

Stemming the HIV/AIDS epidemic in South Africa: Are our HIV/AIDS campaigns failing us?*

Piet Swanepoel*

- * Prof Piet Swanepoel is project leader of the Epidasa Project on the Improvement of HIV/AIDS Public Information Documents funded by the South African-Netherlands Programme for Alternatives in Development (Sanpad) and co-ordinator of the programme in Document Design, Department of Afrikaans & Theory of Literature University of South Africa, Pretoria. e-mail: swaneph@unisa.ac.za

Abstract

Media-based campaigns are critical tools in changing the behaviours that are fuelling the HIV/AIDS epidemic in South Africa. However, given the absence of an effective behaviour-change response in the face of the epidemic, many have come to doubt the efficacy of these campaigns. Campaign designers that profess to using best-practice principles in designing HIV/AIDS campaigns, also report that although some of these campaigns book changes in beliefs and attitudes, they seldom have a significant effect on the behaviours that are fuelling the epidemic.

This situation raises a number of general questions with regard to South African HIV/AIDS campaigns which are discussed in Section 2 of this article: How effective are media-based campaigns in general in changing health-related behaviours? Are South African HIV/AIDS campaigns successful or not? If not, why not, and what could be done to optimize their efficacy? What aspects of South African HIV/AIDS campaigns contribute to their efficacy and could be up-scaled in future campaigns?

Section 3 of the article provides a critical analysis of the processes followed in the design of the Living Positively Campaign and of the design features of the messaging of the booklet Living Positively with HIV and AIDS. This analysis clearly indicates that despite claims by campaign designers of adherence to best-practice heuristics, very few of these are implemented in the design of HIV/AIDS campaigns.

1 INTRODUCTION

.1 Behaviour change and the efficacy of South African HIV/AIDS campaigns: some critical research questions

Given the lack of a cure or a vaccine for HIV/AIDS, changes in the behaviours that are fuelling the epidemic in South Africa are essential. Media-based campaigns, for example, the *Beyond Awareness 1&2* campaign, the *Soul City* campaign, the *Khomanani* campaign and the *loveLife* campaign, are critical tools in the larger effort to redress these multiple HIV/AIDS-related behaviours.

However, the claim is often made that media-based campaigns such as these are not very effective in facilitating the scope and rate of the behaviour change required to counter the HIV/AIDS epidemic effectively (see AIDS Foundation of South Africa 2000; Kelly, Parker & Oyosi 2001). Behavioural data such as the following are often used as support for this claim:

- the high prevalence of HIV/AIDS (an estimated 11.4% of the population is infected)
- the fact that there still is a high incidence of new HIV-infections (an estimated 1500 to 2000 cases per day)
- that the uptake of voluntary counselling, testing and referral (VCT) is low (only an estimated 20% of the population are aware of their HIV-serostatus)
- most people who are HIV-positive only utilize VCT and care and support systems once they start presenting with opportunistic infections
- there is a continued denial of the illness
- (fear of) stigmatization and discrimination of people living with HIV/AIDS

(PLWA) and those associated with them is high, and fear of stigmatization still has a profound impact on the efficacy of HIV/AIDS prevention and care and support programmes

(See Jennings et al. 2002; Pettifor et al. 2004; and, Shisana 2002.)

Furthermore, a number of recent baseline studies and evaluation reports suggest that South African HIV/AIDS campaigns indeed have some effect in changing the beliefs motivating these problematic behaviours, but limited success in changing the behaviours themselves (see Department of Health 2004; Kelly and Parker 2000; Kelly, Parker and Oyosi 2001; Pettifor et al. 2004; Shisana 2002; Soul City 2000 and 2001).

Despite these claims, South Africa could hardly do without media-based campaigns. Given their agenda-setting function, their reach, their potential to effect changes in the determinants of problematic health behaviours, and the problematic behaviours themselves, (see Hornik 2002; Snyder 2001; Snyder and Hamilton 2002; Viswanath and Finnegan 2002; and Yzer 1999), they could in principle be very effective tools in supporting more comprehensive programmes to address the determinants of the range of problematic HIV/AIDS-related behaviours in South Africa.

Given their limited impact on behaviours and the need to optimise the efficacy of HIV/AIDS campaigns in South Africa, there is however an urgent need for *action-orientated* research in South Africa to determine answers to the following questions:

- (1) How effective are media-based campaigns (in general) in changing the problematic behaviours that are fuelling the HIV/AIDS epidemic ?
- (2) How effective are South African HIV/AIDS media-based campaigns in achieving their behaviour-change goals?
- (3) If not optimally effective in this regard, what can be done to optimize their efficacy?
- (4) What aspects of these campaigns (for example, methodologies, strategies, campaign components, etc.) have been proven to be effective and could be up-scaled in future campaigns?

Very limited research has been forthcoming, either from those involved in the design and implementation of HIV/AIDS campaigns in South Africa, or from the research community at large, to answer these questions comprehensively and to any significant depth.

However, a number of researchers have argued that South African HIV/AIDS campaigns could be significantly improved if campaign designers adhered more strictly to the large body of *design*

heuristics (guidelines) that has been forthcoming from the growing body of international action-orientated research on best practices in health/AIDS campaign design (see, for example, Coulson 2002; Kelly and Parker 2000; Kramer 2004; Quakisa 2003; Swanepoel 2003; and Yun, Govender and Mody 2001). Generalising over the recommendations of these authors, the claim is made that the efficacy of South African HIV/AIDS campaigns could be improved if they

- are theory-, evidence- and best-practices based
 - are strategically designed in consultation with their target audiences to address both the personal and contextual determinants of specific problematic HIV/AIDS-related behaviours in specific contexts
 - are audience-specific and culturally sensitive
 - are thoroughly pretested before production and implementation

In practice though, some campaign designers that purport to have adhered to these design guidelines or heuristics, still report limited campaign successes. For example, in the evaluation report of the Khomanani Campaign currently running in South Africa (see Department of Health 2004) the claim is made that campaigns were strategically planned; that international and local best-practice models of behaviour change were used; that a rigorous evidence-based approach was followed; and, that social-level change, as well as individual level change was encouraged. Although some successes were booked with some of the sub-campaigns, others, such as the *Living Positively Campaign*, however, witnessed very little positive impact on either target groups' beliefs, knowledge or behaviours (see the Department of Health 2004 and the discussion in Section 3).

The foregoing thus also raises a number of questions for urgent research in as much as it indicates that there could either be problems with the best-practice heuristics that are proposed for the improvement of campaigns, or with their application in the practice of designing these campaigns and their components. Research is therefore necessary to answer the following questions :

- (5) How valid, generalizeable, useful and usable are the best-practice guidelines that have been forthcoming for the design of media-based health/ AIDS-campaigns and their components?
- (6) Do campaign designers (despite their claims) in fact adhere to these heuristics in designing campaigns?
- (7) If adhered to in practice, how do campaign designers utilize these heuristics in designing specific campaigns and their components?

1.2 Goals and methodology

Section 2 of this article focusses on a number of the issues raised by questions (1)-(4). Besides

addressing the general question of whether health campaigns can successfully change problematic health-related behaviours, current research on South African HIV/AIDS campaigns and on best practices in designing these campaigns will be discussed within the framework of the Intervention Mapping (IM) campaign design protocol of Bartholomew et al. (2001).

Aspects of Questions (5) - (7) are addressed in Section 3, which critically analyses aspects of (i) the design, implementation and evaluation of the *Living Positively Campaign* in South Africa (one of the sub-campaigns of the Khomanani Campaign currently running in South Africa), and (ii) the design of the messaging of the booklet *Living Positively with HIV and AIDS*. For this part of the analysis the best-practices framework of Section 2 and a case study methodology, combined with methods for a process evaluation (see Bartholomew et al. 2001) were used.

As will be indicated, this case study exemplifies some of the major problems of the practices followed in designing South African HIV/AIDS campaigns and their components, and it sheds some light on the question as to whether and how campaign designers adhere to best-practice guidelines when designing and evaluating campaigns. Furthermore, it illustrates the usefulness of a best-practices campaign design framework as an instrument to trouble-shoot problems with the design of campaigns and their components.

2 VARIABLES AFFECTING HIV/AIDS CAMPAIGN FAILURES AND SUCCESSES

2.1 Can media-based campaigns effectively change problematic health-related behaviours?

The general question of whether media-based health campaigns are indeed effective in changing problematic health behaviours is not a new one, and one to which no unqualified answer has been forthcoming. Over the last five decades opinions on this question have evolved from the view that they have very limited to no effect, that they can be successful if one adheres to certain design principles and practices, to the view that they have moderate effects on behaviour (on average 9%; see Snyder and Hamilton 2002), but are more successful at changing the antecedents (beliefs, knowledge, attitudes) of problematic health behaviours (see Viswanath and Finnegan 2002; Yzer 1999).

Given the diversity of health campaigns, it is also argued that universal judgements on the efficacy of campaigns to change health behaviours are impossible. Presently though, some would contend that the evidence indicates that campaigns have the potential to change a wide range of variables, including problematic behaviours, but that the outcome is dependent on a range of campaign internal and external variables (for example, the goals of the campaign, its design and guiding behaviour

change principles, its implementation, the cognitive and behavioural responses of its target audiences and the impact of secular trends; see Hornik 2002). Controlling these variables should therefore be a major goal of campaign designers in their effort to optimize the efficacy of their campaigns.

2.2 How effective are South African HIV/AIDS campaigns in changing HIV/AIDS-related behaviours?

Given the behavioural data cited above, the obvious answer to the question of whether South African campaigns have been effective in facilitating the rate and scope of behaviour change required in the face of the HIV/AIDS epidemic, must be: no.

The data provided in evaluation reports of South African HIV/AIDS campaigns also provides one with no unambiguous answer with regard to their general efficacy. The first reason being that most of the HIV/AIDS campaigns have not been systematically and comprehensively evaluated for their impact. The second reason is that most of these evaluations suffer from internal and external validity problems (see Department of Health 2004 for an evaluation of the Khomanani Campaign; Pettifor et al. 2004 for an evaluation of the loveLife Campaign; and Soul City 2001, 2002 for an evaluation of the Soul City 4 Campaign).

As argued by Shisana (2002), and demonstrated by Kelly and Parker (2000) in their analysis of youth responses to current HIV/AIDS information, most people in South Africa are exposed to a variety of information resources on various aspects of HIV/AIDS: non-purposive and purposive mass-media, informal communication networks and exposure to people living with HIV/AIDS (PLWA). Given the compounding effect of multiple sources and messages, ascribing changes in HIV/AIDS-related behaviours and their determinants to the impact of the messaging of any specific HIV/AIDS campaign becomes nearly impossible without feasible arguments (and the use of methodological strategies) that rule out alternative explanations for these changes. (See also Yzer 1999 and Hornik 2002 for a discussion of these problems.)

2.3 Why are South African campaigns not effective?

Given the lack of process evaluations of South African HIV/AIDS campaigns and the limited empirical research that has been forthcoming, it is currently impossible to answer this question in depth.

Whereas impact evaluations such as those referred to above determine whether campaigns in fact do have a (significant) effect in achieving their goals, process evaluations are needed to explain why these campaigns succeed or fail (see Bartholomew et. al. 2001). Process evaluations do so by linking the impact outcomes with (a) the processes followed in the design of a campaign, and (b) the design

features of the components of the campaign.

As far as could be ascertained, none of the national South African campaigns have in fact undergone systematic and comprehensive process evaluations.

Process-orientated empirical research on aspects of South African HIV/AIDS campaigns is also still very limited. Most of the research that has been conducted, revert to international best practices in the design of AIDS/health campaigns as a yardstick to analyse South African campaigns and to make suggestions for their improvement. This line of research has also received new impetus from the EPIDASA project currently running in South Africa. The major goal of this project is to improve various aspects of the design of HIV/AIDS public documents (see the EPIDASA web site at: <<http://www.epidasa.org>>.)

In the rest of this section, the focus will fall on problems with South African campaigns that have been identified with regard to (i) the choice of behaviour change strategies, and (ii) current practices in designing HIV/AIDS campaigns and their components and their campaigns.

2.3.1 Choice of behaviour change strategies

Current best-practice approaches to the design of health/AIDS campaigns advocate an ecological approach to behaviour change communication. Underlying this approach is the assumption that to optimize HIV/AIDS behaviour change, campaigns seldom can “go it alone”, but (i) have to be supported by various and different types of interventions; (ii) must be tailored to the stages of the epidemic within a community, and (iii) must target audiences with regard to where they find themselves on the continuum of behaviour change. This approach is captured in the following model for effective behaviour change communication of Family Health International/USAID (2002):

| Stages of behaviour change continuum | ↔ | Enabling factors | ↔ | Channels |
|--|----------|--|----------|-----------------------------------|
| Unaware communication | | Providing effective | | Mass media |
| Aware environment: Concerned | | Creating an enabling and traditional media | | Community networks |
| Knowledgeable Motivated to change | | Policies, community values, human rights | | Interpersonal/group communication |
| Trail behaviour change Sustained behaviour change | | | | |

Figure 1: A framework for behaviour change communication (Family Health International/UNAIDS 2002:7)

More specifically, this model indicates that to change problematic health-related behaviours, mass-

media campaigns

- (i) must be supported with other communication interventions, utilizing both informal community networks and folk media and interpersonal channels of communication
- (ii) must be supported with interventions (by way of communications and/or through functional policies, infrastructure and service provisions) that create enabling environments for behaviour change to take place and to be sustained at different levels: structurally, institutionally and on the community, interpersonal and intrapersonal level
- (iii) must be targeted at and tailored to the behaviours and their antecedents of specific audiences in the process of behaviour change within these contexts.

Point (iii) above ties in with current best-practice approaches to the design of campaign messaging within the ecological approach to behaviour change, viz. that campaign messaging should be targeted and tailored to the needs and capabilities (holistically seen) of specific audiences in specific contexts. This general approach is a response to the growing realization that to effect behavioural changes, campaign messaging also has to be adjusted to the progression of the disease in a community, existing levels of knowledge, attitudes and behaviours in response to the HIV/AIDS epidemic, and individuals and communities 'capital' to effect and sustain the required behaviour changes.

As Kalichman and Hospers (1997) and King (1999) point out, HIV/AIDS campaign messaging can be divided into various generations. The first generation of campaign messaging focussed on the general public at large, on HIV/AIDS as a health problem, and on providing general information of how one could effectively avert these problems by performing specific behaviours.

Much of the behavioural change strategies of this first generation were also premised on the highly generic Knowledge-Attitude-Practices/Behaviours Model (KAP/B Model), motivating the assumption that if one fed the public with the correct information, this would change their attitudes and, consequently, their behaviours. Given the focus on the health problem and solutions to it, audience analysis and segmentation was no priority.

Although this approach lead to some behaviour change in some individuals and specific risk groups, it did not facilitate the scope and rate of behaviour change required to effectively redress the epidemic.

The second-generation of HIV/AIDS messaging therefore also focussed on (i) the knowledge and the complex of skills required to perform propagated health-related behaviours, and (ii) the contextual determinants of behaviour change. As most of the problematic contextual determinants (structural inequalities, gender roles, culturally enshrined practices, policies, infrastructure and provisions) are difficult to change and require long-term solutions, the focus on messaging was also on more short-

term methods and strategies to perform the required behaviours in the face of these contextual barriers.

Perhaps one could discern as a third generation approach, the focus on tailored messaging designed to target very specific audiences with regard to very specific behaviours in specific challenging contexts (see also Fishbein, Von Haften and Appleyard 2001 and the discussion in Section 2.3.2).

2.3.1.1 The South African response

The need for a broader, ecological approach to HIV/AIDS-related behaviour change is evident in countries experiencing generalized HIV/AIDS epidemics, such as South Africa. As Shisana (2002) points out, in South Africa HIV/AIDS infection is relative, target audiences are heterogenous and a range of complex contextual behavioural determinants are at play, e.g. culture, gender disempowerment, sexual coercion, rape, child abuse, violence, poverty, economic necessity (e.g. transactional sex), migration, disability (e.g. visual and aural impairment), language, illiteracy, limited access to preventive resources (e.g. condoms, counseling, STD treatment, HIV testing), health system inefficiencies, and a lack of appropriate criminal justice and rights frameworks.

From the vantage point of the ecological approach to behaviour change interventions, a number of problems with the South African response have been pointed out by Kelly and Parker (2000; 2001) and Parker (1997). They specifically note the following :

- an over-reliance on mass-media to effect HIV/AIDS-related behaviour changes
- under-utilization of interpersonal channels of communication
- under-utilization of folk media and community forms of (informal) communication
- an overemphasis on individual-level behaviour change without due consideration of the need for the creation of enabling environments to support and sustain behaviour change, especially without due consideration of the structural, institutional and community-level variables that are either impeding behaviour change or of those that in fact support emergent positive behavioural changes
- the lack of audience-segmentation and tailoring of messages, thus a continuation of the practice of targeting the whole population with general “exhortations” to change their behaviour without taking cognisance of and tailoring messaging to the behavioural changes that have already been made and the needs and abilities of specific target groups to effect and sustain the required behaviour changes

As Kelly and Parker (2000: 58) note, millions are still wasted on HIV/AIDS campaigns that keep on appealing to general audiences at the level of basic awareness and which target behaviours in contexts that do not have “the basic prerequisite resources to engender a sustained and appropriate response. “

2.3.2 Process problems

A number of the problems with South African HIV/AIDS campaigns that have been identified, as well as the proposals as to how they can be improved, relate to the various stages that are discerned in process models for the design of (health) campaigns. To situate these problems and solutions, and to facilitate the analysis that will be provided in Section 3, a brief description is provided below of the Intervention Mapping Model. Discussion of the problems and solutions then follow.

2.3.2.1 Intervention Mapping

To facilitate the strategic planning of health/AIDS-campaigns, various researchers have proposed normative campaign design models (see, for example, Rice and Atkins 2001; Bartholomew et al. 2001; Parker, Dalrymple and Durden 1998; McQuire 1994, 2001; National Cancer Institute 2002; and, National Network of Libraries of Medicine 2000). For the purposes of this article, the Intervention Mapping model (abbreviated to: *IM*) of Bartholomew et al. (2001) will be used as it is the most detailed of these models, incorporates a number of best practice heuristics for campaign design, and has been used extensively as model for the design of health/AIDS campaigns (see Bartholomew et al. 2001 and the IM web site at <<http://www.informationmapping.unimaas.nl>>).

As most general models for the design of interventions, IM breaks up the design process into a number of steps, and indicates with regard to each of these (i) what design activities have to be executed, (ii) what methodologies can be used, and (iii) how the outcomes of each phase feeds into the other. The major steps of this model are presented in Figure 2 , but in a somewhat modified form to focus in more detail on the design of media-based campaign messages for HIV/AIDS-interventions.

1 Problem assessment

- 1.1 Identify the at-risk population, quality of life and HIV/AIDS-related health problems
- 1.2 Analyse the problematic HIV/AIDS-related behaviours and their personal and environmental determinants
- 1.3 Determine the target audience's resources and capacities to deal with HIV/AIDS
- 1.3 Determine the critical personal and contextual determinants of the problematic HIV/AIDS-related behaviours

| | |
|---|---|
| 2 | Campaign design |
| 2.1 | Derive proximal objectives for the intervention |
| <ul style="list-style-type: none"> • Specify the changes that have to be accomplished in the determinants of these behaviours at the different levels to change the problematic HIV/AIDS-related behaviours • Select specific goals that have to be achieved to change the problematic behaviours at the different levels of intervention • Select specific audiences for the intervention • Combine the intervention goals, behaviours and their determinants for each target audience at each level | |
| <ul style="list-style-type: none"> • 2.2 Select theory-based change methods and strategies • Select appropriate theory-based change methods to attain each of the intervention goals at each level of intervention • Select theory-based methods to change each of the determinants of the problematic HIV/AIDS-related behaviours at each level of the intervention • Select appropriate general methods (i.e. those that pertain to effective communication, effective learning and those that ensure cultural specificity) • Translate the chosen methods into appropriate strategies for message design • Combine the messages strategies into a intervention plan for each level of intervention • Design a campaign theory, i.e. specify how each message design strategy will achieve each of the stated goals of the intervention | |
| <ul style="list-style-type: none"> • 2.3 Design and develop each component of the intervention • Design the messages to change each of the determinants of the problematic behaviours for each component of the intervention • Select appropriate channels, media and formats for conveying campaign messages • Develop the content (messages) for each of the chosen channels, media and formats | |
| <ul style="list-style-type: none"> • 2.4 Pretest the materials with the intervention group and revise • 2.5 Develop a plan for the implementation and the evaluation of the intervention • Develop a linkage system • Specify adoption and implementation performance objectives • Specify determinants • Create an implementation plan | |
| <ul style="list-style-type: none"> • 2.5 Develop an evaluation plan for the intervention • Develop an evaluation model • Develop effect and process evaluation questions • Develop indicators and measures • Specify evaluation designs • Write an evaluation plan | |
| 3 | Implement the intervention according to the implementation plan and monitor implementation |
| 4 | Evaluate the intervention according to the evaluation plan |

Figure 2: The Intervention Mapping Model (Bartholomew et al. 2001)

(See Bartholomew et.al. 2001 and Kok et.al. 2004 for a detailed discussion of the model and its application.)

How does IM put into practice the view that the efficacy of HIV/AIDS campaigns can be optimized if they are theory- and evidence based, if they target specific audiences, and are tailored in their messaging?

Besides consultation with members of the target group throughout the design process, the use of theories and empirical evidence are major methodological tools for the execution of the activities in each step of the model.

Bartholomew et. al. (2001) (see also Glanz, Rimer and Lewis 2002) discern a number of major behavioural theories that campaign designers can use for the identification of the determinants of the problematic health behaviours at various levels, and for deriving methods and strategies to change them. Behavioural theories (i) specify in detail what intermediate constructs correlate or are causally related to the problematic behaviour; (ii) make explicit hypotheses about the weighting and relationships between these constructs that can be empirically tested, and (iii), when finally testing the efficacy of messages, provide an explanatory framework for why messages and messages components achieve behavioural changes (or not).

Theories of learning, information processing, communication and persuasion are equally critical as they motivate a number of design strategies that could be used to make messages comprehensible, foster elaboration of message content and motivate people to change their beliefs, attitudes and behaviours. These theories have generated (and still do) a major body of text-effect studies that focus on the question of whether, how and why certain design features of texts (including their content) influence the key mediating determinants of people's behaviours (see, for example, such round-up studies as Atkin 2000, 2002; Crano and Burgoon 2002; Hoeken 1998; Maibach and Parrot 1995; O'Keefe 1990; Perloff 2001, 2003; and Rodenburg and De Stadler 2003).

Likewise, empirical evidence, either primary new research or available research, should inform the design process in every step. Quantitative and qualitative empirical research to identify the critical determinants of people's health related behaviours and to segment audiences is a prerequisite in phases 1 and 2 of the IM. In choosing appropriate methods and strategies, and in finally designing messages evidence of the empirical efficacy of theory-derived design heuristics are equally critical. For example, research on how successful (or not) theory-derived design strategies are with regard to specific audiences, under what conditions and why, is a major guideline for campaign designers in designing the messaging of a campaign (see Kok et al. 2004).

The principle of targeting and tailoring campaign messages can be illustrated with the methodological procedure developed and tested by J. Fishbein of the Ahnenberg School of Communication and his

research colleagues.

Fishbein and Yzer (2003) point out that media-messages should target the critical beliefs that motivate specific health-related behaviours. The major methodological question is thus how one can best go about identifying those critical beliefs that motivate a problematic HIV/AIDS-behaviour and that could realistically be targeted in a media-based campaign. Although some beliefs may be obvious, the determination of these beliefs cannot be left solely to the intuition or subjective assessment of one or a few individuals (even if they are experts in the field). This is an empirical question that requires empirical research. In general though, target audiences may lack certain knowledge (i.e. have a gap in their belief structure), hold beliefs that motivate the problematic behaviour (i.e. problematic beliefs), or hold beliefs that may support the desired behaviour.

To identify the problematic beliefs, the following steps can be followed:

- First get as clear an understanding as possible of the problematic behaviour and its motivating beliefs by utilising a relevant theory of the behaviour, a theory-guided literature study of the behaviour and its determinants, and structured or semi-structured interviews with (a representative sample of) the target audience and experts or other agents that play a key role in the behaviour.
- Secondly, use the theory and the data gained from the first step to design a questionnaire/survey that can be used to elicit information on the weighting of the determinants of the behaviour and their relationships by (a representative sample) of the target audience.
- Administer the questionnaire and analyse the data statistically to determine the weighting of the determinants of the behaviour and their relationships by (a representative) sample of the target audience.
- Using the results of the statistical analysis, select the critical beliefs according to the following criteria:
 - Select those beliefs with the strongest correlation with intention and behaviour.
 - Select those beliefs which are held by the largest proportion of the target audience.
 - Select those beliefs which can realistically be changed - empirically based beliefs are nearly impossible to change with media-based interventions and may even backfire
 - In the case of beliefs that support the desired behaviour, select those whose relation with the intention-behaviour can be strengthened.

- Determine whether the target audience should be further segmented on the basis of the selected beliefs and their correlation with demographic and other relevant variables.

(For a detailed discussion of this methodological approach, see Fishbein, Von Haften and Appleyard 2001; and, Fishbein and Yzer 2003.)

2.3.2.2 South African HIV/AIDS campaigns: process problems and solutions

The problems with the evaluation of South African campaigns have already been discussed in Section 2.2. Most of the other problems relate to the various stages and activities of the design process.

These include:

- the practice of leaving the design of campaign messaging in the hands of “creative teams” that rely more on their “gut feelings” in designing these messages than on theories and empirical evidence
- the lack of strategic planning of campaigns
- the fact that campaigns are not theory-based or lack an explicit theoretical foundation
- the lack of adequate formative empirical research to support campaign design
- the dearth of fundamental social research on all aspects of HIV/AIDS to support the formative research required for effective campaign design
- the lack of audience segmentation and cultural sensitivity
- no or inadequate pretesting of campaign materials before they are implemented

(See Coulson 2002; Kelly and Parker 2000; Kramer 2004; Quakisa 2003; Swanepoel 2003; and, Yun, Govender and Mody 2001.)

Most of the strategies that have been proposed to improve South African campaigns should also be interpreted in terms of the IM. Kelly and Parker (2000: 53-60), for example, provide the following list of action-orientated heuristics for the improvement of South African campaigns:

Planning

- Research target groups with regard to existing behaviours, behaviours that can be realistically changed amongst different sections of the population.
- Define specific behaviour change objectives for specific behaviours of

specific audiences rather than generalising to the community as whole

- Identify contextual determinants of behavioural responses.
- Determine the relationships between contextual behavioural determinants and their relationships with the personal behavioural determinants.
- Identify and plan for interventions to change problematic contextual determinants at the macro-systemic, meso-systemic, and micro-systemic levels.
- Identify positive behaviours and determinants of behaviours that should be endorsed, strengthened and diffused to the relevant audiences
- Develop indicators for monitoring and evaluation that are sensitive to the ecological determinants of the behaviour.

Intervention

- Move beyond message-based, individual orientated interventions.
- Deploy or promote the necessary resources to create enabling contexts for behaviour change.
- Develop and promote opportunities for involvement in sustainable HIV/AIDS related social action.
- Engage with supportive national efforts.

Whether and how campaign designers heed to these heuristics in practice, is the topic of Section 3. To illustrate problems in this regard, the design methodology of the Living Positively campaign and the design features of one of the campaign components, viz. the booklet *Living positively with HIV/AIDS*, is analysed in more detail.

3 APPLYING HEURISTICS IN PRACTICE: THE *LIVING POSITIVELY CAMPAIGN* (LPC) AS CASE STUDY

3.1 The impact of LPC

3.1.1 The objectives of LPC

The LPC is one of the three major campaigns of the overarching Khomanani campaign. The first phases of the LPC werelaunched in 2002, and in terms of media-spend and coverage, it had two peaks - in September/October 2002 and July/August 2003.

The LPC had the following objectives :

- (1) To focus on reducing stigma and negative attitudes towards people living with HIV or AIDS (PLWHA)
- (2) To promote voluntary counselling and testing (VCT)
- (3) To encourage wellness and health seeking behaviour among PLWA

As noted in Department of Health (2002), the goals of the LPC were to encourage care and support in the community for PLWA, and to facilitate openness and acceptance of PLWA. Specific priority areas to achieve these objectives were to encourage HIV-positive individuals to live positively, to encourage VCT in an effort to “help people understand their HIV/AIDS status as the first step towards keeping them healthy”, to reduce blame, denial and fear of people living with AIDS, and to increase exposure/disclosure so that more people get access to those they know are HIV-positive or living with AIDS (Department of Health 2002).

In Department of Health(2002) objectives (1) and (3) are further worked out in terms of target audiences, (sub-)objectives, change areas and impact indicators:

Improve care and support for people living with and affected by HIV/AIDS

Objective: Encourage people living with HIV/AIDS to live positively

| Sub-objective | Target group | Change area | Indicator |
|---|--|--|--|
| Increase awareness that by living positively, HIV/AIDS need not be a death sentence | People living with AIDS, their caregivers and health workers | Increased knowledge | Increase in the awareness of factors that promote health and well-being. Decrease in the number of people who see HIV/AIDS as an instant death sentence |
| Seeking early treatment for TB | People living with HIV/AIDS and health workers | Increased number of people seeking diagnosis and treatment of TB | Significant increase in the number of people seeking diagnosis and treatment of TB |

To facilitate openness and acceptance of people living with HIV/AIDS

| Sub-objective | Target group | Change area | Indicator |
|-------------------------------|---------------------|--------------------|---|
| Reduce blame, denial and fear | All | Attitudes | Increase in those who are supportive of people living with HIV/AIDS |

| | | | |
|----------------------------------|-----|-----------|---|
| | All | Norms | Increase in those who believe others are supporting people living with HIV/AIDS |
| Increase exposure and disclosure | All | Attitudes | Increase in the number of people who have seen/heard of someone with HIV/AIDS |

No clear objectives, target groups, change areas and impact descriptors were formulated for VCT.

The objectives of the LPC are directly linked to a number of objectives which were determined for the Khomanani campaign before the various major and minor campaigns were run. Department of Health (2002) notes that the objectives as discussed above, were “established through a consultative process that included the Department of Health, the ACT consortium, provinces and other stakeholders. The objectives were aligned with the government’s five-year HIV/AIDS/STD strategic plan for South Africa.”

3.1.2 Campaign input

The campaign utilized television, radio, billboards and outdoor media, small media and utility items for campaign messaging. The media component was supported by interpersonal channels of communication by way of social mobilization in six sentinel sites. Although not clear in its description, the messaging was carried by 3 media spots (*VCT: Test negative*, *VCT: Test positive*; and *My son*); a number of campaign components that were used in a television and radio campaign that focussed on “decreasing the stigma and discrimination of PLWA (to dispel misconceptions and stereotypes of HIV and AIDS)”; two radio spots and one television advert that focussed on the VCT message, “i.e. to encourage listeners and viewers to come in for voluntary testing and counselling”; and, billboard and outdoor-media messages. A variety of small media were used: leaflets on VCT and Mother-to-Child-Transmission of HIV, and two booklets - one on living positively and one on the stigmatization of PLWA.

3.1.3 The impact of LPC

To evaluate the impact of The LPC, a pre-/post-test design was used: a national survey was used to assess the relevant baseline knowledge, attitudes and behaviours, which was then compared with a follow-up survey to determine impact of the campaign.

What was the impact of the campaign? In the evaluation report the impact results are provided only with regard to objective (1) (reducing stigma and promoting pro-social behaviour toward PLWA) and objective (2) (encouraging VCT):

Reducing stigma and promoting pro-social behaviour toward PLWA

- There was an increase in knowledge of healthy living options in respondents exposed to the Khomanani campaign (overall; but not necessarily to LPC) in that more respondents could name two or more options for positive living (76% exposed; 67% unexposed; 70% at baseline).
- There was no change in the intention of the proportion of the respondents who had indicated they would consider helping someone with HIV and AIDS at baseline (50% stated they intend to do so; 10% actually had done so), although there was a significant improvement in the attitudes towards PLWA.

Encouraging VCT

- There was no change in the attitudes towards disclosure, with around 25% of the respondents saying they would not disclose their status.
- There were no significant differences in the proportion of respondents who had been for an HIV test between baseline and follow-up; testing among women remained stable, but there was a decline in the proportion of men who went for testing (29% to 24%) and in the number of people under the age of 30 (27% to 24%). In the social mobilization sites, however, data from the sentinel site feedback suggest an increase in the uptake of VCT by women; in the community survey in the sentinel sites, 45% of residents said they felt more willing to go for an HIV test.

(Department of Health 2004: 24-27).

The impact of the campaign on PLWA was not measured, and with regard to the other change areas, there were no reported behavioural changes, and a slight improvement in some areas of knowledge and “willingness”. As indicated above though, increase in the knowledge of ways that PLWA can live positively, did not induce a higher level of pro-social behaviours towards PLWA.

3.1.4 Problems with the impact assessment

There are a number of problems with the impact assessment, of which some have already been discussed in Section 2 of this article.

The first relates to the validity of the impact results. As the authors of the evaluation report note, the LPC “was not branded in the same way as some of the other campaigns. It did not have specific logos

or a distinctive slogan. As a result, there were no independent indicators that could be used to determine exposure to the Positive Living Campaign “ (Department of Health 2004:24). Consequently, it becomes difficult to relate any of these impact findings in a meaningful way with exposure to the campaign and its components. Confounding of the influence of exposure to other sources of information is thus a real problem in evaluating the findings of this campaign.

The same applies, as the authors readily admit, with regard to the impact findings that relate to one of the general goals of the LPC, namely to increase exposure to people living with HIV/AIDS. The impact data clearly indicates an increase in the number of respondents indicating that they were affected by AIDS in the family (30%), knowing someone that had died of AIDS (57%) or knowing someone infected with HIV (42%). As the authors note, however, “More people who were classified as exposed had personal knowledge of infected people and AIDS deaths. This would also make them more knowledgeable on the change areas, independent of the campaign messaging” (Department of Health 2004:26).

From the foregoing one must conclude that there was no sufficient planning for the evaluation of the campaign, leading to major problems with the internal and external validity of the results of the evaluation report.

The second problem relates to the way in which components of the campaign were aligned with the real-world contexts in which people have to perform the propagated behaviours. With regard to the poor impact of the LPC campaign on the uptake of VCT, the authors note that the ‘VCT component was a fairly minor part of the campaign, partly because at the start of the campaign, VCT sites were still being set up’ (Department of Health 2004:24). In Department of Health (2002) it was also noted that media campaigns have to concur with government services: “Advertising services that are not yet available causes disillusionment for patients and annoyance among health workers.” Seeing that adequate VCT services had not been established at that time (2002), the promotion of VCT, and more specifically the prevention of Mother-to-child transmission, were in fact not prioritized (Department of Health 2002).

The LPC was launched in a period during which the South African government’s VCT policy, the inadequacies of VCT sites (see Masuko 2001) and the provision of anti-retroviral therapy came under immense international and national pressure. Given these deficiencies and an overburdened public health care system, government’s strategy was to promote positive living and home-based care as the solution to alleviating the plight of PLWA. Immense media coverage of these issues and the public’s opinion that government was not doing enough to address the epidemic and should be providing ART for all those in need of it (see Shisana 2002), clearly indicate that “secular trends” in any case already jeopardized the potential of the VCT component of the campaign to have significant

effects.

The foregoing thus raises the question of whether it in fact made sense to embark on a VCT campaign, especially in the light of Kelly and Parker's (2000: 58) concern that millions are still wasted on HIV/AIDS campaigns which target behaviours in contexts that do not have "the basic prerequisite resources to engender a sustained and appropriate response. "

Much the same can be said with regard to the objective of The LPC to reduce the anti-social behaviour of the South African public towards PLWA by increasing their knowledge of ways in which PLWA can live a positive and productive life. The baseline survey (see Case 2002: 85-89) assesses (i) beliefs about the impact of HIV/AIDS on those affected (CASE 2002:87) (i.e. ability to live a productive and healthy life), and (ii) knowledge of life style changes that PLWA could make to live positively with the illness.

With regard to (i) the baseline results indicate a high rate of agreement (75%) with the statement that PLWA can lead a positive life for many years (i.e. that HIV/AIDS is not a immediate death sentence, and that they can continue to work and make a positive contribution to society). With regard to (ii), 80% of the respondents were aware that PLWA could change their lifestyles to stay healthy and that there are various ways of doing so (CASE 2002:89). The question thus arise of whether the baseline assessment in fact was sufficient motivation to target these beliefs in the general population and whether or not more tailored campaigns were not necessary. The baseline report itself does not provide an interpretation of the survey results; consequently, one does not know whether the results are indeed indicative of the need to target these beliefs in a campaign.

The third problem relates to the alignment of the questions of the baseline survey, the goals of the campaign and the design of the campaign itself. As noted in CASE (2001:12): "many of the campaigns had not been finalised by the time the baseline survey was being conducted, and it was therefore difficult to accurately link the questions in the survey with campaign messages".

The problem is worsened by the fact that the goals of the campaign were decided beforehand (see the consultation process described above), i.e. before extensive problem analyses had been done of the behaviours and determinants which had to be targeted in the various components of LPC. This "dis-alignment" of survey questions, the goals of the campaign, and the messaging that had to achieve the stated goals clearly indicates that there was little adherence to the various procedural guidelines provided by most normative process-orientated design models (see the discussion of IM in Section 2 of this article).

A related problem is the fact that a major objective of the campaign was "to encourage wellness and

health seeking behaviour among PLWA”, while PLWA’s health seeking behaviours and their determinants were not empirically assessed in the baseline survey (and consequently not in the follow-up survey). Thus the impact of the campaign on PLWA’s health-seeking behaviour could not be assessed, especially since the survey questions were not formulated in such a way that the responses of PLWA could be filtered out from the rest of the responses.

Campaigns can fail for a variety of reasons, but the evaluation report does not go into much detail of why the LPC had such a limited impact. Besides the problem of the time frame of the campaign (short exposure) which is mentioned, the authors do not relate the limited impact of The LPCto such factors as the problematic nature of the behaviours that had to be addressed, secular trends, or to some of the processes followed in the design of the components of the campaign. Given the limited impact of the LPC, the question arises as to the (in)adequacies in the processes followed in the design of the LPC and of the design features of the campaign components.

3.2 Process problems

3.2.1 Formative research

The evaluation report (Department of Health 2004) does not provide a process evaluation of the Khomanani campaigns; consequently no data is available on how the successes or failures of the LPC as these relate to the processes followed in designing the campaign. However, on the basis of the information provided in the report with regard to the general processes followed in designing the Khomanani campaigns and the LPC in particular, and the available campaign documents (literature overviews, surveys and campaign materials) a preliminary assessment can be made to support the general claim that the design of the LPC in effect suffers from most of the problems with South African HIV/AIDS campaigns as these are discussed in Section 2.

The evaluation report (Department of Health 2004) makes a number of claims with regard to the processes followed in the design of the LPC:

- that the design was informed by a specific process model (see Figure 3)
- that international and local best-practice models of behaviour change were used
- that a rigorous evidence-based approach was followed
- that social-level change, as well as individual level change was encouraged.



Figure 3: The design model of the Khomanani Campaign (Department of Health 2004:8)

With regard to the three first steps, the authors also note that the formative research included the following:

- An overall literature review and stakeholder interviews. These identified the needs of the target audience for each campaign and broad strategic direction.
- In addition, specific information was obtained from quantitative and qualitative research among the target audience. This research led to the development of the messages and materials, and was used as a baseline to assess the impact of the campaign.
- Materials developed were tested to ensure they were appropriate, understandable and acceptable.

(Department of Health 2004: 8.)

As could be established from the available data, only one literature overview ACT/Johnnic (2001)(*Living Positively Campaign. Literature Review*), some focus group data, and information from the baseline survey was used as input to the design of the messaging of LPC.

Closer inspection of the content and quality of the formative research for the campaign, however, clearly indicates that the elicited data could hardly enable campaign designers to come up with campaign components that are theory- and evidence-based and which are strategically designed to address the specific contextual and personal determinants of the problematic HIV/AIDS-related health problems of people living with HIV/AIDS in South Africa.

The article on *Living Positively Campaign. Literature Review* provides a broad thematic discussion of HIV/AIDS-related stigma and discrimination as they were identified as the major barriers to the

wellness and health seeking behaviour of PLWA. The main themes covered are the forms of they are manifested in different contexts and their negative consequences on PLWA; the legislation that pertains to stigmatization and discrimination in South Africa; and, strategies for interventions (see Department of Health 2002). Although such data could in fact provide campaign designers with guidelines as to what broad strategies to adopt, it does not focus on the specific determinants (beliefs, attitudes practices/behaviours, if one sticks to a KAP/B-framework) that motivate the various problematic health seeking behaviours of PLWA, and which should be targeted in the components of a campaign.

The baseline survey data also provides one with little empirical evidence on which to base the design of campaign messages to reduce AIDS-related stigma. In the section that pertains to positive living (Case 2002: 85-89) respondents' (i) attitudes towards people with HIV/AIDS are assessed with two proxy questions (Eat a meal with someone with HIV/AIDS (67%); Allow your child to play with an HIV+ child (59%)). The first question assesses people's beliefs about the contagiousness of the disease in a single context, but not in all the contexts that could be relevant when one has to interact with a PLWA, for example, those requiring close body contact with a PLWA. Furthermore, as indicated in various theoretical models (see, for example, Bos 2001), AIDS-related stigma is a function of a number of variables, of which different ones may function more strongly in different contexts. However, these variables are not assessed in the survey.

The analysis provided by Jennings et al. (2001), also done for the Department of Health, but not properly referenced and used in the literature review article, clearly indicates how such a theoretical analysis could be done to identify the critical range of beliefs that motivate the stigmatizing attitudes and behaviours of specific target groups that have to be targeted in the messaging of campaigns. (See also Nyblade 2003 for such a methodological approach to addressing (fear) of AIDS-stigma.)

With regard to the use of theory-driven analyses of the target groups, it must be noted that no theories or theory-driven literature overviews were provided of the determinants of peoples' decisions whether or not to present themselves for VCT.

The health promoting or health-impeding behaviours of PLWA are treated in a short section in the article *Living Positively Campaign. Literature Review*. According to this analysis, the impeding factors for PLWA to live openly with their illness is compromised by their fear of stigma, environmental factors, mental/emotional factors, and physical factors. Closer inspection of this section of the article clearly indicates a confusion of fear of disclosure and, consequently, to live openly, the ability of PLWA to cope with their own health problems, and the emotional and physical consequences for PLWA as a result of various stressors. This research document therefore provides campaign designers with no systematic overview of the various stressors that PLWA have to cope with and how

they cope with them (as, for example, done in Alonzo and Reynolds 1995), nor does it theoretically relate the various variables mentioned above in a coherent model (as, for example, done by Pakenham and Rinaldis 2001 in a stress and coping model).

Equally disconcerting is the fact that no theory- and evidence-based formative research was undertaken with the participation of PLWA's on their health seeking behaviours and their determinants. The focus group data elicited from communities were aimed at assessing what "communities viewed as the essential features of living positively within their communities", and thus reflects their "concerns". These include:

- Continued social interaction
- Being responsible
- Having a positive mental attitude
- Healthy living
- Actively seeking support
- Community stigmatization and low self-esteem on the part of those infected

(Department of Health 2004:22.)

These concerns are also those that are tested in the baseline survey, viz. .

(ii) beliefs about the impact of HIV/AIDS on those affected (CASE 2002:87)(ability to live a productive and healthy life):(iii) and knowledge of life style changes that PLWA could make to improve living positively with the illness.

Although no documentation is provided on precisely how the baseline data was utilized by the creative teams in designing the messages of the campaign, it can be preliminary stated that no theory- and evidence-based formative research was done that could in a significant way support the messaging of the VCT component of the campaign. The KAP/B-based analysis is, to say the least, based on a simplistic assumption of what determinants drive VCT-uptake behaviours or the health-promoting behaviours of PLWA. Furthermore, there is little evidence that an attempt was made to understand the relevant problematic behaviours from the viewpoint of the target audience and their responses within their unique cultural, social, economic and political environments.

In as much as the documentation allows one to draw such conclusions, one could state that with regard to the formative research done for the LPC no support could be found for the claim that it is based on a rigorous evidence-based approach or "that international and local best-practice models of behaviour change were used." At most one could say that the general information that was obtained during the formative research stage could in fact provided the campaign designers with very little on

which to base the design of the various campaign components.

3.2.2 Features of the messaging

The information and education approach followed by the Khomanani campaign designers clearly manifests itself in the design of the booklet *Living Positively with HIV and AIDS* (A4; 44 pages ; full colour) (abbreviated to: *LPHA*).

Firstly, LPHA targets all South Africans, all people living with HIV/AIDS, and all people who voluntarily or of necessity take on the role of caregivers for people living with HIV/AIDS (see LPHA, p.1).

Secondly, It broadly covers almost all relevant topics relating to HIV prevention, VCT, and support and care of people living with HIV/AIDS. Thirdly, it typically seeks to provide people with the correct information, general solutions to specific problematic behaviours, to stimulate awareness, and to motivate people to seek further information, should they need it.

The overall impression that one gets, is that PLHA was meant as a sort of general handbook for all South Africans (living with HIV/AIDS or not), but with little regard for the specific information needs of specific target audiences and the complexities of performing the propagated behaviours within the contingencies of their specific social, cultural and economic contexts (see the discussion in Section 2 with regard to the problems of this approach).

The problem with this approach is clearly manifested, for example, in the messaging in LPHA that focusses on people living with HIV and AIDS, and which is tended to help them live positively with the disease. The major problems that PLWA typically encounter, and which are discussed in a typical problem-solution format, are the following:

- coping with the emotional turmoil on receiving a HIV-positive test result
- the psychological stresses one experiences after leaving the VCT site (for example, coping with self-blame, or coping with the issue of disclosure)
- the problems PLWA experience in disclosing their HIV positive status to others
- coping with the emotional and physical problems one will encounter in the different stages of the disease, from being HIV-positive and healthy, to being HIV-positive and sick and to having AIDS and being near death

The major question one should ask in this regard, is how people living with HIV and AIDS would respond to the information provided in LPHA. Obviously, the best way to get clear answers in this regard is to test these messages with PLWA themselves. Given that no data to this effect is available,

one can, however, trouble-shoot some of the problems that could arise in this regard by utilizing the predictions of the various stress and coping models that are generally used to explain and predict PLWA's coping behaviours in facing the many threats they could experience in the passage from testing positive for HIV to death (see, for example, Alonzo and Reynolds 1995; Miller 2001; and, Pakenham and Rinaldis 2001).

With regard to each of the problems discussed in LPHA (as potential stressors), these models hypothesize that PLWA's reactions will be determined, first of all, by their appraisal of the severity of the problem and their own susceptibility to it (combined: the threat component). Secondly, it will be determined by their appraisal of (i) the efficacy of the suggested solutions/propagated behaviour to alleviate the problem or to minimise its impact (response efficacy), (ii) their own ability to perform the behaviour (self-efficacy), (iii) their control over performing the required behaviour, and (iv) the costs involved in performing the propagated behaviour.

Negative cognitive and behavioural responses will typically result if the threat component is high and one does not believe that the propagated solution is effective, that one does not have control over or the means to perform the required behaviour, and that the potential costs of performing the behaviour may outperform the potential benefits.

Given these predictions, how does the messaging in LPHA with regard to each of these problems and solutions fare? A few examples will suffice.

A very explicit graphic and verbal presentation is made in LPHA (p.15) of the stressful emotional reactions people may experience on receiving an HIV-positive test result: shock, anger, fear, guilt (the threat/problem). As solution, LPHA then provides the following:

Always remember that these feelings are normal. There are many ways of trying to deal with your feelings. Learn to be hopeful. Hope gives you strength to cope with problems. It also helps you to live a normal and healthy life.

Whether people will accept such emotional distress as being "normal", and whether they will judge that hope, the emotional leg of the positive living approach, is an effective solution to such emotional stress, and, equally important, whether they in fact believe that they will be able to counter these stressful feelings with feelings of hope, are empirical questions that have to be answered by testing such messages with PLWA themselves.

A major problem with the suggested solution (propagated behaviour), however, is that PLWA are given little guidance on how to become hopeful. Given that people indeed believe the source of the

information in LPHA and that hope is appraised as an effective response to such emotional stresses, people will want to know how one can learn to be hopeful, and they will have to be convinced that they will be able to stay hopeful irrespective of whatever personal or environmental barriers they may encounter. Unfortunately the messaging does not focus on these issues.

More problematic in this regard is the fact that hope and positive living are themselves constructs which are completely undertheorised in the literature which is supposed to support the messaging of LPHA. It is not clear for example, whether it should be equated with dispositional optimism (and its counterpart, dispositional pessimism) (see Scheier and Carver 1992) - in which case it will be difficult to learn - or whether one should interpret it as a more positive feeling associated with the construct of efficacy.

With regard to how one could cope with the psychological distress (due to fear, feelings of guilt and being dirty, embarrassment and shame) following a positive HIV-test, PLWA are advised to talk to someone. LPHA (p. 17) advises PLWA that they could discuss their emotional problems with a range of people: a friend or member of one's family, a counsellor, a doctor or health worker, a minister, a traditional or faith healer, the AIDS help line counsellors, or they could join a support group. However, LPHA simply assumes (and states) that each of these people will provide PLWA with (some aspect of) the psychological support they will need. No attention is given to PLWA's own concerns about the ability of these people to do so, or how they will be able to cope with the possible negative reactions these people might have upon learning of one's HIV-positive status. For example, the stigmatizing attitudes and behaviours of health care workers towards PLWA and the ambiguous reaction of religious leaders to people living with the disease are well-known. PLWA, more than anyone else, are well aware of these facts, and little is done to enhance their belief in the trustworthiness or expertise of the source of the information provided in LPHA if these issues are simply ignored.

The emotional stress that the prospect of having to disclose one's HIV-status causes in PLWA and the negative effects this has on their physical well-being are topics extensively discussed in the literature, so too the fact that failure to disclose is a barrier to accessing care and support from their loved ones, family and community. The beneficial effects of disclosure are also well-attested.

In trying to persuade PLWA to disclose, LPHA uses the well-known technique of highlighting the disadvantages of not disclosing (feelings of unhappiness and stress that can weaken the immune system; LPHA, p. 19) and by pointing out the advantages of disclosure (emotional relief, love and support).

For people living with HIV and AIDS, however, the obvious problems are who to disclose to, how to disclose one's status, to try and predict how people will react to this knowledge, how to cope should people react negatively, and how one can insure that people will keep information about their HIV-

status confidential (see Burris 1998).

On the question of whom to disclose one's status to, LPHA, makes the suggestion that one should first make a list of people and then decide whom they can trust. This list may include one's parents, children, close friends, people you work with, and classmates. Disclosure to one's children is discussed in more detail. However, one of PLWA's major fears and concerns are, of course, disclosure to their sex partners, but this issue LPHA does not address at all. The only reference to PLWA's sexual partner(s) and sex is made in a small block (see PLHA, p. 29):

Continue to have sex if you want to. Sexual touch can help you stay healthy for longer. But remember that you will still need to have protected sex, even if you and your partner are HIV positive. Always use a condom.

Although this piece of advice may address PLWA's concern (see van Dyk and van Dyk 2003) that the illness itself will negatively effect their sexual performance or their fear that disclosure of their status will jeopardize their ability to have access to sex, it still completely underprofiles the role of one's sexual partner(s) and of sex and PLWA's concern in this regard.

On how to disclose one's status, LPHA makes the suggestion that PLWA could first try and educate those they want to disclose to about HIV/ AIDS and to help them cope with their fears. LPHA, p.21, notes:

It may help to do these things before you tell anyone you are HIV positive:

- Talk about HIV generally.
- If the person has the wrong information, give them the facts about HIV and AIDS.
- Give them this book to read.
- Invite them to talks about HIV and AIDS where they can get more information.
- Help them to deal with their fears about HIV and AIDS. Many people have wrong ideas about how HIV is spread. This makes them afraid of other people who are HIV positive.

Although one could accept that PLWA can and should be agents to educate those close to them and their communities about HIV/AIDS, the feasibility of first doing so before disclosing one's own status to those closest to you - without at least raising strong suspicion of one's own HIV-status - can be questioned. If empirical evidence does exist that it is indeed a feasible and successful strategy, then

this should have been provided to convince PLWA of its efficacy. However, given that people are stigmatized and discriminated against solely on the basis of association with HIV/AIDS, most PLWA and those not living with the disease in fact avoid any situation that could be the basis for such inferences (see Van Dyk and Van Dyk 2003).

The lack of argumentative support to enhance the plausibility of some of the statements made in LPHA, is even more evident in the simple statements made about the problem of predicting how people will react to the information of one's positive status and PLWA's fears of breaches of confidentiality. To this LPHA, p. 16 simply states:

- Most people will accept you. (And on p. 28: "Most people will support you and not reject you.")
- You have the right to ask the person not to tell anyone else.

The first statement is provided with no empirical backing, and it is mum on what PLWA should or could do if people do not accept them. The authors of LPHA either expect or assume that PLWA will simply accept this statement on the basis of its source. However, the wide-spread fear of AIDS stigmatization and discrimination (see Jennings et al. 2001) clearly indicates that people in fact do not believe this statement or do not do so without reservation.

The problem with the second statement is that having a right to ask someone to treat the information about one's HIV-status as confidential, is in no way a guarantee that those you disclose to will indeed keep it confidential. People's fears of breaches of confidentiality and especially of the possibility that it may expose them to AIDS-stigma and discrimination, is side-stepped in LPHA. Furthermore, simply indicating that people's fear of PLWA (and subsequent stigmatization and discrimination) is based on ignorance, does little to assist one on how to cope (either positively or negatively) when you - as a person living with HIV or AIDS- are faced with the stigmatizing beliefs, attitudes and behaviours of others. Neither does it provide one with any strategies on how to cope with the emotional distress that disclosure of one's status might cause those to whom one discloses (for example, one's loved ones).

The third strategy that LPHA (p. 16) suggests is "You do not have to tell everybody that you are HIV positive." Avoiding disclosure is in fact one of the major coping strategies PLWA themselves employ as this allows them to avoid the potential negative consequences of disclosure and having to deal with it. As Stein (1996) indicates, at least some PLWA find it an easier coping strategy to present oneself as normal (for as long as you can) and to avoid all forms of negative ideation about one's illness rather than letting one slip into the sick-role that disclosure forces upon you.

LPHA's treatment of how PLWA can live positively when facing the inevitable physical and mental

decay they will experience as the disease progresses to the final stage of death, is certainly the most depressing part of LPAH. Despite the claim by Shisana (2002) that “AIDS kills” has never been a message of one of the national campaigns, LPHA does not fail to bring this message home. The long section on the various opportunistic infections that one could be prone to, underscores the painful episodes that PLWA must be prepared to face, and the pictorial presentations of how PLWA decay physically and mentally provides a vivid description of the burdens one will have to endure in the passage to death.

LPHA’s advice to PLWA is once again couched in simple problem-solution statements, and obviously not supported by in-depth analysis of how PLWA in South Africa experience the trajectory from VCT to death physically, emotionally and socially, and how they cope with the problems on each of these levels (see Alonzo and Reynolds 1995 for such an analysis).

Staying positive through these stages and trying to die with dignity is dependant on a range of variables. LPHA’s advice is to stay positive and to avoid stress, to eat healthy, treat opportunistic infections, and go for regular medical check-ups. These behaviours may indeed be effective to alleviate a variety of the problems PLWA face, but PLWA’s ability to perform them are largely contingent on whether they indeed have access to healthy foods, have access to hospital care or someone that could treat them with the suggested home remedies, etc. In as much as the poor are disproportionately effected by the epidemic, and people in rural areas often do not have access to health care, they often can not effect these responses. Mental and physical suffering then becomes the harsh reality that these people have to face.

One should keep in mind that the Living Positively Campaign was launched and ran during the period in which free and universal access to anti-retroviral therapy (ART) in the public health sector for all PLWA in need of it became a prominent political and health issue. This finally lead to the South African government’s roll-out plan to provide ART to 53 000 of the nearly half a million PLWA who are in need of it.

Before the roll-out plan was put into action, positive living and home-based care were in fact the only strategy that health educators and campaign designers could offer PLWA to cope with the illness. LPHA, p.25, does advise PLWA to “Find out about anti-HIV medicine” and points out its benefits, but also notes:

These medicines are very expensive and need to be taken every day, month after month and year after year.

thereby underlining that it is an option that is most probably completely out of the reach of most economically deprived PLWA.

It is telling that in the booklet *HIV and AIDS. Prevention, Care and Treatment* (A3, full colour; 54 pages), the follow-up to *Living Positively with HIV and AIDS*, very little has remained of the positive living and home-based care strategy. The focus in the latter is primarily on ART and the variety of ways in which it can effectively address most of the structural factors contributing to the disease (poverty, gender roles, stigmatization and discrimination) and those problems (discussed above) that PLWA have to face up to in coping with the disease. The irony is, however, that by October 2004, only about 15 000 of the estimated half a million PLWA in South Africa that are in need of ART, were on government's ART-programme (Treatment Action Campaign, 2004) - ineffective implementation of the programme and people's fear of being stigmatized often being cited as the major causes.

Given that government's ART-programme only provides for the treatment of 53 000 people living with AIDS, and the fact that state hospitals are crumbling under the demands for the treatment of people who have full-blown AIDS, the reality that campaign designers will have to face up to is that the positive living and home-based care strategy is most probably the only one they will have to address the plight of those living with HIV and AIDS for some time to come. Systematic and comprehensive evaluation of the positive living campaign therefor becomes an urgent necessity.

Using evaluation indicators for the efficacy of this campaign such as how many ways people can remember to live positively with the disease (see the discussion above) is of little help. The development of detailed evaluation indicators assessing each and every aspect of the campaign is essential, including an assessment of the interface between a campaign and its messaging and developments on the level of policy, infrastructure and provisions, the formative research that underlies the campaign, the messaging methods and strategies adopted, and the (in)efficacy of the pretesting of the materials of the campaign. If nothing else, the above analysis of these issues indicates that there could be major problems with all these aspects of the campaign.

4 Conclusion

The analysis of the Living Positively Campaign and of the booklet *Living Positively with HIV and AIDS* brings one to the conclusion that in designing HIV/AIDS campaigns and their components, the campaign designers paid very little attention to the major problems that have been identified with South African HIV/AIDS campaigns. However, there are obvious limitations to this study, especially with regard to the analysis of The LPC and LPHA. For the most part it relies on a single interpretation of the available campaign documents that could be accessed. Furthermore, it is limited to a single case study. This study should therefore be followed-up with an in-depth exploration of the topics raised in closer collaboration with the campaign designers themselves and with the target-audiences of these campaigns. Hopefully, though, it has indicated that there could be possible problems with

South African HIV/AIDS campaigns and that these require urgent attention.

The “failure” of health campaigns in general and HIV/AIDS campaigns in particular, is not a unique South African phenomenon. As studies such as Crano and Burgoon (2002), Glanz, Rimer and Lewis (2002), and Hornik (2002) indicate, even well-planned and -executed health campaigns can and do fail, and for a variety of reasons. On the question of whether South African HIV/AIDS campaigns are effective or not, no unambiguous answer follows from the above analysis, but it should be indicative of the fact that there might be major problems with these campaigns. Finding out why, should be a major impetus for best practices research which can provide campaign designers with guidelines that could help them optimize the efficacy of such campaigns.

Support from the broader research community in South Africa is a major requirement in this regard, but a critical evaluation by campaign designers of current practices in designing these campaigns is equally essential. When people’s lives are at stake, window-dressing of current practices as “state of the art”, as being heavily evidenced-based and based on international and local best-practice models of behaviour change does little to improve current practices. In fact, it raises a number of ethical questions with regard to how campaign designers go about designing HIV/AIDS campaigns and how they present the results of the impact of these campaigns.

* The research for this article was carried out within the framework of the EPIDASA project and was supported by funding from the South African-Netherlands Programme for Alternatives in Development.

References

- ACT/Johnnic. 2001. Living Positively Campaign. Literature Review. Available: <<http://www.aidsinfo.co.za>>.
- Aids Foundation of South Africa. 2000. AIDS in South Africa. Available:<http://www.aids.org.za/aids_in_south_africa.htm>.
- Alonzo, A. A. and Reynolds, N. R. 1995. Stigma, HIV and AIDS: An exploration and elaboration of a stigma trajectory. *Social Science Medicine*, 41.3: 303-315.
- Atkin, C. K. 1994. Designing persuasive health messages. In: Sechresi et. al. (Eds.) 1994: 99-110.
- Atkin, C. K. 2001. Theory and principles of media health campaigns. In: Rice and Atkin (Eds.) 2001: 49-68.
- Atkin, C. K. 2002. Promising strategies for media health campaigns. In: Crano and Burgoon (Eds.) 2002: 35-64.
- Bartholomew, L. K., Parcel, G. S., Kok G. and Gottlieb, N. H. 2001. *Intervention mapping. Designing theory- and evidence-based health promotion programs*. Mountain View, California: Mayfield Publishing Company.
- Bos, A. 2001. *HIV stigma and social interaction. Examining strategies to influence perceiver's emotional and behavioural reactions in initial encounters*. PhD Thesis, University of Maastricht.
- Burris, S. 1998. Law and the social risk of health care: Lessons from HIV testing. *Albany Law Review*, 61: 831-895.
- CASE. 2001. *Baseline study for Khomanani Campaign*. Available: <<http://www.case>>
- Coulson, N. 2002. Developments in the use of the mass media at the national level for HIV/AIDS prevention in South Africa. Available: <<http://www.comminit.com/stcoulson/std-5496.html>>.
- Crano, W. D. 2002. Introduction. In: Crano and Burgoon (Eds.) 2002: 3-18.
- Crano, W. D & M. Burgoon. (Eds.). 2002. *Mass media and drug prevention: Classic and Contemporary theories and research*. Mahwah, New Jersey: Lawrence Erlbaum.
- Delate, R. 2001. *The struggle for meaning: A semiotic analysis of interpretations of the loveLife His&Hers billboard campaign*. Available:<<http://www.cadre.org.za>>.
- Department of Health. 2002. Campaigns: Overview of DoH initiatives. Available: <<http://www.aidsinfo.co.za>>.
- Department of Health. 2004. *Moving the nation to ACT. A research report on The Khomanani Campaign 2002-2004*. Available: <<http://www.aidsinfo.co.za>>.
- Family Health International/UNAIDS. 2002 Behaviour change communication (BCC) for HIV/AIDS. A strategic framework. Available: <<http://www.fhi.org/en/ais/aidschap/aidspubs/handbooks>>.
- Fishbein, M. The role of theory in HIV prevention. *AIDS CARE*, 12.3: 273-278.
- Fishbein, M., Von Haften, I., and Appleyard, J. 2001. The role of theory in developing effective interventions: implications from PROJECT SAFER. *Psychology, Health & Medicine*, 6.2: 223-238.
- Fishbein, M. and Yzer, M. C. 2003. Using theory to design effective health behaviour interventions. *Communication Theory*, 13: 164-183.
- Glanz, K., Rimer, B. K., and Lewis, F. M. (Eds.) 2002. *Health behaviour and health education. Theory,*

research and practice. San Francisco: John Wiley & Sons. (Third Edition.)

Glanz, K., Rimer, B. K., and Lewis, F. M. 2002(a). The scope of health behaviour and health education. In: Glanz, Rimer, and Lewis (Eds.) 2002: 3-21.

Glanz, K., Rimer, B. K., and Lewis, F. M. 2002(b). Theory, research, and practice in health behavior and health education. In: Glanz, Rimer, and Lewis (Eds.) 2002: 22 -39.

Hoeken, H. 1998. *Het ontwerp van overtuigende teksten. Wat onderzoek leert over de opzet van effectieve reclame en voorlichting*. Bussum: Uitgeverij Coutinho.

Institute for Health Policy Studies. 2002. *HIV prevention in California*. (Report prepared for the Office of AIDS, California Department of Health Services, by the University of California, San Francisco.). Office of AIDS, California Department of Health Services.

Hornik, R.C. 2002. Public health communication: Making sense of contradictory evidence. In: Hornik (Ed.) 2002: 1-22.

Hornik, R. C. (Ed.) 2002. *Public health communication. Evidence for behavior change*. Mahwah, New Jersey: Lawrence Erlbaum Associates.

Jennings, R., Mulaudzi, J., Everatt, D., Richter, M., Heywood, M. 2002. Discrimination & HIV/AIDS. Available: <<http://www.alp.org.za>>.

Kalichman, S. C. and Hospers, H. J. 1997. Efficacy of behavioral-skills enhancement HIV risk-reduction interventions in community settings. *AIDS*, 11: 191-199.

Kelly, K. J. 2000. *Communicating for action. A contextual evaluation of youth responses to HIV/AIDS*. Available: <<http://www.cadre.org.za>>.

Kelly, K. and Parker, W. 2000. *Communities of practice. Contextual mediators of youth responses to HIV/AIDS*. Available: <<http://www.cadre.org.za>>.

Kelly, K. and Parker, W. 2001. From people to places: Prioritising contextual research for social mobilisation against HIV/AIDS. Available: <<http://www.cadre.org.za>>.

Kelly, K., Parker, W. and Oyosi, S. 2001. *Pathways to action. HIV/AIDS prevention, children and young people in South Africa. A literature review*. Available: <<http://www.cadre.org.za>>.

King, R. 1999. Sexual behavioural change for HIV: Where have theories taken us? Available: <<http://www.unaids.org>>.

Kok, G., Schaalma, H., Ruiter, R., and Van Empelen, P. 2004. Intervention Mapping: A protocol for applying health psychology theory to prevention programmes. *Journal of Health Psychology*, 9.1: 85-98.

Kramer, A. 2004. *'Ek het die storie net uit my duim gesuig..'* A study into the relation of a designer's profile with the design characteristics and design process of public information documents on HIV/AIDS in South Africa. MA Thesis, Radboud University, University of Nijmegen. Available on-line at: <<http://www.epidasa.org>>.

Kreuter, M., Farrell, D., Olevitch, L. and Brennan, L. 2000. *Tailoring health messages. Customizing communication with computer technology*. Mahwah, New Jersey: Lawrence Erlbaum.

O'Keefe, D.J. 1990. *Persuasion. Theory and Research*. Newbury Park: Sage Publications.

- Maibach, E. and Parrott, R. L. (Eds.) 1995. *Designing health messages. Approaches from communication theory and public health practice*. Thousand Oaks: Sage
- Maibach, E.W., Rothschild, M. L. and Novelli, W. D. 2002. Social marketing. In: Glanz, Rimer, and Lewis (Eds.) 2002: 437- 461.
- Masuku, T. 2001. Voluntary Counselling and Testing strategy. Paper delivered at the AIDS Forum, University of Pretoria, 2001-10-26.
- McQuire, W. J. 1994. Using mass media communications to enhance public health. In: Sechresi et. al. (Eds.) 1994: 125-152.
- McQuire, W. J. 2001. Input and output variables currently promising for constructing persuasive communications. In: Rice and Atkin (Eds.) 2001: 22- 48.
- Miller, C.T. 2001. A theoretical perspective on coping with stigma. *Journal of Social Issues*, (2001). Available: <<http://www.findarticles.com>>.
- National Cancer Institute. 2002. Making health communication programs work. A planners guide. Available: <<http://oc.nci.nih.gov/services/HCPW/HOME.htm>>.
- Nybalde, L. et. al. 2003. *Disentangling HIV and AIDS stigma in Ethiopia, Tanzania and Zambia*. International Centre for Research on Woman.
- Packenhams, K. I. and Rinaldis, M. 2001. The role of illness, resources, appraisal, and coping strategies in adjustment to HIV/AIDS: The direct and buffering effects. *Journal of Behavioral Medicine*, 24.3: 259-279.
- Parker, W. 1997. Action media: Consultation, collaboration and empowerment in health promotion. *African Media Review*, 11.1: 54-63.
- Parker, W., Dalrymple, L. and Durden, E. 1998. *Communicating beyond Aids awareness. A manual for South Africa*. Available: <<http://www.aidsinfo.co.za>>.
- Perloff, R. M. 2001. *Persuading people to have safer sex. Applications of social science to the AIDS crisis*. Mahwah, New Jersey: Lawrence Erlbaum.
- Perloff, R. M. 2003. *The dynamics of persuasion. Communication and attitudes in the 21st century*. Mahwah, New Jersey: Lawrence Erlbaum.
- Pettifor, A. E., Rees, H. V., Steffenson, A., Hlongwa-Madikizela, L., MacPhail, C., Vermaak, K., Kleinschmidt, I. 2004. *HIV and sexual behaviour among young South Africans. A national survey of 15-24 year olds*. Available: <<http://www.lovelife.org.za>>
- Qakisa, M.E. 2003. Theories, models and strategies in developing an effective HIV/AIDS campaign in South Africa. *Communicare*, 22.2: 45-64.
- Rice, R. E. and Atkin, C. K. 2001. *Public communication campaigns*. Thousand Oaks: Sage . (Third edition.)
- Rodenburg, C. en De Stadler, L.G. 2003. 'n Teksevalueringskema vir VIGS-tekste. Taalsentrum, Universiteit van Stellenbosch. Available: <<http://www.epidasa.org>>.
- Salis, J. F. and Owen, N. 2002. Ecological models of health behavior. In: Glanz, Rimer, and Lewis (Eds.) 2002: 462-484.
- Sechresi, L., Backer, T. E., Rogers, E. M., Campbell, T. F. and Grady. M. L. (Eds.) 1994. *Effective*

- dissemination of clinical and health information*. Rockville: US Department of Health and Human Services (AHCPR Pub.No.95-0015).
- Scheier, M. F. and Carver, C. S. 1992. Effects of optimism on psychological and physical well-being: Theoretical overview and empirical update. *Cognitive Therapy and Research*, 16.2: 201-228.
- Shisana, O. 2002. *Nelson Mandela/HSRC Study of HIV/AIDS. South African National HIV Prevalence, Behavioural Risks and Mass Media Household Survey 2002*. Available: <<http://www.cadre.org>>.
- Snyder, L. B. 2001. How effective are mediated health campaigns? In: Rice & Atkin (Eds.) 2001: 181-191.
- Snyder, L. B. and Hamilton, M. A. 2002. A meta-analysis of U.S. health campaign effects on behaviour: Emphasize enforcement, exposure and new information, and beware of the secular trend. In: Hornik (Ed.) 2002: 357-384.
- Soul City. 2001. Soul City 4 -Impact evaluation: AIDS. Available: <<http://www.soulcity.org.za>>.
- Soul City. 2002. Soul City 4. Impact evaluation. Aids. October 2000. Available: <<http://www.soulcity.org.za>>.
- Stein, J. 1996. Coping with HIV infection: The theory and the practice. *African Anthropology*, 111.2: 67-83.
- Swanepoel, P. 2003. Die (on)effektiwiteit van MIV/vigs-voorligtingsveldtogte en -voorligtingstekste in Suid-Afrika: normatiewe raamwerke, probleme en riglyne vir oplossings. *Tydskrif vir Nederlands & Afrikaans*, 10.1: 5-51.
- Treatment Action Campaign. Access to treatment could have saved her life. *Mail&Guardian*, 2004-10-29.
- Van Dyk, A. C. and Van Dyk, P. J. 2003. "Whats the point of knowing?". Psychosocial barriers to HIV/AIDS Voluntary Counselling and Testing programmes in South Africa. *South African Journal of Psychology*, 33.2: 118-125.
- Viswanath, K. and Finnegan, J. R. 2002. Reflections on community health campaigns: Secular trends and the capacity to effect change. In: Hornik (Ed.) 2002: 289-313.
- Yun, H., Govender, K., and Mody, B. 2001. Factoring poverty and culture into HIV/AIDS campaigns. *Gazette*, 63.1: 73-95.
- Yzer, M.C. 1999. *Mass media campaigns to promote safe sex: An evaluation of public campaigns in the Netherlands*. PhD Thesis, University of Groningen.