some extent, to the spread of HIV infections amongst young people. Therefore, it is imperative that communication on the matter clearly states that although contraceptives can protect unwanted pregnancies; they definitely cannot reduce the risk of HIV infection if unsafe sexual activities are practiced. The causal effect chain therefore suggests that:

> **Intensifying communication that provides clarity on the use of contraceptives ⟶ increases knowledge amongst users on what contraceptives cannot do when it comes to protecting against HIV/AIDS ⟶ which can change attitude on the use of contraceptives ⟶ and support the adoption of protective sexual activities even in instances where contraceptives have been used**

8. Service providers must intensify communication that advocates for the consistent use of condoms. Current HIV/AIDS communication needs to have explicit scenes or programmes that will show the importance of using condoms during all sexual encounters. HIV/AIDS communication campaigns must go beyond simply encouraging the use of condoms but must also clearly emphasize the importance of consistently using condoms. Consistency can reduce the risks of pregnancy, as well as STD and HIV infections. Studies have shown that inconsistency in the use of condoms amongst young people has contributed to the high prevalence of HIV/AIDS amongst young people in South Africa. Therefore

HIV/AIDS communication campaigns which emphasise, not only on use, but on the consistent use of condoms will help reduce the risk of infection.

The causal effect chain therefore suggests that:

Intensifying HIV/AIDS communication on the consistent use of condoms ⟶ will increase understanding of the importance of consistently using condoms if people are to be protected from HIV infections ⟶ which will influence the change of attitude towards the manner in which condoms are used ⟶ and support correct condom usage behaviour that can reduce the risk of infection

7.6 SUGGESTIONS FOR FURTHER RESEARCH

Based on the findings of this study, suggestions for further research are offered here. To continue fighting the spread of HIV infections amongst young women, research that seeks to understand the responses of young women to HIV/AIDS messages is critical. In this case, the research needs to focus on understanding the way in which young people construct their meanings of HIV/AIDS communication messages. Such studies will provide insight into whether correct meanings are constructed from the different HIV/AIDS messages. In addition such studies will also assist to establish whether or not young women`s interpretation and meanings they draw from HIV/AIDS communication impact on the effectiveness of the message. Findings from such studies will also improve on the quality of HIV/AIDS communication campaigns in order for them to effectively communicate with the target population.

Studies can also be done to further explore other ways that can be used to reach those with limited access to HIV/AIDS communication campaigns, especially those living in rural

areas. Increasing access to HIV/AIDS communication messages is critical towards behaviour change.

7.7 CONCLUSION

HIV/AIDS communication campaigns in South Africa have had significant success in increasing the awareness of HIV/AIDS, and its related issues, amongst young women. This exposure has seemingly contributed to a clear understanding of how HIV infections can be contracted as well as how to reduce the risk of infection. Although this success has been noted, there are still some concerns that need to be effectively addressed in order to realize full success in reaching and communicating with those most vulnerable to the epidemic.

This chapter has, therefore, provided a summary of the findings on the main research objectives of the study, provided recommendations based on the findings of the study and provided suggestions for further studies related to HIV/AIDS communication and young women in South Africa.

8. BIBLIOGRAPHY:

Abraham, C., & Sheeran, P. 2003. Implications of goal theories for the theories of reasoned action and planned behaviour. *Current Psychology,* 22, 264-280.

AfricomNet. (date unknown). *Theories and Models of Behaviour Change*. [Online] Available: www.africomnet.org/capacity/toolkit.day2/handouts15.doc

Airhihenbuwa, C., Makinwa, B. & Obregon, R. 2000. Towards a New Communications Framework for HIV/AIDS. *Journal of Health Communication*, 5(51): 101-111

Albarracin, D., Fishbein, M., Johnson, B. T., & Muellerleile, P. A. 2001. Theories of reasoned action and planned behavior as models of condom use: A meta-analysis. *Psychological Bulletin,* 127, 142-161

Amaro, H. & Raj, A. 2000. On the Margin: Power and Women`s HIV Risk Reduction Strategies. *Sex Roles: A Journal of Research,* 42(7): 723-749

Anderson, J. 2011. *Future Federal Directions in Mobile Technology*. http://blog.aids.gov/2011/01/future-federal-directions-in-mobile-technology-in health.html (accessed: January, 10, 2011)

Anarfi, J.K. 2005. Under reaction to sexual behavioural change among the Youth in Ghana. In S. Agyei-Mensah, J.B. Casterline and D.K. Agyeman (eds). *Reproductive Change in Ghana: Recent Patterns and Future Prospects* (Accra: University of Ghana, 225 25).

Armitage, C. J. 2006. Evidence that implementation interventions promote transitions between the stages of change. *Journal of Consulting and Clinical Psychology,* 74, 141-151.

Armitage, C. J., & Conner, M. 2001. Efficacy of the theory of planned behaviour: A meta analytic review. *British Journal of Social Psychology,* 40, 471-500.

Ascroft, J. and S. Masilela. 1994. Participatory Decision Making in Thrid World Development. In S. White with K. S. Nair and J. Ascroft (Eds.), *Participatory Communication: Working for Change and Development* (pp.259-294). New Delhi: Sage Publications.

Avert. 2010. *HIV/AIDS in South Africa*. [Online] Available: http://www.avert.org/aidssouthafrica.htm (Accessed: January, 2011)

Azjen, I.1991. The theory of planned behavior. *Organizational Behavior and Human Decision Processes,* 50, 179-211.

Azjen, I. 1985. *Action-control: From cognition to behavior.* Berlin,Germany: Springer. In Kuhl, J., and Beckmann, J. (Eds.). From intentions to actions: theory of planned behavior. (11-39). New York: Springer-Verlag.

Azjen, I., & Fishbein, M. 1980. *Understanding attitudes and predicting social behavior*. Englewood Cliffs. NJ: Prentice-Hall.

Azjen, I., & Fishbein, M. 2005. *The influence of attitudes on behavior*. In D.Albarracín, BT Johnson and MP Zanna (Eds.). The handbook of attitudes (173-221). Mahwah, NJ: Erlbaum.

Azjen, I., & Manstead, A.S.R. 2007. Changing health-related behaviors: An approach based on the theory of planned behavior. In K. van den Bos, M. Hewstone, J. de Wit, H. Schut, M. Stroebe (Eds.). *The scope of social psychology: Theory and applications* (pp. 43-63). New York: Psychology Press.

Bandura, A. 1986. Social Foundations of Thought and Action. Englewood Cliffs, NJ: Prentice-Hall.

Bearth, T., Cisse, G., Singy, P. & Singo, G.D. 2012. *HIV/AIDS Communication Facing African Multilingualism- A Socio-Medical Conundrum*. A Critical Shift from Chronic Condition: Learning from the Frontliners. Geneva Health Forum, April 18-20, 2012.

Becker, M.H. 1974. The Health Belief Model and Personal Health Behaviour. Health Education Monographs, 2 (4): 324-473

Becker –Berton, A., Bertrand, J. & McKee, N. 2004. Strategic Communication in the HIV/AIDS Epidemic. New Delhi, India: Sage Publication.

Bertrand, J. T. and Anhang, R. 2006. *The effectiveness of Mass Media in Changing HIV/AIDS related behaviour among Young People in the Developing Countries*. The Communication Initiative Network.

Blankenship, K., Friedman, S. & Dworkin, S. 2006. Structural Intervention, Challenges and Opportunities for Interdisciplinary Research. *Journal of Urban Health*, 83, 59-72

Bless, C., Higson-Smith, C. & Kagee, A. 2006. *Fundamentals of Social Research Methods*: An African Perspective, 4th Ed. Cape Town: Juta & Co. Ltd

Boyer, C & Keggles, S. 1991. AIDS Risk & Prevention among Adolescents. *Social Science &Medicine*, 33(1): 12

Burns, K.K. 2005. *Multi&/or Mixed Method Design*. Nursing 503-session 10, Qualitative Research 4. [Online] Available: http://www.ualberta.ca/ (Accessed: May, 2011)

Caesar-Kasenga M. 2007. *Parliament, Politics and AIDS: The Case of South Africa*. IDASA

Chen, I.Y.L. , Chen, N.S., & Kinshuk. 2009. Examining the Factors Influencing participants' Knowledge Sharing Behavior in Virtual Learning Communities. *Educ. Technol. Soc*., 12 (1): 134–148.

Charmaz, K. 1990. 'Discovering' chronic illness: Using Grounded Theory. *Social Science and Medicine*, 30(11): 1161-1172

Charmaz, K. 2006. *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis.* London: Sage Publications.

Chitando, A. 2011. *Narrating Gender and Danger in Selected Zimbabwe Women`s Writings on HIV and AIDS*. University of South Africa.

Clubbers Guide. 2010. MXit Created Bridge Across Social Networks. [Online] Available: http://clubbersguideonline.co.za/News.aspx?i=46 (Accessed: January, 2011)

Colle, R.D. 2000. The Enter-Educate approach for promoting social change. *The Journal of Development Communicatio*n. Johns Hopkins University.

Coolican, H. 1994. *Research methods and statistics in psychology (2nd edn.)*. London: Hodder& Stoughton

Corner, J. 2000. The Contested Core of Media Research. In Curran, J. & Gurevitch, M. (Ed). Mass Media and Society. 3rd Edition. New York: Oxford University Press Inc.

Cury, A. & Rossi, M. P. 2008. Sexual activity among female teenagers: a comparison between two groups of middle class adolescents from a private clinic according to pregnancy status. *Rev. Bras. Saude Mater. Infant*, 8(3): 251-256

DasGupta, T. 2008. The Power of Peers. NGO-Pulse, Issue 134. Web 2.0, Social Networking, Toolkit. [Online] Available: http://www.sangonet.org.za (Accessed: August, 2010)

Deane, J. 2007. Presentation at UNAIDS meeting on Communication for Social Change. [Online] Available: http://road%20challengeds%20in%20health%20communication_en.pdf (Accessed: August, 2010)

Department of Economic Development and Environmental Affairs (DEDEA). 2008. *Strategy and Implementation Plan for Support and Development of Co-operatives in the Eastern Cape Province*. [Online]Available: http://www.dedea.gov.za/Policies/Approved%20Provincial%20Cooperative%20%20 trategy.pdf (Accessed: June, 2011)

Deborah G, Nowak, G., Valente, T., Sapsis, K. & Martin, C. 2002: Youth Performing Arts Entertainment-Education for HIV/AIDS Prevention and Health Promotion: Practice and Research. *Journal of Health Communication: International Perspectives*, 7:1, 39 57

Department of Health (Republic of South Africa). 2007. *HIV and AIDS and STI Strategic Plan for South Africa*, 2007–2011; March 2007

Derzon, J. H. & Lipsey, M. W. 2002. A meta-analysis of the effectiveness of mass communication for changing substance –use, knowledge, attitudes and behaviour. In Crano, W.D. & Burgoon, M. (Eds.). *Mass Media and Drug Prevention: Classic and Contemporary Theories and Research*. (231-258). Matwah, NJ: Lawrence Erlbaum Associates Publishers.

DrumBeat. (2005). *HIV/AIDS: Behaviour Change, Social Protection, Inequality and Hope.* [Online] Available: http://www.comminit.com/hiv aids/category/sites/global/hiv aids (Accessed: May, 2011)

Dworkin, Shari L., & Blankenship, Kim. 2009. Microfinance and HIV/AIDS Prevention: Assessing its Promise and Limitations. AIDS and Behavior, 13(3): 462-469.

Eastern Cape Department of Health. 2006. *Province of the Eastern Cape Department of Health Annual Report*, 2005-2006.

Erasmus, G. & Nkau, D.J. 2009. *HIV/AIDS: Towards a 10 year Review of the Population Policy Implementation in South Africa (1998-2008).* [Online] Available: www.population.gov.za/pop_dev/idex.../5-HIV-and-AIDS.html (Accessed: June, 2012)

Ellis, E. 2012. Rising abortions put strain on resources. The Times Newspaper, 12 June 2012. [Online] Available: www.timeslive.co.za/thetimes/2012/ (Accessed: June, 2012)

Fishbein, M., & Ajzen, I. 1975. *Belief, Attitude, Intention and Behavior: An Introduction to Theory Research.* Reading. MA: Addison-Wesley

Fishbein, M., & Ajzen, I. 1975. *Belief, attitude, and behavior.* Reading, MA: Addison Wesley.

Fishbein, M. & Middlestadt, S. E. 1989. Using the theory of reasoned action as a framework for understanding and changing AIDS-related behaviours. In Mays, V.M., Albee, G. W. & Schneider, S. F. (Eds). Primary prevention of AIDS: Psychological approaches (89-110). Newbury Park: Sage Publications.

Fisher, L.B., Williams, I., Austin, B., Camargo, A. & Colditz, G. A. 2007. Predictors of Initiation of Alcohol Use Among US Adolescents. Findings from a Prospective Cohort Study. *Arch Pedriatr Adolesc Med*, 161, 959-966

Flick, U. 1998. *An Introduction to Qualitative Research*. Sage Publication.

Fourie, P.J. (2009*). Media Studies Media Content and Media Audiences,* Vol 3. Cape Town.

Freimuth, V.S. 1992. Theoretical foundations of AIDS media campaigns. In Edgar, T., Fitzpatrick, M. A. & Freimuth, V. S. (Eds). AIDS: A communication perspective (91 110). Hillsdale, NJ; Erlbaum.

Freire, P. (1997). *Pedagogy of the Oppressed* (Rev. ed.). New York, NY: Continuum

Fuller, L.K. 2008. *African Women`s Unique Vulnerabilities to HIV/AIDS. Communication Perspectives and Promises*. New York: Palgrave Macmillan

Glasser, B. & Strauss, A. 1967. *The Discovery of the Grounded Theory*. New York: Aldine

Govender, P. 2012. *Our Teens Swap books for babies*. Sunday Times Newspaper, 15 April 2012. South Africa.

Graeff, J.A., Elder, J.P. & Booth, E.M. 1993. *Communication for Health and Behaviour Change. A developing Country perspective.* San Francisco: Jossey-Bass Publishers

Gray, J. 1997. Spiritual Perspective on Social Support in women with HIV Infection.Pilot Study, Image. *The Journal of Nursing Scholarship*, 29(1): 97

Grbich, C. 2007. *Qualitative Data Analysis: An Introduction*. London: Sage Publications.

Grinnell, R.M. & Williams, M. 1990. *Research In Social Work: a Primer*. Itasca, IL: Peacock

Hall, S. 1980. Encoding/Decoding. In Graddol, D. & Boyd-Barrett, O. (Eds). *Media Texts: Authors and Readers*. Clevendon: Multilingual Matters.

Hanan, M. A. 2003. *MARCH- media awareness related campaign for HIV, project proposal.* (unpublished). Canada: York University

Hersey, J. C., Niederdeppe, J., Evans, W. D., Nonnemaker, J., Blahut, S., Farrelly, M. C. 2003. The effects of state counter industry media campaigns on beliefs, attitudes, and smoking status among teens and young adults. *Preventive Medicine, 37,* 544-552.

Huebsch, J. C. 1986. *Communication 2000*. 2edition. Durban: Butterworths

Hulley, S.B. & Cummings, S.R. 1988. *Designing Clinical Research*. Baltimore: Williams & Wilkins

Human Sciences Research Council (HSRC). 2008. *South African National HIV Prevalence, Incidence, Behaviour and Communication Survey:* A turning tide among teenagers. [Online] Available: http://www.hsrc.ac.za/Document-3239.phtml (Accessed: August 2010)

IRIN. 2007. *South Africa Teenage Pregnancy figures causes alarm*. [Online] Available: http://webcache.googleusercontent.com/search?q=cache:2BRYTWig9VsJ:www.irinnews.org/Report.aspx%3FReportId%3D70538+20082010+teenage+pregnancy+figures+in+South+Africa&cd=3&hl=en&ct=clnk&gl=za (Accessed: May, 2011)

Jackson, L.D. & Diffy, B.K.1998. *Health Communication Research: Guide to Developments and Directions*. Westport, CT: Greenwood Press

Johnson S, Kincaid L, Laurence S, Chikwava F, Delate R, and Mahlasela L. 2010. *Second National HIV Communication Survey 2009: Findings from Eastern Cape Province*. Pretoria: JHHESA.

Kaiser Family Foundation 2007. Young Africans, Broadcast Media and HIV/AIDS. Menlo Park, CA: Kaiser Family Foundation

Kaiser Family Foundation. Love life: South Africa`s National HIV Prevention Program for Youth. [Online] Available: http://www.kff.org/about/lovelife/cfm (Accessed: June, 2012)

Kalichman, S.C. (2003). *The Inside Story on AIDS: Experts answers your questions* American Psychological Association (APA): USA

Karim, Q. A. 2011. HIV onslaught 'decimating' teenage girls in South Africa. [Online] Available: http://sciencespeaksblog.org/2011/03/09/karim-hiv-onslaught %E2%80%98decimating%E2%80%99-teenage-girls-in-south-africa/#axzz2Cz8G0tq2 (Accessed: August, 2012)

Katz, I & Low-Beer, D. 2008. Why has HIV stabilized in South Africa, yet not declined further? Age and sexual behavior patterns among youth. Sexually Transmitted Diseases 35: 837–842

Kitzinger, J. 2003. Understanding AIDS: researching audience perception of AIDS. *In getting the Message: news, truth and power (Elridge J., Ed*). London: Routledge

Krenn, S. & Limaye, R. (2004). *The Role of Social and Behaviour Change Communication in Combating HIV/AIDS*. John Hopkins Bloomberg School of Public Health Center and Communication Programs, United States.

Leonard, L.N.K., Timothy, P.C., & Kreie, J. 2004. What Influences IT ethical Behaviour Intentions-Planned Behavior, Reasoned Action, Perceived Importance, or Individual Characteristics? *Information. Management*, 42: 143– 158.

Lerner, D. (1958). *The Passing of Traditional Society*. New York, NY: Free Press.

Lioeanjie, L. 1996. AIDS Education: Innovative Methods for Adolescents in New Orleans', in M.K. Moore and M.L. Forst (eds) AIDS *Education: Reaching Diverse Populations*. (133–146). London: Praeger

Love life. HIV Prevention that works. [Online] Available: http://www.lovelife.org.za/about/index.php (Accessed: August, 2010)

Luciano, D. 2007. Integrating HIV and Violence Against Women Policies and Programs-a Needs Assessment in the Dominican Republic. Washington, DC: Development Connections, UNIFEM. [Online] Available: http://www.dvcn.org/Documents/ManualHIVVAWEN.pdf

MacGregor, K. 2001. Universities Fight South Africa AIDS crisis. *Times Higher Education Supplement*, April 12

MacPhail, C., Pettifor, A. E., Pascoe, S. & Rees, H. V. 2007. *Contraceptive Use and Pregnancy among 15-24 year old South African women: A nationally representative cross sectional survey*. BMC Med 5:31. [Online] Available: http://www.biomedcentral.com/1741-7015/5/31 (Accessed: May, 2011)

Maharaj, P. 2006. Reasons for Condom Use among Young People in KwaZulu-Natal: Prevention of HIV, Pregnancy or Both? *International Family Planning Perspectives*, 32(1): 20-34

Malhotra, Y., & Galletta, D.F. 1999. Extending the Technology Acceptance Model to Account for Social Influence: Theoretical Bases and Empirical Validation. *Proceedings of the 32nd Hawaii International Conference on System Sciences. 1-14.*

Martin, G. & Pear, J. 2007. *Behaviour modification: What is it and how to do it*. 8th Edition. Upper Saddle River, NJ: Pearson Prentice Hall

Masten, A. S., & Gerwitz, A. H. 2006. Vulnerability and resilience in early child development. In K. McCartney & D. Phillips (Eds.), *Blackwell handbook of early childhood development* (pp. 22-43). Malden, MA: Blackwell.

McDonald, R. & Bunton, G. 2002. Health promotion: Disciplinary Developments. In Bunton, R. & McDonald (Eds), *Health promotion: Disciplines, diversity and development* (2nd Ed). (9-27). London: Routledge.

McFadden, P. 2003. Sexual Pleasure as a Feminist Choice. *Feminist Africa*, 2, 61-65

McKenzie-Mohr, D. 2000. Promoting Sustainable Behaviour: An Introduction to Community-Based Social Marketing. *Journal of Social Issues*, 56, 543-554

McKinlay, J.B. & Marceau, L.D. 1999. A tale of 3 tails. *American Journal of Public Health*, 89(3): 295-301

McLea, H. 2011. *Pregnancy Tsunami.* Timeslive Newspaper. [Online] Available: www.timeslive.co.za/thetimes/2012/ (Accessed: June, 2012)

McLuhan , M. & Fiore, Q. 1967. *The medium is the message*. Harmondsworth: Penquin.

Mefalopulos, P. 2002. *Participatory Communication Strategy Design*. Harare, Zimbabwe: SADC/FAO.

Medrano, L. 2008. *The Psychological Impact of HIV/AIDS on Women and Adolescents*. Paper Presented at the Inter American Commission of Women: Executive Committee 2006 2008, Washington, D.C, May 8-9, 2008.

Mendoza, A. M. 1997. *Bridging Information towards transformation. Can it work?* Paper Presented at the UNAIDS Consultation Meeting on Communications Programming. Geneva, Switzerland.November 7-11

Mersham, G M, Rensburg, R S & Skinner, J C 1995. *Public relations, development and social investment: A southern Africa perspective*. Pretoria: J L van Schaik Publishers.

Mersham, G. M. 1992b. *'A graphic communication model for development'*. Occasional paper no. 2, Department of Communication Science, University of Zululand.

Michal-Johnson, P.& Bowen, S. P. 1992. The place of culture in HIV education. In T. Edgar, M.A. Fitzpatrick & V. S. Freimuth (Eds), AIDS*: A Communication Perspective* (147 172), Hillsdale, NJ: Erlbaum

Minja, H., Schellenberg, J. A., Mukasa, O. & Nathan, R. 2001. Introducing ITN in the Kilombero Valley, Tanzania: The relevance of local knowledge and practice for an IEC Campaign. *Tropical Medicine International Health*, 6, 614-623

Monette, D. R., Sullivan, T. J. & Dejong, C. R. 2002. *Applied Social Research: tool for the human services*. 5th Edition. Orlando: Harcourt College Publishers

Montano, D. E. & Kasprzyk, D. 2002. The Theory of Reasoned Action and the Theory of Planned Behaviour. In K. Glanz, B. K. Rimer, & F.M. Lewis (Eds), *Health Behaviour and Health Education: Theory, research and practice* (67-98). San Francisco: Jossey Bass

Montgomery, C. & Brocato, V. 2004. Younger women, older men and the spread of HIV in Africa. *Making the Connection*, 3(2): 1-12

Mugari, S. 2011. *Obstacles School-Going Female Adolescents in Gweru Face in Translating HIV/AIDS Knowledge and Attitudes into HIV Preventive Sexual Behaviours*. Stellenbosch University.

Mseleku, T. 2007. Re-launch of the Khomanani Campaign: Department of Health awards a tender. ECDOH News.

Mwiturubani, D.A & Ayalew, G. 2009. *Youth, HIV/AIDS and Social Transformations in Africa.* Dakar, SEN: Counsel for the Development of Social Science Research in Africa(CODESRIA), 2009. p 3. http://site.ebrary.com/lib/ufhza/Doc?id=10344582&ppg=14 (Accessed: May, 2012)

Namyalo, S. 2005. *Challenges of translating and disseminating HIV/AIDS messages in a multilingual and multicultural nation: The case of Uganda*. [Online] Available: http://www.csrs.cn/atelier/ausanne/com1920_Namyalo.pdf

Nikolova, R., Carignan, M., Moscovitz, N. & Demers, L. 2004. The Psychogeriatric and Risk Behavior Assessment Scale (PARBAS): a new measure for use with older adults living in the community. *Archives of Gerontolog & Geriatrics*, 39(2): 188

Neuman, W.L. 2003. *Social Research Methods: qualitative and quantitative approaches*, 5th Ed. Boston: Allyn & Bacon *New Dictionary of Social Work.* 1995. Revised edition. Pretoria: State Printers

Obregon, R. & Mosquera. 2005. *Participating and Cultural Challenges for research and practice in health communication*. [Online] Available: biblioteca.clacso.edu.ar/ar/libros/edicion/media/19Chapter13pdf. (Accessed: May, 2011)

Özer, G.& Yilmaz, E. 2011. Comparison of the theory of reasoned action and the theory of planned behavior: An application on accountants' information technology usage African *Journal of Business Management*, 5(1):50-58

Onwuegbuzie, A. J. & Teddlie. C. 2003. A Framework for Analyzing Data in Mixed Methods Research. In Tashakkor, A. & Teddlie, C (Eds). Handbook of mixed methods in social and behavioural research. Thousand Oaks; CA: Sage

O'Dea, J. W. 1993. Teaching as entertainment: A comment on a 20th century phenomenon. *Education Canada, 37,* 24-29.

Parker, W., Dalrymple, L., & Durden, E. 2000. *Communicating Beyond Aids Awareness: A Manual for South Africa*. Beyond Awareness Consortium. Johannesburg. South Africa.

Parker, W., Makhubele, B., Ntlabathi, P & Connolly, C. 2007. Concurrent sexual partnering amongst young adults in South Africa: Challenges for HIV prevention. Centre for AIDS Development, Research and Evaluation (CADRE), South Africa http://www.jhuccp.org/legacy/countries/south_africa/CADRESexualPartnershipsMai Report.pdf (Accessed: August, 2011)

Parker, W. 2006. *Claims and realities in programme evaluation: reflections on LoveLife, South Africa*. [Online] Available: http://www.cadre.org.za/files/Parker%20Toronto%20THPE0580.pdf (Accessed: May: 2012)

Parker, W. 2007. *HIV/AIDS Communication in Selected African Countries: Interventions, Responsibilities and Possibilitie*s. Zambia: SIDA, Haile Selassie Ave

Parker, W. 2003. *Re-appraising youth prevention in South Africa: The case of loveLife*. Presented at the South African AIDS Conference in Durban, August 2003. [Online] Available: www.cadre.org.za/files/reappraising_youth.pdf (Accessed: May, 2012)

Pettifor, A.E. 2004. HIV and Sexual Behavior Amongst Young South Africans: *A national survey of 15-24 year olds*, April 2004

Pettifor, A.E., Maesham, D.M., Rees, H.V. & Padian, N.S. 2004. Sexual power and HIV risk, South Africa. *Emerging Infectious Diseases* 10: 1996–2004

Piotrow, P. T., Kincaid, D. L., Rimon, J. G. & Rinehart, W. 1997. *Health Communication*. Westport: Praeger Publisher

Ragnarsson, A., Onya, H. E. & Aaro, L. E. 2009. Young people`s understanding of HIV: A qualitative study among school students in Makweng, South Africa. *Journal of Public Health*, 37(2): 101-106

Rampersad, R. (Dr). 2007. *Communication and HIV/AIDS : The Application of Mersham's Graphic Communication model for Effective Communication Strategies*. 14th Global Public Relations Symposium Bledcom, 5 -7 July 2007, Lake Bled, Slovenia.

Reddy, S.P., Panday, S., Swart, D., Jinabhai, C.C., Amosun, S.L. & James, S. 2003. *Umthenthe Uhlaba Usamila: The South African Youth Risk Behaviour Survey 2002*. Cape Town: South African Medical Research Council

Relv, M.V. 1997. Illuminating meaning and transforming issues of spirituality in HIVdisease and AIDS. An application of Parse`s Theory of Human Becoming. *Holistic Nursing Practice,* 12(1): 1-8

Review Me. 2011. *Teenagers and Alcohol*. [Online] Available: reviewme.co.za/2011/04/23/teenagers…(Accessed: October, 2012)

Romano, J.L. & Netland, J.D. 2008. The Application of the Theory of Reasoned Action and Planned Behavior to Prevention Science in Counseling Psychology. *The Counseling Psychologist,* 36: 777

Robinson, N. 1999. *The use of focus group methodology-with selected examples from sexual health research*

Rosen, L. 2010. Rewired: Understanding the Generation and the way they learn. [Online] Available: http://blog.discoveryeducatio.com.pennsyvania/2010/09/15/dr-larryrosen rewired-understanding-the-generation-and-the-way-they-learn (Accessed: January, 2011)

South African Government Information. 2009. *Key facts of the National Communication Survey on HIV/AIDS, 2009*. [Online] Available: http://www.info.gov.za/issues/hiv/survey_2009.htm (Accessed: October, 2012)

Salawu, A.S. 2001. Theatre as a vehicle for Development Communication in Africa. In B. Folarin (ed.), *Topical Issues in Communication Arts & Science*, 1, 131-143

Salawu, A.S. 2004. Beyond Entertainment and Marketing of Condom: A Review Of The Impact of Drama For The Prevention of HIV/AIDS in Nigeria. *Journal of Social and Policy Issue*, 1(1): 45-47

Salmon, C. T. & Atkin, C. 2003. *Using media campaigns for health promotion*. In T. L. Thompson, A. M. Dorsey, K. I. Miller, & R. Parrott (Eds.), *Handbook of Health Communication* (pp. 285–313). Mahwah, NJ: Lawrence Erlbaum

SAPA. 2012. *Unsafe sex rife in Eastern Cape schools*. [Online] Available: http://www.iol.co.za/lifestyle/family/kids/unsafe-sex-rife-in-eastern-cape-schools 1.1290501 (Accessed: August, 2012)

Scrutinize. 2009. *Scrutinize at the University of the Western Cape*. [Online] Available: http://www.scrutinize.org.za/H.I.ViCTORY/index.php?option=com_content&view= rticle&id=102:&catid=3 (Accessed: May, 2011)

Seaberg, J.R. 1988. Utilizing Sampling Procedures. In Grinnell, R.M. (ed), *Social Work Research and Evaluation*, 3rd Ed. Itasca, IL: Peacock

Seopa, T. 2008. Love Life Generation on Mobile. [Online] Available: http://www.bizcommuity.com/article/196/78/25657.html (Accessed: June, 2010)

Servaes, J. (1991). Toward a New Perspective for Communication and Development. In F. L. Casmir (Ed.), *Communication in Development* (pp. 51-86). Norwood, NJ: Ablex Publishing.

Setswe, G. 2009. *The HIV and AIDS Epidemic in South Africa: Where are we*?. South Africa: HSRC

Sheeran, P. 2003. Descriptive Norms as an additional predictor in the theory of planned behaviour: A meta-analysis. *Current Psychology: Developmental, Learning, Personality, Social*, 22, 218-233

Shisana, O., Rehle, T., Simbayi, L.C. & Parker, W. 2005. *South African National HIV Prevalence, HIV incidence, Behaviour and Communication Survey*. Cape Town: HSRC Press

Shisana O, Rehle T, Simbayi LC, Zuma K, Jooste S, Pillay-van-Wyk V
Mbelle N, Van Zyl J, Parker W, Zungu NP, Pezi S & the SABSSM III Implementation Team. 2009. South African national HIV prevalence, incidence, behaviour and communication survey 2008: A turning tide among teenagers? Cape Town: HSRC Press

Singhal, A. 2004. *Entertainment-Education and Social Change: History, Research and Practice.* Taylor & Francis

Singhal, A. 2000. *International Workshop UNAIDS HIV/AIDS communication for behaviour and social change;* Programme Experiences, Examples and Way forward. Geneva.

Singhal, A. & Everett, R. 2003. *Combating AIDS: Communication Strategies in Action*. London: Sage Publications

Singhal , A., & Rogers, E. M. 1999. *Entertainment–Education: A communication strategy for social change*. Mahwah, NJ: Lawrence Erlbaum Associates.

Soul City Institute. One love fact Sheet. [Online] Available: http://www.soulcity.org.za/projects/onelove/onelove-fact-sheet/view (Accessed: August, 2011)

Soul City. 2000. *Soul City Heart Beat of the Nation Soul Multi-Media Audience Reception*.

South Africa Department of Health. 2005. *National HIV and Syphilis Prevalence Survey*. South Africa.

Strauss, A. 1987. *Qualitative Analysis for Social Scientists*. Cambridge: Cambridge University Press.

Strauss, A. & Corbin, J. 1998. *Basics of qualitative research techniques and procedures for developing grounded theory,* 2nd Edition. Thousand Oaks: Sage Publications

Strydom, H., Fouche`C.B., Delport, C.S.L. & AS de Vos. 2005. *Research at Grass roots for Social Sciences and Human Services Professions*, 3rd Edition. Pretoria: Van Schaik Publishers

Stroker, D. J. 1985. *Sampling*. Personal Communication to the author. Pretoria: Human Sciences Research Council

Sutton, S., McVey, D., & Glarz, A. 1999. A comparative test of the theory of reasoned action and the theory of planned behavior in the prediction of condom use intentions in a national sample of English young people. *Health Psychology, 18*, 72-81.

Svenkerud, P., Singhal, A. & Papa, M.J. 1998. Diffusions of Innovations Theory and Effective targeting of HIV/AIDS programmes in Thailand. *Asian Journal of Communication*, 8(1): 1-30

Swanepoel, P. 2005. Stemming the HIV/AIDS epidemic in South Africa: Are our campaigns failing us? COMMUNICATIO Journal, 31(1): 61

The Communications Initiative (TCI). 2008. *Siyayinqoba Beat It! Campaign*. [Online] Available http://www.comminit.com/en/node/278114/38. (Accessed: August, 2011)

Tlou, E. R. 2009. *The application of the theories of Reasoned Action and Planned Behaviour to a workplace HIV/AIDS related health promotion programmes*. [Online] Available: http://ur.unisa.ac.za/bitstream/handle/10500/3182/thesis_tlou_e.pdf?sequence=1 (Accessed: October, 2012)

UNAIDS. 2006. *Report on the Global AIDS epidemic*; May 2006

UNAIDS. 2006. *2006 Report on the Global AIDS epidemic*. [Online] Available: http//www.unaids.org/ (Accessed: May, 2011)

UNAIDS. 2007. *2007 AIDS Epidemic Update, December*. [Online] Available: http://data.unaids.org/pub/EPISlides/2007/2007_en.pdf (Accessed: May, 2011)

UNAIDS. 2007. 2007 AIDS Epidemic Update. Geneva, Switzerland: UNAIDS, 2007.

UNAIDS. 2008. *2008 Report on the Global Epidemic*. Geneva, UNAIDS

UNAIDS. 2008. "Estimated number of people living with HIV by country." *2008 Report on the Global AIDS Epidemic*. [Online] Available: http://data.unaids.org/pub/GlobalReport/2008/20080818_gr08_plwh _1990_2007_en.xls on October 27, 2008. (Accessed: May, 2011)

UNAIDS. 2008. 2008 Report on theGlobal AIDS Epidemic, Geneva, Switzerland

UNAIDS. 2009. *2009 Epidemic Update*. Geneva, UNAIDS

UNAIDS. 2010. *Report on Global AIDS Epidemic*. [Online] Available: http://www.unaids.org.org/globalreport/Global_report.html (Accessed: May, 2011)

UNAIDS. 2011. *Global HIV/AIDS Response: Epidemic update and health sectors progress towards Universal Access.* Progress Report 2011. [Online] Available: http:// www.unaids.org/en/media/unaids/contentassests/documents/unaidspublication/2011/ 0111130_ua_report_en.pdf (Accessed: June, 2012)

UNAIDS, UNICEF, WHO. 2011. *Global HIV/AIDS Response.* [Online] Available: http:// ww.who.int/hiv/pub/progress_report2011/en/index.html (Accessed: June, 2012)

UNAIDS. 2012. UNAIDS Report on the Global AIDS Epidemic, 2012. [Online] Available: http://www.unaids.org.en/media/unaids/contentassets1120_UNAIDS_GlobalReport_ 2012_withannexes_en.pdf

UNESCO. 2005. *Mother tongue literacy in Sub-Saharan Africa, Education for All.* Global Monitoring Report Literacy for Life.

UNFPA. 2002. *Communication/Behaviour Change Tools Programme Briefs No. 1 Entertainment-Education*

UNFPA. 2005. State of World Population 2005. *"The Unmapped Journey: Adolescents, Poverty, and Gender*." UNFPA, 2005.

UNFPA. 2009. *UNFPA Annual Report 2009*. [Online] Available: http://unfpa.org/public/home/publications/pid/6057 (Accessed: May, 2011)

UNGASS. 2002. *Gender and Women`s vulnerability to HIV/AIDS in Latin America and the Carribean.* Prepared for the program on women, health and development. Pan American Health Organisation, Washington: DC

UNICEF. 2010. *Towards Universal Access: Scaling up Priority HIV/AIDS Interventions in the Health sector.* [Online] Available: http://www.who.int/hiv/pub/2010progressreport/en/index.htm. (Accessed: May, 2011)

UNICEF. 2011. *Global HIV/AIDS Response: Epidemic Update and Health Sector Progress towards Universal Access 2011*. [Online] Available: http://www.who.int/hiv/pub.2011progressreport/en/index.html (Accessed: June, 2012)

USAID. 2009. *HIV Prevention across the youth spectrum*. [Online] Available: http://www.usaid.gov/our_work/global_health/aids/TechAreas/prevention/youghfactheet.htm/ (Accessed: April, 2012)

U.S. Department of Health and Human Services. 2005. *Office of Disease Prevention and Health Promotion. Healthy People 2010*. Volumes 1 and 2. [Online] Available: http://www.healthypeople.gov/document/HTML/Volume1/11HealthCom.htm. (Accessed: November, 2012)

Utulu, A. U. 2011. The effect of advertisement messages: The Case of HIV and AIDS Awareness Campaigns in Nigeria. *Journal of Biology, Agriculture and Healthcare*, 1(1): 15-16

Van Dyk, A.C. (1999) *Aids Care and Counselling.* Cape Town: Maskew Miller Longman.

Vaughan, P. W. & Roger, E.M. 2000. A staged model of communication effects: Evidence of an entertainment-education radio soap opera in Tanzania. *Health Communication*, 5, 203-227

Wasserman, S. & Faust, K. 1994. *Social Network Analysis: Methods and Application*. New York: Cambridge University Press

Weinstein, N. D. 1993. Testing four competing theories of health-protective behavior. *Health Psychology, 12,* 324-333.World Health Organisation. 2007. *Towards Universal Access: scaling up priority HIV/AIDS intervention in the health sector*. Progress Report, April 2007. Geneva: WHO

Wellings, K., Wadsworth, J., Johnson, A.M., Field, J., Whitaker, L & Field, B. 1995. Provisions of Sex Education and Early Sexual Experience. The Relation Examined. *British Medical Journal*, 311 (7002): 417-418

World Bank. 1997. *Confronting AIDS: Public Priorities in global epidemic*. New York: Oxford University Press

World Health Organisation (WHO). (2007) *Towards Universal Access: scaling up priority HIV/AIDS intervention in the health sector*. Progress Report, April 2007. Geneva: WHO

Wright, K.B., Sparks, L. & O`Hair, H.D. 2008. *Health Communication in the 21st Century*. Oxford: Blackwell

Zhusupov, B. 2000. *Women, Youth and HIV/AIDS in Kazakhstan.* Expert Group Meeting on "The HIV/AIDS Pandemic and its Gender Implications". 13-17 November 2000 Windhoek, Namibia

9. APPENDICES

9.1 APPENDIX1: CONSENT FORM

University of Fort Hare
Together in Excellence

Ethics Research Confidentiality and Consent Form

Our Department of Communication at the University of Fort Hare is asking female students from your school to answer some questions, which we hope will benefit young people and the community at large.

The Department of Communication at the University of Fort Hare is conducting research regarding HIV/AIDS Communication and Youth Behavior in South Africa. We are interested in finding out more about the response of female students to HIV/AIDS communication. We are carrying out this research to help understand why certain risk behaviours still persist amongst the youth despite the many HIV/AIDS communication strategies.

Please understand that you are not being forced to take part in this study and the choice whether to participate or not is yours alone. However, we would really appreciate it if you do share your thoughts with us. If you choose not take part in answering these questions, you will not be affected in any way. If you agree to participate, you may stop me at any time and tell me that you don't want to go on with the interview. If you do this there will also be no penalties and you will NOT be prejudiced in ANY way. Confidentiality will be observed professionally.

I will not be recording your name anywhere on the questionnaire and no one will be able to link you to the answers you give. Only the researchers will have access to the unlinked information. The information will remain confidential and there will be no "come-backs" from the answers you give.

The interview will last around 35minutes. I will be asking you questions and ask that you are as open and honest as possible in answering these questions. Some questions may be of a personal and/or sensitive nature. I will be asking some questions that you may not have

thought about before, and which also involve thinking about the past or the future. We know that you cannot be absolutely certain about the answers to these questions but we ask that you try to think about these questions. When it comes to answering questions there are no right and wrong answers. When we ask questions about the future we are not interested in what you think the best thing would be to do, but what you think would actually happen.

If possible, our department would like to come back to this area once we have completed our study to inform you and your community of what the results are and discuss our findings and proposals around the research and what this means for young people.

CONSENT

I hereby agree to participate in research regarding **HIV/AIDS Communication and Youth Behaviour**. I understand that I am participating freely and without being forced in any way to do so. I also understand that I can stop this interview at any point should I not want to continue and that this decision will not in any way affect me negatively.

I understand that this is a research project whose purpose is not necessarily to benefit me personally.

I have received the telephone number of a person to contact should I need to speak about any issues which may arise in this interview.

I understand that this consent form will not be linked to the questionnaire, and that my answers will remain confidential.

I understand that if at all possible, feedback will be given to my community on the results of the completed research.

……..

Signature of participant **Date**:……..

9.2 APPENDIX 2: RESEARCH QUESTIONNAIRE

University of Fort Hare
Together in Excellence

PROJECT TITLE: HIV/AIDS COMMUNICATION AND YOUTH BEHAVIOUR IN SOUTH AFRICA: A CASE OF FEMALE HIGH SCHOOL STUDENTS IN THE EASTERN CAPE PROVINCE.

SECTION 1

Demographics

1. Age.....

2. Level of education (indicate grade).....

HIV/AIDS Campaign Awareness

Circle the correct responses.

3. Have you heard about HIV/AIDS?

Yes No

4. Through what media did you hear of HIV/AIDS?

a) Radio b) television c) newspaper d) school e) friend f) clinic
g) other (specify).....

5. Do you know of any HIV/AIDS communication methods or programmes?

Yes No

6. Select at least three HIV/AIDS communication programmes you are familiar with from the list provided.

a) Soul city b) scrutinize c) it begins with you d) Siyayinqoba-beat it e) love-life

7. Name any other HIV/AIDS communication programs that you know of besides the options provided in question 6.....

8. Are you aware of any factors or problems that can expose you to HIV Infection?

a) Yes b) No c) Partly d) Not sure

SECTION 2

Relevance of HIV/AIDS Communication Strategies

Circle the correct responses.

9. Select factors that you believe can expose you to HIV infections. **Rank** according to importance using this scale: **1: very important, 2: quite important, 3: important, 4: less important 5: Not important**

a) Multiple sexual partners

b) alcohol and drug abuse

c) Early sexual debut d) culture

e) Unprotected sexual activities

f) Contraceptive pills

10. Do you feel that current HIV/AIDS communication programmes are addressing problems or factors that may expose you to HIV infection?

a) Yes b) No c) Partly d) Not sure

11. Have your individual questions on or about HIV/AIDS been answered by current HIV/AIDS communication programs?

a) Yes b) No c) Partly d) Not sure

12. Do you get a clear understanding of the messages communicated through HIV/AIDS programmes?

Yes No c) Partly d) Not sure

13. Is the language used in the HIV/AIDS communication programmes easy for you to understand?

a) Yes b) No c) Partly d) Not sure

14. Do you have easy access to HIV/AIDS messages or communication programmes?

Yes No

SECTION 3

Factors Influencing the Understanding and Use of HIV/AIDS Messages

Circle the correct responses.

15. Have you found it difficult to understand messages in HIV/AIDS communication programs?

Yes No

16. Have you ever failed to implement any advice from HIV/AIDS communication?

Yes No

17. Are there factors or obstacles that have made it difficult for you to understand and use advice contained in HIV/AIDS messages?

Yes No

18. From the list provided below, please select at factors that you believe have contributed to your failure to understand and use advice contained in HIV/AIDS messages. **Rank** your responses according to importance**. 1: very important, 2: quite important, 3: important, 4: less important 5: Not important**

a) Peer pressure

b) Clarity of messages

c) Language used in communication campaigns

d) Lack of access to HIV/AIDS campaigns

e) Ignorance

SECTION 4

Impact of Current HIV/AIDS Communication Strategies on Female Youths

Circle the correct responses.

19. Has any HIV/AIDS communication campaigns changed and increased your knowledge about HIV/AIDS?

Yes No

20. Has any HIV/AIDS communication campaigns changed or influenced your attitude/s towards positive and protective behaviour against HIV/AIDS?

Yes No

21. Have you adopted any positive or protective behaviour as a result of your exposure to HIV/AIDS communication campaigns?

Yes No

22. Would you regard HIV/AIDS communication campaigns as important in the fight against HIV/AIDS?

Yes No

9.3 APPENDIX 3: FOCUS GROUP DISCUSSION GUIDE

1. Are you aware of any HIV/AIDS communication campaigns? Name and briefly discuss the campaigns you are aware of.

2. What factors or problems do you think can expose you to HIV Infection?

3. Do you feel that current HIV/AIDS communication programmes are clearly addressing problems that may expose you to HIV infection? Why?

4. Have your individual questions on or about HIV/AIDS been answered by current HIV/AIDS communication programmes? Why and How?

5. Do you get a clear understanding of the messages communicated through HIV/AIDS programmes? Why?

6. Has any HIV/AIDS communication campaigns increased your knowledge about HIV/AIDS, changed your attitude/s towards positive and protective behaviour against HIV/AIDS and compelled you to adopt any positive or protective behaviour as a result of your exposure to HIV/AIDS communication campaigns?

7. Are there instances were you have found it difficult to understand messages in HIV/AIDS communication programs? Why?

8. Have you ever failed to implement any advice from HIV/AIDS communication? Why

9. Are there factors or obstacles that have made it difficult for you to understand and use advice contained in HIV/AIDS messages?

10. Would you say that current HIV/AIDS communication campaigns have helped you in the fight against HIV and AIDS? Why?

11. Would you say that current HIV/AIDS communication programmes need to be changed in order to effectively reduce HIV incidence amongst young people? Why?

9.4 APPENDIX 4: EASTERN CAPE DEPARTMENT OF EDUCATION CLEARANCE LETTER

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Province of the
EASTERN CAPE
EDUCATION

STRATEGIC PLANNING POLICY RESEARCH AND SECRETARIAT SERVICES
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Enquiries: Dr Heckroodt Email: bernetia@iafrica.com

12 January 2012

Nkosinothando Mpofu

Communications Department

University of Fort Hare

Private Bag X1314

ALICE

5700

Dear Ms Mpofu

PERMISSION TO UNDERTAKE A DOCTORATE THESIS: HIV/AIDS COMMUNICATION AND YOUTH BEHAVIOUR IN SOUTH AFRICA – A CASE OF HIGH SCHOOL FEMALES IN THE EASTERN CAPE PROVINCE

1. Thank you for your application to conduct research.
2. Your application to conduct the above mentioned research in nine Secondary Schools in different Education Districts of the Eastern Cape Department of Education (ECDE) is hereby approved on condition that:
   a. there will be no financial implications for the Department;
   b. institutions and respondents must not be identifiable in any way from the results of the investigation;
   c. you present a copy of the written approval letter of the Eastern Cape Department of Education (ECDoE) to the District Directors before any research is undertaken at any institutions within that particular district;
   d. you will make all the arrangements concerning your research;

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Ikamva eliqaqambileyo!

e. the research may not be conducted during official contact time, as educators' programmes should not be interrupted;

f. should you wish to extend the period of research after approval has been granted, an application to do this must be directed to the Director: Strategic Planning Policy Research and Secretarial Services;

g. the research may not be conducted during the fourth school term, except in cases where a special well motivated request is received;

h. your research will be limited to those schools or institutions for which approval has been granted;

i. you present the Department with a copy of your final paper/report/dissertation/thesis free of charge in hard copy and electronic format. This must be accompanied by a separate synopsis (maximum 2 – 3 typed pages) of the most important findings and recommendations if it does not already contain a synopsis. This must also be in an electronic format.

j. you are requested to provide the above to the Director: The Strategic Planning Policy Research and Secretarial Services upon completion of your research.

k. you comply to all the requirements as completed in the Terms and Conditions to conduct Research in the ECDE document duly completed by you.

l. you comply with your ethical undertaking (commitment form).

m. You submit on a six monthly basis, from the date of permission of the research, concise reports to the Director: Strategic Planning Policy Research and Secretariat Services.

3. The Department wishes you well in your undertaking. You can contact the Director, Dr. Annetia Heckroodt on 043 702 7428 or mobile number 083 271 0715 and email: annetia.heckroodt@edu.ecprov.gov.za should you need any assistance.

DR AS HECKROODT

DIRECTOR: STRATEGIC PLANNING POLICY RESEARCH AND SECRETARIAT SERVICES

9.5 APPENDIX 5: UREC CLEARANCE LETTER