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CHAPTER 1   OVERVIEW OF THE STUDY

1.1   INTRODUCTION

A pressing global problem that cut across sociocultural, political, economic and religious boundaries as well as continental and national boundaries, is the epidemic of HIV/AIDS. In the words of Bertrand (2004:113) the HIV/AIDS epidemic "has emerged as the greatest public health challenge of contemporary times". An aspect of this problem is the sociocultural implications of the epidemic, and that is the subject of concern of this study. This first chapter begins with an overview of the global challenge of the HIV/AIDS epidemic. The overview set the tone for a brief exposé of the epidemic in Sub-Saharan African, in South Africa and on the municipal level of the Ekurhuleni Municipality. The financial burden experienced on the global and national levels resulting from the epidemic is then briefly discussed followed by a presentation of the rationale, the problem statement, the research question, the research objectives and the research design of the study.

1.2   THE GLOBAL CHALLENGE OF THE HIV/AIDS EPIDEMIC

According to the UNAIDS Global Report, by the end of the year 1997, virtually every country in the world had been affected by HIV/AIDS (UNAIDS Global Report 1997). By the year 1999, the epidemic had reached its peak (UNAIDS Global Report 2010). Through 2007/2008, the epidemic had claimed the lives of over two million people worldwide. In addition to the millions of deaths, people infected, and new infections; millions of children became orphans because their parents or guardians had died (UNAIDS Global Report 2009).

The gloomy picture created by the HIV/AIDS epidemic up until 2009 seemed to have given way to some rays of hope by the end of 2010. The overall growth of the global AIDS epidemic appeared to have stabilised. For it could be said "at the cusp of the fourth decade of the AIDS epidemic, the world had turned the corner. It has halted and began to reverse the spread of HIV" (UNAIDS Global Report 2010:7). There has been remarkable progress in the health sector's response to HIV. That progress is the result of the dramatic expansion of access to evidence-informed HIV prevention, testing and counselling, treatment and care services in low and middle-income countries (World Health Organization 2011:2). A report of the UNAIDS Global Report (21012:6) notes that the end of 2011 ushered in a new era of hope in:

Countries and communities across the world that had previously been devastated by AIDS—unprecedented gains were achieved in reducing the number of both adults and children newly infected with HIV, in lowering the number of people dying from AIDS-related causes and in implementing enabling policy frameworks that accelerated progress.

These successes were achieved in significant measures because of the global solidarity in the HIV/AIDS response during the past decades. This global solidarity has continued to generate extraordinary health benefits attributed to the extraordinary health benefits of the development of powerful new tools to prevent people from becoming infected and from dying from AIDS-related illnesses (UNAIDS Global Report 2012:8). The emergence of these powerful tools combined with the historic success in bringing HIV programmes to scale enabled the laying of the foundation for the eventual end of AIDS (UNAIDS Global Report 2012:8). However despite all these gains, HIV/AIDS remains one of the world's most pressing health challenges (UNAIDS Global Report 2012:8). Hence, unusual partnerships have been formed between countries, regional and sub-regional groups, organisations and individuals, and world organizations. Some of such partnerships are between UNAIDS and the World Health Organization (WHO), national and local governments, traditional and religious institutions and groups. All these bodies are making various concerted efforts to contain the spread of the virus by facing the challenge. To eventually achieve the dream of zero new infections, zero discriminations and zero Aids-related deaths, it is necessary to continue to provide medication and care for those living with the virus and to support orphaned children in a sustained and consolidated manner (UNAIDS Global Report 2010).

The magnitude and enormity of the challenges posed by HIV/AIDS have not only led to the unusual formation of the partnerships mentioned. It has also meant the commitment in the past and present and hopefully in the future of significant amounts of resources in the form of monetary and human capital to various initiatives, strategies and activities. The aim of all this is the curbing and curtailing the spread of the virus, caring for those living with the virus and provide care for those orphaned (How we're Spending 2013). In a 2001 report on global spending on HIV/AIDS, Alagiri, Collins, Summers, Morin and Coates (Global Spending on HIV/AIDS 2001:2) stated:

The enormity of the global AIDS epidemic, whether measured in lives lost, children abandoned, or health and economic systems destabilized, necessitates an unprecedented response from the international community.

That report also stated that the UNAIDS had identified continued growth in bilateral funding for international AIDS from 1987 through 1996. There had been stable funding from 1996 to 1997 and continued increase in growth between 1997 and 1998; the United States being the largest bilateral donor in 1998. The report indicated that there was no dispute that significant

resources were required to address the AIDS epidemic, particularly in the developing nations. There had emerged in 2011 encouraging signs "in the quest to close the global AIDS resources' gap as HIV spending increased by 11% compared with 2010" (UNAIDS' Global Report 2012:62). The total global HIV investment in 2011 was US$16.8 billion.

One of the strategic activities aimed at helping to curb and contain the spread of HIV is the large-scale coordinated efforts that broadcast effective prevention messages. There is a global need for these strategies according to Noar, Palmgreen, Chabot, Dobransky and Zimmerman (2009). A form of the strategy of broadcasting effective prevention messages "widely utilised to fulfil such a purpose in the HIV/AIDS area is the mass communication campaign" (Noar et al. 2009:16). The mass communication campaigns are used worldwide at national, regional and local levels. They are used to create awareness and provide necessary information and knowledge to the general population on the nature of the virus and disease and their devastating consequences. These campaigns are also used to inform and educate people living with HIV on how they can live their lives with dignity; and how to prevent becoming infected. In that regard in situations or contexts of the epidemic Foreman (2003:3) noted:

> More effective communication about the disease and greater flows of information are central to the success of AIDS strategies, and for reducing the vulnerability that flows to and from HIV infection. Information and communication are sources of power—they confer the power to protect against infection, to influence decision makers, and to live lives of dignity and equality once infected. They are both the prerequisites and enablers of an effective response.

Thus Bertrand (2006:4) states "it is hard to imagine a program designed to bring about some type of change in behaviour or health status that does not utilise at least some type of directed communication". Noar et al. (2009:16) add "the importance of campaigns for HIV/AIDS prevention in the near future is unlikely to wane" given the current disturbing data of the HIV/AIDS epidemic (UNAIDS Global Report 2013) even though the fight against the epidemic has made a lot of progress. It is critical therefore, Noar et al. (2009:16) opine, these "researchers continue to study such efforts in attempts to better understand the most efficient and effective methods for carrying out such campaigns", this study is an effort in that direction.

1.3   STATE OF THE HIV/AIDS EPIDEMIC IN SUB-SAHARAN AFRICA

Sub-Saharan Africa remains the most severely affected region of the world with HIV/AIDS. The estimate of the infection is nearly one in every 20 adults of the population of the region is living with HIV (UNAIDS Global Report of 2012). That accounts for 69% of people living
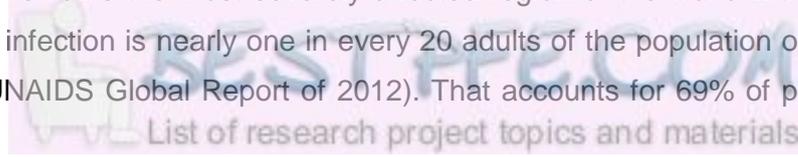
with the virus worldwide, and the regional prevalence of HIV infection in sub-Saharan Africa is nearly 25 times higher than regions such as Asia. However, it is noted that the 23 countries with steep declines in HIV infection are in sub-Saharan Africa, "where the number of people acquiring HIV infection in 2011 (1.8 million [1.6-2.0 million]) was 25% lower than in 2001 (2.4 million [2.2-2.5 million]). Despite these gains, however, sub-Saharan Africa accounted for 71% of the adults and children newly infected in 2011. AIDS-related causes of death in sub-Saharan Africa declined by 32% from 2005 to 2011. However, the region still accounted for 70% of all the people dying from AIDS in 2011. This situation points to the importance of continuing and strengthening HIV prevention efforts in the region" (UNAIDS Global Report 2012:11).

1.4 THE SITUATION OF THE HIV/AIDS EPIDEMIC IN SOUTH AFRICA

In the sub-Saharan region, South Africa has the highest number of people infected and affected by HIV/AIDS. The country also has the highest prevalence of HIV/AIDS compared to other countries of the world (AIDS Foundation [sa]:1; World Health Organization 2011). In 2009, it was estimated that 5.6 million South Africans were living with HIV/AIDS. An estimated 310 000 died of AIDS (AVERT [sa]). Thus, it is acknowledged in South Africa's 'National Strategic Plan on HIV, STIs and TB 2012' (NSP 2007 – 2011) that HIV/AIDS is a problem and one of the main challenges and prominent health concern facing the country. The HIV/AIDS epidemic contributes "significantly to the burden of disease faced by South Africans" (South Africa National Department of Health [sa]:1). However, though the epidemic still poses a significant challenge, there has been some progress in combating it in the country in recent years. Over the past four years, the epidemic has stabilised at the national antenatal prevalence of around 30%. Data from population-based serosurvey and sentinel surveillance of pregnant women suggest that the HIV epidemic has reached a plateau in South Africa. Despite that fact "the absolute number of people living with HIV (PLHIV) is on the steep increase of approximately 100 000 additional PLHIV each year" (Global Aids Response Progress Report 2012:12).

As noted by Foreman (2003) effective communication about the disease and greater flows of information are central to the success of AIDS strategies. Noar et al. (2009) have pointed out that communication campaigns are essential for HIV/AIDS prevention. These campaigns are an essential and important component of the strategies used in the fight against HIV/AIDS in South Africa (Global Aids Response 2012). The campaigns are used to create awareness and to educate the population about HIV/AIDS in many parts of the world (Bertrand, O'Reilly, Denison, Anhang & Sweat 2006; Noar, Palmgreen, Chabot, Dobransky & Zimmerman 2009;

USAID 2013). In that regard, large-scale communication campaigns related to raising awareness and providing knowledge about HIV/AIDS are planned and implemented. An example of these communication campaigns is the South African Department of Health's premier AIDS-awareness campaign, 'Khomanani', meaning 'Caring Together', which has run since 2001. 'Khomanani' is a communications campaign that uses "the mass media to broadcast its messages, including radio announcements and the use of situational sketches on television" (AVERT [sa]:3). Other such campaigns are Soul City, which target adults and Soul Buddyz, which targets children. Both utilise broadcast, print and outdoor media. Another example is the 'LoveLife' campaign, which ran from 1999 to 2005, using a broad range of media targeting mainly the teens.

Assessments of the outcomes of some of the above HIV/AIDS communication campaigns have yielded results of successes in creating awareness among large numbers of the population. For example the major survey in 2008 of the large-scale communication campaigns mounted in South Africa: Khomanani, Soul City, Soul Buddyz and LoveLife indicated that "over four-fifths of South Africans had seen or heard about at least one aspect of the four campaigns, from less than three-quarters in 2005" (AVERT [sa]:1). The findings of the Second National HIV Communication Survey of 2009 (JHHESA 2012) indicated that there have been significant messaging achievements in particular areas of HIV. There was the exposure of about 90% of the population aged 16-55 years to more Health Communication Programmes. This latter Survey also noted the following as challenges needing attention to strengthening prevention messages for behaviour change: delaying sexual debut, intergenerational sex, transactional sex, alcohol use and risky sexual behaviour. A 2012 research project by Peltzer, Parker, Mabaso, Makonko, Zuma and Ramlaga (2012:5) identified communication campaigns as continuing to play a significant role in creating awareness and helping to bring about progress in the fight against HIV/AIDS in South Africa. The report of the research also associated higher HIV mass communication exposure with the reduction of HIV risk behaviour, for example, condom use and having HIV test. However, the research did not find any association between higher HIV mass communication exposure and reduction of the number of sexual partners (Peltzer et al. 2012). The results of this research seem to suggest the need to do more in HIV/AIDS communication campaigns to ensure that higher exposure of the target audience to the campaigns may also be associated with higher reduction of the number of sexual partners, delay in sexual debut and increase in condom use; all of which could lead to rise in reduction of new infections as envisioned in the NSP.

As on the global level, South Africa also invests a sizable amount of its resources into the fight against HIV/AIDS. A report of South Africa's Human Sciences Research Council (HSRC 2003) noted that the county had paid a total of US$33.3 billion on core HIV/AIDS expenditure and US$511287.699 on expanded expenditure. In a summary report of the seventh meeting of the Budget and Expenditure Monitoring Forum (BEMF 2011), South Africa was expected to spent more than R13 billion on the response to HIV/AIDS and TB in 2009/2010. Communication campaigns are programmes on which more was spent and will continue to be spent in the future; for example Peltzer et al. (2012:1) have noted that in South Africa "social and behavioural communication interventions are a critical component of HIV/AIDS prevention and numerous communication campaigns have been implemented intensely across the country through government initiatives and nongovernmental organisations over the past decade".

Besides the national HIV/AIDS campaigns, there are numerous communication campaigns that are planned and implemented by metropolitan municipalities, regional and local bodies. One such municipality that plans and implements its HIV/AIDS communication campaign in line with the national policies and guidelines is the Ekurhuleni Metropolitan Municipality in the Gauteng Province. Therefore the HIV/AIDS communication campaign of the Ekurhuleni Metropolitan Municipality served as the context for testing the sociocultural assessment instrument developed in the study.

1.5   BACKGROUND OF HIV/AIDS CAMPAIGN IN EKHURULENI MUNICIPALITY

Ekurhuleni is one of the three metropolitan municipalities of Gauteng, one of the nine provinces of South Africa. The name Ekurhuleni, a Tsonga word, means "a place of peace" - symbolic of the diversity of the city and its vision of an equitable and progressive community. Ekurhuleni Municipality covers a land area of approximately 2000 square kilometres with a total population of about three million people, which is 5.6% of the national population, and 28% of Gauteng's population. It has a business sector that boasts more than 41 000 industries; and it is referred to as 'Africa's Workshop' because it hosts the largest concentration of industries in Africa (City of Ekurhuleni HIV/AIDS Indaba, June 2010). According to the 2001 national census (Metapedia [sa]) more than eleven languages of four ethnic groups of people inhabit the Ekurhuleni metropolis as shown in Table 1.1

Culture /Language	Population	%
Zulu	754 411	30.42%
Afrikaans	321 103	12.95%
Northern Sotho	282 641	11.40%
Sotho	287 398	11.22%
English	277 950	8.60%
Xhosa	213 389	8.60%
Tsonga	141 484	5.70%
Tswana	76 896	3.10%
Swati	45 357	1.83%
Ndebele	25 753	1.79%
Venda	25 753	1.04%
Other	18 396	0.74%

Ethnic Group	Population	%
Black African	1 891 452	76.26%
White	482 080	19.44%
Coloured	67 064	2.70%
Indian / Asian	39 664	1.60%

Table 1.1   Demography of Ekurhuleni

From the demographic information above, it is evident that Ekurhuleni is not a monoculture or monolingual metropolis but rather a multicultural and multilingual metropolis because the population comprises people of different cultures and languages. Sullivan (2009:335) defines culture as "an accumulation of values, rules of behaviour, forms of expression, religious beliefs, occupational choices, and so on, by a group of people who share a common language and environment." Applying this understanding of culture to the people who populate Ekurhuleni metropolis it is important to note that while some of the groups of the population share the same culture, the Afrikaans culture is different from the Zulu culture, as it is also different from the Xhosa or the Venda cultures. The various cultural groups share the same environment – the Ekurhuleni metropolis, but they do not share an original common language though some have learned to understand and speak some of the other languages. Thus, it can be said that within the multicultural environment of the metropolis, some level of enculturation and acculturation take place. The process of enculturation is that of some degree of interaction and encounter that take place among the people of the different cultures (Sullivan 2009). In the interaction and encounter there occurs a process of socialisation or assimilation into a culture or cultures other than one's own and in this process, the people learn some values, rules and expectations of each other's culture which is the process of enculturation.   From a communication perspective the process of enculturation entails learning and passing on cultural practices and beliefs to those born into a particular culture or those who join it through marriage, adoption, or other means (Sullivan

2009:5). Acculturation, on the other hand, is the process of culture change, which results from the contact between two or more distinct cultural groups (Schenker 2008; Sullivan 2009). These could be "changes in language, identity, expressive behaviour, political affiliation, rituals, religious beliefs, value systems, marriage patterns and technology" (Sullivan 2009:178). In communication terms, this has to do with its ritualistic function making acculturation "a process undergone by different cultural groups when they interact and adopt cultural patterns from one another" (Sullivan 2009:6) and occurs to some degree in the multicultural and multilingual environment in this case of the Ekurhuleni metropolis.

It is hence argued that people's values and value systems play some determining role in how and to what extent they socialize into different cultures and allow changes in their culture in the process of acculturation. Hence the multicultural and multilingual environment of the Ekurhuleni metropolis arguably generates the processes of enculturation and acculturation that result in some levels of socialization/assimilation into the culture/s other than one's own and some degree of cultural change. Values are said to constitute a pervasive and comprehensive concept that is variously defined and elusive to comprehend (Hartung 2007:843). Malle and Dickert (2007:1012) suggest two different yet related meanings that provide a framework for some level of understanding and appreciation of this elusive concept. One of the two distinct meanings has economic or decision-making sense, and the other has a social-psychological meaning. The former meaning relates to the worth of an object or activity for an individual or community. The latter meaning is "an abstract desirable end state that people strive for or aim to uphold, such as freedom, loyalty, or tradition" (Malle & Dickert 2007:1011). In line with the second meaning proposed by Malle and Dickert (the meaning being adopted in this study) values according to Oles and Hermans (2003) are defined as belief about preferable end states or behaviours and the internal criteria that guide information processing, evaluation of the internal and external world of a person and the selection of behaviour:

The above definitions or descriptions of values can hence be seen as criteria that one acquires as a member of a particular group for the selection or choice of an action. In other words the values that a person upholds or beliefs in, that might have been acquired because he belongs to a particular group – be it cultural, religious or educational group; are determinants for the choice or preference of special end states or behaviours. The determining role of values thus is due to its "overreaching life goals and guiding principles for determining what constitutes desirable outcomes and modes of behaviour" (Hartung 2007:843). In the process of enculturation and acculturation the values of cultural groups that are also those of the individual in the group, serve as the criteria for the acceptable level

of socialization into and assimilation of cultural elements other than one's own. The same applies to the degree of cultural change that is allowed and acceptable in the different cultural groups. Pertaining to issues of health and in the case of HIV/AIDS the assumption is that some aspects of the cultural groups' values serve as the criteria or plays a role in the choice of response to messages or activities of communication campaigns.

The Ekurhuleni Metropolitan Municipality HIV/AIDS Unit's communication campaign strategy is part of and flows from the HIV & AIDS and STI Strategic Plan for South Africa 2007-2011. This HIV & AIDS and STI Strategic Plan in turn "flows from the National Strategic Plan of 2000-2005, the Operational Plan for Comprehensive HIV and AIDS Care, Management, and Treatment (CCMT)" and this "represents the country's multi-sectoral response to the challenge of HIV infections and wide-ranging impacts of AIDS" (HIV & AIDS Strategic Plan for South Africa 2007-2011:7). The implication of this is that the activities and programmes of the Ekurhuleni Metropolitan Municipality HIV/AIDS Unit are not developed independently or in isolation. Rather they are aligned to and guided by the NSP. The scourge of the HIV/AIDS epidemic in the municipality is thus being fought on the level of the community at large and through a workplace programme in line with the National HIV/AIDS Policies (Full Term Report 2000/2005 Ekurhuleni Metropolitan Municipality 2005:51) based on the following set of key guiding principles: Supportive Leadership, Leadership role of Government, Greater Involvement of People Living with HIV, Young People (aged 15-24) as a Priority Group for HIV Prevention, Effective Communication and Effective Partnerships are the basis of the NSP. Of these sets of principles, the one pertaining specifically to communication is of particular interest to this study. The nineteen specific interventions needed to reach the goals of the NSP (HIV/Aids Strategic Plan for South Africa 2007-2011:43) are structured under four key priority areas as indicated in Table 1.2.

Prevention	Treatment, Care and Support	Research, Monitoring and Surveillance	Human Rights and Access to Justice
1. Reduce vulnerability to HIV infection and the impacts of AIDS 2. Reduce sexual transmission of HIV 3. Reduce mother-to-child transmission of HIV 4. Minimize the risk of HIV transmission through blood and blood products	5. Increase coverage to voluntary counselling and testing and promote regular HIV testing. 6. Enable people living with HIV and AIDS to lead healthy and productive lives 7. Address the special needs of pregnant women and children 8. Mitigate the impacts of HIV and AIDS and create an enabling environment for care, treatment and support	9. Develop and implement a monitoring and evaluation framework for appropriate indicators 10. Support research in the development of new prevention technologies 11. Create an enabling environment for research in support of the NSP 12. Development and promotion of research on behaviour change	16. Ensure public knowledge of and adherence to the existing legal and policy provision 17. Mobilise society and build leadership of people living with HIV in order to mitigate against stigma and discrimination 18. Identify and remove legal, policy, religious and cultural barriers to effective HIV prevention, treatment and support 19. Focus on human rights of women and girls, including people with disabilities.

Table 1.2   NSP Goals and Specific Interventions

While communication is relevant to and linked to all the key priority areas, it is of particular significance in the key priority area of Prevention, which entails Information, Education and Communication (IEC). The South Africa government through its Department of Health has invested many resources in the production and dissemination of IEC materials through existing popular mass media. The information, education and communication materials "are of sound technical quality and widely available—stakeholders disseminating similar messages, articulated around ABC, stigma-mitigation and human and legal rights" (HIV & Aids Strategic Plan for South Africa 2007-2011:43).

The year 2004 saw the establishment of the Ekurhuleni Metropolitan Municipality HIV/AIDS Unit (City of Ekurhuleni HIV/AIDS Indaba June 2010). The Unit falls under the umbrella of

the Health Department of Health of the Municipality and it strives to address the four goals of the NSP on HIV/AIDS and Sexually Transmitted Infections through the implementation of an HIV/AIDS Community Support Programme. The Programme works in partnership with relevant role players within the Ekurhuleni Municipality educating communities on HIV/AIDS through door-to-door HIV/AIDS education campaigns and it links communities to local services (Full Term Report 2000/2005 Ekurhuleni Metropolitan Municipality 2005; City of Ekurhuleni HIV/AIDS Indaba, June 2010). This Community Support Programme comprises some focused interventions aligned to the Ekurhuleni Metropolitan Municipality theme on HIV/AIDS. The theme is 'Ekurhuleni Action Now against HIV/AIDS' (Report on Achievements: Multi-sectoral HIV/AIDS Unit Community Support Programme2010). One of the objectives of the Community Support Programme is the reduction of HIV infections through information, education and counselling and the provision of services to support behaviour change. Some specific activities of the programme are door-to-door education campaigns, the distribution of pamphlets, posters and stickers with messages/information on HIV/AIDS. Other activities include: the annual High Schools' Debates on HIV/AIDS; the setting up of structures at ward level; the HIV/AIDS Indaba – that is local level gatherings where there is discussion of HIV/AIDS issues and plans are adopted as to how to respond to the pandemic; and outreach programmes in the form of road shows that target high-risk areas and groups (Report on Achievements: Multi-sectoral HIV/AIDS Unit Community Support Programme 2010).

To carry out the door-to-door education campaign, volunteers from the Wards in Ekurhuleni are recruited, trained and grouped into teams. Each team has a leader, a trainer, and some volunteers whose door-to-door education campaign activities on HIV/AIDS cover all 88 wards of the municipality. According to records, between July 2009 and March 2010, the teams had visited 334 515 households, reaching 1 070 796 people (City of Ekurhuleni HIV/AIDS Indaba, June 2010). The volunteers are empowered through monthly HIV/AIDS courses to help them carry out their responsibilities of educating and providing relevant information on HIV/AIDS (City of Ekurhuleni HIV/AIDS Indaba, June 2010).

1.6   RESEARCH RATIONALE

As discussed above, communication campaigns are one of the communication strategies used globally to combat the HIV/AIDS epidemic. According to Brown (2001:1) communication is an "interactive process where humans influence some form of change in another's attitude, belief or behavior" and it is "intertwined with culture through all of human life". Brown's description highlights three characteristics of communication. Firstly, that

communication is an interactive process. Communication being an interactive process means communication is not just an act, but a series of activities that involve more than one person, which makes it interactive and participative. Secondly, the result of the interaction between the people in communication entails some form of influencing, which causes some change in the individual/s attitude, belief or behaviour. In other words, in communication 'something' happens to the persons involved. Thirdly, there is an intimate link between communication and culture. This link between communication and culture is "an invisible, shared design that unconsciously patterns the actions of people so that they can interact and achieve together" (Kikoski 1999:19). Communication thus does not only serve to transmit information but also has a ritualistic function (Heath & Vasqueq 2001), reflecting "humans as members of a social community" (Rimal & Lapinski 2009:1). It is people's way of exchanging information, and it also signifies their symbolic capability. Hence, it is at the heart of who people are as human beings. That implies that people engaged in communicative activities/transactions are guided by 'something' they share. That is a design, which is not visible to them, but which, nevertheless patterns, guides or directs their interaction; something that is part of who they are; something cultural. That invisible shared design could be what Varey (2002:116) refers to in his assertion "a set of rules for how people will interact in exchange relationships – what constraints and ways in behavior and decisions are accepted". Varey's assertion could also be what Berhó and Defferding (2008:272) mean by saying that culture serves as "a vehicle for communicative activities." Kikoski's (1999:19) assertion that culture is a "pervasive, shared, and unwritten consensus that helps pattern and make predictable the lives of people who interact" summarises the previous points. It also highlights how culture influences or impacts on communication. Therefore, in the intertwining relationship between communication and culture, culture influences communication (Hwa-Froelich & Vigil 2004:107; So, Gilbert & Romero 2005:806). In communicative activities then culture, the invisible shared design, determines what acceptable communicative behaviour is. It does that by "establishing certain rules or codes, conscious or unconscious obedience to which brings approval and violation of which brings disapproval" (Kikoski 1999:19). If that is the case, the following two questions should be answered. If intervention efforts to change behaviours are communicative acts (Rimal & Lapinski 2009), should such efforts focus mostly on the transmission function of information exchange to the neglect of ritualistic processes in communication? For communicative transactions to be efficient and achieve their intended purposes should the cultural context and its specificities of the persons in the communication transaction, be acknowledged and taken into consideration?

If it is assumed that communication and culture are intimately intertwined and culture is pervasive in the lives of people and if culture establishes certain codes that guide communicative activities in order that expected influencing change of attitude, beliefs and behaviour in interaction may take place. Moreover, if communication campaign is one of the widely employed communication strategies in the fight against HIV/AIDS; it should be ascertained whether planners and implementers of HIV/AIDS communication campaigns are aware of the vital importance of ensuring that they take seriously into consideration not only the transmission function of communication but also its culturally determined ritualistic function.

1.7   RESEARCH PROBLEM

Based on the rationale the research problem of the study is that there is a lack of adequate research to investigate the intimate and intertwining relationship between communication and culture and how such relationship and the active participation of the target audience may or may not influence the planning and execution of HIV/AIDS communication campaigns to ensure their achievement effecting and sustaining the health-related behaviour change.

1.8   RESEARCH QUESTIONS

As the research problem focussed on the relationship between communication and culture and how that relationship impacts on or affect the planning and implementation of a health communication campaign, the following research questions guided the inquiry of the study.

Research question 1:

On the assumption that the sociocultural context and factors such as the worldview, religious beliefs, traditions and customs associated with health and related aspects of the way of life of the target group have some determining influence on the manner in which messages of HIV/AIDS communication campaigns are perceived, accepted, ignored or rejected; is it necessary in planning and implementation of health communication campaigns, to take into consideration the sociocultural context and factors?

Research question 2:

Will the active involvement and participation of the target audience in the communication campaign process ensure that the sociocultural context and factors as they pertain to health
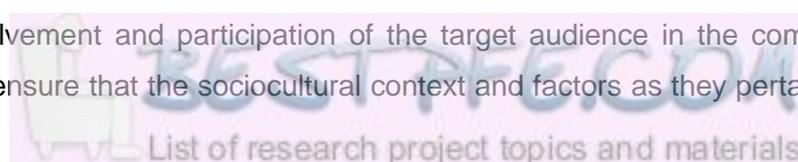
issues, are taken cognisance of and incorporated into the process of the campaign, in order that the campaign might be socioculturally appropriate?

Research question 3:

Will systematically planned, socioculturally appropriate communication campaigns underpinned by relevant theory ensure the sociocultural appropriateness of such campaigns and make them more conducive to structured and systematic assessment?

1.9   OBJECTIVES OF THE STUDY

In the light of the rationale, the problem statement, and the research questions, the study aimed to achieve the following objectives.

Objective one: To construct a theoretical sociocultural health communication campaign model that takes into account the intricate intertwining relationship between communication and culture based on sound theory.

Objective two: To use the theoretical sociocultural health communication campaign model constructed as part of the study to guide the development of a theoretical sociocultural assessment instrument as a tool with the potential to assess the following:

> If and to what extent, communication campaign planners involved the target audience as partners in the campaign process;

> If cognisance was taken and incorporation made of relevant elements of the sociocultural context and factors of the target audience in the planning and implementation of the campaign, and

> If and to what extent appropriate sociocultural theory underpinned the whole campaign process.

Objective three: To ascertain the appropriateness of the theoretical sociocultural assessment instrument by testing it in an HIV/AIDS communication campaign of the Ekurhuleni Metropolitan Municipality HIV/AIDS Unit.

1.10   RESEARCH DESIGN

To ensure a systematic and comprehensive research process that lead to the realisation of the objectives of the study it was necessary to review relevant literature related to the subject of the study. The literature review helped to articulate and clarify the theoretical perspective that underpinned the reflection and discussion of the study. The conceptual framework set the parameters within which the research process was confined. Within the set parameters, the basic research methodological approach of this study was the combination of qualitative and quantitative methods. The qualitative techniques were applied in the utilization of document data of non-numeric information (Creswell 2003, Lugovskaya 2009) in the process and manner of developing the sociocultural assessment instrument. Elements of quantitative techniques were applied in the manner and use of numeric non-statistical information through arithmetic ordinal data structure in which qualitative constructs were associated with quantitative arithmetic units in the questionnaire with predetermined closed-ended questions that had answers labelled in numbers to solicit ordinal numeric non-statisitcally (calculated summation) data. That combination made the overall methodological appraoch of this study 'mixed methods research'.

As pointed out in the section on the situation of the HIV/AIDS in South Africa, the HIV/AIDS communication campaign of the Ekurhuleni Metropolitan Municipality was sampled to test the sociocultural assessment instrument. The sampling method was thus purposive sampling - the selection of a case, just a unit in which to test the theoretical sociocultural assessment instrument in the form of a group-administered interactive questionnaire (Yerushalmi, Henderson, Mamudi, Singh & Lin 2011).

1.11   CONCLUSION

The discussion of this chapter highlighted health communication campaign as one of the widely used communications strategies to inform and educate people about HIV/AIDS and to promote behaviour that help curtail the spread of HIV. As noted in the discussion while substantial monetary and human resources are committed to the development and implementation of such communication campaigns; the level of infection of HIV has not changed as much as desired even though there is considerable progress. The degree of progress seems to suggest some missing links in the campaign process. The missing links that were assumed and argumented for in this study were the absence or insufficient active involvement and participation of the target audience in the campaign process, the inadequate cognisance of the influence of the cultural contexts and cultural elements on the

health attitudes and behaviour of the target audience, and the intertwined relationship between culture and communication.

The communication campaign of the HIV/AIDS Unit of the Ekurhuleni Metropolitan Municipality is a municipal level example that mirrors the South African government's efforts to use communication strategy of communication campaign to inform and educate the people about HIV/AIDS and to promote behaviour that help curtail the spread of HIV. This HIV/AIDS Unit offers the opportunity to test the theoretical sociocultural assessment instrument developed in the study. To investigate the assumptions three objectives were set based on the rationale, the research problem and the research questions. The brief discussion on the research design delineates the process and manner of the conduct of research. To have a better understanding of the main concepts employed in the research a review of the relevant literature was undertaken and forms the subject of the next chapter.

CHAPTER 2   DEFINING THE KEY CONCEPTS

2.1   INTRODUCTION

This chpater defines the key concepts of this study - assessment, communication, communication campaign, health communication, development communication, health communication campaign, conceptual model, culture, model, modelling, social, sociocultural, structure and theory; and related terms that make up the topic of the study. The meanings and/or understandings and the dynamics of these concepts and terms as conceptualised by some scholars are briefly presented and discussed. Their operational definitions as understood and used in this study are also offered.

2.2   CONCEPTUAL AND OPERATIONAL DEFINITIONS OF KEY CONCEPTS

Coleman (2004) opines that the necessity for a definition in the field of knowledge is non-debatable because no field of knowledge can have any coherence without a common understanding of the limits of its entity. Fields of knowledge thus have boundaries, though the necessity of definition is non-debatable. It is worthwhile noting that there is no one universally accepted definition of concepts. That is because according to Bracken (2004:186) "concepts vary in their inclusiveness, generalizability, preciseness, and importance" and consistent with this observation, he continues   "there is no one definition of what constitute a basic concept." In setting the necessary boundaries in this study, it was helpful to distinguish between conceptual and operational definitions. Conceptual definitions explain abstract concepts in concrete terms while operational definitions convert the concrete terms into measurable criteria (Remund 2010). A conceptual definition thus articulates the meaning of an entity, phenomenon or reality, while operational definition articulates how it is measured (Pati 2012) in a particular field of study such as the present one.

2.2.1   Assessment

Ward and Rose (2002) note that there is no concise definition for the term assessment. From its Latin etymology of *ad sedere*, which means 'to sit down beside', assessment can be understood as being primarily concerned with providing guidance and feedback of 'something,' such as a reality, entity, phenomenon or event and in this regard, Anderson (2003) posits that at its core, assessment refers to gathering information for use in the

decision-making process about something. The process involves looking at, making inferences about and estimating the worth of that 'something.' According to Lusthaus, Adrien, Anderson, Carden and Montalvan (2002:171) the term assessment is "often used as a synonym for evaluation; sometimes recommended for approaches that report measurement without making judgments on the measurements". The use of the two terms synonymously suggests a close relationship between them. This possible close relationship seems reflected in the definition of evaluation by Farell, Kratzmann, McWillieam, Robinson, Saunders, Tiknor and White (2002:8) who opine that it is a "course of action used to assess the value or worth of a program". Farell et al.'s definition complement Valente's (2001:106) definition that evaluation is "the systematic application of research procedures to understand the conceptualization, design, implementation, and utility of interventions". This definition contextualises evaluation within the field of research, which could be scientific.

The point made that assessment has to do with making inferences about and estimating the worth of that 'something' is quite an important one as that distinguishes it from measurement. Although as also noted, assessment is sometimes recommended for approaches that report measurement without making judgments on the measurements. Measurement is the process of quantifying data (Huitt 1996) while assessment is a process that involves obtaining data or information relative to some known objective or goal (Kizlik 2012) thus referring to collection of data to better understand an issue or something (Huitt 1996). That would mean without the quantification of the data – measurement, it is possible to achieve an objective or goal through the process of assessment. In other words the design of a process of gathering, collecting or obtaining data connected to some goal or objective implicitly or explicitly can lead to or yield result of some understanding or information relative to the objective or goal for which the assessment was designed. In its broad sense, assessment includes testing thus making tests, which are assessments made under contrived circumstances so that they may be administered, a special form of assessment (Kizlik 2012). For the purpose of this study and taken a cue from the definitions of the scholars mentioned above, assessment is operationally defined as a systematic process of obtaining data or information about a reality, entity, phenomenon or event relative to some objective or goal in order to better understand that about which the data or information is being gathered. The process includes making inferences about and estimating the worth of that which is assessed.

Since assessment and evaluation are synonyms, the two terms are used interchangeably in this study.

2.2.2   Communication

Heath and Bryant (2000) point out that over the past 50 years there have been hundreds of definitions of the concept communication. Segrin and Flora (2005:15) make a similar observation by pointing out "there are numerous definitions of communication that reflect diverse perspectives in the communication discipline". Due to these diverse perspectives Heath and Bryant (2000) contend that no definition of communication is entirely satisfactory. In their view, therefore, for a definition to be good, it should accurately and completely, feature key elements of communication and point to the relationship between them. For this reason, Heath and Bryant (2000) are of the opinion that one definition can be better than another definition because it more accurately and completely captures the essence of the phenomenon of communication.

For a definition of communication to accurately and completely feature key elements that make it what it is supposed to beit is necessary to recall that historically, the term communication has two different meanings (Perry 2002). Quoting the 'Office of Technology Assessment' Perry (2002:4) explains that the English word 'communication' is derived from the Latin word *communis* that refers to "communion or idea of a shared understanding of, or participation in, an idea or event". That is the first meaning which implies that in communication, there is or should occur a certain amount of sharing or arriving at a common understanding of 'something,' be it an idea, an event or reality/phenomenon. In this sense, communication entails establishing something of 'link' or 'connection,' some relationship or association between those engaged in it. By the late 17th century, the "notion of imparting, conveying, or exchanging information and materials was incorporated into the concept" (Perry 2002:4). The incorporation of those notions gave it the second meaning, which complements the first meaning by highlighting what takes place when a link or connection, relationship or association has been established by those engaged in communication activity – something is 'given' from the one to the other. From these two historical meanings that do not exclude one another, communication has to do with some form of interaction necessitated by an idea or event. Encapsulated in the interaction is a transaction of transmission, that is the imparting, conveying, or exchanging of information and/or some materials between those engaged in communication. This understanding of communication may be the understanding that led Gerber in the 1960s as quoted by Heath and Bryant (2000) to define the concept communication simply as interaction through messages. For Sullivan (2009) communication is the process of conveying information from one person to another. A process by which we assign and convey meaning in an attempt to create shared understanding. According to Talbot, Astbury and Mason (2010 communication means to

transmit information, ideas or feelings. The above definitions highlight the interactional aspect of communication. Complementing this interactional aspect of communication is the definition proposed by Segrin and Flora (2005:15) that communication is "a transactional process in which individuals create, share and regulate meaning." The creation, sharing and regulating of meaning by individuals mean that communication relies on intersubjectivity, subjects or persons (entities) in a relationship. The fact that communication rely on subjectivity implies that shared meaning is "a state where a person understands the other and is understood by the other," making communication a "mutual process that extends beyond one person's interpretation" (Segrin & Flora 2005:16). Thus, it is the subjects in communication who together create, share and regulate meaning; in which sense, communication is defined as "the symbolic exchange of shared meaning, and all communicative acts have both a transmission and a ritualistic component" (Rimal & Lapinski 2009:1). In appreciating and adopting both the transmission and ritualistic functions of communication, one avoids the danger of impoverishing the meaning and essence of communication by focusing on only one of its functions. For if one adopts only the transmission view of communication then the chances are that one's focus would be only or mainly on the components or elements of transmission,namely, source, receiver, message and channels. If one adopts only the ritual view the chances are that the focus would be only, or mainly, social and cultural components or elements of the ritualistic aspects of communication, namely interactional ceremonies and networks, and the meanings derived thereof.

It is necessary to note that communication occurs either intentionally or unintentionally (Barry 2007:1). Intentional communication would be the case where the source has intended or decided to send a particular message to a receiver. Unintentional communication would be the case where a receiver, receives what he considers or perceives as a message intended by a sender. Such a perception might derive from some symbols, signs or expressions in the form of body language, voice tonality and/or words that the receiver considers a message sent by the sender even if the former did not intend that.

Based on the above, in this study communication is operationally defined as: the interactional and transactional process in which individuals and/or communities create, share and regulate meaning through certain symbols, signs or expressions, intentionally or unintentionally by imparting and conveying some information via body language, voice tonality, words and/or some other forms that takes place in particular, social and cultural context/s and not in a (social and cultural) vacuum. As noted above there are various elements of communication. These elements can be regarded as the determinants of

communication types in the sense that while one can speak of communication in broad terms, depending on the nature and type of content, source, form, channel, receiver and purpose, one can also talk about specific types or forms of communication. For example, development communication, health communication, military communication, aviation communication, church communication, educational communication (Berger, Roloff & Roshos-Ewodsen 2010).

2.2.3   Communication Campaigns

Etymologically the term campaign is derived from the military domain (Atkin & Salmon 2010), where it represented a distinct phase of a war designed to accomplish specific objectives. Over the years applications of the term have broadened to encompass communication strategies devised to produce a wide variety of social, political, health, and commercial effects on a population (Atkin & Salmon 2009:419). It is worth noting that from its etymological origins a campaign was designed to accomplish specific objectives or "generate specific outcomes in a relatively large number of individuals, within a specific time, and through an organized set of communication activities" (Silk 2009:88). Campaigns are imminently 'social' because they are social events occurring in a social environment, which means they depend on the impact that human communication has on the behaviour of other humans. Being imminently social implies that campaigns are socially constructed (Parrott, Egbert, Anderson & Sefcovic 2002).

Rice and Atkin (2009:1) define communication campaigns in broad terms as "purposive attempts to inform, persuade, or motivate behavior changes in a relatively well-defined and large audience, generally for noncommercial benefits to the individuals and/or society at large, typically within a given time period, by means of organized communication activities involving mass and online/interactive media, and often complemented by interpersonal support". For Coffman (2002b:2), communication campaigns are those campaigns that "use media, messaging, and an organized set of communication activities to generate specific outcomes in a large number of individuals and in a specific period of time. They are an attempt to shape behaviour toward desirable social outcomes". She adds "very rarely do public communication campaigns feature only communication through media channels-- Usually they coordinate media efforts with a diverse mix of other communication channels, some interpersonal and some community-based" (Coffman 2002b:5).

The two definitions above have some similarities in content as demonstrated in Table 2.1.

Main Characteristics of Communication Campaign according to definition of Rice and Atkin (2009)	Main Characteristics of Communication Campaign according to definition of Coffman (2002)
Communication Campaigns:	
• purposive attempts to persuade or motivate behaviour changes; • directed towards well-defined and large audience; • carried out within specific timeframe, meaning they are time-bound; • benefit individuals as well as society at large; • organized communication activities; • using mixed communication channels of mass and online/interactive media complemented by interpersonal media.	 • in a large number of individuals • in a specific period of time • organized set of communication activities to generate specific outcomes • use media, messaging; very rarely do feature only communication through media channels… Usually they coordinate media efforts with a diverse mix of other communication channels; some interpersonal and some community-based.

Table 2.1   **Comparative Table of Two Definitions of Communication Campaigns**

The essentials of these two definitions are summarised as follows: communication campaigns entail organised sets of communication activities that carry messages communicated with mass and interpersonal media, both traditional and contemporary. A large number of individuals are the target audience of the messages of the campaign and not just an individual or small group of people.

The definition by Silk (2009:1) highlights some of the features of the definitions of Rice and Atkin and Coffman above, namely that communication campaigns "are intended to generate specific outcomes in a relatively large number of individuals, within a specific time, and through an organized set of communication activities". He adds that these "campaigns employ communication strategies and theories to influence large audiences in some measurable way" and in pro-social campaigns the objective is to "persuade-or to influence an attitude, increase knowledge, promote awareness, or even change behavior".

From the three definitions above, it is clear that communication campaigns are complex. Silk (2009:1) explains that poignantly when he posits that communication campaigns are "an art as well as a science. In other words, high-quality graphics and creative ideas are necessary to attract and maintain attention, but so is a fundamental understanding of communication theory to maximize understanding of audiences, message content, and evaluation strategies". Silk's definition and explanation underpoint/s the need for communication campaigns to be underpinned by communication strategies and theories. His explanation emphasises the point that communication campaigns ought to be strategically planned and executed and not done haphazardly, and the planning and execution should be theory-based.

Though none of the three definitions above uses the term influence, they all seem to suggest that communication campaigns do influence or are intended to influence their target audience. Persuasion and motivation are, therefore, essential characteristics of communication campaigns. To persuade or to motivate, which entails exercising influence can be accomplished by various means, including arguments, entreaty, and expostulation (Sullivan 2009). That implies that at the heart of communication campaigns, is an effort to influence the target audience with messages so that the target audience may change or modify certain behaviours. Unlike propaganda which is an attempt to deceive or coerce recipients of a messages by means of outright deception, selective information (Propaganda [media studies] 2009), the mode of influencing or persuading in communication campaigns does not use coercion, manipulation or deception to convince people to think or act in a certain way or change behaviour. Rather, the persuasion of communication campaigns presents people with reasons why they should adopt an attitude, opinion or behaviour (Carden 2004).

To appreciate the dynamics of persuasion in communication campaigns, Carden (2004:2) refers to Aristotle's description of persuasion "as an art of proving something true or false, and (he) identified three ways to offer such proof: through ethos (source credibility), logos (logical appeals) and pathos (emotional appeals)". Ethos is source credibility – that is, trustworthiness of the source of the message, which in modern translation might be "image" of the source, which affects the effectiveness of the appeal. Logos refers to appeals based on logic and reason, appeal to the intellect. Pathos refers to arguments that are based on emotions such as love, fear, guilt, hate or joy which may lead a person or persons "to accept a claim based on how it makes you feel without fully analysing the rationale behind the claim" (Edlund 2010; Logos_Ethos_Pathos 2010). Aristotle's description and explanation of persuasion and his identification of the three ways of persuasion highlight the need to ensure

that the source or image of the campaign's messages is credible, believable and trustworthy. The appeal or argument of the message should be presented in a logical manner that can be considered reasonable by the target audience. Also, the appeal should not be directed only to the intellectual capacity of the target audience but also to their emotions.

The provision of information, that is the act of persuading or motivating in communication campaigns are all geared towards forming attitudes of the target group, increasing their knowledge about certain aspects of life or topic, and achieving social and behaviour change (Cappella 2003). Behaviour change thus is one of the main eventual objectives if not 'the' main objective of communication campaigns. It is important to note, however, that behaviour change is not something that occurs overnight or in an instant. Behaviour change occurs over time for individuals and populations and thus needs time to occur as Change Models belonging to the category of theoretical models of behaviour change explain (Donovan 2012:16).

Based on the definitions discussed, the operational definition of communication campaigns in this study is: strategically organised sets of communication activities based on theory/theories, which carry messages using multifaceted traditional and contemporary media; directed, within a specific timeframe, towards a relatively well-defined large group of people with their sociocultural context. Communication campaigns aim at persuading the target audience and influence their attitude, increase their knowledge and information on the campaign issue/s, promote awareness, and/or facilitate change of their particular behaviour that is being targeted.

2.2.4   Health Communication

Rogers (1996) and Ratzan, Payne and Schulte (2004:398) define health communication in its broadest sense as "any type of communication whose content is concerned with health". Barry (2007:2) adds, "where the focus is on health-related transactions and the factors that influence these". However as a field according to Ratzan et al. (2004:398) "health communication is more clearly defined as the process through which one person, group, or governmental or private organization uses various communication strategies and channels to educate, motivate, and perpetuate information, skills, and behaviours that are generally accepted to benefit (improve) the health of individuals and the public".

Over the past 35 years, this field has developed and became a vibrant and important field of research with different branches or perspectives. Its focus has broadened to include

"research on health care teams, collaboration within health care, the organization of health care institutions, the communication effects of managed care, communication between health care and members of disenfranchised groups, and the transnational comparative studies of health care systems" (Ellingson 2002:3). As a field therefore, health communication is broad and complex, multifaceted and multidisciplinary (Ratzan et al. 2004). It is a field influenced by the "fields of social and clinical psychology, behaviour change theory, medical sociology, cultural anthropology, marketing--and communication theory" (Wolff 2008:472). Health communication draws from the "research and theory of just about every other area of communication research, including intrapersonal communication, interpersonal communication, group communication, organizational communication, media studies, public relations, intercultural communication, rhetorical studies, and new information technologies" (Kreps 2009:1). Thus, not surprisingly, he goes on to explain "health communication scholars apply a wide range of different theories, models, and research methods from different areas of communication inquiry to examine health communication phenomena". Accordingly scholars in the health communication field adopt "theories and methods that derive from many other related disciplines, such as psychology, sociology, anthropology, public health, medicine, nursing, health education, epidemiology, and social work" (Kreps 2009). Hence "health communication science provides a research-based foundation for developing strategies to inform and influence individual and community health decision" (Beato & Telfer 2010:24).

Based on the preceding discussion health communication is operationally defined in this study, in general terms, as an interactional and transactional process in which individuals and/or communities create, share and regulate meaning pertaining to health matters/issues. They do so either intentionally or unintentionally by imparting and conveying health information and health-related materials within particular sociocultural contexts. As a field, health communication is operationally defined as a complex, multifaceted and multidisciplinary communication inquiry and/or related activities that strategically applies different theories, models and research methods to examine health communication phenomena.

Alhough health communication is a field in its own right it is important to note that it is related to development communication. For as Wolff (2008) notes above, health communication as a field is influenced by many other fields and considered a subset of development communication. A brief exposé below of the relationship between the two is helpful to grasp the value of health communication as it pertains to the HIV/AIDS epidemic.

2.2.5   Health Communication Campaign

In the light of the discussion above on communication, communication campaigns and health communication, it is argued for the purpose of this study that a health communication campaign is a strategic communication activity, which originates in a social, cultural context involving human beings and pertains to human behaviour. Furthermore it is argued that it is a strategic communication activity developed and sustained by human beings and carried out in a sociocultural context by human beings. Hence, based on the operational definitions of communication, communication campaign, and health communication, health communication campaigns are operationally defined as an integrated communicative design of specific health message/s strategically and purposefully constructed and packaged; in sets of health communicative activities and processes of transmission and rituals. These activities and processes, which are time-bound, aim at informing, persuading and/or motivating a relatively well-defined large target audience toward some health attitude and behaviour change should benefit the individual and the society. As these health communication campaigns are persuasive campaigns the target audience or receivers of the messages in health communication campaigns are not exposed to a single persuasive message, but to multiple messages, systematically and strategically put together (planned and not haphazard) with the aim of accomplishing a set of persuasive goals (Stiff & Mongeau 2003). A visualisation of the health communication process as a persuasive communication process is illustrated in Figure 2.1
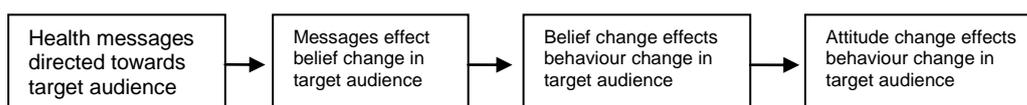
Figure 2.1   Health Communication Campaign as persuasion with the framework of Belief Change ⟶ Attitude Change ⟶ Behaviour Change
(Based on Infante et al 2003:103)

In Figure 2.1, the designed health messages are directed towards the target audience. If the messages are received positively, they should bring about change in the target's belief about the health problem or issue. If the process continues, the change in belief again brings about change in the attitude of the target audience towards the health problem or issue. This change in attitude then translates into a change in health behaviour.

2.2.6 Development Communication

The coinage of the terminology 'development communication' in the 1970s is attributed to Professor Emeritus, Nora Quebral, formally of the College of Development Communication at the University of the Philippines at Los Banos. According to Kumar (2011:2) Quebral defined the field as "the art and science of human communication applied to the speedy transformation of a country from a state of poverty to a dynamic state of economic growth and makes possible greater economic and social equality and larger fulfilment of human potential". This definition points to the fact that in its earliest years development communication was regarded as an art and science (of communication) whose application to the process of development facilitated the process of the minimisation or eradication of poverty, which then leads to transformation in a country's population. The transformation process provides the people with greater possibilities of economic growth and social equality which in turn translates into better lives in every way, including areas or aspects of life such as "nutrition, health education, housing and employment, etc." (Kumar 2011:1). It could be said that the end result of the development communication process was expected to be the transformation from a lower or lesser quality of life to a higher one, intended or geared towards empowering the recipient communities to take charge of their life situations and improve them.

While Quebral is credited with coining the terminology and pioneering the term's initial definition, it is worth noting that scholars such as Everett Rogers, Wilbur Schramm and Daniel Lerner in the 1960's were dealing with issues of development communication or communication for development in their scholarly work and writings though they did not use such a terminology. These scholars "advocated the modernization theory, which simply held that the developing countries needed to adopt new technologies (including communication technologies) and increase production at all levels that could lead to development" (Srampickal 2006:3), that was regarded as the rapid transfer of technology of the North Atlantic nations to the 'backward non-Western world'. This initial understanding and practices of development communication, which was anchored in the modernisation theory quickly evolved since already in the mid-to-late 60's the theory faced criticism and was countered with the dependency theory. This dependency theory suggested that merely adapting modern technologies made the targets of (development) communication ever more dependent. Moreover, these technologies could not be adapted exactly as many of the targeted countries and populations lacked basic infrastructures such as electricity and transportation. As the understanding and practice of development communication have evolved, according to Srampickal (2006:3) it "generally refers to the planned use of

strategies and processes of communication aimed at achieving development" and signifies an "attempt at informing, creating awareness, educating, and enlightening the people so that they can better their lives in every way." In the light of this, Srampickal (2006:3) further explains that the all-embracing focus on development communication has led researchers to "examine communication in five general areas. Agricultural communication explores ways in which governments can use the diffusion of innovation theories to promote farming technique. Health communication includes information about health, family planning, and HIV/AIDS prevention and so on. Population, education, and environment communication utilise strategies of education on these issues. Challenging the status quo in civil society promotes the various kinds of participatory communication for empowerment of local peoples. And challenging social structures uses similar tools to educate, for example, the lower cast in India". In relation to the second general area – health communication, Bertrand (2004:114) notes that the Diffusion of Innovation Theory of development communication "provides useful insights into the difficulty of achieving behaviour change necessary to curb the HIV/AIDS epidemic in developing countries". Health communication understood in this context, is considered part of or a subset of development communication even though as mentioned above the former is also a field in its right and can be treated as such.

What distinguish development communication from general communication according to Kumar (2011:2) are the three main ideas that define its philosophy: "development communication is purposive communication, it is value-laden, and it is pragmatic. In the development context, a tacit positive value is attached to what one communicates about, which shall motivate the people for social change. Development communication is goal-oriented. The ultimate goal of development communication is a higher quality of life for the people of a society by social and political change". In the definition of health communication offered by Ratzan et al. (2004), development communication is said to use various communication strategies to educate, motivate and perpetuate information, skills, and behaviour which if accepted benefit (improve) health. That explanation implies that the philosophy that defines health communication, health communication campaigns, in particular, is the same as or similar to those that define development communication – that is, purposive communication, value-laden, pragmatic and goal-oriented. Another characteristic of development communication, which also defines health communication, is voluntary behaviour change. Colle (2008:1) opines communication is a "vital partner in initiatives that involve voluntary behaviour change…most of the effort we put into development communication involves helping people develop themselves and their communities, and this invariably involves voluntary actions". The word behaviour, Colle explains, cover "a wide variety of phenomena, ranging from believing something will improve

a family's welfare to using a condom or adopting (or avoiding) biotechnology-developed seed varieties". Among health communication efforts and activities aimed at curbing the spread of HIV is the promotion of the use of condoms, that is a voluntary act, a characteristic of development communication and an indication of the relationship between the two forms or types of communication.

Colle (2008:1) asserts that development communication entails strategic communication. That means it is not "a hoc practice of designing an occasional poster or radio spot for a given cause". Rather it is a combination of "a series of elements – extensive use of data, careful planning, stakeholder participation, creativity, high-quality programming, and linkages to other programme elements and levels, among others—that stimulate positive and measurable behaviour change among the intended audience". Health communication, particularly, HIV/AIDS communication campaigns, which as discussed above falls under the umbrella of development communication, hence is regarded as strategic communication. Strategic communication is a concept and communications strategy which McKee, Bertrand and Becker-Benton (2004:26) note is a "promising response to the HIV/AIDS epidemic that has been vastly under-utilized to date", but which Colle (2008) points out, is now being applied to efforts to combat the HIV/AIDS problem. McKee et al. (2004) said strategic communication is an approach to the design and implementation of programs that increases their impact on behaviour and social change. Connolly-Ahern (2008) adds that strategic communication is "the purposeful communication by a person or an organization designed to persuade audiences with the goal of increasing knowledge, changing attitudes, or including desired behaviour".

2.2.7   Culture

As far back as the 1950s, Kroeber and Klunckhohn (1952) observed that there are hundreds of definitions of the concept, culture. This observation is reiterated in recent years albeit in various formulations. For example, Smith (2000:1) states, "At the start of any text, it can be useful to define the central concept. In the case of 'culture', this has proven to be surprisingly, even notoriously, difficult". According to Levy (2007), culture as a concept has attracted numerous definitions and interpretations. Torop (2008:1) opines, "The proliferation of definitions of culture and their frequent disparity clearly indicate that the principles of defining culture are numerous and sometimes very different".

While the literature abounds with hundreds of definitions of culture, many of these definitions take their cue from E. B. Tylor's definition in his work 'Primitive Culture' in the late 19th

century. Tylor defined culture as "that complex whole which includes knowledge, belief, art, morals, laws, customs, and any other capabilities and habits acquired by man as a member of society" (Spencer-Oatey 2012:1). The idea that culture is complex as stated by Tylor's seems to have found expression in the definition rendered by Kroeber and Kluckhohn (1952). According to them, culture consists of patterns, explicit and implicit, of and for behaviour acquired and transmitted by symbols, constituting the distinctive achievements of human groups, including their embodiments in artefacts. The essential core of culture consists of traditional, that is, historically derived and selected ideas and especially their attached values. Cultural systems may, on the one hand, be considered as products of action, and on the other hand as conditioning elements of further action.

While the concept culture may seem difficult to define thus giving rise to hundreds of definitions, Williams (1958:93) describes it simply as something 'ordinary' - the whole way of life of people, which includes the arts and learning of people, their special processes of discovery and creative effort. The ordinariness of culture, Williams (1958:93) explains, makes it present in every society and every mind. Hence, every human society has its shape, its purpose, and its meanings. Williams' explanation could be understood as implying that people of any given culture are conditioned by their culture, which is learned. That might have prompted Hofstede (1993:81) to posit that culture is "learned, not inherited" and it "derives from one's social environment, not from one's genes". That understanding of culture might have prompted Hall (1959:29) to state "culture controls our lives-It is a mould in which we are all cast, and it controls our daily lives in many unsuspected ways". Hall (1959:47) further explains that culture is "learned and shared behaviour" hence it comprises assumptions, values, and belief that are shared by members of a specific group. Within the group, the 'self' of the individual is formed through the interaction that takes place between its members (Hofstede 1991). As a person's 'self' is formed in the context within which certain assumptions, values, and beliefs are shared the point made by Hall that culture controls our lives seem to have some validity. For culture "provides a set of rules for how people will interact in exchange relationships – what constraints and ways in behaviour and decisions are accepted" (Varey 2002:116); and culture also "dictates who we are and how we respond to the world around us" (Abramson, Trejo & Lai 2002:21).

From the preceding discussion, it is deduced that culture has a characteristic of distinguishing particular groups of people or society in the general population of the world or countries. That may be the reason why UNESCO's (2002) Universal Declaration on Cultural Diversity, states, "culture should be regarded as the set of distinctive spiritual, material, intellectual and emotional features of society or a social group, and … it encompasses, in

addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs". This set of distinctive features with all that it encompasses the culture are "shared, learned, and passed on from generation to generation-influences how people perceive the world around them and helps them make decisions" and "guide their interactions with each other" Knott (2002:2). Culture then according to Frierson, Hood and Hughes (2002:63) is "a cumulative body of learned and shared behaviour, values, customs, and beliefs common to a particular group or society".

The definitions of the concept culture presented so far emphasise the integrated functioning of cultural traits. That together give a special character to the way of life of a reproductive social group a character that distinguishes one particular group from all other such groups (Biernatzki 2009). While that emphasis is still operative, it is however, necessary also to understand the contemporary reality of social groups that are "increasingly interactive with each other, and whose cultural 'boundaries' are less clearly definable than in the past" (Biernakzki 2009:99). An example of this is the multicultural situation of the inhabitants of the Ekurhuleni metropolis discussed in Chapter 1. Today more people live in intercultural and multicultural situations. The blurring of boundaries between groups has shifted the emphasis to the meanings assigned to the various aspects of their lives and experiences by the members of a social group that may not be homogeneous. In multicultural situations as people of different cultures interact, they learn from each other, adapting to each other. The elements of culture, for example, language, norms, values, beliefs and ideologies are thus shared when people from different cultures, living and interacting with each other are open to learning from each other mostly in an informal manner.

Based on the various definitions and descriptions presented, for the purpose of this study, culture is operationally defined as a complex and multifaceted set of sub-concepts and processes, some of which are abstract, for example, how the world is perceived and some concrete, how one behaves and is expected to relate to one's environment. Furthermore culture influences aspects of the way of life of people such as their beliefs and behaviour, which distinguishes one society from another. It is not static but dynamic, a process, and it changes over time. In the process of change, it sometimes keeps some of its core elements. Though culture is acquired through learning within a society and is specific to a society, it is possible for a person to become multicultural by learning and adopting different cultural traits due to intercultural situations.

2.2.8   Social

Vygotsky (1993:15) defined the concept social in a very broad sense as everything cultural. He posited that culture was "the product of man's social life and his public activity." If social is every cultural and culture is a product of man's social life, then it could be surmised that for Vygotsky, the meaning of concepts social and culture are virtually the same. For Kimberly (2005:48) the term social implies "interaction with others." The presentation of what social is in the Collins COBUILD Dictionary (1987) helps clarify further the definitions of Vygotsky and Kimberly. According to that Dictionary the concept social relates to society and the way it is organized; and society refer to people, in general, thought of as a large organized group of people who relate to each other and have their way of life. Since as by Vygotsky posited social is cultural, and culture is a product of man's social life and his public activity, man is not a being in isolation but one in interaction with others. Being in interaction with others is what social is all about according to Kimberly. Man is therefore, a social being; making him a being in society, hence the adage 'no man is an island', or in the words of Aristotle (Politic): 'Man is by nature a social animal', and John Donne (Devotions upon Emergent Occasions, no. 17): 'No man is an island, entirely onto itself.'

Based on the above and for the purpose of this study, social is understood as human beings in relationship with each other interacting and being interdependent, and their interaction and interdependence ensure their survival as a group and as individuals within the group.

2.2.9   Sociocultural

The combination of the concepts social and culture is the source of the concept 'sociocultural', used as a compound concept in the social sciences. Since sociocultural theory derives from Vygotsky (1993), the assumption is that he coined the term sociocultural to explain his thoughts and ideas on how society and culture influence the learning and developmental process of a person (Pérez 1998). Based on this assumption it could be said that any attempt to define the concept sociocultural must of necessity take into account Vygotsky's definition of the two concepts, social and culture explained above - social is everything cultural, and culture is the product of man's social life and his public activity. For, as Kimberly (2005:49) notes, "Vygotsky saw that which is social as a concept that intersected with the concept of culture." The way Vygotsky saw the two concepts might have prompted Kroeber (1948) to posit that the two concepts are counterparts resembling the two sides of a sheet of paper. That is in the sense that they both relate to human beings as they are organized, are interdependent and interact; and how they specifically live their

mode of organization and relationships in their existential context – physical and non-physical. It is the combination of the elements of the two concepts, which makes one group of people distinct from other groups.

Sociocultural in this study is therefore understood to refer to the context and relational dynamics between people of a given society and how that affects and influences their pattern of thought, knowledge, beliefs, values, behaviour, customs and traditions.

2.2.10   Model

A model in the scientific field is regarded not only as a physical or material representation of some reality but also as a representation in the mathematical or pictorial form of some phenomenon. In the words of English (2003), "a model is used to describe, make sense of, explain or predict the behaviour of some complex system." That implies that there are different types of models, and the different models serve different purposes depending on whether they are meant to describe, explain or predict reality. In science, models are considered as conceptual systems of realities, which consist of elements, relations, operations, and rules governing interactions expressed using external notation systems. That makes models in science a formalised interpretation or representation of entities, phenomena or processes in mathematical or pictorial form, and as Van Driel and Verlop (2002) put it, a model is a simplified representation of reality. The overarching idea coming out of these definitions or descriptions of model is that of representation. A model represents something other than itself. Being an interpretative description, explanation or prediction that may or may not conform to the true nature and processes of the entity or phenomenon they represent, the set of ideas, propositions and concepts that form modelling and model is said to constitute a theory.

2.2.11   Conceptual Model

The process of conceptualising, which is a way of thinking of the structure of phenomena, be they natural or social phenomena, results in the formulation or creation of conceptual models. These are intellectual – something in the mind, representations of the structures and processes of natural and social phenomena or activities. Hence according to Kauffman (2007:241), "conceptual models mean the way we think about things," not the actual things themselves. The structures of the things or phenomena people think about may be real, which means they may correspond to the reality or imaginary. Essentially, conceptual

models are mental representations of the structures of phenomena - representations of the structures of physical or social systems, which may be real or imaginary. 'Representation' is here understood as using one thing to stand for another thing and using mental constructs to represent some physical or social reality. A conceptual model, therefore, stand for something other than itself as it is not the actual reality, but only represent or purport to represent such reality.

A conceptual model has within itself a set of expressions or terms, which are intended to denote some aspect of the modelled phenomenon/activity or describe it. That is its ontological characteristic, which is that which makes the model 'something', which potentially visible. It is important to note, however that the set of expressions is mere conceptions about the phenomenon or activity and not the realities. As a conceptual model has an ontological characteristic, it also has epistemological characteristic. That means it can be investigated through different types of inquiry and alternative methods, and possibly yield knowledge and understanding of the reality that it purports to represent (Poetschke 2003; Vasilachis de Gialdino 2009). The epistemological characteristic provides a mental frame and structure/s that enables investigation of that which is conceptualised, and the result of the investigation/s could be the acquisition of knowledge and understanding of what it represents. Hence though mere conceptions the set of expressions have the value of enabling a search for answers to questions about the modelled phenomenon or activity as to 'what it is', 'how it is' and 'why it is' – a reference to the conceptual model's epistemological value or significance. The manner in which the set of expressions are constructed in a model, and what logical structures they have, would depend on the type and nature of the model. To say a conceptual model is something in the realm of conceptions is, therefore, to imply that the materials needed for its construction are concepts.

A conceptual model in this study is therefore described as a representation in the pictorial or diagram form of mental structure/s; of expression of relationships and processes of concepts purporting to represent a phenomenon, reality, entity or activity that may be real or imaginary. The conceptual model makes it possible to discuss the purported phenomenon, and the model can be subject to inquiry or investigation for verification.

2.2.12   Modelling

According to Silvert (2000:1) modelling "is an essential and inseparable part of all scientific, and indeed all intellectual, activity." For Justi and Gilbert (2002) modelling is one of the most important parts of scientific reasoning. While in the view of Greca and Moreira (2001),

modelling is the scientist's main activity for generating and applying scientific theories. In science modelling is considered a process of generating abstract, conceptual, graphical and/or mathematical models – a process of constructing cognitive artefacts, which are externalised mental models, which may be real or imaginary" (Hestenes 2006). It is important to note that there are two sides to the process of modelling – the cognitive and the practical (Parkinson, 2007). If modelling remains on the cognitive level alone, it is considered as being abstract or a purely mental activity. That is, generating or mentally constructing sets of ideals, propositions, concepts or principles – a thinking process. When the thinking process results in constructing mathematical, pictorial or graphical representation of reality, then modelling can be said to be on the practical level, hence modelling is fundamental to science and of great utility to scientists (Schwarz & White 2005).

Modelling in this study is operationally defined as a process involving the cognitive activity of generating generalised hypothetical descriptions, explanations and/or predictions of inter-related set of ideas and/or concepts of some phenomena and the construction of a model/s in a mathematical or pictorial (graphic) form of representation of the phenomenon.

2.2.13   Structure

A natural/physical or a social phenomenon or entity has some structure that refers to a framework of identifiable elements, components, entities, factors, members and parts of the phenomenon (Business Dictionary [sa]). This framework of identifiable elements defines the boundary or boundaries of the phenomenon, and it is within the boundary/boundaries that the various elements connect with each other. Hence, structure is said to be a fundamental and sometimes intangible notion covering the recognition, observation, nature, and stability of patterns and relationships of entities (Scientific modelling 2011). That means the structure of a phenomenon or entity is 'that which gives it its shape or form'; and that which gives it shape or form is what is recognized and/or observed as being the stable patterns of relationships within the phenomenon or entity. Stable patterns of relationships are the relationships between the various parts of the phenomenon or entity, be it a natural, physical or social entity. That refers to the elements that link the parts of phenomenon or entity. The structure of a model or structure in modelling thus is the manner in which the set of relationships of the ideas or concepts represent the phenomenon and gives shape to the phenomenon. It is important to emphasize that such structure, the set of relations between the various elements in modelling, is something conceptualised, something that is 'thought of'. That set of relations includes what Hestenes (2006) refers to as the relation of "belonging

to," which specifies composition of the ideas, the set of objects belonging to the phenomenon as understood and used in this study.

2.3   CONCLUSION

This chapter focused on the key concepts of the study and presented definitions as found in the literature and operational definitions were then presented for each key concept as they were understood and used in this study. The key concepts were in four categories: assessment; communication together with communication in general, communication campaigns, health communication, health communication campaigns, and development communication; culture and its related concepts of social and sociocultural; model and its associated concepts of conceptual model and modelling; and structure.

In summary assessment was understood and operationalised as a systematic process of obtaining data about something relative to some objective. Communication was regarded as an interactional and transactional process of imparting and conveying information via different forms, while communication campaign was considered as strategically organised sets of communication activities based on theory/theories that aim at persuading and encouraging change in some particular attitude and behaviour related to the campaign message. Health communication was operationalised as an interactional and transactional process in which individuals and/or communities create, share and regulate meaning pertaining to health matters/issues; and health communication campaign is a strategic communication activity, which originates in a social, cultural context involving human beings and pertains to human behaviour. Development communication was considered as a value-laden, pragmatic, purposive strategic communication that is oriented towards the goal of bringing about or achieving a higher quality of life. Culture was operationalised as as a complex and multifaceted set of sub-concepts and processes, some of which are abstract, for example, how the world is perceived and some concrete, how one behaves and is expected to relate to one's environment, while social was understood as human beings in relationship with each other interacting and being interdependent, and their interaction and interdependence ensure their survival as a group and as individuals within the group; and sociocultural being the context and relational dynamics between people of a given society and how that affects and influences their pattern of thought, knowledge, beliefs, values, behaviour, customs and traditions. Structure was operationalised as a framework of identifiable elements, components, entities, factors, members and parts of either a natural/physical or a social phenomenon or entity.

Both the conceptual and operational definitions presented and discussed helped set the boundaries within which their meanings assisted in articulating the issues investigated in the study. The parameters set for the concepts provided flexible boundaries within which to discuss the theoretical approach of the study and the development of a conceptual framework in the next chapter.

CHAPTER 3: THEORETICAL APPROACHES TO HEALTH COMMUNICATION CAMPAIGNS AND THE CONCEPTUAL THEORETICAL FRAMEWORK OF THE STUDY

3.1   INTRODUCTION

In the previous chapter, it was concluded that the conceptual and operational definitions of key concepts set the boundaries of their meanings as used to articulate issues, which are the subject of this study. Issues such as the intricate intertwined relationships between communication and culture and the effects and implications of such relationship on health communication campaigns. Articulation of such issues involved using ideas, propositions, concepts or principles. Such use of ideas, propositions, concepts or principles is not haphazard but follows a system of 'linking' and that form of linkage characterises the concept 'theory' (Health & Bryant 2000), This chapter therefore, reflects on theoretical and current approaches, and inherent challenges in evaluating health communication campaigns. That reflection is followed by a presentation and discussion of the conceptual theoretical framework of the study. As the chapter focuses on theories/models the reflection begins by clarifying the meaning of 'theory'.

3.2   DEFINITION OF THEORY

Heath and Bryant (2000:10) define theory as "a systematic and plausible set of generalizations that explain some observable phenomena by linking concepts (constructs and variables) in terms of an organizing principle that is internally consistent". According to Anderson (2009) theory is simply a way of thinking about something, a set of instructions that tells what and why things are (the way they are); how and why they function (the way they function) and the value it all represents. For what is regarded as a theory to be a true theory Anderson (2009) is of the view that it must have certain characteristics, namely it must have an object of explanation and must contain or connect to a method of analysis. Gleaned from the two definitions is that theory essentially offers explanations, descriptions or predictions about observable entities, phenomena or events through generating concepts, which are "abstract ideas or mental symbols that are typically associated with corresponding representations in language or symbologies which denote all the objects in given categories or classes of entities, events, phenomena, or relationships between them" (Bangura 2012). Concepts thus are the building blocks of theory (Health & Bryant 2000). Once these blocks are utilised to construct a theory it helps in answering questions of 'what', 'why and how' of phenomena and predict the behaviour or circumstances of phenomena. That is, it takes

explanations of the past and present and extend them to future circumstances; and/or control behaviour (suggest how something should be). A good theory then as Heath and Bryant (2000:10) opine should "guide additional speculation, explanation, and prediction". These two scholars list the following as characteristics of a good theory: it must be heuristic, parsimonious, internally consistent and capable of being falsified. Being heuristic means it can be used to guide something valuable such as guiding the design of a communication campaign. It is parsimonious if it can be stated briefly and succinctly. If it is logical and reasonable, then it is internally consistent, and being capable of being falsified implies that it can be disproven just as it can be proven (Heath & Bryant 2000).

Based on the above and within the context of this study, a theory would be considered appropriate if it describes phenomena; it explains why the phenomena are, what and how they are; and it predicts sequences of actions, events and outcomes of phenomena. By doing so, it will assist or suggest how to control the activities and the outcome of such activities (Heath and Bryant 2000). In addition to these criteria a theory must be open to the possibility of being validated. That implies the proposed or assumed set of relationships must be such that they can be validated or open to being proven right or wrong.

3.3   THEORIES OF HEALTH COMMUNICATION CAMPAIGN

In the 7th edition of Griff's (2009) book 'A First Look at Communication Theories,' one finds a list of more than 70 communication theories, which are grouped under their specific areas of communication studies and/or practice: Interpersonal Communication, Group and Public Communication, Mass Communication and Cultural Context. A few of the theories, for example, the Elaboration Likelihood Model, System Theory and Theory of Planned Behaviour/Reasoned Action, are used in more than one field or area of studies and/or practice. Since this study is concerned with the field of health communication with a special focus on health communication campaigns, discussion on communication theories and models in this section focuses particularly on those theories and models that are commonly used in this field of studies and practice.

According to Bowes (1997:8), traditionally health communication campaigns have been "grounded in behaviour change theories such as Health Belief Model, the Theory of Reasoned Action and Bandura's Social Learning/Cognitive theories". However, some communication scholars, among them, Kelly (1999) have raised questions concerning the adequacy and/or appropriateness of some theories and models (especially the traditional ones) used to guide the design and implementation of health communication campaigns. For

instance, have been questions about the limitations of communication campaigns that focus on individuals to change behaviour without adequately paying attention to factors such as the social and physical environment that have some determining influence on an individual's health behaviour. Referring to HIV/AIDS communication campaigns, Airhihenbuwa, Makinwa and Obregon (2000:101) also express their concern by pointing out "there is a need for an evaluation of current approaches to prevention and care, especially in terms of the relevance of theories and modules currently used to guide HIV/AIDS communications in Africa, Asia, Latin America and the Caribbean". Similarly, Airhihenbuwa and Obregon (2000) note that most of the theories and models used to develop HIV/AIDS communication campaigns are those with their origin in social psychology, focusing mainly on individualism. Bandura (2000) refers to this individualism by explaining the differences that exist between target audience/s, such as differences in demographics, health needs and risk factors. In view of these Bandura (2000) levels criticism against theories and models that have the individual as their focus, as such theories miss the social and environmental factors that may also serve as determinants (influencing factors) in health behaviour change. The questions and criticisms of these scholars point to the need for inclusion of theories with broader perspectives than the individual perspective only.

There is thus a need for the development of innovative theories and models, which unlike the "classical" models pay attention to regional contexts in the knowledge that "differences in health behaviours are often the function of culture. Therefore, culture should be viewed for its strength and not always as a barrier" (Airhihenbuwa & Obregon 2000:1). The need for such broader perspective or framework and the shift of focus from the individual to other factors, prompted the Joint United Nations Programme on HIV/AIDS (UNAIDS) to initiate a project of workshops organized between 1997 and 1999. These workshops brought together leading researchers and practitioners from different parts of the world to examine the application of existing communication theories, models, or frameworks, and rethink their adequacy for HIV/AIDS prevention and care. The participants of this project developed a communication framework for HIV/AIDS with a focus on five domains of "contexts" that they regard as influencing behaviours, namely: government policy, socioeconomic status, culture, gender relations and spirituality (Airhihenbuwa et al. 2000). This is similar to earlier studies in 1988 conducted by McLeroy, Bibeau, Steckler and Glanz. who identified similar multiple levels of influence on human behaviour, namely: the individual or intrapersonal factors; organizational or institutional factors; community factors and public policy factors. Hornik and Yanovitzky (2003:204) express concern that often "models of effect assume that individual exposure affects cognitions that continue to affect behaviour over a short term". Contrarily, these scholars explained the "effects may operate through social or institutional paths as

well as through individual learning, require substantial levels of exposure achieved through multiple channels over time, take time to accumulate detectable change, and affect some members of the audience but not others". The points raised by these various scholars highlight the need in planning and designing health communication campaigns, to take cognisance of individual, social, institutional, and community factors that have bearings on an individual and group's health behaviour, and not only focus on the individual and individualism. The call for such a shift of focus, however, should not mean a rejection of theories or modules that focus on the individual. Airhihenbuwa et al. (2000:103) for example note that participants at the UNAIDS workshops acknowledged "the individual is a crucial part of the 'context' and the new framework could draw on salient elements of existing theories and models".

Keeping the above remarks in mind, a selection of eight theories/models frequently used in health communication campaigns namely, Health Belief Model (HBM), Theory of Reasoned Action (TRA), Theory of Planned Behaviour (TPB), Stages of Change, Social Learning Theory/Social Cognitive Theory (SLT/SCT), Social Marketing, Health Communication Process and Seven Steps Approach are examined for the purpose of this study. The choice of these eight theories/models is based on the need to have a general overview of the main areas of focus of existing theories/models. These main areas of focus are individual/intrapersonal, interpersonal, community/group, research/practice and process. Another reason for the choice of the eight theories/models is their making up both micro-level and macro-level theories/models that typify the issues of discussion in this study. The micro level theories/models are those that focus on individuals and their interactions, while the macro level theories/models focus more on upon social structure, social processes and problems and their interrelationships (Cruickshank 2011, MLA Citation 2011). The examination of the theories/models is done against the background of earlier discussions regarding communication campaigns in general, but with particular reference to health communication campaigns, and some points raised by scholars regarding the strengths and limitations of the theories/models in guiding the process of health communication campaigns.

The first four theories (HBM, TRA, TPB and Stages of Change) are individual level health behaviour theories/models, which serve as framework for analysis and understanding some of the internal mental processes in an individual, and because such analysis and understanding may be in a position to make some predictions of health behaviours. The fifth theory, SLT/SCT, is an interpersonal or social context level behaviour theory which complements the individual level theories by drawing attention to interpersonal and

environmental factors, which are absent in the first four, but are significant for a much broader understanding of human behaviours in general and for the purpose of this study, health behaviours in particular. These first five theories/models highlight how individuals, social environments and health behaviour interact – that is, the relationship between the three. The sixth theory/model, Social Marketing is a research and practice model focusing on key concepts and methodological approach in planning and implementation of communication campaigns, highlighting the place and roles of target audience and the context of their life. The seventh and eighth models highlight the steps in communication campaigns as being a process.

The classification or grouping of the eight selected theories into the four levels (individual-interpersonal/social and environmental context, research and practice and processual theories/models) highlight paradigm shifts and the main thrust of the groups of theories and models. A brief discussion of each of these theories and models is presented below in chronological sequence of development. The discussion highlights the paradigm shifts and how theories and models complement each other. Furthermore it indicate they provide the necessary framework for a broader and more comprehensive understanding of human behaviour – both individual and community/group (behaviours); and how they can serve as powerful tools to underpin or guide the different stages and process of communication campaigns in general and health communication campaigns in particular.

3.3.1   Health belief model

The Health Belief Model (HBM) is one of the first and most widely used conceptual frameworks for understanding health behaviour and planning health campaigns (Lapinski and Witte 1998; Airhihenbuwa and Obregon, 2000). It is a psychological model that "attempts to explain and predict health behaviours by focusing on the attitudes and beliefs of individuals" (Family Health International, 2002) and by doing so allow people to control their health behaviours (Infante, Rancer and Womack 2003). It serves as a framework for motivating people to take positive health actions (Recourse Center for Adolescent Pregnancy Prevention (ReCAPP) 2004) or avoid risky health behaviours. Developed in the 1950s by social psychologists Godfrey Hochbaun, Stephen Kegels & Irwin Rosenstock) with a phenomenological orientation, the theory's original purpose was to systematically explain and predict preventative health behaviour (Brown 1999). It was "developed in response to the failure of a free tuberculosis (TB) health screening programme" and has since been "adapted to explore a variety of long-and-short-term health behaviours, including risk behaviours and the transmission of HIV/AIDS" (University of Twente 2009:1). HBM is

premised on the assumption that people naturally fear diseases or negative health conditions (Glanz & Rimer 1997; University of Twente 2009) and it hypothesizes that a person will take some health-related action under these three conditions: a feeling that an undesirable health condition can be avoided; a positive expectation that the undesirable or negative health condition can be prevented it one follows a recommended course of action; and confidence or belief in one's ability to successfully take the recommended action (ReCAPP 2004; Lezin 2004; University of Twente 2009).

Since HBM is premised on the assumption that people naturally fear diseases and negative health conditions and would take preventative actions to avoid them, it seems quite appropriate that one of the three conditions (mentioned above) necessary for a person to take some health-related action to avoid disease or negative health condition relates to feeling. 'Fear' according to Collins Cobuild English Dictionary (1987) "is the unpleasant feeling you have when you think you are in danger" and 'feeling' is "an emotion, such as anger or happiness"; while according to the Oxford Dictionary (2010), 'fear' is an unpleasant emotion caused by the threat of danger, pain or harm". If fear has to do with unpleasant feeling or emotion of a possible danger then, it seems natural to counteract such a feeling of possible danger with an opposite feeling of positive expectation. HBM comprises three main elements/variables, namely, individual perceptions, modifying factors and the likelihood of action, and each of these three main variables has minor or sub variables under them. These subsets of variables may influence a person to take a particular health action to lessen the chances of getting some infection or disease, or suffering some health-related malady (Glanz and Rimer 1997, University of Twente 2009). HBM thus stipulates that an individual's "health-related behaviour depends on the person's perception of four critical areas: the severity of a potential illness, the person's susceptibility to that illness, the benefits of taking a preventative action, and the barriers to taking that action" (Grizzell, 2004). How these sets of variables relate with and affect each other is illustrated with the arrows in Figure 3.1.

Individual Perceptions	Modifying Factors	Likelihood of Action

Demographic variables
[age, sex, race, ethnicity, etc.]

Socio-*psychological variables*

Perceived benefits of
preventative action
minus
Perceived barriers to
Preventative action

Perceived susceptibility to
disease "x"

Perceived seriousness
(severity) of disease "x"

Perceived threat
of disease "x"

Likelihood of Taking
Recommended Preventative
Health Action

Cues to action
Mass Media Campaigns
Advice from others
Reminder postcard from physician dentist
Illness of family member or friend
Newspaper or magazine article

Figure 3.1   Health Belief Model (Bowes 1997)

3.3.1.1   *Individual perceptions*

Being an individual level model as mentioned above, it seems quite appropriate that one of the main variables (of the model) is individual perceptions. This variable helps to explain and predict why and how a person may respond to the threat of disease, based on how he/she perceives that threat.

In other words, the manner in which an individual perceives the threat of disease helps determine the level or intensity of action or response the individual may take to minimise or avoid the threat. The first two critical areas on which an individual's health related behaviour depends are, susceptibility to illness and severity of potential illness, which form a set of variables under individual perceptions.

This is illustrated in Figure 3.1 where the arrow points from the box with the first set of variables (perceived susceptibility and perceived severity to disease) towards the box with perceived threat of disease. This indicates that the individual's perception of the threat of disease (that is his/her perception of being susceptible to the disease) is a reference to his/her subjective assessment or evaluation (Lapinski & Witte 1998) of the risks of contracting a disease or health-related condition. This perceived susceptibility could be rated high, low or moderate. When the individual perceives that it is very likely or inevitable that a health condition will be contracted, then the susceptibility is rated high. If the subjective perception is the unlikelihood of contracting the health condition, then susceptibility is rated

low, and when one operates on statistical probability, the susceptibility is rated as moderate (Infante et al. 2003). Linked to the perceived susceptibility is the individual's belief or opinion as to the seriousness of the health condition in question. Perceived severity, like perceived susceptibility, is thus part of the individual's perceptions of the threat of disease. Lapinski and Witte (1998:143) explain that the "severity of a health threat can be evaluated in terms of physical/medical harm (for example disease, illness) as well as social harm (for example, stigmatisation)". The levels or volumes of intensity of the two variables (perceived susceptibility and perceived severity) are determining factors on the magnitude of the health threat from the perspective of the individual. The perceived threat of disease or health condition reflects the individual's belief about how susceptible he/she is to the medical condition and the severity of that condition (Alcalay & Bell 2000). This again has implications as to whether or not, and to what extent or degree, a person is likely to take some action to minimise or avoid the undesirable health condition.

3.3.1.2   Likelihood to action

Perception of how susceptible one is to a negative health condition, coupled with perception of the nature and level of severity of the threat to one's health as the model postulates should lead to the likelihood of the person taking some appropriate preventative action (recommended) to minimise or avoid the negative health condition (Lapinski & Witte 1998). This explains the variable likelihood of action as one of the main elements of the model, and it implies that the likelihood of a person taking a preventative action to avoid disease is conditioned by the manner in which he/she perceives the danger that the disease poses. This likelihood of action (a health-related behaviour) also depends on the person's perception of two critical areas of the benefits of taking the preventative action and the barriers to taking that action that he/she has to overcome in taking such actions. Likelihood of action is thus conditioned by individual perceptions as illustrated in the Figure 3.1.

The individual may take action to prevent a negative health condition if he/she perceives benefits of such preventative action when perceived barriers can be eliminated. Perceived benefits therefore refer to positive effects such as reduction of risks or complete prevention of a negative health condition that the individual estimates would accrue to him/her if the recommended preventative action were taken – the person's assessment of the efficacy of effectiveness of the recommended action. A person is unlikely to take the recommended action "even in the face of considerable threat, if it is not perceived to be an effective response" (Alcalay & Bell 2000). In this regard, perceived barriers may be considered as an individual's assessment of whether the recommended preventative action will be expensive,

painful, upsetting, time-consuming or simply inconvenient (Infante et al. 2003) – that is, the individual's assessment of the tangible and psychological costs of the recommended action (ReCAPP 2004).

The difference between the weight of what is perceived as benefits (in taking the preventative action) and barriers (the price of the recommended action) determines the strength of the likelihood of taking the recommended preventative health action.

3.3.1.3   Modifying factors

A third main variable of the HBM model is modifying factors. As illustrated in Figure 3.1, this variable also has sub-variables relating to factors that may indirectly impact on or influence (as the arrows from the box indicate) the individual's likelihood or non-likelihood of taking the recommended action through their direct impact or influence on a person's perception of the health threat. Positing these cues to action in the model highlights the need of using (if not always at least sometimes) some form of motivation or strategies to get people to behave or act in the recommended manner to achieve the desired goal. That is, stimulating the individual to take the recommended preventative action because "perception of a threat does not necessarily lead to adoption of recommendation even when perceived benefits of the recommendation are high and barriers are minimal" (Alcalay & Bell 2000:11). Hence, the arrow from the box with cues to action directed towards the box with perceived threat of disease indicates such cues may serve to modify the perception of threat of disease. This leads to the likelihood of taking recommended preventative health action as the arrow from the box with perceived threat points to or is directed towards the box with likelihood of taking preventative health action.

3.3.1.4   Modified health belief model

To ensure that the Health Belief Model fits better or responds better to the challenges of changing habitual unhealthy behaviours, Bandura (1977) introduced the concept of self-efficacy, which was later popularized by Rosenstock, Strecher, and Becorker (1988). The challenge has been whether the processing of perceived susceptibility, perceived severity, perceived benefits, and perceived barriers are enough to lead to an individual's readiness to act on a recommended health preventative action even if cues to action activate that readiness and stimulate overt behaviour. In the viewpoints of the three scholars mentioned, the process of the variables that make up the HBM illustrated in Figure 4.1 are not

necessarily enough, hence adding the element of self-efficacy. Self-efficacy refers to the confidence a person has in his/her ability to perform the recommended action (Rosenstock, Strecher & Becorker 1988). Glanz and Rimer (1997) and Janz, Champion and Strecher (2002) also share a similar view in that the individual who perceives a threat of disease additionally need to have confidence in his/her ability to take the action. In the absence of such confidence, the action may not be taken.

Since Figure 3.1 does not include the element of self-efficacy, a modified version, which is a contribution of this study, is presented in Figure 3.2.
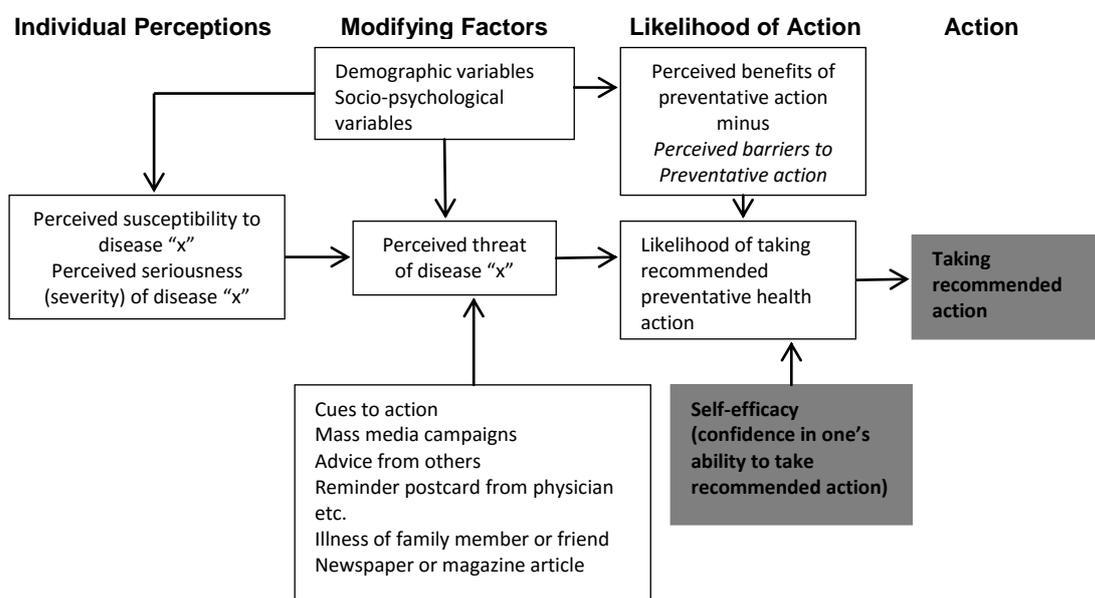
Figure 3.2   Modified Health Belief Model (adapted from Bowes 1997)

In addition, 'Action' is added to the main variables of Individual Perceptions, Modifying Factors, and Likelihood to Action. This is to indicate that the individual's readiness to act on the recommended action activated and stimulated by cues to action is actualised put into action. Self-efficacy illustrated in Figure 3.2 by the shaded box opposite 'Cues to action', impacts on 'Likelihood of taking recommended preventative action', which is indicated by the arrow. The presence of self-efficacy moves 'likelihood of action' from the level of possibility (a potential) to a probability (actuality), which translates into taking the action which is indicated with an arrow from the second shaded box with the inscription 'Taking Recommended Action'.

Self-efficacy depicted with a shaded box impacts on 'Likelihood of taking recommended preventative action', which is depicted with an arrow from the former to the latter. The presence of self-efficacy moves 'likelihood of taking action' from the level of possibility (a

potential) to a probability (actuality), which translates into taking the recommended action. This is depicted with an arrow from the box with 'Likelihood of taking recommended preventative health action' to the second shaded box with 'Taking recommended action'.

The main target of HBM is the individual, and that the communication process employed is persuasive (communication). In terms of the individual (personally), the communication process he/she is engaged in, could be designated as intrapersonal. That is, a communication process which takes place within oneself involving (internal) characteristics such as "knowledge, attitude, beliefs, motivation, self-concept, developmental history, past experience, skills, and behaviour" (Glanz & Rimer 1997). It is an internal monologue and process of reflection that may have, as content, one's relationship with others and the environment. Thus, it is not an exclusively self-contained communication but also related to and influenced by outside sources (Eilers 1994). Some of the demographic and socio-psychological variables together with the cues to action are outside sources in the case of HBM. They affect the individual's perception but only in as far as they influence (and not control) his/her internal reflection process.

It is accepted that HBM is one of the earliest and most influential health communication theories, which has been tested empirically as the basis for a variety of educational campaigns of health behaviours (Lapinski & Witte 1998). It is however "criticized for placing too much emphasis on abstract, conceptual beliefs" (Northhouse and Northhouse 1992), thus being essentially a rational-cognitive model, which assumes that the individual is a "rational" decision-maker (Airhihenbuwa & Obregon 2000) at all times. It gives "little consideration of the totality of the health information process at a community level" (Bowes 1997) and seems to ignore the "larger context in which health care decisions are made" (Alcalay & Bell 2000:11). It is a model anchored in the use of one's rational faculties. If used in a health communication campaign, it assumes that the person in the decision-making process is in a "rational" state – meaning he/she can perceive and engage in some mental (rational) assessment process as to whether or not and why he/she should or should not take a proposed recommended action. It is not clear whether this is always the case and whether people are always in a position to look at issues of health-related conditions from a logical perspective or if there are no other factors that influence health behaviour other than a person's health beliefs – factors that may be cultural, socio-economic, environmental or physical. With regard to HIV/AIDS which is the subject of this thesis, it poses the questions whether people always approach the issue from a logical perspective and whether peoples' emotions and strong sexual feelings which sometimes if not always defy rational processes, are not elements to be taken into consideration. For instance, it has been observed that a

considerable number of adolescents and even many adults do not seem to approach the issue of HIV/AIDS from such logical perspective. Rather they seem to optimistically perceive or consider themselves as invulnerable to the harm of HIV/AIDS and so easily discount risks of the virus or disease (Airhihenbuwa & Obregon 2000).

In criticising HBM it is necessary to keep in mind the original purpose for its development, which was to help explain health-related behaviour – why people behaved the way they did (Glanz & Rimer 1997), and "cast light on why it is so difficult to motivate people to take action to prevent disease" (Alcalay & Bell 2000:9). According to its original purpose then, it was meant to serve as "an overarching framework on how to promote preventive behaviours" (Lapinski & Witte 1998). On the basis of this original purpose it must be pointed out that the fact that it has been used extensively by researchers as framework for various health communication campaigns (Family Health International, 2002), some of which had objectives broader than the scope of the model, does not detract from its value for the purpose for which it was developed. On the contrary, the fact that it has been used so extensively over so many years is an indication of how valuable it is. The pressure is on those who employ it as a framework to ensure that it is not over-stretched beyond its original scope. The fact that its most basic level of health promotion is the individual does not make it any less valuable as the individual is a crucial part of society in its various units or levels of groups, organizations and communities. These levels are composed of individuals and any meaningful attempt to understand people at these levels cannot ignore an understanding of the individuals. In the case of health-related behaviours, therefore, HBM is very useful as an important health communication conceptual framework, which helps to elaborate the causal forces that predispose beliefs in individual decisions about these behaviours (Bowes 1997). Complemented with other frameworks, especially those whose basic levels are broader than the individual and which take cognisance of other factors like the social, the cultural, the political, the economic, and the religious influences, HBM can serve as a powerful tool for understanding and designing campaign messages that are relevant and necessary for the individual to come to the decision to change risk-related health behaviour.

3.3.2   Social learning/cognitive theory

One of the criticisms levelled against the Health Belief Model is that, being an individual level model, it focuses almost entirely on the individual and cognitive processes that maybe taking place within oneself. As Bowes (1997) states, the model hardly pays attention to the totality of the health information process at the community level. In other words the model seems to pay little attention to what happens (or processes that take place) on the community level as

if the individual is isolated, removed from or insulated from the community. This seems to suggest, as Alcalay and Bell (2000) opine that the larger context in which health care decisions take place is not considered. Criticisms such as those above might have been voiced out in earlier years leading Bandura in the 1970s to propose the Social Learning Theory (SLT) to complement the strengths of HBM. The premise of SLT is the assumption or belief that human behaviour is the result of a three-way interaction and interrelationship between personal cognitive factors, behaviour and environmental factors. Behaviour is seen as a triadic, dynamic and reciprocal interaction of personal cognitive factors, behaviour and the environment (Bandura 1977), which is "neither driven by inner forces nor buffeted helplessly by environmental influences. Rather, psychological functioning is best understood in terms of a continuous reciprocal interaction between behaviour and its controlling conditions" (Bandura 1971:2). While this theory does not deny the notion of behaviourists' position that "response consequences mediate behaviour, it contends that a behaviour is largely regulated antecedently through a cognitive process" (The Communication Initiative 2003:44). Based on the brief explanation of the assumption on which SLT is premised, it is clear that rather than reject the assumptions of HBM, SLT takes them and builds on them, acknowledging the value of psychological processes and functioning within the individual that may explain behaviour, and highlighting the role of behavioural and environmental factors.

SLT places a strong emphasis on a person's cognitions and considers response consequences of behaviour as that which a person uses to form expectations of behavioural outcomes. In addition to the emphasis on the cognitive aspect, SLT also emphasizes that most human behaviour is vicariously learned – that is "people learn not only through their own experiences, but also by observing the actions of others (models) and the results of those actions" (Glanz & Rimer 1997:18). Thus, reciprocal determinism is an essential component of the theory (Denzine 2008). This component – reciprocal determinism – is a construct of a model "that represents the idea that human learning and behaviour can best be explained by examining the interaction between a person's cognitive processes, behaviour, and the environment" (Denzine 2008:2). In light of this construct in the application of SLT, the target is encouraged to "observe and imitate the behaviours of others, see positive behaviours modelled and practiced, increase their own capacity and confidence to implement new skills, gain positive attitudes about implementing new skills and experience support from their environment in order to use their new skill" (ReCAPP 2004:2). It is important to point out though that people are most likely to model behaviour observed if the model is believable and credible.

The three main tenets of SLT are thus: the response consequences, which influence the likelihood that a person may perform a particular behaviour again in a given situation; in addition to learning by participating in an act personally, a person also learns by observing others (models) – vicarious learning; and the modelling of behaviour observed is most likely to occur if an individual can identify with the model (Brown 1999)

Figure 3.3 exemplifies the dyadic, dynamic and reciprocal interaction of personal cognition, behaviour and environment.

Cognitive Factors (also called "Personal Factors")
- Knowledge
- Expectations
- Attitudes

Determines Human Behaviour

Environmental Factors
- Social Norms
- Access in Community
- Influence on Others (ability to change own environment)

Behavioural Factors
- Skills
- Practice
- Self-efficacy
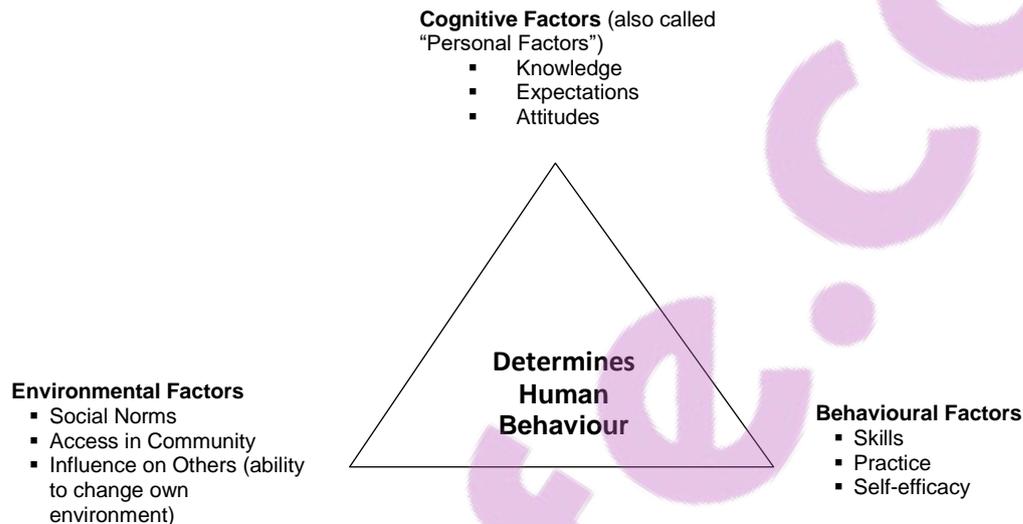
Figure 3.3   Dyadic and Reciprocal Interaction of Personal Cognition, Behavioural Environment of Social Learning/Social Cognition Theory Model (ReCaPP 2004)

Reciprocal determinism is the three-way interactive influence between personal factors, behavioural factors and environmental factors. Personal characteristics such as cognitive competence and beliefs are determined by behaviour and environmental factors such as social influences and physical structures. Behaviour is determined by personal characteristics and environmental factors and the environment is determined by personal factors and human behavioural factors (Darton, Elster-Jones, Lucas & Brooks 2007). This however does not mean that all sources of influence are of equal strength. There is the recognition that certain sources of influence may be stronger than other sources and their occurrences are not simultaneous.

Expectations under cognitive or personal factors refer to beliefs of likely behavioural outcomes that are a person's evaluation of anticipated outcome resulting from performing a particular behaviour. Observational learning is a reference to the ability of a person to learn from the observation of others. This is a learning process, which complements direct experience.

To learn anything one needs to pay attention. The level of attention will determine the level of learning. The more attention one pays in the process of learning the more one learns. If attention is dampened for any reason, the level of observational learning decreases. A distraction by competing stimuli also decreases levels of learning. Among other factors, the characteristics of a model also influence attention. Colour and something that is dramatic are examples of model's characteristics that draw more attention from the learner. In the words of Boeree (1998:3), "If the model is attractive, or prestigious, or appears to be particularly competent, you will pay more attention. And if the model seems more like yourself, you pay more attention".Boeree (1998) further points out that there are certain steps that need to be taken in the modelling process in which a person learns from another's experience. These steps are attention, retention, reproduction and motivation.

In observational learning, it is necessary to be able to retain or to remember what one has paid attention to. Imagery and language facilitate the process of retention or remembering. What the learner sees the model do or say, is stored in the form of mental images and/or verbal descriptions. What has been stored can later be reproduced in the learner's own behaviour.

Reproduction involves translating the images and/or descriptions that has been learned into actual behaviour. The reproduction must be something that is within the capability of the learner; if not, it will not be possible to reproduce it. To be able to reproduce or imitate the model it is necessary to be motivated – there must be reason or motive for reproducing or imitating. Motivation thus is also a necessary step in the process of modelling. Behavioural capacity is the knowledge and skill a person needs to have in order to influence behaviour and the environment. This may require clear instructions and/or training. Self-efficacy is the confidence a person has in his/her ability to take a certain action and persist in that action. Reinforcement is a response to a person's behaviour that might increase or decrease the chances of the behaviour being repeated.

3.3.3   Theory of reasoned action and theory of planned behaviour

As mentioned above, the Theory of Reasoned Action (TRA) and the Theory of Planned Behaviour (TPB) are unlike the Social Learning/Cognitive Theory (SLT), which is a social/community level theory, both like the HBM individual level theories. Though both are individual level theories like HBM, the assumptions on which they are premised are different and their respective focuses are also different as indicated below.

3.3.3.1   Theory of reasoned action

Ajzen and Fishbein formulated the Theory of Reasoned Action (TRA) in 1980. It is a theory premised on the assumption that human behaviour is the result of human intention, thus providing a framework for predicting people's behaviour from their behavioural intentions (Brown 1999b; Alcalay & Bell 2000; Montaño & Kasprzyk 2002). Based on this assumption, the process of arriving at a decision to behave in any given manner by a person is rational (a process). In other words, when a person behaves in a given manner it is because he/she has formed the intention (reasoned out) to behave in that particular manner, and the actualisation of this intention is that behaviour. Human behaviour, therefore, can be characterized as "reasoned action" (Infante et al. 2003). Action that is the result of conscious deliberation and choice; action that has been 'thought through'; advantages and disadvantages of the consequences (of the action) having been calculated, and the choice made to proceed with it (action); individuals "process information and are motivated to act on it" (Montaño & Kasprzyk 2002:73).

The hallmark of the model is its emphasis on conscious deliberation (Perloff 2003), which makes behavioural intent the most important determinant of human behaviour (Brown 1999b). Behavioural intent, however, does not just occur by itself. It is triggered, provoked or influenced by two major elements: attitudes and a norm - attitude towards behaviour and subjective norm respectively. The former refers to a person's judgment as to whether performance of a particular behaviour is good or bad, and the latter refers to his/her perception of the social pressures put on him/her to perform or not perform the behaviour (Ajzen & Fishbein 1980). The relationship between the four major components of the model (attitude, subjective norm, intention, and behaviour) is illustrated in Figure 3.4.
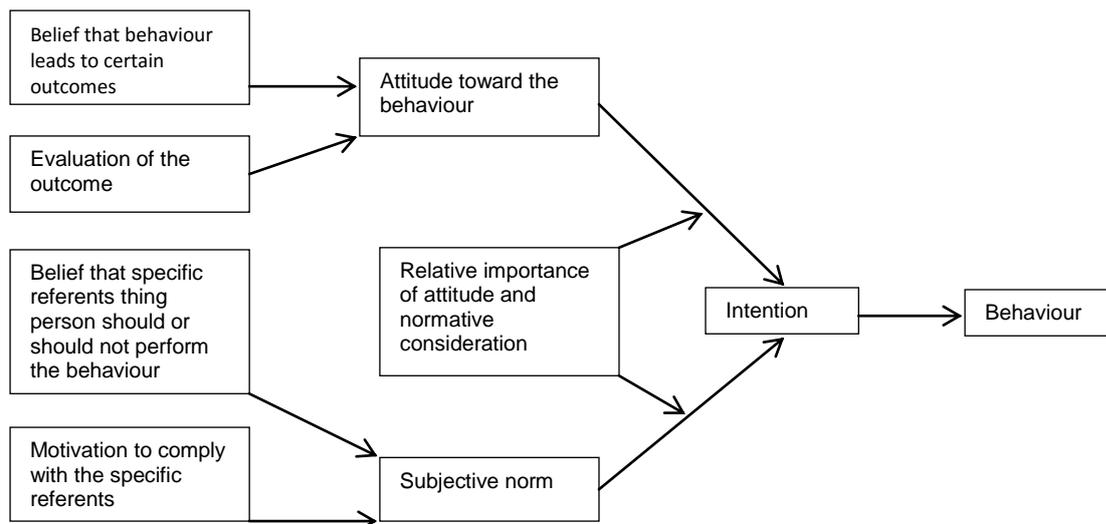
Figure 3.4 **Theory of Reasoned Action** (Perloff 2003:91)

It can be noticed there are other elements present besides the four major components. According to the theory, attitude towards behaviour consists of two subcomponents – behavioural beliefs and outcome evaluation. The former is a person's belief/s about the consequences of the particular behaviour that he/she is contemplating to engage in, while the latter is his/her evaluation of the consequences of the behaviour. If his/her perception of the outcome of performing the particular behaviour is positive, he/she will have a positive attitude toward performing that particular behaviour. If perception of the outcome is negative, the attitude towards the behaviour will be negative. A subjective norm also has two sub-components as indicated: belief about the expectation of relevant others and motivation to comply with the expectation of the relevant others. These are also determining factors for the performance of behaviour. If a person believes that relevant others' view of performance of behaviour is positive, the individual is motivated to meet their expectation by performing the behaviour. However, if their view of the behaviour is negative, the person's subjective norm will be negative and so may not perform the behaviour. A combination of positive attitude towards behaviour and positive subjective norm ensures strong behavioural intention of the individual, which should translate into the performance of the behaviour.

From the foregoing discussion, it seems clear that the core assumption of the theory is that people have control over their behaviour since behaviour is the result of a process of conscious deliberation of the interaction and interdependence of the four components discussed. In the words of Alcalay and Bell (2000:12), "within the realm of volitional behaviour – those actions under our complete control – people typically behave as they intend to act". The strength to act seems to be conceived as being dependent on two factors:

the level of importance of the individual's attitude and behaviour (that is the level of importance attached to the particular behaviour) and his subjective norm. The strength to act is thus, shaped by the relative importance of attitudinal and normative consideration of the person indicating that the success of this theory is dependent on its application to behaviours that are under a person's volitional control. The question arises in cases where a person's behaviour is not fully under his/her volitional control, even though he/she may be highly motivated by his/her attitudes and subjective norm but actually not able to perform the behaviour as a result of other factors (Brown 1999b).

3.3.3.2   Theory of planned behaviour

The question above exposes one of the fundamental limitations or shortcomings of TRA, which was acknowledged by Ajzen (1991), one of its originators who saw the need to adjust the model by introducing a fifth component (in addition to the four that make up TRA) by bringing into being the Theory of Planned Behaviour (TPB). This fifth component is perceived behavioural control, which refers to how much control a person perceives him/her having over a particular behaviour in question. Perloff (2003:94) explains it as "a subjective estimate of how easy or difficult it will be to perform the behaviour". For Brown (1999:3) it "indicates that a person's motivation is influenced by how difficult the behaviours are perceived to be, as well as the perception of how successfully the individual can, or cannot, perform the activity". The more a person perceives that he/she can easily perform an action the more successfully he/she would be in actualising the intention into behaviour. The opposite of that is the more difficult an individual perceives the performance of an action the less successful he/she would be in performing the behaviour.

In TRA the argument is that behavioural intention is determined by the two major factors of attitude towards behaviour and subjective norm. In TPB, Ajzen (1991) argues that the determining factors of behavioural intention are attitude, subjective norm and perceptions of behavioural control (Perloff 2003). An illustration of how these three factors influence behaviour is depicted in Figure 3.5.
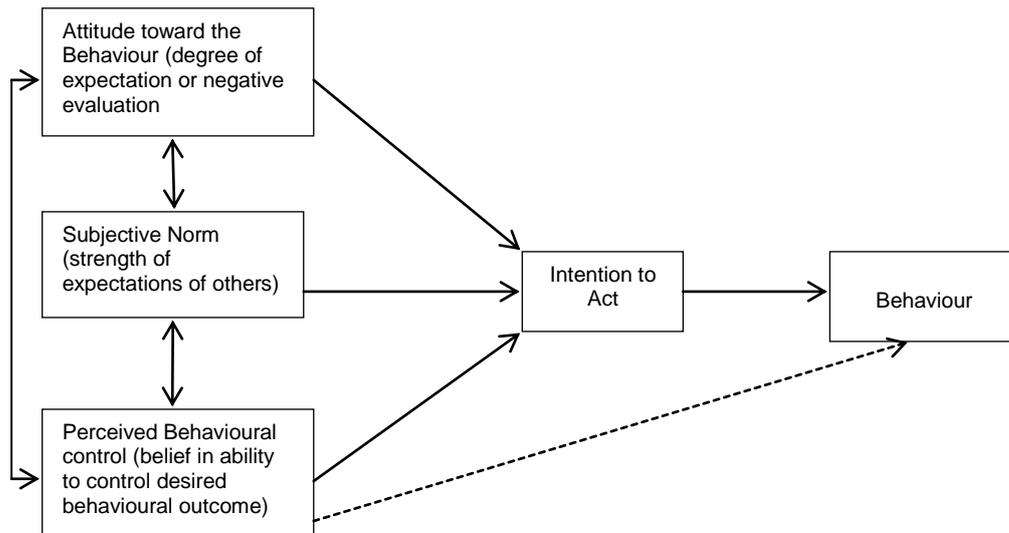
Figure 3.5 **Theory of Planned Behaviour** (Infante et al. 2003:132)

The confidence a person has of his/her capability in performing a behaviour is influenced by his/her perceived behavioural control, which in essence is a "combination of two dimensions, self-efficacy (ease or difficulty in performing the behaviour or likelihood that the person can actually do it) and controllability (people's beliefs that they have control over the behaviour, that the performance of the behaviour is–or is not–up to them)" (Infante et al. 2003:131). Montaño and Kasprzyk (2002) point out that this theory has been used quite extensively to explain a variety of health behaviours and the results of these studies have validated the assumption that perceived control is a determinant, a direct predictor of both behaviour intent and behaviour.

Based on these studies, one may not easily dispute the usefulness of TPB in health campaigns. TRA, TPB and HBM are models of intrapersonal health behaviour. Thus, what has already been discussed in this regard is applicable to the TRA and TPB as well. Despite their differences, which lie primarily in the absence of the component of perceived behavioural control from TRA, both theories emphasize that attitude can predict behaviour under certain circumstances. Both also acknowledge that when subjective norms apply, attitude will not predict behaviour nor will attitude translate into action when there is a lack of psychological ability. Even with the introduction of the component of perceived behavioural control in TPB, it is not certain that when all the components of the theories are operational, behaviour is automatically predictable. Nor is it certain that a person is always psychologically capable of going through that conscious deliberation which leads to the actualisation of his intention; and human beings may not always be consciously in control of their behaviour. There is no certainty that human beings always have the psychological

and/or emotional strength or capacity to actualise their intentions. In other words, it is not certain that the presence of attitude towards behaviour, subjective norm, perceived behavioural control, and behavioural intention automatically lead to behaviour. There could be other major factors that serve as determinants or significantly contribute as determinants of behaviour.

Brown (1999) for example notes the absence of factors such as personality and demographic variables in TPB as limitations of the theory. He also draws attention to the fact that TPB pays little or no attention to the unconscious motives of human beings – motives that often if not always defy rational explanation. The theory is also criticised for not taking into consideration emotional and fear-arousal elements (Rimer 2002).

3.3.4   Stages of change model

The origin and development of Stages of Change Model is attributed to James Prochaska (2002) and colleagues in their work with smoking cessation and treatment of drug and alcoholic addiction (Whitelaw, Balwin, Bunton & Flynn 2000). Recently though, the model has been applied to a wide variety of other health behaviours (Glanz & Rimer 1997; Prochaska, Redding and Evers 2002). It is a model used "all over the world as a platform for promoting behaviour change with a wide variety of populations and an array of non-healthful behaviours" (Redlich 2003:1) including behaviour topics such as diet, exercise, sun exposure, stress management, high-risk sex and depression (Cancer Prevention Research Center 2004a). The theory is premised on the assumption that behaviour change is a process and not an event. This means that it is something that takes place gradually and over a period of points of entry and exit of any of the stages at any time and not a "once-off" thing or activity. It is posited therefore that individuals go through a five-stage process of change, namely: precontemplation, contemplation, preparation, action and maintenance. The 'process' nature of the stages makes it a circular and not a linear model, hence it is not a matter of an individual or individuals having to go through these stages sequentially by starting from stage one through stage two to stage five. On the contrary, in the process of behaviour change, individuals (though they all go through the same stages) are not at the same levels of motivation, or readiness to change. Rather they are at different points or levels of motivation and readiness to change, and so can enter and exit the process at any point, often recycling, and so each person can benefit from different interventions, matched to their stage at that time (Glanz & Rimer 1997).

Figure 3.6 a visual illustration, is a contribution of this study towards understanding and appreciating the elements and dynamics of the model.
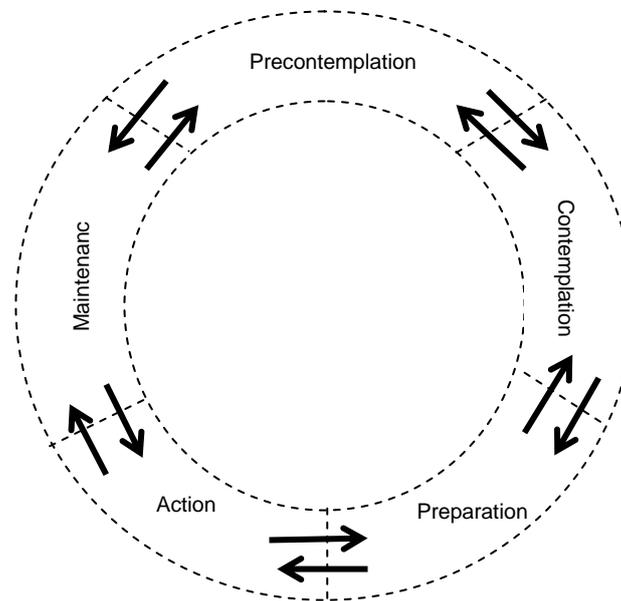
Figure 3.6   Cyclical Stages of Change Model

The figure depicts the idea of individuals being able to enter and exit the process at any stage. The dashed (lines) nature of the two circles plus the dotted bars that divide one stage from the other together with the directions of the arrows (from and to each stage) indicate the open points of entry and exit of any of the stages at any time.

Of the five components that make up the model, precontemplation is the stage in which people are unaware, uninformed or not sufficiently informed of a problem and its consequences. Alternatively, they may have tried to change a number of times without success and so have become demoralized and lost confidence in their ability to change and so have resigned to their situation. In the case of the former group of people because of their lack of or insufficient awareness of the problem, at this stage, they have not thought about changing their behaviour to avoid the risks involved. For the latter group of people, because of their demoralization and/or frustration over past failures, at this stage they do not intend to take any action (Prochaska et al. 2002). Precontemplation is thus a stage in which there is no intention to change behaviour in the near future (Cancer Prevention Research Centre 2004b).

In the contemplation stage, both categories of people mentioned above begin to think about change of behaviour. Those who were unaware or not sufficiently aware have now gained

sufficient awareness of the problem and its consequences. Those who were aware and have tried before to change without success seem to be confronted with the magnitude of the consequences of not changing. Both are more aware of the need to change but at this stage have no commitment or determination yet to change. Nevertheless the possibility of such commitment or determination in the future is what is being thought about.

The preparation stage finds people making plans to change, where thinking about the possibility of change has at this stage evolved into intention to change and to plan what actions to take to effect the change, but the action itself does not occur at this stage.

Having taken into consideration the costs and benefits of the required change and having decided on the necessity of change and planned what action/s to take to effect the change, the individual takes action – the plan is implemented. Action is observable. Hence, behaviour change is said to have occurred if it is observed that the person has taken action.

The fifth stage, of maintenance as Prochaska et al. (2002) explain, is that period during which people who have taken certain specific actions to change behaviour, try to prevent a relapse and consolidate their gains by continuing with the desirable actions and grow in their self confidence in sticking to their newly acquired behaviour.

As in the case with the three theories discussed earlier, the Stages of Change Model is an individual level model. The focus is on individuals with very little consideration if any given to "interaction of social, cultural and environmental issues as independent of individual factors" (King 1999:6). In communication terms, like the other three models, it can be categorized as an intrapersonal communication model. Due to its focus on individuals, some of the criticisms levelled against the other theories may be applicable to the Stages of Change Model. That, however, does not minimize the value and usefulness of the model especially as a framework for selecting appropriate interventions of messages in communication campaigns. By identifying targets' position in the change process, campaign planners would be in a better position to tailor their messages to respond or correspond to targets' real change needs (Zimmerman, Olsen & Bosworth 2000). One of model's greatest contributions to efforts at behaviour change is helping to understand such change as a gradual process that needs time. It also helps to create the understanding that the fact that a person may have attempted or started a behaviour change process and has relapsed or reverted to previous behaviour does not mean that she cannot make an effort to try again and may be able to enter the process again from where she left off.

3.3.5 Social marketing

Alcalay and Bell (2000) note that social marketing as an academic field traces its roots back to the famous question of Wieb (1952-1679): "Why can't you sell brotherhood like you sell soap?" Seemingly, this question had provoked the social scientists to take a closer look at successful commercial marketing principles and techniques of selling 'products' and draw lessons from these for the purpose of being in a position to successfully sell ideas, attitudes and behaviours. Thus, the 'birth' of social marketing as an academic discipline emerged in the 1970s when Philip Kotler and Geral Zaltman came to the realization that the same marketing principles and techniques could be used albeit with some differences in successfully selling ideas (Weinreich 2003).

According to Andreasen (1995:7) social marketing is "the application of commercial marketing technologies to the analysis, planning, execution and evaluation of programs designed to influence the voluntary behaviour of target audiences in order to improve their personal welfare and that of their society." For Alcalay and Bell (2002:2), it is "the design, implementation, and control of programs seeking to increase the acceptability of a social ideal or practice in a target group." In the Social Marketing Quarterly (2011:1), social marketing is said to be "a process that uses marketing principles and techniques to influence target audience behaviours that will be benefits society, as well as the individual." These definitions highlight the point that social marketing is an activity that has to do with planning persuasive strategies with the ultimate objective of influencing behaviour. This comes out from the notions of 'design and implementation' on the one hand, and 'seeking to influence the voluntary behaviour' of the target audience on the other hand. Essentially then, it could be said that social marketing has to do with planning and implementation of persuasive strategies that seek to persuade the target audience to accept the product and/or services being presented in as attractive and acceptable manner as possible. The acceptance of the product implies acceptance of new behaviour, which means social marketing aims at bringing about change in behaviour. Important to note is the element of the place of the target audience in social marketing as pointed out in the definition of the Social Marketing Institute above – that is, the target audience are placed at the centre or core of social marketing process: data collection, programme development, and programme delivery. This highlights the fact that the target audience are not merely consumers of products but also active participants of the process of the social marketing.

The persuasive strategies used in social marketing can be termed market strategies since the emergence of social marketing was influenced by the nature, dynamics and principles of

marketing, therefore social marketing "utilizes concepts of market segmentation, consumer research, idea configuration, communication, facilitation, incentives, and exchange theory to maximize target group response" (Alcalay & Bell 2002:2). Marketing, according to Rothschild (1999:30), consists of "voluntary exchange between two or more parties, in which each is trying to further its own perceived self-interest while recognizing the need to accommodate the perceived self-interest of the other to achieve its own ends." Marketing, in the sense that Rothschild has explained it, differs from the marketing concept in commercial terms. At the core of social marketing, as in commercial marketing, is the idea of voluntary exchange – 'a giving and a taking', in which self-interests of the parties come into play. In the case of social marketing, however, it is not the fulfilment of self-interest in terms of maximizing profits (financial gain for the organization) as is the case in commercial marketing (Maibach, Rothschild & Novelli 2002). With social marketing, the reason for one party in the transaction applying marketing principles and techniques in determining the needs and wants of a target audience, and delivering desired satisfaction more effectively, and efficiently is to help improve the other party's personal welfare and that of their society at large.

The focus of social marketing, like in commercial marketing, is a consumer or target audience. The purpose of this focus on people is to learn what they want and need rather than merely trying to persuade them to buy what one has decided to produce or service to offer with the hope or wish that it will be wanted or needed. In this regard, Weinreich (2003) explains that in social marketing the campaign planners talk first to the consumer/target audience about their needs and not about a product. This is done to identify their real needs as the future buyers or receivers of a service perceive it. Having identified the real needs, the product or service is tailored according to the particular needs that have been identified. In social marketing, therefore, the target audience is not mere recipients of whatever product or service is being offered them, but active participants in the process of determining 'what' and 'how' the product should be to ensure the fulfilment of their self-interest.

In its planning and implementation process, social marketing uses the marketing mix of commercial marketing. Dennis (2002) defines a marketing mix as the "blend of tools and techniques that marketers use to provide value for customers." Barker (2013:107) refers to this blending of tools and techniques as "the amalgamation of elements of the promotional mix such as public relations, marketing, advertising, promotion and online media". The traditional 4Ps (Product, Price, Place and Promotion) of MaCharty, which was widely known and used in the 1960s (Alcalay & Bell 2000; Maibach et al. 2002; Weinreich 2003), the 4Cs (Customer, Cost, Convenience and Communication) (Lauterborn 1990), the Integrated Marketing Communication (IMC), the Integrated Communication (IC) and Relationship

Marketing were/are the main marketing mix. Of these marketing mix, Kitchen and Schultz (1999:35) note that though in terms of its theoretical and conceptual development IMC is still in its infancy, it is "the major communications development of the last decade of the 20th century" and it is "here to stay. It is not a management fad. It reflects major conceptual and practical changes in the way(s) agencies and the clients they service approach the marketing communication task". Other scholars such as Griffin (1997) have also expressed positive viewpoints about IMC and the concept's popularity has not waned in any significant manner as "many scholars still embrace its use" (Barker 2013:102).

Integrated Marketing Communication (IMC) is a social marketing mix adapted planning and implementation. As the name seems to imply, it could be said that at the heart of this marketing approach is, "integration" – that is, the bringing together of different marketing components and elements in a marketing communication plan in order to maximize and benefit from the communicative strengths of each approach. This idea seems in line with the 1989 definition of IMC by the American Association of Advertising Agencies. The Association's definition was a "concept of marketing communication planning that recognizes the added value of a comprehensive plan that evaluates the strategic roles of a variety of communication disciplines…and combines these disciplines to provide clarity, consistency, and maximum communication impact through the seamless integration of discrete messages" (Schultz 1993). Simply put, IMC "ensures that all forms of communications and messages are carefully linked together" - that is, "integrating all the promotional tools, so that they work together in harmony" (MMC Learning [sa]). Another definition of IMC provided by Niemann (2005:27) is "the strategic coordination of all messages (internally and externally) to create dialogue between the customer and the organisation, which attitudinally and behaviourally move the customer towards brand loyalty" (Niemann 2005:27). In the definition of the American Association of Advertising Agencies one could assume that, though not mentioned specifically the communication planning in question aims at finding the best way to reach and sell products to customers (since is a commercial marketing approach), but Niemann's definition specifically mentions the customer who is the target of the marketing organization. The purpose of targeting the customer according to Niemann's definition is not only to sell a product but also (though this is not stated explicitly in words) to establish a relationship between the customer and the organization as the customer would hopefully move towards the brand of the organization both attitudinally and behaviourally. It could be assumed therefore that once the movement towards the brand has been established, the customer would remain loyal to the organization through the purchasing and making use of its product even if not regularly; and the organization in turn would find various ways of remaining in dialogue with the customer. The aspect of establishing a relationship comes out

specifically and clearly in the definition of 'Dynamic Integration Online' above. An element that is mentioned in the definition of Dynamic Integration Online that does not appear in the other two definitions is 'stakeholders'. This means the definition of Dynamic Integration Online envisages that IMC leads to the establishment of a relationship, not only between the organization (a marketing firm for example) and the customer, but also the establishment of a relationship with other stakeholders. From this brief discussion of IMC, it could be said that what it contributes to social marketing to enhance it, is the idea of integration of all relevant communication tools and means – linking them to ensure or to achieve maximum effect.

Integrated Communication (IC) as the name suggests has some relationship with IMC, and as Niemann (2005) points out, IC is the evolved offspring of IMC though the former is defined as a separate discipline. The evolvution of IMC to IC is labelled a paradigm shift by Barker (2013:109) – a shifting of perspective "from an external customer-oriented focus, to focus on the integration and alignment of both internal and external messages, in support of the corporate brand of the organization." I In this paradigm shift IC retained some characteristics of IMC as Niemann,s (2005:30) definition of IC attests to: "the strategic management process of organisationally controlling or influencing all messages and encouraging purposeful, data-driven dialogue to create and nourish long-term, profitable relationships with stakeholders". In this regard according to Barker (2013:109) the "IC approach and the consistency of messages remain the same as within the IMC perspective". When Niemann's definition of IC is compared to his definition of IMC, it is clear that though she considers both as strategic processes, they strategize differently. IMC's strategy is coordination of messages, while IC's is the managerial, strategic process of controlling or influencing all messages. This is a fundamental difference according to Niemann (2005). With IMC, the marketing or communication departmental strategy drives the messages of the organization, while with IC the strategic intent of the organization as a whole drives all the communication of the organization.

The shift in perspective from an external customer-oriented focus of IMC to focus on the integration and alignment of both internal and external messages of IC did not end the process of shift in perspective. The latter shift as Barker (2013) notes was in support of the corporate brand of the organisation, thus bringing the corporate brand of the organisation into the limelight; and it is therefore not surprising that the "next perspective was that of integrated brand communication (IBC)" (Barker (2013:109), of which she argues "all the actions and messages communicated, both internally and externally" ought to be "brand-focused through the manipulation of overlapping concepts" thus making "strategic brand-building" (Barker 2013:112) in all the actions and messages of this marketing mix, the main

elements unlike in the case of IMC and IC in which the focus is the consistency of the messages communicated. According to Barker (2003:11) the "dominant marketing management paradigm founded on the manipulation of the mix began to be questioned" because "it provided inadequate explanation of the marketing services—given that services had become the largest sector in the advanced industrial economics". Consequently there was marketing calls for recognition of both the buyer and the seller; a call that brought about a new perspective – relationship marketing (RM) in the marketing concept evolution. RM emphasised on exchange relationships of mutual satisfaction "where the focus is on communicating *with* rather than *to* customers", emphasising "the importance of feedback and two-way communication" (Barker 2013:110). The emphasis on the importance of the two way communication and feedback means marketers may not just concentrate on transactional elements of marketing where plans and objectives continue almost exclusively to be focused on the product (Costa 2012). Rather there is the need for interaction (building human relationship) between the marketer and the customer in which the former endeavours to engage the latter "over their lifetimes, offering for their brands a combination of hard and soft attributes that encompass performance, added values, service, and a broader affinity with values and interests" (Costa 2012:228). RM thus:

> seeks to combine all internal and external marketing activities by highlighting the significance of inter-relational relationship marketing", making it a "commercial activity between economic partners, service providers and customers which aims to create, maintain and enhance long-term relationships, in order to achieve mutually beneficial objectives based on profit, trust, commitment and mutual benefits between these parties (Barker 2013:110).

Based on the discussions on social marketing and on commercial marketing mix, which the former uses in its planning and implementation, it can be concluded that social marketing is a target-orientated marketing approach. This means two things. Firstly, social marketing is a planning, implementation and evaluation of a communication activity, which targets its audience, the people at whom the marketing strategy is directed. Maibach et al. (2002) refer to this as a "consumer-orientated process." In social marketing, however, unlike in commercial marketing, the target audience are not being targeted for commercial purposes as in the case of the marketing mix approaches presented above, but they are targeted because of some social concerns that need addressing. What is done at the different stages of the social marketing process is therefore to improve the personal wellbeing of the target audience and society as a whole. Though the self-interest of the organization, as the other party in the process, is also at stake, this interest in the final analysis is the success of the activity, which in reality is the improvement of the wellbeing of the target audience. In addition, the people, as the target, are not merely recipients of whatever the marketers

provide. They have the power of choice: they are free to choose, to accept or reject the behaviour being promoted. The marketers are at pains to ensure that the target will use the power of choice to accept or reject the new behaviour offered in the social marketing program. The social marketers do this through two main types of research, namely target audience or formative research and environmental research. Using these two types of research, they try to understand the target's problem and perceived needs, and the best way to respond to these by maximizing benefits and minimizing barriers. The marketers also try to understand the sociocultural, economic, political and religious contexts, which may influence the choice of the targets (Rothschild, 1999; Maibach et al. 2002). Using or incorporating the insights, tools, techniques and strategies of the commercial marketing mix whenever possible and appropriate, should enhance and add value to the activities of social marketing.

As noted, in its planning and implementation process social marketing uses the marketing mix of commercial marketing and as discussed, the marketing mix perspective or concept, IMC has evolved. It is therefore argued that in the use or incorporation of the insights, tools, techniques and strategies of the commercial marketing mix in social marketing, it is crucial to take cognisance of Barker's (2013:113) proposal that in any strategy decision taken by an organisation, all the "perspectives should be considered" to ensure that the focus of the strategy decision is on "the strategic intent of the organisation" (Barker 2013:114); the focus of that intent being the creative integration of the relevant key thrusts of each perspective and using creative strategic communication "across the myriad of marketing communication activities". This emphasises "the need for an alternative strategic communication perspective on IMC" according to (Barker 2013:114) and responding to that need she proposes the strategic integrated communication (SIC),

> which is seen as the process of strategically managing mutually beneficial organisation and stakeholder relationships, where the planning thereof recognises the added value of an SIC approach through the integration of all functions. The process should be information driven, interactive, and should focus on consistency in terms of brand, messages, knowledge creation and sharing, processes, functions and the strategic intent of the organisation.

3.3.6   The health communication process

In the operational definition of a health communication campaign, such a campaign is said to be strategic and purposeful. Being strategic and purposeful requires planning and not just something that happens or happens haphazardly. Planning is thus essential to ensure success in health campaigns. Planning contributes in helping to identify the main problem

and solution, the correct approach and ensures effective resource use and allocation. Planning also helps to avoid unwanted outcomes (Corcoran 2011:7). As it is planned and purposeful, a health communication campaign is a process (a series of activities/events) and not just an activity or event as discussed in Chapter 2. Being a strategic, purposeful process of activities, it evolves and has an on-going character. This means it has within itself different stages, which are interrelated and interdependent. Various models of communication campaigns thus propose or suggest different numbers of stages or steps in the campaign process.

Four such models commonly known by their acronyms are RACE, ROPE, RAISE and ROISE. RACE is the acronym for 'research, action, communication, evaluation.' This model of a communication campaign was proposed and outlined by John Marston in 1963 in his book, The Nature of Public Relations (Public Relations, History [sa]). ROPE is the acronym coined by Jerry Hendrix and stands for 'research, objectives, programming and evaluation'. Robert Kendall is the originator of the acronym RAISE, which is the formula for 'research, adaptation, implementation strategy, evaluation, and ROISE, is an acronym for 'research, objectives, strategies, implementation and evaluation' (Smith 2009). These acronyms reflect the stages or steps comprised in each model. The first three of these models: RACE, ROPE, RAISE, comprise 'four-stage/step' process, while the fourth, ROISE has five stages or steps. These models are used mainly in public relations' campaigns, which according to Davis (2004:4) is "communication with people who matter to the communicator, in order to gain their attention and collaboration in ways that are advantageous to the furtherance of his or her interests or those of whoever or whatever is represented". As per this definition, in a communication campaign process two categories of people are important, namely, the communication planner and the target audience. In terms of the definition of Davis above, the communication campaign planner maybe regarded as the communicator and the target audience as the people with whom communication is carried out. In this sense, the target audience is of great importance to the communication campaign planner. Thus, the target audience is an indispensable component of the whole campaign process since it is their attention and collaboration that the campaign planner seeks to gain, and the messages and activities of the campaign are directed to the target audience.

While the four models presented above propose a number of stages/steps in the communication campaign process, it is not clear if the stages/steps are lineal or circular. A model of the process of health communication campaign, of National Cancer Institute (1992) of United States of America's however clearly indicates the circular nature of the stages/steps in a communication campaign as illustrated in Figure 3.7. There are four stages

in the campaign process - planning and strategy development; developing and pre-testing concepts, messages and materials; implementation; and evaluation or assessment.
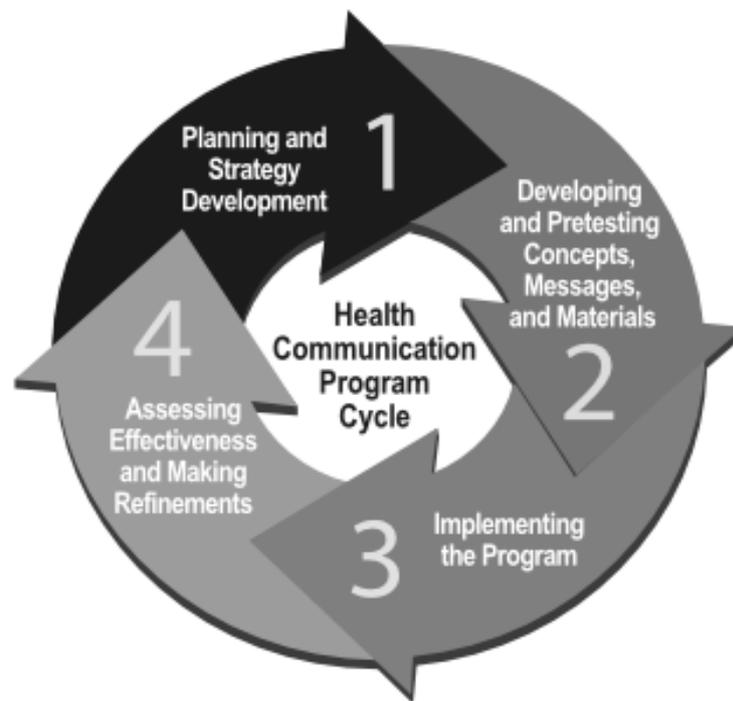
Figure 3.7   **The Health Communication Process**
(National Health Institute. 2010:22)

Unlike the Health Communication Process model that has, as its first step in the communication campaign process 'planning and strategy development,' RACE, ROPE, RAISE and ROISE all have "research" as their first step. That means before any planning is done, or strategy developed, relevant information is gathered and the data collected is interpreted or analysed – that is, studying the situation, identifying the problem and opportunity (MSMPR 24 Seven, 2009) before embarking on planning and developing. The strength of the Circular Process of Communication Campaign is how it depicts or illustrates the connection between the four stages – the one flowing into the other, thus highlighting the interconnectivity between and interdependence among the stages. The four stages as illustrated in the figure flow from and into each other in a sort of symbiotic manner and they "constitute a circular process in which the last stage feeds back into the first as you work through a continuous loop of planning, implementation, and improvement" (National Institute of Cancer 1992:11)". Its limitation is the absence of the research component, which is present in the RACE, ROPE, RAISE and ROISE. Researching before planning and developing strategy for a communication campaign ought to be regarded as an important component of the progress of the campaign.

3.3.7   Seven steps approach

While the models discussed briefly above serve as a very insightful and helpful guide on how to research, plan and execute communication campaigns, it is necessary to note that as conceptualised representations of how to plan and execute a communication campaign, they do not specify or indicate anything about behaviour change, which is what communication campaigns seek to bring about. Because behaviour change can be said to be one of the main eventual objectives if not 'the' main objective of a communication campaign, there seems to be more that needs to be taken into consideration than what the models offer – that is, 'best practice' of developing a campaign according to stages. In this regard, Robinson (2009:1) cautions that when it comes to issues of behaviour change it is not simply or merely a matter of deciding on what behaviour to change or what would or should be the outcome of the communication campaign, "draw up a plan, assemble the tools and resources and manufacture the thing." Executing a communication campaign in this manner would seem to imply assuming that the campaign planner has the true knowledge and correct behaviour, which the target audience does not have, and, all it takes is to inject this knowledge into this audience that is passive, and the expected change will take place. Such an approach to communication campaigns, Robinson (2009) opines, is based on the assumption that 'awareness building' or 'awareness creation' is the key to behaviour change. Such an assumption accordingly is inadequate. In the light of his criticism, Robinson proposes an alternative model, which he refers to as a 'Seven-Step Approach.' The seven steps or key elements of the model are 'Knowledge, Desire, Skills, Optimism, Facilitation, Stimulation and Reinforcement'. Robinson considers these steps as pre-conditions that can be expressed as affirmations, as illustrated in Figure 3.8.
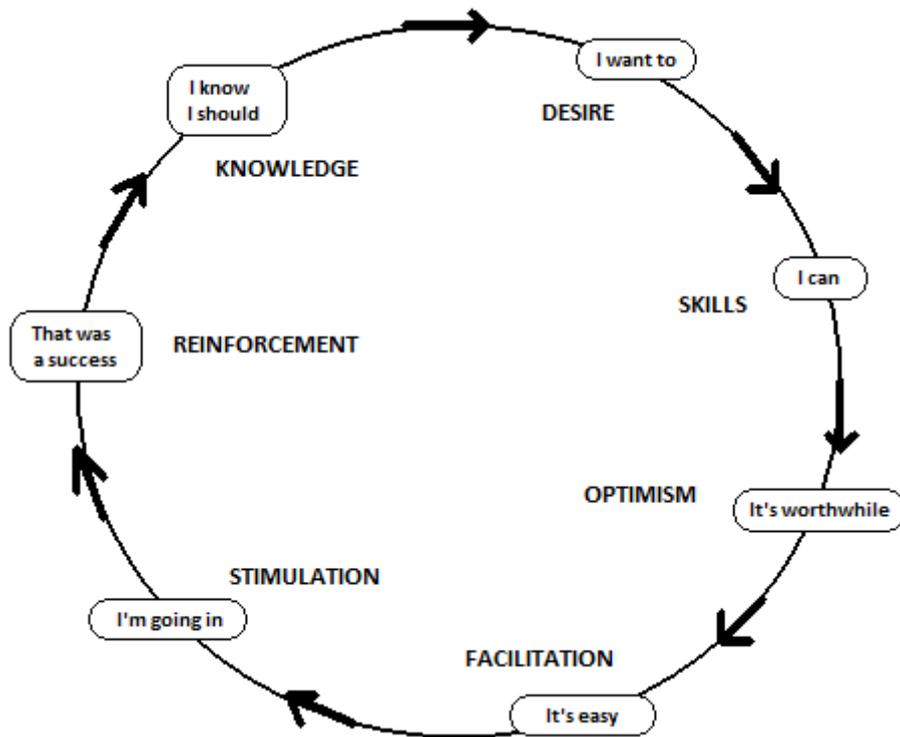
Figure 3.8   Seven Steps Approach (Robinson 2009)

Each of these conditions is regarded as an obstacle that must be overcome in the process of behaviour change; hence, the model can be considered as a set of seven doors that a person has to go through in the process of communication campaign in order to achieve behaviour change.

According to Robinson (2009), the first step in the process is knowledge or awareness. In this first step in the process of a communication campaign, the target group who are expected to change certain behaviour must know or become aware of three things: firstly, that there is a problem; secondly, not only is there a problem but also that there is some practical, viable solution or alternative to the problem. Thirdly, they should be able to identify the personal cost of inaction and the benefits of action in concrete terms. In short, they should own the problem, and the campaign should aim at harnessing the people's judgement.

The second step of Robinson's (2009) Seven Step Approach communication campaign process is Desire. This step entails imagining being in a different future. The target audience must be assisted to imagine or visualise a different, desirable future without the problem or a minimisation of the problem. Desire complements Knowledge. The latter has to do with the intellect while the former is an emotion – both are needed.

The third step, Skills, entails knowing 'what to do,' that is, the ability to visualise the necessary steps to take to reach the goal or to change one's behaviour. Unlike emotions, skills have to do with rationality, and the best way to help the target audience to acquire the skills in a communication campaign, according to Robinson (2009), is to breakdown the required action into simple steps possibly using illustrations to make visualisation easy.

The fourth step, Optimism is the belief that success is probable and inevitable, and this belief must be engendered in the target audience. One would expect that campaign planners themselves have this optimism, that they exude it so that the target audience can sense and literally feel it.

Facilitation, the fifth step in Robinson's (2009), Seven Step Approach, is the provision of outside support for the target audience. This support in the form of unblocking real-world obstacles, maybe in various forms depending on the nature, dynamics and particularity of the campaign.

The sixth step in the campaign or education process is Stimulation, or 'having a kick-start' which Robinson explains as being the creation of moments that reach into the lives of people and compel them into wakefulness. He further explains that there are two kinds of such moments, threat or inspiration, being either threatening or inspirational. Whether the stimulation is a threat or an inspiration may depend on the nature of the problem and its consequences or repercussions if there is inaction. It may well be that in certain cases it would not be a matter of either threat or inspiration but a combination of both.

Reinforcement, the seventh and last step of Robinson's 'Seven Step Approach,' is the step that is meant to ensure that the behaviour change that has occurred or is occurring as a result of the communication campaign or education is maintained and possibly enhanced. The target audience must continue to receive reinforcement messages so that they may maintain the change achieved or being achieved, and build on it and not revert to old behaviours.

The insights gained from discussing RACE, ROPE, RAISE and ROISE, the Health Communication Process, and the Seven Steps of Robinson above, in light of the findings of Vygotsky's work on human behaviour and SDT suggest that integrating them in the framework of GST would offer a powerful and practical framework for developing and carrying out communication campaigns. The Health Communication Process, RACE, ROPE, RAISE and ROISE models maybe seen as offering a general framework or structure of a health communication campaign – specifying or delineating the stages or steps in the

process intended to bring about behaviour change. The Seven Step Approach complements these models by highlighting some of the specific elements or factors pertinent to human behaviour that need to be taken note of in the research, planning and strategy development, developing and pre-testing concepts, messages and materials, implementing a monitoring and evaluating the programme. It is assumed that if these models are integrated at a strategic level,, communication campaign planners would not be regarded as experts with the sole prerogative of the 'know what and know how' in the development of communication campaigns. In other words, the task of conceptualising, planning and implementing these campaigns would not be without the involvement, participation or contribution from the target audience. On the contrary, the communication campaign planners would endeavour to find appropriate ways of involving the target audience at least through their elected or appointed representatives.

The characteristic of communication campaigns, of being a design of messages purposefully constructed and set within specific timeframes (Coffman 2002b), emphasises communication campaigns' characteristic of being planned activities. The identification and analysis of the problem that needs to be addressed, the selection and construction of the messages, the packaging of activities and processes of transmission, the choice, and use of the relevant and appropriate transmission channels, both mass and interpersonal, are or must all be by design – that is, planned (Smith 2009; Atkin 2009). This means the activities and processes, and choices of channels used, are all deliberate, and are done systematically, and there should be reason behind each activity, process or choice. This explains why communication campaigns must be a theory based (Lapinski & Witte1998; Coffman 2002a; Atkin & Salmon 2009), that is, theory or theories ought to guide their planning, design, implementation, monitoring and evaluation and assessment.

It is also important to note that communication campaigns are not conducted in a social vacuum since such campaigns are within the scope or framework of human communication; and human communication always takes place in a context (Clive, 2009). Every campaign is thus somewhat affected by the particular political, economic and social structures of the society in which it is conducted (UNAIDS 1997) because communication campaigns take place "through a medium, and among individuals and groups situated historically, politically, economically, culturally, and socially" (Clive 2009:2). The factors or elements of the context are particularly important when campaign messages seek to bring about behaviour change. It is assumed in the study that these factors have some determining influence on people's behaviour, for as stated by the National Institute for Cancer (1992:11), "For a communication

program to be successful, it must be based on an understanding of the needs and perceptions of the intended audience".

A criticism levelled against some communication campaigns by Windahl, Signitzer and Olson (1992) which finds some resonance with the criticism of Robinson (2009) discussed above, relates to shortcoming of communication campaign in practice, of unfolding according to a linear model of communication – from a sender to receiver. This criticism highlights the importance and needs to involve members of the intended target audience in the planning and designing of a campaign that seeks to address their personal or community problems. The communication campaign process thus ought to be interactive, participative and dialogical to ensure that the intended target audience is regarded merely as recipient of what the campaign planners have planned and implemented, without any input and participation from the target audience as to what and how it views the issues being addressed. If this criticism is taken for what it is worth, it is expected, for the sake of achieving maximum intended results in a communication campaign that it be non-negotiable that as many members of the target audience as possible be involved in the planning and implementation of the campaign.

In this regard, the interactive model of communication campaigns proposed by Rensburg and Angelopulo (1996) is very helpful. This model regards the needs and predispositions of the audience as fundamental to the determination of the campaign structure and message. It also regards the meaning shared in the campaign as a product, which is the result of the interaction between the campaign planner/s, the communicators, and the audience. The model stresses that the audience's aims, needs and predispositions should determine the nature of the campaign. This, in turn, would largely determine its success. The use of this model in the development of a health communication campaign could ensure that the campaign agenda does not arbitrarily originate from the campaign planners. In this model, emphasis is on the need to have some members of the target audience of the campaign involved in the process of planning and implementation. This is not an attempt to undermine or weaken the value of someone from outside of the target audience being the one to identify a problem that needs to be attended to through a campaign. What is important is that regardless of who identifies the problem, the targeted audience or at least some of its representatives, should be involved in the process of analysing the problem and in the development, implementation and even in the assessment of the campaign.

3.4 CURRENT APPROACHES AND INHERENT CHALLENGES IN EVALUATING HEALTH COMMUNICATION CAMPAIGNS

According Bertrand and Anhang (2006) it is "hard to imagine a program designed to bring about some type of change in behaviour or health status that does not utilize at least some type of directed communication", such as a health communication programme. An indication that health communication programmes are taking place in different parts of the world is a review of 283 articles related to health communication in a study commissioned by United States Agency for International Development (USAID 2000). Another indication is a study commissioned by the Swedish International Development Cooperation Agency (Sida 2007) to inform understanding of the relevance of focused prevention activities in 11 African countries. However, not only are health communication programmes/interventions taking place but also evaluation research / activities that are designed and implemented to ascertain or evaluate the value of different aspects of these health communication programmes/interventions.

The research work of scholars such as Bertrand, O'Reilly, Denison, Anhang and Sweat (2006) attest to the presence of evaluation activities. In their research work, these scholars systematically examined the effectiveness of 24 mass media interventions on changing HIV/AIDS-related knowledge, attitudes and behaviours. There is also the review work of Myhre and Flora (2000) who updated previous reviews by systematically examining 41 published articles of empirical evaluations of international HIV/AIDS prevention campaigns. Several other evaluation studies are available in the literature confirming the presence of evaluation activities connected with health communication programmes. Currently evaluations of health communication programmes that have already been planned and implemented to verify or ascertain their effectiveness is gaining ascendancy, and there are calls to scale up such evaluation, especially those related to HIV/AIDS health communication programmes (Bennet, Boerma & Brugha 2006). One such study is the evaluation by Torabi, Crowe, Rhine, Daniels & Jeng (2000) of HIV/AIDS education in Russia using a video approach.

The communication programme evaluated by Torabi et al. (2000) was a quasi-experimental design, with pre-post tests and intervention through video education / control groups, used to study 20 public schools from urban and rural areas of St. Petersburg, in Russia. According to the evaluation researchers, the results of their study "provided evidence that video education can prove useful in reaching a significant number of students and improving their knowledge and attitudes regarding HIV/AIDS" (Torabi et al. 2000:7).

Another evaluation study is the 'Evaluation of the 100% Condom Programme' in Thailand (UNAIDS Global Report 2000). This evaluation study was undertaken by UNAIDS and the Ministry of Public Health of the Royal Thai Government with the support of the Institute of Population and Social Research of Mahidol University – a study that examined the effectiveness of a 100% condom programme pioneered in Thailand's province of Ratchaburi. The 100% Condom Programme sought to address the "observation that sex work establishments requiring condom use or sex workers insisting on condom use would often lose clients and money to those who did not" (UNAIDS Global Report 2000:2). The results of the intervention suggested that it was effective but the question that arose was 'How to judge or evaluate the essential components of the programme and the factors that had contributed to its success, and also identify programme's limitations?' It was in an effort to address this question, that the evaluation study in question was designed and implemented. The evaluation design was a two-phase strategy research work to explore the effectiveness of health communication approach that made use of different channels – mass media, group media and interpersonal media in the provinces of Thailand.

The first phase of the evaluation comprised analysis of existing data and in-depth interviews with key provincial officials who were involved in the implementation of the programme. The information gathered in this phase was used to identify the most important programme components. The identification of the most important components helped to develop ways of defining and measuring 22 programme inputs. This was followed by designing detailed questionnaires to assess the inputs in the provinces. In the second phase implementing officials, sex workers, sex establishment managers and owners, young men and pharmacists were surveyed to measure local level programme inputs. Surveys were also used with sex workers and young men to determine the programme's local impact on behaviour. The results of the evaluation study suggest evidence of effectiveness of the 100% Condom Programme at the provincial level. This evidence was gleaned from the interviews with sex workers and with young men who had visited sex workers at some point. These two sources of information "indicated that the programme, in conjunction with other prevention activities in the community and the national AIDS education and condom promotion campaign, made major progress towards its objective of 100 per cent condom use" (UNAIDS Global Report 2000:28).

The study of Bertrand and Anhang (2006) under the title 'The effectiveness of mass media in changing HIV/AIDS-related behaviour among young people in developing countries' is yet another example of evaluation research activities connected with health communication programme. The study involved reviewing the strength of evidence for the effects of three

types of mass media interventions "on HIV/AIDS-related behaviour among young people in developing countries and to assess whether these interventions reached the threshold of evidence needed to recommend widespread implementation" (Bertrand and Anhang 2006:205). The three types of mass media are radio only, radio with supporting media, or radio and television with supporting media. The method the researchers employed in the study entailed a systematic review of published or released studies between 1990 and 2004 that had evaluated mass media interventions. Eligibility for inclusion in the review were studies that had used a pre-intervention versus post-intervention design or an intervention versus control design, or had analysed cross-sectional data comparing those who had been exposed to the campaign with those who had not been exposed. In addition, to be included in the review, the studies had to have comprehensive reports on quantitative data for most of the outcomes of interest. Fifteen programmes that had been evaluated met the criteria for inclusion and were reviewed. Eleven of these programmes were from Africa, two from Latin America, one from Asia and one each from other countries. According to the findings of the review, mass media interventions' effectiveness was supported by the data. Also supported by data was the effectiveness of mass media "to increase the knowledge of HIV/AIDS transmission, to improve self-efficacy in condom use, to increase condom use and to boost awareness of health providers" (Bertrand & Anhang 2006:205).

Keating, Meekers and Adewuyi (2006) have also subjected a Vision Project of media campaign on HIV/AIDS awareness and prevention in Nigeria to evaluation. This health communication campaign (Vision Project) aimed at improving access to, and creating awareness of, family planning and reproductive health (FH/RH) services, HIV/AIDS awareness and condom use. The evaluation study sought to identify determinants of FP/RH programme exposure and assess the effect of a FP/RH mass media campaign on HIV/AIDS awareness and condom use. The study assessed the extent, to which exposure to the media campaign, which drew on behaviour change communication and community mobilisation as core strategies, translated into increased awareness and prevention of HIV/AIDS. The evaluation researchers analysed data from the 2002 and 2004 FP/RH Surveys from Bauchi, Enugu and Oyo States in Nigeria. These were household surveys conducted among adults living in the Vision Project area. Interviews were conducted to obtain verbal informed consent from selected participants representing households that had been selected through the use of random sampling. A survey questionnaire was then administered to sampled respondents. Questions of the questionnaire related to family planning, sexual activity and behaviour, and exposure to various media campaign programmes on radio, television, advertisements in newspapers and information from clinics or community health workers. According to the researchers, data from their study "shows that the F/PRH media campaign

by Vision and its partners is reaching a large portion of the target population, and exposure to these mass media programs can help increase HIV/AIDS awareness" (Keating et al 2006:11). In effect the results of their study suggest that the media campaign of the Vision Project was effective. The results of the evaluation research activities of health communication programmes discussed above suggest that such interventions generally achieve their objectives, thus indicating their effectiveness.

Other studies include that of that of Menon 's (2004) on an Evaluation of the Power of the Cosmic as an Element of an HIV/AIDS Communication; the evaluation of *Soul BuddyzSeries* 2 (2005) to determine the reach and impact of the communication-centred edutainment initiate that used media to educate children on issues such as HIV/AIDS; using Soap Operas for Social Change like Ethiopia, an assessment of a radio soap opera series developed and implemented in an effort to change attitudes and behaviour related to health and well-being; Botha and Durden's (2004) study on Using Participatory Media to Explore Gender Relations and HIV/AIDS Amongst South Africa Youth, to evaluate the Drama in AIDS Education which uses drama, peer education, and participatory media development in an effort to critically engage young people to communicate effectively about issues relating to sex, sexuality, and HIV/AIDS.

However, Hutchinson and Wheeler (2006) point out that in spite of the evidence supporting the effectiveness of health communication programmes, seldom has an economic evaluation of these programs been carried out. This observation by Hutchinson and Wheeler can be framed as a question such as in the words of Bertrand (2006:3): "How effective are these interventions, however, in bringing about the desired change? And at what cost?" Alternatively, one could ask, 'Does the value of the effectiveness of the interventions measure up to the value of human-power, financial and other resources invested in the interventions'? Alternatively, in the words of Ratzan (2006:1) "What is the bang for the buck?" Can it be said that one gets one's money's worth on the basis of the results of the programmes/interventions' success?

If a health communication programme is said to be successful, how successful is it really from the perspective of its overall cost or investment? The challenge is how to ascertain realistically the value of success of a health communication programme in relation to the structural and programmatic cost. That is, being able to measure success of the programme and at the same time also 'costing it' – determining its cost-effectiveness. For as Hutchinson and Wheeler (2006) opine, analysis of cost-effectiveness of a health programme is an important planning and evaluation tool because it puts a price tag on achievable health gains. In other words, such analysis relates value of resources (inputs) used in the health

programme to some measure of its output, and this can be expressed as a ratio. However, if the cost of a programme is measured, how does one obtain appropriate estimates of cost and at the same time measure the success of the programme in bringing about the desired change? In response to this question, Bertrand (2006) explains that depending on the design of the analysis, the data allow one to answer a series of questions that help in the effort of obtaining appropriate estimates and measuring of success. These questions are: What is the cost per person reached by different channels or by any channel? Which channel produced the greatest change for the cost? What would be the incremental change in outcome expected from a specific increase in cost?; and How do communication programmes and their subcomponents – individually and in combination, rank in cost effectiveness relative to other programmes that seek to effect behaviour change?

It may be assumed that if these questions are asked and correct answers sought in the planning and implementation of an evaluation, it would be feasible to cost, that is, put a price tag on the components of the evaluated programme and at the same time measure its success. That is, to determine its value in terms of what it costs to plan and implement it in relation to the value of its outcomes. It has been noted that unlike efficacy evaluation, which assesses the effects of an intervention when conditions are ideal thus normally being carried out in intricately controlled trials, effectiveness evaluation assesses effect in real-world conditions. It is therefore important to take cognisance of the fact that historically cost-effective analysis of health was focused on evaluations of medical intervention, which often if not always, used randomised controlled trials and mathematical modelling for determining effectiveness (Hutchinson & Wheeler 2006).

The nature of most health communication programmes in recent times, however, turn towards being full-coverage communication programmes, that is, employing combinations of mass media, group media and interpersonal communication. Some even incorporate elements of entertainment education, and are planned and implemented on national and subnational levels. On such levels, particularly with broadcast media, randomised controlled trials according to Bertrand (2006) are almost never viable options as evaluators cannot randomly allocate subjects to experimental (exposed) and control (non-exposed) groups. Guilkey, Hutchinson and Lance (2006) make the same assertion when they note that the use of randomised controlled trials is not the norm in the evaluation of health communication programmes because many such programmes use mass media, which cannot be individualised or manipulated by researchers. This is not to imply or to mean that randomised controlled trails are of no value in evaluations of health communication programmes. They have their value especially in experimental designs in which they provide

a 'good standard' for assessing success and are "clearly feasible and appropriate for evaluations involving counselling, print materials, mass mailing, and home visiting, in which researchers and designers can control who receives an intervention and at what level of intensity" (Guilkey et al 2006:48).

In health communication programmes in which there is direct link between programme and outcome such as when the outcome is exposure or programme reach, cost-effectiveness calculation may be straightforward and easily determined and experimental design would be valuable. For instance using "surveys to inquire whether various populations have heard communication messages, seen billboards, or read messages in print media or elsewhere. The information gathered from the survey can be directly linked to data on the cost of the programme to determine the cost per exposed individual" (Guilkey et al 2006:49). An example of this is Menon's (2004) evaluation of the power of the comic as an element of an HIV/AIDS communication that had been mentioned above. This was an evaluation of the South African health communication intervention series, eKasi comics, which covered topics including, among others, HIV/AIDS, reactions of people to HIV/AIDS, disclosure, opportunistic infections, sexually transmitted infections, knowing your partner's past, and condom usage. The evaluation's objective was to ascertain how the programme forms a component of a wider communication strategy, assess the outcomes of the intervention, and determine its national and regional relevance. The research design comprised focused group discussion involving 89 respondents, thematic analysis of the comics and analyses of letters received by the offices of eKasi in connection with the comic series. The findings of the study suggest that the programme was successful, based on its societal-fictional match. On measuring behaviour change, the report noted some difficulty though interviews analysed suggest that the probability and possibility of behaviour change is high. On cost-effectiveness, the findings suggest that the comic was cost-effective, "as working on 5 readers per comic it works out to 10c a reader" (Menon 2004:2). This is a very straightforward calculation.

For evaluations of full-coverage and/or on a national or subnational level health communication programmes, Bertrand, (2006) explains that researchers have to rely on non-experimental data collected from a random sample of individuals and on more sophisticated analytical techniques including multivariate regression analysis and econometric methods such as simultaneous equations model, propensity point/s matching, or longitudinal data methods. When it is a health communication programme where the link between the programme and the outcome is less direct as may be the case where "attribution of behaviour change due solely to the effects of exposure to the program becomes more

tenuous" (Guilkey et al 2006:49) then, cost-effectiveness calculations become quite complicated. The evaluation research of Kincaid and Do (2006), however, of a national level health communication intervention in the Philippines gives some direction on how to overcome or minimise the complication of cost-effectiveness calculations when planning and implementing cost-effective and measurement of effectiveness evaluation of a full-coverage health communication programme on national or subnational level. The study of these scholars is an evaluation in which the link between programme and outcome, a causal inference, is sought. By combining the strengths of three usually distinct statistical methods, namely structural equation modelling, propensity point/s matching and biprobit regression, Kincaid and Do (2006) demonstrated that valid estimates of the impact of full-coverage communication programmes can be obtained from sample survey data. Using structural equation modelling, they were able to test the theoretical pathways by which the health communication campaign under study affected behaviour and allowed for theory-driven as well as method-driven evaluation. They used propensity point/s matching to create a valid counter-factual condition with which to estimate the direct, net effects of the communication campaign, as this was a prerequisite for cost-effectiveness analysis. To test for the exogeneity of communication exposure in the equation for behaviour, and to test 'strong ignorability' assumption of propensity point/s analysis, the researchers used biprobit regression method. Using these three statistical methods together, the researchers endeavoured to demonstrate the causal attribution of the impact of the health communication campaign justifiable.

Kincaid and Do (2006), in their study, further explain that the multivariate causal attribution analysis is appropriate under four conditions, the first of these being the implementation of a population-level intervention that can be evaluated by means of a sample survey of the population of interest. Since the implementation of a programme is expected to have already taken place before the evaluation, the assumption here is that the effects of the programme were intended to be causal whether or not the expected outcomes are eventually observed. The second condition is the assumption of an appropriate theory of causality. This second condition follows from the first condition, in the sense that the appropriateness of the assumed theory of causality is dependent on or based on the assumption of causal effect. The value of the second condition lies in the need to substantiate assumptions with theory that can be tested. In other words relying on assumptions alone without theoretical backing or grounding is not enough or adequate in scientific research. The third condition is an appropriate theory of communication and change that is used to design the programme. At the core of theory-driven evaluation, as discussed earlier in this study, is identification and definition of an explicit or implicit theory/s that underpin the programme being evaluated, and

this third condition is in reference to that. The fourth condition is the availability of a counter-factual condition to estimate the net effects of the intervention. This counter-factual conditions is to be able to establish with some degree of certainty what would have happened to each subject in the programme if they had not been exposed to the treatment - that is, exposed to the communication programme. Knowing this condition helps in estimating the net effects of the programme.

On the strength of the results of their study, Kincaid and Do (2006:87) emphasize that if a programme is poorly designed and has no effect, no research design or statistical analysis will show that behaviour change has occurred. In other words, a research design or statistical analysis does not and cannot 'manufacture' or 'cause-to-be' behaviour change of a poorly designed and implemented programme. For a research design or statistical analysis to show that behaviour change has occurred because of an outcome of a programme, the design of the programme must have been properly designed to yield behaviour change. As to cost-effectiveness, the two researchers explain that based on their analysis, cost-effectiveness depends greatly on the number of people reached by the programme. The more people reached by the intervention, the more or the better cost-effective the programme would be.

These points of emphasis based on the results of empirical studies by Kincaid and Do (2006) bring out the essence of evaluation research that seeks to establish or ascertain success of health communication programme. That is, it is not the evaluation research that generates success of the communication programme, rather it is the programme itself, which if properly designed and implemented ensures success, or brings about behaviour change in the case of a health communication programme. Evaluation research merely investigates whether or not and to what extent the programme was properly designed and with what effect. In recent times, it is more often acknowledged that it is not enough in evaluation research to merely, ascertain the attainment of stated objectives of programmes without also ascertaining how cost-effective a programme has been. The real success of a health communication campaign as a result of its being evaluated should be determined or calculated by matching the attainment of stated objectives with the total cost of the investment in the campaign.

3.5 CONCEPTUAL INTERACTIVE-PARTICIPATORY COMMUNICATION CAMPAIGN MODEL

As a summary of all the salient points discussed above regarding the need that communication campaigns should to be interactive and participative the influence of the context or environment such as political, economic, social, cultural, beliefs and worldview, and the need to include motive and sustain efforts at behaviour change, a new conceptual interactive and participative communication campaign model is proposed in Figure 3.9 as part of the contribution of this study to the field of communication campaign study and practice. The proposed model incorporates elements of the Health Communication Process (National Cancer Institute 1992), RACE, ROPE, RAISE and ROISE, and Robinson's Seven Steps Approach (2009) and is built on the premise of the theoretical underpinnings of the study.
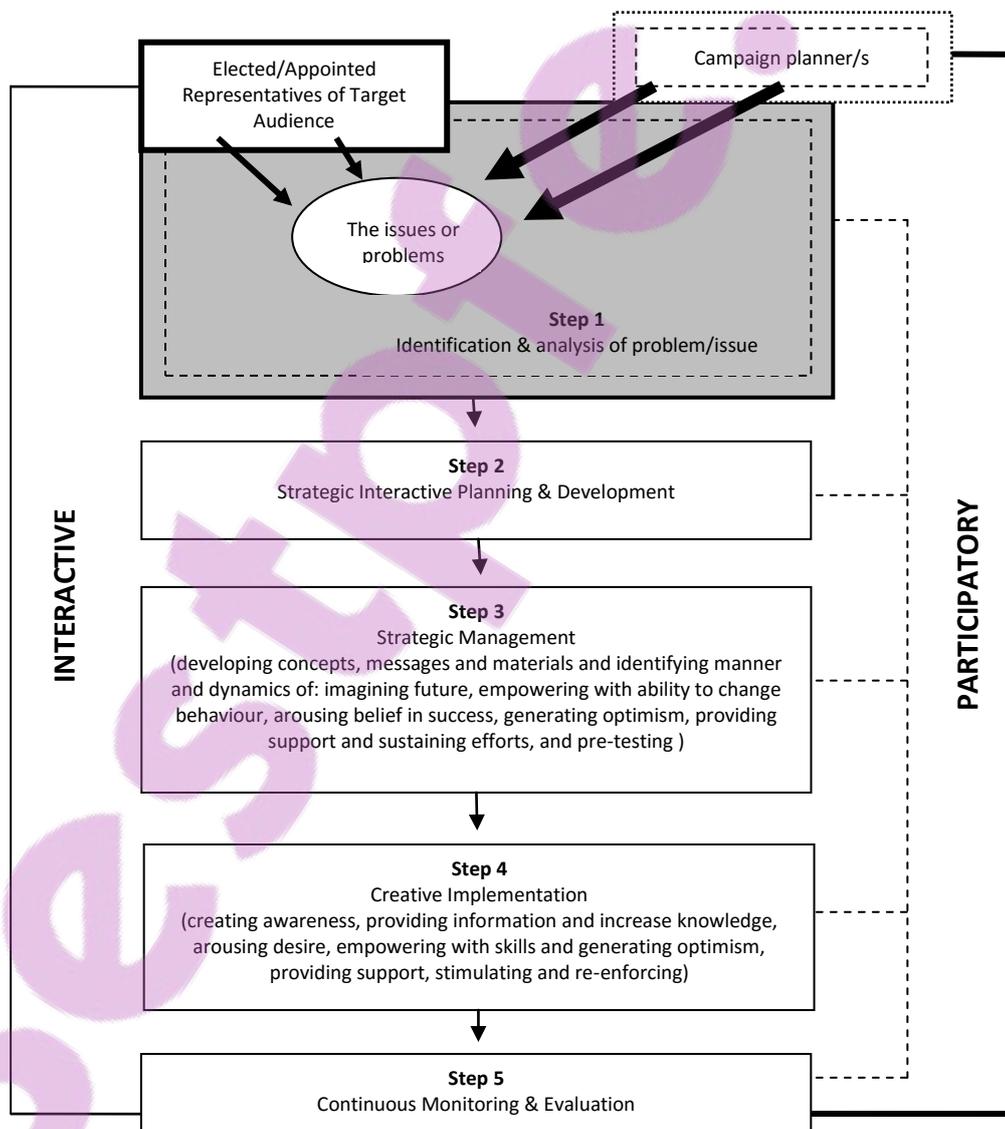
Figure 3.9   Conceptual Interactive-Participatory Communication Campaign

The elected or appointed representatives of the target audience of a health communication campaign

The planner/s of health communication campaign
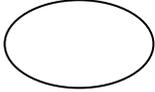
The identified health problem, which is the concern of both the communication planner/s and the target audience of the communication campaign

A representation of the context/environment of the target audience and the 1st Stage in the campaign process

A representation of the 2nd, 3rd, 4th, & 5th Stages of the campaign process
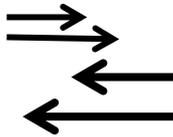
Arrows indicating that the health issue or problem is the concern of both the target audience and the campaign planner/s
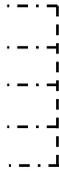
A representation of different types of monitoring/evaluation that take place along the life span of the campaign

The basic premises of the proposed model are:

Communication campaign planners must deliberately engage the target audience through their elected or appointed representatives in the process of identifying, articulating and analysing the problem that is to be taken up in the campaign; this engagement should not be an afterthought or something considered as a mere appendix to the planning but ensure the participatory and interactive communication.

In articulating and analysing the problem of the campaign, the context, for example, the cultural and social beliefs and worldview, the political and economic environment, of the audience should be considered.

The involvement of the target audience's representatives in the campaign should be part of the whole strategic integrative campaign process, that is, throughout the whole life of the campaign the target audience's involvement and participation should be guaranteed. This must include identifying and analysing the problem, setting objectives and developing an overall strategy, and choosing appropriate, relevant and meaningful concepts, messages

and media. To reach other people with a message, it is necessary to know what codes they understand. The audience representatives must also be involved in the implementation and finally the evaluation of the campaign.

The campaign must not consist only of messages that create awareness by providing information, but lead to creating and acquiring more knowledge on the problem with the hope that it would in itself lead automatically to behaviour change. It should also include the dynamics of enabling the target audience to imagine a different and more desirable future if the problem is eradicated or minimised. The campaign must arouse the belief that success is a real possibility, provide tangible and relevant support by un-blocking obstacles, stimulate the process of taking steps to change behaviour, and provide appropriate reinforcement of efforts towards behaviour change.

As illustrated in Figure 3.9, the following steps are included in the proposed Interactive-Participative Communication Campaign Model. These five steps represent the five phases in the communication campaign process: Step 1 - identification and analysis of problem or issue; Step 2 – strategic interactive planning and development of the campaign; Step 3 – strategic management; Step 4 – creative implementation and monitoring; and Step 5 – continuous assessment/evaluation. In order to ensure the participation of the target audience, this process should be interactive and involve elected representatives of the target audience with campaign planners.

3.5.1   Identification and analysis of the problem or issue

In this phase, the main activity is the identification and analysis of the problem of concern and a critical question to be answered here is, 'Who identifies and analyses the problem?'. The answer to this question is considered of crucial importance to how the campaign process develops and progresses and with what results. As stated above, a basic premise of the Interactive Communication Campaign Model is that the target audience should not be regarded as mere recipients of the planning and efforts of the campaign planners; but should actively participate in the process of the communication campaign through their representatives – the leaders in local opinion. The campaign planners, therefore, are to engage the target audience through these representatives. There ought to be some level of interaction between the two on the nature and dynamics of the problem. This necessary dialogue is illustrated in the model with the use of two arrows – from the target audience towards the campaign planners and vice versa. The first purpose of this dialogue is for both to agree that there is a problem that needs to be addressed. Hence, the core of the answer
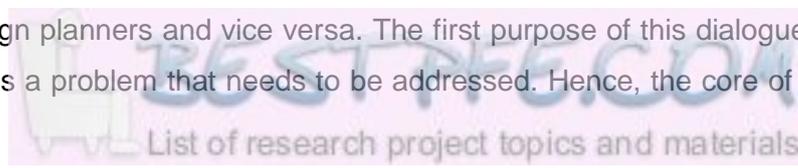
to the question does not hinge on determining who pointed this out but rather on both acknowledging the problem, which most probably affects the target audience more than the campaign planners. Though the campaign planners may be the first to point it out, it may not necessarily mean that they became aware of the problem first.

In the model, a section of the box labelled "Elected or Appointed Representatives of the Target Audience" is inside the grey shaded box, which represents the context/environment, the life situation of the target audience. As can be noticed, the box labelled "Campaign Planner/s" unlike that of the "Elected or Appointed Representatives of the Target Audience" does not enter but sits on top of the grey shaded box and extends beyond it. The positioning of the two boxes and the extension of the box "Campaign planner/s" slightly beyond the grey shaded box indicates that the campaign planners may not be from within the life context or environment of the problem as the target audience – they, campaign planner/s maybe outsiders.

The set of arrows from the elected or appointed representatives and the campaign planner/s towards the circle (the problem/issue) is an illustration that both the campaign planners and the target audience are concerned about the problem/issue. The difference in thickness of the set of arrows illustrates that the campaign planner/s who may not (experientially) be as close to the problem as the target audience, but as experts may have more knowledge of the problem than the latter based on study/research or information gathered.

The dotted box within the grey shaded box depicts the elements of influence of the context/environment such as political, economic, social, culture, beliefs and worldview; elements that may have some determining influence on the way the target audience perceive and react or respond to the problem/issue.

In this model, the target audience would be actively involved and participate in the analysis of the problem – that is, they participate or take part in the process of analysing the identified health problem. This will be in line with first step in Robinson's (2009) Seven Steps Approach, which advocates that the target audience who are expected to change certain behaviour must know and be aware that there is a problem and not only that there is a problem but that there is some practical, viable solution or alternative to the problem. In addition, they should be able to identify the personal cost of inaction and the benefits of action in concrete terms. This would be active involvement of the target audience. Such involvement would empower them to consider taking the necessary action to address the problem. Together with the campaign planners, then they would decide to take the next step, developing an overall plan and strategy to tackle the problem.

3.5.2   Strategic interactive planning and development of the campaign

Having completed the tasks of identifying and analysing the problem in Step 1, the communication campaign process moves to Step 2, overall strategic planning and development. The movement from Step 1 to Step 2 is illustrated with an arrow. The two main activities of this phase of the campaign process is setting campaign objectives and developing campaign strategies. The campaign objectives are based on the analysis of the problem and the need to respond in a communication campaign to create awareness about the problem among the target audience, who need to change their behaviour. The objectives are set not just by the campaign planners, but through consultation and collaboration with the target audience, through their representatives. This consultation and collaboration are depicted with a "thinner" lines on the left side of the model and the "thicker" lines on the right, beginning from Step 1 and both connecting to Step 2. Once the objectives have been set, the campaign planners and the representatives of the target audience move on to tackle the task of developing strategies, for example determining what needs to be done, how it should be done, by whom and when.

3.5.3   Strategic management

In this step the development and pre-testing of concepts, messages and campaign materials takes place. This is the phase of the campaign process, in which the strategies that had been developed in Step 2 begin to unfold. The manner of developing concepts, messages and materials and the identification of the manner and dynamics of how to concretely motivate and sustain the target audience's behaviour change (their management), would have been part of the strategy developed in Step 2. As mentioned above it is expected that representatives of the target audience will participate in the activities of this step, that is, the process of developing appropriate and relevant concepts to be framed in messages (codes) that the target audience can receive and understand and/or decode, taking into consideration their real life context with its various elements. To ascertain the appropriateness and relevance of the developed concepts, messages and materials of the campaign, they are pre-tested among a section of the target audience during this phase of the campaign process. Once the campaign planners together with the representatives of the target audience are satisfied with results of the pre-testing the campaign process moves to the next step.

3.5.4   Creative implementation and monitoring

This fourth step of the campaign process, the step of implementation can be termed the 'roll-out' and 'sustaining' phase of the campaign, when what has been developed and produced in the previous step is rolled out among the target audience. Essentially, it is the phase of implementing what has been planned and developed in Step 3, that is, the creation of awareness and educating the target audience by providing information on the problem; motivate and sustain their response and their efforts to change their behaviour.

3.5.5   Continuous assessment/evaluation

Continuous assessment or evaluation is needed to ascertain whether the objectives set in Step 2, which warranted the development of Steps 3 and 4, have been achieved or not; and to determine what is need and how the campaign should be adapted to achieve the objectives.   As can be noticed in the box representing Step 5, however, it is not only evaluation that is to take place but also monitoring. Monitoring cannot be done or should also not be done only at the end of the timeframe but during the course of the life span of the campaign. This requires that other appropriate forms of assessment/evaluation – context, formative, process, outcome and impact, should be carried out at various stages in the process of the campaign. The nature of these forms of assessment/evaluation is discussed further on in the study.

3.6   THE THEORETICAL CONCEPTUAL FRAMEWORK OF THE STUDY

In this section, the theoretical conceptual framework that helped to set the parameters for the conceptualisation of the relationships and dynamics of the elements of culture, communication, the individual and the community against the background of the theories/models discussed above are presented in the following sequence. First by discussing system theory to serve as a meta-theory to explain the connectivity, integration and intertwining of the four main variables of this study. That is how the four variables form a 'whole' while at the same time each one remain unique with its own parts and on its own form a 'whole'. An entity on its own that does not have to be considered as a part of the others to necessarily give it its meaning and value. Second, discuss the work of Semenovich Vygotsky (1896-1934) on human development and social interaction; thirdly, by complementing the views of Vygotsky with some of the tenets of self-determination theory. The discussion of the theoretical approach leads to a presentation and discussion of the

theoretical conceptual framework of the study. The theoretical conceptual framework served as the basis and justification for the need to construct a sociocultural health communication model, which guided the development of a theoretical sociocultural assessment instrument that is socioculturally appropriate for assessment of the health communication campaign.

3.6.1   General system theory

It was noted in the discussion of Chapter 2 that communication is an interactive process comprising a series of activities, which are interlinked and interdependent and communication and culture are intertwined and interdependent. The second research question of the study was that the target audience of a communication campaign should actively be involved in the campaign process from beginning to end. Such involvement would require their interaction and relationship with the campaign planners. That should ensure that the sociocultural context and elements, such as worldview, religious beliefs, traditions and customs are taking into consideration in planning and execution of communication campaigns as stated in the second research question. Because communication and culture as discussed are both complex realities and health communication is a complex field, it is assumed that health communications campaign are complex.

To understand the complexities of the different realities/phenomena that are the main variables in the study; and be able to conceptualise the interconnectedness and interdependence and the dynamics of relationships between the various elements of these realities, General System Theory (GST) was chosen as the meta-theory to form basis of the theoretical framework of the study. The choice was based on the fact that, the "goal of GST is to model the properties and relationships common to all systems, regardless of the specific components or the academic disciplines in which they are located" (Bailey 2005:3). Physical, biological or social systems may all appear to be quite different in terms of their components and relationships, but they may all display certain common properties and the study of these common properties is the goal of GST. To understand and appreciate the value GST it is important to understand that a system is elements in interaction (Schoech 2004:1), a "bounded set of components and the relationships among them" (Bailey 2005:3). That makes systems' thinking "a theoretical approach to understanding phenomena" (Schoech 2004:1). The theoretical thinking is an abstract way of conceptually understanding the elements in their interaction in phenomena; making a system "an integrated set of interacting variables that together create a larger pattern or whole" (Littlejohn 2009:1); the 'whole' being the phenomenon and the interacting variables being the elements or parts of

the phenomenon (in interaction). The set of interacting elements that form an integrated whole, is intended to perform some function (Skyttner 2001:53) and it is this function that gives purpose to the phenomena. To understand a system therefore, requires an understanding of the integration of the parts "forming a complex whole that can be separated by boundaries from an environment of elements not belonging to the system" (Marcinkowski 2008:771). These elements or components are the internal entities located within the system's boundaries; are interrelated and assumed to be of the same basic nature (Bailey 2005). All systems thus have four aspects, which Littlejohn (2009:1) name as objects, attributes, internal relationships, and an environment. The objects refer to the parts or elements. The attributes are the characteristics of the objects and those of the system as a whole. Internal relationships are the patterns of the interaction among the objects and the environment is the system of influences that act on or affect the system in any way.

There is a distinction between concrete and abstracted systems. Concrete systems are those whose internal units/components are empirical objects, such as living organisms or mechanical entities. These types of systems are also referred to as physical, biological, social or veridical systems. Different from the concrete, are the abstracted systems, also referred to as theoretical, conceptual or symbol systems, whose components are concepts. The components of abstracted systems unlike those of concrete systems are "nonempirical entities such as concepts and variables and their boundary/boundaries may not be visible or empirically determinable" (Bailey 2005:3).

In this study as part of the theoretical framework the GST helped to conceptualise, understand and explain the relationships, interactions, connectedness, interdependence and functioning of communication and culture, the individual and his behaviour, the community and sociocultural context, the different components of the proposed sociocultural health communication model and its eventual construction. GST, which Bevir (2009:203) opines is little more than a metaphor to describe complex set of parts or components forming a larger whole, thus provided part of the theoretical basis for this study.

3.6.2   The work of Vygotsky espoused in his sociocultural theory

Communication, as discussed, is a human activity that takes place in transactions in which meaning is created, shared and regulated by individuals in a society. This interactional transaction is not carried out by a person merely as an individual but as a person in relationship with another or others. Culture, as also discussed, sets the rules for how people interact and what they exchange in relationships. Thus, the two variables – communication

and culture, are conceptualised in this study as interrelated and interdependent. It was for this reason that the work of Vygotsky was selected to serve as part of an appropriate framework for this study. His work describes and explains human behaviour as socially and culturally generated, and conditioned activity.

The results of Vygotsky's research in the areas of developmental psychology, education and psychopathology laid the foundations for the field of sociocultural studies. The sociocultural studies relates to studies of situated, contextualised human behaviour. That is, human behaviour not of an individual in isolation but human behaviour as it is influenced and affected by and also influencing and affecting social and cultural environment or factors. One of Vygotsky's main arguments is that human behaviour cannot be understood by a study of the individual only. Wink and Putney (2002:85) state "just as one cannot separate water into distinct parts and still maintain the integrity of water, so, too, one cannot separate the individual from the context and still have a complete understanding of either. The unification of a person with that of social, cultural, historical, and political context; informs our understanding of this dialectical relationship". Understanding human behaviour necessarily requires taking into consideration the environment in which that particular behaviour is found since elements or aspects of the environment (social, cultural, historical, political) invariably have some determining influence on the behaviour either overtly or covertly. This argument of Vygotsky applied to the assumption of this study that communication is a socially and culturally generated and conditioned human behaviour implies that the understanding of communication activity cannot be separated from the activity's social and cultural environment.

Vygotsky arrived at his conclusion from his research on child development in which he discovered that the higher order functions of a person develop out of social interaction. He pointed out that in the history of the cultural development of a child, there is a concept of twofold structures. The first structure or the first process of cultural development is the point of origin of the whole process or history. That is the initial behaviour of the child, which is a natural psychological whole that depends mainly on biological features. That, Vygotsky referred to as the primitive structure (Vygotsky 2004:360). The main feature of this structure is that "the reaction of a subject and all stimuli are at the same level and belong to one and the same dynamic complex which … has an extremely clear affective tinge" (Vygotsky 2004:359). The second structure or second process of cultural development is not something completely different from the first but it is to be "understood as a change in the basic original structure and development of new structures that are characterized by new relations of the parts" (Vygotsky 2004:359). That is the higher structure, which represents a

genetically more complex and higher form of behaviour. In the first structure, behaviour comprises of stimulus and response (perception and action), and this forms a 'whole' – behaviour that is genetically primary, most elementary and simple. Between the stimulus to which behaviour is directed and the person's action, there is no intervention of any kind.

Unlike the first structure, in the second structure, an intervention between stimulus and response/reaction is present. Here the whole operation assumes the character of a mediated act. Based on the results of experiments Vygotsky notes that the structure of the whole process changes, that is, the very structure of the whole process changes in behaviour, depending on the position of the middle stimulus (sign) – that which intervenes. Accordingly it is possible to "distinguish clearly two orders of stimuli of which some are stimuli-objects and others, stimuli-means; each of these stimuli according to its relations uniquely determines and directs behaviour. The uniqueness of the new structure is the presence in it of stimuli of both orders" (Vygotsky 2004:360). That is, stimuli of the primitive structure and stimuli of the higher structure with the latter playing a more determining role. From these experiments Vygotsky arrived at the conclusion that it is possible to assume the following as a rule: "in the higher structure, the sign and methods of its use are the functional, determining whole or focus of the whole process" (Vygotsky 2004:360). In other words, what determines behaviour in the higher structure is not merely a matter of stimulus – that is, response activity but more importantly the presence of an intervening factor, the external factor/s – the social and cultural and the manner in which these external factors influence the subject.

Applying Vygotsky's explanation of the first or primitive structure in the process of cultural development to understand the relationship between communication and culture, is applied in this study. It is deduced that the communicative behaviour of a child, particularly that of an infant, such as crying when hungry or feeling some discomfort; or giggling and laughing when tickled, are all reactions to stimuli – communicative behaviours that are genetically primary, most elementary and simple. As the child grows, gradually his communicative behaviour changes – he can utter some words, initially just repeating what he hears without much understanding if any at all. As this process of cultural development continues, he begins to understand, create and share meaning, which are regulated among other things by his social and cultural environment. According to Vygotsky's findings, the child who is growing has now moved into the realm of the second or higher structure of cultural development. That has been possible because of the intervention of external factors – the learning to communicate meaningfully within his social and cultural settings; a learning that has taken place through his interaction with others.

Vygotsky further explains that the basic law of nature is the law of stimulus – response, which is engrained in the primitive structure. Human behaviour, however, is not subject only to this law, thanks to the second structure that enables or facilitates the process of a person acquiring mastery of his/her behaviour. This mastery of behaviour comes about through appropriate stimulation. The appropriate stimulation is a mediated process, which is always accomplished through certain auxiliary stimuli: the environment – culture or social factors, or more specifically social interaction, which for the purposes of this study is a communicative activity. A communication campaign is within the category of such activity. Hence, while cultural development of behaviour builds on the natural or biological development, the two are distinct. This distinction is however not an ontological one because culture – the social interaction, the communicative act; does not create something completely new. Culture "only uses what is given by nature, modifies it, and places it at the service of man" (Vygotsky 2004:368). Human behaviour is thus essentially the result of the activities of the two processes of development – the biological and the cultural or social interaction. Hence all human behaviour is because of some stimuli – biological and sociocultural (Vygotsky 1997), and so it is possible to talk about inherited reaction and acquired reaction (behaviour). The former is conferred at birth and the latter arises and develops as the person grows through sociocultural interaction. It is, therefore, the "social environment that determines how behaviour evolves" (Vygotsky 1997:49) or to put it differently, sociocultural factors and conditions are determinants of human behaviour and to understand human behaviour it is required that a person understand the sociocultural context within which that behaviour originates and/or is sustained. This point is important for this study, which is premised on the assumption that sociocultural factors influence positively or negatively health communication campaigns that aim to bring about sexual behaviour change.

Vygotsky also draws attention to the fact that the social environment is not a static, elemental, and stable system of elements. Rather it is a dialectically developing dynamic process requiring that a person's relationship with his surrounding (environment) should not be a simple dependence but always bear the character of purposefulness, and of activity (Vygotsky 1997). As noted previously a person has the capacity of mastery of behaviour and in his process of development he does not "only master the items of cultural experience but the habits and forms of cultural behaviour, the cultural methods of reasoning" (Veer & Valsiner 1994). In human development, a person goes through a transition from "direct, innate, natural forms and methods of behaviour to mediated, artificial, mental functions that develops in the process of cultural development" (Vygotsky 1998:168). Hence, a person's behaviour is not totally at the mercy of natural, innate forces, nor external forces of sociocultural forces. In the context of this study concerned with sexual behaviour change to

help curb the spread the human immune virus, interventions such as health communication campaigns ought be designed, packaged and delivered in such a manner as to appeal to and touch on people's capacity to master behaviour. For while the sexual instinct or stimulus to engage in unprotected sex may be the result of direct innate and natural biological stimulus; humans have the inner capacity of choosing a different response behaviour by opting to engage in protected sex since one has the capacity through the process of developmental learning in social interaction to master his behaviour. It was therefore, assumed in that the messages and processes of health communication campaigns if properly developed and utilized could serve as an intervening or mediated factor between the stimulus and the response/reaction, which if adequately mastered, should lead to the desired behaviour/change promoted by in campaign.

The importance and crucial nature of social interaction (a communicative activity) in the development of human behaviour are also brought out or stressed in Vygotsky's notion of a 'zone of proximal development' (ZPD), which is one of the essential tenets of his work. The ZPD explains the difference between a child's capacity to solve problems on his own, and his capacity to do so with the assistance of others. ZPD "includes all the functions and activities that a child or a learner can perform only with the assistance of someone else, while the actual developmental level of the child refers to all functions and activities that the child can perform on his own without help from others" (Guerra 2001:3). In other words, in human development there are certain things, functions and activities, that a person can perform on his own while the capacity or ability to do some other things is dependent on the assistance that the person receives from others. That means in the latter case, there is a need for intervention and the one who intervenes in the case of a child, could be an adult, for example, parent, older sibling, guardian or teacher who has already mastered the particular or specific function. Vygotsky's notion of ZPD could be understood as a process of 'assisted learning'. In other words, in the process of the development of a child there are certain functions and activities that can be learned properly or fruitfully only if the child receives some necessary assistance from someone older with the required experience of the functions and activities the child has to learn to perform.

One of the implications of Vygotsky's ZPD for the process of learning is the presupposition that human learning is socioculturally specific. That means it presupposes or has a specific social and cultural nature, and it is part of the process by which, a child grows into the intellectual life of those around him. It is important to note that though in a child's development and learning, social interaction is important and vital, this does not mean or imply that the child or for that matter any person in the process of learning is a mere passive

recipient. Whatever intervention or influence comes from outside is or has to be processed by the individual, and, it is this processing that facilitates the mastery of behaviour mentioned above. What is processed is the experience of the individual, which leads to the formation of new reactions (behaviours). Thus, Vygotsky (1997:47) states, "the individual's own experience is the only teacher capable of forming new reactions in the individual. Only those reactions are real for an individual that are given to him in his personal experience" (Vygotsky 1997:47). Consequently, it is "impossible to exert a direct influence on, to produce changes in, another individual, one can only teach oneself, that is, alter one's own innate reactions, through one's own experience" (Vygotsky 1997: 49).

It is, therefore, the sociocultural environment; the different factors of this environment and how a person perceives and experiences this, and responds, that teaches the individual. As a result, what is important and necessary for effective learning that leads to or brings about change in human behaviour is the creation or provision of an enabling social environment. Thus an individual's experience and the formation of his conditional reflexes is "determined wholly and without exception by the social environment. It is only necessary to change the social environment and human behaviour likewise changes at once" (Vygotsky 1997:48) and it is the "social environment that determines how behaviour evolves" (Vygotsky 1997:49).

Although Vygotsky's work was primarily about childhood development, it may not be out of order or out of context to understand and apply his findings to human learning from childhood to adulthood. That is, applying his findings to adult learning as well, for as a Tswana saying goes, "Thuto ga e golelwe," which means, one does not outgrow learning. Learning is a process of the whole of life not only during childhood. If as Hofstede (1993) asserts, culture is not inherited nor derived from one's genes but learned from one's social environment, and, it is the sociocultural environment that teaches the individual, then particular functions and activities appropriate to the different stages of life would require assistance from people within the social environment with the required knowledge and competence. Tha means even in adult life one needs assistance in acquiring competence in the performance of certain functions and carrying our certain activities. Assisted learning is therefore part of the process of learning through the whole of life. Hence, Vygotsky's notion of the ZPD is thus applicable to social learning of adults. Applied to health communication, particularly learning on sexual behaviour, ZPD offers valuable lessons for the development, implementation and evaluation of health communication campaigns. Such a communication campaign developed and implemented in the understanding of the ZPD, becomes an intervention that offers the assistance needed for those who are sexually active, the

knowledge and competence of sexual behaviour (mastery of sexual instinct and desires) that empowers and enables them to either abstain or engage in safe and protected sex.

Vygotsky's theoretical assumptions discussed above underpinned the attempt of developing a sociocultural theoretical assessment instrument. It was assumed that intervention in the social environment (and not the mere focus on the individual) has a greater chance of effecting change in human behaviour. For this reason, it was also assumed that, to achieve its objective/s of bringing about behaviour change, it is necessary for a communication campaign not to focus only on the individual. The campaign needs also to take seriously into consideration, the individual's sociocultural environment or context, which serves as an intervening or mediated factor/s - how these factors hinder or promote the required behaviour change. In the light of these assumptions, and based on the insights of Vygotsky's sociocultural studies, it was necessary, in developing the sociocultural assessment instrument to ensure that the instrument has the appropriate features. That is features can detect and verify if the campaign planners were aware of the necessity of the sociocultural factors and incorporated them in the planning and implementation of the campaign.

3.6.3   Self-determination theory

One of the main tenets of Vygotsky's work as discussed in he preceeding section is that human behaviour results from biological (stimulus – response) and social interaction (stimulus – social interaction – response) processes. The biological process is outside the control of a person while the social process is within his control. To complement this understanding of human behaviour as socially and culturally generated activity, and in support of the choice of Vygotsky's findings as part of the theoretical framework for this study, attention now turns on Self-Determination Theory (SDT) formulated by Edward L. Deci and Richard M. Ryan (Moller, Deci & Ryan 2007). SDT comprises a set of mini-theories namely, Cognitive Evaluation Theory, Organismic Integration Theory, Causality Orientations Theory and Basic Needs Theory. Like the sociocultural studies of Vygotsky, SDT is a theory that has its origins/roots in the field of human/social psychology, whose central focus is the "effects of social environment on people's attitudes, values, motivations, and behaviors" (Lange, Kruglanski & Higgins 2012:416).

Both Vygotsky's studies and SDT acknowledge the impact of environmental forces on the human being. However, SDT's approach to human motivation and personality is different from that of Vygotsky's studies and other social psychology theories and models. The difference lies in SDT's approach of using "traditional empirical methods while employing an

organismic metatheory that highlights the importance of humans' evolved inner resources for personality development and behavioral self-regulation" (Deci & Ryan 2000:68b). SDT's position, therefore, is that "the human organism is evolved to be inherently active, intrinsically motivated, and oriented toward developing naturally through integrated processes" (Lange et al. 2012:416); and since these qualities are inherently active and intrinsically motivated, they do not need to be learned as they are inherent in human nature. But "they develop over time, play a central role in learning, and are affected by social environments" (Lange et al. 2012 417). SDT's arena of investigation thus is "people's inherent growth tendencies and innate psychological needs that are the basis for their self-motivation and personality integration as well as for conditions that foster those positive processes" (Deci & Ryan 2000b:68). In other words, SDT seeks to explain the inherent growth tendencies and innate psychological needs. That is, explaining the nature and active processes of intrinsic motivational dynamics and how the integration of psychic elements of the human organisms bring about a "unified sense of self and integration of themselves into larger social structures" (Deci & Ryan 2000b:229). That makes SDT's concerns twofold: the specific nature of positive human developmental tendencies and the examination of social environments that are either conducive or antagonistic toward these tendencies (Deci & Ryan 2000b), that is, the development and functioning of personality within social contexts (Overview of Self-Determination Theory 2006).

SDT posits that the evolved human organisms are inherently active and intrinsically motivated where intrinsic motivation is a key construct for explaining human growth, and since motivation "concerns energy, direction, persistence and equifinality-all aspects of activation and intention" and it "is at the core of biological, cognitive, and social regulation" (Deci & Ryan 2000b:69), intrinsic motivation can be regarded as the 'motor' or 'engine' of the human organism that propels it towards growth and development and integration into its social context. It is that which ignites or give energy/vitality to the potential of the inherent growth tendencies and integration into the social context. Intrinsic motivation thus can be described as "the natural inclination towards assimilation, mastery, spontaneous interest, and exploration that is so essential to cognitive and social development" (Deci & Ryan 2000b:70). This explanation fills the gap in Vygotsky's work discussed above as to the origin or source of the capacity/ability for mastery of behaviour.

It is important to note that in SDT motivation is not considered a singular construct. People are regarded as being not moved to act by a single factor but "by very different types of factors, with highly varied experiences and consequences" (Deci & Ryan 2000b:69). A person may be motivated to act or behave in a certain manner because he values a

particular activity or because of the presence of some strong external coercion. The former action will be the result of internal motivation while the latter will be the result of external pressure. Thus Deci and Ryan (2000b:70) point out, "despite the fact that humans are liberally endowed with intrinsic motivational tendencies, the evidence is clear that the maintenance and enhancement of this inherent propensity requires supportive conditions as it can be fairly readily disrupted by various nonsupportive conditions". The required supportive conditions for the maintenance and enhancement of the inherent propensity are the "fundamental nutriments – namely, ambient supports for experiencing competence, relatedness and autonomy" (Deci & Ryan 2000b:229). These are the three psychological needs, the universal psychological necessities, the nutriments required for proactive, optimal development and psychological well-being (Deci & Vansteenkiste 2004).

The need for competence concerns people's innate desire to be effective in dealing with their environment (Deci & Vansteenkiste 2004). Effectiveness in dealing with the environment implies being able to master it. If this innate desire or inherent motivation (to master the environment) receives support and nourishment, then the competence potential is actualised. When the competence potential is actualised a person is in the position to take hold of his/her inner drives and emotions, and respond to or deal with external (social environmental) factors in such a manner as to ensure that he is not at the mercy of such factors as to be passively controlled by them. Being in control facilitates the person's process of growth and optimal development. The second need, which is the need for relatedness concerns people's universal natural tendency to interact with, be connected to, and experience caring for other people (Baumeister & Leary 1995). Like social animals, human beings do not live in isolation of each other, and so many of their activities in life involve others and are directed at experiencing the feelings of belonging thus their need for relatedness. The third need – the need for autonomy is a reference to the universal urge that people have to be causal agents. That is, to experience volition to act in accord with their integrated sense of self, endorsing their actions at the highest level of reflective capacity (Deci & Vansteenkiste 2004), and the urge to be responsible for one's action or choice of action. That is not an urge to be independent of others. If it were an urge to be independent of others, this need would be diametrically opposed to the need of relatedness and such opposition would not argue well for integration and well-being. To be autonomous is a need to have a choice in deciding on one's action whether independently initiated or as a response to request from some other person.

The satisfaction of each one of the needs is essential for optimal development of active organisms. If any of them is neglected or thwarted, the result is non-growth, imbalance and

psychological ill health. Based on studies conducted Deci and Ryan (2000b) assert that there are no instances of optimal, healthy development in which a need for competence, relatedness, or autonomy are neglected, irrespective of whether the individuals were conscious of the value of these needs. In other words, psychological health or well-being requires the satisfaction of all three needs and it is not a matter of the satisfaction of one or the other, or two of them minus one, but all three. The satisfaction of these needs actualises the proactive and growth/development potentials of human beings thus prompting and effecting the "integration of their psychic elements into a unified sense of self and integration of themselves into larger social structures" (Deci & Ryan 2000b:229). Deci and Vansteenkiste (2004) explain that due tothe fact that these needs are essential, people ordinarily tend to gravitate toward situations that allow their (needs) satisfaction while they move away from those that thwart the needs. These scholars further explain that though ordinarily people would orientate toward situations that allow them to satisfy and away from situations that frustrate the satisfaction of the needs, it is important to bear in mind that in many cases the satisfaction (of the basic needs) are not normally their specific intention for (their) behaviour. Normally people do what they find interesting and personally important to them and in the process of doing so find satisfaction. The specific intention for human behaviour, therefore, is not necessarily the satisfaction of the basic psychological needs, although it may be so in certain cases. Another factor to consider is the fact that the proposition of the three psychological needs is not part of the meta-theory of SDT. That means the proposition is not an assumption, rather it is a theoretical postulate formulated to provide an interpretation of various empirical results. The main assumption of the theory is that "satisfaction of the basic psychological needs constitutes the central psychological process through which intrinsic motivation, the integrative tendency, and intrinsic goal pursuits are facilitated, resulting in well-being and optimal development" (Deci & Vansteenkiste 2004:26)

The SDT's special contribution understanding to sociocultural theory is that in explaining the phenomenon of human behaviour, it acknowledges the role of social or environmental factors – that is, how and whether these factors hinder or undermine self-motivation, social functioning, and personal well-being (Ryan & Deci 2000). It emphasizes what is referred to in SDT as intrinsic motivation, which is the "motivational instantiation of the proactive, growth-oriented nature of human beings" (Deci & Vansteenkiste 2004:26). SDT thus complements sociocultural theory in understanding human behaviour through its proposition that human behaviour is not simply the result of biological and/or social interaction, but also the result of intrinsic motivation that is innate in the human person - the 'self' of a person, which is not merely a set of biological factors or "a set of cognitive mechanisms and structures but rather

a set of motivational processes with a variety of assimilatory and regulatory functions" (Deci & Ryan 1991:238). Nor is the self simply a reflection of social forces but something that "represents intrinsic growth processes whose tendency is toward integration of one's own experience and action with one's sense of relatedness to selves of others. Thus, the self is not merely an outcome of social evaluations and pressures but instead is the very process through which a person contacts the social environment and works toward integration with respect to it (Dec & Ryan 1991).

While the self is not meely a reflection of social forces, the latter plays the special roles of serving as autonomy support, structure and frame for involvement for the former in its activity, growth and optimal development. Autonomy support describes a context that does not pressurize a person to perform in specified ways, but rather encourages initiative so that a person feels responsible for his/her choice of action or behaviour. Structure connotes the extent to which behaviour-outcome contingencies are understandable, expectations are clear, and feedback provided. Involvement refers to the degree to which significant others (for example, parents for children, teachers for students, chiefs for subjects, and pastors/priests for congregation members) are interested in and devote time and energy to a relationship (serving as role models and promoting activity, growth and optimal development). Involvement concerns others "dedication of psychological resources that the target person can use as a basis of support and an aid to effectance" (Deci & Ryan 1991:246).

Based on the preceeding discussion, it is surmised that self-determination theory, as a complementary theory to social cultural theory, offers a good theoretical basis for the development, implementation and assessment of a health communication campaign that aims to bring about behaviour change in its target population, which in the case of this study, would be sexual behaviour change. This theory proposes an understanding of human behaviour that takes cognisance of the self of a person – a proactive organism that has within itself the potential or capacity for growth and well-being and optimal development. A self that is not merely controlled by or at the mercy of its internal drives and emotions and/or external factors or forces such as social or environmental contexts but has within itself the potential to act on and master both forces. The theory also helps in understanding the phenomenon of the social context that may facilitate the process of growth and well-being (serving as an autonomy support, offering structure and frame for involvement) or frustrate such process. In the light of the assumptions and principles of this theory, the development of health communication campaigns to bring about behaviour change ought to pay attention to elements of the intrinsic motivations of human beings. In addition to that, the campaign

should be considered as an element of the social context, which as an autonomy support system, provide a structure, encourage and promote the involvement of the target audience. An assessment instrument that is underpinned by SDT should theoretically similarly pay attention to identifying and analysing the elements of the intrinsic motivations and social contexts that had formed the basis of the planning and execution of the campaign.

Based on the rationale of the study, the research problem, and research questions and the discussion of the theoretical framework in the preceding section, Figure 3.10 was developed as a conceptual model of the study.
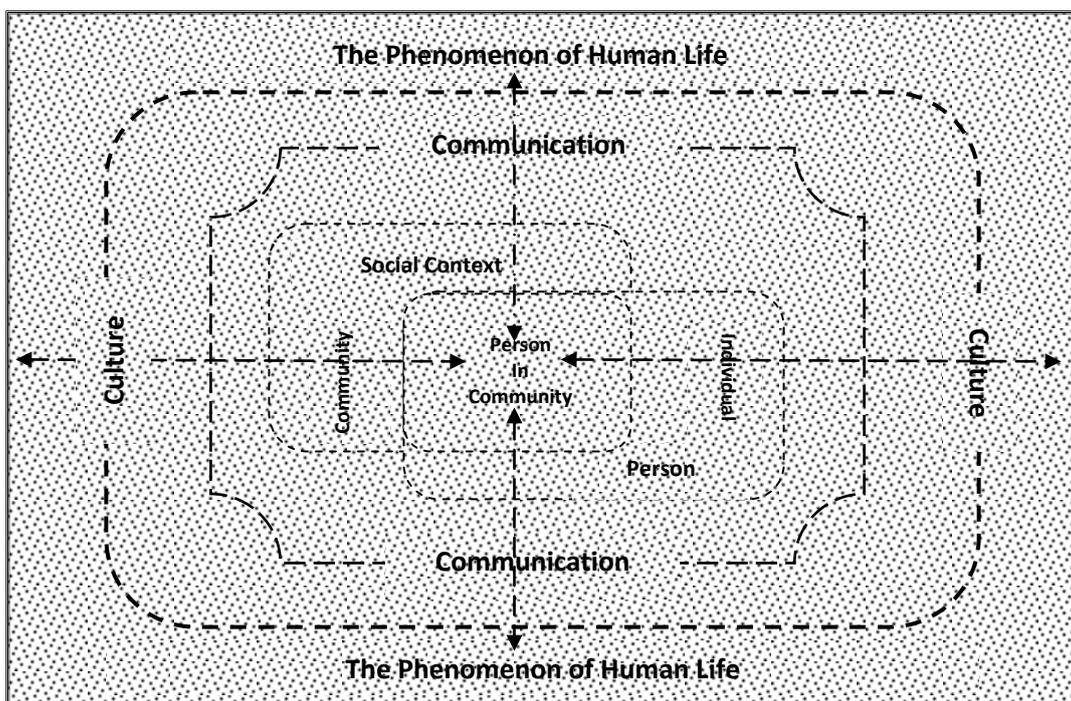
Figure 3.10   **Theoretical Conceptual Framework of Interrelationship and Interdependence of Communication and Culture**

Legend
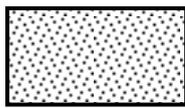
The outer square box depicts the phenomenon of human life (a suprasystem), which is made up of various elements/components (systems) depicted by the dotted pattern. Among these elements are culture, communication, the individual person and the community (social context) which are key variables in this study.

A depiction of culture, a key component of human phenomenon, that affects and is affected by the other components of life.

A depiction of communication - also a key component of human life, which like culture affects and is affected by other elements of life
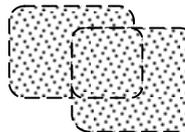
The two boxes represent the individual and his community or the society he lives in. While the two are distinguishable, they are also interdependent and interrelated. The community/society needs individual persons to constitute it (so that there be society), and the individual does not live in isolation of others but lives in community and that is depicted with the small box between the two.
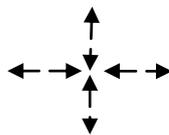
The arrows depict the relationships of interconnectivity and interdependence between culture and communication in the context of the human phenomenon, and how that interconnectivity and interdependence affect and influence the individual and the community and the relationship between the two.

HIV/AIDS communication campaigns aim at creating awareness and providing information and knowledge that promotes sexual behaviour that prevents infection and help to curb the spread of HIV. Human sexual behaviour thus is a significant variable in HIV/AIDS communication campaign. Human behaviour is an integral component of what constitutes a human being and not an isolated, independent entity. In explaining the origin and nature of the human being Vygotsky has pointed out that at its primary level (primitive structure), or lower order of functioning, human behaviour is the result of stimulus - response. At its higher order of functioning, the secondary or higher structure, human behaviour results from stimulus – intervention – response. In human development and balanced growth, therefore – in the zone of proximal development, the intervention, the assistance of others is important and crucial. The necessity, importance and crucial nature of the intervention that is generated, does not imply that the human being is merely at the mercy of the influence of his social context for his growth and development. As explained in SDT, the human being has within himself inherent growth tendencies and the capacity and ability to be intrinsically motivated. The social context is what provides the structure, and framework, and nutriments needed by the individual to meet his needs of competence, relatedness and autonomy in its process of growth and development. Understanding human behaviour as earlier explained above, therefore, requires understanding the relationship between the individual and his social context; and what influence or impact, the latter exerts on the former. Since human beings are communicative and cultural beings, it also means that the understanding of human behaviour requires understanding the relationship, interdependence and

connectedness of human behaviour, the social context, communication and culture. Figure 3.10 was developed to depict the conceptualisation of the relationship, interaction, interdependence, interconnectedness, and dynamics of these variables.

The human being (with his behaviour), his social context, the communicative and cultural elements that are all part of his life are depicted as contained in the phenomenon of human life that is illustrated with the patterned solid line outer box. The pattern box represents all the various elements that make up or constitute human life. Among these elements are the key variables of the study mentioned. The individual is connected to his social context. The two are culture specific, and both being within the broken-line curved-out corners box with the inscription 'Culture' depicts this culture specificity. Not only are human beings cultural beings, they are also communicative beings, and the process and manner of their communicative activities are conditioned by their culture. This is depicted with the broken-line curved-in corners box inside the culture box. From the perspective of GST, the phenomenon of human life is conceptualized as a supra system. The individual, the social context, culture and communication are conceptualised as subsystems of human life. Each subsystem on its own may also be conceptualised as a system with its own boundary and its particular elements being its subsystems. The boundaries of subsystems of human life are illustrated with broken lines to indicate that they are not isolated from each other, but rather relate with and interact with each other – they are interconnected and interdependent. The four broken line arrows depict the interconnectedness and interdependence of these variables. The human being does not live in isolation from others but interacts and is interdependent on others.

3.7   CONCLUSION

In Chapter 2, the conceptual and operational definitions of the key concepts and related terms of the study were discussed. This discussion laid the foundation for the presentation and discussion on eight widely used and cited theories/models in the literature - some as the intellectual foundation or framework for health promotion or education and health behaviour and some highlighting and helping to explain the complexity of human behaviour from the perspective of its sociocultural context. The eight theories/models selected and discussed highlight some of the significant factors and the relationships between them that helped in identifying and understanding seemingly different behaviours of a person through knowledge about the internal mental processes that take place within him. The discussion also helped to understand how interaction with others and the environment influences the behaviour of an individual, group or community.

The individual level health behaviour theories (HBM, TRA, TPB and Stages of Change) assist in understanding some of the internal mental processes of the individual in understanding and making some predictions of health behaviours. The fifth theory, SLT/SCT, as an interpersonal, community level health behaviour theory, complemented the individual level theories by drawing attention to environmental factors which are absent in the first four, which are significant for a much broader understanding of human behaviour. They highlighted how individuals, environments and health behaviour interact. The sixth model, Social Marketing – a research and practice model, sheds light on key concepts and methodological approaches in planning and implementing communication campaigns in which target audience play important roles and the context of their life is taking into consideration. It was noted that in its planning and implementation process social marketing uses the marketing mix of commercial marketing, notable among them IMC, which has evolved over the years into other new marketing perspectives – IC, IMB, RM and most recent perspective of SIC. As a summary of all the salient points discussed regarding the need for communication campaigns to be interactive and participative, a new interactive-participative communication campaign model was developed as a contribution of this study to the field of communication campaign study and practice.

It is important to note that no single theory or model by itself is composed of all the significant factors and all the necessary interrelationships and interactions between these factors for the understanding of the totality of human behaviour. Each theory or model highlights some factors and to get a broader understanding and be in a position to predict with a certain amount of accuracy certain aspects of human behaviour, it may be necessary to have more than one theory or model as intellectual foundation or framework. It is necessary to add here that in using theory or model as framework for planning and implementation of health communication campaigns, what is important is to ensure it is a theory or model, which is relevant to the health problem and behavioural factors in question. Hence, it should not be a matter of just choosing or selecting any kind of theory or model to underpin or guide the campaign process but rather selecting theory or model that is more appropriate and suitable. It is also important to appreciate the point discussed in the theoretical approaches and inherent challenges in evaluation of health communication campaigns that in determining the success of such campaigns it may be necessary to match the attainment or non-attainment of stated objectives with the cost of what had been invested in the campaign process.

The discussion of the eight theories/models and the current approaches and inherent challenges to evaluating health communication campaigns; and the development of the new

interactive-participative health communication campaign model laid the foundation and provided the necessary conceptual tools for constructing the theoretical conceptual framework, which set the parameters for the conceptualisation of the relationships and dynamics of the elements of culture, communication, the individual and the community against the background of the eight theories/models; and provided the conceptual boundaries within which to conduct the investigation of the study.

In light of the assumption that sociocultural contexts and factors have some determining influence on the nature and dynamics of communication campaigns, and having discussed the theoretical approaches and foundations to health communication campaigns, it is now possible to turn attention to modelling a sociocultural health communication campaign model to guide the development of the sociocultural assessment instrument. The reflection and discussion of the next chapter thus revolves around the modelling of the sociocultural health communication campaign model.

CHAPTER 4   MODELLING   A   CONCEPTUAL   SOCIOCULTURAL   HEALTH COMMUNICATION CAMPAIGN MODEL

4.1   INTRODUCTION

In the preceding chapter, it was argued that this study is based on the argument that a conceptual sociocultural health communication campaign model could serve as a framework for developing a theoretical assessment instrument for assessing sociocultural elements or variables of health communication campaigns. The premise of that argument was the view that human behaviour is a complex activity, which can be understood from the perspective of the individual as well as and more especially from the perspective of the sociocultural context because elements of a person's sociocultural context have some determining influence on his behaviour. Hence, if health communication campaigns are designed to influence or bring about change in human behaviour, then a more appropriate model or framework that highlights or typifies the relevant sociocultural factors is needed. That could guide the development of an appropriate theoretical assessment instrument with appropriate elements/factors for the assessment of campaigns. The focus of this chapter was, therefore, the construction of a conceptual sociocultural health communication campaign model.

4.2   STRUCTURES AND STAGES FOR THE MODELLING A CONCEPTUAL SOCIOCULTURAL HEALTH COMMUNICATION CAMPAIGN MODEL

Based on the discussion and understanding of modelling and its related concepts and particularly in light of the operational definition of modelling in Chapter 2, the focus of this section is to achieve the first objective of the study, which is the construction of the conceptual sociocultural health communication model. It has previously been explained that there are different kinds of models used in the different fields of natural and social sciences, psychology and the philosophy of science. This implies that by its very nature, the dynamics of modelling (the construction of models) is not the same for all models. Nonetheless, it can be presumed that there are certain common elements that ought to be present in all modelling since all models are essentially surrogate objects that seek to depict or portray real phenomena or activities by representing their properties (Hestenes 1998).

As already discussed, modelling leads to model construction. Hence, it can also be presumed that there ought to be some common structures, requiring certain common specifications that modellers take into consideration when modelling, no matter the specific

nature of the model. Similarly, regarding the process of modelling, it can be presumed that there are some common stages or steps to be followed (in modelling). In this regard Hestenes' (1996) 'Model Specification' provides a good example of structures and specifications, while his 'Model Development' serves as a good guide for the process of modelling as it elucidates the various stages in the process. Complementing the insights of Hestenes and also serving as a good guide for modelling are the insights of Justi and Gilbert (2002) presented in their 'model of modelling' framework. Given this, the insights of the scholars in Model Specification and Model Development of Hestenes; and the 'model of modelling' framework of Justi and Gilbert are adopted and adapted as a guide in the construction of the conceptual sociocultural assessment model for this study. In making use of Hestenes' insights, however, it is important to remember and appreciate that he is a physicist and his work and insights into modelling are very much influenced and anchored in the scientific field of his expertise which is the natural or physical science. He has, however, explained that his insights and propositions on modelling are "sufficiently general to apply to any branch of physics, indeed, to any branch of science. Therefore it can be regarded as a general scientific method" (Hestenes 1996:206). This means it belongs to what is regarded as a body of techniques or specific ways for investigating phenomena, acquiring new knowledge, or correcting and integrating previous knowledge, and is based on the gathering of observable, empirical and measurable evidence subject to specific principles of reasoning. In making use of Hestenes' insights for the purpose of this study, which is in the field of social science, however, it is important to keep in mind his caution that the "implementation of each stage in a particular model is theory-specific, that is, the tactical details in modelling vary from theory to theory" (Hestenes 1998:17). Hence, the use of his insights requires tailoring them to the particular needs of the present study. Because purpose is crucial, the modeller engaged in the modelling process should first be very clear as to the purpose of his/her modelling. The need to be clear on the purpose of modelling is demonstrated in the 'model of modelling' framework as illustrated in Figure 4.1.
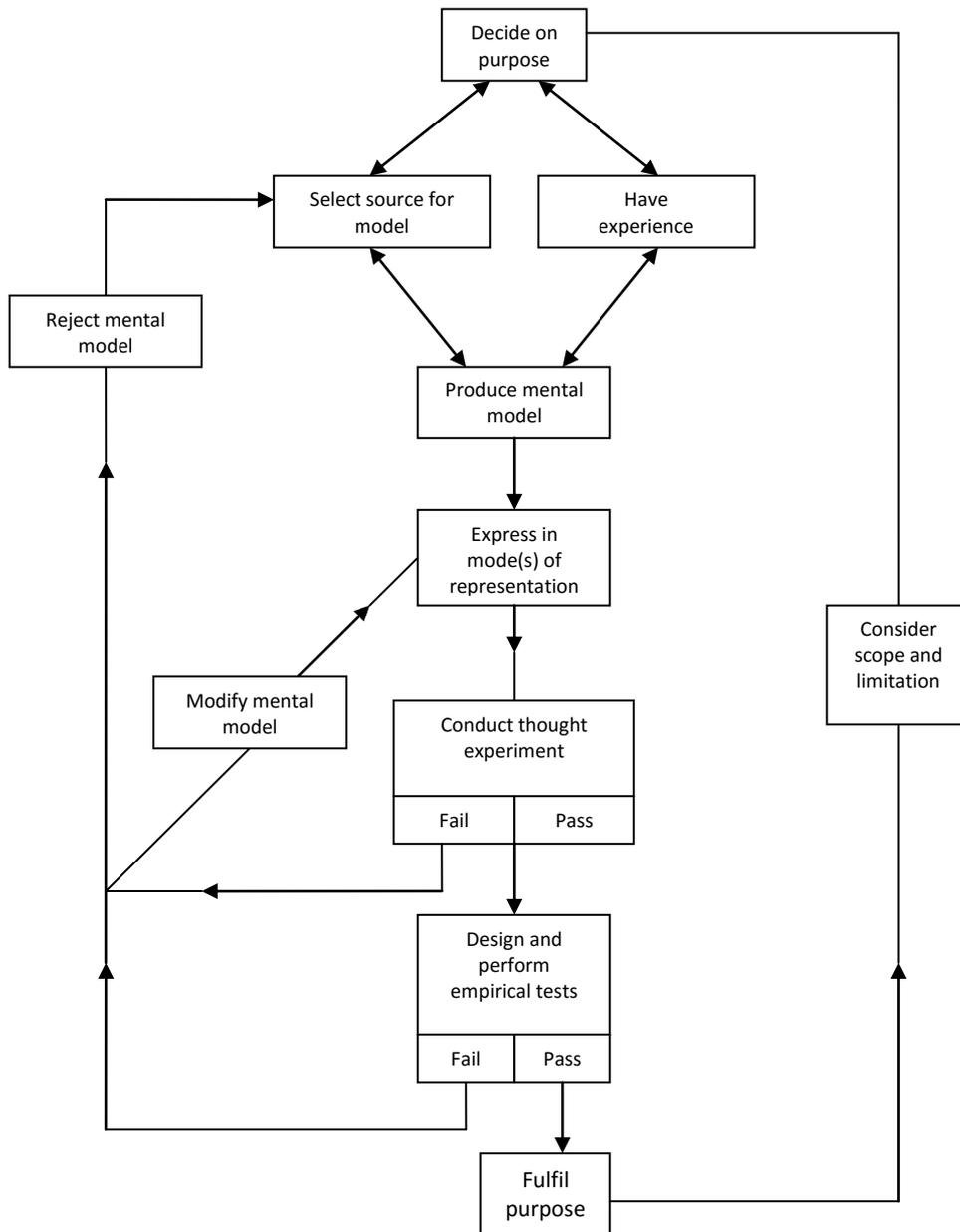
Figure 4.1   A 'Model of Modelling' Frame (Justi & Gilbert 2002:371)

Arriving at this clarity of purpose (that is, deciding on purpose) is, according to Justi and Gilbert (2002:370), a process of decision that "will be enmeshed with some initial, direct or indirect, qualitative or quantitative, experience of the phenomenon being modelled: making observations of it." This means in order for a modeller to be in a position to construct a model (of some phenomenon) he/she needs to have had some experience of that particular phenomenon because one cannot construct something that he/she has not had any experience or knowledge of either directly or indirectly. To have experienced the phenomenon either directly or indirectly would imply that particular phenomenon has been

selected as the source from which the model would derive. That is why in Figure 4.1 the boxes marked 'Select source for model' and 'Have experience' are on the same level and placed directly under the box marked 'Decide on purpose'. Hence, in modelling, once a decision has been made on the purpose of the model and having selected the source and experienced the phenomenon either directly or indirectly; the modeller proceeds to produce a mental model. This means the modeller generates a sort of mental picture of the generalised, hypothetical descriptions of the inter-related set of ideals, propositions, concepts or principles based on the direct or indirect experience of the phenomenon being modelled. Having produced the mental model, the modeller's next step is to decide in which form or mode to express the representation: mathematical, graphic or material (physical). As illustrated in Figure 4.1 then, the box marked 'Express in mode of representation' comes under the one marked 'Produce mental model'. According to Justi and Gilbert (2002:371), the "process of expression does seem to be cyclically developmental in respect of the mental model, with the act of expression leading to a modification in the mental model." By this, they mean when the modeller has produced the mental model and decided on the mode of expression. He may need to revise the mental model and/or the expression of the mode of representation a few times before being satisfied with the outcome of the process between the two stages ('Produce mental model' and 'Express in modes of representation'. As illustrated in the figure, there are two arrows between the two stages – one arrow is directly between the two stages (the arrow pointing from 'Produce mental model' to 'Express in mode/s of expression'. Then there is an arrow pointing from the latter to the former on the right side of the two boxes. The nature of the positions of these two arrows indicates the cyclical nature of the process between the two stages.

Once the modeller is satisfied with the mental model and its expression of representation, he/she moves to the next stage in modelling. This is the stage of conducting thought experiments, which entails exploring the implications of the mental model through 'thought experimentation' (Justi and Gilbert 2002). That is, conducting a 'mind experiment' – a mental activity of designing and carrying out an experiment using the different elements or components of the model as a form of mental rehearsal (Reiner and Gilbert 2000) to test the generalised, hypothetical descriptions or explanations of the inter-related set of ideals, propositions, concepts or principles. If the results of the mental experimentation are considered unsuccessful or failed, then as Figure 4.1 illustrates, there may be the need to modify the mental model. It is only when the outcomes of the mental process of 'Produce mental model', 'Express in mode(s) of representation' and 'Conduct thought experiments' are considered successful as illustrated in the figure, that the next step is taken by the modeller, that is moving to the next stage – 'Design and perform empirical tests'. Justi and

Gilbert (2002:372) explain that the 'empirical testing' phase is the stage in modelling when the practical work of designing and conducting empirical tests takes place. When the testing has been completed, then follows collection and analysis of data, and finally evaluation of the results produced, against the model. If the results of the empirical test are, the purpose of modelling has been achieved; it means the model has successfully gone through verification – the purpose has been fulfilled. This may be followed by a phase in which the modeller or others who have been concerned with or had some interests in the process of modelling may attempt to persuade others of the value of the model. This attempt to persuade others of the value of the model may expose its scope and limitations, which may lead to a reconsideration of some of the earliest elements or components in the model-production cycle. However, if the empirical tests yield a result of failure of the model to produce predictions that were confirmed in the thought experimental phase, then an attempt will have to be made to modify it and to re-enter the cycle as illustrated in Figure 5.1. If, after repeated attempts, the sub-cycle of model modification and thought and/or empirical testing yield unsuccessful results, then the model will have to be rejected (Justi and Gilbert 2002).

The foregoing brief overview of Justi and Gilbert's 'model of modelling' framework portrays it as a very simple and practical framework for modelling. It presents modelling as a cyclical process that begins with a decision on the purpose of the model and moves through the different phases. That is, the phases of selecting the source of model, having either a direct or indirect experience of the entity or phenomenon, producing a mental model, expressing the mode(s) of representation, conducting thought experiments, which if considered successful leads to designing and performing empirical tests, but if unsuccessful, requiring modification of the mental model and going through that sub-cycle again. Successful empirical tests signal fulfilment of the purpose of the process of modelling. This may lead to advocacy of the value of the model, which in turn may highlight the scope and limitations of the model, requiring re-consideration of some elements or components of the sub-cycles. Unsuccessful empirical tests will require modification of the mental model, and further empirical tests, which may lead to rejection of the model if such attempts all end in failure.

While in the explanation of their 'model of modelling' framework, Justi and Gilbert (2002) specifically use the terms 'phases or steps', which can be understood as the stages used by Hestenes (1998), they did not mention structures. Though these scholars did not specifically mention structures which Hestenes mentions, it can be assumed that the 'model of modelling' framework also includes structures since the framework provides components or elements the two scholars consider necessary for modelling, and also showed the relations between these components. For as discussed above, structures are what give a

phenomenon or entity its shape or form; and that which gives it shape or form is what is observed as being the stable patterns of relationships between the various parts or components within the phenomenon or entity. Having briefly discussed the 'model of modelling' framework, which provides some basic understanding of the dynamics of modelling, in the next two sections attention is focused specifically on the insights of Hestenes on the different structures and stages as presented in his Model Specification and Model Development. These insights of Hestenes help to consolidate the insights provided by Justi and Gilbert.

4.2.1   Structures in modelling

In his 'Model Specification', Hestenes (2006:17) identifies five structures, which he defines as the set of relations in a system. This set of relationships includes "the relations of 'belonging to', which specifies composition, the set of objects belonging to the system". If modelling or the process of constructing a model is regarded as a system then the set of relationships according to Hestenes' definition, will be what constitutes the building blocks of the system (the different parts), in the form of sets of relationships, which are five in number. These five structures or sets of relations are systemic, geometric, object, temporary and interaction structures. They are not concrete things but conceptualisations and all five of them do not necessarily have to be present or found in all modelling. As Hestenes (2006) explains, all models are idealisations, representing only a structure that is relevant to the purpose for which it is constructed. Hence, the purpose for which a model is constructed will determine which of the five structures are relevant to it and ought to be into account in the modelling process. It is worth noting Hestenes' explanation that the purpose for which a model is constructed determines which of the five structures are relevant to it. It could be assumed with this explanation that what Hestenes thinks about purpose in modelling is in line with Justi and Gilbert's (2002) explanation that the first step in model development is to decide on its purpose. Furthermore, a careful study of Figure 4.1 (Justi and Gilbert's 'model of modelling') reveals that it is a system, a whole with parts, and as the arrows in the figure illustrate, the different parts of the system are interconnected, interrelated and interdependent. They indicate sets of relations within the system Hestenes (2006) talks about in his Model Specification, in connection with structures in model development. In that regard it could be said that even though Justi and Gilbert (2002) did not specifically mention structures in their 'model of modelling' framework as Hestenes has done in his 'Model Specification' they are in agreement that the presence of certain structures ought to be taken

into consideration in the process of modelling. The five structures of Hestenes' 'Model Specification' are briefly discussed below.

4.2.1.1 *The systemic structure*

The systemic structure is the specification of the composition, environment and connections of the system – object or phenomenon. Composition specifies the internal parts of the system. That is specification of what constitutes or forms the internal elements or objects of a system. Composition is thus a concept that enables the modeller to specify what constitutes the 'inside' of a system. Environment specifies what constitutes the 'outside' of the system. It is the specification of that which is or can be identified as external to the system but linked to it in the sense. It is that which gives the system its context, making it possible for the system to be situated and differentiated from some other objects/phenomena (which are not part of it). Connections specify the links within and outside the system. That is the specification of how the elements within the system are linked to each other and how the system itself relates to or is linked to what is not part of it, its environment.

These three specifications enable a modeller to conceptualise and/or identify the elements within and outside a phenomenon; the set of relations of the elements within and outside the system; the nature and dynamics of the relations between the elements inside the system, and the connection of the system with what is outside it. The systemic structure, therefore, provides a modeller with a frame of reference. From this frame, the modeller conceptualises or has a mental picture of what constitutes the elements within an object or phenomenon, what constitutes its boundary or environment, how the elements within it are connected or linked, and how the object/phenomenon is connected to or linked to what is outside of itself. This mental picture or conceptualisation of the object/phenomenon helps to describe or explain it in a general manner. It is this mental picture that is translated into a mathematical or graphic form in a model, giving it a structure. It can be said then, that the systemic structure provides a conceptual description or explanation of the object or phenomenon, which taken as a system, is a whole with parts that are connected and with boundary differentiating it from other objects or phenomena. The focus of the description or explanation is on the internal parts (what these parts are and how they are constituted); the environment (what comprises the boundary of the object or phenomenon and how it is affected or influenced by and/or influences elements outside itself); and on the connections (how the parts are related and what constitutes the product of such relations).

To further understand and appreciate Hestenes' insights of providing a framework for modelling and how his insights complements the insights of Justi and Gilbert, an attempt is made to show what can be regarded as the systemic structure in Justi and Gilbert's (2002) 'model of modelling' framework. The elements of composition, environment and connections of the framework are the following.

The elements of composition includes 'Decide on purpose', 'Select source for model', 'Have experience', 'Produce mental model', 'Express in mode(s) of representation', 'Modify mental mode', 'Conduct thought experience', 'Design and perform empirical tests', 'Fulfil purpose', 'Consider scope and limitation of model', and 'Reject mental model'. These are the components or objects forming the internal parts of the system – the 'model of modelling' framework. They are specifications of the internal parts or what can be referred to as the 'building blocks' of the model. It should be remembered though, that these are not material or physical objects or blocks but concepts that assist the modeller in the process of modelling a model, giving him/her a framework with which to go about the construction of the model.

Environment – if the context of the 'model of modelling' framework is the mind as it is conceptualisation of the process of modelling, then its environment is what would be considered as outside the mental activity. The process of modelling relates to a reality, as the result is a representation of the reality in some mathematical or pictorial form, a representation that ought to be verified through empirical testing. The aspect of environment of Hestenes' 'Model Specification' helps the modeller using the framework of Justi and Gilbert to delineate the boundary or boundaries of the mental activity from the reality itself.

Connections – in light of Hestenes' explanation of connections of the systemic structure of his 'Model Specification', the arrows in Justi and Gilbert's 'model of modelling framework' can be taken or considered as what indicate or specify the connections between the internal components or elements of the framework. This concept of connections also makes it possible for a modeller using the framework to be able to conceptualise or visualise the link or connection of his/her mental activity with the reality outside. The explanation of Hestenes and the framework of Justi and Gilbert complement each other and offer the modeller a simple but useful framework with which to go about constructing a model in the process of modelling.

4.2.1.2   The geometric structure

The second structure of Hestenes' Model Specification is the geometric. That specifies two things: the position and the configuration of the system. Position refers to the specification of the geometric position of the system in reference to something that is external to it - an external frame of reference that is not a constituent part of the system but has some referential relation with it, such as the environment in which it is. In system's language, position could be understood as referring to a supra-system of a system. Configuration is the specification of the geometrical relations among the parts or elements of the system. The geometric structure enables the modeller to visualise or conceptualise the position of the system (being modelled) in reference to what is external to it and how the model's internal parts are configured or related to each other. That can, therefore, be considered as a further explication of how a system is specifically positioned within its context or environment, and how the internal parts are specifically connected. The geometric structure, in other words, brings the systemic structure into sharper focus.

4.2.1.3   The object structure

The third structure, the object, specifies the composition of the intrinsic properties of the object/phenomenon. It is a structure that helps to 'zero in' on the internal parts of the system, specifying those parts that belong intrinsically to the system, that is, those properties of the system without which it would not be what it is meant to be. These are properties that ought to be present for the system to be what it is or what it is meant to be. These may be shared with some other system. Their presence or absence does not affect the basic nature of the system.

4.2.1.4   The interactive structure

The fourth structure of Hestenes' Model Specification is the interactive. This structure is a frame of reference for conceptualising properties of the system (object or phenomenon) that act on each other. They are mutual properties of a system thus they are also referred to as causal links, bonds or couplings. As they interact with each other influencing and being influenced on or by each other, they either cause change or constrain.

4.2.1.5 *The temporary structure*

The temporary structure specifies temporary change in the structure of the system. This structure helps to conceptualise an object/phenomenon. That is to visualise how it is composed. How does it relate to its environment? What internal and external connections does it have? How is it positioned in reference to some external frame? What relations exist among its parts? What are the intrinsic properties of the parts, and what are the properties of their links? The modeller should visualise possible or probable changes in the structure of the system that may be temporary and not permanent.

The five structures presented in his Model Specification, taken together, provide the parameters for visualising and conceptualising a natural or a social phenomenon. They enable the modeller to attempt to describe or explain the phenomenon's composition, both external and internal. That is a description or explanation as to what belongs to its internal parts, and how these parts are related and interdependent, and interact how they; how the phenomenon fits into its environment and relates with it; how it is influenced, and/or acted upon, and how the phenomenon in turn influences and/or acts upon its environment, and with what change or changes. The advantage or value of the insights of Hestenes' Model Specification is that it provides the necessary structures – the building blocks for constructing a model. It serves as a useful frame not merely for being able to describe and explain a natural or a social phenomenon but more importantly, these structures make it possible for the model to be validated as certain specifications are provided or assumed.

Validation, as discussed previously, is essential in any meaningful modelling process. This point is also emphasised by Justi and Gilbert (2002) in their 'model of modelling' framework. One of the components of the framework is designing and performing empirical tests. The essence of validation lies in the fact that a model remains merely an assumption of the nature and/or process of the real natural or social phenomenon it purports to represent. If it cannot be validated or empirically tested as to whether it is close to that which it seek to portray or represent or how close it is or how it is. In that way Justi and Gilbert (2002) specifically mention that if after repeated modification and repeated empirical tests of a model it fails to meet the standards against which it is tested, it ought to be rejected and the process abandoned. If through the verification of its structures the model is validated then the assumption that necessitated or provided the grounds or reason for the development of the model is proven – the theory is tested and the purpose for which the model was modelled is fulfilled. In that regard the distinction between model development and model deployment discussed earlier becomes very relevant and important; the former being the

theoretical aspect of modelling, which through its construction using the structures can be tested or verified, and the latter being the empirical, practical aspect of the process of modelling. This distinction is not one of a sharp separation of the two aspects, theoretical and empirical, as these two are often inter-related; but rather a distinction that is more a matter of emphasis. In the construction of the sociocultural assessment model, then, these five structures of Model Specification are taken into consideration.

4.2.2   Stages in model development

As to the process of modelling, Hestenes (1998:18) suggests that model development can be analysed into four essential stages: Description, Formulation, Ramification, and Validation which is illustrated in Figure 4.2.
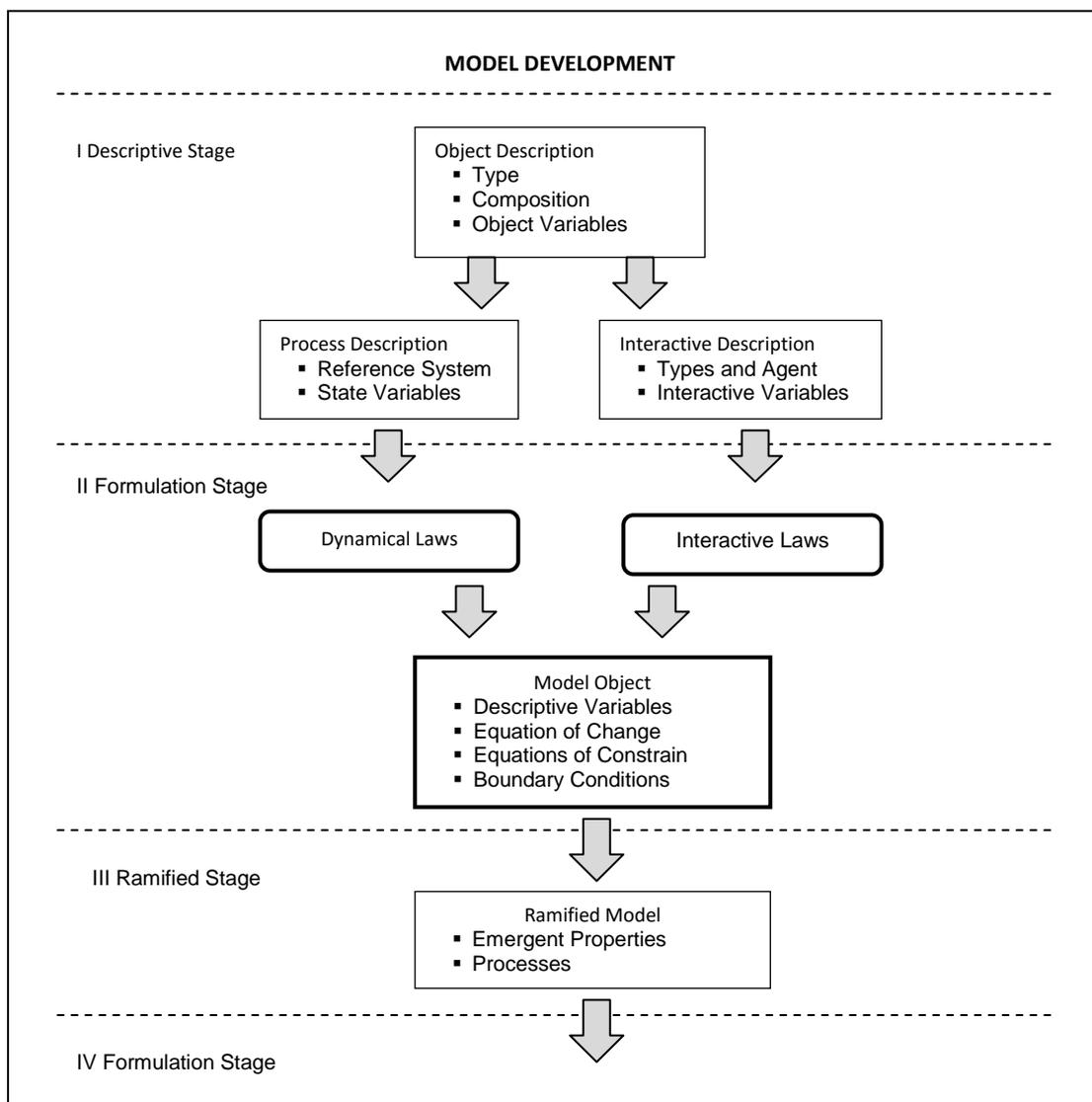
Figure 4.2   Model Development (Hestense 1998:18)

This figure presents a visual of systematic outlines for the entire process of model construction, indicating the kind of information processing that takes place in each stage. The four stages can thus be considered as forming the life cycle of model development and as such, the development (process) can itself be regarded as a model of the modelling process. That is, it is a pictorial representation of modelling or a 'model of modelling' similar to Figure 4.1 of Justi and Gilbert.

If as discussed above the implementation of each stage in a particular model is theory-specific thus making the tactical details in modelling vary from theory to theory, then it may be assumed that modelling ought to be theory-driven. In other words, the modelling process must be premised on theory and modelling ought to be guided by theory. What theory drives the process, however, is dependent on the kinds of properties being modelled, that is, whether it is social, physical, chemical or biological model. The theory provides a system of principles that direct the modelling process. It means the choice of theory sets the parameters of the modelling process, providing the framework within which to conceptualise the object/phenomenon being modelled. A brief description of each stage of model development (Hastenes 1998) helps to clarify this point.

4.2.2.1   The description stage

The first stage of the modelling process – the description, as illustrated in Figure 4.2, comprises three sets of descriptions: object description, process description and interaction description. This stage begins with the choice of object and (its) properties to be modelled. Once a modeller has decided on the object/phenomenon for modelling he proceeds to describe what type of object/phenomenon it is, its composition – a reference to its internal parts, its environment and its connections, external and internal causal links. At this stage the object/phenomenon's intrinsic properties, object variables – the fixed, non-changeable properties, are also described or specified. Essentially the 'object description' provides answers to questions such as 'what is this phenomenon'? What is the composition of this phenomenon and what are the properties that belong to its very nature without which it would not be what it is? If the earlier discussion on the systemic structure is called to mind, it will be noticed that the object description is in effect a description of the systemic structure. It is important not to lose sight of the fact that this description is a conceptualisation description.

The 'process description', which is an element of the description stage, situates the phenomenon in its context by providing a description of the phenomenon's frame of

reference. This description is an acknowledgement that the phenomenon being modelled exists in some specific context and not in a vacuum. Considered as a system, it is located in a supra-system with other subsystems. Hence, it is the specification of how the object/phenomenon is positioned in reference to its supra-system or other systems. Process description thus can be seen as description of the geometric structure of Model Specification discussed above.

In object description, the internal and external parts of the phenomenon are specified, but how do these parts relate and interact with each other? That is the question that is dealt with in 'interaction description', also an element of the first stage, the description stage. In interaction description, a modeller specifies the type and agent of interaction – that is, which of the parts of the phenomenon, acts on another or others, and which parts act on one another. At this stage of modelling a modeller specifies the mutual or shared relations of/between the properties of the phenomenon and how these interactions influence, that is, change or constrain the object variables of the phenomenon.

In the case of a social science model completion of the three sets of descriptions in the first stage of model development should result in the production of a complete list of object names and descriptive variables for the model and supply the model with a social interpretation by providing referential meanings for the variables. In effect, this first stage of modelling should provide the general form of the model – what it is, what it is composed of and how the elements that form its composition are arranged.

If as has been discussed above, a model presents in mathematical or pictorial/graphic form what constitutes a theory, which is an integrated set of relationships of ideas used to describe, explain, predict and/or control behaviour of a system, which may be a natural or social phenomenon. Then it should be clear that the first stage of the modelling process as proposed by Hestenes is exactly what it is: a 'First Stage', that of description. Being a first stage, it is not nor can it be the end of modelling but only a part of the process– describing the model. It is important to reiterate that this description is all part of the conceptualisation process of modelling.

Compared with the 'model of modelling' framework of Justi and Gilbert (Figure 4.1), what happens in this 'descriptive stage' of Hestenes' 'model development' seems to correspond with what happens in the latter's 'select source for model', 'have experience' and 'produce mental model'.

4.2.2.2   *The formulation stage*

If the results of modelling as pointed out requires validation, that is, validating whether it is a true representation of what it purports to represent, with the potential of being used to explain, predict and/or control behaviour of a phenomenon, then part of the process of modelling should be the articulation of the dynamics of the various aspects and interactions of the components or variables of the phenomenon. The conceptualisation of the dynamics and interactions are formulated in a certain manner as to be understood and applied in the predictions of the model. What is predicted as changes are the expected result/s of the dynamics and interactions. In that regard in the Formulation Stage of Hestenes' Model Development (Figure 5.2) he talks about the laws of dynamics and interaction, which are applied to get definite equations of change for the stated variables. The choice of laws depends on the type of model and descriptive variables. In essence a modeller guided by Hestenes' Model Development formulates or indicates at the formulation stage, what laws, be they natural or social depending on the nature of the phenomenon, regulate or should regulate the dynamics and interactions of the variables of the phenomenon. He also has to indicate the expected change or changes and or constrains if any, and what boundary conditions exist. Thus, as illustrated in Figure 5.2, the two arrows from the Descriptive Stage, one from the Process Description and the other from Interaction Description, lead to Dynamic Laws and Interaction Laws. These two laws are applied to the elements of the Model Object, which as illustrated are Descriptive Variables, Equations of Change, Equations of Constraint and Boundary Conditions. As Hestenes (1998:18) explains the implementation of the formulation stage should produce "an abstract model object consisting of the set of descriptive variables and equations of change and constraint, sufficient to determine values of the state variables". That means that what is formulated in this second stage is something abstract – it is a conceptualisation, it is something thought of, something imagined, as to how the interactions of the variables produce change and/or how they constrain each other, and the nature of their boundary conditions. In other words, it could be said that in the formulation stage, a modeller specifies how the object/phenomenon operates and with what effect.

As with Hestenes' 'descriptive stage' there seems to be some correspondence with a section of Justi and Gilbert's framework, hence it is argued that there is correspondence of the former's 'formulation stage' and the latter's 'express in mode(s) of representation', is a correspondence of some similarities, not exact replicas.

4.2.2.3 The ramification stage

The third stage of Hestenes' Model Development is the ramification stage, which entails working out the special properties and implications of the abstract model and as such, it is largely mathematical as the equations of change are solved to determine trajectories of the state variables with various initial conditions. Since the modelling of the sociocultural assessment model is in pictorial form and not mathematical, this stage in its development does not entail working out equations of change in a mathematical manner. Rather this stage is concerned with working out the determination of the pathways of the intervention activities; and how to compare these with the standards set in order to arrive at a judgment or conclusion as to the achievement or non-achievement of a communication campaign. This 'ramification stage' of Hestenes' 'model development' corresponds to Justi and Gilbert's 'conduct thought experiments' in the 'model of modelling' framework.

4.2.2.4 The validation stage

The fourth and last stage of model development according to Hestenes (1998:20) is the Validation Stage "concerned with evaluating the ramified model by comparing it with some real object-in-situation which it is supposed to describe". In the case of a model in mathematical form, the validation may involve checking the reasonableness of numerical results or conducting an experimental test. In the case of an assessment model in pictorial form, this would involve verifying whether or not the use of the model helped to achieve the purpose for which it was modelled – assessing a communication campaign. In effect, therefore, this validation stage though it is part of the development process falls within the second part of modelling discussed above, that is, the deployment process, and this involves matching the model to a specific empirical situation, which results in a concrete model that represents objects/phenomena and/or process in that situation. The 'validation stage' of Hestenes' 'model development' corresponds to the 'design and perform empirical tests' of Justi and Gilbert's 'model of modelling' framework.

From the fore-going discussion, it can be said that Hestenes' insights into modelling and specifically his Model Specification and Model Development serve as a very valuable guide for modelling. Model Specification helps to specify the structures in modelling, and Model Development (with its concept of stages) offers a framework for the process of modelling. While Justi and Gilbert did not use the same set of the concepts that Hestenes used a closer study of their insights gleaned from 'a model of modelling' framework and Model Specification and Model Development, reveal that they complement each other, and

together make a good basis for understanding and embarking on a task of modelling scientific models. With these insights, attention now turns to the task/act of modelling the proposed sociocultural assessment model.

3.3 A CONCEPTUAL SOCIOCULTURAL HEALTH COMMUNICATION CAMPAIGN MODEL

As explained above, one of the most important and crucial aspects of modelling are clarity on the purpose of the model being constructed. The model being constructed in this study is a conceptual sociocultural health communication campaign model. It is designed in such a manner as to indicate and highlight the sociocultural elements of human communication and behaviour in a health-related context, and is meant to serve as an appropriate theoretical framework and sociocultural assessment instrument for health communication campaigns.

Adopting Hestenes' systemic structure in his 'Model Specification' and complementing it with Justi and Gilbert's 'model of modelling' framework as a guide for understanding the process, dynamics and components of modelling the conceptual sociocultural health communication campaign model; the model and its design is conceptualised as a system. Conceptualised as thus the conceptual sociocultural health communication campaign model is first visualised as a 'whole' with interrelated, interconnected and interdependent parts and processes. As a system it ought to have as one of its basic structures, a systemic structure, which constitutes specification of its composition, its environment/boundary and its connections – the links or connections among the internal parts.

That understanding of the concept of the systemic structure makes it possible to mentally picture or generate a conceptual representation of the model's internal parts, its environment, and what the connections of that which constitutes the model looks like. The systemic structure of Hestenes' (2006) Model Specification and Justin and Gilbert's 'model of modelling framework' serve as very useful tools that enable a modeller to conceptualise the structure of a model. It allows the researcher to specify and explain in some detail what should be the composition, the environment and connections of an intended model, as is done below for the sociocultural health communication model.

In developing or building the model, it is necessary first to delineate what constitutes the 'whole' – the system itself, which, in this case, is the conceptual sociocultural health communication campaign model. The next step will be to identify and incorporate the inner parts (the subsystems) followed by specifying how these parts are connected, related and interdependent; and the process of such connectivity, relatedness and interdependence.

4.3.1 Modelling the outer and inner structures of the conceptual sociocultural health communication campaign model

The first building block of the conceptual sociocultural health communication campaign model is illustrated in Figure 4.3 with the 'big' black outline (outer box), a miniature of which is shown in the Legend with an explanation. This 'outer box' visualised as representing the 'whole' of the system – the conceptual sociocultural health communication model, also serves to delineate its boundary with whatever else is not part of this particular conceptual model.
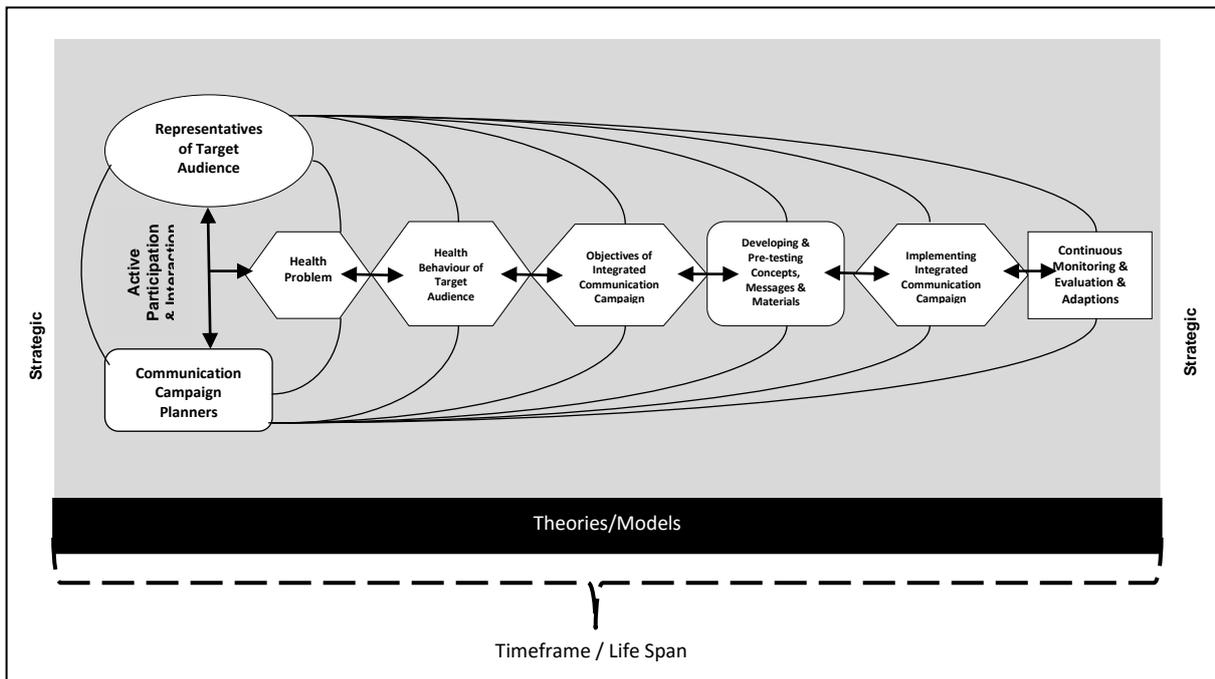
Figure 4.3   A Conceptual Sociocultural Health Communication Campaign

The outer box designates the 'whole' model (a conceptual sociocultural health communication model) with its 'parts' (elements and process).

The inner grey (background) designates the sociocultural context of the target audience
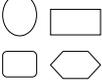
The inner parts/components (subsystems) of the 'whole' – system, the conceptual sociocultural health communication campaign process

The curved lines and arrows illustrate the connections between all the components of the composition and also highlighting the active participation and interaction of both the campaign planners and the representatives of the target audience.

Theories/models underpinning the different stages (strategic & integrated planning & design, developing & pre-testing of concepts, messages & materials, implementation, continuous monitoring, evaluation & adaptions) of health communication campaign process
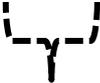
The timeframe or life span of the campaign - long enough to allow for occurrence of change and measurement

Having identified and constructed the outer parameters of the model the next step is to identify the building blocks to use in constructing the inner structures or inner parts of the model. That requires specifying its inner compositions. From the earlier discussion on a communication campaigns in general, and health communication campaigns in particular, the inner compositions were identified as the sociocultural context of the target audience; the representatives of the target audience and the communication campaign planners; the health problem and the health behaviour of the target audience; the objectives of the communication campaign; the theories or models that underpin the whole communication campaign; developing and pre-testing concepts, with messages and materials; implementation of the communication campaign; the continuous and adaptions; the underpinning theories/models; and sufficient time.

These elements or building blocks constitute the parts or subsystems of the model. The sociocultural context of the target audience, that is sociocultural factors such as beliefs, traditions, worldview, taboos (particularly as these pertain to health in the case of this study), is considered very significant. This context influences the whole campaign process from beginning to end. That is the reason for the grey background, which, depicts or represents this element is quite broad and pronounced covering the internal parts except for the dark portion at the bottom depicting the theories that underpin the communication campaign process.

4.3.2 Modelling the connections of the parts and processes of the conceptual sociocultural health communication campaign model

As illustrated with curved lines and arrows in Figure 4.3 and explained in the Legend, all the parts of the model are interconnected, interrelated and interdependent. There is connection between the Communication Campaign Planners and the Representatives of the Target Audience. This connection between the two is due to the presence of the Health Problem, which has to do with the Health Behaviour of the Target Audience. Health Problem and Health Behaviour of the Target Audience are concerns to both Communication Campaign Planners and Representatives of the Target Audience, thus there is connection between the Communication Campaign Planners, Representatives of the Target Audience, Health Problem and Health Behaviour of the Target Audience. The Health Problem and the Behaviour of The Target Audience that generated the concern of the Communication Campaign Planners and the Representatives are the reasons for the formulation of the Objectives of the integrated health communication campaign (in an effort to do something about the problem to either minimise it or eradicate it completely). Hence, there is a connection between Communication Campaign Planners, Representatives of the Target Audience, the Health Problem, the Health Behaviour of the Target Audience and the Objectives of the health integrated communication campaign. The connection between Communication Campaign Planners, Representatives of the Target Audience, the Health Problem, the Health Behaviour of the Target Audience and Objectives of the integrated health communication campaign lead to Integrated Developing and Pre-testing Concepts, Messages and Materials to be directed towards the Target Audience, thus a connection between all of them.

The connection described leads to Continuous Monitoring and Evaluation, which is also connected to the Communication Campaign Planners, Representatives of the Target Audience, Health Problem, Health Behaviour of the Target Audience, Objectives of the Integrated Communication Campaign and Developing and Pre-testing of Concepts, Messages and Materials. Thus, conceptualisation of connections between all the components of composition: communication campaign planners, representatives of target audience, the health problem, health behaviour of the target audience, integrated campaign objective/s, development and pre-testing of concepts, messages and materials, and integrated implementation, and continuous monitoring, evaluation and adaptions.

The whole integrated communication process, from beginning to end is to be theory based and this is depicted with the dark frame underneath the grey shade designating the sociocultural context of the target audience. As the whole process of the integrated

communication campaign is to be set within a timeframe or life span that is long enough. To allow for the occurrence of expected behaviour change and also allow for assessemnt of the process to be carried out the "dashed" lines with the with "upper arms" touching the dark frame depicts the need for adequate timeframe to be considered.

4.3.3 Representatives of the target audience and communication campaign planners

It was argued previously that the target audience of a health communication campaign are not or should not be considered or treated as passive recipients or consumers of campaign messages and activities that is been planned and implemented by communication campaign planners without the involvement and input of the former. The involvement and active in participation, and input of the target audience as discussed should be in the following manner: through participation in the process of identifying, articulating and analysing the health problem. Ensuring that their sociocultural context – elements and factors of their cultural, social, religious beliefs and worldview that have some influence on or determine their perceptions of the health problem are taking into consideration; and in the design, implementation and monitoring the campaign process and activities. That requires the campaign process to be interactive and dialogical, especially the planning and implementation as discussed in Chapter 3 and depicted in Figure 3:9. It is argued that there ought to be some genuine ongoing interaction, dialogue and consultation between the target audience and communication campaign planners to ensure achievement of objectives the campaign. It is then to be expected that the process of evaluation to establish the level of achievement of objectives of the communication campaign would include ascertaining whether and to what level, there was ongoing interaction, dialogue and consultation between the two groups throughout the campaign process. The need for interaction, dialogue and consultation between the representatives of the target audience and the communication campaign planners is illustrated in Figure 4.3 with the arrow between the Representatives of the Target Audience and the Communication Campaign Planners plus the curved line joining the two on the left side of Representatives of Target Audience and Communication Campaign Planners.

4.3.4 Strategic

The inscription 'Strategic' on the right and left in the outer box that designates the 'whole' conceptual model is to clearly highlight the point that the whole health communication
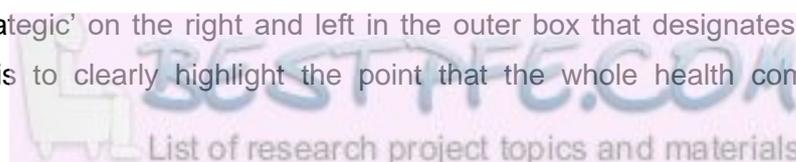
campaign process as Barker (2013:115) will put it, ought to be strategic in the sense of building on

> planning by being strategic in coordinating communication actions, by focusing on how it is presented based on the needs of all internal and external stakeholders, as obtained through environmental scanning. To do this, synergy is needed not only to ensure that stakeholders have a positive experience through the management of knowledge and information obtained, but also to create trust, loyalty and integrity through integrated communication.

The inclusion of the word 'strategic' is to make a statement and stress the point that health communication campaigns as understood in the study is not or should not be haphazard but systematic – well planned and executed.

4.3.5 Active participation and interaction

The point has been made and stressed that in a communication campaign process the target audience through its elected or appointed representation should be involved in the whole communication process – from the beginning to end (planning to evaluation). The involvement envisaged here is one of active participation and interaction of 'respectful' partnership relationship that engenders and sustains the trust, loyalty and integrity, mentioned in the quotation of Barker (2013) mentioned above. This point is brought out in the conceptual social health communication campaign model with the inscription 'active participation and interaction' between the 'Representatives of the Target Audience and the Communication Campaign Planners.

4.3.6 The health problem and the health behaviour of target audience

The need to ascertain whether the target audience are/were involved in the identification and analysis of the health problem is illustrated with the arrow between the Representatives of the Target Audience and Communication Campaign Planners and the two curved lines from the two respectively, and joining the Health Problem and Health Behaviour of the Target Audience respectively. The interaction, dialogue and consultation between the two involve identifying and analysing the health problem and the associated behaviour of the target audience. That is achieved by their investigating and answering the question: What is the health problem and what is the link between this problem and the health behaviour of the target audience? Once this question has been satisfactorily investigated and answered, the process continues by investigating sociocultural factors that may have some influence or determining effects on the perception, attitudes and health behaviour of the target audience.

In addition is investigation of culturally or traditionally appropriate and/or acceptable source and means of communicating the problem (who communicates)? That is, determining 'who' socioculturally is considered the right person to communicate messages about the particular health problem in question; how this person is expected to communicate; where it is considered appropriate for him to undertake such communication, and what means is he expected to use to communicate effectively. This investigation is done by answering the question as to socioculturally who, how, where and with what means messages of such health problem are communicated effectively. Another aspect of the investigation would be the communication campaign planners' awareness of their own perception and positions on the health problem; and whom they would consider as the most or more competent person to communicate messages and with what means or channels to communicate messages of the nature of the health problem. That can be done by asking and answering the question on whom the Communication Campaign Planners would consider more competent or appropriate to communicate messages of the nature of the health problem and with what means. Once the above investigation has been carried out, the next step would be to determine whether there are similarities or dissimilarities between the answers to the questions about the target audience and those about the communication campaign planners. The answers to the questions should help to establish which sociocultural factors need to be taken into consideration in the planning and implementation of the intervention and why.

The health problem related to the health behaviour of the target audience within a communication campaign context does not remain a problem without some action being taken to address the problem. The very fact of identifying and analysing the problem in a sociocultural communication context is for the purpose of doing something about the problem. Doing something about it requires setting some objectives as to what to do.

4.3.7   Objectives of the communication campaign

It is assumed that a health problem or issue is what necessitates the planning and design, and the implementation of a health communication campaign to either minimise or eradicate the problem. The indispensable connection between the health problem and the objectives is illustrated in Figure 4.3 with the arrow from the Health Problem and Health Behaviour of the Target Audience, and the curved lines from the Representatives of the Target Audience and Communication Campaign Planners to Objectives of the Communication Campaign. The strategic planning and integrated implementation of a health communication campaign thus presupposes a strategic and integrated objective or some objectives to be achieved. It is the

achievement or non-achievement of the objectives that would largely determine the success of the communication campaign. The continuous evaluation and adaptions of the health communication campaign must involve the critical study and analysis of the link between the objectives and the health problem. Using the conceptual sociocultural health communication campaign model as a guide or practical framework it should be possible to develop an appropriate sociocultural assessment instrument to access variables of the campaign process.

4.3.8   Developing and pre-testing concepts, messages and materials

If in a communication campaign it is necessary to set objectives, then it is also necessary that certain steps be taken in order to achieve them. As illustrated in the model (Figure 5.9), the setting of objectives is followed by developing and pre-testing concepts, messages and materials. This stage in the campaign process entails working on what concretely to do and how to go about doing it to achieve the objectives. Health communication campaign in this study has operationally been defined as: a systematically organized attempts by means of communication processes, to influence a target audience through a series of specifically designed health messages intended to shape, reinforce, and/or alter perception and beliefs about designated health problems or issues. The intention of the communication processes is of bringing about attitude change concerning the designated health problems or issues, which in turn leads to health behaviour change. A careful analysis of this operational definition reveals that at the heart of the communication campaign process is the design of a series of health messages. If there are no messages to be communicated, there can be 'no talk' of a communication campaign, or simply, there can be no communication campaign. The presence or availability of messages to be communicated makes communication campaigns possible. That is the essence of communication campaigns. Thus, what happens between the Communication Campaign Planners and Representatives of the Target Audience due to the presence of the Health Problem and Health Behaviour of the Target Audience, which results in Objectives of the Communication Campaign, all lead up to the Development and Pre-testing of Concepts, Messages and Materials of the campaign. The messages to be communicated in the campaign ought to be chosen carefully and formulated and packaged in such a manner as to ensure that they are socioculturally appropriate and relevant and can be understood and accepted by the target audience. The hope is that once this is done it would create awareness that will ultimately motive the target audience to take certain steps to alter perceptions, belief and attitude about the health problem, which eventually should bring about behaviour change. That is not done in isolation of the

elements of the communication process that have preceded it. Rather the development and pre-testing of concepts, messages and materials are done within the context and perspective of the relationship and interdependence of the Representatives of Target Audience, Communication Campaign Planners, Health Problem, Health Behaviour of Target Audience and the Objectives of Communication Campaign. This relationship and interdependence between all these elements is illustrated in the model with the connecting arrows and connecting curved lines between all of them. The manner of developing the concepts, messages and materials and the proposed mode of communicating the messages of the campaign becomes crucial for the success or failure of the campaign. To ensure that the concepts, messages and materials of the campaign are socioculturally appropriate and relevant, it is required that they be first pre-tested before being communicated to the target audience.

4.3.9   Implementing integrated communication campaign

It is the objectives of a health communication campaign to determine what concepts, messages and materials are used to create awareness and motivate behaviour change. The process and dynamics of developing and pre-testing the concepts, messages and materials are not merely for the sake of doing so but for the purpose of using them to achieve the objectives, and their being used in this manner is what the implementation component of the communication campaign process is all about. Thus, the implementation or intervention is intimately linked to the objectives through the development and pre-testing of the concepts, messages and materials. In the absence of objectives, the intervention (if it exists at all) would be aimless or directionless. The objectives, however, are not implemented simply as objectives (in some theoretical manner) but rather in some form of messages and materials. That is why between 'objectives' and 'implementation' as illustrated in Figure 4.3, there is 'developing and pre-testing of concepts, messages and materials', indicating the relationship and interdependence between these elements. The component 'Health problem' necessitates setting objectives that lead to the development and pre-testing of concepts, messages and materials, followed by implementation of a health communication campaign. If as illustrated the health problem is linked to health behaviour of the target audience through their representatives and the communication campaign planners then, it is presupposed that there is or must be relationship and interdependence between all the above-mentioned elements as Figure 5.3 illustrates with the arrows and the curved lines.

4.3.10   Continuous monitoring and evaluation

Monitoring and evaluation are essential components of the health communication campaign model. As illustrated in Figure4.3, the two in a logical sequence, are positioned after the Implementing Communication Campaign. Though positioned after implementation the double-headed arrows linking the six stages in the communication campaign process and the two outer curved lines linking Representatives of the Target Audience and Communication Campaign Planners to the Continous Monitoring and Evaluation are meant to indicate that monitoring and evaluation should not take place only at the end of the process. Rather they should be continuous – integral parts of the whole campaign process – from beginning to end. That ensures that as the communication campaign is being designed, pre-tested and implemented, adaptation and improvements can be made as needed. In other words, ongoing monitoring and evaluating the activities of the various stages of the campaign can lead to some adjustment in the campaign process to better fit the sociocultural context or respond to particular sociocultural factors. Similarly if the theories or models underpinning the campaign are judged to need some revision, as a result of continuous monitoring and evaluation of the various stages, this might help improve the chances of the campaign being successful. At each stage of the communication campaign process, monitoring and evaluation are supposed to take place to discover any gaps that may need attention to ensure that the goals of the campaign are being achieved. Assessing whether the goals of the campaign are being achieved is thus an ongoing process throughout the lifespan of the campaign. Such an assessment embraces critical evaluation of the presence or absence of the theories/models that underpinned the campaign process. If theories or models underpinned the process, were they appropriate and how have they contributed to the success of lack thereof of the campaign's process. If no theories or models underpinned the process, what possible difference would there have been if they were incorporated?

To evaluate the overall success of the health communication campaign it is necessary to know what the outcomes of the implementation/intervention are. There is, therefore, the need to investigate the intervention outcomes or impact. Once this is known it is then possible to investigate how the outcomes and/or impacts came about. That is done by tracing and analysing the pathways of the various components and factors of the communication campaign, and the underlying implicit or explicit theory or theories, with particular attention being paid to analysis of the transformation process if the various components and factors of the intervention.

4.4   CONCLUSION

The focus of this chapter was the modelling of the conceptual sociocultural health communication campaign model to guide the development of a theoretical sociocultural assessment instrument. To ensure that the conceptualisation and development of the conceptual sociocultural assessment model is in line with what the conceptual sociocultural assessment model is said to be and for it to be an appropriate instrument for theory-driven assessment, the main points of the operational definitions of conceptual sociocultural assessment model and theory-driven assessment were recalled and served as points of reference.

The 'model of modelling model frame' in Figure 4.1 was used as a framework for the construction of the conceptual sociocultural health communication campaign model. The choice and use of the 'model of modelling frame' as the framework was based on its suitability in providing a logical frame for the structures and the stages in the assessment process. With the structures, a description of the composition of the model's components and factors was provided. Their positions in relation to each other were also specified and a suggestion made as to how they are expected to function to make the conceptual model an appropriate sociocultural assessment instrument for health communication campaigns. On the basis of the assumption that evaluation of the outcome of a communication campaign should be a study and an analysis not just of elements or components of the implementation stage of the campaign but also of the elements and components of the planning stage of the process; the conceptual sociocultural health communication campaign model, as envisaged and designed takes into account the relationship and dynamics between the planning and implementation stages, and their resultant product, which is the outcomes. The planning and implementation are envisaged as being strategic and all their elements being integrated. In view of that the sociocultural assessment model is presumed to be an instrument with the potential of being used to systematically, critically and comprehensively to examine a health communication campaign to ascertain or establish the active involvement and participation of the target audience in the whole campaign process and the underpinning of each stage of the campaign by relevant theories/models. The examination of the communication campaign begins at the initial stages of the conceptualisation and planning of the campaign and requires paying particular attention to sociocultural components and factors, and moving on to the implementation stage, leading to the outcomes as illustrated in Figure 4.3. Thus the necessity for the whole process of the campaign to be integrated. Determination of the achievement of stated objectives of the communication campaign using the sociocultural assessment instrument is not meant to be simply a matter of ascertaining whether the

outcomes correspond to the objectives. Rather and more importantly, is to be able to explain how and why the relationships and dynamics of the mechanisms of the components and factors – particularly sociocultural factors, produced the outcomes. The use of the sociocultural assessment instrument as an assessment tool for communication campaigns will be an attempt to examine the interrelationships, interdependence and interactions of the various components and factors (particularly sociocultural ones) of the communication campaign from its planning stage through its implementation stage, to its outcomes. The next chapter, which lays the foundation for the design, development and testing the theoretical sociocultural assessment instrument for health communication campaigns discusses the theoretical perspectives and development of such an instrument.

CHAPTER 5   THEORETICAL PERSPECTIVES AND FOUNDATIONS OF A THEORETICAL SOCIOCULTURAL ASSESSMENT INSTRUMENT

5.1   INTRODUCTION

The focus of the previous chapter had been on the modelling of a theoretical conceptual sociocultural health communication campaign model to guide the development of a theoretical sociocultural assessment instrument for health communication campaigns. To lay the foundation for the practical work of constructing the model, insights of some scholars on the nature and process of modelling were discussed. Particular reference was made to the insights of Hestenes' 'Model Specification' and 'Model Development' and Justi and Gilbert's 'Model of Modelling' Framework. The insights of these scholars were singled out because they highlighted the essential components and dynamics of modelling, which in this study were considered as guide for the understanding and process of constructing the theoretical sociocultural health communication campaign model. The focus of discussion in this chapter is on the theoretical perspectives and foundations of the process of assessment. Hence, the discussion centres on further discussion on assessment and attainment of stated objectives; foundational assumptions and implications of theories for the assessment instrument, and models of assessment.

5.2   ASSESSMENT AND RELATED TERMS

In Chapter 2, there was a brief discussion on the concept 'assessment' and the concept, for the purpose of this was study operationally defined as a systematic process of obtaining data or information about a reality, entity, phenomenon or event relative to some objective or goal in order to better understand that something about which the data or information is being gathered. Based on this operational definition it was argued that assessment is a process that involves looking at something, making inferences about and estimating the worth of that 'something. Embedded in the concept assessment are the concepts attribute, variable and indicators. According to Bartholomew (2006:xx), assessment is central to science and may be simply defined as the "problem of assigning numbers to objects in a meaningful way." It is worth noting in Bartholomew's definition the use of the word 'problem' as it raises questions on what a 'problem' is and whether it has any special significance in the understanding of assessment. It is assumed that Bartholomew might have taken it for granted that the use of the word 'problem' in his definition would be understood and appreciated as offering some special meaning and significance to the process of assigning

numbers to objects. It is thus, argued that assessment is not merely a matter or process of assigning numbers in some arbitrary or illogical manner but that it is an observation of the real world carefully and deliberately for the purpose of describing objects and events in terms of the attributes composing a variable (Babbie 1992). The process of assessing is thus a 'problem' in the sense that it poses a challenge of careful and logical thinking as one observes the real world with the intention of describing objects and events, making inferences and estimating the worth of what had been carefully and deliberately observed – that is, the careful and deliberate observation are for the purposes of obtaining information and data; and the assigning of numbers to objects is meant to assist in obtaining the information and data. Assessing, therefore, requires some knowledge and/or experience of the attributes and variables of the objects or phenomena being assessed.

An attribute is a characteristic or quality, which describes something, an object or a phenomenon (Babbie 1992). Examples of attributes are female, male, old or young, student, graduate, honest, dishonest, and intelligent. For instance, if a person is said to be an intelligent and honest young female student, these attributes are used to describe or say something about the person. These attributes help to give an idea of who that person is. If one had no knowledge and/or experience of any of these attributes it may be impossible to assess them. A variable, on the other hand, is a logical set of attributes. For example, male and female are attributes of the variable gender or sex; and farmer, teacher, taxi driver and baker are attributes of the variable occupation. It is worth noting that a variable ought to have two important qualities. Firstly attributes composing it should be exhaustive (that is a researcher should be able to classify every observation of the variable in terms of one of the attributes) and secondly, the attributes must be mutually exclusive (Pelletier, Corsi, Hoey, Houston & Faillace 2010; Rural Studies – RLST 3060 [sa]). That is the classification of every observation must be in terms of one and only one of the attributes. For example, the definition of employed and unemployed in a scientific study should be such that no one can be both employed and unemployed at the same time.

To understand and appreciate better what assessment is in the scientific field, it is necessary and important to distinguish between the physical and social sciences. Bartholomew (2006: xiv) explains that, in the physical sciences, assessment is "largely a matter of establishing standards of the basic physical quantities of length, mass, time and electrical charge". He further points out that these concepts such as length, are well defined and without much ambiguity in the physical sciences; and physical scientists' focus in assessment is mainly on how to assess the established standards and the quantities derived from them in an accurate and reproducible manner using ready-made and generally acceptable assessing

instruments. In the field of social science it is significant to note two levels of assessment. The first is the level at which concepts are well understood and their definitions agreed upon – these are concepts that are susceptible of direct assessment. An example is counting people in a population, which has to do with the straightforward determination of the number of people. The second level of assessment concerns or deals with concepts such as intelligence, attitude towards a particular issue, poverty, and unemployment, that unlike the first level concepts may be ill-defined, ambiguous and providing ample scope for argumentation, with no ready-made instruments to assess them (Bartholomew 2006). The assessing approach to these concepts or entities, therefore, is an indirect one via looking for assigned indicators that are measurable.

Indicators in scientific language serve to provide evidence that a certain condition exists or certain results have or have not been achieved and as Horsch ([sa]1) explains, the indicators help to "assess progress towards the achievement of intended outputs, outcomes, goals, and objectives". Indicators help to ascertain and provide understanding on the status of a programme, project or intervention as to what stage it is at (where it is), which possible future direction it would take (where it is going), and its proximity to achieving its stated goals or objectives (Sustainable Measures 2007). In social science, indicators are measurable, empirically grounded characteristics of abstract concepts (Sullivan and Feldman 1994). Abstract concepts on their own are not observable or measurable for the very reason that they are abstract. Yet, in a scientific study a sociologist scientist may need to assess an abstract concepts such as well-being while his/her counterpart political scientist might need to assess ideology (Sullivan & Feldman 1994). To arrive at some assessments of well-being and ideology, they would both have to turn to assessable and empirically grounded characteristics of well-being and ideology respectively. Thus, for instance, the political scientist might go about the assessment of ideology by asking people a series of questions on public issues, presenting different alternatives. In a similar manner the sociologist might ask people questions on their income, consumption, types of accommodation, education, health policies, (The World Bank [sa]) to arrive at assessment of well-being. What the scientists assess are those characteristics of the concepts such as the attributes, ideology and well-being and they arrive at the assessment by calculating the values that had been attached to those characteristics, which are the indicators of the concepts.

According to Babbie and Mouton (2004) there are three classes of "observables" in assessment: direct observables, indirect observables and constructs. The direct observables are things or phenomena that can be observed simply and directly, for example, the colour of an orange or a mark on the forehead of someone. Indirect observables refer to

phenomena that are subtle and/or complex to observe. For example, a checked mark against or beside the term "female" in a questionnaire, which helps to observe indirectly a person's sex. The third class of observables are constructs, which are theories based on or deduced from observation but in themselves cannot be observed directly or indirectly (Babbie & Mouton 2004) because in themselves they do not exist. An example is "compassion", which is a conceptualisation inferred. Another example of this third class of observable is IQ, which is a mathematical construction from observations of answers given to some set of questions referred to as an IQ test. IQ in itself is, however, not observed directly or indirectly but inferred or deduced from the answers given. Carmines and Zeller (1994) contribute to a better understanding and appreciation of the notion of the three classes of observables in assessment by explaining that, the assessment process involves both theoretical and empirical considerations. Empirically the focus in assessment in a scientific study is on the observable response that may take the form of a mark on a self-administered questionnaire, the behaviour recorded in an observational study, or an answer given by a respondent to an interviewer. From a theoretical perspective, the focus is on the underlying unobservable and directly un-measurable concept represented in the response of respondent(s) in the study. The focus of assessment thus, is on the "crucial relationship between the empirically grounded indicator(s) – that is, the observable response – and the underlying unobservable concepts" (Carmines and Zeller 1994:2).

For the purpose of this study based on the discussion above and the discussion on assessment in Chapter 2; noting the distinction made between the physical and social sciences regarding assessment particularly, and combining the definitions of Babbie (1992), Anderson (2003) and Bartholomew (2006), assessment is further operationally defined in the following manner: a process of careful and deliberate observation of a phenomenon or activity and gathering information connected to some objective or goal for the purpose of identifying and describing; making inferences and/or estimating the worth of the phenomenon or activity by assigning numerical but non-statistical value(s) to the attributes that compose variables in the form of numbers or some other symbols, which help to give the variables some specific meaning/s in both the physical and social sciences.

The specific phenomenon or activity under observation in this study is a health communication campaign. The attributes of this campaign are the main components of strategic planning and development; developing and pre-testing concepts; messages and materials; creative implementation; and continuous monitoring and evaluation. The variables of the attributes to which numbers/symbols are assigned for the purpose of assessment are the target audience, the health problem, the sociocultural context of the target audience, and

the underpinning theories or models. The assessment of these variables is meant to ascertain or determine the level or degree to which a health communication campaign took into account the presence and involvement of the target audience' their sociocultural context and factors, and the underpinning theories and models in attaining or achieving its stated objectives.

The assessment process in this study is compared to beaming light on the 'whole campaign' and at the same time 'throwing spotlights' on particular or specific components of the campaign process as illustrated in Figure 5.1.
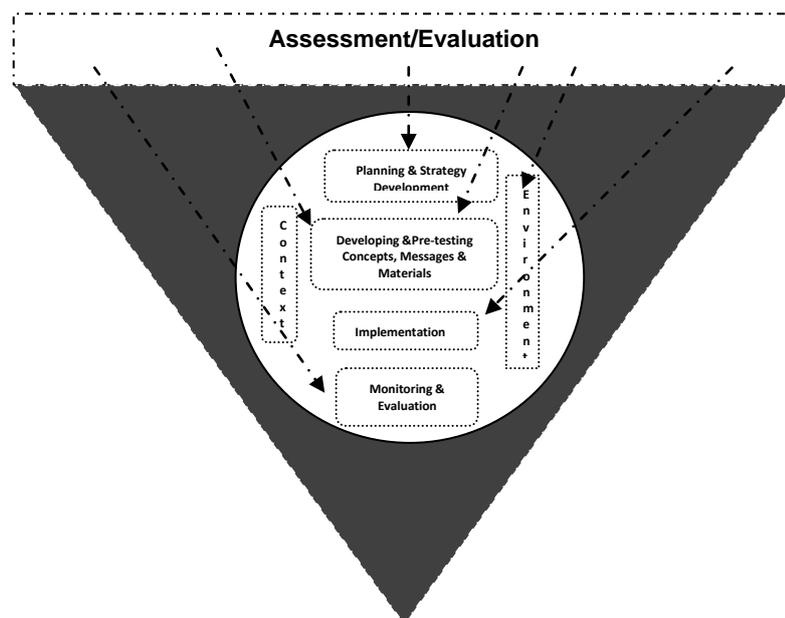
Figure 5.1   Assessment Process Model

Legend

The whole assessment/evaluation process

The whole communication campaign process

Particular or specific components of the campaign process

Assessment of the whole campaign

Assessment of particular/specific components of campaign
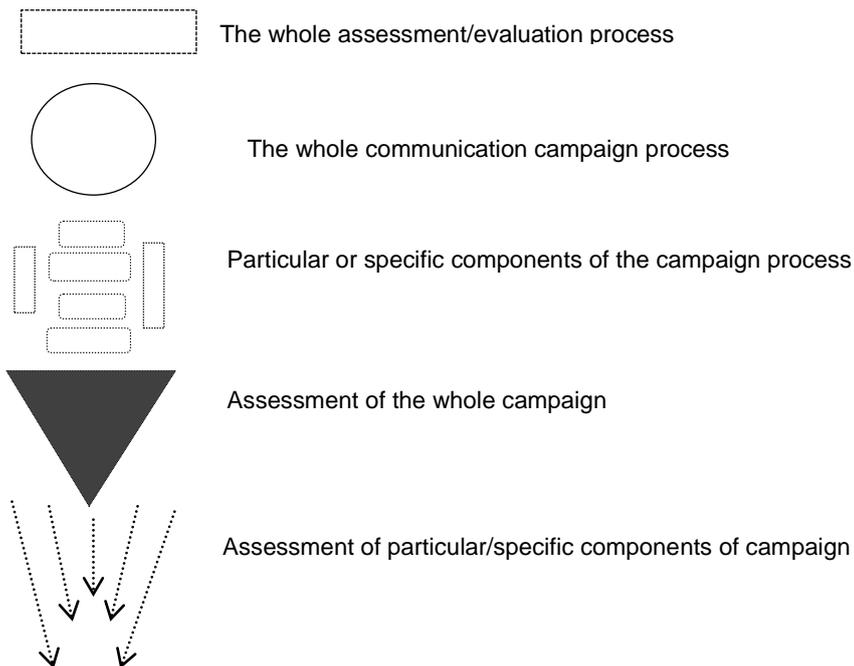
The dash-dotted box on top with the inscription 'Assessment' represents the assessment process as a whole, which takes into consideration the whole reality of the communication campaign (the big circle). The inverted shaded triangle illustrates the beaming light (assessment) on the whole campaign. The process at the same time also focuses (depicted by the arrows) on particular components of the campaign.

Based on the above definitions and the illustration in Figure 5.1 assessment can be regarded in general terms as the subjection of activities of phenomena to a process of critical and systematic inquiry to determine whether, and to what extent, the activities are or are not in line/conformity with the set standards or norms. In this study, this general understanding of assessment is particularised in relation to HIV/AIDS health communication campaigns and because of that assessment is considered as the subjection of an HIV/AIDS health communication campaign to a process of systematic inquiry of verifying whether and to what extent the campaign process meets the standards of consultation and involvement of target audience (at least through their representatives) in the whole comunication campaign process; taking into consideration and incorporation of sociocultural elements and factors of the target audience pertinent to the specific health issues; and appropriate theory or theories underpinning each step/stage of the process.

The purpose of such systematic inquiry is to arrive at a judgement as to whether the whole communication campaign and/or specific parts or aspects of the communication campaign can be said to be or to have been in line with the specified standards. In other words, the assessment process is geared towards determining whether the various activities and processes of the campaign taken as a whole or the activities and processes of certain parts subjected to some specific consideration (Hornik & Yanovitzky 2003) yield a convergence or divergence between the standards and the elements or variables specified. It is thus, possible to pronounce judgement on the campaign process based on the level and intensity of the presence or non-presence, participation and active involvement of the target audience through their representatives in the campaign process; the influence of sociocultural norms and values of the targeted audience, and the grounding or non-grounding of the activities and processes on theories/models (David 2008).

As in general terms assessment is argued to be a process of critically and systematically collecting, analysing and interpreting data. In a specific way, evaluation is a process used to gauge the achievement or non-achievement of stated objectives of a project, while assessment is a process whereby particular or some specific aspects of a project are examined. The processes in both assessment and evaluation are the same or similar but their scope can be different. Evaluation may be used to examine a broader (bigger) reality while assessment may be (but not necessarily or always) limited to the examination of particular or specific aspect/s of that reality. Part of the assessment/evaluation process is to draw some conclusion based on the results of the preceding activities of gauging the achievement or non-achievement of stated objectives and/or the examination of specific aspects of a project, which in the case of this study, is HIV/AIDS health communication campaign.

In light of the operational definition of assessment, assessment instrument in this study is regarded or considered as an instrument designed purposely for use in subjecting a particular reality, entity, phenomenon, programme or project to a process of systematic inquiry that aims at arriving at some judgment as to the convergence or divergence of evidence of the data with or from the stated standards.

5.3   FOUNDATIONAL ASSUMPTIONS AND IMPLICATIONS OF THEORIES FOR THE ASSESSMENT INSTRUMENT

In Chapter 2 it was argued that a communication campaign by its nature is neither arbitrary nor haphazard and in Chapter 3 eight commonly used theories and models that serve as

framework for health communication education and promotion were discussed. It was pointed out that communication campaign, like any form of communication activity, involves and/or is directed towards specific target group/s. Target group/s of a communication campaign live in certain specific context/s and function within particular structures that may be social, cultural, political, economic and religious. That has implication for the nature and process of the communication campaign as it is affected by the context/s and structure/s of the target group/s (Drucker and Gumpert 1996). Hence, it could be said that, communication campaigns do not occur in a vacuum (Bensing, Dulmen & Tates 2003) but rather occur within specific social, cultural, political, economic and religious contexts of the people involved in or engaged in the communication campaign activity. In view of that, in the Interactive-Participatory Communication Campaign Model (Figure. 3.9), the need was stressed for a communication campaign framework (among other things) to take cognisance of the context of the target audience and their involvement or participation in the whole communication cycle or process of the campaign.

If communication campaigns are purposefully planned and systematically executed activity as Nwosu ([sa]) asserts then it may be assumed that in the planning and/or implementation of communication campaigns some goals or objectives should be achieved (Campaign Communication 2011). In that regard in the European Commission's Information Provider's Plan ([sa]) for instance, determining goal/s or setting objective/s is proposed as the first step in a communication plan and it is suggested that the goal or objective/s should be: specific, measurable, actionable, relevant and timely. To ascertain whether such goal or objective has been achieved and/or is being achieved, there would be the need to assess the campaign (NHTSA Tools [sa]). If the planning and implementation of the campaign ought to take into consideration the contexts and structures of the target audience, then it should be imperative to ensure that the assessment instrument also take account of such contexts and structures. In other words, the assessment instrument should be context and/or structure relevant. Base on the fact that assessment is a formal, disciplined, systematic and critical approach to investigate or examine something, the development and use of such instrument for the examination or investigation ought to be guided by some formal and systematic frameworks. For that purpose, there are various theories and models of assessment. That is theories/models that underpin the development and practice of assessment. They are theories/models on which assessments are grounded, giving focus and direction, providing the principles that guide the activities and/or explain phenomena in the assessment. Wilson-Cooper and Christie (2005) point out that, scholars have actively engaged in developing a rich body of assessment theory literature over the past 40 years. Thus there is a body of assessment theories available. As there are different theories/models of assessment, it is

important and necessary to recognise that not any of these theories would be appropriate to explain any or every phenomenon. The choice of a theory or theories/models on which to ground assessment has to be determined by the nature and characteristics of that which is to be assessed or the phenomenon to be examined.

Because one of the objectives of this study is the development of a theoretical sociocultural assessment instrument for health communication campaigns, it was argued that the main phenomenon in such campaigns is human health behaviour brought about by the intervention of communication campaigns. In that regard, the three theories already discussed in Chapter 3 – general systems theory, sociocultural theory and self-determination theory are considered important, relevant and appropriate for grounding the development and use of the theoretical sociocultural assessment instrument. These theories embody elements that help to explain the phenomenon (human behavioural change, which health communication campaigns are expected to effect, or bring about), highlight the significant variables that ought to be examined in order to arrive at a conclusion or to determine whether or not and to what extent health communication campaigns are effective. Insights gained from the discussion on the three theories are being complementing by a brief discussion of six 'types' and four 'models' of assessment/evaluation as the basis for developing the theoretical sociocultural assessment instrument. The choice of the six assessment/evaluation types was made on the basis of their significance in helping to understand and appreciate assessment as a process of different steps – each step with its specific characteristics (Assessment Process [sa.]). As discussed previously, a communication campaign is a process that evolves and has an on-going character, and contains within itself different stages that are interrelated and interdependent. The different types of assessments/evaluation with their specific characteristics can be applied to specific stages of a campaign process. Choosing a particular evaluation type for the assessment of a particular stage in communication campaign has the value of providing the evaluator with a focus thus enabling him to deal with specific aspects and elements of the campaign process pertaining to the specific step or stage. For the purposes of this study that seeks to develop a theoretical sociocultural assessment instrument for health communication campaigns, understanding the nature and characteristics of all the six types of assessment helped to highlight certain significant aspects of the whole process of assessment of a communication campaign.

5.2.1 Types of assessment

Since a communication campaign is a process of a number of stages each with its specific or particular characteristics, to adequately assess such a campaign it may be necessary to take into consideration those specific or particular characteristics of each stage that are relevant to each particular or specific stage. It is in light of this that the importance or necessity of the different types of evaluation come to the fore as each type deals with specific or a particular stage of the campaign process. For the purposes of this study seven of the evaluation types - formative, summative, context, process, impact and outcome, are briefly presented and discussed, and their relevance to the study indicated.

5.2.1.1 Formative evaluation

The formative evaluation assesses programme, project or intervention activities in an ongoing manner and by such assessment enhances the likelihood of success as it provides indications of what has happened or is happening and why. That helps to provide information for improvement of a programme, project or intervention during its design or implementation phases (Harvey et al 1995) by detecting problems and weaknesses in the components in order to revise them (Marsh II 2005). In a general sense formative evaluation examines the delivery of a programme, project or intervention, looking at its quality of implementation, and the organisational context, personnel, procedures and inputs (Evaluation and Research Glossary 2006). It begins with the initial development of the programme, the project or the intervention and continues throughout its lifespan, helping to keep track of its activities "so that modifications or improvements can be made on an ongoing basis" (Burroughs 2000:45). Its focus is on "examining core activities undertaken to achieve project goals and intended outcomes" (Kellogg Foundation 2005:24) and thus it is typically conducted during the development or improvement of a programme, project or intervention (Scriven 1991). Hence, it is an evaluation done at several stages or points of the developmental life of the programme, project or intervention (National Science Foundation 2005). Doing the evaluation properly, it should provide continuous direction to the programme, project or intervention, and help to keep the objectives in focus.

In the discussion on the concept 'evaluation' it was noted that the most important purpose of evaluation of a programme, project or intervention is not so much to prove something about it as to help improve it. In view of that formative evaluation is of particular significance to a programme, project or intervention, for it is an evaluation type that provides information or

feedback for the needed improvement at the different steps or stages of the programme. Based on that fact, in the development of a theoretical sociocultural assessment tool for health communication campaign, it is necessary to ensure that it is designed in such a manner as to make it appropriate for detecting and assessing the following. Whether or not and to what extent the target audience are/were consulted, involved and participated actively in the campaign process. Whether consideration is/was given to sociocultural factors such as worldview, traditional customs and beliefs of the target audience relating to health and health behaviour and incorporated in the campaign process. Whether theory/model underpinned each component of the campaign process and whether this evaluation type is built into a health communication campaign.

5.2.1.2   *Summative evaluation*

While formative evaluation assesses an on-going intervention, summative evaluation in contrast concerns itself with assessing the effects or results of an intervention. Thus, it is an evaluation type that provides information on an intervention's ability to have done what it was designed to do (Summative vs. Formative Evaluation [sa]). The information provided could be on short-term effectiveness or long-term impact information (Evaluation Purpose [sa]) after examining and describing what happened, and assessing whether it (the programme, the project or the intervention) can be said to have caused the expected outcome; and also determining its overall impact (Introduction to Evaluation 2006). Summative evaluation, therefore, helps to ascertain whether a programme met its objective/s and differences that have come about because of the programme, project or intervention. As Burroughs and Wood (2000:47) point out the "purposes of summative evaluation can range from making judgments about overall program effectiveness (were objectives reached?), to discovering program effects (whether or not predicted by objectives)".

Due to its nature, characteristics and purposes, summative evaluation is important for this study because in developing a tool that is used to assess communication campaigns one cannot ignore elements of this evaluation type as such elements integrated into the assessment instrument help provide information on whether a campaign is in line with the set standards on short-term or long-term basis.

5.2.1.3   *Context evaluation*

Context evaluation is an evaluation that is context specific. That means its focus is on examining the environment in which a programme, project or intervention operates or the process involved in their development. It is based on the philosophy that every programme, project or intervention is located within a community, which are part of a larger or umbrella organisation. The Kellogg Foundation (1998:21) articulates this philosophy in the statement "The characteristics of the community and umbrella organization influence a project's plans, how the project functions, and the ability to achieve the project goals". Context evaluation helps to provide an understanding of the real context of interventions, such as a health campaign or a development project. It investigates how a programme operates, or will operate in a particular social, political, physical and/or economic environment (Program Evaluation 101 2005). Patton (1982:21) insightfully expressed the paradigm shift of this evaluation type from the "hypothetic-deductive" paradigm of evaluation which mainly used one method to a method of "choices emphasizing multiple methods, alternative approaches and most importantly the matching of evaluation methods to specific evaluation situations and questions".

Context evaluation can serve many purposes during the lifespan of an intervention. For instance in the early part of intervention it might focus on assessing the needs, assets and resources of the target community to help plan relevant and effective interventions within the context of the community or organisation. Alternatively, it could focus on the political and economic atmosphere or context of the target to ascertain how these may hinder or facilitate the implementation of the intervention. In the later phases of campaign or project implementation, context evaluation could focus on gathering contextual information to help modify the campaign, or project plans and/or explain problems that have arisen (Kellogg Foundation 1998; Stufflebeam 2002).

Context evaluation can be said to be a multi-faceted, flexible and open evaluation type. That is because it takes cognisance of specific contexts under consideration and adjusts to the specific context by using and or adopting appropriate evaluation tools suitable for the context. It is an evaluation type that acknowledges that any given context of human situation or activity comprises various elements or components and is not static but dynamic, thus the importance and necessity of matching evaluation methods or approaches to the specific situations or activities. The possibility of choosing and using multiple methods or alternative approaches gives this type of evaluation the unique advantage of capturing various elements

of the context that may not necessarily have direct but indirect (and significant) influence on an intervention.

This type of evaluation is of particular significance to the present study because the study aims at developing a theoretical sociocultural assessment instrument for health communication campaigns. It is assumed that elements of a campaign's context would have some determining influence on whether or not and to what extent the campaign process remains in line with set standards. Of particular interest to this study is the sociocultural context of the target audience of communication campaigns. Some of the relevant elements of this context are the target audience's worldview, traditions and customs as they relate to health and health behaviour. Integrating elements of context evaluation in the theoretical sociocultural assessment instrument would help identify and consider those relevant sociocultural elements in the design, planning and implementation of the campaign. In the evaluation of the campaign therefore, the study and analysis of the identified elements of the context as to whether and to what extent they played a role in the campaign will form part of the basis of arriving at a conclusion about the campaign.

5.2.1.4   *Process evaluation*

Proess evaluation is an evaluation type used to measure effort and the direct outputs of a programme, project or intervention as to what and how much was accomplished. It examines the implementation and how the activities of the programme, are working (Coffman 2002a). It assesses the extent to which procedures and tasks as described in the design are carried out (Farell et al. 2002; ATSDR – Evaluation Primer 2002). That is to say, it examines whether a programme, project or intervention is being carried out as planned. Its underlying principle is that "before you can evaluate the outcomes or impact of a program, you must make sure the program components are really operating and, if they are operating according to the proposed plan or description" (National Science Foundation 2005:9). It, therefore, focuses on examining the core activities being undertaken to achieve the objectives and intended outcomes of a programme, project or intervention. As the name 'process' indicates, it is an evaluation that regularly occurs throughout the lifespan of the programme, project or intervention, and in this sense it is similar to formative evaluation. Process evaluation addresses a broad array of programme, project or intervention elements. Some potential purposes include identifying and maximizing strengths in the intervention; identifying and minimizing barriers to implementation activities and determining if campaign or project goals match target population needs (Kellogg Foundation 1998).

The relevance of this evaluation type for the present study lies precisely in the fact that it may occur several times during the life of an intervention used to examine core activities that may occur at different steps or stages of intervention and to determine if project goals match target population needs. Communication campaigns, and for the purpose of this study, health communication campaigns in particular as discussed in Chapter 2 are processes of different or several steps or stages. Process evaluation can, therefore, be appropriately used to evaluate the various core activities of the different steps or stages. Like formative evaluation, the information that it provides because of the evaluation would help identify and maximize the strengths of the campaign and hopefully eliminate or minimize weaknesses and obstacles. These elements of process evaluation taken into consideration and integrated into the theoretical sociocultural assessment instrument would help keep the sociocultural standards discussed above under the spotlight of the asessment/evaluation process of the health communication campaign thus, guiding the entire process of the campaign.

5.2.1.5   Outcome evaluation

Outcome evaluation is used for collecting and presenting information on a programme, project or intervention "needed for judgments about the effort and its effectiveness in achieving its objectives" (ATSDR – Evaluation Primer 2002:3). It focuses on assessing whether or not the programme, project or intervention has achieved its stated long-term goals or objectives. It measures and/or assesses the effect and changes that result from the programme, project or intervention; and in the case of a communication campaign it "assesses the outcomes in the target populations or communities that come about as a result of campaign strategies and activities" (Coffman 2002a:13). To get accurate measurements or assessments of effect and changes that result from the campaign will presuppose that measurements or assessments are also taken of the target population before the campaign's implementation. Thus it is an evaluation type, which (in the case of a communication campaign) requires or involves some form of measurements/assessment "before" (pre) and "after" (post) campaign implementation and possibly other measurements/assessments at several points between. That is measuring/assessing what the campaign was "designed to affect, like attitude, behaviour, or policy change" (Coffman 2002a:14).

To the extent that this evaluation type measures/assesses the effects and changes that result from interventions such as health communication campaign, some if not all of its elements are important and necessary for inclusion in the theoretical sociocultural

assessment instrument for assessing health communication campaigns, ensuring that sociocultural elements and factors discussed above are accounted for.

5.2.1.6   *Impact evaluation*

Impact evaluation is an evaluation type that according to Rossi and Freeman (1993) investigates the magnitude of both positive and negative changes produced by a programme, project or intervention. It assesses the overall effects, intended or unintended of the programme (Evaluation and Research Glossary 2006). It focuses on the long-range results of the programme and changes both positive and/or negative that have occurred because of the intervention. It is an "evaluation designed to identify whether and to what extent a programme has contributed to accomplishing its stated goals (more globally than outcome evaluation)" (ATSDR – Evaluation Primer 2002:3), examining immediate influence on the awareness, knowledge, skills, attitudes, or behaviours of individuals who have participated in a programme, project or intervention (ATSDR – Evaluation Primer 2002). That evaluation type may address questions that seek to find out if the intervention met its objectives; if differences have resulted because of the intervention and whether such differences are beneficial or deleterious and to whom; if the results are in line with the goals/aims originally envisioned in the planning and development of the intervention. In the case of a communication campaign it is effectively an evaluation type, which measures/assesses "community level change or longer-term results that are achieved as a result of the campaign's aggregate effects on individuals' behaviour and the behaviour's sustainability. Attempts to determine whether the campaign caused the effects" (Coffman 2002a:13)

Using the theoretical sociocultural assessment instrument to guide a health communication campaign would assist in determining some measure or level of impact of the campaign by identifying how significantly the sociocultural elements or factors have played some role, if any, in the results of the campaign.

5.3   MODELS OF ASSESSMENT

It was argued that assessment is a formal, disciplined, systematic and critical approach to investigate or examine something. One of the main purposes of assessment as discussed is to provide information that may help improve 'that something' that may be a programme, a project or intervention. Effective programme assessment is, therefore, a systematic way to

improve and account for the programme, project or intervention's "action involving methods that are useful, feasible, ethical, and accurate" (CDC Evaluation Working Group: Summary of the Framework for Program Evaluation 1999:1). There are models of assessment, which serve as practical non-prescriptive instruments, designed to summarise and organise the essential elements of the programme (CDC Evaluation Working Group: Summary of the Framework for Program Evaluation 1999). In order to appreciate the nature and significance of these models of assessment it may be useful to recall the operational definition of 'model': a mathematical and/or pictorial or graphic representation of phenomena in the form of generalized, hypothetical descriptions of interrelated set of ideas, propositions, concepts or principles that contribute to theory. In the light of the operational definition of model, assessment model can be regarded as an instrument in mathematical and/or pictorial/graphic form (a representation) of a formal, disciplined, systematic and critical approach to investigate or examine something. That instrument is non-prescriptive and clearly defines or shows elements of a programme, project or intervention that the evaluator ought to look at and how to look at them in a logical way in order to draw or arrive at some conclusion or judgment. The instrument helps define the parameters of evaluation, delineating what concepts and their integration and interrelationships are to be studied, and the processes or methods needed to extract critical data (Evaluation Models 2006).

As there are different types or kinds of assessment, it may be assumed that there are also different kinds of assessment models/instruments. Thus, one kind of model used to guide a particular evaluation process may not necessarily be suitable for another kind. For example, if one needs to conduct a formative evaluation the concepts to be studied and the processes or methods needed to extract critical data may not necessarily be the same as those needed for an impact evaluation. While this is not a denial of the possibility of some overlapping of concepts or processes, the model to be used to guide a formative evaluation process would be different from that used in an impact evaluation process. Additionally the nature and characteristics of the programmes, projects or interventions to be evaluated may be different from each other. Thus, it cannot be a matter of 'one evaluation model fits all'. Since the concern of this study is health communication campaign and if and how its sociocultural context and elements might impact on it. The model being developed to guide an assessment of a health communication campaign ought to have components that are appropriate and can clearly define or show elements of the campaign that the evaluator ought to look at and how to look at them in a logical manner in order to draw or arrive at a judgment on the campaign. As basis and guide for the development of the theoretical sociocultural assessment instrument, four evaluation models, Logic, Participative, Empowerment, CDC framework are briefly discussed in this section. The basis of the choice

of these four models is their relevance and appropriateness for health communication intervention, and what and how they contribute to the development of the theoretical sociocultural assessment instrument for health communication campaigns.

5.3.1   Logic model

The logic model may be considered as a tool that presents a layout illustrating or depicting the components of a programme, project or intervention in diagram, flowchart or picture form. It illustrates the intervention's set-up, planned activities, and expected results. Hence, Penna and Phillips (2005) describe a logic model as a diagrammatic representation of a programme, showing what it is supposed to do, with whom, and why. This type of model describes the main elements of an intervention, showing how these elements are expected to work together to achieve set goals or expected outcomes. It can include any number of elements depending on the nature of the intervention "showing the development of a program from theory to activities and outcomes" (Program Evaluation 101 2005:2). As a tool it serves as a road map of the intervention, highlighting how it (the intervention) is expected to work and the sequence of activities, and how the desired outcomes are to be achieved. As the term 'logic' suggests, the illustration (of the setup, planned activities, and expected results) is in a logical (sequential) manner, showing the relationships between the various components by use of boxes and/or arrows. Used as a tool of evaluation (that is, as an evaluation model), it can be an effective way for charting the process of the intervention (W.K. Kellogg Foundation 1998). It enables evaluators to stay focused on outcomes as they endeavour to assess the links of the activities and process to the desired or projected outcomes while keeping the underlying intervention theoretical assumptions/principles in the forefront of their minds.

Farell, McWillieam, Robinson, Saunders, Tiknor and White (2002:13) note that there is no right or wrong way of developing this model, as it is "merely a useful tool to show in a picture or diagram what is going to be done, and what the expected results of the program or evaluation are". Thus, there can be as many logic models as there are programmes, projects or intervention (Evaluation Models 2006). That would mean that there could be several ways to depict a logic model. Even though that may be the case, it is deduced, based on its nature (logic model) that there are certain guiding procedures that ought to be followed to ensure that any such model is scientifically verifiable. In this regard, the logic model's main components are considered as input, output and outcome. In the explanation of the Center for Disease Control (2002), input refers to the resources dedicated to or consumed in a programme, project or intervention (that is, what is invested). Output is the direct products of

the programme activities and operations (referring to what is done with what has been invested and who does what and/or who is reached), and outcome is the result of the input plus the output. A shell of a possible (conceptualised) logic model base on Program Action – Logic Model (Program Development and Evaluation 2005) is presented in Figure -5.2 as an illustration of this model.
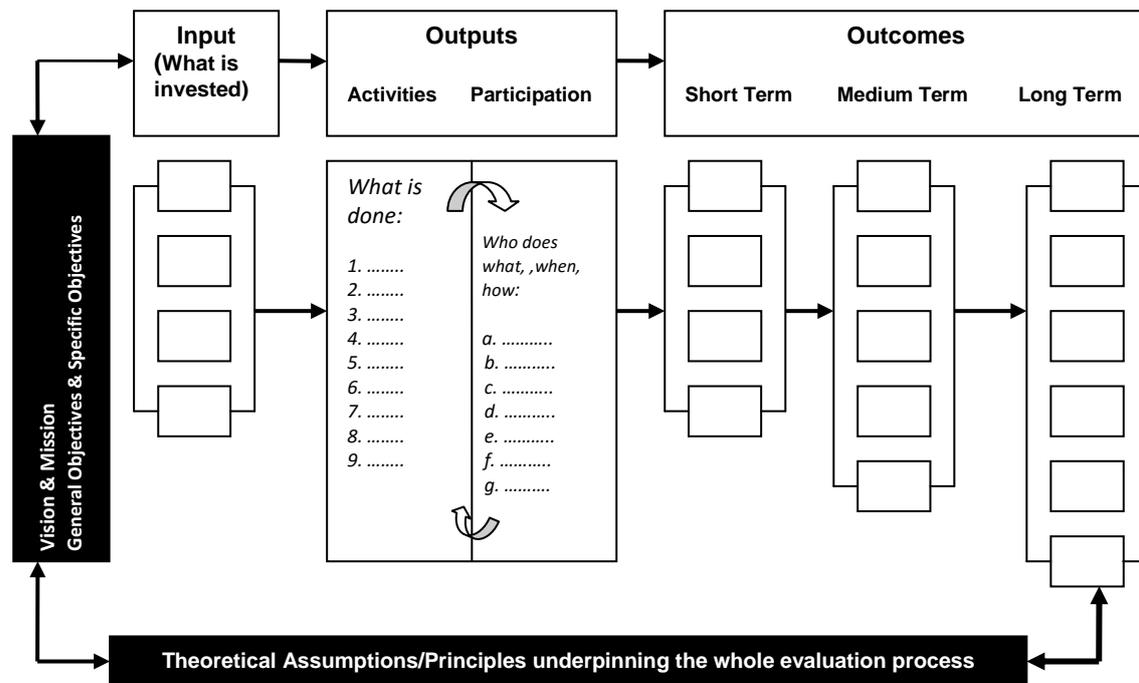
Figure 5.2   Adaptation of Logic Model of Program Development and Evaluation
(Kellogg Foundation 2005)

The figure illustrates a conceptual frame of a possible Logic model of a project, programme or intervention. The three top boxes indicate the three main components of inputs, outputs and outcomes in this type of model. Under the input are five sets of boxes, each would contain one of the investments (for example time, number of personnel, resources such as needed /required materials. The number of boxes could be more than five or less depending on the number of what is invested). What is invested in the input goes (indicated with the arrow) into the output for utilisation or processing. Under output there is a box with two columns – one contains expected or envisaged activities to be carried out (and there could be a number of them, which in the case of this shell are nine) in the programme, project or intervention.

The second column contains the envisaged participation of the people involved in the programme. In the case of this illustration, six individuals or groups of people are expected

to perform the various activities. The model would thus specify who among them does what, how and when. In other words, who among the people involved, takes care of doing which activities. How are these activities expected to be done, and when they are done. The two arrows in the two columns – one from the activities column to the participation column and the other from the participation column to the activities' column, indicate the interconnectivity between the two in the utilization or processing of the input. The utilisation or processing of the input in the output results in or should result in the outcomes and this is indicated with the arrow leading from output to outcomes. These outcomes may be short term, medium term or long term. As indicated with the smaller set of boxes under outcomes, the expected short-term outcome may be fewer than that of the medium term, which may also be fewer than the expected or envisaged long-term outcomes. The nature and characteristic of the project, programme or intervention would, however, be that which will determine which of the three expected outcomes would be more or less. The arrows between the input, output and outcomes illustrates the expected logical sequence or process of the programme, project or intervention. To objectively evaluate a project or intervention, evaluator/s need to keep in mind the vision and/or mission and the objectives set (for the project or intervention), and the theoretical assumptions or principles that underpin the evaluation process, against which the analysis and interpretation of the outcomes are made. The presence of the vision/mission and objectives and the theoretical assumptions/principles are illustrated with the black boxes on the left and bottom respectively; and to indicate that these ought to be constantly kept in mind by the evaluator/s three arrows are showing linking them (vision/mission, objectives and theoretical assumptions/principles) and inputs, outputs and outcomes.

Based on the focus that a particular logic model may have, the Kellogg Foundation (2005) explains three types of the logic model, which are the 'outcome model' – it highlights the goals and objectives of the intervention; 'activities model' that highlights how the various activities of the intervention are linked together in the process of implementation; and 'theory model' which highlights the links between the theoretical constructs and explains the underlying assumptions of the intervention.

All three types could be present in one model with one or the other being highlighted (as the focus) more than the others would.

A careful study of the logic model reveals that it is not merely an evaluation tool but also a useful resource in programme, project or intervention planning, design and implementation. When used in that manner (as a resource) it ensures that evaluation component is built into the development and implementation of a programme, project or intervention thus providing a powerful base from which to conduct on-going evaluation of a programme, project or

intervention (Farell et al. 2002). That can be counted as one of the benefits of the logic model. For if as has been discussed earlier, one of the purposes of evaluation/assessment is to provide information, which would help improve a programme, project or intervention. Then the logic model can serve the valuable purpose of not only illustrating the infrastructure, inputs, process and outcomes of an intervention, spelling out how the intervention produces outcomes and clarifying thinking about the intervention. It can also help to reveal and provide information on where some steps in the intervention have broken down or not proceeding according to plan, and thus prompting some remedial actions that would help fix the problem.

When used as an evaluation tool, the logic model can be a very practical and "handy" tool for evaluation planners and executors as it can provide the evaluator/s with the focus and framework for his/her (evaluation) activities. In other words, the evaluation data that he/she collects ought to be based on what falls within the context of the model regarding its infrastructure (structure). What is invested and how these investments are expected to be utilised or processed; how they were actually utilised (that is the manner and process by which they were utilised by whom and for whom and for what purpose), and the outcomes of the utilization process (whether or not they are those that were expected – if not why?). Such data is analysed against the background of the theoretical assumptions made in the model and so would the interpretation of the analysed data be done from the perspective of such theoretical assumptions or principles. In light of all the points discussed above it can be said that properly conceived, designed, and implemented the logic model can be a valuable and practical tool for evaluation/assessment as it gives some sort of complete diagrammatic or pictorial view of what and how the evaluation process would be carried out, and what to expect.

The logic model served as a useful tool for this study by offering a practical conceptual frame that guided the development of the theoretical sociocultural assessment instrument. It provided the framework for developing the theoretical sociocultural assessment instrument in a logical diagrammatic manner, incorporating all the relevant sociocultural components.

5.3.2   Participatory model

The Participatory model of evaluation is based on the understanding that reality is not a given actuality waiting to be discovered by the detached researcher. Rather it is a constructed understanding—an informed perception developed by those engaged in the activity under scrutiny (Evaluation and Participation 2006). Hence, it is a model that requires

the direct involvement of all or most stakeholders. That is, communities for which programs, projects or intervention outputs are intended, researchers, and policy makers; and because it requires the direct involvement of all stakeholders, Lynos and Chipperfield (2000) opine that it can be considered as a model concerned with "addressing power differentials between researcher and the researched and thus producing non-hierarchical, non-manipulative relationships". That makes it an evaluation model that engages "the primary users in the 'nuts and bolts' of problem formulation, instrument selection, data collection, analysis, interpretation, recommendations and reporting" (Cousins & Earl 1995). All the different stakeholders each bring 'first-person' perspective of the issues faced or under consideration. They all get involved in the evaluation process right from the beginning and have a voice in identifying progress, obstacles, strengths or weakness - involvement at all levels: planning, information gathering, analysis and dissemination of results (Farell et al. 2002).

The involvement or participation of all stakeholders in the process provides an opportunity for critical self-assessment, which can be used to improve the programme, project or intervention under consideration. In this model, evaluation is not seen merely as something very external to the programme, project or intervention but rather as a complementary and integral part of its on-going planning, design and implementation. Hasenfield, Hill and Weaver (2005) draw attention to two special features of this type of (evaluation) model, namely: Multiple outcome measures and Opening the "black box". Multiple outcome measures refer to the need for the outcome of the evaluation to reflect the diversity of interests of the various stakeholders. Opening the "black box" refers to the crucial need to have a thorough understanding of the experiences of all participants, hence the need to track these experiences right from the beginning of the process. The focus of this model, therefore, is not on only measuring outcomes but also paying attention to all the dynamics of the process and making sure that all stakeholders participate actively in the whole process.

The direct involvement of programme or intervention participants makes them part of the subjects and not merely objects of the evaluation. They participate in given direction to the process of the evaluation and work with outside evaluators. Thus, they are not merely people (or objects) to be worked on but co-evaluators who become directly involved in determining what data is collected, how such data is collected and with what means, how it is analysed and what meaning is attached to it. It could, therefore, be said that they are part owners of the evaluation from its planning, design and implementation and hence, also part owners of the results.

In the case of an intervention that seeks to empower or build the capacity of the target group, the participatory evaluation type is very appropriate because empowerment requires power change as it challenges basic assumptions about power that does not exist in isolation nor is it inherent in individuals but created in relationship (Page & Czuba 1999). For as mentioned above Lyons and Chipperfield (2000) have argued that the participatory model address power differentials between all the stakeholders and produces non-hierarchical, non-manipulative relationships. In that sense the empowerment of the target group cannot or should not be only a matter of it having its voice heard and its views are taken into consideration but must have the genuine experience of being treated as equals (that does not mean being identical with other stakeholders) in the evaluation process from beginning to end. However, to really feel and be empowered or capacitated, it would not be enough for the target audience of the intervention to become involved only in the process of the evaluation. It would be necessary to have them involved in the actual planning, designing and implementation of the intervention itself with evaluation being an integral and integrated component. It is in view of this necessity that for the purposes of this study, the Interactive-Participative Communication Campaign Model (Figure 3.9) is proposed. The model as earlier explained in Chapter 3, suggests that the target audience should be active participants in all five stages of the campaign namely, identification and analysis of problem/issue; strategic planning and development; strategic management; creative implementation; and continuous monitoring and evaluation.

Though final evaluation comes at Stage 5, it does not mean that no evaluation or assessment takes place in the four preceding stages. Stage 5 is the final stage of the overall campaign but continuous monitoring and evaluation as an on-going process forms part of Stages 1 to 4 and thus monitoring and evaluation/assessment provide valuable feedback information that helps to improve the intervention at each stage.

Being active participants in the campaign process target audience have and share knowledge on the problem or issues. That helps them to own the problem and not regard it as the perception of some outsiders. Through their sharing of (their) knowledge and experience of the problem and the opportunity to search for practical and viable solutions or alternatives, they would be more inclined to own the problem. Having owned the problem and being part of the search effort to find solutions, they are or would be more readily open to do something about it, thus their desire for a better or different future. They would be eager to acquire the necessary skills that would enable them to work at changing their behaviour. Having knowledge, and being fired up by the desire for a better future and with the necessary skills to work on their behaviour they would become optimistic and grow in

confidence of their being able to achieve success in their efforts. The campaign planners who have genuinely taken the target audience as subjects and not merely as objects of the campaign and considering themselves as facilitators of the process would be eager to provide the necessary support for the target audience and supply the necessary and appropriate stimulation and also provide necessary and appropriate reinforcements.

While from the foregoing it can be deduced that the participatory model has some valuable characteristics, it is important to appreciate that using this type of evaluation model can be very taxing on individual's and/organisations or community's time, resource and patience. As Farell et al. (2002) notes, time is of the essence in this type of evaluation and it is a necessary and indispensable element. To get all stakeholders (the majority or a good number of them) involved in the process of the evaluation in a meaningful way, would require much time for explanations and coaching. That requirement of lots of time, in turn require a great amount of patience especially on the part of professional evaluators who would have to progress according to the pace of the non-professional evaluators (who may need the time to understand the process and be in a position to make meaning and critical contributions). Working with and/or dealing with a diverse group of people (various stakeholders – each with their or his/her expectations) is not easy. It requires a good amount of diplomacy in negotiations to ensure all are on board and there is consensus on the responsibility of how the process should unfold regarding the creation of evaluation plan, determination of indicators, data collection procedures and analysis and how to interpret the results (Zukoski & Luluquisen 2002). It is also important to note that because of the nature of the participatory model of evaluation, intervention design cannot be taken as a given (in the sense that it cannot be changed in the process of implementation). For there can always be change due to external and internal pressures (on the intervention) which may not have been foreseen in the conceptualisation and design stage.

The understanding and appreciation of the philosophy and elements of the participatory evaluation model served as guide for ensuring that in the development of the theoretical sociocultural assessment instrument for health communication campaign, the identification and assessment of the place and role of the target audience in the monitoring and evaluation process of the health campaign were not overlooked.

5.3.3 Empowerment model

In the previous section, under the topic participatory model, the concept empowerment was briefly discussed. It was explained that the participatory model seeks to engage the primary
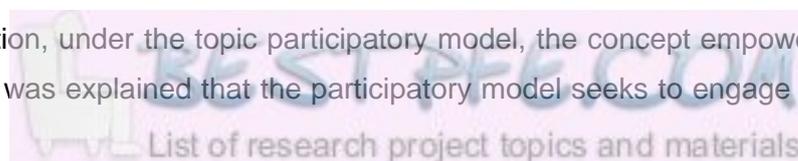
users of a programme or project in the 'nuts and bolts' of various stages in the process, addressing power differentials between all the stakeholders, challenges assumptions about the way things are and can be. That is basic assumptions about power, helping, achieving, and succeeding (Page & Czuba 1999). Alsop, Bertelsen and Holland (2006:1) define empowerment as "the process of enhancing an individual's or group's capacity to make purposeful choices and to transform those choices into desired actions and outcomes" – an evaluation process that uses "evaluation concepts, techniques, and findings to foster improvement and self-determination" (Fetterman, 2001:5). The definition suggests that at the heart of empowerment model of evaluation is the desire or goal to effect improvement of something (project, programme or intervention) or someone / some people (individuals, organizations, communities, and societies or cultures) and bring about self-determination of the persons involved in the evaluation process. Although that evaluation can be applied to persons (as individuals, organizations, communities, and societies or cultures), as Fetterman (2001) explains, the focus is usually not on these persons per se but on programmes or interventions. In other words, the design of empowerment evaluation is geared towards helping people to help themselves and improve their programmes or interventions. Self-determination comes about through the active involvement of the participants and their critical self-evaluation and reflection of the activities and processes of the programme or intervention (Fetterman 2001). This critical self-evaluation and reflection help to initiate and effect improvement in the intervention. The clients of this evaluation model are thus active participants (not just objects) who conduct their evaluations assisted by outside evaluator/s. In this sense, empowerment evaluation is necessarily collaborative and participative in nature hence it overlaps participatory and collaborative approaches of evaluation. The overlap, however, does not imply sameness in the sense as to mean empowerment, participatory and collaborative models of evaluations being the same. Though there is some similarity as mentioned, empowerment has its distinctive characteristic, which is its emphasis on fostering self-determination. As Patton (1997:2) puts it, the emphasis on fostering self-determination is the "defining focus of empowerment evaluation and the heart of its explicit political and social change agenda". That means in empowerment evaluation it is not a matter of participants simply being given the opportunity to participate actively and/or collaboratively in the evaluation process. Their active participation and/or collaboration are also meant to bring about certain self-awareness and build their capacity or release and actualise their potential.

Since external evaluators serve as coaches or facilitators in the process of evaluation and the process is geared towards building capacity or actualising some potential it can be assumed that participants are not merely or only involved but are also in control of the

process. Generally then, the external evaluator/s is often brought in at the beginning of the process to work with the community or participants until the latter is able to maintain the momentum of the evaluation independently (Farell et al. 2002). Thus, for Fetterman (1995; 2001) facilitation is one of the five 'facets' of empowerment evaluation. The other facets are training, advocacy, illumination, and liberation. Training received by participants to enable them conduct their own evaluation is what helps them to be in control. For if indeed they master the art and dynamics of the evaluation in which they are involved then they cannot but also have control over the process. In this evaluation, evaluators engage in advocacy on behalf of the groups that are disempowered or support these groups in advocating for themselves. Having received training that has enabled the participants to be in control indicates the acquisition of a certain level of illumination (or enlightenment) by them. They are not just ignorant passive participants but knowledgeable participants. Being illuminated or enlightened makes these participants experience liberation – they are in control of what is happening, giving it direction and purpose.

In a general sense then, this evaluation model seeks to foster self-determination of the communities involved in the programme, project or intervention. That is because their involvement is active in self- and–group reflective manner. It enables them to develop the ability to identify problems and 'bottle-necks', and shortcomings of the programme, project or intervention, and to respond creatively to these by finding appropriate solutions and carrying them out. Thus, the more this critical reflective process go on, the more (necessary) improvements of the programme, project or intervention are made. That leads to a greater sense of responsibility and ownership of the programme, project or intervention, and this invariably increases a sense of accountability on the part of the community (all those involved). Since all stakeholders are active participants in the process there is also a sense and feeling of inclusion with each person given the opportunity to share his/her experience and express his/her views, hence the democratic participation principle of the model. The sharing of experiences and open and frank expression of views facilitate a process of learning by the community, group or organisation members. In view of all the above, Fetterman (2001) notes ten sets of principles that guide this approach of evaluation: improvement, community ownership, inclusion, democratic participation, social justice, community knowledge, evidence-based strategies, capacity building, organizational learning, and accountability.

The empowerment evaluation process requires following certain steps (Fetterman 2001 and Farell et al. 2002): establishing a mission or vision statement, taking stock, planning for the future, and keeping on course.

The aim of developing a mission/vision statement is to determine a guiding focus for the programme and that provides a starting point for developing evaluation activities and strategies that reflect the intended results, processes, impact, or outcome of the initiative.

Taking stock is a process that helps the stakeholders determine the status of the programme, project or intervention at any particular time and to identify its strengths and weaknesses. That entails reviewing the programme, project or intervention activities and ranking them according to their level of significance. It serves as the community's baseline assessment.

Having taken stock or assessed where the community is in its efforts, a plan is then created for the future based on the findings of the assessment thus providing future direction of the programme, project or intervention.

So that the focus of the programme, project or intervention is kept and also to make the evaluation process easier in the future, a 'monitoring system' is developed and kept functional. That could involve keeping records of documentation of the programme, project or intervention 'workings' (for example, information on services, when they are offered, who attends etcetera).

Based on its nature, the empowerment model of evaluation embraces the four types of evaluation mentioned above – formative, process, impact and outcome. For a community to be in the position to make critical self-evaluation; contribute to improvements of a programme, project or intervention; and build capacity because of its participation in the programme, project or intervention. That community must invariably be involved in the creative monitoring of the evaluation process of the planning and implementation and overall assessment of such programme, project or intervention. That is exactly where the value of the empowerment model lies as far as this study is concerned. The theoretical sociocultural assessment instrument is not intended for use to assess only outcomes of health communication campaigns. It is meant to assess the objectives set, the planning done, the implementation (with particular interest in the involvement and participation of the target audience) and how the campaign had facilitated the process of building the capacity or empowering the target audience through self-determination to change and/or adopt sexual behaviour that limits or eradicates their chances of being infected by HIV/AIDS. Thus, the empowerment evaluation model like the logic and participatory evaluation models served as a guide for the development of the theoretical sociocultural assessment instrument.

5.3.4   CDC Framework

The CDC (Centre for Disease Control) Framework, Figure 5.3 (CDC Evaluation Working Group: Summary of the Framework for Program Evaluation, 2006) is a model developed in an Evaluation Working Group organized by the Centre for Disease Control and Prevention of the United States Government. The model is a framework specifically for conducting public health programme evaluation.
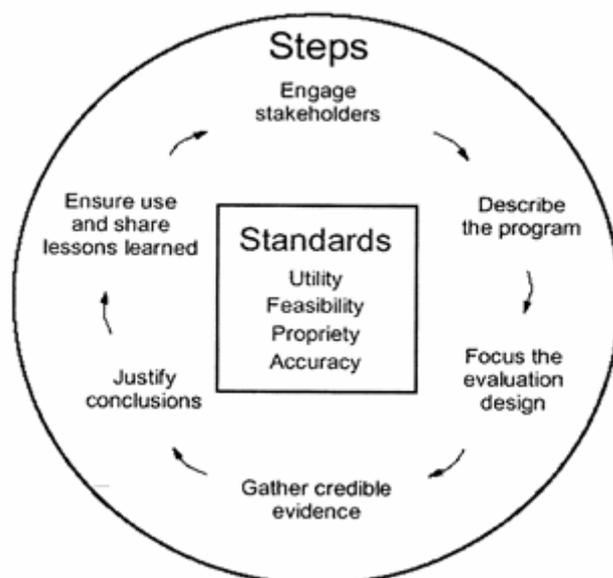
Figure 5.3:   **CDC Framework** (CDC Evaluation workshop 2006)

As depicted in the figure, the framework comprises a six-step programme evaluation practice and four standards for effective programme evaluation. It is said to be a "practical, nonprescriptive tool, designed to summarise and organise essential elements of programme evaluation" (CDC Evaluation Working Group, 2006:2). The steps and standards are briefly explained as follows.

5.3.4.1   *Engage stakeholders*

The first step requires that all those involved in the programme operation (for example, sponsors, collaborators, administrators, managers, and staff); those served or affected by the programme (for example, clients, family members, advocacy groups, sceptics, opponents, officials); and primary users of the evaluation (for example, the specific persons in a position to do or decide something regarding the programme) must be engaged in the

inquiry. That would ensure that their perspectives are understood and taken into consideration.

5.3.4.2   Describe the programme

This second step sets the frame of reference for all subsequent activities of the evaluation process. Aspects of this frame of reference would include the need (what problem, issue or opportunity the programme addresses and who experiences it?); the expected effects (what possible changes would result from the programme?); activities to be undertaking (steps, strategies, or actions the programme would take to effect the desired or anticipated change); resources (assets available to conduct the programme activities – for example, time, talent, information or effects); context (the operating environment around the programme that might influence it – for example, history, geography, politics, sociocultural and economic conditions); and logic model (hypothesized sequence of events for bringing about the desired or anticipated change).

5.3.4.3   Focus the evaluation design

Having adequately described the programme in the second step; this third step focuses on issues of the greatest concern to the stakeholders and determines how to use resources more efficiently since not all design options would be equally important, urgent or necessary. In this step also, the purpose of the evaluation is set and clarified: specific users of the findings of the evaluation are identified; how the users would use or apply the information and experiences generated from the evaluation is also clarified and determined; the methods that would be more appropriate for evaluation are also determined (for example, research design, data collection procedures, analyses of data and compilation of report).

5.3.4.4   Gather credible evidence

Those involved in the evaluation ought to strive to collect data that will "convey a well-rounded picture of the program and be seen as credible by the evaluation's primary users" (CDC Evaluation Working Group 2006:5). Some aspects of data gathering that affect perceptions of credibility are indicators (translation of general concepts regarding the programme, its context, and its expected effects into specific measures that can be interpreted to provide systematic, valid and reliable data); sources (the nature of documents,

persons, observations to be accessed to gather evidence, and the integration of these data); quality (trustworthiness of the information gathered); quantity (determining the sufficient amount of information required); and logistics (techniques, timing physical infrastructure to be used in gathering and dealing with data).

5.3.4.5   Justify conclusions

This step entails linking evaluation conclusions to the evidence gathered and judged against values, standards and criteria set by the stakeholders. The following elements form part of what constitutes justifying conclusions. Standards (that is, the values the stakeholders have provided as a basis for forming judgements, and the level of performance agreed on as that which must be reached for the programme to be considered successful). Analysis and synthesis (the procedures to be used to examine and to summarize the findings of the evaluation), interpretation (the practical significance of the findings of the evaluation), judgment (justification of claims of the program's merit, worth, or significance based on available evidence), and recommendations (suggested actions to be considered because of the findings of the evaluation).

5.3.4.6   Ensure use and share lessons learned

Since the lessons learned in the course of the evaluation would not translate automatically or necessarily into informed decision-making and appropriate action, deliberate effort is made to ensure that lessons learned are used and disseminated. Five elements are considered critical for ensuring use and dissemination. These are Design (the organization of the evaluation right from the start, included how lessons learned would be used by the primary users). Preparation (included in the evaluation process must be steps to be taken to rehearse eventual use of findings). Feedback (communication channels must be open and functional among the parties to the evaluation). Follow-up (identification of how technical and emotional needs of users are to be supported, elimination of possible obstacles to lessons learned being lost or ignored and putting in place safeguards for preventing misuse of the evaluation). Dissemination (specifying how procedures or lessons learned are to be communicated appropriately to relevant audiences).

The four standards would ensure a programme's attainment of stated objectives are utility (the programme must serve the information needs of intended users); feasibility (evaluators must be realistic, prudent, diplomatic and frugal); propriety (evaluators ought to behave

legally, ethically, and with regard for the welfare of those involved and those affected); and accuracy (evaluators must reveal and convey technically accurate information).

Adherence to these steps and standards of the framework is said to allow an understanding of each programme's context and improve how programme evaluations are conceived and conducted (CDC Evaluation Working Group 2006:1). That is a comprehensive framework, which contains very many essential elements of programme assessment. The fact that it is non-prescriptive adds additional value to it. That means it is open and flexible and it is possible to assume that the objective and context of the assessment would determine the focus and the prioritisation of the elements. As a framework, therefore, it could be a valuable tool for assessment and like the models presented and described above, the CDC Framework served as a practical and useful guide for the development of the proposed theoretical sociocultural assessment instrument in this study.

5.4   A THEORY-DRIVEN ASSESSMENT CONCEPTUAL FRAMEWORK

In the sections above, the nature and some of the theoretical perspectives of assessment have been discussed. In was argued that because assessment is a formal, disciplined, systematic and critical approach to investigate something, the instrument or tool used for assessing ought to be guided by some formal systematic framework. That means or requires that the assessment should be underpinned by theories/models. Health communication campaigns are interventions and the theoretical sociocultural assessment instrument developed in the study is for use in assessing sociocultural variables to determine how and to what extent sociocultural elements were taken cognisance of and incorporated in the strategic planning and design, creative implementation, and continuous monitoring and evaluation of health communication campaigns. As a summary of the salient points discussed in the preceding sections, this section sets out to discuss and propose a theory-driven assessment conceptual framework to serve as a tool for developing a theoretical sociocultural instrument for assessing sociocultural variables of health communication campaigns. In Chapter 3 the argument was made that to ensure maximum attainment of stated objectives of communication campaigns it is necessary to involve representatives of the target audience in the different stages of the communication campaign process. It was also argued that besides the target audience being involved in the different stages of the communication process it is necessary that their sociocultural context and factors such as worldview and beliefs; and aspects of their politics and economics, which pertain to the problem or issue being addressed by the campaign, ought to be taken into consideration because such context may have some determining effect or impact on the attainment or

non-attainment of the stated objectives of the communication campaign. The need for the presence of representatives of the target audience in the communication campaign process is illustrated in the proposed Interactive-Participative Communication Campaign Model (Figure 3.9). In that model the presence of the members of the target audience is envisaged in all the five stages of the communication campaign process – identifying and analysing the health problem, strategic planning and development, strategic management, creative implementation and continuous monitoring, and assessment/evaluation. If for maximum attainment of stated objectives the target audience is to be actively involved and participate as much as it is practically possible in the different steps of the communication campaign process, then their active involvement and participation in the assessment step should not be any less active. As discussed, theory-driven assessment does not only concentrate on the outcomes of an intervention that is, the end-product of the intervention process. It also concerns itself with identifying the problem that necessitated the intervention. Using the Interactive-Participative Communication Campaign Model as an example, that would mean theory-driven assessment should be part of the first step through to the fifth step of the communication campaign process. In other words as part of the assessment process, it ought to be ascertained what theory underpins the problem a campaign seeks to address. From the first step through to the second, third, fourth and fifth steps, theory-driven assessment helps to determine and establish what and how the components of the intervention are supposed to relate and interact or function to produce the expected results, and what underlying mechanisms facilitate the process of functioning. Hence if the target audience through its representatives is involved in identifying and analysing the problem leading to development and implementation of the intervention, then the value of its contribution in the assessment process cannot be over emphasised or under estimated.

Health communication campaigns are interventions and the theoretical sociocultural assessment instrument being developed in this study is for use in assessing sociocultural variables in order to determine the level of attainment or non-attainment of stated objectives of such communication campaigns. In this regard, programme theory discussed above is considered a useful conceptual tool in helping to develop a theory-driven assessment conceptual framework as a tool for developing the theoretical sociocultural assessment instrument for health communication campaigns. As already discussed, programme theory suggests two assumptions in a programme – descriptive and prescriptive. Descriptive assumption describes casual processes that generate the problem that form the focus of a programme, which in health communication campaigns would be the health problem. Prescriptive assumptions are the assumptions of what is or should constitute the components and activities (actions) of a programme so that it might be a successful

programme (Chen 2004). In light of its proposition of the two simultaneous assumptions programme theory, as a conceptual tool helps in understanding and appreciation of the simultaneous descriptive and prescriptive nature of health communication campaigns. If that is kept in focus in the development of the theoretical sociocultural assessment instrument it would ensure that, the instrument contains components that can help to unearth the implicit or explicit problem and intervention theories of health communication campaigns. Programme theory is thus, assumed to provide the basis for establishing the standards about which assessment of the attainment of stated objectives of the health communication campaign is carried out. Given this assumption, to have an appropriate conceptual framework to guide the development of the theoretical sociocultural assessment instrument for health communication campaigns that is in line with the third objective of this; the elements of the programme theory are combined with elements of the theory-driven assessment to construct a theory-driven assessment conceptual framework illustrated in Figure 5.4.
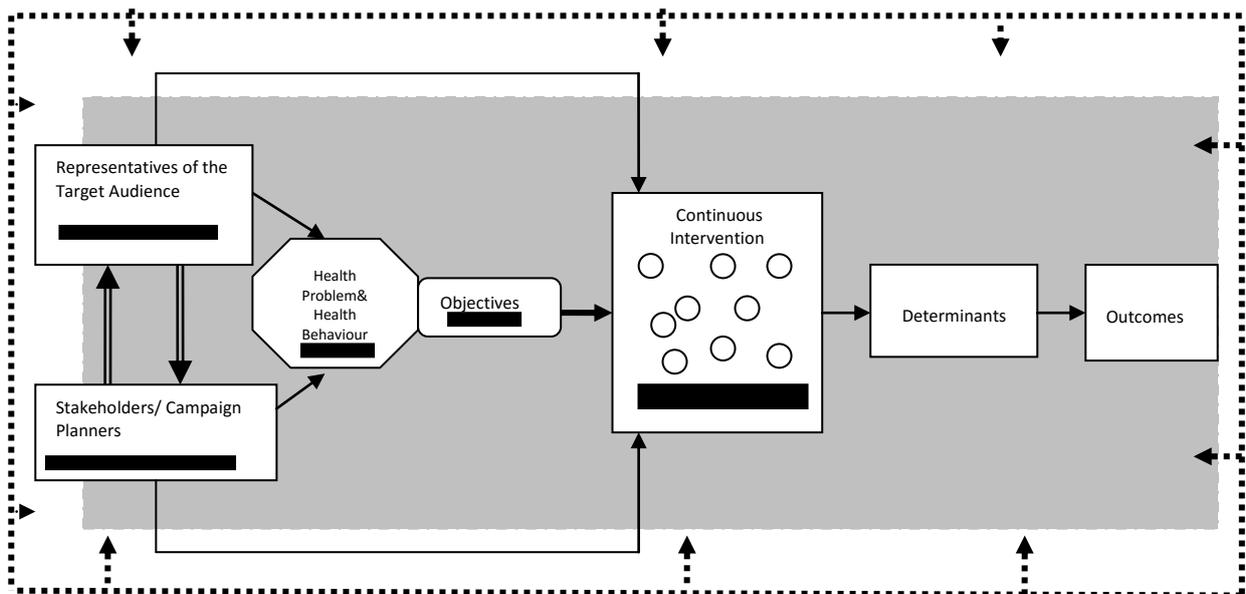
Figure 5.4:   A Theory-Driven Assessment Framework

Legend

Theory-driven assessment process encompassing the whole communication campaign process & not limited to some parts

Elements/variables that are assessed

The underpinning theories/models in the assessment process

The sociocultural context

The connection between the various elements
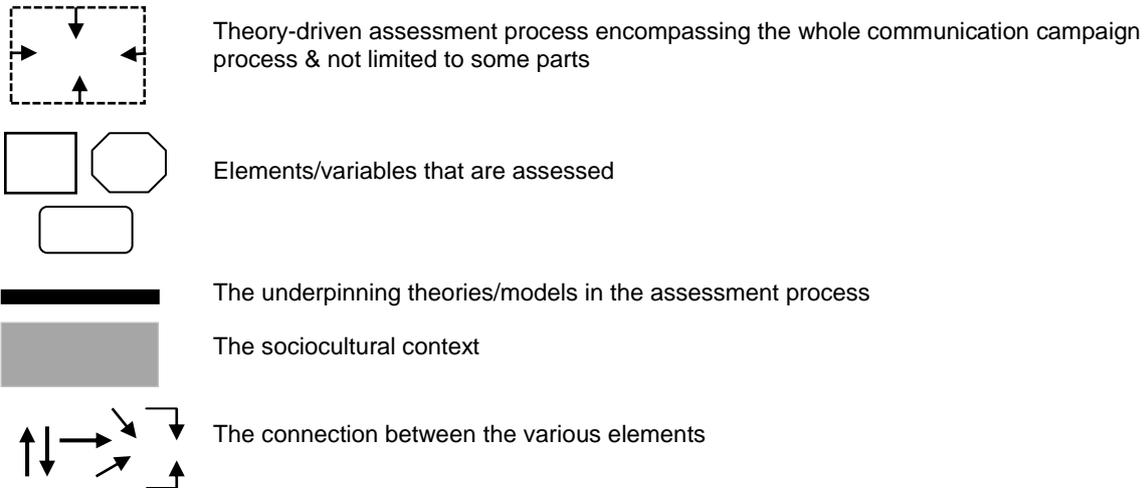
The dotted square on the outside represents a theory-driven evaluation process, which encompasses the whole communication campaign process. The arrows pointing inside towards the various elements of the communication campaign process illustrate that the evaluation is not focused on or limited to only the outcomes. While the outcome of the communication campaign is important in assessing attainment of stated objectives, the determination of whether or not the campaign has attained its stated objectives is dependent on the outcome as well as on whatever else activities or processes occur in the communication campaign process. In essence, the outcome is the result of activities or processes that occurred to produce it. That is why it is necessary for the assessment to encompass the whole process including the interaction and consultation or non-interaction and non-consultation between the stakeholders/communication planners and the target audience regarding what the problem really is and why and how to tackle it to eliminate it. That is, what objectives to pursue in the communication campaign. That interaction and consultation is illustrated with the arrows between the target audience and stakeholders/communication planners within the assessment process, and the arrows from both groups to the Problem represented by the hexagon and the rounded corners' box representing the Objectives of the communication campaign. The interaction and consultation between the stakeholders/communication planners and representatives of the target audience in identifying the problem to be addressed and setting objectives might lead to deciding on what intervention activity to initiate. That is illustrated with the arrow leading from the Problem and Objectives to the box marked 'Intervention', and the arrows directly from the two groups to the Intervention box. The Intervention comprises various activities (components and factors) and these are illustrated with the small circles within the

Intervention box. For the activities or functioning of the components/factors of the intervention to result in some outcome certain underlying mechanisms must be present and these are illustrated with the box of Determinants between the Intervention and the Outcome. An important and indispensable aspect of theory-driven assessment is the identification and definition of the explicit or implicit problem theory and the intervention theory in order to be in a position to establish or set the standards or criteria that serve as the reference for comparing the reality of the outcome to determine the level of attainment of stated objectives. In this study not only are theories/models considered necessary to underpin the Problem and Intervention of health communication campaigns, as Problem Theory and Intervention Theory would have it. It is assumed that it is necessary for theories/models to underpin all the major components of the communication campaign process hence; the dark shaded boxes in Figure 5.5 illustrate theories/models underpinning those components. The sociocultural context is a component of both the action model and the change model and this is depicted with the shaded grey background that is an illustration that the sociocultural context affects the whole of the communication campaign process and is taken into consideration throughout the whole process.

The proposed theory-driven conceptual framework portrays the process of assessment as a system of a logic model. For such assessment to be holistic, the relationship, interaction and interdependence of the various parts of the whole intervention process have to be seriously taken into consideration. Since the theoretical sociocultural assessment instrument being developed in study is meant for use in the assessment of health communication, specifically an HIV/AIDS communication campaign, it is necessary to ascertain what current approaches are used and to establish whether there are any inherent challenges in these approaches that need to be considered.

As argued before, the focus of sociocultural assessment is the verification of the extent to which sociocultural factors and their relationships or interconnectivity with other factors were taken into consideration and/or played any significant role in the planning and design implementation and outcome of a communication campaign. Hence, the theoretical sociocultural assessment instrument being developed in this study as a theory-driven assessment instrument is designed to have the potential of being used to study critically, analyse and determine, among other things, whether the health problem or issue that necessitated the intervention poses any sociocultural challenges; the underpinning theory has any sociocultural significance or relevance in relation to the problem; the objectives of the intervention have any reference to sociocultural factors relevant to the problem; the intervention theory has any bearing on sociocultural components and factors; and whether

sociocultural factors played any significant role in the transformation processes of the intervention.

These five points ought to be taken into consideration in the development of the theoretical sociocultural assessment instrument to ensure that the instrument can be used to sufficiently determine or verify which sociocultural factors/elements of health communication campaigns were to be taken into consideration in the planning, design, implementation and evaluation of campaigns and the reasons why.

5.5   CONCLUSION

This chapter has dealt with some terminologies and concepts pertinent to understanding and developing a theoretical sociocultural assessment instrument. As indicated at the start of the study the concept sociocultural is a combination of two terms, society and culture. Both terms pertain to the nature and existence of human beings as social animals who live in groups and interact with each other, thus making them relational beings; and as groups they have their way of life or way of being. As indicated in Chapter 2 and in this chapter the concept assessment that is interchangeable with the term evaluation, refers to the process of critically analysing and comparing plans and stated objectives of a programme, project or intervention with actual activities or results of activities of the programme, project or intervention. This comparison is done with a view of making a judgment on whether and to what extent the actual activities correspond with/to the plans, and whether the stated objectives are or have been achieved. Having discussed the meaning of assessment, some types and models of assessment were presented and discussed, and their relevance to the study indicated. For the theoretical and/or philosophical basis of developing the theoretical sociocultural assessment instrument, sociocultural, self-determination and systems theories were presented and discussed, and their particular relevance to the study indicated.

From the various definitions of assessment presented and discussed it can be said that in daily living, human beings constantly at least unconsciously make assessments – that is, they examine, comparing different phenomena or aspects of phenomenon and make judgments or draw conclusions. Such assessment is not necessarily systematic or scientific. For systematic or scientific assessment, there ought to be an element of intentionality that is, the deliberate intention and decision to engage in or conduct an assessment. That involves taking certain specific steps and going through certain specific stages, for as the discussions above have elucidated, assessment is a process of several specific steps. From a scientific perspective the process of assessment require that there must be "something" worth

assessing because the assessment process is not an activity undertaken for the sake of just doing something. Rather it is for the purpose of learning something about that which is assessed for the purpose in most cases being to improve and/or to know the success and/or impact or the ultimate outcome of that "something" or "activity", which could be a programme, project or intervention such as a health communication campaign.

Programmes, projects and interventions normally go through different stages: planning, designing, implementation, monitoring and evaluation. Though as the sequence of the stages shows evaluation is at the end, in reality only one type of evaluation, the outcome evaluation, may be at the end while the others (context, formative, process, empowerment and impact) may occur at other stages of the life span of a program, project or intervention. It is possible to conduct one of these evaluations of a programme, project or intervention without necessarily engaging in the others. However, for a health communication campaign that is a process of different stages, seeking to draw attention to health issue/s and motivate behaviour change, it would be expected that its assessment is not limited to application of one or just a number of evaluation types but rather if not all, most of the evaluation types discussed would be applicable. That would ensure a comprehensive and systematic analysis of the whole process of the campaign.

Human behaviour is a complex activity. Certain aspects of it can be understood from the perspective of the individual while other aspects only make sense from the perspective of the individual in his/her sociocultural context. Elements of context have some significant determining influence on his/her behaviour. Thus, to assess any aspect of human behaviour it would be necessary to use a sociocultural assessment tool that comprises elements that make it possible and/or easier to pay attention to or capture sociocultural factors that positively influence behaviour; or negatively prevents, hinders or slows down the pace of the processes entailed in human behaviour. Such sociocultural tool is conceived as incorporating elements of other assessment models, specifically those of logic, participative, empowerment and CDC framework in the following manner.

The logic model would help in visualising the development and presentation of the sociocultural assessment instrument.

In the presentation and explanation of the Interactive Communication Campaign Model (Figure 4.9), the point was made that targeted audience of a communication campaign should be involved in the different stages of the campaign process. It was in that sense that elements of the participative assessment model came into play since assessment ought to be part of the 'whole' lifespan of a campaign; and the target audience are also to be involved

and aprticipate actively in all the various stages of the lifespan of the campaign. The incorporation of elements of the participative model in the sociocultural assessment instrument would ensure that it is possible to determine if and how the target audience participates actively in the planning, designing and implementation, monitoring and evaluation of the campaign.

A health communication campaign seeking to draw attention to health issue/s and motivate health behaviour change seeks in essence to empower people to decide and make a choice between certain ways of behaviour that are detriment to their health and ways of behaviour that promote good health and their well-being. Incorporation of elements of empowerment assessment model into the proposed sociocultural assessment instrument would enhance the latter, as the former highlights the elements of critical self-evaluation and reflection, and fosters self-determination. It is possible to determine if the target audience, consciously and actively assumed responsibility for the assessment/evaluation of the campaign alongside external evaluators.

The elements of 'Steps' and 'Standards' of the CDC framework provide guidance for the development of the theoretical sociocultural assessment instrument by helping to identify or ascertain the necessary steps to be taken and standards to adhere to, making the theoretical sociocultural assessment instrument a comprehensive, systematic, practical, flexible and effective assessment instrument for health communication campaign.

These five points were taken into consideration in the construction of the theory-driven assessment framework to guide the development of the theoretical sociocultural assessment instrument. An instrument that can be used to sufficiently determine or verify sociocultural factors or elements in health communication campaigns. The next chapter then focuses on the development of the theoretical sociocultural assessment instrument for health communication campaigns.

CHAPTER 6   RESEARCH METHODOLOGY

6.1   INTRODUCTION

The discussions on the key concepts and their operational definitions in Chapter 2 and on the conceptual theoretical framework in Chaper 3 set the scope and demacated boundaries of the study. To ensure that work on the three objectives of the study as presented and discussed in Chapter 1 are underpinned by relevant theories, the reflection in Chapter 3 also focused on theoretical approaches to health communication campaigns. That was followed in Chapter 4 by a discussion on modelling that laid the foundation for modelling the theoretical sociocultural health communication campaign model to guide the development of the theoretical sociocultural assessment instrument. Chapter 5 chapter dealth with the theoretical perspectives and foundations of sociocultural assessment instrument That prepared for and set the stage for delving into the task of the research, that is developing the theoretical sociocultural assessment instrument and testing it in a health communication campaign in order to achieve the second and third objectives of the study. A first step in the research work was the delianation and clarification of the research methodological approach.

As briefly mentioned in the research design in Chapter 1 the general methodological approach adopted in the study was a combination of elements of qualitative and quantitative research techniques. That made the overall methological approach a mixed methods research, which Lugovskaya (2009:3) describes as a "field of inquiry that uses both qualitative and quantitative methods to answer research questions within a single study". The combiation of the two methods is what makes a research approach a 'mixed' methods. The choice of the mixed methods research was based on the paradigmatic view taken in relation to the current nature and dynamics of HIV/AIDS communication campaigns, which served as the reasons for the objectives of the study.

According to Chilisa and Kawulich (2012) no one paradigm or theoretical framework is 'correct' since every researcher has his own view of what constitute truth and knowledge, which guides his thinking, beliefs, and assumptions, and frames how he views the world. That explanation of Chilisa and Kawulich cannot be construed to mean that in the scientific field a researcher operates solely from his personal, subjective paradigm, which is, or might be unrelated to the paradigms of others. Thomas Kuhn, a historian of science considered the scholar who introduced the concept paradigm into the physical and the social sciences (Hesbol 2006) and the author of 'The Structure of Scientific Revolutions' published in 1962

explains that a paradigm is a framework of theories, ideas, and/or methods which essentially shape and determine people's understanding of the world (Kuhn 1962). While there is no such thing as a 'scientific community' characterized by a paradigm or a collective acceptance of an agreed framework of theories, ideas or methods, there exist scientific communities that focus on their particular disciplines and areas of research (Blackshaw 2005). As in its general usage, paradigm captures a meaning of a worldview or perspective and thus can serve as a meta-theory. In the case of research paradigm it "includes conceptions of methodology, purposes, assumptions, and values" and "typically consists of an ontology (the nature of reality), an epistemology (what is knowable and who can know it) and a methodology (how one can obtain knowledge)" (Matthison 2005:290). From Kuhn's explanation of a paradigm and Matthison's view that paradigm includes conceptions of methodology, it is assumable that a researcher's paradigmatic view would influence or determine his choice of research method. For as Ritzer (2005:543) opines a paradigm "serves to define what should be studied, what questions should be asked, how they should be asked, and what rules should be followed in interpreting the answers obtained". The paradigmatic view adopted in study therefore defined the methodological approach adopted to achieve the objectives.

6.2   INTEGRATING QUALITATIVE AND QUANTITATIVE TECHNIQUES

The paradigmatic view of the study was that communication and culture are intertwined   – the two being intimately interrelated and interdependent, and influencing the communicative and cultural behaviour of human beings. It was in light of this paradigmatic view that the research method opted for was the integration of qualitative and quantitative techniques in the belief that the quotation generally attributed to Albert Einstein is valid - "Not everything that can be counted counts, and not everything that counts can be counted". In this combination of the two methods, the general framework was not to seek to confirm any hypothesis about the phenomena of culture and/or communication but rather to explore the possible relationship between the two phenomena. Adopting that as the general framework the theoretical sociocultural health assessment instrument was envisaged to be flexible and not in a rigid style as would have been the case if the general framework were (only) quantitative (Family Health International [sa]). The instrument was developed as a group-administered questionnaire, which gives it a qualitative character but the questions are designed as 'closed-ended'. Qualitative method questions are normally 'open-ended'. Applying the mixed methods techniques allowed for the use of closed-ended questions on an instrument of group-administered questionnaire. The combination of qualitative and

quantitative research methods was thus, regarded as more appropriate for this study as it sought to test the appropriateness of the sociocultural assessment instrument in one case of a health communication campaign. That was on the assumption that while quantitative method has been available to the social and human scientists for years and the qualitative method has emerged primarily during the last three to four decades. The mixed method research which is acknowledged to be new, and still developing both in form and in substance (Creswell 2003) offers this study a flexible but systematic methodological approach to achieve the objectives of the study.

According to Tashakkori and Teddlie (2006) the main tenet of mixed methods research is that, a research question, not the paradigm or the purpose, dictates the method of inquiry. If the views of these two scholars are taken into consideration then the choice of mixed research methods even in its quasi form in this study could be regarded as inappropriate. That is because as earlier explained the choice of the research method of this study was influenced and determined by the paradigmatic view of communication and culture and the envisaged nature and purpose of the theoretical sociocultural assessment instrument. While Tashakkori and Teddlie (2006) may have good and valid reasons to suggest that research question/s and not paradigm or purpose should determine the choice of a mixed research method, in this study it is argued that their position cannot be regarded as the absolute criterion (without exception) for the choice of mixed methods research. That is because as Pinto (2010:813) describes, the mixed methods research is "a research orientation that possesses unique purposes and techniques" and "integrates techniques from quantitative and qualitative paradigms to tackle research questions that can be addressed by mixing these two approaches". The two characteristics of this methodological approach highlighted in Pinto's description - the flexibility to accommodate researches of unique character and the integration of techniques of both qualitative and quantitative paradigms to tackle research questions that can be addressed by mixing the two were of particular interest and significance to this study. The research questions of the study flowed from the research problem, which flowed from the rationale that formed the basis of the paradigmatic view of the study. Thus, the research questions of the study were based on and intimately linked to the paradigmatic view and purpose of the study. Moreover as Lugovskaya (2009:1362) opines, the choice of "research questions should be the central issue in any investigation and should drive the choice of methods". Centrality though cannot be taken to mean 'the only way' or 'the only possibility'. It is therefore argued that the uniqueness of the paradigmatic view and purpose from which flowed the research questions of this study are what is central to the investigation of the study. The integration of the qualitative method and some quantitative techniques therefore amounted to what Wilson (2008) describes as the

systematic combination of the two techniques, which Tashakkori and Teddlie (2006:669) consider as the utilisation of "both narrative and numerical data and analyses for answering research questions". That offers the flexibility of using qualitative and quantitative methods to answer research questions within a single study, as done in this study.

6.2.1   The qualitative and quantitative techniques

Qualitative and quantitative methods in their "classical" stance may seem antithetical research approaches. However, when their value and strengths are properly and systematically combined in mixed methods research, it is made a pragmatic, interactive and integrative design model, which makes a study more successful and resourceful by eliminating the possibility of distortion by strict adherence to a single formal theory (Pinto 2010). Hence, the utilisation of both narrative and numerical data - collection, analyses and interpretation, in mixed methods research offers a researcher, such as in this study, the possibility of not being constrained in his choice of method to solely select either the quantitative or qualitative approach for the study. This possibility frees the researcher from being "restricted to selecting among a menu of preplanned designs" and instead being able to create "a design that is likely to answer his or her research questions" (Behar-Horenstein 2008:576). That was precisely one of the reasons for choosing mixed methods research for this study.

It was worth noting Crotty's (1998) suggestion that the decision to use a quantitative or qualitative method is based on a chain of ontological, epistemological, theoretical and methodological assumptions that a researcher makes. In the case of this study, the ontological assumptions are related to understanding the nature of the dynamics and intricacies of the intertwining and the interrelated relationship between culture and communication and the subsequent impact or influence of such a relationship on cultural and communicative health behaviour. The epistemological assumptions pertained to the ways envisaged to approach the understanding of the relationship. The theoretical assumptions related to how the paradigm, concepts, theories and models adapted in the study shaped the focus of the subject matter and the methodology having to do with the assumptions relating to conversion of all the above into a research design that enabled and facilitated carrying out the research.

Van den Hoonaard, Deborah and Elise (2008) note that there are different types of qualitative research. As that is the case Taylor-Powell and Renner (2003), assert that there is 'no single or best way' of this type of research. Nor are there hard and fast rules for the

methodological approach used in a study though the "the approach should be systematic and transparent (clearly explained)" (Neill [sa]:1). This was what was done in the application of the qualitative technique of document data in achieving the second objective of the study to develop the theoretical sociocultural assessment instrument in the study. Quantitative research on the other hand as the name suggests is concerned with quantifying research data. It asks questions such as 'how many', 'how long' and/or 'the degree to which' (McDonald & Headlam 2002) and as Gunter (2002) puts it the basic concepts that characterise the quantitative method relate to relevant modes of measurement and procedures for analyses of relationships between such measurements. In this study as explained below, the Likert-type scales of multiple-item scales and summated ratings were chosen to quantify the selected sociocultural and health communication constructs in the development of the theoretical sociocultural assessment instrument. The adapted quantitative technique discussed helped with establishing how to analyse the relationships of the sociocultural assessment variables in the assessment process.

6.2.2   Research sample

Bloor and Wood (2006) explain that there are two broad types of sampling methods: probability and non-probability (purposive) sampling. Probability sampling may be random or systematic, with cases selected in accordance with probability theory. Purposive sampling on the hand is virtually synonymous with qualitative research according to Palys (2008) and in this method the selection of cases is according to reasons other than mathematical probability (Bloor & Wood 2006). In both qualitative and quantitative research therefore, sampling is used but differently. While in qualitative research sampling methods are non-prescriptive, in quantitative research it is prescriptive. This means in qualitative research, sampling is often unique to the particular study and/or context, and there are no rules concerning the most appropriate sample sizes. Which implies that in quantitative research it is necessary and important to select a sample that will best approximate the characteristics of the population for which inferences will be made (Laher & Botha 2012). The method of sampling in qualitative research includes a range of sampling approaches such as quota, convenience, intensity, critical, criterion, typical, pragmatic case. The list of the range of purposive strategies is virtually endless because there are many objectives that qualitative researchers might have, thus any given list would reflect only the range of situations the author of that list has considered (Palys 2008).

As the third objective of the study was to ascertain the appropriateness of the theoretical sociocultural assessment instrument developed by testing it in an HIV/AIDS communication campaign, the sampling method chosen was purposive. It was purposive because choosing the HIV/AIDS communication campaign of the Ekurhuleni Municipality's Health Unit as sample was convenient. It was convenient because of its availability (Bloor & Wood 2006), for the purpose of this study (convenience sampling) and it was a typical case of purposive sampling as it involved taking as sample "what one would call typical, normal or average for a particular phenomenon" (Purposeful Sampling [sa:1]). The choice of sample was a pragmatic approach to sampling since due to the nature of the study it was considered an exemplar (Palys 2008) of South Africa Government's HIV/AIDS communication campaign as the HIV/AIDS Unit, comprising a team of 10 persons for the group-administered interactive questionnaire was deemed appropriate. For the intention of the study was not to find a sample that will best approximate the characteristics of a population for which inferences could be made (Laher & Botha 2012) but a sample, in this instance, a unit with ten participants, a case in which to test the theoretical sociocultural assessment instrument developed in the study. The sample choice in the study therefore was due to the unique nature of study. The sample thus brought into the methodological approach some elements of case study method not in its typical form but in a sort of 'quasi' form as the choice of the sample – the case, allowed the freedom of combining the qualitative and quantitative data (King, Koehane & Verba 2004) – narrative and numerical data, and the choice of the nature of the unit to be studied as informed by theory (Hawkins 2009); and the focus was on one instance (Stacks 2005; Blatter 2008; Salkind 2008) - the Ekurhuleni Municipality Health Department HIVAIDS Unit's HIV/AIDS Communication Campaign, without seeking to find any universal rule/s but to understand the case sampled, in its own unique environment (Aalito & Heilmann 2009).

6.2.3   Data collection method

As noted above one of the reasons for the choice of the mixed methods research was the point made by Behar-Horenstein (2008) that it frees a researcher from being restricted to selecting from among a menu of preplanned designs to being able to create a design that is likely to answer his research questions. Answering the research questions of this study were based on the rationale and problem statement. The objectives of study were therefore meant to help answer the questions. The first two objectives required the construction of a conceptual theoretical communication campaign model and the development of a theoretical sociocultural assessment instrument respectively, and the third objective required using the

developed theoretical sociocultural assessment instrument to gather data, the analysis of which helped to ascertain the appropriateness or non-appropriateness of the instrument for the purpose for which it was developed. The method of data gathering in the study was therefore unique in the sense that the process and manner of constructing and developing the conceptual theoretical communication campaign model and the theoretical sociocultural assessment instrument formed part of the data collection process of the study together with the manner and process of testing the assessment instrument. The mixed methods research chosen as the basic methodological approach in the study allowed for or offered the freedom to employ the unique method of data gathering in the study for as Creswell (2003) opines, in the mixed methods approach both emerging and predetermined approaches, and both quantitative and qualitative methods can be used. In addition to that, collection of data can be both quantitative and qualitative and can be integrated at different stages of the inquiry provided a rationale is developed for such mixing. Creswell's explanation that in mixed methods approach both emerging and predetermined approaches are used is important for this study as the manner and use of the mixed method approach is considered as contributing to an emerging approach. Thus, the unique method of data collection in the study was the combination of document data (documentation) and a group-administered interactive questionnaire (Yerushalmi et al. 2011).

Questionnaire belongs to the data collection method under the general name of survey (Sullivan 2009) – a method and format in which the same questions are asked of each respondent and thus providing a simple and efficient way of constructing and structuring data set (de Vaus 2007:1103). It was time-saving' (Mentz 2012:100) and was more suitable for the type of data that needed to be collected by the use of the theoretical sociocultural assessment instrument for as Daniel (2010) put it the collection of qualitative, quantitative, or mixed mode data may be collected directly or indirectly from either individuals or groups. Typically, questionnaire requires three elements: items, respondents and an interviewer/administrator (Daniel 2010). Those items were incorporated in the theoretical sociocultural assessment instrument and its use.

Developing the theoretical sociocultural assessment instrument as a group-administered interactive questionnaire with closed-ended questions brought into focus an old methodological debate that has been ongoing for decades. That is the debate on the dilemma between open-ended and close-ended response alternatives in social research - which of the two methods is more appropriate, particularly in survey? Among British sociologists that debate and the quest to resolve the dilemma has led to the call for what has been termed 'methodological pluralism', which according to Payne, Williams and

Chamberlain (2004:153) is "a tolerance of a variety of methods in sociological research, because methods should be seen as part of the research process as a whole" - a tolerance that "extends to either side of the dubious dichotomy between 'quantitative' and 'qualitative' method". The question is should such a dilemma exist in the first place? May be that is why Payne et al., might have used the expression 'dubious dichotomy' by which they might be saying that dichotomy between quantitative and qualitative methods is doubtful, ambiguous and unconvincing. That would not be to imply that the two types or methods are the same. They are two different research approaches but being different does not and should not imply their being antithetical either. It is argued that the fundamental question should be 'for what reason/s are the methods used?' Over the years researchers who used the survey have sought to resolve the dilemma by opting for the closed-ended response alternative as questionnaires have generally not comprised questions with open-ended response alternative (Gobo 2011). On the other hand Groves, Fultz and Martin (1992:60) have noted that "the closed questions did not capture the same dimensions of meaning that are revealed by the open question". As the debate continued over the years and the dilemma persisted, Rensis Likert introduced what is termed the "fixed question/free answers" technique (Gobo 2011). This is a technique of fixing the questions of a questionnaire (close-ended questions). While the questions were/are close-ended the interviewee did not or does not choose his answers from the alternative response as is ordinarily done with close-ended questionnaires. Instead the interviewer transcribes the comments (on the questions) of the interviewee and then on conclusion of the interview the interviewer choose the response alternative which he thinks is the closet match with the interviewee's comments. This technique did not seem to have gained much ascendency since till today, "there are those who believe that the fixed response alternatives have considerable advantages" (Gobo 2011:5). A variant of Likert's "fixed questions/free answers" was proposed by Galtung (1967:120) known as "open question/closed answer". As the name denotes it was a reverse of Likert's but the procedures of both were guided by the same principle of making the interview into a conversation between the interviewer and the interviewee (Gobo 2011). In describing the distinction to be made in interviews between close questions and closed answers, Galtung (1967:120) explained:

> In the former, the respondent is given, orally, the answer alternatives: 'Which candidate do you favour, Allende, Frei or Duràn?' which means the response variable is spelt out for him as in the questionnaire. In the latter he is asked 'Which candidate do you favour?' The question is open, but the interviewer may have closed the answers by a precoding in his schedule. This, however, is only known to him and not to the respondent, and hence serves only administrative purposes like facilitation of coding. It does not structure the mind of the respondent.

According to Gobo (2011), Galtung's technique, which he renames 'conversational survey' is a valid alternative to the close-ended and open-ended survey particularly in mixed methods research in which different methodologies such as survey, discursive interviews and focus groups, could be used within the same research project. Hence, he re-name's Galtung's technique 'conversational survey' and asserts that it is "a valid alternative, given that many of the advantages of mixed methods are obtained using a single method. In other words, Galtung's technique combines both qualitative and quantitative approaches in a *single instrument*". These insights of Gobo (2011) and those of Yerushalmi, Henderson, Mamudi, Singh and Lin (2011) on the explanation of their group-administered interactive questionnaire, which they proposed as an alternative to individual interviews provided inspiration and guidance in the development of the theoretical sociocultural assessment instrument of this study.

6.2.4   Data analysis

According to McDonald and Headlam (2002:8), in any form of research, one will be "required either to count things and/or talk to people". This distinction, McDonald and Headlam contend, broadly describe the classification of quantitative and qualitative research methods. In a 'layman's language' this could mean in the analysis of quantitative data some measure or level of arithmetic or mathematical calculation is done to interpret and explain the data and in the analysis of qualitative data also there could be some arithmetic or mathematical calculation done in order to interpret or explain the data. While in the view of McDonald and Headlam (2002) since in any form of research (qualitative, quantitative or mixed methods) some arithmetic or mathematical calculation may be done, and that would mean percentages could be given in qualitative research; Morgan (1996:301) is of the view that it is not appropriate to give percentages in reports of qualitative data such as focus group data. This may imply that in qualitative research, different methods of data analysis are used depending on the type of qualitative research and the purposes researchers have for conducting their particular research. To achieve their specific purposes researchers they may pursue different types of analysis. Thus, Dey (1993:2) points out that the relevance and applicability of any particular procedure opted for should depend "entirely on the data to be analysed and the particular purposes and predilections of the individual researcher". In choosing a method of analysis in qualitative research, therefore, the researcher ought to be clear about the type of data he has, his purpose for the research and his preference or special liking, which, it is assumed would be in line with the type of data collected and the purpose of the research. Dey (1993) explains further that a basic core of qualitative data

analysis is what it deals with, and that is meanings, while quantitative data deals with numbers. This, Dey (1993:3) goes on to explain has "implications for analysis, for the way meanings are analysed through conceptualization, whereas the way numbers are analysed is through statistics and mathematics". Qualitative data are therefore words rather than numbers; and words describe, explain and suggest new perspectives (Linacre 1995, Du Plooy 2002; Babbie and Mouton 2004). This does not imply however that numbers are not useful in qualitative data. A lot of counting takes place when judgements of qualities are being made, and when a theme or pattern is identified there is isolation of something that happens a number of times and consistently happens in a specific manner. In addition, when something is said to be important or significant that estimate has been achieved partly by making counts, comparisons or weights (Miles & Huberman 1997). The distinction between qualitative and quantitative data analysis thus, does not make the two diametrically opposed (as if the one is concerned only with meanings and the other only with numbers). In social science, number depends on meaning, and meaning is informed by numbers; and enumeration depends upon adequate conceptualization, and adequate conceptualization cannot ignore enumeration (Dey 1993). In dealing with meanings to which numbers may be assigned in qualitative data analysis, what is important is the emphasis on how to categorize the data and make connection between the categories relative to the objective or goal of the research.

As the general methodological approach of the study was mixed method research, which combined both qualitative and quantitative techniques, the analysis of the data collected through the use of the theoretical sociocultural assessment instrument was also both qualitative and quantitative.

6.3   DEVELOPMENT OF THE THEORETICAL SOCIOCULTURAL ASSESSMENT INSTRUMENT FOR HEALTH COMMUNICATION CAMPAIGNS

Having presented and discussed the construction of the conceptual theoretical sociocultural health communication campaign model (the first objective of the study) in Chapter 3, the theory-driven assessment framework in Chapter 5, and in the preceding sections having specified the methodological approach adopted to achieve the second and third objectives of the study, it is now possible to present and discuss the work of developing the theoretical sociocultural assessment instrument in the next sections of this chapter.

The concepts sociocultural and assessment have both been discussed and operationally defined in preceding chapters. 'Instrument' which together with sociocultural and

assessment make up the name of what was developed, is the generic term that researchers use for an assessment device such as survey, test, questionnaire (Research Rundowns [sa]). The theoretical sociocultural assessment instrument is thus, not a theory or model but a theoretical assessment device in the form of questionnaire consisting of questions specifically constructed in such a manner as to solicit answers that enable researchers determine whether the following factors have been considered in health communication campaigns process: whether the target audience are/have been involved and participated in the communication campaign process and if yes on what level of intensity. Whether the influence of sociocultural factors such as worldview and beliefs and traditional customs relating to health and health behaviour are or were taken into consideration in all the four core areas of the campaign, namely, strategic planning and development, design – developing and pre-testing of concepts, messages and materials, creative implementation, and continuous monitoring and evaluation/assessment; and whether relevant theories or models (if any) underpinned the four stages.

It is worthwhile noting that the theoretical sociocultural assessment instrument as developed was envisaged to be administered to health communication campaign planners and the results of such administering to help improve and/or enhance an ongoing communication campaign or a new one being planned. In developing the theoretical sociocultural assessment instrument therefore, it was important to keep in focus the argument that assessment should go beyond merely assessing relationships between intervention and outcomes, and rendering 'yes' or 'no' answers as to whether the intervention had achieved its objectives, to include explanation on the causal mechanism responsible for the observed outcomes. In doing this, systematic study and analysis of the transformation processes of the components and factors of the whole campaign process that helped turn intervention into outcomes are required. The need to pay attention to the behaviour and processes or functioning of the various sociocultural components and factors of the campaign process from strategic planning through to continuous monitoring and evaluation was presupposed. In this regard, it had been useful to discuss different types of assessment highlighting the different aspects of the assessment process. That discussion helped in understanding the nature and dynamics of the assessment process, which in turn made it possible to envisage the standards of the theoretical sociocultural assessment instrument against which to assess variables of health communication campaigns envisaged as covering the behaviour and functioning of the various components and factors of the entire communication process and not just part/s of it.

6.3.1 The theoretical sociocultural assessment instrument

Given the reasons advanced in the preceding section, the development of the theoretical sociocultural assessment instrument was guided by the conceptual theoretical sociocultural communication campaign model (constructed for that purpose), the theory-driven assessment framework; and the philosophy and the structure of two Communication for Change (C-Change)'s tools - the Social and Behaviour Change Communication (SBCC) Quality Assessment Tool (C-Change 2009) and the Social and Behaviour Change Communication Capacity Assessment Tool (SBCC-CAT) (SBCC-CAT 2011).

C-Change is a USAID funded project implemented by FHI 360 and its partners: CARE; Internews; Ohio University; IDEO; Center for Media Studies, India; New Concept, India; Soul City, South Africa; Social Surveys, South Africa; and Straight Talk, Uganda. FHI 360 is a global non-profit health and development organisation with a rigorous, evidence-based approach towards improving lives in the areas of family planning, reproductive health, HIV/AIDS and malaria in lasting ways by advancing integrated, locally driven solutions (C-Change 2009; C-Change 2013; FHI 360. 2013).

6.3.1.1 *The SBCC quality assessment tool*

The SBCC Quality Assessment Tool is used to assess existing social behaviour change communication capacity and critical needs of organisations. The assessment is done through a measurement carried out across three key competency areas identified as central to social and behaviour change communication. Corresponding to these key areas are the three components of the tool: SBCC Planning and Design, Programme Implementation, and Research, Monitoring and Evaluation (C-Change 2009). Each of the three components of the tool has sub-components with their own specific questions to help with the assessment. The Planning and Design Component has the following as sub-components: Theory-driven Planning and Design; Collection and Use of Data; Negotiation and Strategic Partnership, and Development of Strategies. The sub-components of the Programme Implementation are Implementation of Communication Strategies; Strengthening of Staff Competencies, Implementation Structure for —, and Supervision of the Quality by SBCC Service Delivery. The Research, Monitoring and Evaluation have as sub-components: Frameworks and Mechanisms; Use of Research in Measure Impact and Utilising and Communicating Results.

In each of the three parts or components, there is a set of questions that the administrator asks the members of the organisation to gauge how well the organisation meets basic SBCC

quality standards. Participants are provided scores ranging from 1 to 4 in respond to each question, with 1 being "weak", 2 being "average", 3 being "good", and 4 being "strong". The average point/s for all of the questions in the section constitute a final, overall point/s for the corresponding standard, or competency (C-Change 2011:1). Figure 6.1. is a sample of part of the SBCC Quality Assessment tool.

SBCC PLANNING AND DESIGN			
1. THEORY-DRIVEN PLANNING AND DESIGN		QUESTION POINT/S	COMMENTS
Answer the questions below with a number point/s from 1 to 4 (1=weak, 2=average,3=good, 4=stong)			
QUESTIONS	1.2 Are you aware of any formal behaviour change and health communication theories such as Stages of Change, Health Belief Model, etc., and are these used in program and intervention design?	A	
	1.2 Do you analyse information on departments and dynamics of behaviour during planning and design (e.g., alcohol abuse, risk perception, stigma etc.)?	B	
OVERALL ASSESSMENT Based on answers to the questions above, calculate the overall rating. (ADD VALUES A & B THEN DIVIDE THIS SUM BY 2)	**1**WEAK SBCC theories never used to drive design. No analysis of determination and dynamics. **2**AVERAGE SBCC theories sometimes used to drive design including analysis of determinants and dynamics. **3**GOOD SBCC theories used frequently to drive design with analysis of determinants and dynamics	OVERALL ASSESSMENT POINT/S	
	4STRONG SBCC theories are always used to drive design with analysis of determination and dynamics.		

The tool assesses SBCC Planning and Design competence via four "sub-competence": using theory to plan and design programs; collecting and using data as part of planning and designing programs; forming and nurturing partnerships as part of planning and designing programs; and developing strategies to guide the planning and design of programs.

Organizations should use SBCC theory to drive the design of programs, including an analysis of behavioural determinants and dynamics. Planning models based on SBCC theories include the BEHAVE Framework, which allows planners to think through the following construct: In order to help (a specific target audience segment). To (take a specific action), We will focus on (benefits and barriers that influence the action). Another example is the "P Process," which lays out a logical framework for a communication intervention— analysis, strategic design, development and testing, implementation and monitoring, and evaluation and re-planning—and has been applied to a wide range of health issues.

Figure 6.1   Sample Part of SBCC Quality Assessment Tool (C-Change 2009:3)

6.3.1.2   The SBCC Capacity Assessment Tool (SBCC-CAT)

The Social and Behaviour Change Communication Capacity Assessment Tool (SBCC-CAT 2011) is in three versions. One version is for use with organisations to assess an organisation's programmes and staff's capacity in social behaviour change communication. A second version is for use with donors and networks to assess their own capacity and that of their partners; while a third version is for use with individuals, staff or participants to assess their capacity. The version for use with organisations, which was adapted in this study seeks to assess quality of the organisations' SBCC programmes based on five

components (SBCC-CAT 2011:4) namely, Unerstandanding the Context through Situation Analysis; Focusing and Designing the Communication Strategy; Creating Intervention and Materials for Change; Implementing and Monitoring Change Processes; and Evaluating and Replanning the Programme.

These five components have sub-components. An example of part of the SBCC-CAT is Figure 6.2.

SBCC-CAT
Component 2: Focusing and Designing the Communication Strategy

Sub-component 1: development of Strategies
A communication strategy is a comprehensive document that guides and links decisions on intended audiences, communication objectives, channels, and materials based on analysis and integrated by a strategic approach.

How does you programme design SBCC programmes?
What sort of tools or approaches do you use?

Question	1	2	3	4	Scores
2.1 Do you have a communication strategy for your SBCC programs? Necessary components of a communication strategy: • Final audience segmentation • Barriers (per audience) • Desired changes (per audience) • Communication objectives (per audience) • Strategic approach • Positioning statement • Key content • Channels (per audience), activities and materials	Programs do not have a communication strategy	Programs' communication strategy includes 2 or 3 of the necessary components	Programs' communication strategy includes 4 to 7 of the necessary components	Programs' communication strategy includes all 8 of the necessary components	☐ = 1 ☐ = 2 ☐ = 3 ☐ = 4
2.2. Do you select audiences and segment them into specific groups to tailor their programs effectively?	Programs address the general population	Programs select audiences but do not segment them into specific groups	Programs select specific audience segments but programs are often not tailored enough	Programs select specific audience segments and create tailored programs for them	☐ = 1 ☐ = 2 ☐ = 3 ☐ = 4

Figure 6.2   Sample Part of SBCC-CAT (SBCC-CAT 2011:5)

6.3.1.3   C-Change SBCC Data Analysis

As the samples of the SBCC Quality Assessment Tool and the SBCC-CAT show, numbers are assigned to selected constructs to enable the assessment. Each part of the tools have sets of questions and the answers provided by participants in the assessment process help to gauge how well an organisation assessed met basic SBCC quality and capacity standards. The participants choose their answers to each question from a score ranging from 1 to 4. The results of the assessment of the quality or capacity of an organisation through the use of these tools, is the tallying of all the overall score of the respective components and the sum total of that divided by '4'. Figure 6.3 is an example of the SBCC

Overall Assessment Score Board for entering the overall score from each section of the assessment tool.

		SECTION POINT/S	OVERALL COMMENTS AND RECOMMENDATIONS
SECTIONS	SBCC PLANNING AND DESIGN		
	PROGRAMMING IMPLEMENTATION		
	RESEARCH, MONITORING AND EVALUATION		
OVERALL ASSESSMENT	Based on the score for the sections above, calculate the overall rating ADD VALUES A+B+C THEN DIVIDE THIS SUM BY 3	OVERALL ASSESSMENT POINT/S	

Figure 6.3   SBCC Overall Assessment Point/s Board (C-Change 2009:14)

To analyse data gathered with SBCC Quality Assessment Tool and SBCC-CAT, C-Change suggests the following for qualitative analysis: thorough review of the information gathered, categorising the information gathered into groups or themes, and determining if there are any patterns in the data. For quantitative analysis if the data is not large, sometimes counting the numbers manually is all that is needed. With larger amount of data, it is recommended that a computer database or spreadsheet to be used to make analysis more accurate (C-Change C-Module5 2012). Both tools can therefore, be used qualitatively and quantitatively.

6.3.1.4   *Flexibility and Adaptability of C-Change Assessment Tools*

The SBCC Quality Assessment Tool is a flexible adaptable tool for use by a wide variety of organizations that focus on a wide variety of issues, including HIV/AIDS, malaria, family planning, and sexual and reproductive health. Moreover, users of this version are at liberty to choose to focus on particular components of the tool that address their own particular needs, or adapt each existing section. The flexibility and adaptability of the SBCC Quality Assessment Tool, it is claimed, as experience has shown also make it a useful tool for a variety of programmes and purposes other than its primary use to date to assess capacities of organisations implementing SBCC programmes related to HIV prevention (C-Change 2009). The SBCC-CAT, for the purpose of this study was considered a good complementing

tool as it highlights in details areas or components of the communication campaign process (SBCC-CAT 2011:4).

One of the first 'real world' experiences of the use of this flexible and adaptable assessment tool was in "Namibia, where C-Change staff adapted the original tool so that it could be used to assess SBCC within a variety of program areas in HIV and AIDS". It is important to note however that because "this assessment tool has not yet been used widely or formally evaluated, it currently represents a dynamic, evolving resource that will be refined as experience with it unfolds" (C-Change 2011:2). The adaptation and use of this capacity assessment tool in this study is an opportunity to contribute to its refinement.

According to the developers of the SBCC Quality Assessment Tool, programme planners of any organization who are interested in improving the design, implementation and M&E of its health and development communication programs (SBCC 2009) can, through the use of this tool, identify the strengths and weaknesses of their current program; and define activities to strengthen and refocus programmes to improve the overall quality of their efforts. It is proposed the administration of the tool may last within a 3-5 hour session and these hours could even be spread over a two-day period to allow for more reflection in the process. The number of people in the assessment process should be limited to ten and made up of staff members including managers, technical and implementation personnel. The rationale of the limit of number of people to ten is to avoid taking longer to come to a consensus on the scoring for each question as may be the case if more people are involved (SBCC 2009). The results of the administration of this tool by an organisation offer it a baseline from which to build and begin planning for improvements to the programme; and the logical next steps then are strategy sessions to determine priorities, and then the creation of a work plan for training action (SBCC 2009).

The theoretical sociocultural assessment instrument was envisaged as an assessment device and not a measuring device and that is one of the reasons why, the SBCC Quality Assessment Tool and the SBCC-CAT were adapted as the basis for the development of the theoretical sociocultural assessment instrument. Though the adapted tools are both designed as assessment tools it is necessary to note that the SBCC Quality Assessment Tool is for assessing existing social behaviour change communication capacity and critical needs. The SBCC-CAT assesses technical capacity and needs of health and development communication, while the theiretical sociocultural assessment instrument is designed to assess sociocultural variables of health communication campaigns. The flexibility and adaptability of the two C-Change tools as their designers envisaged made their adaptation in this study feasible.

6.3.2   The Parts of the theoretical sociocultural assessment instrument

As noted in the preceding sections, in the SBCC Quality Assessment Tool and the SBCC-CAT numbers are assigned to selected constructs to enable the assessment process. Each part of the two tools has sets of questions. The answers provided by participants in the assessment process help to gauge how well an organisation meets basic SBCC quality standards in the C-Change tools. The design and development of the theoretical sociocultural assessment instrument were based on the structure of the two tools. In each part of the theoretical sociocultural assessment instrument based on the two adapted tools, numbers are assigned to the possible answers a participant may choose from in answer to the questions. The numbers chosen, representing the answers of the participants help to gauge or gage not to measure in statistical terms how well sociocultural standards are being or were met in a health communication campaign. The participants involved in the assessment process choose their answers to each question from 'points' not 'scores' (as in the C-Change tools), ranging from 1 to 4. The provision of a 'scale' ranging from 1 to 4 indicates that in the C-Change tools the points scale rating was used. Using the term 'points' instead of 'scores' in this study was deliberate for the purposes of avoiding the numeric-arithmetic data obtained being confused with statistical data relating to measurement.

The variables of the attributes to which numbers are assigned in the assessment instrument of the study are the target audience, the health problem, the sociocultural context of the target audience, and the underpinning theories or models. Assigning numbers to these variables required their coding (coding being a system of numbers into which language is converted to allow meaning to be derived) of the instrument. Coding the instrument in this case meant deciding on the choice of assessment scale. In this study that is simply the gauging, grading or the placing of numbers in a hierarchical or nominal scales, which "are made up of variables with levels that are qualitatively different from one another" (Stemler & Birney 2007:1); and not as in a measurement scale, which in a typical quantitative research would be statistical as scaling is a branch of measurement that involves the construction of an instrument that associates qualitative constructs with quantitative metric units (Trochim 2007). The quantitative technique applied in this case is therefore not in statistical sense but in simple arithmetic-numeral sense. The application of scaling did not involve associating qualitative constructs with quantitative metric units but with quantitative arithmetic-numerals in gradation (not in statistical measures but in arithmetic numbers' assessment) - assigning numbers to concepts to obtain data reletive to the objectives or goals of this study.

Though scaling was not used in its statistical sense, the Likert Scaling method that comprises two basic ways of rating scales (Babbie & Mouton 2004) was adapted. The two basic ways of the Likert-type rating scaling are the odd numbered points scaling and the even numbered points scaling, which were used as a guide in the development of the sociocultural assessment instrument designed in a non-statistical even numbered points scaling on a length of 4 points. The Likert-type scale is a multiple-item scales and summated ratings that enable quantifying constructs which are not directly measurable (Gliem & Gliem 2003). Figure 6.4 illustrates the odd numbered 7 and 5 points scaling and the even numbered 4 points scaling.

Strongly Disagree (1)	Disagree (2)	Disagree Somewhat (3)	Neutral (4)	Agree Somewhat (5)	Agree (6)	Strongly Agree (7)
◯	◯	◯	◯	◯	◯	◯

Disagree (1)	Neutral (2)	Agree Somewhat (3)	Agree (4)	Somewhat Agree (5)
◯	◯	◯	◯	◯

Strongly Disagree (1)	Disagree (2)	Agree (3)	Strongly Agree (4)
◯	◯	◯	◯
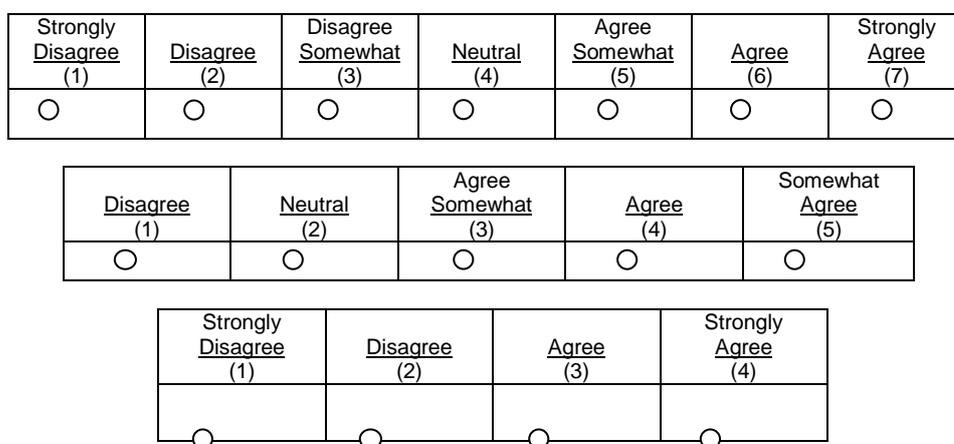
Figure 6.4   Odd Numbered 7 & 5 Points Scaling and Even Numbered 4 Points Scaling (Insight Central 2010)

The Odd numbered points scaling allows respondents to select a middle option (Taylor-Power 2008) or a neutral response (Saoro 2011) such as, 'neither agree or disagree' or 'don't care' (Gill 2009), while the even numbered points scaling does not allow for a selection of a middle option or a neutral response as it is regarded as 'forced choice' scales. In other words, the even numbered points force respondents to take sides; they either agree or disagree (Taylor-Power 2008; Gill 2009; Insight Central [sa]). That makes the choice of answers a 'forced choice' with no middle option or neutral answers. The reason for the choice of this even numbered 4 points scaling is that, the use of the instrument is meant to ascertain specifically whether the three items mentioned in the second objective of the study are/had been present in the campaign process; and if yes, on what level. Hence, the point is firstly, either they are/were present or not present. Point '1' on the scale therefore represents "no/never", which represents an answer of 'was never present, did not happen or did not take place'. That is the first determination a respondent makes. The stipulated variables are/were "not present", "did not happen" or "did not take place". There can be no middle option or neutral response to this. If they are/were present, did happen or did take place,

then comes the second determination – at what level: Point '2' - "some/sometimes" represents sometimes the variable/s "was present, did happen or did take place" but only a few times - between 1 and 3 times, which is not frequent enough. Point '3' - "most/frequently" represents 'the variable/s "was present, did happen or did take place" frequently – more than 3 times but not above 5 times. Point '4' – "yes/always" represents the presence of the variable/s "was present, did happen or did take place" more than 5 times. The codification of answers that way is to help draw out meaning from data that is generated with the theoretical sociocultural assessment instrument, for as Dey (1993) has explained, in social science meanings are informed by numbers and adequate conceptualization cannot ignore enumeration.

There is some debate among researchers about which of the two types of rating scales is more appropriate and should be used or which of the two scale types is the more effective (Gill 2009) – the odd numbered points scale ratings or the even numbered points scale rating. The point however is not or should not be which is better than the other but rather what is the reason for choosing one over the other? There are reasons a researcher might prefer an even numbered points scale over an odd numbered points scale (Insight Central 2010) and vice-versa. While some supporters of the odd numbered points scaling might argue that providing a neutral response or middle option ensures that respondents do not manufacture opinions instantaneously. Others who advocate for the even numbered scales might "argue that in reality people are never neutral on issues and always have an opinion, even if they had not previously conceived of it" (Gill 2009:1). As Taylor-Power (2008:1) puts it: "There is no preferred or better choice" therefore it could be said that the reasons for the choice one makes in choosing either the even numbered scale or the odd numbered points scale should be valid enough to justify the choice.

Following the example of the SBCC Quality Assessment Tool (C-Change 2009) and the SBCC-CAT (C-Change 2011), in the sociocultural assessment instrument, each stage of the communication campaign process has its own specific set of questions to help determine the value of the elements or activities of each component. The point/s chosen in answer to a question serves as the respondents' choice of the value they attach to the answer as indicated in Figure 6.1 (the sample part of the SBCC-CAT). Noted in Figure 6.1 is the comment that the overall assessment of each component is the calculation of the overall rating based on the answers to the questions of the component. That is achieved by adding the value of the answers to each question in the component and then dividing that by the number of the questions. The points from that calculation give the overall assessment point/s of the component. To arrive at the overall group assessment point/s for each part or

component of the theoretical sociocultural assessment instrument, the overall assessment point/s of the components are added then the points obtained divided by the total number of overall assessment points. The average point for all the questions in each particular part or component constitutes the overall point/s for the corresponding standard within that communication campaign component, which is the standard point/s. Using the numbers 1, 2, 3, and 4 to represent 'socioculturally weak', 'socioculturally average', 'socioculturally good' and 'socioculturally strong' respectfully for the standard point/s obtained, a determination can be made of the sociocultural strength or appropriateness of each stage of a communication campaign assessed through the use of the theoretical sociocultural assessment instrument. Since as stated in the objectives of the study, the assessment instrument was envisaged to have the potential to assess three things, namely, involvement or non-involvement of target audience in the communication campaign process; taking cognisance of or ignoring elements of the sociocultural context; and whether theory underpinned the campaign process. The sociocultural strength of a campaign is dependent on the presence or absence of those three things. To arrive at the sociocultural strength or appropriateness of a communication campaign as a whole, the standard points for the four stages are added and the total divided by 4, the number of stages. The following is the presentation and discussion of four stages of the sociocultural assessment instrument.

6.3.2.1   *Stage 1: Strategic planning and development*

"Stage 1" in the theoretical sociocultural assessment instrument deals with the strategic planning and development component of health communication campaigns. A first set of questions of this stage are about the elements of the Target Audience (through its representatives) and the Communication Campaign Planners as illustrated in Appendix 1a. A second set of questions relate to the Health Problem and the Health Behaviour of the Target Audience (confer Appendix 1b). The third set of questions are in relation to the Objective/s of the Health Communication Campaign (confer Appendix 1c); and the fourth set of questions relates to Theory-Driven Planning and Strategy Development (confer Appendix 1d).

As Figure 4.4, which is an illustration of the proposed theory-driven conceptual framework for the theoretical sociocultural assessment instrument depicts, the grey shaded background represents the sociocultural context. This context is a component of both the action model and the change model and thus affects the whole communication campaign process. Hence all the elements of Appendixes 1a (Campaign Planners and the Target Audience), 1b (Health Problem and Health Behaviour of the Target Audience) and 1c (Objectives) are

within a specific sociocultural context and form one unit – a sub-system of the health communication campaign process. The position of the Representatives of the Target Audiences in Figure 4.4 and how they are linked to the Communication Campaign Planners with arrows depicts partnership between the two. The connection of the two to the Health Problem and Health Behaviour of the Target Audience and the Objectives highlights the prominence of the Target Audience. The questions in "Stage 1" of the theoretical sociocultural assessment instrument thus seek to determine: whether and to what extent the Representatives of the Target Audience is/was engaged as active participants in the strategic planning and development component of the communication campaign process; whether the elements of the sociocultural context of the target audience are/were taken into consideration; and whether appropriate and relevant theories/models underpinned the components of this unit of the communication campaign process?

Following the procedure of calculating the point/s of the C-Change Assessment tool adapted in the study. To determine the sociocultural standard of the strategic planning and development stage, the average point/s for each set of questions are added then divided by the number of sets of questions to give the overall standard point/s and these are to be recorded as part of Stage 1 in a Point/s board as illustrated in Figure 6.5

STANDARD	POINT/S
Relationship/interaction between Communication Campaign Planners and Representatives of the Target Audience	A
Health Problem and Health Behaviour of the Target Audience	B
Objective/s of the Health Communication Campaign	C
Theory-Driven Planning and Design	D
Add values A+B+C+D and divide this by 4. Enter the number in the box to the right	**OVERALL STANDARD SOCRE FOR STAGE 1: PLANNING AND STRATEGY DEVELOPMENT**

Figure 6.5   Points board for the overall standard point/s for Stage 1: Strategic Planning Development

6.3.2.2 Stage 2: Developing and pre-testing concepts, messages and materials

The focus of the second stage in a communication campaign process, identified in this study as "Stage 2", is designing the campaign – that is, developing and pre-testing concepts, messages and materials. At this stage, effort is made or should be made to ensure that the campaign concepts, messages and materials are appropriate not only for creating awareness or to increase knowledge but also and more importantly to move the target audience towards behaviour change. The concepts and message/s of the campaign therefore ought to be such that the target audience clearly and easily understand them. The concepts and messages should also be in such a manner as to evoke deep emotions in the target audience to generate sincere desire in them for a different and possibly better future when the health problem, which is assumed to be the result of their health behaviour, would be eradicated or minimised/reduced. Additionally, the choice of channels and modes for delivering the concepts and messages should be worked out in such a manner as to be appropriate for the context of the target audience. The set of questions in "Stage 2" of the sociocultural assessment instrument (confer Appendixes 2a, 2b, 2c and 2d) relate to the choice of concepts and the manner of developing and packaging of the messages; the choice of the communication channels and the mode of communicating the message.

The questions of "Stage 2" as they are conveyed in this part of the assessment instrument seek to determine whether the concepts used are socioculturally appropriate and relevant and whether the manner of packaging the messages is socioculturally appropriate. For the choice of concepts and the manner of developing and packaging the messages to be appropriate and relevant, it is assumed that the target audience would have been actively involved through their representatives in the discussion/s and related activities on and for the choice of concepts and the development and packaging of the messages. Some of the questions also probe to find out whether the choice of communication channels and the mode of communicating are/were socioculturally appropriate, and whether or not the representatives of the target audience are/were involved in any way in their being chosen. Since this stage of the communication process, like that of the previous stage ought to be theory-driven, there are questions in this portion of the assessment instrument that seek to find that out.

To determine the standard of developing and pre-testing concepts, messages and materials in a similar manner as is done in the first part of the assessment process, the average points for each set of questions of this part of the assessment instrument are added up. The total

points arrived at in the addition is divided by the number of sets of questions to give the overall point/s and recorded in the overall points board as exemplified in Figure 6.6.

STANDARD	POINT/S
Communication Campaign Message/s & Materials' Development	A
Choice of Communication Campaign Channels	B
Involvement of Target Audience in Message Delivery	C
Theory-Driven Development and Pre-testing of Concepts, Messages and Materials	D
Add values A+B+C+D and divide this by 4. Enter the number in the box to the right	**OVERALL STANDARD SOCRE FOR STAGE 2: DEVELOPING & PRE-TESTING CONCEPTS, MESSAGES & MATERIALS**

Figure 6.6   Points board for the Overall Standard point/s for Stage 2

6.3.2.3   Stage 3: Programme implementation

It could be said that the first two stages of the communication campaign process lays the foundation for the third stage, which is the implementation component. In the case of a health communication campaign, in the first stage the health problem in relation to the health behaviour is identified, discussed and analysed. The identification, discussion and analysis of the health problem and health behaviour lead to the planning and developing strategy/strategies as to how to eradicate or minimise the effect of the problem. Part of the strategy is to set objectives as to how to go about tackling the problem. This is followed by developing concepts, messages and materials for use to inform and motivate the target audience towards changing negative behaviours, which have created the health problem. Once the above have been done, the campaign programme is ready for implementation. Creative implementation is the intervention activity or activities. The creative implementation stage of the communication campaign process thus relates specifically to the 'what' and 'how' of the intervention process – 'what is done' and 'how what is done is done' to inform and motivate the target audience towards behaviour change. What is done in the implementation stage is or should be geared towards achieving the objective/s set in the first stage. The assessment process of this component of the communication campaign thus seeks to determine if the activities of the implementation stage are/were in line with the objectives set. The set of questions in "Stage 3" of the assessment instrument as presented

in Appendixes 3a and 3b seek to determine whether the target audience are/were involved in carrying out some of these activities. Also to be ascertained is whether the manner in which the activities are/were carried out was socioculturally significant and relevant; and whether any theories/models underpinned these activities; and the manner in which they are/were carried out.

As is done for the assessment of the first and second stages, to determine the standard of programme implementation the average point/s to the questions of each set of "Stage 3" of the assessment instrument are added, and the total divided by the number of sets of questions to give the overall point/s. The overall point/s for this stage is calculated by entering the average point/s from the boxes on the pages of the set of questions as shown in overall points' board, Figure 6.7

STANDARD	POINT/S
The Nature and Dynamics of the Campaign Implementation	A
Theory-Driven Monitoring and Evaluation	B
Add values A+B and divide this by 2. Enter the number in the box to the right	**OVERALL STANDARD SOCRE FOR STAGE 3: CAMPAIGN IMPLEMENTAION**

Figure 6.7   Points Board for Overall Standard Point/s for Stage 3

6.3.2.4   Stage 4: Continuous programme monitoring and evaluation

As earlier explained monitoring and evaluation in a campaign process do not or should not take place only at the end of the whole process. Rather they can and should be part of all the stages of the communication campaign process in order to identify any gaps that need attention to ensure the achievement of stated objectives of the campaign hence the designation of Stage 4 as Continuous Programme monitoring and Evaluation. This makes assessment an ongoing and continuous process in the life span of a communication campaign. In light of that the set of questions in "Stage 4" of the theoretical sociocultural assessment instrument relating to monitoring and evaluation of a health communication campaign is developed in such a manner as to be applicable to each component of the campaign process individually and all of them severally as shown Appendixes 4a and 4b.

As is done for the assessment of the first, second and third stages to determine the standard the average point/s, the questions of each set of "Stage 4" of the theoretical sociocultural assessment instrument are added, and the total divided by the number of sets of questions to give the overall point/s. The overall point/s for this stage is calculated by entering the average point/s from the boxes on pages of the set questions as shown in overall point/s board, Figure 6.8

STANDARD	POINT/S
The Nature and Dynamics of Monitoring and Evaluation	A
Theory-Driven Monitoring and Evaluation	B
Add values A+B and divide this by 2. Enter the number in the box to the right	**OVERALL STANDARD SOCRE FOR STAGE 3: MONITORING AND EVALUATION**

Figure 6.8   Points board for the Overall Standard Point/s for Stage 4: Monitoring and Evaluation

The questions on the theoretical sociocultural assessment instrument were framed in such a manner as to solicit answers that help describe what happened and how/why what happened, happened in the whole campaign process from Stage 1 to Stage 4. Being essentially a qualitative assessment instrument administered in an interactive group session, the data gathered with the instrument are also essentially qualitative in nature dealing with meanings through conceptualisation, which are given numerical value.

6.4 PROCESS OF ADMINISTERING THE THEORETICAL SOCIOCULTURAL ASSESSMENT INSTRUMENT IN AN INTERACTIVE GROUP SESSION

As explained above the theoretical sociocultural assessment instrument is to be administered by a facilitator (not a member of the group) to a mixed group of communication campaign planners. This group may include management, technical and implementation staff - for example, project directors and programme managers. The facilitator ought to be familiar with the instrument and know how to administer it. The administration of the instrument could take place in a session of about two to three hours or more. Alternatively, parts of it could be spread over a number of days depending on the particular situation of each group and/or availability of time. What is important is to ensure that the allotted time is

long enough to allow for each question to be reflected upon and answered by individual members of the group followed by group discussion of their answers leading to consensus on a group point/s for each question. Preferably, the group should be limited to between 10 but not more than 15 people. The following steps are to be followed.

Step 1: The group together with the facilitator assemble at a convenient location. The facilitator gives a brief introduction on the purpose of the assessment, which is to assist the campaign planners and/or the organisation or institution that has some stake in the health communication campaign to identify strengths and weaknesses from a sociocultural perspective. He stresses in the introduction that the assessment is not intended as a criticism of the current or completed campaign but rather as a participatory method that can assist the planners and the organisation or institution to discuss the sociocultural standards and identify gaps (if any) that need attention and areas for strengthening.

Step 2: The facilitator explains his need to understand the campaign by inviting the leader of the group to describe briefly the structure and process of the campaign being assessed. Either the facilitator or the leader notes the key points of the description on a flip chart or newsprint.

Step 3: The facilitator reviews the variables to be assessed with the group and explains the assessment process. The group is allowed to ask questions or seek clarification on the process of the assessment.

Step 4: Once the group has indicated that it understands the process, the facilitator takes them through each of the Four Stages of the communication campaign process. He poses each question and allows sufficient time for personal reflection and answering the question. When each participant has answered the questions in each Stage, the facilitator leads the group in discussion to arrive at a consensus on the 'group point/s' to be assigned to each question. This is done for all the Four Stages.

6.5 ISSUES OF RELIABILITY AND VALIDITY IN THE USE OF THE SOCIOCULTURAL ASSESSMENT INSTRUMENT

The sociocultural assessment instrument may be used as a qualitative, quantitative or mixed methods research instrument. As explained it is meant to be administered as an interactive group administered questionnaire. That requires the members of the group to answer the questionnaire individually then discuss their answers and agree on group points, and the results analysed and interpreted. This raises the issue of reliability and validity – in other

words, should reliability and validity be ascertained in the use of the instrument, if yes, how? As McDermott (2009) has noted, in the design and interpretation of research results, researchers concern themselves with the concepts validity and reliability. The reason for this concern of researchers, McDemott (2009) explains is that researchers draw conclusions based on their research findings, and these require some certainty as to the correctness of their measuring the phenomena. Validity relates to the need to demonstrate how accurately a research instrument measures what it is supposed to measure and reliability pertains to establishing if there is consistency in the measuring. In the words of Tavakol and Dennick (2011:1) validity "is concerned with the extent to which an instrument measures what it is intended to measure" and reliability is "concerned with the ability of an instrument to measure consistently". Though the two concepts are important in both qualitative and quantitative research, it is worthwhile noting that quantitative studies are frequently based upon standardised instruments that are administered to randomly selected sample population hence issues of validity and reliability can be assessed in a relatively forthright manner, while in contrast, qualitative studies are usually not based upon standardised instruments and often utilise smaller, non-random samples and that make assessing the accuracy of qualitative findings less straightforward (Qualitative Research Assessment Tool [sa]). Due to that difference between qualitative and quantitative research there has arisen debate among qualitative and quantitative researchers as to whether qualitative research meets the scientific rigors of research and/or whether qualitative researchers should even concern themselves with the concepts validity and reliability. Some quantitative researchers have gone as far as charging that "there is no way to establish the validity or truth value of scientific claims or observations in qualitative work" and based on such a charge "considerations of qualitative research prompt thought of relativism and loosely established truths" (Merrick 1999:25).

Such criticisms had led some qualitative scholars in the 1980s to reject the concepts reliability and validity and such a rejection resulted in a "shift for "ensuring rigor" from the investigator's actions during the course of the research, to the reader or consumer of qualitative inquiry" (Morse, Barrett, Mayan, M., Olson & Spiers 2002:1). Other qualitative researchers while not rejecting the value of the two concepts were rather of the view that the manner of application of the concepts in quantitative research could not be applied in exactly the same manner in qualitative research. Hence in an attempt to avoid confusion in the use of the concepts in qualitative research, these qualitative researchers proposed and/or chose to substitute the concepts with parallel concepts such as "trustfulness" and "authenticity criteria" (Morse et al. 2002). The ongoing debate on validity and reliability in qualitative research is acknowledged in this research. The application or non-application of the two

concepts in a qualitative research that uses the theoretical sociocultural instrument and the justification of application or non-application is the responsibility of the researcher. In the case of the testing of the instrument in this study however, the following is noted.

The instrument was developed as a qualitative-quantitative instrument. Its quantitative characteristic is non-statistical numeric/arithmetic and it is not intended for a sampling variability of a statistic as it would be for example in the case of a percentage in which case it would be "reliable if it does not vary by any non-negligible amount from one sample to another of the same size and are drawn in the same manner from the same population" (Knapp 2008). As discussed earlier the framework of the study did not seek to confirm any hypothesis nor to find any universal rule as the sample was purposive with no intention to approximate its characteristics with a population for which inferences could be made.

The sociocultural instrument was developed as an *assessment* and not a *measuring* instrument. In Chapter 2, it was argued that assessment is a process involving obtaining data or information relative to some known objective or goal, and it entails inferences and estimating the worth of 'something'. Assessment in the study is different from measurement, which as explained in Chapter 5 may be used to assess established standards and the quantities derived from them in an accurate and reproducible manner using ready-made and generally acceptable measuring instruments. Measurement therefore can be understood simply as the performance of an operation on data in order to prepare them for statistical analysis (Stemier & Birney 2007). Sullivan (2009) points out that reliability relates to the ability of a measure to produce consistent test scores; a study thus is considered by quantitative researchers as reliable if its results can be replicated (Smith 2004), and reliability is a requirement for any measurement (Juni 2007); while there is no such expectation of replication in qualitative research (Simon 2011) nor is reliability as understood and applied in quantitative studies, a requirement for assessment as it is understood in this study.

The purposive sample chosen for the study as explained above was a unit of ten persons. The results of the test of this sample which was not meant for replication in the quantitative sense was also too small for any attempt of subjecting the results to reliability test according to quantitative rules. For as Guo, Pohl and Gerokospoulos (2013) point out for statistical test if the sample size is too small, not much information can be obtained from the test; and that limits one's ability to draw any meaningful statistical conclusions. Since too small a sample run the risk of failing to find a real statistical effect because of inadequate statistical power (Acheson 2010) reliability as understood and applied in quantitative research was not considered applicable in this study.

6.6   CONCLUSION

The focus of this chapter was the discussion of the methodological approach and the development of the theoretical sociocultural assessment instrument for health communication campaigns, which was the second objective of the study. The process of the development of the instrument began by highlighting the three things the instrument is meant to be used for. The first objective of the study – the construction of the conceptual theoretical sociocultural health communication campaign model plus the theory-driven sociocultural assessment framework meant to guide the development of the instrument were also brought into focus. Two tools of the Communication for Change – the SBCC Quality Assessment tool and the SBCC-CAT, which were adapted to serve as additional guide and basis for the development of the sociocultural assessment instrument were also presented and discussed. That discussion led to the actual work of developing the theoretical sociocultural assessment instrument. Each of the four parts of the instrument based on the philosophy and structural framework of the two tools of C-Change were worked on and explained. Numbers that were attached to constructs to provide answers to the questions were modelled on the Likert even-numbered '4' points scale as explained. Having developed and explained the theoretical sociocultural assessment instrument, the process of administering it was explained. With the development of the theoretical sociocultural assessment instrument the second objective of the study was achieved; leaving the third of the three objectives to be achieved. That leaves the third objective – testing the theoretical sociocultural assessment instrument in a health communication campaign, to be attended to, and that forms the discussion of next chapter.

CHAPTER 7   TESTING THE THEORETICAL SOCIOCULTURAL ASSESSMENT INSTRUMENT, THE RESULTS AND THE FINDINGS

7.1   INTRODUCTION

As the second objective of the study – developing a sociocultural assessment instrument was achieved the task left was to test the instrument in the purposive sampled HIV/AIDS communication campaign of the Ekurhuleni Municipality Health Department's HIV/AIDS Unit to achieve the third and final objective of the study. The steps taken in testing the instrument, the test results and their analysis and findings are presented in this chapter. It had been explained that the instrument could be used either as a qualitative or quantitative research instrument. Its use in this study was qualitative since it was developed as part of the study and used for the first time in the study and thus no claim of standardisation; and the sample utilised in the test was small and non-random.

7.2   TESTING THE INSTRUMENT

The following were the steps taken to test the instrument.

Step 1: The researcher submitted a written request to the Ekurhuleni Metropolitan Municipality's Health Department – that is, the Municipality's organ responsible for the HIV/AIDS Unit, to research the Unit's HIV/AIDS communication campaign by testing a theoretical sociocultural assessment instrument developed. Included in the request was an explanation of the nature of the research and how the theoretical sociocultural assessment instrument could serve as a useful assessment instrument for the Unit's HIV/AIDS health communication campaign assessments.

Step 2: Acceptance of the request and the granting of permission for the test through the issuing of a certificate for research by the Chief Executive Officer of the Health Department to the researcher.

Step 3: The researcher arranging to meet the Executive Manager and Manager of the HIV/AIDS Unit, to explain and discuss the nature and process of the research and set a suitable date for administering the instrument.

Step 4: The researcher meeting the ten members of the Ekurhuleni Municipality Health's HIV/AIDS Unit made up of the executive manager plus nine planners and implementers (all

with the designation of AIDS Coordinator and having responsibility of particular sectors – confer Appendix 2) of the Municipality's health communication campaigns Unit on the agreed date at the Municipality's Swartkoppies Offices, Alberton.

Step 5: Administering of the questionnaire to the group of ten people in the following manner.

The manager of the HIV/AIDS Unit, one of the team members present who had previously informed and briefed his team about the permission granted by the Chief Executive Officer of the Health Department for the research to be conducted welcomed the researcher and briefly explained the reason for his presence among them. In his explanation, the manager pointed out the probable value of the findings of the research for the work of the Unit. The researcher then gave a brief background to the study, explained the nature of the instrument and the process to be used in administering it. He stressed that the assessment was not intended to find fault with or criticise the HIV/AIDS communication campaign being carried out by the Unit but to test the campaign against the sociocultural standards proposed in the instrument and to provide an opportunity to identify sociocultural gaps, if any, in the campaign process.

After explaining the process of administering the instrument, the researcher handed each of the ten participants, copies of the Theoretical Sociocultural Assessment Instrument for Health Communication Campaigns (confer Appendix 1).

Once each of the ten members of the HIV/AIDS Unit's team had received copies of the instrument, the researcher proceeded to instruct them to individually study, reflect on and answer the two questions under Q.1.1 of Stage 1: Planning and Developing Strategy (confer Appendix 1). They were to follow the instructions indicated on the instrument by assigning a point of 1 to 4 according to their judgement. They were given time for each participant to complete the above exercise.

When each participant had complied with the instruction given above the researcher invited each member to share his/her answer to Question 1.1.1.1. The point given by each to the question was noted by the researcher in the column of a table prepared for the purpose (confer Appendix 3). A discussion then followed to arrive at a consensus on a "group point" that was considered the realistic point to be assigned as answer of the group to the question. This was recorded on a copy of the instrument by the researcher (confer Appendix 4).

After arriving at a consensus on a "group point/s" for Question 1.1.1, the participants also discussed and agreed on the group answer to the sub-question (confer Appendix 4).

Following the process above the participants discussed their individual point to Q1.1.1.2 and arrived at a group point (confer Appendix 4).

Having entered the two points for Q1.1.1.1 and Q1.1.1.2, the researcher, together with the participants, following instructions on the research instrument added the two points and divided the sum total by 2 to get the overall assessment point for the questions on Relationship/Interaction between Communication Campaign Planners and Representatives of the Target Audience. This point was entered in the box provided for in the instrument (confer Appendix 4).

The process explained above was used in answering all the questions under Stage 1 and all the questions in Stages 2 – 4 (confer Appendix 4). That is, first individually studying and reflecting on a question. Second, answering the question. Third sharing the individual points recorded. Once each set of questions had been answered, participants shared their individual answers in the group followed by discussing the answers to arrive at a consensus on a "group point" for the question and recording that. Answers to sub-questions were also first shared individually followed by discussion to arrive at a consensus of a group answer to the sub-questions.

7.3   RESULTS AND FINDINGS

The testing of the theoretical sociocultural assessment instrument in the Ekurhuleni Municipality Health Department's HIV/AIDS Unit yielded numerical – ordinal data, and text data (confer Appendix 3 and 4). For each stage in the communication campaign process, the answers of each of the ten participants are presented in a table followed by a presentation of the results of the group answers to each set of questions and an analysis in a simple table. After presentation of results of the group answers to all the sets of questions in a stage in the communication campaign process, a table of the overall points for the particular stage are also presented in a table and briefly discussed.

7.3.1   Stage 1: Planning and Developing Strategy

Stage 1 of the questionnaire contains four set of questions (Q1.1.1.1 – Q1.1.4.3) of a total of eleven questions which each participant answered individually.

7.3.1.1 Analysis of individual's answers to questions of Stage 1

Table 7.1 presents the answers of each participant to the eleven questions. That is followed by a brief analysis of how they answered the questions.

Questions	Participants' Individual Answers to Stage 1 Questions									
	P1	**P2**	**P3**	**P4**	**P5**	**P6**	**P7**	**P8**	**P9**	**P10**
Q1.1.1.1	4	4	4	4	4	3	4	4	4	4
Q1.1.1.2	4	3	4	4	4	3	3	4	4	4
Q1.1.2.1	3	3	3	3	4	3	3	3	3	4
Q1.1.2.2	3	4	3	3	4	3	3	4	3	4
Q1.1.2.3	3	3	4	4	3	3	3	3	3	3
Q1.1.2.4	2	2	2	2	3	3	2	2	3	2
Q1.1.3.1	3	3	2	4	3	3	4	3	3	4
Q1.1.3.2	4	3	3	3	4	3	2	3	4	3
Q1.1.4.1	2	2	3	2	2	2	3	2	2	2
Q1.1.4.2	3	2	2	2	2	2	2	2	3	2
Q1.1.4.3	3	2	3	2	2	2	2	2	2	2

Table 7.1   Individual participants' answers to questions of Stage 1: Planning and Strategy Development

Q1.1.1.1 – Relationship/Interaction between communication campaign planners and target

The answer of each participant – all members of the Ekurhuleni Municipality Health Department HIV/AIDS Unit, to Q1.1.1.1 about the relationship/interaction between them and the target audience was 4 Points. This point stands for 'yes/always', an affirmation by all the participants who took part in the group administered interactive questionnaire that in the Unit's communication campaign there were more than 5 times relationship/interaction.

In answer to the sub-question of Q1.1.1.1 which was on the nature of the interaction and purpose of the relationship/interaction. The participants who had all acknowledged in the main question that there was relationship/interaction also agreed that the interaction occurred in their operational area when they were creating awareness and engaged in education on the HIV/AIDS; interacting to do analysis and agree on the intervention and policies.

Q1.1.1.2 – Relationship of Partnership

On whether the participants regarded the target audience they interacted with as partners who would make valuable contribution to the campaign process, seven of them answered

with point '4' each and the remaining three participants answered with point '3'. That indicates that according to the majority of the group there was strong partnership while for the minority the partnership was good.

Q1.1.2.1 – Identification of the Health Problem

According to the individual answers to Q1.1.2.1 which asked whether there was discussion and consultation between the campaign planners and the target audience, eight of the participants were of the view that discussion and consultation on that issue took place frequently as they answered the question with '3' points each. The two remaining participants were of the view that discussion/consultation took place took place more than frequently. Their answers were '4' points - "yes/always".

Q1.1.2.2 – Target Audience Perception of the Health Problem

Question 1.1.2.2 sought to find out if the campaign planners consulted and discussed with the target audience its perception about the health problem that necessitated the communication campaign in the hope that such perception would be taken into consideration in the campaign process. According to the individual answers given by the participants, six of them were of the view that there were such consultation and discussion frequently. They answered the question with '3' points each. The remaining four participants answered with '4' points each, indicating that the consultation/discussion took place more than frequently.

Q1.1.2.3 – Cultural/Traditional Beliefs and Taboos Associated with the Health Problem and Health Behaviour

On whether the campaign planners got to know and took into consideration in the campaign process, the target audience's cultural/traditional beliefs and taboos they held about the health problem and their health behaviour, eight participants answered with '3' points each and two with '4 points each'. That indicates that they were all agreed that there was such consultation - eight of them being of the view that the consultation/discussion were on frequent basis while for the remaining two participants the consultation/discussion took place more than frequently.

Question 1.1.2.3 had a sub-question aimed at finding out if there was such a consultation/discuss; what types of cultural/traditional beliefs, taboo, etcetera were discussed. As the answers of the participants to the main question were acknowledgement that the consultation/discussion took place they named the following belief/taboos: Witchcraft and bewitching, multiple and concurrent partners, gender stereotyping.

Q1.1.2.4 – Appropriate and Acceptable Communicator of Health Problem and Health Behaviour in the Sociocultural Context

Seven participants in answer to the question whether there was consultation/discussion with the target audience on who within their sociocultural context was more appropriate and acceptable to talk about issues relating to the health problem and the health behaviour in question, they were of the opinion that the consultation/discussion on those issues took place sometimes as they answered with '2' points each. The remaining three participants answered with '3' points which stood for "most/frequently". This indicates that all ten participants agreed that there were such consultation/discussion but when it came to how often the majority (seven out of ten) were of the opinion that they happened sometimes and the minority (three out of ten) were of the view that they happened more than frequently.

Q1.1.3.1 – Setting Objectives of Health Communication Campaign

The question of Q1.1.3.1 sought to ascertain if in setting objectives of the health communication campaign, the campaign planners consulted and held discussion with the target audience to ensure that the latter contributed to the process of setting the objectives of the communication campaign. Three participants answered with '4' point each; indicating that in their view there was such consultation/discussion on a high level. Six participants also agreed that there were consultations/discussion on the objectives of the communication campaign but for them such consultation/discussion was not on more than frequent basis, rather on frequent basis as they answered with '3' points each. The remaining participant while also of the view that consultation/discussion took place, thought that only happened sometimes thus not frequent enough – answered with '2' points – "some/sometimes".

Q1.1.3.2 – Investigating Relevance of Objectives in Relation to Sociocultural Context

All the ten participants had responded to the previous question by acknowledging that they (the communication campaign planners) had consulted and discussed with the target audience on setting objectives of the campaign. In this question (Q1.1.3.2) what was at stake was to find out if the campaign planners in consulting/discussing the objectives of the campaign with the target audience, also talked about or investigated the relevance of those objectives in relation to the sociocultural context of the campaign. All ten participants were in agreement that such consultation/discussion did take place. However when it came to the level or intensity, they did not agree. Four of them answered with point '4' – "yes/always". Six participants answered with point '3' – "most/frequently" and one participant answered with point '2' – "some/sometimes".

None of the ten participants answered the sub-question of Q1.1.3.1, which sought to know what the relevance was and what concrete suggestions the target audience made in relation to that. The non-response to the sub-question raises a question as to whether the question was not understood or difficult to answer.

Q1.1.4.1 – Need of Understanding Health Problem from Perspective of Theory/Model

This question wanted to know if the communication campaign planners explained to and discussed with the target audience why it was necessary for them to understand the necessity of the health problem to be based on appropriate theory or model; and if yes, what theory of model was used.

The answers of all the participants indicated that they agreed the explanation/discussion took place since none of them answered with point '1' – "no/never". Eight of them, forming the majority answered with point '2' – "some/sometimes". The remaining two participants answered with point '3' – "most/frequently". In answer to the sub-question, they mentioned HIV Consulting and Testing (HCT), Prevention of Mother-to-Child Transmission (PMTCT). Note: The question was about theory/model but what they gave as theories do not meet the criteria for what makes a theory or model as understood in this study.

Q1.1.4.2 - Need of Understanding Health Behaviour from Perspective of Theory/Model

Q1.1.4.2 was about understanding health behaviour from the perspective of theory/model. To this question eight of the participants answered with '2' point each indicating that in their view there were discussion/explanation "some/sometimes". The remaining two participants answered with '3' points each - "most/frequent". That indicates that while all the ten participants agreed that discussion/explanation about the issue under consideration had taken place, for the majority the discussion/explanation only took place sometimes while for the remaining two participants the discussion/explanation took place sometimes.

Q1.1.4.3 – Influence of Theory/Model on Objectives of the Health Communication Campaign

As the two preceding questions were on theory/model that underpinned health problem and health behaviour, the present question was geared to find out if the campaign planners discussed with and explained to the target audience how the identified or chosen theory/model influenced the setting of objectives of the communication campaign. Eight of the participants answered the question with '2' points each indicating that in their view there was discussion/explanation "some/sometimes". The remaining two participants answered

with '3' point each indicating that in their view the discussion/explanation took place frequently.

7.3.1.2   Analysis of group answers to questions of Stage 1

After the ten participants who took part in the group administered interactive questionnaire had answered the questions individually, they shared their answered in a group discussion and then agreed on a group answer to each question. The group answers to the eleven questions under Stage 1 are presented and analysed below.

- Relationship/interaction between communication campaign planners and representatives of the target audience

The group points assigned to questions Q1.1.1.1 and Q1.1.1.2 was '4' each (confer Appendix 4). While in their individual answers Q1.1.1.1 had a unanimous '4' points and seven participants gave Q1.1.1.2, '4' points each and the rest three participants gave '3' points each. When it came to group answers for those two questions; after the participants shared their individual answers and discussed the difference in their answer to question Q1.1.1.2; those who answered with point '4' explaining and giving reasons why they gave that point and those who had answered with point '3' also having had the opportunity to explain and give their reasons for their choice of answer, the group came to an agreement that as a group their answer was '4 points'. For both questions then the group answers were point '4' each.

In discussing as a group the sub-question of Q1.1.1.1, which was meant to validate the point/s assigned to the main question the participants agreed that they (as the communication campaign planners) were familiar with the operational area of the campaign. They had meetings with members of the population to engage them in analysis of the problem, agreeing on the nature and process of intervention. The former also had consultations with the latter on national and provincial governments' policies relating to HIV/AIDS. Table 7.2 presents the results for this set of questions.

Q1.1 Relationship/Interaction between Communication Campaign Planners and Representatives of the Target Audience			
Questions	Q1.1.1.1	Q1.1.1.2	Overall Group Assessment Point/s of Q1.1
Observed point/s	4	4	4+4÷2 = 4

Table 7.2   **Test result of questions on relationship between communication campaign planners and representatives of the target audience**

To arrive at the overall group assessment point of the answers to the two questions, the two points of '4' point each were tallied to get '8' points. The '8' points was divided by 2 (representing the number of questions in that set of questions). Dividing 8 by 2 gave an overall group assessment point of '4' points for the relationship/interaction and a sense of partnership between the campaign planners and target audience during the communication campaign process in the first stage of planning and developing strategy.

- Health problem and health behaviour of the target audience

For the second set of questions (Q1.2) of Stage 1, the group assessment points for Q1.1.2.1, Q1.1.2.2 and Q1.1.2.3 were '3' point each (confer Appendix 4). The fourth question Q1.1.2.4 was '2' points. The numerical point of '3' points each to questions Q1.1.2.1, Q1.1.2.2 and Q1.1.2.3 in words were "most/frequently" each, while the numerical points of point '2' for question Q1.1.2.4 in words was "some/sometimes". To get the overall group assessment points for the set of questions, the points of answers to each question were tallied (3+3+3+2) to get a total of 11 points. The total points were divided by the number of questions (4 questions) in the set to get the overall group assessment point of 2.75 points (confer Appendix 4) as shown in Table 7.3.

Q1.2 Health Problem and Health Behaviour of the Target Audience				
Questions	Q1.1.2.1	Q1.1.2.2	Q1.1.2.3	Q1.1.2.4	Overall Group Assessment Point/s of Q1.2
Observed point/s	3	3	3	2	3+3+3+2÷4 = 2.75

Table 7.3   **Test result of questions on health problem and health behaviour of the target audience**

The overall group assessment point of 2.75 indicates that according to the participants in the group administered interactive questionnaire, the consultation/discussion with the target audience on issues of health problem and health behaviour fell on the level/intensity of "some/sometimes". An indication that as a group the campaign planners sometimes gave

the target audience the chance to share their perception of the health problem and articulate what cultural beliefs and taboos they associated with the health problem. Given that the identification of HIV/AIDS as a health problem had been done on the national level and is no longer considered something new, it seems understandable that the consultation on the health problem by the group was only done sometimes. Moreover, since the campaign planners carry out national government policies and directives, there was no need for frequent or always consulting the target audience about their perceptions of the health problem or their cultural beliefs and taboos. For as the answer to the sub-question, Q1.1.2.3 (confer Appendix 4) indicates having some idea about cultural/traditional beliefs and taboos (such as bewitching, cultural attitude and practices of male domination – gender stereotyping) associated with HIV/AIDS was helpful to the campaign planners as to what and how to design some to the campaign messages for better effect. It is worthwhile to note that, the behaviour of having multiple and concurrent partners, which is not necessarily a cultural/traditional practice, was also mentioned in the answer to the sub-question of Q1.1.2.3.

Q1.1.2.4 got '2' points, which unlike answers to Q1.1.2.1, Q1.1.2.2 and Q1.1.2.3 that yielded group '3' points. That is indicative of the fact that 'who' 'when' and 'how' someone communicates or talks about the health problem in question had somehow been decided on in the policies and directives of the national and provincial governments hence there was no need to consult on that on a frequent or more than frequent basis.

- Objective/s of health communication campaign

The overall group assessment point of '3' points as shown in Table 7.4 indicates that the communication campaign planners as a group frequently consulted and discussed with the target audience on the objective/s of the campaign.

Q1.3 Objectives of the Health Communication Campaign			
Questions	Q1.1.3.1	Q1.1.3.2	Overall Group Assessment Point/s of Q1.3
Observed point/s	3	3	3+3÷2 = 3

Table 7.4   Test result of questions on objectives of the health communication campaign

The overall group assessment point of Question 1.3 ('3' points) links up with the overall group assessment point of Question 1.2 ('2.75' points) in the sense that while the identification of what could be said to be the general health problem had been done on the

national level, that is, the national government had identified the problem and issued policy and directives. There were still elements or aspects of the problem that needed identification and discussion on the local level (the operational area of the campaign). As such there was frequent (point/s of 3 points respectively for questions 1.1.2.1, 1.2.2 and 1.1.2.3) consultation and discussion on the health problem, the target audience's perception (of the problem) and their cultural/traditional beliefs and taboos, associated with the problem.

- Theory-driven planning and strategy development

Q1.4 comprised four questions – Q1.1.4.1, Q1.1.4.2, Q1.1.4.3 and Q1.1.4.4. Each question got group assessment '2' points answers. The tally of the four questions of '2' points each gave a total of 8 points. The 8 points divided by the number of questions (4) in the set gave the overall group assessment point of 2 points (confer Appendix 4) as show in Table 7.5.

Q1.4 Theory-Driven Planning and Strategy Development					
Questions	Q1.1.4.1	Q1.1.4.2	Q1.1.4.3	Q1.1.4.4	Overall Group Assessment Point/s of Q1.4
Observed point/s	2	2	2	2	2+2+2+2÷4 = 2

Table 7.5   Test result of questions on theory-driven and strategy development

The overall group assessment point of '2' points indicates that in the strategic planning and development stage of the communication campaign process, the campaign planners sometimes explained and helped the target audience to understand the health problem and the health related behaviour. This was not only from the perspective of the target audience, but also from the perspective of some relevant and appropriate theories or models. The point also indicates that the campaign planners sometimes explained how the chosen theory/s influenced the setting of objectives of the health communication campaign. As the overall point of Question 1.3 indicates, there were discussion and consultation sometimes (between the members of the HIV/AIDS Unit and representatives of the target group) on setting objectives of the campaign. It might have been that sometimes they engaged in discussion and explanation of the need to understand HIV/AIDS from the perspective of some theories or models.

However, the answer given as to what theory or model was used raises questions on whether the participants in the testing process (of the assessment instrument) understood what a theory/model is, as discussed in Chapter 2 of this study. HIV Consulting and Testing (HCT) and Prevention of Mother-to-Child Transmission (PMTCT) given as the theories/models used or applied in Stage 1 of the communication campaign process cannot

be considered as theories or models. This point is discussed in more detail below on the level of sociocultural appropriateness of the Ekurhuleni HIV/AIDS communication campaign.

7.3.1.3 Overall standard point/s of Stage 1

The result of tallying the overall group assessment points assigned to each set of questions under Stage 1: Strategic Planning and Development of the communication campaign process gave the overall standard point for the Stage as shown in the Table 7.6.

Stage 1: Strategic Planning and Development		
Standard	Individual Point/s	Overall Point/s
Relationship/interaction between communication campaign planners and representatives of the Target Audience	4	2.94
Health problem and health behaviour of the target audience	2.75	
Objective/s of the health communication campaign	3	
Theory-driven planning and design	2	
The overall standard point/s for Stage 1 of the Communication Campaign, that is, Planning and Strategy Development was arrived at by adding the individual point/s and dividing the total sum by 4 (the number of individual point/s).		
The overall standard point/s of Stage 1: 4+2.75+3+2÷4 = 2.94		

Table 7.6   Overall Standard Point of Stage 1: Planning and Strategy Development

As per the individual points of the four components of the Strategic Planning and Development stage of the campaigned assessed, the element of relationship/interaction between the campaign planners and the target audience was socioculturally strong (4 points). The sociocultural strength of the target audience's involvement in consultation and discussion about the health problem and health behaviour associated with the health problem was average as the point/s obtained was 2.75 points. The target audience's involvement in consultation and discussion about the objectives of the communication got 3 points, making that element socioculturally good. As to consultation and discussion on appropriate theory underpinning the first stage of the campaign, a point/s of 2 points makes that socioculturally average.

With those individual component points added and divided by the number of components of the stage, Stage 1 had an overall standard point of 2.94 making that component of the HIV/AIDS communication campaign of the Ekurhuleni Municipality HIV/AIDS Unit "socioculturally average".

7.3.2 Stage 2: Development and pre-testing concepts, messages and materials

The questions of Stage 2 of the theoretical sociocultural assessment instrument relate to the development and pre-testing of concepts, messages and materials of the communication campaign. Fifteen questions grouped into four sets were answered. The participants' individual answers to each question are presented in Table 7.7.

Questions	Participants' Individual Answers to Stage 2 Questions									
	P1	**P2**	**P3**	**P4**	**P5**	**P6**	**P7**	**P8**	**P9**	**P10**
Q2.2.1.1	4	4	4	4	4	3	4	4	3	4
Q2.2.1.2	4	4	4	4	4	3	4	4	3	4
Q2.2.1.3	4	4	4	3	4	4	3	4	4	4
Q2.2.1.4	4	4	4	4	4	3	4	4	4	3
Q2.2.1.5	2	1	1	1	2	1	1	1	2	1
Q2.2.2.1	3	3	2	4	3	3	4	3	3	4
Q2.2.2.2	4	4	4	4	4	3	3	4	4	4
Q2.2.2.3	2	3	3	3	3	3	3	3	3	2
Q2.2.3.1	3	4	4	4	3	4	4	4	3	2
Q2.2.3.2	4	4	3	3	2	4	4	3	4	2
Q2.2.3.3	4	4	4	4	3	4	4	3	4	3
Q2.2.3.4	4	3	3	3	4	3	4	3	3	3
Q2.2.4.1	1	1	1	2	1	1	1	1	2	1
Q2.2.4.2	1	1	1	2	1	1	1	2	1	1
Q2.2.4.3	2	1	1	1	2	1	1	1	1	1

Table 7.7   Individual participants' answers to questions of Stage 2: Developing and pre-testing concepts, messages and materials

7.3.2.1   Analysis of individual's answers to questions on Stage 2

Q2.2.1.1 – Concepts of the Health Communication Campaign

In response to the question if the campaign planners consulted and discussed with the target audience what concepts relating to the health problem and health behaviour would be easily understood in the sociocultural context of the communication campaign, eight participants chose '4' points each as their response, which stood for "yes/always". Two participants for their part responded with "3" points each – "most/frequently".

Q2.2.1.2 – Messages of the Health Communication Campaign

As in response to the previous question on concepts, the same participants answered in the same manner the question on messages. The same eight participants answered the question with '4' points each and the remaining two as they had done in answering the

previous question, answered the question with '3' points. In answering the two questions – on concepts and messages, the participants were consistent in their views. The same eight participants were of the view that there was consultation/discussion more than frequently – "yes/always" on concepts and messages; and two were consistent in their answers of "most/frequently".

Q2.2.1.3 – Packaging of the Communication Campaign

As to how the messages of the communication campaign should be packaged so as to make an impact in the sociocultural context, eight participants were in agreement that consultation/discussion took place more than frequently by answering with "4" points each – "yes/always", and the remaining two were of the view that the consultation/discussion happened frequently by answering with "3" points each "most/frequently".

Q2.2.1.4 – The Nature and Form of Communication Campaign Messages

On the question of the nature and form of the messages of the communication campaign eight participants answered the question with "4" points each – consultation/discussion took place between campaign planners and target audience more than frequently – "yes/always". Two answered with "3" points each – consultation/discussion took place frequently – "most/frequently".

Q2.2.1.5 – Pre-test of Packaged Messages

In answering the question on consultation/discussion on how best to pre-test packaged messages, three participants answered with "2" points each – indicating that they were of the view that consultation/discussion on that issue took place only sometimes – "some/sometimes". According to the answers of the majority of the group (seven participants) there was no consultation/discussion between the campaign planners and target audience. They answered with "1" point each – "no/never".

Q2.2.2.1 – Communication Campaign Channels

On the question of whether there was consultation/discussion between the campaign planners and the target audience as to what communication channels (interpersonal, group, radio, drama etc.) would best suit the communication of the campaign messages, three of

the participants answered with '4' points each – "yes/always", six of them answered with '3' points each – "most/frequently", and one answered with '2' points – "some/sometimes".

Q2.2.2.2 - Sociocultural Appropriateness of Communication Channels

The question that sought to verify if there was consultation/discussion between the campaign planners and the target audience on how socioculturally appropriate were the communication channels selected, eight participants answered with '4' points each – "yes/always" and the remaining two participants answered with '3' points each – "most/frequently".

Q2.2.2.3 – Best way to use Selected Communication Channels to Deliver Messages

This question was on whether the campaign planners consulted/discussed with the target audience how best the selected communication channels could be used in the delivery of messages. In answer, eight of the participants chose '3' points each – "most/frequently" and the rest chose '2' points each – "some/sometimes".

Q2.2.3.1 – Training/Preparation of Target Audience for Involvement in Message Delivery

Six participants in answering the question if the target audience was prepared in any way to be involved in the process of message delivery answered with '4' points each; three answered with '3' points each and the remaining participant answered with '2' points.

Q2.2.3.2 – Trained Target Audience Given Opportunity to Deliver Messages

The preceding question had sought to find out if the target audience was trained to participate in the campaign message delivery. The present question as a follow up wanted to ascertain if the training had taken place whether the target audience having been trained was also given the opportunity to make use of the skills and competence gained in the training. Five of the participants answered with '4' point each; three answered with '3' points each and the remaining two answered with '2' point each.

Q2.2.3.3 – Credible and Acceptable Communicators of Communication Campaign Messages

On whether there was consultation/discussion between the campaign planners and the target audience as to who would be credible and acceptable communicators of the communication campaign messages, seven of the participants answered with '4' points each and the remaining three answered with '3' points each.

Q2.2.3.4 – Pre-test of Communication Campaign Channels

This question aimed at finding out if there was consultation/discussion between the campaign planners and target audience on how best to pre-test the selected channels to communicate the campaign messages. In answer to the question, three answered with '3' points each and the remaining seven answered with '3' points each.

Q2.2.4.1 – Need for Choice of Message/s to be informed by Appropriate Theory/Model

The question sought to ascertain if the campaign planners discussed/explained to the target audience the need for choice of campaign message/s to be informed by relevant theory/model. Eight of the participants answered with '1' point each – "no/never". The remaining two participants answered with '2' point each – "some/sometimes".

None of the participants, not even the two who answered the main question with '2' "some/sometimes" answered the sub-question: "If yes, what theory or model as it?"

Q2.2.4.2 - Need for Choice of Communication Channels to be informed by Appropriate Theory/Model

Just like the preceding question, this question that sought to ascertain if the campaign planners discussed/explained to the target audience the need for the choice of campaign channels of communication to be informed by appropriate theory/model, eight participants answered with '1' – "no/never" and the remaining two answered with '2' – "some/sometimes".

Again just as in the case of the preceding question none of the participants, not even the two who answered the main question with '2' "some/sometimes" answered the sub-question: "If yes, what theory or model as it?"

Q2.2.4.3 – Need for Involvement of Target Audience Involvement in Message Delivery to be informed by Theory/Model

The manner of the participants' answers to this question was similar to that of the previous two questions. Eight of them answered with '1' – "no/never" and the remaining two answered with '2' – "some/sometimes". And the sub-question was not answered.

7.3.2.2   Analysis of group answers to questions of Stage 2

As done with the questions of Stage 1 so also for Stage 2 after the ten participants had answered the questions individually they shared their answered in the group discussion and agreed on a group answer to each question. The group answers to the fifteen questions under Stage 2 are presented and analysed below.

- Communication campaign messages and materials' development

The first set of questions of this Stage sought to ascertain whether or not and to what extent there was consultation and discussion between the communication planners and the target audience regarding concepts to be used in the campaign; what the messages should be? How they should be packaged and what communication materials were used and in which form. The first four questions (Q2.2.1.1, Q2.2.1.2, Q2.2.1.3 and Q2.2.1.4) of the first set of questions were answered with 4 points each and the fifth question – Q2.2.1.5 with 1 point (confer Appendix 4). Adding the 4 Points each of Q2.2.1.1 to Q2.2.1.4 plus the 1 Point of Q2.2.1.1.5 gave a total of 17. This total was divided by the number of questions - 5 to get 3.4 as the overall group assessment point as presented in Table 7.8

Q2.1 Communication Campaign Messages & Materials' Development					
Questions	Q2.2.1.1	Q2.2.1.2	Q2.2.1.3	Q2.2.1.4	Q2.2.1.5	Overall Group Assessment Point/s of Q2.1
Observed point/s	4	4	4	4	1	4+4+4+4+1÷5 = **3.4**

Table 7.8   Test result of Developing and Pre-testing Concepts, Messages and Materials

- Choice of communication campaign channels

The second set of questions of Stage 2 had three questions in total relating to the choice of communication campaign. As the group discussed their individual answers they came to the agreement to give '3' points to first the question (Q2.2.2.1); the second question (Q2.2.2.2), '4' points and the third question (Q2.2.2.3) '4' points (confer Appendix 4). The total of the

three points was 10 points. That total divided by 3 (the number of questions) gave an overall group points of 3.3 points as presented shown in Table 7.9

Q2.2 Choice of Communication Campaign Channels				
Questions	Q2.2.2.1	Q2.2.2.2	Q2.2.2.3	Overall Observed Assessment Point/s
Observed point/s	3	4	3	3+4+3÷3 = 3.3

Table 7.9   Test results of Choice of Communication Campaign Channels

- Involvement of target audience in message delivery

The first two questions (Q2.2.3.1 and Q2.2.3.2) of third set of questions designed to ascertain whether and how the target audience was prepared for involvement in the delivery of the campaign messages yielded '4' points each. The third question (Q2.2.3.3) to find out if the target audience was consulted as to what type of person/s in their sociocultural context would be considered more credible and acceptable to communicate the message of the campaign netted '4' points and the fourth question (Q2.2.3.4) to ascertain if the campaign planners discussed with the target audience how best to pre-test channels or means chosen to carry/communicate the messages of the campaign yielded '3' points. The four points gave a total of 15 points. The overall group assessment points of 15 points divided by 4 (the number of questions) was 3.75 Points (confer Appendix 4) as shown in Table 7.10.

Q2.3 Involvement of Target Audience in Message Delivery					
Questions	Q2.2.3.1	Q2.2.3.2	Q2.2.3.3	Q2.2.3.4	Overall Observed Assessment Point/s
Observed point/s	4	4	4	3	4+4+4+3÷4 = 3.75

Table 7.10   Test results of questions on involvement of target audience in message delivery

- Theory-driven development and pre-testing of concepts, messages and materials

The three questions of the fourth set of questions of Stage 2 (Q2.2.4.1, Q2.2.4.2 and Q2.2.43) designed to find out whether or not the development and pre-testing of concepts, messages and materials were underpinned by theory got '1' point each thus giving an overall group assessment point of '1' (confer Appendix 4) as presented in Table 7.11

Q2.4 Theory-Development and Pre-testing of Concepts, Messages and Materials				
Questions	Q2.2.4.1	Q2.2.4.2	Q2.2.4.3	Overall Observed Assessment Point/s
Observed point/s	1	1	1	1+1+1÷3 = 1

Table 7.11   Test results of questions on theory-driven development and pre-testing of concepts, messages and materials

7.3.2.3   *Overall standard points of Stage 2*

The result of tallying the overall group points assigned to each set of questions in Stage 2 of the communication campaign process and dividing that by the number of set of questions gave the overall standard points of 2.87 points (3.4+3.33+3.75+1÷4 = 2.87) as shown in the Table 7.12.

Stage 2: Developing and Pre-testing Concepts, Messages and Materials		
Standard	**Individual Point/s**	**Overall Point/s**
Communication Campaign Message/s & Materials' Development	3.4	
Choice of Communication Campaign Channels	3.33	
Involvement of Target Audience in Message Delivery	3.75	
Theory-Driven Development and Pre-testing of Concepts, Messages and Materials	1	2.87
The overall point/s for Stage 2 of the Communication Campaign, that is Development and Pre-testing Concepts, Messages and Materials was arrived at by adding the individual point/s and dividing the total sum by 4 (the number of individual point/s).		
The overall observed point/s for Stage 2: 3.4+3.33+3.75+1÷4 = 2.87		

Table 7.12   Overall Standard Point/s of Stage 2: Developing and pre-testing of concepts, messages and materials

On assessing the elements of the second component of the Ekurhuleni Municipality HIV/AIDS Unit's communication campaign, the element of consultation and discussion between the campaign planners and the target audience on the campaign's messages and development of materials yielded 3.4 points making that element of the campaign socioculturally good. Discussion and consultation on appropriate campaign channels was also socioculturally good as the assessment yielded 3.33 points. So also was the element of involvement of the target audience in message delivery socioculturally good with 3.75 points. The element of pre-testing of concepts, messages and materials and the necessity of the whole component being unpinned by theory was socioculturally weak as the assessment

was 1 point. Thus the overall standard points of 2.87 for Stage 2 indicates that for the Development and Pre-testing Concepts, Messages and Materials in the communication campaign process of the HIV/AIDS Unit of Ekurhuleni Municipality Health Department was "socioculturally average".

7.3.3 Stage 3: Campaign Implementation

The individual answers of the participants to questions in the two sets of questions in Stage 3 (Creative Communication Campaign Implementation) of the campaign process are presented in Table 7.13.

Questions	Participants' Individual Answers to Stage Questions									
	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
Q3.3.1.1	4	4	4	4	4	3	4	4	4	4
Q3.3.1.2	4	3	4	4	4	3	3	4	4	4
Q3.3.1.3	3	3	3	3	4	3	3	3	3	4
Q3.3.1.4	3	4	3	3	4	3	3	4	3	4
Q3.3.1.5	3	3	4	4	3	3	3	3	3	3
Q3.3.1.6	2	2	2	2	3	3	2	2	3	2
Q3.3.2.1	3	3	2	4	3	3	4	3	4	3
Q3.3.2.2	4	3	3	3	4	3	2	3	4	3
Q3.3.2.3	2	2	3	2	2	2	3	2	2	2

Table 7.13   Individual participants' answers to questions of Stage 3: Creative Campaign Implementation

7.3.3.1   *Analysis of individuals' answers to questions of Stage 3*

- *Q3.3.1.1 – Understanding Campaign Implementation*

The first question of the first set of questions of Stage 3 sought to find out if the campaign planners had discussed/explained what constitutes implementation of communication campaign to the target audience. To this question, all the participants answered with '4' – "yes/always".

- *Q3.3.1.2 – Suggestions of Target Audience on Implementation of Campaign*

The purpose of this question was to find out if when discussing and explaining what constitute implementation of communication campaign by the campaign planners to the target audience the latter was given the opportunity to make suggestions about what that

could constitute. Seven of the participants answered '4' – "yes/always" and the remaining three answered '3' – "most/frequently".

- *Q3.3.1.3 – Dynamics of Implementation of Communication Campaign*

Question 3 in this first of questions asked if the campaign planners in discussion with the target audience explained to them the dynamics of the implementation of communication campaign. Two of the participants answered '4' – "yes/always", while the remaining eight participants answered with '3' – "most/frequently"

- *Q3.3.1.4 – Contribution of Target Audience on Dynamics of Implementation*

If the campaign planners discussed and explained the dynamics of campaign implementation to the target audience, was the latter given an opportunity to suggest some socioculturally appropriate ways of implementation? That was what Q3.3.1.4 sought to find out. Four of the participants answered '4' – "yes/always". Six answered '3' – "most/frequently".

- *Q3.3.1.5 – Need for Target Audience to Play Active Roles in Actual Implementation of Campaign*

The question sought to ascertain if campaign planners discussed/explained the need for target audience to be actively involved and participate in the implementation of the campaign. In answer, eight participants noted '3' – "most/frequently" and the remaining two noted '4' – "yes/always".

- *Q3.3.1.6 – Actual Involvement of Target Audience in Implementation of Campaign*

If the need for target audience to be involved in the implementation of the communication campaign was discussed and explained to the target audience, did it get the opportunity to actually be involved and participate in the implementation process? To that end, seven of them chose '2' – "some/sometimes" while the remaining three chose '3' – "most/frequently".

- *Q3.3.2.1 – Need for Implementation Component of Communication Campaign to be Informed by Theory/Model*

The three questions of the second set of questions of Stage 3 dealt with theory/model. The first of these questions sought to find out if the campaign planners discussed/explained the

need for the whole component of implementation of communication campaign to be informed by appropriate theory/model. The answer of three participants was '4' – "yes/always"; five answered with '3' – "most/always", and one answered '2' – "some/sometimes".

To the sub-question, what theory/model it was. The answer given was HCT and Abstain, Be Faithful and Condomise (ABC).

- *Q3.3.2.2 – Theory/Model that Informed Decision to Implement Campaign in the manner of Implementation*

This question was designed to find out if the campaign planners discussed/explained to the target audience the theory/model that informed the decision to implement the campaign in the manner in which it was implemented. Three participants answered '4' – "yes/always"; six answered '3' – "most/frequently", and one answered '2' – "some/sometimes".

The names given to the sub-question as to what theory/model, was HCT and Abstain, Be Faithful and Condomise (ABC) as in response to Q3.3.2.1.

- *Q3.3.2.3 – Theory Underpinning Involvement of Target Audience in implementation*

The last question in the set on theory/model sought to find out if the campaign planners had discussed/explained to the target audience the theory/model that underpinned the need of target audience involvement in campaign implementation. To this question, eight participants answered with '2' – "some/sometimes" and the remaining two answered '3' – "most/frequently".

This question also had a sub-question to find out what the theory/model was, and like in Q3.3.2.1 and Q3.3.2.2 the answer given was HCT and Abstain, Be Faithful and Condomise (ABC).

7.3.3.2   Analysis of group answers to questions of Stage 3

As done with the questions of Stages 1 and 2, for the questions of Stage 3 the participants shared their individual answers and in discussion came to agreement on the group's points for each question. The group answers to the nine questions of Stage 3 are presented and analysed below.

- Nature and dynamics of campaign implementation

The first set of questions in this stage had six questions dealing with the nature and dynamics of implementation of a communication campaign. The questions were framed in such a manner as to help determine (based on the points assigned to each question) the level of participation or non-participation of the target audience in the implementation process of a health communication campaign. Of the six questions, four (Q3.3.1.1, Q3.3.1.2, Q3.3.1.5 and Q3.3.1.6) (confer Appendix 4), yielded '4' points each while two questions (Q3.3.1.3 and Q3.3.1.4) yielded '3' points each. That gave an overall group assessment points of 3.7 as presented in Table 7.14

Q3.1 The Nature and Dynamics of the Campaign Implementation						
Questions	Q3.3.1.1	Q3. 3.1.2	Q3.3.1.3	Q3.3.1.4	Q3.3.1.5	Q3.3.1.6	Overall Observed Assessment Point/s 4+4+3+3+4+4÷6 = 3.67
Observed point/s	4	4	3	3	4	4	

Table 7.14   Test result of the Nature and Dynamics of the Campaign Implementation

- Theory-driven campaign implementation

Responses to the second set of three questions (Q3.3.2.1, Q3.3.2.2 and Q3.3.2.3) dealing with theory-driven campaign implementation, framed to determine whether the process of implementation of the communication campaign was underpinned or driven by theory/model yielded an overall group assessment point/s of 3 Points. The first of the three questions, which asked if there was discussion and explanation with representatives of the target audience regarding the need for the implementation process to be informed by appropriate theory/model, secured '3' points. The second question, which tried to find out if the theory/model that informed the decision to implement the campaign in the manner in which it was implemented had been discussed and explained, also got '3' points. The third question was to help determine if the target audience were aware of what theory/model underpinned the need for them to be active participants in the campaign implementation process. That question also secured '3' points (confer Appendix 4). The overall group assessment points was thus 3 points as shown in Table 7.15.

Q3.2 Theory-Driven Campaign Implementation			
Questions	Q3.3.2.1	Q3.3.2.2	Q3.3.2.3	Overall Observed Assessment Point/s
Observed point/s	3	3	3	3+3+3÷3 = 3

Table 7.15   Test result of Theory-driven Campaign Implementation

7.3.3.3   Overall points of Stage 3

The result of tallying the overall group assessment points assigned to each set of questions in Stage 3 of the communication campaign process gave the overall standard points for the Stage as 3.34 as shown in Table 7.16.

Stage 3: Campaign Implementation		
Standard	**Individual Point/s**	**Overall Point/s**
The Nature and Dynamics of the Campaign Implementation	3.67	3.34
Theory-Driven Campaign Implementation	3	
The overall point/s for Stage 3: Campaign Implementation of the Communication Campaign was arrived at by adding the individual point/s and dividing the total sum by 2 (the number of individual point/s).		
The overall observed point/s for Stage 3: 3.4+3÷2 = 3.34		

Table 7.16   Overall Standard Point/s of Stage 3: Campaign implementation

The components of Stage 3 of the communication campaign process are only two elements. The first element of the components secured 3.67 points, making it socioculturally good. The second element got 3 points and thus making it socioculturally good. The two points added and divided by 2 (the number of elements) gives the overall standard points of 3.34 for the Stage, which should be an indicating that the Campaign Implementation in the communication campaign process of the HIV/AIDS Unit of Ekurhuleni Municipality Health Department was "socioculturally good". However the answers given as to what theories (confer Appendix 4) underpinned this stage of the communication campaign process clearly show that what was considered theory/model in the study was not understood in the same manner by the participants in the group administered interactive questionnaire. What they gave as theories/models are approaches/strategies and not theories/models. Hence if HCT and ABC are disqualified as theories/models, and instead of assigning three points to each of the questions (Q3.3.2.2, Q3.3.2.2 and Q3.3.2.3), a point of 1 is assigned, thus given an overall point of 1, the overall standard point of the Campaign Implementation would be 2.33

points. That would make Stage 3 of the communication process socioculturally 'average' and not 'good'.

7.3.4 Stage 4: Continuous Monitoring and evaluation

The questions of Stage 4 of the communication campaign process dealt with monitoring and evaluation of the process. The two sets of questions answered were on the nature and dynamics of monitoring and evaluation and the underpinning theory of the monitoring and evaluation. The individual answers of the participants to each of the questions are presented in Table 7.17.

Questions	Participants' Individual Answers to Stage 4 Questions									
	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
Q4.4.1.1	4	4	3	3	4	4	4	4	3	4
Q4.4.1.2	4	4	4	4	4	4	4	4	3	4
Q4.4.1.3	2	2	2	2	2	1	1	3	2	2
Q4.4.1.4	2	2	2	2	2	2	2	2	3	2
Q4.4.1.5	3	4	4	4	3	4	4	4	4	4
Q4.4.2.1	1	2	2	1	1	1	1	1	2	1
Q4.4.2.2	4	3	3	4	4	4	4	4	3	3
Q4.4.2.3	1	1	1	1	1	1	1	1	2	1

Table 7.17   Individual participants' answers to questions of Stage 4: Monitoring and evaluation

7.3.4.1 *Analysis of individual participants' answers to questions of Stage 4*

- *Q4.4.1.1 – Need to Monitor and Evaluate Communication Campaign Process continuously*

On whether the campaign planners had discussed/explained to the target audience the need to monitor and evaluate the communication campaign process continuously, seven of the participants answered '4' – "yes/always". The remaining three participants answered '3' – "most/frequently".

- *Q4.4.1.2 – The Structure, Format and Dynamics of Continuous Monitoring and Evaluation Process*

In this question, the participants were asked if there was discussion/explanation to the target audience of the nature of the structure, format and dynamics of the monitoring and

evaluation process in the communication campaign. Nine of the participants answered '4' – "yes/always". One answered '3' – "most/frequently".

- *Q4.4.1.3 – Contribution/Suggestion of Target Audience to Sociocultural Appropriateness on Monitoring and Evaluation of Communication Campaign*

To the question if the target audience contributed or suggested socioculturally appropriate ways to monitor and evaluate the communication campaign, seven participants answered '2' – "some/sometimes"; two answered '1' – "no/never", and one answered '3' – "most/frequently".

- *Q4.4.1.4 – Need for Target Audience to Play Active Role in Monitoring and Evaluation*

When asked if the campaign planners discussed/explained to the target audience the need for the latter to be actively involved in the monitoring and campaign process, nine participants answered '2' – "some/sometimes" and one answered '3' – "most/frequently".

- *Q4.4.1.5 – Target Audience's Involvement in the Monitoring and Evaluation Process*

In answer to the question if the target audience actually got involved in the monitoring and evaluation process of the communication campaign, eight of the participants answered '4' – "yes/always", and the remaining two answered '3' – "most/frequently".

- *Q4.4.2.1 – Need for Monitoring and Evaluation of Campaign Process to be Informed by Theory/Model*

This question sought to find out if the campaign planners discussed/explained the need for the monitoring and evaluation component of the communication campaign to be underpinned by an appropriate theory/model. Seven participants answered '1' – "no/never"; the remaining three participants answered '2' – "some/sometimes".

To the sub-question, which asked what theory/model was explained, the participants did not answer.

- *Q4.4.2.2 – Theory/Model that Informed Continuous Monitoring and Evaluation of Communication Campaign*

This question sought to find out if the campaign planners discussed/explained to the target audience the theory/model that informed the decision to monitor and evaluate the communication campaign in the manner in which it was monitored/evaluated. Six participants answered '4' – "yes/always", and the remaining four participants answered '3' – "most/frequently".

To the sub-question that asked what theory/model, three participants answered 'Attendance Register' and 'Multi-sectoral Approach'. The rest did not give any answer.

- *Q4.4.2.3 – Theory/Model that Unpinned Need for Involvement of Target Audience in Evaluation and Monitoring Process*

The question sought to find out if the campaign planners had discussed/explained to the target audience the theory/model that underpins need for active involvement of target audience in monitoring and evaluation process of communication campaign. Nine participants answered '1' – "no/never" and one answered '2' – "some/sometimes".

The sub-question question was not answered.

7.3.4.2   *Analysis of group answers to questions of Stage 4*

- Theory-driven campaign monitoring and evaluation

The overall group assessment points of the first set of questions (Q4.4.1.1, Q4.4.1.2, Q4.4.1.3, Q4.4.1.4 and Q4.4.1.4 under Stage 4 was 3.2 points. Three of the questions (Q4.4.1.1, Q4.4.1.2 and Q4.4.1.5) were 4 points each and two questions (Q4.4.1.3 and Q4.4.1.4) were 2 points each (confer Appendix 4) as shown in Table 7.18

Q4.1 The Nature and Dynamics of Monitoring and Evaluation						
Questions	Q4.4.1.1	Q4.4.1.2	Q4.4.1.3	Q4.4.1.4	Q4.4.1.5	Overall Group Assessment Point/s
Observed point/s	4	4	2	2	4	$4+4+2+2+5 \div 5 = 3.2$

Table 7.18   Test result of questions on the nature and dynamics of monitoring and evaluation

The set of questions ascertaining whether the monitoring and evaluation components of the communication campaign process were underpinned by theory/model obtained an overall
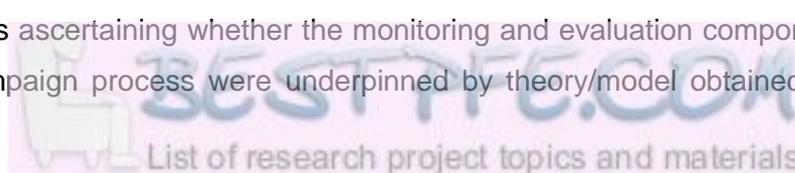
assessment of 2 Points. The first of the three questions (Q4.4.2.1), which was seeking to find out if there was discussion and explanation on the need for monitoring and evaluation to be informed by appropriate theory/model, was 1 Point; the second question (Q4.4.2.2) 4 Points and the third question 1 Point (confer Appendix 4). The points of the group assessment and the overall group points for Q4.2 are presented in Table 7.19.

Q4.2 Theory-Driven Campaign Monitoring and Evaluation				
Questions	Q4.4.2.1	Q4.4.2.2	Q4.4.2.3	Overall Group Assessment Point/s
Observed point/s	1	4	1	1+4+1÷3 = 2

Table 7.19   **Test result of questions on theory-driven campaign monitoring and evaluation**

In the individual answers to question Q4.4.2.2, six of the participants gave 4 points each in answer to the question. As the majority had given 4 points each and the minority gave 3 points each in discussing to agree on a group's point – they agreed on 4 points. To the sub-question that asked what theory/model was used, the answer they agreed on were 'Attendance Register' and Multi-sectoral Approach'. These two are not theories. Hence if the 4 points assigned were reduced to 1 point to indicates no theory/model underpinned Stage 3, the overall group assessment point/s would be 1 point.

7.3.4.3   *Overall standard points of Stage 4*

The result of tallying the overall group assessment points of the answers to the questions under Stage 4 of the communication campaign process gave the overall standard points for the Stage as 2.6 as shown Table 7.20.

Stage 4: Continuous Monitoring and Evaluation		
Standard	**Individual Point/s**	**Overall Point/s**
The nature and dynamics of Monitoring and Evaluation	3.2	2.6
Theory-Driven Monitoring and Evaluation	2	
The overall point/s for Stage 4: Campaign Monitoring and Evaluation of the Communication Campaign was arrived at by adding the individual point/s and dividing the total sum by 2 (the number of individual point/s).		
The overall observed point/s for Stage 4: **3.2+2÷2 = 2.6**		

Table 7:20   **Overall Standard Point/s of Stage 4: Continuous Monitoring and evaluation**

If the above suggested reduction of the points the participants allotted to Q4.4.2.2 is not considered and the points remained '4' then the overall standard point/s of 2.6 for Stage 4 indicates that the Continuous Monitoring and Evaluation component in the communication campaign process of the HIV/AIDS Unit of Ekurhuleni Municipality Health Department that was assessed as "socioculturally average". However if the suggestion is taken into consideration and a reduction in the points is made which would mean instead of the overall group assessment points of that component being '2' points it is given '1' point, the overall standard points would be 2.1 (and not 2.6). Since it is within the range of '2' the monitoring and evaluation stage will still be regarded as socioculturally average.

7.4   OVERALL SOCIOCULTURAL STANDARD

The total of the points of each stage in the communication campaign process obtained divided by 4 (the number of stages) gave the Ekurhuleni Municipality Health Department's HIV/AIDS Unit communication campaign assessed an overall standard points of 2.94, which makes it socioculturally average as shown in Table 7.21.

OVERALL SOCIOCULTURAL STANDARD POINTS OF THE STAGES	
STAGES	STANDARD POINT/S
Planning and developing strategy	2.94
Developing and pre-testing concepts, messages and materials	2.87
Campaign implementation	3.34
Monitoring and evaluation	2.6
Total	11.75
Overall sociocultural standard assessment point/s (11.75 ÷ 4)	**2.94**

Table 7.21   Results of the overall sociocultural standard

7.5   DISCUSSION OF THE RESULTS

As explained in the previous chapter, in assessing the level of sociocultural standard of a health communication campaign using the theoretical sociocultural assessment instrument, a campaign that obtains an overall points of 4 is regarded as having been socioculturally "strong"; 3 points is socioculturally "good"; 2 points is socioculturally "average" and 1 point socioculturally "weak". It was also explained that the theoretical sociocultural assessment instrument as a qualitative research instrument is meant to help determine appropriateness of health communication campaigns based on three main concerns. These concerns are the level of involvement and participation of the target audience in the communication process,

the level of cognisance taken of the context and the sociocultural factors of the target audience, and the level of theories/models underpinning the whole campaign process.

According to the research findings discussed above, the Ekurhuleni Municipality Health Department's HIV/AIDS Unit's communication campaign obtained an overall sociocultural assessment points of 2.94. Since an overall points of 2 points represents a socioculturally "average" health communication campaign, it can be concluded based on the points gained that, from the perspective of sociocultural standard, the case studied – Ekurhuleni Municipality Health Department's HIV/AIDS Unit communication campaign was socioculturally "average".

These findings indicate that the sociocultural gap in the Ekurhuleni HIV/AIDS communication campaign is that it did not pay adequate or sufficient attention to the need for theories/models underpinning the whole communication campaign process. As the results indicate (confer Appendix 4), on questions pertaining to the kind of theory/model and how that underpinned the Strategic Planning and Development Stage of the campaign process, all three questions obtained 2 points each. Hence, the overall 'assessment points' for theory-driven planning and design of this stage of the campaign process was 2 points ("average"). Similarly not much (if at all any) attention was paid to theory in the development and pre-testing of concepts, messages and materials. As the results reflect (confer Appendix 4), the answers to the three questions meant to determine whether or not, and what theory/model underpinned that stage in the campaign process, gained 1 point each ("no/never"). That gave the overall assessment points for theory-driven development and pre-testing of concepts, messages and materials '1' point. That meant no consideration was given to the necessity and role of theory in the development and pre-testing of concepts, messages and materials.

In answer to the three questions relating to theory-driven campaign implementation (confer Appendix 4), each question received 3 points. Based on these points, it could be assumed that theory/model played some central role at that stage of the communication campaign, since 3 points represent "most/frequently" – 'good'. Answers to the three sub-questions of the main questions (Q2.2.2.1, Q2.2.2.2 and Q2.2.2.3) respectively specifically designed to find out what particular theory/model underpinned the implementation process of the campaign raise questions about both the individual 3 points each and the overall 3 points. All three questions had HIV counselling and testing (HCT) and Abstain, Be Faithful, Condomise (ABC) given as the underpinning theories/models. These two (HCT and ABC) and PMTCT (given as theory/model in answer to the sub-questions of Q1.1.4.1) however, do not meet the criteria of what constitutes theory/model according to the understanding and operational

definition of theory/model discussed in Chapter 2 of this study. ABC is not a theory or a model in the sense in which that is described or defined in this study. The ABC is rather an approach (a way to behave or behaviour) for preventing sexual transmission of HIV (AVERT - HIV and AIDS in South Africa 2010). Similarly, HCT is not a theory or model but a campaign launched in South Africa in April 2010 to scale up awareness of HIV. Part of the campaign's strategy is "publicising the availability of free testing and counselling" (AVERT - HIV and AIDS in South Africa 2011:3).

If it is accepted that HCT, PMTCT and ABC are not theories or models according to the understanding of what theories and models are, as discussed in Chapter 2. Then it would be a confirmation that the main gap in the HIV/AIDS communication campaign of the Ekurhuleni Metropolitan Municipality's Health Department was the lack of theory or model underpinning the different stages of the campaign process. Had it not been for this gap, the campaign could have achieved an overall 3 points or more to have made it a socioculturally 'good' health communication campaign.

From the testing of the theoretical sociocultural assessment instrument and the points obtained it was observed that the participants in the group administered interactive (questionnaire) assessment process did not understand theory and model in the same way as these two concepts are generally understood in the scientific field, and particularly as operationally defined in this study. This lack of understanding affected some of the points assigned to questions on theory-driven aspects of the communication campaign. In a future use of the instrument it would be necessary to modify the key steps in administering the instrument by including an explanation on what theory/model-driven communication campaign means and to specify the description or definition of theory and model as operationally described, defined or understood by researchers conducting such studies . An alternate is to discuss it with the participants who are the planners and implementers of the communication campaign to ensure they understand what is meant by theory-driven communication campaigns. It is argued that such modification would assist participants in the use of the instrument in assessing a particular communication campaign not to confuse theory/model with a strategy or an approach adopted in a health programme to fight against a particular health problem. If this modification is not done, it would be possible that points assigned to questions dealing with aspects of theory-driven communication campaign in the assessment instrument would not be the appropriate or correct points as is evidenced in this study. That in turn may result in the determination of the sociocultural standard of the communication campaign being skewed either upwards or downwards, which would be a

distortion and not the right result (of the stand), which could mean the results might not be correct.

7.6   CONCLUSION

In this chapter the manner and process of testing of the Theoretical Sociocultural Assessment Instrument for Health Communication Campaigns developed in this study has been presented and discussed. According to the findings the Strategic Planning and Development Stage of the Ekurhuleni Municipality Health Department HIV/AIDS Unit's communication campaign assessed was socioculturally average. The first three overall assessment points of this Stage were 4, 2.75 and 3. The total of these points is 9.75, which divided by 4 (the total number of overall assessment points) gave an overall assessment standard point of 3.25 – "most/frequent". The fourth overall assessment point on theory was 2 points. That means with regard to that component of the communication campaign being theory-driven the point gained was average - "some/sometimes".

Regarding Stage 2 of the communication campaign process, "Development and Pre-testing of Concepts, Messages and Materials", the overall assessment point of 2.87 means this stage of the communication campaign was also average - "some/sometimes". The reason for this overall assessment point is the fourth component's 1 point (theory/model not underpinning the Stage). The overall point of 3.34 points for Stage 3, the Creative Campaign Implementation as it stands, means this stage was good - "most/frequent". The results of Stage 4 (of the communication campaign process), namely, Continuous Monitoring and Evaluation are questioned because of what is given as the theory/model that underpinned this stage. Attendance Register and Multi-sectoral Approach are not theories. Hence, if the 4 point assigned to question 4.2.2 is reduced to 1 point to indicate that no theory/model underpinned this stage, the overall assessment point for the set of questions under 'Theory-Driven Campaign Monitoring and Evaluation' would be 1 point. This would then give the overall points for monitoring and evaluation as 2.1 and not 2.6 point, which would mean socioculturally in this Stage of the communication campaign process, monitoring and evaluation happened only "some/times".

CHAPTER 8   CONCLUSION

8.1   INTRODUCTION

The research problem of this study was the lack of adequate research to investigate the intimate and intertwining relationship between communication and culture, and the possible impact or influence of the active or non-active involvement and participation of a target audiences on the planning and execution of HIV/AIDS communication campaigns. The main aim of the study was thus to develop a Theoretical Sociocultural Assessment Instrument for Health Communication Campaigns for use in assessing whether in the planning and execution of health communication campaigns the target audience get actively involved in and participate in the planning and execution of the campaigns; whether cognisance is taken of the cultural context and significant factors of the target audience; and whether appropriate theories/models underpinned the various components of the communication campaign process.

The development of such an assessment instrument warranted it being testing as part of the research to ascertain its appropriateness for the purpose for which it was developed. Hence part of the research process was to test the instrument in a purposive sampled HIV/AIDS communication campaign. In the preceding chapter, the testing of the instrument, the results obtained and the findings were presented and discussed. This concluding chapter begins with highlights of the preceding chapters followed by a presentation of the main contributions of the study, the limitations of the research and recommendations for further or future research.

8.2   HIGHLIGHTS OF PRECEDING CHAPTERS

The discussion of Chapter 1 highlighted health communication campaign as one of the widely used communications strategies to inform and educate people about HIV/AIDS and to promote behaviour that help curtail the spread of HIV. It was assumed and argued that in HIV/AIDS campaigns there seems to be the missing links of absence or insufficient active involvement and participation of the target audience in the communication campaign process; inadequate cognisance of the the crucial intertwining relationship between communication and culture and as a result the influence of the cultural contexts and factors of the target audience on their health attitudes and behaviour. It was noted that while substantial monetary and human resources are committed to the development and

implementation of such communication campaigns; the level of infection of the HIV has not changed as much as desired even though there is considerable progress, and that could be as a result of the missing links. Thus the need to investigate such assumed missing links. Hence the setting of the three objectives of the study – contructing a conceptual sociocultural health communication campaign model to guide the development of a theoretical sociocultural assessment instrument as a tool with the potential of examining and ascertaining the missing links, and testing the constructed theoretical assessment instrument as part of the study.

In Chapter 2 the conceptual and opreational definitions of the key concepts and related terms used in the study were conceptually and operationally defined. The definitions set the boundaries within which their meanings assisted in articulating the issues investigated. Having conceptually and operationally defined the key and related concepts in Chapter 2, eight widely used and cited theories/models in the literature relating to health promotion and education, and health behaviour; and some current approaches and inherent challenges to evaluating health communication campaigns were presented and discussed in Chapter 3. That led to the development of a new conceptual interactive-participative health communication campaign model, which laid the foundation and provided the necessary conceptual tools for developing and constructing the theoretical approach and theoretical conceptual framework of the study based on the argument that a conceptual sociocultural health communication campaign model could serve as a framework for developing a theoretical assessment instrument for assessing sociocultural elements or variables of health communication campaigns. Thus in the next chapter – Chapter 4, the work of constructing the conceptual sociocultural health communication campaign model was undertaken and that meant the achievement of the first objective of the study. With the construction of the conceptual sociocultural health communication campaign model to guide the development of the theoretical sociocultural assessment instrument having been completed; it was necessary before embarking on the development of the assessment instrument to become conversant with the theoretical perspectives and foundations of the process of assessment, and that formed the presentation and discussion of Chapter 5 – a discussion that centered on further understanding of assessment and attainment of stated objectives; foundational assumptions and implications of theories for the assessment instrument, and models of assessment. Having that as a foundation, the stage was set for the development of the theoretical sociocultural assessment instrument for health communication campaigns. That formed the presentation and discussion of Chapter 6 and with that the second objective of the study was achieved. After achieving the second objective, there remained the third and last objective to be attended to – that of testing the

theoretical sociocultural assessment instrument. Chapter 7 therefore was focused on the presentation and discussion of the test, the results obtained and their analysis.

8.3   MAIN FINDINGS OF THE STUDY

According to the results of the assessment presented and discussed in the preceding chapter Stage 1 of the communication campaign process of the HIV/AIDS Unit of the Health Department of the Ekurhuleni Metropolitan Municipality obtained overall standard points of 3.25 (most/frequently), making this stage of the communication campaign process socioculturally good. Stage 2 with 2.87 (some/sometimes) overall standard points was socioculturally average. Obtaining overall standard points of 3.34 (most/frequently) made Stage 3 socioculturally good, and Stage 4 with overall standard points of 2.1 (some/sometimes) was socioculturally average. The total of these four overall standard points was 11.56 points. Dividing this overall points of 11.56 by 4 being the total number of the stages in the communication campaign process gives an overall standard points for the whole communication campaign as 2.89 (some/sometimes). That gives an overall sociocultural assessment of the communication campaign study of 'average'. Thus according to the criteria set in this study, the main findings of the research was that the communication campaign of the HIV/AIDS Unit of the Health Department of the Ekurhuleni Metropolitan Municipality studied was socioculturally average. That indicates a gap in the communication campaign process. The gap was the absence or lack of of appropriate theories/models underpinning the different stages and components of the campaign process, which is one of the missing links the theoretical sociocultural assessment instrument was developed to verify or ascertain.

As per the findings, of the three criteria a health communication campaign must fulfil or complied with – ensuring the active involvement and participation of the target audience in all the stages of the communication campaign process and taken cognisance of and incorporating elements of the sociocultural contexts and factors of the target audience in the communication campaign process; and ensuring that all the different stages of the campaign process were underpinned by appropriate theories/models, in order that it might be deemed or considered 'socioculturally weak' (1 Point), 'socioculturally average' (2 Points), 'socioculturally good' (3 Points) or 'socioculturally strong' (4 Points), the communication campaign of the HIV/AIDS Unit of the Health Department of the Ekurhuleni Metropolitan Municipality fulfilled the first two criteria but did not fulfil the third criterion indicating a gap – a missing link, in that communication campaign process thus making the campaign 'socioculturally average'.

The findings of the research based on the results obtained through the use of the theoretical sociocultural assessment instrument developed as part of the study indicate that the instrument served as a useful and functional instrument for ascertaining the sociocultural appropriateness of the health communication campaigns and thus can be used for other such health communication campaigns.

8.4   MAIN CONTRIBUTIONS OF THE STUDY

The research problem of the study was the lack of adequate research to investigate the intimate and intertwining relationship between communication and culture, and how such a relationship and the active involvement and participation of the target audience in a health communication campaign process may or may not influence the planning and execution of such campaign. In response to that lack, the study was undertaken to investigate that intertwining relationship between communication and culture, and the active involvement and participation of a target audience in a health communication campaign process. Since as argued such investigation has been inadequate the necessary assessment tools for that type of investigation are also invariably inadequate. For that reason the development in this study of an assessment tool with the potential of ascertaining or verifying the relationship between communication and culture and the impact or influence of such relationship on health communication campaign process; the ascertaining or verification of the active or non-active involvement and participation of the target audience in a health communication campaign, and ascertaining if all different stages of a communication campaign process are underpinned by appropriate theories/models is a contribution of this study to the field of such research.

 To develop the Theoretical Sociocultural Assessment Instrument, a Conceptual Sociocultural Health Communication Campaign Model was first constructed as a guide for the former. A Theory-driven Assessment Framework was also constructed as additional guide for the development of the assessment instrument.   That model and the assessment framework, products of this study are also contributions of the study, and may be used, as proposed, by other researchers in the future or modified to suit the needs of their particular study. In addition, they may together with the theoretical sociocultural assessment instrument also serve as basis for the development of similar models, frameworks and assessment instruments.

Besides the construction of the Conceptual Sociocultural Health Communication Campaign Model, the Theory-driven Assessment Framework and the development of the Theoretical

Sociocultural Assessment Instrument for Health Communication Campaigns, six other models were constructed as part of this study, and they are also contributions of the study: the Cyclical Stages of Change Model, the Conceptual Interactive-Participative Communication Campaign Model, the Theoretical Conceptual Framework of Interrelationship and Interdependence of Communication and Culture, the Assessment Process Model and the Theory-Driven Assessment Framework.

The use of the Theoretical Sociocultural Assessment Instrument as a group administered interactive questionnaire, which is the achievement of the third objective of the study, offered the Ekurhuleni Metropolitan Municipality HIV/AIDS Unit the opportunity to review and assess the different stages of its communication campaign from the perspective of its sociocultural appropriateness, and this is also a contribution of the study.

8.5   LIMITATIONS OF THE RESEARCH

While the results indicate that the objectives set for the study have been achieved, and point to the strengths of the research, it has been noted that there are some limitations. Firstly, being a study of one particular case of testing the theoretical sociocultural assessment instrument of one health communication campaign, and though using 'quasi' mixed methods research that combine qualitative and quantitative techniques, data analysis was not statistical. The results of the research can therefore not be generalised. Secondly, because the Theoretical Sociocultural Assessment Instrument as developed and administered in the research does not include a sound definition or explanation of a theory/model and the results of the research indicate that the respondents' understanding of a theory/model was different from what is presupposed in the instrument, that affected the overall standard points obtained. Thirdly, the assessment instrument developed was tested only in one case of health communication campaign, that of the HIV/AIDS Unit of the Health Department of the Ekurhuleni Metropolitan Municipality. It has not as yet been studied and critiqued by any other individual or group of communication campaign experts and therefore cannot be said to have been rigorously tested and it being a reliable sociocultural assessment instrument established. Hence, there is the need for further testing of the instrument in other health communication campaigns to ascertain its suitability and it being a reliable instrument.

8.6   RECOMMENDATIONS FOR FUTURE RESEARCH

In view of the limitations of the research mentioned above, the following recommendations are made for future research. In any future use of the instrument, it will be necessary to include a definition or explanation of what a theory/model is, and if possible to also give a brief description and/or definition of the theory/model as operationally described/defined in the research being undertaking. This would help the participants involved in the administration of the assessment instrument not to confuse communication theory/model with an approach/strategy. Since the instrument has been tested only once in this study, it is recommended that other researchers use it in a number of studies so that its usefulness might be improved and to address the issue of subjectivity.

8.7   CONCLUSION

Three assumptions formed the premise of this study. The first assumption was that, the active involvement of a target audience by their active involvement, collaboration and participation is needed in a health communication campaign process. The second assumption was that the sociocultural context and factors of the target audience should be taken into consideration in the planning and implementation of a health communication campaign. The third assumption was that health communication campaigns should be theory-driven. Based on these assumptions the research problem was the lack of adequate research to investigate the relationship between communication and culture, and how such relationship and the active involvement and participation of the target audience in communication campaign process may or may not impact/influence the planning and execution of health communication campaigns.

In light of the research problem the study sought to ascertain if it is possible and practicable to ascertain if the target audience of a communication campaign played any active and significant role in the in the campaign process? Whether the sociocultural context and variables such as their worldview, traditions and customs, and beliefs relating to health communication and health behaviour are or were taken into consideration in the planning and implementation of the campaign; and whether or not the whole campaign process was theory-driven or underpinned by a theory/model?

Flowing from the assumptions and problem statement, the objective of the study was to construct a conceptual sociocultural health communication campaign model to serve as framework and guide for the development of a theoretical sociocultural assessment

instrument for health communication campaigns. The HIV/AIDS communication campaign of the Health Department of the Ekurhuleni Metropolitan Municipality was the communication campaign researched by testing the theoretical sociocultural assessment instrument as developed in the study.

To achieve the objectives of the study, the first step was to lay the foundation, through a literature review, noting current understandings of the nature and dynamics, inherent challenges and theoretical approaches to communication campaigns in general and health communication campaigns in particular. Forming part of this was to understand certain pertinent aspects of human behaviour, particularly human health behaviour. A key characteristic of communication campaigns (something vital to their nature and dynamics) was that a communication campaign is a planned activity of several steps, which are interrelated, interconnected and interdependent. Hence, a good communication campaign is not haphazard or arbitrary but deliberate and complete. This means all the steps in the whole process are to be carefully thought-out; and anchored on appropriate theories/models.

Knowledge gleaned from the literature review on communication campaigns and human behaviour; and subsequent reflection on this knowledge in light of the assumptions, problem statement and objectives of this study, resulted in the construction of a Conceptual Interactive-Participative Communication Campaign Model (Figure 3.9) as a contribution of this study. The model highlights the need for communication campaigns to be interactive and dialogical, in the sense that there ought to be interaction and dialog between the campaign planners and the target audience. Reflection and discussion on six widely used and cited theories and models, as intellectual foundation/framework for health education and health behaviour, resulted in the construction of the Cyclical Stages of Change Model (Figure 3.6) as a contribution of this study. The main aim of health communication campaign is to influence a target audience in such a manner as to bring about attitude change regarding some health problems or issues, which in turn should lead to health behaviour change. The 'Cyclical Stages of Change Model' highlights the fact that behaviour change is a process comprising precontemplation, contemplation, preparation, action and maintenance, and not just a once-off event or activity. Individuals go through this process differently because not all would be at the same level of motivation or readiness to change, hence, not all would be at the same stage in the process at the same time. Moreover, passage (movement) through the different stages is not unidirectional, but can also be bidirectional or two-way. Thus, for instance, a person who has progressed from the precontemplation stage to contemplation stage in the process of behaviour change may instead of moving on to preparation stage, revert to precontemplation stage. This could be due to an experience of demoralisation and

loss of confidence resulting from perceived or real lack of success at changing. Health communication campaign planners therefore need to be aware of, and take into consideration, the fact that different members of the target audience would respond differently to messages and activities of the campaign depending on what level of motivation and readiness to change they are at.

Health communication campaigns take place within a particular social and cultural context. This is because the target audience of any such campaign are social and cultural beings, thus they are sociocultural beings. The human being, therefore, is not an entity on his/her own. A person is a relational being in relation with and interacting with others, who depends on and is influenced by others. He/she in turn influences other persons, some of whom also depend on him/her. This makes human behaviour complex, something that cannot be understood and explained only from the perspective of the individual, but requires understanding elements of his/her social and cultural context. Sociocultural and self-determination theories provided insights into some of the essential aspects of the nature and dynamics of the complexity of human behaviour. According to the sociocultural theory, human behaviour is the result of two processes – biological stimuli and social or cultural context. The former originates from within the individual while the latter originates from socially and culturally generating and/or socially and culturally conditioned activity. This explanation of human behaviour by sociocultural theory falls short of explaining the origin of the capacity or ability an individual has within him/herself to master behaviour. Biological stimuli are mainly involuntary and socially and culturally generated and/or conditioned activity, mainly outside the individual's control. If a person's behaviour originates solely from these two sources then it would be right to maintain that the individual is not wholly (personally) responsible for his/her behaviour. This lacuna in the explanation of the origin of human behaviour by sociocultural theory is augmented by the explanation of self-determination theory, which states that, besides biological stimuli, human beings have within themselves certain innate motivation that makes them volitional or self-determined and thus responsible for some, if not all, of their behaviour.

The above laid the foundation of the study. The next step in the process of achieving the objective of the study was to understand the nature, the dynamics and the materials necessary for constructing a model. In essence, that was understanding the act of modelling, which is a cognitive/intellectual [mental] process of generating generalised, hypothetical descriptions, explanations and/or predictions of interrelated set of ideas and/or concepts of some phenomena represented in mathematical or pictorial [graphic] form. In this regard, Justi and Gilbert's 'Model of Modelling Framework' (2003) and Hestenes' 'Model

Development' (1998) complemented each other in providing the necessary understanding of the nature, dynamics, materials (building blocks) and process of modelling. Two important (and necessary) elements are required in (the act of) modelling, namely, structures and steps. Structures are the specifications of different set of relations (systemic, geometric, object, temporary and interaction) between the ideas and/or concepts, which are not concrete realities but conceptualisations that give the form, framework or shape of the model. The number of structures required in a particular act of modelling is determined by the type and nature of the model being constructed. The modeller is the one who decides on which set of relations to take into considering in modelling, based on the type of model he/she is constructing. Steps are the sequence (the flow) that the modeller follows in the modelling process – that is, determining what ought to be done first, followed by what (before moving on to something else) in the modelling process.

Understanding the act of modelling and deciding on which set of ideas or concepts would compose the structure of the sociocultural health communication campaign model, and the steps to take in the modelling process, paved the way for the actual work of modelling the sociocultural health communication model. That work resulted in the construction of the Conceptual Sociocultural Health Communication Campaign Model (Figure 4.3). Being a model designed as framework and guide for the development of the sociocultural assessment instrument for sociocultural health communication campaigns, it incorporates two vital elements. These elements, are firstly, the presence of the target audience (through their representatives) and their relationship with the communication campaign planners, their active participation in all the various steps of the campaign process, and, secondly, the anchoring of the communication campaign (the whole process) on theory/model, making it a campaign that is theory/model-driven. The position taken in this study with regard to the presence of the two elements/components in the model is that:

The target audience (of a health communication campaign) should not be treated or considered merely as recipients of messages. That is, they are targets at which conceptualised, designed and packaged messages are directed, without any input from them, with the hope that the messages would propel or motivate them to modify and/or change belief/perception and attitude about certain health problem, which in turn would result in behaviour change. Rather, the target audience should be recognised and treated as collaborators and active participants in the whole communication campaign process. Their inputs are to be considered as necessary to ensure higher level of sociocultural appropriateness of the health communication campaign.

The presence and active participation of the target audience in the health communication campaign process is not enough. This presence and active collaboration and participation should be complemented by the anchoring of the campaign on an appropriate and relevant theory/model. In other words, each individual stage or step of the campaign process should be underpinned by theory or a model, thus ensuring that the campaign is theory-driven from beginning to end.

Having constructed the sociocultural health communication campaign model, the next major step was to work on developing the sociocultural assessment instrument (using the former as framework and guide). Before embarking on developing the sociocultural assessment instrument, however, it was necessary to first explore the meaning of assessment and evaluation and their relationship. The two concepts are closely related, and are used interchangeably. They both connote a process of stating standards or setting norms against which collected or gathered data are compared, for the purpose of arriving at a judgement as to the convergence or divergence of evidence of the data with or from the stated standards respectively. This is a process of critically and systematically collecting, analysing, and interpreting data and drawing some conclusion. To help elucidate the intricate nature and dynamics of the relationship between the two concepts, particularly in assessment/evaluation of a communication campaign, the Assessment Process Model (Figure 5.1) was developed as another contribution of this study. This model presented guidelines for the assessment/evaluation process where it is possible to evaluate the whole communication campaign, and the individual or particular stages of the process, separately. The Logic Model and CDC Framework for Program Evaluation (2006) provided the background for understanding and appreciating the nature and dynamics of the process of evaluation; and since the sociocultural assessment instrument was developed for sociocultural health communication campaigns, it was necessary to understand the nature and dynamics of measuring/measurement. Measurement is a process of careful and deliberate observation of a phenomenon or activity. This deliberate observation is for the purpose of identifying and describing, and/or assigning value/s to the attributes that compose phenomenon or activity in the form of numbers or some other symbols, which help to give the variables some specific meaning/s in both the physical and social sciences. To determine if the phenomenon or activity has achieved its stated objectives, the phenomenon or activity is deliberately observed, and values in the form of numbers or some other symbols are assigned to its attributes/variables. Assigning these values helps to give the variables some specific meaning/s.

The preceding reflection led to the development of the Theory-driven Evaluation Framework, another contribution of this study, as a tool that highlights and explains vital components that ought to be present in an evaluation process. In addition, the Framework draws attention to the need for evaluation to encompass the whole communication campaign process, not just the outcome. The Theory-driven Evaluation Framework is a framework that serves as a guiding tool for evaluators in the planning and implementation of assessment of communication campaigns. For the purposes of this study, the Theory-driven Evaluation Framework, guided the development of the Sociocultural Assessment Instrument by making it possible and easier to decide which pathways of a communication campaign should receive attention and which standards should be the focus of the evaluation process.

After developing the Theoretical Sociocultural Assessment Instrument, the next logical step in the research process was to test the instrument to verify its suitability as an appropriate sociocultural assessment instrument. The testing was carried out in the HIV/AIDS communication campaign of HIV/AIDS Unit of the Health Department of the Ekurhuleni Metropolitan Municipality.

The research results show that the first and second assumptions on which this study was premised, and which served as standards against which the Ekurhuleni Municipality HIV/AIDS communication campaign was assessed, fulfilled the criteria and guidelines set. The first assumption was the active involvement and participation of target audience (through their recognised representatives) in the whole process of a health communication campaign. The second assumption is the need for communication campaign planners to take cognisance of the sociocultural context and factors of the target audience. If this need is recognised and responded to appropriately, it should contribute to the sociocultural health communication campaign. This seems to have happened in the Ekurhuleni Municipality HIV/AIDS communication campaign as the results indicate.

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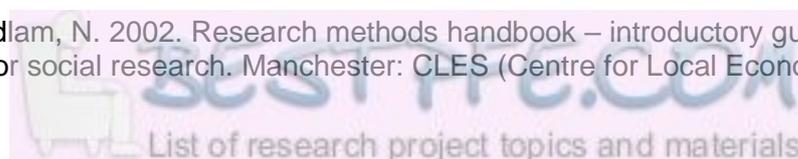
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THE THEORETICAL SOCIOCULTURAL ASSESSMENT INSTRUMENT

Stage 1: Strategic Planning and Development Q1.1 Relationship/Interaction between Communication Campaign Planners and Representatives of the Target Audience	
Answer the questions below with a number point/s from 1 to 4 (1=no/never, 2=some/sometimes, 3=most/frequently, 4=yes/always)	**Question point/s**
Question — 1.1.1 Do/did you have any relationship/interaction with target audience through (its) credible and recognized representatives? If yes, what is/was the nature of interaction and for what reason? ……………………………………………………………… ……………………………………………………………… ……………………………………………………………… ……………………………………………………………… ………………………………………………………………	**A**
1.1.2 In your relationship with the target audience, do/did you regard their representatives as partners who would make valuable contribution to the campaign process?	**B**
Scoring Guide — **Yes/Always (4)** -- Relationship/interaction with the target audience through its representatives always takes/took place. **Most/Frequently (3**) -- Relationship/interaction with the target audience through its representatives frequently takes/took place. **Some/Sometimes (2) --**Relationship/interaction with target audience through its representatives sometimes takes/took place. **No/Never (1)** -- Relationship/interaction with target audience never takes/took place.	**Overall Assessment Point/s for Relationship/inter-action between communication campaign planners and representatives of target audience** (Add values of A+B then divide this sum by 2. Enter number in box below.

Appendix 1a   Q1.1 of Stage 1: Strategic Plaaning and Development Stage

Stage 1: Strategic Planning and Development	
Q1.2 Health Problem and Health Behaviour of the Target Audience	
Answer the questions below with a number point/s from 1 to 4 (1=no/never, 2=some/sometimes, 3=most/frequently, 4=yes/always)	**Question Point/s**
Question 1.2.1 In identifying the health problem do/did you consult and discuss with representatives of the target audience?	**A**
1.2.2 Do/did you consult and discuss with the representatives of the target audience their perception of the health problem?	**B**
1.2.3 Do/did you consult and discuss with representatives of the target audience what cultural/traditional beliefs, taboos etc., they associate with the health problem and health behaviour? If yes what are these? ……………………………………………………………… ……………………………………………………………… ……………………………………………………………… ………………………………………………………………	**C**
1.2.4 Do/did you consult and discuss with the representatives of the target audience as to who within their sociocultural context, would be the more appropriate person to talk about the health problem and health behaviour; how he/she would go about talking it, and at what times and where?	**D**
Scoring Guide **Yes/Always (4)** -- Consultation and discussion with the target audience through its representatives always takes/took place.	**Overall Assessment Point/s for health problem and health behaviour of the target audience** (Add values of A+B+C+D, then divide this sum by 4. Enter number in box below.)
Most/Frequently (3) -- Consultation and discussion with the target audience through its representatives frequently takes/took place.	
Some/Sometimes (2) -- Consultation and discussion with the target audience through its representatives sometimes takes/took place.	
No/Never (1) -- Consultation and discussion with the target audience through its representatives never takes/took place.	

Appendix 1b Q1.2 of Stage 1: Strategic Planning and Development Stage

Stage 1: Strategic Planning and Development Q1.3 Objective/s of the Health Communication Campaign		
Answer the questions below with a number point/s from 1 to 4 (1=no/never, 2=some/sometimes, 3=most/frequently, 4=yes/always)		**Question Point/s**
Question	1.3.1 In setting objective/s of the health communication campaign do/did you consult and discuss with representatives of the target audience what the objective/s should be and why?	**A**
	1.3.2 Do/did you do investigation of the relevance of the objective/s in relation to the sociocultural context and the health behaviour of the target audience in consultation with their representatives? If yes, what is the relevance and what was the concrete suggestion/s of the representatives of the target audience? …………………………………………………………… …………………………………………………………… …………………………………………………………… …………………………………………………………… ………………………………………………………….. …………………………………………………………… ……………………………………………………………	**B**
Scoring Guide	**Yes/Always (4)** -- Consultation and discussion of objective/s with target audience through its representatives always takes/took place.	**Overall Assessment Point/s for objective/s of the health communication campaign.** (Add values of A+B then divide this sum by 2. Enter number in box below).
	Most/Frequently (3) -- Consultation and discussion of objectives/s with the target audience through its representatives frequently takes/took place.	
	Some/Sometimes (2) -- Consultation and discussion of objective/s with the target audience through its representatives sometimes takes/took place.	
	No/Never (1) -- Consultation and discussion of objective/s with the target audience through its representatives never takes/took place.	

Appendix 1c Q1.3 of Stage 1: Strategic Planning and Development Stage

Stage 1: Strategic Planning and Development Q1.4 Theory-Driven Planning and Strategy Development		
Answer the questions below with a number point/s from 1 to 4 (1=no/never, 2=some/sometimes, 3=most/frequently, 4=yes/always)		**Question Point/s**
Question	1.4.1 Do/did you discuss and explain to the representatives of the target audience the need to understand their health problem from the perspective of some relevant and appropriate theories or models? If yes, what theory or model is/was used? …………………………………………………………… ……………………………………………………	**A**
	1.4.2 Do/did you discuss and explain to the representatives of the target audience the need to understand their health behaviour from the perspective of some relevant and appropriate theories or models? If yes, what theory or model is/was used? …………………………………………………………… ……………………………………………………	**B**
	1.4.3 Do/did you discuss and explain to the representatives of the target audience how the chosen theories or models influence the settings of objective/s of the health communication campaign?	**C**
Scoring Guide	**Yes/Always (4)** -- Discussion and explanation of theory or model with target audience through its representatives always takes/took place.	**Overall Assessment Point/s for theory-driven planning and design** (Add values of A+B+C then divide this sum by 3. Enter number in box below).
	Most/Frequently (3) -- Discussion and explanation of theory or model with the target audience through its representatives frequently takes/took place.	
	Some/Sometimes (2) -- Discussion and explanation of theory or model with the target audience through its representatives sometimes takes/took place.	
	No/Never (1) -- Discussion and explanation of theory or model with the target audience through its representatives never takes/took place.	

Appendix 1d   Q1.4 of Stage 1: Theory-Driven Strategic Planning and Developomt

Stage 2: Developing and Pre-testing Concepts, Messages and Materials Q2.1 Communication Campaign Message/s & Materials' Development		
Answer the questions below with a number point/s from 1 to 4 (1=no/never, 2=some/sometimes, 3=most/frequently, 4=yes/always)		**Question Point/s**
Question	2.1.1 Do/did you consult and discuss with the representatives of the target audience what concepts should be used in the health communication campaign in order that they may be understood within the context and maybe easily accepted?	**A**
	2.1.2 Do/did you consult and discuss with the representatives of the target audience what the messages of the communication campaign should be?	**B**
	2.1.3 Do/did you consult and discuss with the representatives of the target audience how the messages of the health communication campaign should be packaged?	**C**
	2.1.4 Do/did you consult and discuss with the representatives of the target audience what campaign materials could and in what form?	**D**
	2.1.5 Do/did you consult and discuss with the representatives of the target audience how best to pretext the packed message/s?	**E**
Scoring Guide	**Yes/Always (4)** -- Consultation and discussion of message development with target audience through its representatives always takes/took place.	**Overall Assessment Point/s for developing and pre-testing concepts, messages and materials of the communication campaign** (Add values of A+B+C+D+E then divide this sum by 5. Enter number in box below).
	Most/Frequently (3) -- Consultation and discussion of message development with the target audience through its representatives frequently takes/took place.	
	Some/Sometimes (2) -- Consultation and discussion of message development with the target audience through its representatives sometimes takes/took place.	
	No/Never (1) -- Consultation and discussion of message development with the target audience through its representatives never takes/took place.	

Appendix 2a   Q2.1 of Stage 2: Developing and Pre-testing Concepts, Messages and Materials

Stage 2: Developing and Pre-testing Concepts, Messages and Materials Q2.2 Choice of Communication Campaign Channels		
Answer the questions below with a number point/s from 1 to 4 (1=no/never, 2=some/sometimes, 3=most/frequently, 4=yes/always)		**Question Point/s**
Question	2.2.1 Do/did you consult and discuss with the representatives of the target audience what communication channel/s (interpersonal, group, radio, drama to use to communicate the message?	**A**
	2.2.2 Do/did you consult and discuss with the representatives of the target audience how socioculturally appropriate the channel/s selected are?	**B**
	2.2.3 Do/did you consult and discuss with the representatives of the target audience how best the channel/s selected maybe used in delivering the message/s?	**C**
Scoring Guide	**Yes/Always (4)** -- Consultation and discussion of communication channel with target audience through its representatives always takes/took place.	**Overall Assessment Point/s for choice of communication campaign channels.** (Add values of A+B+C then divide this sum by 3. Enter number in box below).
	Most/Frequently (3) -- Consultation and discussion of communication channel with the target audience through its representatives frequently takes/took place.	
	Some/Sometimes (2) -- Consultation and discussion of communication channel with the target audience through its representatives sometimes takes/took place.	
	No/Never (1) -- Consultation and discussion of communication channel with the target audience through its representatives never takes/took place.	

Appendix 2b   Q2.2 of Stage 2b: Developing and Pre-testing Concepts, Messages and Materials

Stage 2: Development and Pre-testing Concepts, Messages and Materials		
Q2.3 Involvement of Target Audience in Message Delivery		
Answer the questions below with a number point/s from 1 to 4 (1=no/never, 2=some/sometimes, 3=most/frequently, 4=yes/always)		**Question Point/s**
Question	2.3.1 Do/did you train and prepare representatives of the target audience to participate or play a role in message delivery?	**A**
	2.3.2 Do/did you give trained representatives of the target audience the opportunity to present some of the messages?	**B**
	2.3.3 Do/did consult and discuss with the representatives of the target audience who they would consider as most credible and acceptable person/s to communicate the campaign messages?	**C**
	2.3.4 Do/did you consult and discuss with the representatives of the target audience how best to pre-test the channels chosen as means of communicating the messages?	**D**
Scoring Guide	**Yes/Always (4)** -- Representatives of target audience involvement in message delivery always takes/took place.	**Overall Assessment Point/s for involvement of target audience in message delivery**
	Most/Frequently (3) -- Representatives of target audience involvement in message delivery frequently takes/took place.	(Add values of A+B+C+D then divide this sum by 4. Enter number in box below).
	Some/Sometimes (2) -- Representatives of target audience involvement in message delivery sometimes takes/took place.	
	No/Never (1) -- Representatives of target audience involvement in message delivery never takes/took place	

Appendix 2c   Q2.3 of Stage 2: Developing and Pre-testing Concepts, Messages

Stage 2: Developing and Pre-testing Concepts, Messages and Materials		
Q2.4 Theory-Driven Development and Pre-testing of Concepts, Messages and Materials		
Answer the questions below with a number point/s from 1 to 4 (1=no/never, 2=some/sometimes, 3=most/frequently, 4=yes/always)		**Question Point/s**
Question	2.4.1 Do/did you discuss and explain to the representatives of the target audience the need for the choice of message to be informed by an appropriate theory/model? If yes, what theory or model is/was it? ………………………………………………………	**A**
	2.4.2 Do/did you discuss and explain to the representatives of the target audience the need for the choice of communication campaign channel/s to be informed by theory/model? If yes, what theory or model is/was it? ………………………………………………………	**B**
	2.4.3 Do/did you discuss and explain to the representatives of the target audience the need for the involvement of representatives of target audience in message delivery to be informed by theory/model? If yes, what theory or model is/was it? ………………………………………………………	**C**
Scoring Guide	**Yes/Always (4)** -- Discussion and explanation of theory or model with target audience through its representatives always took place. **Most/Frequently (3**) -- Discussion and explanation of theory or model with the target audience through its representatives frequently took place. **Some/Sometimes (2) -**- Discussion and explanation of theory or model with the target audience through its representatives took place sometimes. **No/Never (1)** -- Discussion and explanation of theory or model with the target audience through its representatives never took place.	**Overall Assessment Point/s for theory-driven programme implementation** (Add values of A+B+C then divide this sum by 3. Enter number in box below).

Appendix 2d   Q2.4 of Stage 2: Developing and Pre-testing Concepts, Messages and Materials

Stage 3: Creative Campaign Implementation		
Q3.1 The Nature and Dynamics of the Campaign Implementation		
Answer the questions below with a number point/s from 1 to 4 (1=no/never, 2=some/sometimes, 3=most/frequently, 4=yes/always)		**Question Point/s**
Question	3.1.1 Do/did you discuss and explain to the representatives of the target audience what would constitute the implementation of the campaign?	**A**
	3.1.2 Do/did the representatives of the target audience contribute to or make suggestions as to what could constitute the implementation of the communication campaign?	**B**
	3.1.3 Do/did you discuss and explain to the representatives of the target audience the dynamics of how the implementation would be carried out?	**C**
	3.1.4 Do/did the representatives of the target audience contribute to or suggests some social and culturally appropriate ways of implementing the campaign?	**D**
	3.1.5 Do/did you discuss and explain to the representatives of need for some of target audience to play active roles in the actual implementation of the campaign?	**E**
	3.1.6 Are/did some members of the target audience actually involved or got involved in the implementation process of the communication campaign?	**F**
Scoring Guide	**Yes/Always (4)** -- Discussion and explanation; contribution/suggestion; involvement of representatives of the target audience on the nature and dynamics of the campaign implementation always takes/took place.	**Overall Assessment Point/s for Nature and Dynamics of the Campaign Implementation** (Add values of A+B+C+D+E+F then divide this sum by 6. Enter number in box below).
	Most/Frequently (3) -- Discussion and explanation; contribution/suggestion; involvement of representatives of the target audience on the nature and dynamics of the campaign implementation takes/took place most frequently.	
	Some/Sometimes (2) -- Discussion and explanation; contribution/suggestion; involvement of representatives of the target audience on the nature and dynamics of the campaign implementation sometimes takes/took place.	
	No/Never (1) -- Discussion and explanation; contribution/suggestion; involvement of representatives of the target audience on the nature and dynamics of the campaign implementation never takes/took place.	

Appendix 3a   Q3.1 of Stage 3: Creative Campaign Implementation

Stage 3: Creative Campaign Implementation		
Q3.2 Theory-Driven Campaign Implementation		
Answer the questions below with a number point/s from 1 to 4 (1=no/never, 2=some/sometimes, 3=most/frequently, 4=yes/always)		**Question Point/s**
Question	3.2.1 Do/did you discuss and explain to the representatives of the target audience the need for the whole component of the implementation of the campaign process to be informed by an appropriate theory/model? If yes, what theory or model is/was it? ………………………………………………………	**A**
	3.2.2 Do/did you discuss and explain to the representatives of the target audience the theory/model that informs/informed the decision to implement in the manner in which it is or had been implemented? If yes, what theory or model is/was it? ………………………………………………………	**B**
	3.2.3 Do/did you discuss and explain to the representatives of the target audience the theory/model that underpins need for active involvement of some members of the target audience in the implementation not just as recipients but also as animators/facilitators? If yes, what theory or model is/was it? ………………………………………………………	**C**
Scoring Guide	**Yes/Always (4)** -- Discussion and explanation of theory/ model that underpins campaign implementation with target audience through its representatives always takes/took place.	**Overall Assessment Point/s for theory-driven programme implementation** (Add values of A+B+C then divide this sum by 3. Enter number in box below).
	Most/Frequently (3) -- Discussion and explanation of theory/model that underpins campaign implementation with the target audience through its representatives frequently takes/took place.	
	Some/Sometimes (2) -- Discussion and explanation of theory/model that underpins campaign implementation with the target audience through its representatives sometimes takes/took place.	
	No/Never (1) -- Discussion and explanation of theory/ model that underpins campaign implementation with the target audience through its representatives never took place.	

Appendix 3b   Q3.2 of Stage 1: Creative Campaign Impolementation

Stage 4: Continuous Monitoring and Evaluation		
Q4.1The Nature and Dynamics of Monitoring and Evaluation		
Answer the questions below with a number point/s from 1 to 4 (1=no/never, 2=some/sometimes, 3=most/frequently, 4=yes/always)		**Question Point/s**
Question	4.1.1 Do/did you discuss and explain to representatives of the target audience the need to monitor and evaluate the communication campaign process?	**A**
	4.1.2 Do/did you consult and discuss with representatives of the target audience the structure, format and dynamics of the process of monitoring and evaluating of communication campaign?	**B**
	4.1.3 Do/did the representatives of the target audience contribute to or suggest some social and culturally appropriate ways of monitoring and evaluating the communication campaign process?	**C**
	4.1.4 Do/did you discuss and explain to the representatives of need for some of target audience to play active roles in the actual monitoring and evaluation process of the communication campaign?	**D**
	4.1.5 Are/did some members of the target audience actually involved in or got involved in the process of monitoring and evaluation of the communication campaign?	**E**
Scoring Guide	**Yes/Always (4)** -- Discussion and explanation; contribution/suggestion; involvement of representatives of the target audience on/in the nature and dynamics of monitoring and evaluation always takes/took place.	**Overall Assessment Point/s for theory-driven programme implementation.** (Add values of A+B+C+D+E then divide this sum by 5. Enter number in box below).
	Most/Frequently (3) -- Discussion and explanation; contribution/suggestion; involvement of representatives of the target audience on/in the nature and dynamics of monitoring and evaluation takes/took place most frequently.	
	Some/Sometimes (2) -- Discussion and explanation; contribution/suggestion; involvement of representatives of the target audience on the nature and dynamics of monitoring and evaluation sometimes takes/took place.	
	No/Never (1) -- Discussion and explanation; contribution/suggestion; involvement of representatives of the target audience on the nature and dynamics of monitoring and evaluation never takes/took place.	

Appendix 4a Q4.1 of Stage 4: Continuous Monitoring and Evaluation

Stage 4: Continuous Monitoring and Evaluation Q4.2 Theory-Driven Campaign Monitoring and Evaluation		
Answer the questions below with a number point/s from 1 to 4 (1=no/never, 2=some/sometimes, 3=most/frequently, 4=yes/always)		**Question Point/s**
Question	4.2.1 Do/did you discuss and explain to the representatives of the target audience the need for the whole component of monitoring and evaluation of the campaign process to be informed by appropriate theory/model? If yes, what theory or model is/was it? ……………………………………………………………	**A**
	4.2.2 Do/did you discuss and explain to the representatives of the target audience the theory/model that informs/informed the decision to monitor and evaluate the communication in the manner in which it is or had been monitored and evaluated? If yes, what theory or model is/was it? ……………………………………………………………	**B**
	4.2.3 Do/did you discuss and explain to the representatives of the target audience the theory/model that underpins need for active involvement of some members of the target audience in monitoring and evaluating the communication campaign? If yes, what theory or model is/was it? ……………………………………………………………	**C**
Scoring Guide	**Yes/Always (4)** -- Discussion and explanation of theory/ model that underpins the monitoring and evaluation of the communication campaign always takes/took place.	**Overall Assessment Point/s for theory-driven programme implementation.** (Add values of A+B+C, then divide this sum by 3. Enter number in box below.)
	Most/Frequently (3) -- Discussion and explanation of theory/model that underpins monitoring and evaluation of the communication campaign frequently takes/took place.	
	Some/Sometimes (2) -- Discussion and explanation of theory/model that underpins monitoring and evaluation of the communication campaign sometimes takes/took place.	
	No/Never (1) -- Discussion and explanation of theory/ model that underpins monitoring and evaluating of the communication campaign never took place.	

Appendix 4b Q4.1 of Stage 4: Continuous Monitoring and Evaluation

APPENDIX 2

LIST OF THE EKURHULENI MUNICIPALITY HEALTH DEPARTMENT HIV/AIDS UNIT MEMBERS WHO PARTICIPATED IN THE GROUP ADMINISTERED INTERACTIVE QUESTIONNAIRE

NAMES	DESIGNATION	WORK AREA	SECTORS RESPONSIBLE
Mr Thabiso W. **Peo**	Executive Manager	Alberton	N/A
Ms Constance **Mabena**	Aids Coordinator	Springs	• Transport • FBO
Mrs Ntale **Mokgabudi**	Aids Coordinator	Nigel / Duduza	• Traditional Healers • Research and Academics
Mr Stanley **Masemola**	Aids Coordinator	Katlehong 1 & 2	• Traditional Leaders • Health
Ms Boitumelo **Sehume**	Aids Coordinator	Thokoza	• NGO • Education
Ms Yvonne **Mashinini**	Aids Coordinator	Benoni / Dayeton	• Orphans and Vulnerable Children • Business
Mr Jonas **Maluleke**	Aids Coordinator	Tembisa	• People Living with HIV • Disability
Mr George **Rakabe**	Aids Coordinator	Kempton Park / Edenvale	• Men • LGBTI
Mr Seage **Matenche**	Aids Coordinator	Germiston / Alberton	• Organised Labor • Sports, Communication
Ms Nsiki **Dudazana**	Aids Coordinator	Boksburg / Vosloorus	• Women • Youth

APPENDIX 3

POINTS OF INDIVIDUAL ANSWERS OF PARTICIPANTS

Stage 1: Planning and Strategy Development

Questions	Participants									
	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
Q1.1.1.1	2	4	4	4	4	3	4	4	4	4
Q1.1.1.2	4	3	4	4	4	3	3	4	4	4
Q1.1.2.1	3	3	3	3	4	3	3	3	3	4
Q1.1.2.2	3	4	3	3	4	3	3	4	3	4
Q1.1.2.3	3	3	4	4	3	2	3	3	4	3
Q1.1.2.4	3	2	3	3	3	3	2	2	3	2
Q1.1.3.1	3	3	3	4	3	3	4	3	3	4
Q1.1.3.2	4	3	3	3	4	3	2	3	4	3
Q1.1.4.1	3	3	3	2	3	2	3	2	3	2
Q1.1.4.2	3	2	2	2	2	2	2	2	3	2
Q1.1.4.3	3	2	3	2	2	2	2	2	2	2

Stage 2: Developing and Pre-testing Concepts, Messages and Materials

Questions	Participants (P...)									
	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
Q2.2.1.1	4	4	4	4	4	3	4	4	3	4
Q2.2.1.2	4	4	4	4	4	3	4	4	3	4
Q2.2.1.3	4	4	4	3	4	4	3	4	4	4
Q2.2.1.4	4	4	4	4	4	3	4	4	4	3
Q2.2.1.5	2	1	1	1	2	1	1	1	1	1
Q2.2.2.1	3	3	2	4	3	3	4	3	3	4
Q2.2.2.2	4	4	4	4	4	3	3	4	4	4
Q2.2.2.3	2	3	3	3	3	3	3	3	3	2
Q2.2.3.1	3	4	4	4	3	4	4	4	3	2
Q2.2.3.2	4	4	3	3	2	4	4	3	4	2
Q2.2.3.3	4	4	4	4	3	4	4	3	4	2
Q2.2.3.4	4	3	3	3	4	3	4	3	3	3
Q2.2.4.1	1	1	1	2	1	1	1	1	2	1
Q2.2.4.2	1	1	1	2	1	1	1	2	1	1
Q2.2.4.3	2	1	1	2	2	1	1	1	1	1

Stage 3: Campaign Implementation

Questions	Participants									
	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
Q3.3.1.1	4	4	4	4	4	3	4	4	4	4
Q3.3.1.2	4	3	4	4	4	3	3	4	4	4
Q3.3.1.3	3	3	3	3	4	3	3	3	3	4
Q3.3.1.4	3	4	3	3	4	3	3	4	3	4
Q3.3.1.5	3	4	4	4	3	3	3	3	3	3
Q3.3.1.6	2	2	2	2	3	3	2	2	2	2
Q3.3.2.1	2	3	2	4	3	3	4	3	4	3
Q3.3.2.2	4	3	2	2	4	3	2	3	4	3
Q3.3.2.3	2	2	3	3	2	2	3	2	2	2

Stage 4: Monitoring and Evaluation

Questions	Participants									
	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
Q4.4.1.1	4	4	3	3	4	4	4	4	3	4
Q4.4.1.2	4	4	4	4	4	4	4	4	3	4
Q4.4.1.3	2	2	2	2	4	1	1	2	2	2
Q4.4.1.4	1	2	2	2	2	1	2	2	2	1
Q4.4.1.5	3	4	4	4	3	4	4	4	4	4
Q4.4.2.1	4	2	2	1	1	1	4	1	2	1
Q4.4.2.2	4	3	3	4	4	4	4	4	3	3
Q4.4.2.3	4	1	1	1	1	1	4	1	2	1

APPENDIX 4

GROUP ANSWERS TO QUESTIONS OF GROUP ADMINISTERED ASSESSMENT INSTRUMENT

Stage 1: Planning and Strategy Development Q1.1 Relationship/Interaction between Communication Campaign Planners and Representatives of the Target Audience	
Answer the questions below with a number score from 1 to 4 (1=no/never, 2=some/sometimes, 3=most/frequently, 4=yes/always)	Question Score
Question — 1.1.1 Do/did you have any relationship/interaction with target audience through (its) credible and recognized representatives? If yes, what is/was the nature of interaction and for what reason? *Yes* *Operational area for* *HIV/AIDS Education* *- for analysis &* *agreeing on intervention* *- Policies of* *consultation*	A 4
1.1.2 In your relationship with the target audience, do/did you regard their representatives as partners who would make valuable contribution to the campaign process?	B 4
Scoring Guide — **Yes/Always (4)** -- Relationship/interaction with the target audience through its representatives always takes/took place. **Most/Frequently (3)** -- Relationship/interaction with the target audience through its representatives frequently takes/took place. **Some/Sometimes (2)** --Relationship/interaction with target audience through its representatives sometimes takes/took place. **No/Never (1)** -- Relationship/interaction with target audience never takes/took place.	**Overall Assessment Score for Relationship/inter-action between communication campaign planners and representatives of target audience** (Add values of A+B, then divide this sum by 2. Enter number in box below. 4

Stage 1: Planning and Strategy Development	
Q1.2 Health Problem and Health Behaviour of the Target Audience	

Answer the questions below with a number score from 1 to 4 (1=no/never, 2=some/sometimes, 3=most/frequently, 4=yes/always)	Question Score
Question	**1.2.1** In identifying the health problem do/did you consult and discuss with representatives of the target audience?	A 3
	1.2.2 Do/did you consult and discuss with the representatives of the target audience their perception of the health problem?	B 3
	1.2.3 Do/did you consult and discuss with representatives of the target audience what cultural/traditional beliefs, taboos etc., they associate with the health problem and health behaviour? If yes what are these? (Yes) - Bewitching - Cultural attitudes x practices, multiple x concurrent partners, Gender stereotypes	C 3
	1.2.4 Do/did you consult and discuss with the representatives of the target audience as to who within their sociocultural context, would be the more appropriate person to talk about the health problem and health behaviour; how he/she would go about talking it, and at what times and where?	D 2
Scoring Guide	**Yes/Always (4)** -- Consultation and discussion with the target audience through its representatives always takes/took place.	**Overall Assessment Score for health problem and health behaviour of the target audience** (Add values of A+B+C+D, then divide this sum by 4. Enter number in box below.) 2.75
	Most/Frequently (3) -- Consultation and discussion with the target audience through its representatives frequently takes/took place.	
	Some/Sometimes (2) -- Consultation and discussion with the target audience through its representatives sometimes takes/took place.	
	No/Never (1) -- Consultation and discussion with the target audience through its representatives never takes/took place.	

Stage 1: Planning and Strategy Development
Q1.3 Objective/s of the Health Communication Campaign

Answer the questions below with a number score from 1 to 4 (1=no/never, 2=some/sometimes, 3=most/frequently, 4=yes/always)		Question Score
Question	1.3.1 In setting objective/s of the health communication campaign do/did you consult and discuss with representatives of the target audience what the objective/s should be and why?	A 3
	1.3.2 Do/did you do investigation of the relevance of the objective/s in relation to the sociocultural context and the health behaviour of the target audience in consultation with their representatives? If yes, what is the relevance and what was the concrete suggestion/s of the representatives of the target audience? (Yes) → ...... ← ..... Similar answer to those of question 1.2-3 above	B 2
Scoring Guide	Yes/Always (4) -- Consultation and discussion of objective/s with target audience through its representatives always takes/took place. Most/Frequently (3) -- Consultation and discussion of objectives/s with the target audience through its representatives frequently takes/took place. Some/Sometimes (2) -- Consultation and discussion of objective/s with the target audience through its representatives sometimes takes/took place. No/Never (1) -- Consultation and discussion of objective/s with the target audience through its representatives never takes/took place.	**Overall Assessment Score for objective/s of the health communication campaign.** (Add values of A+B, then divide this sum by 2. Enter number in box below. 3

Stage 1: Planning and Strategy Development		
Q1.4 Theory-Driven Planning and Strategy Development		

Answer the questions below with a number score from 1 to 4 (1=no/never, 2=some/sometimes, 3=most/frequently, 4=yes/always)		Question Score
Question	1.4.1 Do/did you discuss and explain to the representatives of the target audience the need to understand their health problem from the perspective of some relevant and appropriate theories or models? If yes, what theory or model is/was used? _HIV Consulting & Testing (HCT) & Prevention of mother to Child transmission (PMTCT)_	A 2
	1.4.2 Do/did you discuss and explain to the representatives of the target audience the need to understand their health behaviour from the perspective of some relevant and appropriate theories or models? If yes, what theory or model is/was used? _HCT & PMTCT (same as above)_	B 2
	1.4.3 Do/did you discuss and explain to the representatives of the target audience how the chosen theories or models influence the settings of objective/s of the health communication campaign?	C 2
Scoring Guide	**Yes/Always (4)** -- Discussion and explanation of theory or model with target audience through its representatives always takes/took place. **Most/Frequently (3)** -- Discussion and explanation of theory or model with the target audience through its representatives frequently takes/took place. **Some/Sometimes (2)** -- Discussion and explanation of theory or model with the target audience through its representatives sometimes takes/took place. **No/Never (1)** -- Discussion and explanation of theory or model with the target audience through its representatives never takes/took place.	**Overall Assessment Score for theory-driven planning and design.** (Add values of A+B+C, then divide this sum by 3. Enter number in box below. 2

The overall score for Stage 1: Planning and Strategy Development

STANDARD	SCORE	
Relationship/interaction between Communication Campaign Planners and Representatives of the Target Audience	A	4
Health Problem and Health Behaviour of the Target Audience	B	2.75
Objective/s of the Health Communication Campaign	C	3
Theory-Driven Planning and Design	D	2
Add values A+B+C+D and divide this by 4. Enter the number in the box to the right	**OVERALL SOCRE FOR PLANNING AND DESIGN** 2.93	

Answer the questions below with a number score from 1 to 4 (1=no/never, 2=some/sometimes, 3=most/frequently, 4=yes/always)		**Question Score**
Question	2.1.1 Do/did you consult and discuss with the representatives of the target audience what concepts should be used in the health communication campaign in order that they may be understood within the context and maybe easily accepted?	A 4
	2.1.2 Do/did you consult and discuss with the representatives of the target audience what the messages of the communication campaign should be?	B 4
	2.1.3 Do/did you consult and discuss with the representatives of the target audience how the messages of the health communication campaign should be packaged?	C 4
	2.1.4 Do/did you consult and discuss with the representatives of the target audience what campaign materials could and in what form?	D 4
	2.1.5 Do/did you consult and discuss with the representatives of the target audience how best to pretext the packed message/s?	E 1
Scoring Guide	**Yes/Always (4)** -- Consultation and discussion of message development with target audience through its representatives always takes/took place.	**Overall Assessment Score for developing and pretesting concepts, messages and materials of the communication campaign.** (Add values of A+B+C+D+E, then divide this sum by 5. Enter number in box below.) 3·4
	Most/Frequently (3) -- Consultation and discussion of message development with the target audience through its representatives frequently takes/took place.	
	Some/Sometimes (2) -- Consultation and discussion of message development with the target audience through its representatives sometimes takes/took place.	
	No/Never (1) -- Consultation and discussion of message development with the target audience through its representatives never takes/took place.	

Stage 2: Developing and Pretesting Concepts, Messages and Materials
Q2.2 Choice of Communication Campaign Channels

Answer the questions below with a number score from 1 to 4 (1=no/never, 2=some/sometimes, 3=most/frequently, 4=yes/always)		Question Score
Question	2.2.1 Do/did you consult and discuss with the representatives of the target audience what communication channel/s (interpersonal, group, radio, drama et cetera) to use to communicate the message?	A 3
	2.2.2 Do/did you consult and discuss with the representatives of the target audience how socioculturally appropriate the channel/s selected are?	B 4
	2.2.3 Do/did you consult and discuss with the representatives of the target audience how best the channel/s selected maybe used in delivering the message/s?	C 3
Scoring Guide	**Yes/Always (4)** -- Consultation and discussion of communication channel with target audience through its representatives always takes/took place.	**Overall Assessment Score for choice of communication campaign channels.**
	Most/Frequently (3) -- Consultation and discussion of communication channel with the target audience through its representatives frequently takes/took place.	(Add values of A+B+C, then divide this sum by 3. Enter number in box below.
	Some/Sometimes (2) -- Consultation and discussion of communication channel with the target audience through its representatives sometimes takes/took place.	
	No/Never (1) -- Consultation and discussion of communication channel with the target audience through its representatives never takes/took place.	3.3

Answer the questions below with a number score from 1 to 4 (1=no/never, 2=some/sometimes, 3=most/frequently, 4=yes/always)		Question Score
Question	2.3.1 Do/did you train and prepare representatives of the target audience to participate or play a role in message delivery?	A *4*
	2.3.2 Do/did you give trained representatives of the target audience the opportunity to present some of the messages?	B *4*
	2.3.3 Do/did consult and discuss with the representatives of the target audience who they would consider as most credible and acceptable person/s to communicate the campaign messages?	C *4*
	2.3.4 Do/did you consult and discuss with the representatives of the target audience how best to pre-test the channels chosen as means of communicating the messages?	D *3*
Scoring Guide	**Yes/Always (4)** -- Representatives of target audience involvement in message delivery always takes/took place.	**Overall Assessment Score for involvement of target audience in message delivery.** (Add values of A+B+C+D, then divide this sum by 4. Enter number in box below. *3·75*
	Most/Frequently (3) -- Representatives of target audience involvement in message delivery frequently takes/took place.	
	Some/Sometimes (2) -- Representatives of target audience involvement in message delivery sometimes takes/took place.	
	No/Never (1) -- Representatives of target audience involvement in message delivery never takes/took place	

Stage 2: Developing and Pretesting Concepts, Messages and Materials Q2.4 Theory-Driven Development and Pretesting of Concepts, Messages and Materials		
Answer the questions below with a number score from 1 to 4 (1=no/never, 2=some/sometimes, 3=most/frequently, 4=yes/always)		**Question Score**
Question	2.4.1 Do/did you discuss and explain to the representatives of the target audience the need for the choice of message to be informed by an appropriate theory/model? If yes, what theory or model is/was it?	A 1
	2.4.2 Do/did you discuss and explain to the representatives of the target audience the need for the choice of communication campaign channel/s to be informed by theory/model? If yes, what theory or model is/was it?	B 1
	2.4.3 Do/did you discuss and explain to the representatives of the target audience the need for the involvement of representatives of target audience in message delivery to be informed by theory/model? If yes, what theory or model is/was it?	C 1
Scoring Guide	**Yes/Always (4)** -- Discussion and explanation of theory or model with target audience through its representatives always took place.	**Overall Assessment Score for theory-driven programme implementation.** (Add values of A+B+C, then divide this sum by 3. Enter number in box below.)
	Most/Frequently (3) -- Discussion and explanation of theory or model with the target audience through its representatives frequently took place.	
	Some/Sometimes (2) -- Discussion and explanation of theory or model with the target audience through its representatives took place sometimes.	1
	No/Never (1) -- Discussion and explanation of theory or model with the target audience through its representatives never took place.	

The overall score for Stage 2: Developing Concepts, Messages and Materials

STANDARD	SCORE
Communication Campaign Message/s & Materials' Development	A 3.4
Choice of Communication Campaign Channels	B 3.3
Involvement of Target Audience in Message Delivery	C 3.75
Theory-Driven Development and Pretesting of Concepts, Messages and Materials	D 1
Add values A+B+C+D and divide this by 4. Enter the number in the box to the right	**OVERALL SOCRE FOR DEVELOPING CONCEPTS, MESSAGES & MATERIALS** 2.9

Stage 3: Campaign Implementation Q3.1 The Nature and Dynamics of the Campaign Implementation		
Answer the questions below with a number score from 1 to 4 (1=no/never, 2=some/sometimes, 3=most/frequently, 4=yes/always)		**Question Score**
Question	3.1.1 Do/did you discuss and explain to the representatives of the target audience what would constitute the implementation of the campaign?	**A** 4
	3.1.2 Do/did the representatives of the target audience contribute to or make suggestions as to what could constitute the implementation of the communication campaign?	**B** 4
	3.1.3 Do/did you discuss and explain to the representatives of the target audience the dynamics of how the implementation would be carried out?	**C** 3
	3.1.4 Do/did the representatives of the target audience contribute to or suggests some social and culturally appropriate ways of implementing the campaign?	**D** 3
	3.1.5 Do/did you discuss and explain to the representatives of need for some of target audience to play active roles in the actual implementation of the campaign?	**E** 4
	3.1.6 Are/did some members of the target audience actually involved or got involved in the implementation process of the communication campaign?	**F** 4
Scoring Guide	**Yes/Always (4)** -- Discussion and explanation; contribution/suggestion; involvement of representatives of the target audience on the nature and dynamics of the campaign implementation always takes/took place.	**Overall Assessment Score for theory-driven programme implementation.** (Add values of A+B+C+D+E+F, then divide this sum by 6. Enter number in box below.) 3.7
	Most/Frequently (3) -- Discussion and explanation; contribution/suggestion; involvement of representatives of the target audience on the nature and dynamics of the campaign implementation takes/took place most frequently.	
	Some/Sometimes (2) -- Discussion and explanation; contribution/suggestion; involvement of representatives of the target audience on the nature and dynamics of the campaign implementation sometimes takes/took place.	
	No/Never (1) -- Discussion and explanation; contribution/suggestion; involvement of representatives of the target audience on the nature and dynamics of the campaign implementation never takes/took place.	

Stage 3: Campaign Implementation	
Q3.2 Theory-Driven Campaign Implementation	

Answer the questions below with a number score from 1 to 4 (1=no/never, 2=some/sometimes, 3=most/frequently, 4=yes/always)		Question Score
Question	3.2.1 Do/did you discuss and explain to the representatives of the target audience the need for the whole component of the implementation of the campaign process to be informed by an appropriate theory/model? If yes, what theory or model is/was it? *HCT × ABC Principles*	A 2
	3.2.2 Do/did you discuss and explain to the representatives of the target audience the theory/model that informs/informed the decision to implement in the manner in which it is or had been implemented? If yes, what theory or model is/was it? *HCT × ABC Principles*	B 2
	3.2.3 Do/did you discuss and explain to the representatives of the target audience the theory/model that underpins need for active involvement of some members of the target audience in the implementation not just as recipients but also as animators/facilitators? If yes, what theory or model is/was it? *HCT × ABC Principles*	C 3
Scoring Guide	**Yes/Always (4)** -- Discussion and explanation of theory/ model that underpins campaign implementation with target audience through its representatives always takes/took place. **Most/Frequently (3)** -- Discussion and explanation of theory/model that underpins campaign implementation with the target audience through its representatives frequently takes/took place. **Some/Sometimes (2)** -- Discussion and explanation of theory/model that underpins campaign implementation with the target audience through its representatives sometimes takes/took place. **No/Never (1)** -- Discussion and explanation of theory/ model that underpins campaign implementation with the target audience through its representatives never took place.	**Overall Assessment Score for theory-driven programme implementation.** (Add values of A+B+C, then divide this sum by 3. Enter number in box below. 2

The overall score for Stage 3: Campaign Implementation

STANDARD	SCORE
The Nature and Dynamics of the Campaign Implementation	A 3.7
Theory-Driven Monitoring and Evaluation	B 3
Add values A+B and divide this by 2. Enter the number in the box to the right	**OVERALL SOCRE FOR MONITORING AND EVALUATION** 3.35

Stage 4: Monitoring and Evaluation		
Q4.1 The Nature and Dynamics of Monitoring and Evaluation		
Answer the questions below with a number score from 1 to 4 (1=no/never, 2=some/sometimes, 3=most/frequently, 4=yes/always)		**Question Score**
Question	4.1.1 Do/did you discuss and explain to representatives of the target audience the need to monitor and evaluate the communication campaign process?	A 4
	4.1.2 Do/did you consult and discuss with representatives of the target audience the structure, format and dynamics of the process of monitoring and evaluating of communication campaign?	B 4
	4.1.3 Do/did the representatives of the target audience contribute to or suggest some social and culturally appropriate ways of monitoring and evaluating the communication campaign process?	C 2
	4.1.4 Do/did you discuss and explain to the representatives of need for some of target audience to play active roles in the actual monitoring and evaluation process of the communication campaign?	D 2
	4.1.5 Are/did some members of the target audience actually involved in or got involved in the process of monitoring and evaluation of the communication campaign?	E 4
Scoring Guide	**Yes/Always (4)** -- Discussion and explanation; contribution/suggestion; involvement of representatives of the target audience on/in the nature and dynamics of monitoring and evaluation always takes/took place.	**Overall Assessment Score for theory-driven programme implementation.** (Add values of A+B+C+D+E, then divide this sum by 5. Enter number in box below.
	Most/Frequently (3) -- Discussion and explanation; contribution/suggestion; involvement of representatives of the target audience on/in the nature and dynamics of monitoring and evaluation takes/took place most frequently.	
	Some/Sometimes (2) -- Discussion and explanation; contribution/suggestion; involvement of representatives of the target audience on the nature and dynamics of monitoring and evaluation sometimes takes/took place.	3.2
	No/Never (1) -- Discussion and explanation; contribution/suggestion; involvement of representatives of the target audience on the nature and dynamics of monitoring and evaluation never takes/took place.	

Answer the questions below with a number score from 1 to 4 (1=no/never, 2=some/sometimes, 3=most/frequently, 4=yes/always)		**Question Score**
Question	4.2.1 Do/did you discuss and explain to the representatives of the target audience the need for the whole component of monitoring and evaluation of the campaign process to be informed by appropriate theory/model? If yes, what theory or model is/was it? Attendance Register x Multi-Sectoral Approach	A 1
	4.2.2 Do/did you discuss and explain to the representatives of the target audience the theory/model that informs/informed the decision to monitor and evaluate the communication in the manner in which it is or had been monitored and evaluated? If yes, what theory or model is/was it? Attendance Register x Multi-Sectoral Approach	B 4
	4.2.3 Do/did you discuss and explain to the representatives of the target audience the theory/model that underpins need for active involvement of some members of the target audience in monitoring and evaluating the communication campaign? If yes, what theory or model is/was it? Attendance Register x Multi-Sectoral Approach	C 1
Scoring Guide	**Yes/Always (4)** -- Discussion and explanation of theory/ model that underpins the monitoring and evaluation of the communication campaign always takes/took place. **Most/Frequently (3)** -- Discussion and explanation of theory/model that underpins monitoring and evaluation of the communication campaign frequently takes/took place. **Some/Sometimes (2)** -- Discussion and explanation of theory/model that underpins monitoring and evaluation of the communication campaign sometimes takes/took place. **No/Never (1)** -- Discussion and explanation of theory/ model that underpins monitoring and evaluating of the communication campaign never took place.	**Overall Assessment Score for theory-driven programme implementation.** (Add values of A+B+C, then divide this sum by 3. Enter number in box below. 2

The overall score for Stage 4: Monitoring and Evaluation

STANDARD	SCORE
The Nature and Dynamics of Monitoring and Evaluation	A 3.2
Theory-Driven Monitoring and Evaluation	B 2
Add values A+B and divide this by 2. Enter the number in the box to the right	**OVERALL SOCRE FOR MONITORING AND EVALUATION** 2.6