

Message strategies in a corpus Dutch voluntary counselling and testing (VCT) campaign texts

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Abstract

HIV-testing within a VCT protocol plays a pivotal role in the management of HIV/AIDS across the world. However, research indicates that the communication interventions which have to motivate high-risk groups to go for VCT meet with mixed levels of success - some have no effect on rates of HIV-testing, others only a small effect. Very little action-orientated research has been forthcoming to explain why these campaigns have such limited success and what can be done to improve their motivational efficacy.

In this article the focus falls on problems with the design of the messaging of VCT campaign texts as variable that determines their motivational efficacy. In Section 2 a critical analysis is provided of two general approaches to health promotion that critically determine the goals, design, and finally the motivational efficacy of the messaging of such campaigns: the Social Marketing– Persuasion approach, the Critical Empowerment approach, and its off-spin, the Decision Aid approach. Section 3 presents a case study of how the designers of a corpus Dutch VCT campaign texts align themselves with these general approaches, how they interpret the goals of the messaging of their VCT campaign texts and what message strategies they employ in the attempt to motivate high-risk individuals to go for VCT. Section 4 outlines a number of areas for urgent action-orientated research.

KEY WORDS: VOLUNTARY COUNSELLING, HIV-TESTING AND REFERRAL; DESIGN OF HIV-TESTING MESSAGES; FUNCTIONS OF HIV-TESTING TEXTS; SOCIAL MARKETING OF VCT; CRITICAL EMPOWERMENT AND VCT; VCT TEXTS AS DECISION-MAKING AIDS

1 Introduction

People who are unaware that they are infected with HIV and practice unsafe sex are major drivers of new infections. Furthermore, people who are unaware of being infected with HIV very often only test late in the progression of the disease, thereby minimising the chances of effective treatment of the disease. Early detection of HIV-infection by means of an HIV-test within a voluntary counselling and referral (VCT) protocol is therefore seen as a critical intervention in the prevention of HIV/AIDS and the management of the morbidity and mortality associated with the diseases (UNAIDS 2001(a)/(b), World Health Organization 2003).

However, motivating those at high-risk of HIV infection to go for HIV-testing, especially if they are in the asymptomatic stage of the disease, has proven to be no easy task. Although HIV/AIDS is currently considered to be a chronic and manageable disease (for those who have access to ART), the prospect of testing HIV-positive instils in most people high levels of fear because of the life-changing consequences of the disease, a fear which is powered by their beliefs about their inabilities to cope with the wide array of negative consequences still associated with having the disease.

Pro-VCT public campaigns, commonly used across the world to motivate people to go for VCT, have also met with mixed levels of success. Some of them have had no impact on HIV-testing rates, others have had a low, but sometimes significant impact, while others seem to be only effective in convincing the worried well to go for testing (cf., for example; Buskens 2005; Department of Health 2004; Fisher *et al.* 1996; Futtermann *et al.* 2001; Griffith *et al.* 1995; Hirose *et al.* 1998; Ivens and Sabin 2006; Kelly *et al.* 2005; McMahon *et al.* 2004; McOwan *et al.* 2002; Mansson 1990; National Alliance of State and Territorial AIDS Directors 2001; Ross and Scott 1993; Sherr and Hedge 1990; Sherr *et al.* 1999).

However, very little research has been forthcoming to explicate why these communication interventions fail in motivating high-risk individuals and groups to go for VCT or why some of them have at least some success. Most of the evaluation studies listed above, for example, only measure the “dose” effect of the campaign components on HIV-testing behaviour but do not filter out the effects of individual campaign components (cf., however, Kalichman and Coley 1995 and McOwen *et al.* 2002).

Given the pivotal role of VCT in stemming the HIV/AIDS epidemic and the critical role that public campaigns have to play in the process of motivating those at risk to present themselves for VCT, there is an urgent need for action-orientated research to determine why campaigns such as these fail and what can be done to improve their efficacy.

VCT communication interventions can fail for a variety of reasons (cf. Hornik 2002). In this article the focus falls on the design features of the messaging of VCT campaign texts as a variable which determines campaign success/failure. In this regard, action-orientated research is required to determine what communication strategies and message design features campaign designers use in practice to motivate those at risk to go for VCT; how effective these strategies and design features are in achieving the motivational goals of campaign texts; for which high-risk groups these strategies and design features are effective; under what circumstances; and, in the final end, why they are effective (or why not)? As the large and growing body of research on health promotion and persuasion and text-effect studies will no doubt testify, these are complex questions to which often only partial and tentative answers have been forthcoming.

Given these complexities, and the dearth of research to support the design of effective messages for VCT campaign texts, this article has a number of modest goals. The first is to explore how a number of seemingly disparate general approaches to health promotion, viz. the Social Marketing–Persuasion Approach (abbreviated to: *SMPA*) and the Critical Empowerment Approach (abbreviated to: *CEA*), of which the Decision-aid Approach (abbreviated to: *DAA*) is an off-spring, could be having an impact on the design of the messaging of pro-VCT campaign texts and their motivational efficacy. The second is to indicate by way of a case study how message designers in practice use a variety of message

strategies, within the confines of these general approaches, in their attempt to motivate different at-risk groups to present themselves for VCT.

The key legal principles and ethical values which should govern the design of interventions to promote VCT are voluntarism, informed consent/decision-making, respect for the autonomy of potential testees in their decision-making, provision of beneficence/non-maleficence (cf. World Health Organisation 2003: 2). Section 2 therefore focuses on how differences of interpretation of these principles and values determine the informational and persuasive goals of VCT campaign texts, the design of the messaging to achieve these goals, and, ultimately, their potential efficacy.

In Section 3 an analysis is provided of the goals and design features of a corpus of printed and electronic texts (mainly printed brochures) currently used in Dutch VCT campaigns. As a case study, it tries to answer the question of how (Dutch) document designers align themselves with these general approaches to health promotion, how they interpret the goals of VCT campaign texts, and what content they select for the messaging of these texts. As far as could be ascertained, only one of these campaign texts has been evaluated for its impact on the uptake of VCT. Consequently, little can be said about the efficacy of the design features of the texts in the corpus. Given the lack of experimental testing of the motivational efficacy of the message design features of most VCT texts, Section 4 outlines a number of critical areas for future research.

The focus on the design features of a corpus Dutch VCT campaign texts follows from the intercultural perspective of the EPIDASA project (cf.<http://www.epidasa.org>), which aims to improve the efficacy of HIV/AIDS public communication interventions in South Africa. Within this project, the message features of the texts in the Dutch corpus will be compared to a corpus of South African VCT texts, and small-scale empirical testing will be undertaken in future studies to determine the effect of some of the message design strategies in both corpora on the uptake of VCT by South African audiences.

2 Current approaches to health promotion and the promotion of VCT

In the World Health Organization's new strategy to increase the uptake of HIV-testing (cf. World Health Organization 2003) a number of legal and ethical principles are indicated as prerequisites for interventions to promote VCT. Besides the principles of privacy and confidentiality, of critical concern here are the principles that taking an HIV test should always be voluntary and be based on informed consent, i.e. it should be free of any form of coercion, and that the decision whether or not to go for an HIV test must be based on a full understanding of the consequences of going for an HIV-test.

The principle of informed consent/decision-making no doubt defines the generally accepted informational goal of VCT messaging, viz. that it should provide potential testees with all the relevant information (and, where applicable the necessary skills) they need to support their decision-making about going for an HIV-test.

Opinions differ, though, on the interpretation of the principle of voluntarism and consequently on how it would have to be applied to the goals and design of VCT messaging. Two major opposing views are those of the Critical Empowerment Approach (CEA) (cf. Tones and Green 2004) and the Social Marketing Approach (SMA), the dominant approach

in the design of messaging of the VCT campaign texts referred to in Section 1 (cf. Maibach, Rothschild and Novelli 2002).

2.1 The Critical Empowerment Approach

The CEA approach places persuasion very close to brainwashing on a continuum of psychological coercion in which primary socialization defines one end of the continuum and empowerment the other. Explicit attempts of health promoters to persuade those at risk to go for HIV are therefore categorically banned as a strategy as it is considered to be a contravention of the principle of voluntarism and the ethical principle of respect for the autonomy of potential testees in coming to a decision whether to go for an HIV-test. As Tones and Green (2004: 39) note: “The role of critical health education is not primarily that of persuasion (which is both ethically dubious and of limited effectiveness), but empowerment.” The CEA thus propagates that health promoters should create conditions to support or empower individuals to make such choices – a strategy not only applicable to the goals and design of communication interventions (cf. below), but also to the environmental variables that have an impact on people’s decisions whether or not to go for an HIV-test.

The new strategy of the World Health Organization to increase the uptake of HIV-testing (World Health Organization, 2003) is in line with this empowerment philosophy, as captured in the dictum that a supporting/empowering environment should be created to motivate at-risk individuals to make the healthy choice (i.e. going for VCT), the easy choice. As such the strategy outlines all environmental and psychosocial factors which have to be addressed which act as barriers to the uptake of VCT. The strategy is thus based on a broad definition of the concepts of health and of the determinants of human agency that underlie the health-related decision-making process. Health is not only defined in biomedical terms as the absence of disease, but as a state of complete physical, mental and social wellbeing (Tones and Green 2004:14), while the determinants of health-related decision-making are not restricted to the set of individual, psychosocial determinants, but taken to include all environmental determinants as these manifest themselves on different levels: the individual, the interpersonal, the communal, the social and the institutional (cf. Tones and Green 2004).

World Health Organization (2003) does not detail what role communication interventions have to play in implementing this strategy, but the goals, design methodology and design features of such interventions are explicated in a number of publications (cf., for example, Dutta-Bergman 2005; Edwards *et al.* 2001; Morris 2003; and Parker 1997). Critical components of the design of so-called “action media“ are the leading role played by the community in all stages of the development of media products, the prioritization of interpersonal channels of communication, small group communication, the use of culturally sensitive interventions, the raising of critical awareness, and the use of advocacy to redress social and economic injustices.

Standard literature search techniques produced no hits of studies in which the CEA has been used as basis for the design of communication interventions to motivate those at risk to go for VCT and of their behavioural impact. Tones and Green (2004: 38) do, however, make the statement that the empowerment model of health promotion “is not only more likely to achieve positive health outcomes in an ethical fashion, but also be more efficient in attaining the important outcomes associated with the prevention and management of disease and disability” – the main goal of VCT programmes. Such a statement, is, however, not unequivocally borne out by evaluation studies of other CE interventions (cf. Campbell,

Williams and Gilgen 2002 and Morris 2003 for an in-depth discussion). As noted in the case of VCT public campaigns, CE interventions thus also meet with mixed levels of success.

2.1.1 The Decision Aid approach

Although the CEA would propagate an informational goal as the major goal of the messaging of VCT texts, it does not provide any detailed guidance on how this goal should inform the design of VCT messaging, nor does it provide criteria for the evaluation of whether not VCT messages attain these goals. World Health organization (2003: 2) merely states that the following elements have to be in place to ensure that potential testees can make a fully informed decision on HIV-testing *in the light of their own circumstances and values*:

- Providing pre-test information on the purpose of testing, and on the treatment and support available, once the result is known
- Ensuring understanding
- Respecting the individuals autonomy

These issues are, however, addressed in more detail in current research and design practices of communication interventions to support decision-making in medical contexts.

The principles of informed consent and voluntarism are taken as point of departure for the design and evaluation of decision aids. O'Connor, Graham and Visser (2005) define these Patient Decision Aids (PtDAs) as follows:

PtDAs are standardized, evidence-based tools intended to facilitate the process of arriving at an informed, values-based choice among two or more health care alternatives (which may include “watchful waiting”). They are designed to supplement rather than replace patient-practitioner interaction. PtDAs help patients to personalize information on options and outcomes, understand that they can participate in decision making, appreciate the scientific uncertainties inherent in that choice, clarify the personal value or desirability of potential benefits relative to potential harms, communicate their values to their practitioners, and gain skills in the steps of shared decision making.

Within the DAA the major goal of VCT-texts would be to provide potential testees with good quality (accurate and detailed) information on treatment choices, based on the best and most up-to-date scientific evidence; to cover all aspects of treatment choice, including outcomes and uncertainties; to help people understand HIV/AIDS as illness; and what to expect if certain choices with regard to HIV-testing and treatment are made (cf. also Ivens and Sabin 2006 and Sherr and Hedge 1990).

A number of instruments for the design and evaluation of decision aids have been developed (cf. the CREDIBLE-instrument (O'Connor, Llewellyn-Thomas and Flood 2004) and the Health Information Quality Assessment Tool (available at <hitiweb.mitretek.org/iq>). Of these, the DISCERN instrument is the most extensive (cf. www.discrim.org.uk). The design and evaluation criteria/principles of these instruments could be taken as indicative of the content categories that have to be included in the messaging of VCT texts to assist potential testees in their decision making. According to the DISCERN instrument the VCT messaging would have to include the following:

- (1) Information on the source of the VCT messaging, the source's credibility (expertise, trustworthiness) and information which could indicate a potential for bias (e.g. co-operation of the source with specific medical companies and possibly collaboration in promoting specific treatment; using emotional language or fear tactics)
- (2) An unambiguous identification of the topic, goal and audience of the messaging
- (3) Information on the scientific accuracy of the information on VCT or other measures (ART, counseling, positive living, etc.) to cope with the negative consequences of HIV/AIDS (i.e. information on the resources consulted for major claims/evidence) and its recency (publication dates and dates of revisions)
- (4) Information on proposed measures of action (e.g., VCT, antiretroviral therapy, anti-discriminatory laws, positive living, etc.) to cope with the negative consequences of HIV/AIDS (i.e. a description of how the treatment/action/measure works/what it entails; its benefits/advantages, response efficacy disadvantages, costs, risks and areas of uncertainty; its effects on overall quality of life)
- (5) Information on what would happen if HIV-infection is not treated (negative consequences of not going for VCT or loss-framing)
- (6) Alternative "treatments" (therapies or actions/measures) to cope with the negative consequences of HIV-infection, with an indication of how the treatment/action/measure works/what it entails; its benefits/advantages, response efficacy disadvantages, costs, risks and areas of uncertainty; its effects on overall quality of life
- (7) Support for the decision making process (i.e. listing additional sources of information on HIV/AIDS, VCT, ART, etc.; indicating whom to contact to assist in the decision-making process on going for VCT (experts, informal support network, etc.); and indicating how to go about deciding on a course of action; for example, what variables to take into account in the decision-making process)

Given that the goal of decision aids is to support people in the decision making process, they are evaluated primarily in terms of their impact on indicators of decision quality (and not primarily on the outcomes of the decision making process). These include increases in knowledge; improvement in the realistic perception of the chances of benefits and harms; degree of decisional conflict (psychological uncertainty related to feeling uninformed); participation in the decision-making process; number of people who remain undecided after counselling; agreement between a client's values and the option chosen; patient satisfaction and degree of anxiety generated. With regard to all these criteria, a number of decision aids have proven efficacy (cf. O'Connor, Llewellyn-Thomas and Flood 2004:65). If seen as decision aids, VCT messages would therefore be deemed to be highly successful even if potential testees decide not to go for an HIV-test (at a specific point in time).

2.2 The Social Marketing – Persuasive approach

One of the major motivations for the use of the SMA in health promotion is the fact that providing people with relevant information on health related issues is often not enough to motivate them to effect beneficial health-related behaviour changes. As Maibach, Rothschild and Novelli (2002:441) explain, information provision to effect behaviour changes is in fact only sufficient "when the benefits of the recommended behaviour are sufficiently attractive, when the barriers to performance are sufficiently minor, or when the alternative behaviors offer relatively less attractive benefits". As already noted in Section 1, however, the fears people have about testing HIV positive, the life-changing consequences of a positive test and

the barriers they face in coping with such consequences, would predict that information provision about VCT/the HIV-test could at most be a necessary intervention but not a sufficient one to increase the uptake of VCT. Secondly, research indicates also suggest that the over-provision of information may in fact make target audiences of interventions wary of propagated behaviours (cf. Edwards *et al.* 2001).

The SMPA also highlights the problems inherent in defining persuasion as coercion. In this model, persuasion would be defined in accordance with a definition such as that of O'Keefe (1990:17), which underlines the fact that persuasion is only possible in a situation where the recipient of such interventions have *the option of complying or not complying to the propagated health behavior* (cf. Hoeken 1998:13- 16, but also Tones and Green 2004: 25-26 for alternative views on the coerciveness of persuasion).

In this framework persuasion is therefore seen as a legitimate goal of health promotion interventions, not only on the basis of how persuasion is defined, but also on the basis of the clear advantages of the clinical management of HIV above the alternative of no treatment (i.e. an untimely and painful death). The beneficence offered by available antiretroviral therapies, as well as the instrumental concern for the infection of others, thus provide further support for communication interventions which have as explicit goal to persuade those at risk of HIV-infection to get tested early.

Besides the ambiguity in the interpretation of the coerciveness of persuasion, the distinction between providing people with the necessary information to make an informed decision and providing them with information to tip the scales in favour of the propagated behaviour is also not that clear cut. This is obvious from the DISCERN criteria discussed in Section 2.1.1 for the *unbiased* provision of information, but which overlap to a large extent to some of the strategies used to persuade people to go for VCT: designing/using a credible source for the information; loss-framing, i.e. spelling out the negative consequences of not going for VCT, presenting scientific evidence to bolster the probability that indicated advantages will materialise if one goes for VCT, or using scientific evidence to mitigate the seriousness of negative consequences, or of the probability that potential testees will be susceptible to them (cf. also the discussion in Hoeken 1998: 14-17). As Edwards *et al.* (2001) seem to imply, ethical problems only arise when different ways of framing information have differential impacts on the determinants of a behaviour and if health promoters then select the options with proven persuasive effects. As their meta-analysis of such framing strategies indicates, however, few of them have received empirical support as to their persuasive effects.

One of the major challenges to any communication intervention with a persuasive goal is that once the receivers of such messages detect the source's persuasive intent, it may well lead to increased processing of the message, but also elicit reactance and counter argumentation (cf. Dilliard and Shen 2005). Strategies to hide such intentions are, of course, routinely used by message designers.

In the practice of health promotion, SMPA is widely used in the design of communication interventions aiming to effect health-related behaviour change, including pro-VCT communication interventions. Most of these interventions involve mass-mediated public campaigns that target the determinants of HIV-testing behaviour on the individual level, using individual-level theories of behaviour and behaviour change and some concepts from interpersonal and social theories.

The SMPA has a well-established methodology for the strategic design of such persuasive communication interventions and relies for the use of persuasive methods and strategies on persuasion theory and current empirical research on text-effects (cf. Maibach, Rothschild and Novelli 2002). Best practices in designing health messages (cf. Bartholomew *et al.* 2001; Capella, Yzer and Fishbein 2003; Fishbein 2000; Fishbein, Von Haften and Appleyard 2001; Fishbein and Yzer 2003) would advocate that to increase the persuasive effect of HIV-testing messages, campaign designers should, first of all, do the necessary theory-based empirical qualitative and quantitative formative research on the salient modal beliefs of the various high risk groups about HIV-testing. This research should then be the basis for deciding what groups to target, which new beliefs about HIV-testing and ART should be introduced, which facilitating beliefs should be strengthened/primed, and which of these should be corrected or changed in the VCT messaging, using persuasion theory and research on text-effect studies as guiding principles.

The individual-level theories most often used for this purpose are, on the one hand, the category of threat-and-coping (process) models, specifically the Health Belief Model, Protection Motivation Theory and Witte's Extended Parallel Process Model (cf. Witte, Meyer and Martell 2001), and, on the other hand, The Theory of Planned Behavior (cf. Fishbein and Yzer 2003) (and its predecessor, the Theory of Reasoned Action) (cf. also Buskens 2005). Although these theories differ in what they would predict to be the proximal determinants of the intention to go for an HIV-test (cf. Fishbein 2003), together they provide a number of determinants (and their antecedent beliefs) which will have to be accounted for in the messaging of VCT texts if one wants target groups to form a strong intention to go for HIV-testing. These are also supported by the bottom-up factor analysis provided by Awad *et al.* (2004) of the major barrier determinants to HIV-testing.

The first of these is (low) risk perception, which is an outcome of peoples' subjective assessment of their chances of having contracted HIV or not. The latter, together with their knowledge of the severity of the consequences of testing HIV-positive, forms their personal beliefs about the threat posed by HIV/AIDS. The second set of major determinants loads onto potential testees' subjective beliefs about whether or not they will be able to cope with the negative consequences should they test HIV-positive. Such assessments are the product of a number of beliefs: whether or not there are affective measures available to address the negative consequences of testing HIV-positive (response-efficacy) and whether or not one will be able to implement such measures (self-efficacy). The latter itself is a complex variable, and outcome beliefs may be determined by such factors as whether one indeed has or will acquire access to the means/resources (personal and social capital) required or whether one sees the use of such measures as feasible, etc.

As predicted by the theoretical models discussed above, peoples intention to go for VCT is also motivated by their attitudes towards VCT, which is itself a consequence of their beliefs about the positive consequences (advantages, benefits, response efficacy, minus the costs) of going for an HIV-test, minus the negative consequences (disadvantages, barriers) of doing so.

Research indicates that people have a much larger set of concerns about the consequences of testing HIV-positive than merely the clinical management of the illness. These in turn demand a much wider range of measures to avert, avoid, or minimize them. Besides the physical consequences (coping with opportunistic infections, a weakened immune system, pain and suffering and eventually death); there are also the mental consequences (coping with a positive test result, shame and self-blame, uncertainty and fear of disclosing one's positive

status, depression, and eventually dementia), the social consequences (rejection by sex partners, family, friends, the community, being stigmatized and discriminated against, accepting the sick role, not being able to fulfill one's social roles), and the economic consequences (not being able to pay for health care, support oneself and family, being denied insurance or loans, etc).

Different measures are required to avert or minimize the broad set of negative threats they pose, and each of these may have their advantages, different degrees of response efficacy, disadvantages, costs, risks and uncertainties in respect of their efficacy (as suggested by the decision aid approach; cf. the discussion above). For example, the clinical management of HIV requires access to adequate health care services and ART, but ART is still no cure for HIV/AIDS. There is also some uncertainty as to its efficacy (e.g. ART is not hundred percent effective in averting mother-to-child-transmission), and there is still little research available on the long-term efficacy of ART to suppress HI-viral replication. Coping with stigma and discrimination requires not only legal interventions, but also mastery of a number of emotional, cognitive and behavioral coping skills. Likewise, the counseling component of VCT could help one cope with the emotional turmoil of getting an HIV-positive test result, but it cannot (and is not meant to) help one cope with the long-term negative psychological consequences of testing HIV-positive. For this, one needs access to long-term counseling support.

In deciding whether or not to go for HIV-testing people may prioritize one or more of these consequences (and at different times). As argued by Alonzo and Reynolds (1995), the physical consequences and the potential for their treatment may be the least of potential testees' concerns when considering going for an HIV-test. For example, the threats posed by a positive HIV-test to one's self-esteem and to one's social well-being (acceptance by one's partner, family or friends) may well override one's concerns about the clinical management of the disease. On the other hand, the clinical management of HIV may be prioritized above other concerns if one is already in the symptomatic stage.

A variable predicted by the Theory of Planned Behaviour to have an impact on people's intention to go for VCT is social and personal norms. However, the impact of this determinant has not been researched with regard to VCT uptake in any depth (cf. the discussion in Section 3).

Despite some commonalities in the determinants of the uptake of HIV-testing by various risk groups, the Theory of Planned Behavior predicts that there could also be variance across high-risk groups with regard to which of these determinants dominate the intention to go for VCT and in the specific salient beliefs that act as antecedents of these determinants. Such differences may therefore require different kinds of communication interventions to persuade people across the different target groups to go for HIV-testing.

Awad *et al.*'s (2004) measure of barriers to HIV-testing and the Theory of Planned Behavior predicts that even if people have formed a strong intention to go for VCT a number of environmental barriers (access to VCT sites, transport, costs, beliefs about stigmatizing attitudes of counselors and staff at sites) or personal performance skills (e.g. making an appointment, coping with the client-provider dynamics in the VCT process; keeping control of the decision-making process) may impede going for VCT.

Persuasion theories and text-effect research (cf., for example, Hoeken 1998; Maibach and

Parrott 1995; McQuire 2001; Perloff 2003; Rice and Atkin 2001; Rodenburg and De Stadler 2003; Salmon and Atkin 2003; Witte, Meyer and Martell 2001) suggest a number of theory-based methods and strategies that campaign designers could utilise in strengthening the beliefs that facilitate the uptake of VCT and to change the barrier beliefs to HIV-testing of their target audiences. The choice of these strategies will be discussed in more detail in Section 3. As propagated by most normative design models (e.g. Bartholomew *et al.* 2001), formative evaluation of the efficacy of chosen message strategies in influencing the beliefs that underlie people's intentions to go for VCT, should be a critical step in the whole design process.

The SMPA has come under heavy criticism, mainly from the quarters of proponents of the CEA (cf., for example, Dutta-Bergman 2005, Kelly and Parker 2001, Martins 2005, Tones and Green 2004). For the evaluation of the corpus Dutch VCT texts in Section 3, the following aspects of the SMPA are of importance: its use of persuasion as method to effect behaviour change; its narrow conception of the determinants of health behaviours as evidenced by its almost exclusive focus on individual-level and on the cognitive determinants of health behaviours; its narrow definition of health as evidenced by its strong focus on the biomedical aspects of health and on measures to cope with disease; its heavy reliance on mass-mediated communication interventions to effect behaviour change despite the fact that they have been shown to have at most small and short-term effects on health behaviours when strategically planned; and, the top-down approach to health promotion.

2.3 Convergence and synergy in approaches to health promotion

As Morris (2003) indicates, it is in principle difficult to argue for the prioritization of any of these models to health promotion on the basis of clear cut evidence of their efficacy in effecting health-related behaviour change. Comparisons are also difficult because they differ with regard to their goals, concepts of health, health behaviour and health behaviour change. On the other hand, they address different aspects of the holistic approach required to effect health-related behaviour change and therefore present mutually supporting approaches – an approach already strategized in, for example, the Intervention Mapping Protocol propagated in Bartholomew *et al.* 2001). In practice, many health promoters therefore combine elements (methods, theories, etc.) from these approaches in the design of interventions (cf. Morris 2003).

The emerging consensus would suggest that to be effective in increasing the uptake of VCT in any population would require the following: (i) different kinds of interventions (e.g. policy, infrastructure, provisions, advocacy and communication interventions) that address both personal and contextual determinants of the uptake of VCT on various levels (the individual, interpersonal, communal, social and institutional); (ii) individual-level interventions that do not only focus on the cognitive aspects of the uptake of VCT, but also the affective determinants; and, (iii) messages to motivate people to go for VCT which utilise not only different formats (advertisements, factual brochures, soap operas, folk songs, etc.), but also mutually supporting channels (mediated and interpersonal communication) and media (mass, small, folk media, etc.). Research clearly indicates all communication intervention formats, channels and media have both advantages and disadvantages (cf., for example, Bartholomew *et al.* 2001: 237-244) and thus that optimal effect can possibly achieved by using them in a mutually supporting way. The main challenge remains though, viz. to optimize the efficacy of each of them.

Taking the advantages and disadvantages of the various approaches to health promotion as an analytic and evaluation framework, Section 3 provides a description of the design trends of the messaging of a corpus VCT campaign texts.

3 Message design trends in a corpus Dutch pro-VCT campaign texts

Until 1999 HIV-testing was not actively promoted in the Netherlands because there were little clinical benefits to knowing one's status, but a number of psycho-social disadvantages should one test HIV-positive. This policy changed after 1999, the major impetus being (1) the positive impact of antiretroviral therapy (ART) in lowering mother-to-child-transmission of HIV (MTCT) and in decreasing morbidity and mortality for those infected with HIV, and (2) the rise in sexually transmitted diseases, the latter indicating high-risk sexual activity and increased danger of HIV-infection.

The new policy is encoded in the programmatic, advisory document *Actief testen! Een programmatische aanpak voor actiever testen en counselen op hiv en andere soa in Nederland* ('Active testing. A programmatic approach for more active testing and counseling on HIV and other STD's in the Netherlands') (Stichting soa-bestrijding *et al.* 2002) (also referred to as the *Active Testing policy*). The policy was the outcome of the cooperation between the specialist national organizations active in the HIV/AIDS field in the Netherlands. It outlines the major motivation for the new active testing policy, provides comprehensive guidance on the changes and improvements needed on the level of policies, infrastructure and provisions to enact the new policy, and gives programmatic advice on the design of the communication interventions that will be needed during the period 2002-2005 to increase the uptake of HIV- and STD-testing.

The Active Testing document (Stichting soa-bestrijding *et al.* 2002:8) was used to identify the organizations responsible for designing the VCT communication interventions for the different high-risk target groups in the Netherlands and to compile the web-based and print texts used by these organisations to promote VCT (cf. Table 1).

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| <p>1. Stichting soa-bestrijding (www.soa.nl) (General public) D1.1 Seksueel Overdraagbare Aandoeningen. Voorkomen-Testen-Behandelen. 2005. (Printed brochure) D1.2 Testen op HIV. Informatie voor zwangere vrouwen. 2004. 5de druk December 2003. (Printed brochure) D.1.3 De harde feiten volgens dokter Fritz.(Adolescents) (www.safesex.nl) (www) 2. Stichting Aids Fonds (www.aidsfonds.nl) (General public) D2.1 Alles over AIDS. Antwoorden op de meest gestelde vragen. Gewijzigde herdruk, September 2000. (Printed brochure) D2.2: Voorkom Aids. Doen een Hiv-test. Gewijzigde herdruk augustus 2002. (Printed brochure) 3. Hiv Vereniging Nederland (www.hivnet.org) (General public/People living with HIV and AIDS) D3.1: Wat is de hiv-test? 09./15-2005 (WWW) D3.2: Leven met hiv. 09/15/2005. (WWW) D3.3 Medische informatie over hiv. 09/15/2005 (WWW) D3.4. Jou leven met hiv. Derde druk juni 2005.(WWW) 4. Schorer Stichting (www.schorer.nl) (Gay and Lesbian) D4.1: Steeds meer mannen weten het. (2003). (Printed brochure) D4.2: Zeker weten. October/November 2005 (Printed brochure) 5. Mainline (www.mainline.nl) (drug users) D5.1 HIV en AIDS (WWW) D5.2 Check it 1: Druggebruikers & de hiv-test. Alles wat je moet weten voordat je een hiv-test laat doen. (Printed brochure) D5.3 Check it (2): Druggebruikers & de hiv-test. Alles wat je moet weten na de hiv-test.(Printed brochure) D5.4 Check it (3):Druggebruikers & de hiv-test. Aandachtspunten voor gesprekken met druggebruikers voor en na de hiv-test (Printed brochure) 6 Indeprostitutie.nl (www.indeprostitutie.nl) (Sex workers) D7.1De hiv-test (WWW) 9 Afapac (Immigrants (“allochtone”))/ 10.Asylum seekers Projectgroep Publiekscampagne AIDS/SOA/SOA Stichting Informatie over AIDS (Printed brochure)</p> |
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Table 1: The corpus Dutch VCT campaign texts

The approach to the promotion of VCT advocated in the Active Testing policy document, adheres completely to the Social Marketing - Persuasion Approach. Voluntary testing based on informed consent is taken as basic principles for the promotion of VCT ((Stichting soa-bestrijding *et al.* 2002:16; Health Council of the Netherlands 1999), but at the same time the major persuasive goals of such communication interventions are clearly stated, viz. “To reach the most important target groups and *to persuade them* with the message that knowledge of one’s serostatus/infection is to one’s own benefit and to stimulate, inform and facilitate the target group to go for testing” (Stichting soa-bestrijding *et al.* 2002:11; my emphasis – PHS). The major motivation for the promotion of VCT is clearly risk driven (increase in STD’s) and the approach to the health problem and its mitigation is driven by the medical model: the major argument presented in the policy document to motivate people to go for VCT is the treatment possibilities offered by antiretroviral therapy. Likewise, the methodology proposed for the design of the communication interventions adheres to the social marketing guidelines presented in Section 2.2 (cf. Stichting soa-bestrijding *et al.* 2002: 11-12).

Precisely how each specialist organisation went about designing their brochures, could not be conducted, mainly due to the fact that the relevant information could not be elicited from the specialist organisations. The trends in the messaging of the corpus, however, clearly indicate that the document designers themselves approached the design process from a variety of approaches (cf. the discussion below).

3.1 General design trends

The 17 VCT-texts included in the corpus for analysis differ enormously with regard to their format (A4, A3, pocket size), the length of text they contain and, consequently, in the number of topics on VCT addressed and the depth of their treatment. However, based on their content, the texts in the corpus can be divided into three distinct categories.

The first comprises texts which focus mainly on VCT/HIV-testing (most of the texts in the corpus). The second category comprises “omnibus” texts in which VCT is discussed in tandem with HIV/AIDS prevention and available care and support services for people living with HIV and AIDS (cf., for example, “Alles over Aids” /“Everything about AIDS” of the AIDS Fonds; and the various HIV/AIDS-related texts on the website of the Hiv Vereniging).

In the third category, exemplified by the brochures “Seksueel Overdraagbare Aandoeningen. Voorkomen-Testen-Behandelen”/“STD’s. Prevention-Testing-Treatment” and “De harde feiten volgens dokter Fritz”/“The hard facts according to Doctor Fritz”, the focus falls mainly on STD’s. The major goal of these brochures are informational in nature and aim at providing those with an STD and those at risk of acquiring one with the basic facts about HIV as a STD and to get them to test as early as possible. As in the treatment of other STD’s, these two brochures provide their readers with short notes on what HIV is, how HIV is transmitted, how HIV-infection can be avoided, the HIV-test, and available treatment. These texts are, on the one hand, an attempt at “normalising” HIV/AIDS by treating it as an STD. On the other hand, the goal is to bring the message home that the presence of an STD increases one’s risk of HIV infection with unprotected anal or vaginal sex., thereby providing a supporting argument to motivate those that present themselves at STD clinics to also have them tested for HIV (cf. Stichting soa-bestrijding *et al.* 2002: 6-7, 9-10).

As far as could be determined, these two brochures have not been evaluated as to whether or not they lead to increases in knowledge of HIV as a viral STD and to what effect they may have on the determinants of the uptake of VCT (cf., however, Fichtner *et al.* 1996).

The VCT texts in the first and second category all aim at behaviour change at the individual level. A coding scheme was developed for the content analysis of these brochures based on the criteria for decision aids (cf. Section 2.1.1), the theory-driven analyses of the determinants of the uptake of VCT within the SMPA (cf. Section 2.2), and recent research on the persuasive strategies to address these determinants as outlined in Bartholomew *et al.* (2001) and Rodenburg and De Stadler (2003). A number of additional categories were added to the list of content categories after a pilot analysis of the content of the messaging of the texts in the corpus. The main goal of the analysis was to determine (i) what topics the document designers found necessary to include in the messaging of the brochures and (ii) what persuasive strategies are employed to get their messages across.

3.1.1 Macro content design

Across the texts in the corpus, and in line with the requirements of the decision aid approach, basic information (albeit with differences in the depth of treatment) is provided to readers that relate to the following theory-determined motivational determinants of the intention to go for VCT (cf. Section 2.2): the severity of HIV/AIDS (the biomedical and the psycho-social consequences of HIV-infection); risk/susceptibility to HIV; the HIV test and the VCT protocol (what they are, how they work/what they entail, and their response-efficacy); the advantages (and costs), disadvantages of HIV-testing; antiretroviral/combination therapy

(what it is, how it works, its (dis)advantages, costs (side-effects), efficacy in reducing viral load and increasing T-cells, limitations on efficacy, and uncertainties (about long-term effects).

Besides the HIV-test and antiretroviral therapy as measures to cope with the biomedical consequences of HIV, the fear of stigma and discrimination are also addressed. A number of the brochures assure the reader of the fact that their right to privacy and the confidentiality of test results will be upheld, they are informed of the possibility of anonymous testing, and of the fact that the disclosure of one's serostatus is the sole prerogative of the testee. Special conditions when testing can be requested or is compulsory are also discussed in some brochures, sometimes in the context of the disadvantages of testing. For example, it is stressed that employers cannot request information on one's HIV-status, but that it could be requested when applying for assurance or a home loan, and what the consequences of one's HIV-status may be in such cases.

Information on the consequences of not going for an HIV-test if one is in fact infected, or of the consequences if HIV-infection is not treated (loss framing) is only addressed directly in the brochure "Steeds meer mannen weten het"/"More and more men know it"; In all the other brochures it is left to the reader to make the necessary inferences from the information provided on the biomedical aspects of HIV and AIDS.

In line with the requirement of the decision aid approach, potential testees are assisted in the decision-making process itself. Target audiences are constantly referred to additional sources of information on HIV/AIDS, VCT, ART, etc. Furthermore it is often indicated whom to contact to assist in the decision-making process (experts, informal support network, etc.) and how to go about deciding on a course of action; for example, what variables should be taken into account in the decision-making process (e.g., advantages and disadvantages; personal values and circumstances).

In all brochures the motivational information is followed by information to assist the reader in implementing the decision to go for an HIV-test: whom to consult if one has not yet come to a decision, but if one has, where and when to go for the HIV-test, what the costs are, and the contact numbers of various organizations active in the HIV/AIDS field.

Information about the source of the message, date of publication and revisions, as well as information about the copy writers and layout and graphic artists involved in the production of the brochure are provided in brochures in the colophon. None of the brochures, however, list any scientific publications as sources of the information provided in the brochures themselves.

None of the brochures provide information to boost potential testees' self-efficacy appraisals. Role modeling and persuasion are commonly used techniques to bolster self-efficacy (cf. Hoeken and Geurts 2003), but none of these are used in these brochures. Detailed information on how to cope with the full range of negative consequences of HIV/AIDS and role model presentations of how people with HIV/AIDS in fact cope or do not cope are only provided either in omnibus texts or in separate publications, but then aimed exclusively at those already diagnosed with the illness, not potential testees.

With the exception of the brochure "Steeds meer mannen weten het", no information is provided on descriptive norms with regard to HIV-testing, i.e. how many of a specific target

group have in fact gone for a test.

3.1.2 Presentation, framing and persuasive strategies

In this section more detail is provided on how message designers of the texts in the corpus present and frame the content of the thematic categories discussed in Section 3.1.1 and some of the persuasive strategies used.

Risk assessment

In line with the threat-and-coping models of the uptake of VCT, assessing one's risk of having contracted HIV is taken in all the brochures to be a necessary first step in deciding whether or not one should present yourself for VCT (cf. Gerrard *et al.* 1993). Based on research on risk assessments, Janz, Champion and Strecher (2002) suggest that to counter the biases that operate in risk assessments, intervention designers should clearly define the population at risk and their risk levels, personalize the risk of the target audience on the basis of their characteristics and unsafe sex behaviors, and by presenting their susceptibility in a way that is consistent with their actual risk, and as being undeniable. Risk should also be presented with qualitative and quantitative examples.

In the Dutch corpus risk assessment is usually introduced by the question 'Who should go for an HIV-test?'/'When should you go for an HIV-test?', or in the commonly used personalized variant 'Should I go for an HIV-test?'. The major approach to risk assessment is to provide potential testees with a list of high-risk factors (e.g. unsafe vaginal and anal sex or contact with body fluids of someone infected with HIV) against which they should determine their absolute risk. Potential testees are then advised to go for a test if their own sexual practices concur with any one or more in the provided list (cf. "Alles over AIDS. Antwoorden op de meest gestelde vragen" / "Everything about AIDS. Answers to the most frequent questions") and "Voorkom Aids. Doen een Hiv-test"/"Avoid AIDS. Do an HIV-test"). Given the prevention goals of VCT programmes, testing before having unprotected sex with a steady partner is advised.

A number of other, innovative approaches to risk assessment are used in the Dutch brochures, each of which might have the effect of forcing the reader to consider each of the risk factors and evaluate his/her own sexual behavior in the light of it. In *Check it (1)* a flow diagram is used in which the potential testee has to answer a yes or no to each of the risk factors, and, based on the answer, advice is provided as to whether or not one should go for a test. In the brochure of the Stichting soabestrijding "Seksueel Overdraagbare Aandoeningen. Voorkomen-Testen-Behandelen"/"STD's. Prevention. Testing. Treatment." a table is provided at the end of the brochure which lists all risk behaviors and then in different columns how (un)safe they are for contracting an STD, HIV or an unwanted pregnancy. An online personal risk assessment questionnaire is available on the web site at Stichting soabestrijding, which provides personal feedback on one's risk of having contracted HIV, given the personal data one has provided. Direct confrontation with the unsafety of recent or past sexual practices is used in the two brochures of the Schorer Foundation.

Group-specific risk factors are placed in focus in a number of the brochures. In the Schorer Foundation's brochure 'More and more men know it' the fact is stressed that most cases of HIV-infection occur within partnerships, thereby countering the belief that being in a relationship protects one from being infected. The problem of condoms that perish during sex

(the phenomenon of the ‘klapkondoom’) is given attention on the web site for sex workers (cf. *Indeprostitutie.nl*). Interchanging drug works (injection needles) and having sex while under the influence of drugs is addressed in *Check it (1)*.

The dangers of HIV-transmission from mother to child for pregnant women is discussed at some length in the brochures aimed either at them exclusively or in those aimed at the general population, although neither of them explicates in detail how such transmission could take place during pregnancy, delivery and breast feeding.

As Weinhardt (2002) and Weinstein and Klein (1995) indicate, changing people’s perception of their risk of HIV/AIDS is complicated and few laboratory interventions have a success record. No research has been forthcoming on precisely how successful current risk-messaging in VCT interventions in fact are in assisting people in making such risk assessments.

Attitudes

As predicted by the behavioural theories discussed in Section 2.2, one’s positive or negative attitude towards HIV-testing plays a critical role in the decision whether or not to go for VCT. A general strategy in influencing peoples attitudes towards HIV-testing is to use pragmatic argumentation (i.e. HIV testing leads to X; X is good/bad; Conclusion: HIV testing is good/bad) to influence their beliefs about the positive and negative outcomes of going for an HIV-test.

A distinct feature of these brochures is (i) the use of a set of standardized arguments to support attitude change and (ii) the trend to mask such arguments as informational propositions.

With regard to HIV testing, arguments are provided to support the advantages of knowing one’s HIV status, irrespective of whether or not the test result is negative or positive. If the test is negative, it is argued (i) that it gives on certainty of one’s status (*the testing-and-certainty argument*); (ii) that it provides psychological relief; and, (iii) that it allows one to take control of one’s health (*the knowledge-and-control argument*) by (iv) preventing HIV-infection (*the testing-prevention argument*). . If the test result is positive, it is argued, that (i) it might also provide psychological relief; (ii) that it allows one to take control of your health, (iii) by accessing the available treatment (*the testing-treatment argument*) (iv) to prevent infecting others and getting reinfected one self; and, (v) to plan for one’s future (*the testing-planning argument*), which may involve both aspects of prevention and treatment.

Although the probability and desirability of the claims made about HIV-testing could be strengthened by different kinds of evidence, i.e. causal (prospective), expert, statistics or examples/exemplars (cf. Hornikx 2005), hardly any such evidence is used. At most one finds vague references to the advice of doctors or some source of expertise (cf. for example, ‘Check it (1)’). Either the source therefore expects potential testees to believe these claims on the basis of the credibility of the source, or trust in the source’s expertise, or its major commitment of protecting the well-being of the potential testees.

The second major feature is the fact that the arguments above are framed/masked as factual statements: only the major claims are presented and the desirability of the positive outcomes and conclusions as to the advantages of HIV-testing are left to the reader to make (cf. also Schellens and De Jong 2004 on this strategy).

The most extended argument to support the advantage of ART (combination therapy) is provided in the brochure ‘‘More and more men know it’’ of the Schorer Foundation. The outright persuasive goal of the brochure is stated up front by the message designers, but in line with the decision-aid requirement that all disadvantages of a medical option must also be provided, the disadvantages and costs of ART are systematically discussed. The major topics addressed are the following:

Combination therapy ((HA)ART)

- 1 What is it?
- 2 How does it work?
- 3 Efficacy/Consequences/Advantages:
 - 3.1 Improvement of quality of life
 - 3.2 Increase in life expectancy
 - 3.3 Decrease in opportunistic infections
 - 3.4 Restore normal role functioning (work)
 - 3.5 Psychological benefits
- 4 Response-efficacy (effective for whom, when and when not; range, modality and rebuttal)
 - 4.1 No cure
 - 4.2 ART resistance
 - 4.3 Restrictions in PMTCT
- 5 Conditions/Costs/disadvantages:
 - 5.1 Life-time adherence
 - 5.2 Strict regimen
 - 5.3 Confidentiality and public intake of ART
 - 5.4 Side-effects
 - 5.5 Long-term consequences
 - 5.6 Uncertainty of long-term effects
 - 5.6 Uncertainty of interaction effects (other medication/drugs/alternative therapies)
 - 5.7 Social/medical pressure to take ART
 - 5.8 Reminder of illness
- 6 Coping with disadvantages/risks/uncertainty

All these topics could be structured logically in the extended Toulmin argumentation form, but once again the impact of this form of argumentation on attitudes have not been tested extensively (cf. Areni 2002; Berney-Reddish and Areni 2005; and Reinard 1984).

A variety of methods are used to explicate the disadvantages of HIV-testing. The first is simply to list all the negative, but mostly psycho-social, consequences under a heading such as ‘‘disadvantages of HIV testing’’. Given that potential testees might prioritize the psychosocial outcomes in their decision-making, one could expect that such an approach may lead to a rejection of the persuasive message. In such cases the list of disadvantages may merely confirm potential testees’ major fears of the consequences of a positive HIV-test.

A second strategy is to either weaken the negative consequences themselves, or to weaken potential testee’s perception of their susceptibility to such negative consequences (e.g. that one’s chances of being rejected by one’s friends is small). A common strategy also used is to hedge statements with modals about potentials testees’ susceptibility to aversive consequences or their severity (cf., however, Berney-

Reddish and Areni 2005 on the potential negative effects of such edges or pledges). Framing disadvantages in conditional terms may be seen as an attempt to manipulate potential testees beliefs that they in fact may not materialize, but that if they do, they may not be so severe.

A third strategy is simply to omit some of the disadvantages. In other cases the advantages and disadvantages appear to cancel each other out, both in number and content. A fourth strategy is to avoid using a subheading such as “Disadvantages”, and to present the disadvantages as a set of questions the potential testers may have should they test HIV-positive, where each question then refers to one of the psycho-social concerns.

Uncertainties about HIV-testing would arise if details about the consequences of testing HIV-positive are ambiguous, complex, unpredictable, or probabilistic; when information is unavailable or inconsistent; and when people feel insecure in their own state of knowledge or the state of knowledge in general about such outcomes. Such uncertainties may be multilayered, and as indicated by Brashers (2001), can pertain to the self, others, relationships, features of one’s context, and to one’s medical and social support network. When uncertainty becomes a threat (e.g. to one’s health, identity management, or precludes effective decision-making), it leads to negative emotional responses (fear, anxiety). However, it can also lead to positive emotional responses when uncertainty is framed as beneficial (cf. Brashers 2001: 482). As is often cited, people may prefer not knowing their serostatus as it keeps their hopes alive that they might not be infected or that some form of treatment or cure would become available. Managing this uncertainty is therefore necessary to maintain optimism/hope.

In expectancy-value models such as these described here, it is assumed that potential testees will weigh the negative and positive consequences of going for an HIV-test and choose an option which suits their personal circumstances best. Although it is often explicitly acknowledged that ART is still no cure for HIV/AIDS and that there are a number of disadvantages to testing HIV positive, some designers explicitly try and “tip the scales” in favor of HIV testing, for example when it is stated that the clinical advantages of testing for HIV outweighs these other (psycho-social) disadvantages.

Loss framing

Loss-framing of HIV-testing, i.e. indicating to potential testees what they stand to lose if they don’t go for the HIV test, has been proven experimentally to increase the uptake of HIV-testing (cf. Kalichman and Coley 1995). Closely aligned with the latter is the strategy to indicate to potential testees what the consequences would be if they were in fact infected but did not go for an HIV test (i.e. utilize a fear appeal), and the strategy of anticipated regret, i.e. an appeal to the regret potential testees may experience if they had not gone early for HIV-testing (while they were in fact infected). All three these strategies are used in texts in the corpus (cf., especially “Steeds meer mannen weten het” and “ ’t wordt tijd voor de test”.)

Normative beliefs

The normative construct aims to capture the motivational aspect that behavioral norms

(descriptive and injunctive) have on individual-level decision-making processes on whether or not to engage in a behavior. Precisely what the norm or norms are with regard to VCT and how they impact on VCT uptake behavior has not been systematically researched. For one, people enter into different role relationships when in interaction with either a sex partner, peers, one's family, or with a health care provider and different norms about VCT may in fact be operative in such contexts.

Given the impact that norms may have on people's decisions to go for VCT, the Theory of Planned Behaviour suggests the following persuasive strategies which could be used in designing pro-VCT messages: (a) changing current negative VCT norms on the community and interpersonal level, (b) portraying the uptake of VCT as the descriptive and injunctive norm, and (c) priming people's concerns for their own well-being and those of (significant) others. Again, however, a number of ethical principles are at stake here. For example, the VCT uptake statistics may not justify portraying the uptake of VCT as descriptive norm, but given the health promoting goals of VCT, it may be portrayed as the injunctive norm, provided that people are also made aware of the possible negative consequences of going for VCT (cf. the principles of informed decision-making).

The only explicit manipulation of the HIV-testing norms occurs in the brochure "Steeds meer mannen weten het". In this case HIV-testing and retesting is portrayed as both the existing and the desirable norm for gay men.

4 Conclusion

As far as could be ascertained, only the brochure "Steeds meer mannen weten het" in the corpus Dutch VCT texts have been evaluated for its effect on the uptake of VCT. As Buskens (2005) shows, the only effect it had was on the targets' knowledge of the testing and treatment argument. This calls for urgent action-orientated research on a number of issues.

Give the assumption that such brochures should provide potential testees with all the information they need to make an informed decision whether or not to go for VCT, research will have to be conducted on what these informational needs are and how brochure should be designed to provide them with this information. Printed brochures are also subject to space limitations, so it should also be researched how effective current strategies are of referring readers to other sources for more information.

There are a number of informational omissions in these brochures of which the effect on the uptake of VCT should also be researched. The first is the fact that the major focus falls on the biomedical aspects of HIV infection and treatment, while most of the other psycho-social determinants of the uptake of VCT and measures to address them are hardly addressed. The omission of information to boost readers' subjective assessment of their self-efficacy is also a major shortcoming, given the experimental proof of its positive impact on behavioural intention.

As indicated in Section 3.2, the designers of the messaging of the texts in the corpus utilise a wide variety of presentation, framing and persuasion strategies. Once again, however, very little empirical testing of the efficacy of these has been forthcoming. With regard to both the macro information design of these brochures and the strategies employed at the micro level an extensive research programme should be launched.

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