UNIVERSITY OF KWAZULU-NATAL

A reception analysis of *Soul City* Beyond South Africa: The case of *Choose Life* in Lesotho

MPOLOKENG MPELI

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Declaration

I, Mpolokeng Mpeli, hereby declare that this dissertation is my own work, has not been submitted for any degree or examination at any other University, and that the sources I have used have been fully acknowledged.

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Mpolokeng Mpeli
June 2005

To my husband and daughter, who endured a great deal of suffering during my long absence from home. Their unconditional love kept me going.

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Abstract

This thesis examines the reception of material developed by *Soul City:* Institute for Health and Development in South Africa and distributed in four Sub-Saharan countries: Botswana, Lesotho, Swaziland and Namibia. *Soul City* is the focus of considerable resource, research and media attention in South Africa. The study thus critically assesses *Soul City's* efficacy in neighbouring states, such as Lesotho. The focus of the study is on *Choose Life*; a booklet intended for 12-16 year olds and assesses its reception by the target group in Lesotho.

The study investigates how message-decoding practices of the target audience in Lesotho will bear on a product originally designed for a South African audience. The sample's interpretation of the *Choose Life* booklet is therefore assessed to determine the extent to which their reception produced 'preferred', negotiated or aberrant meanings. Therefore Stuart Hall's encoding/decoding model (1980) offers the theoretical framework upon which the reception of *Choose Life* is analysed. Development communication models are also used to explain the role of *Soul City* as the agent and Youth in Lesotho as beneficiaries in the implementation of the project.

Results established by this study indicate that there is need to conduct extensive formative research of target audiences and also involve beneficiaries in projects intended for them. Different readings of the booklet were observed which were attributed to age, gender, place of residence (Urban or rural), cultural and communication barriers. This means these factors were supposed to have been considered by *Soul City* prior to the *Choose Life* intervention.

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Chapter One

Introduction and background

This chapter outlines the background to, and the context of, this study. Firstly, the rationale behind this study and its scope is provided. Secondly, an overview of the HIV/AIDS situation in Lesotho is presented. Finally, a brief history of *Soul City* and a discussion of the campaign follow.

Rationale and scope of study

HIV prevalence has continued to increase despite the numerous communication campaigns implemented all over Africa (Parker, Dalrymple and Durden 2000; Tomaselli and Shepperson 1997). This does not mean that governments and civil society should suspend communications-based health interventions altogether. Shortcomings should rather be identified and recommendations made to feed into subsequent campaigns. By the end of 2003, of the 37.8 million people living with HIV in the world, approximately 28.2 million of those are in Sub- Saharan Africa (UNAIDS/WHO, 2003: 7). This indicates that Africa, especially Sub-Saharan Africa, is worst hit by the pandemic. The implication of this is the probability that the region will lose many to AIDS, with obvious adverse social and economic consequences.

Lesotho has the fourth highest prevalence of HIV/AIDS in Southern Africa. This research is designed to contribute to the development and enhancement of existing and future communication strategies for social change in the fight against HIV/AIDS and other social issues in Lesotho. This includes internal and external communication interventions. Additionally, this research is intended to support clear understanding of the application of theory in communication campaigns aimed at social change.

Public health communication is the main theme in the Entertainment-Education (EE) for health promotion module offered in Culture, Communication and Media Studies (CCMS) at the University of KwZulu-Natal (UKZN) in Durban. *Soul City,* as one of the case studies in the module, is the focus of considerable resource, research and media attention in South Africa. This raises questions around evaluations of *Soul City's* efficacy in neighbouring states, such as Lesotho.

The study investigates how message-decoding practices of the target audience in Lesotho will bear on a product originally designed for a South African audience. The sample's interpretation of the *Choose Life* booklet is therefore assessed to determine the extent to which their reception produced 'preferred', negotiated or aberrant meanings. This is with the view that it is possible to separate the two countries culturally; although their proximity to each other and migration suggests that there might be notable cultural *similarities*. The study also explores whether exposure to *Choose Life* would have any bearing on the reception of the *Soul City* television series being presently broadcast on Lesotho television. *Soul City* is involved in this initiative in collaboration with the Lesotho based *Phela* Health and Development Communications (*Phela*).

Overview of HIV/AIDS in Lesotho

In 2000, 240 000 people were living with HIV/AIDS in Lesotho, a country which has a population of 2, 108 000. The number of reported AIDS cases was 14,640 (Maw, 2000: 2). However, these statistics were based on full-blown AIDS cases from hospitals; hence in reality the figures were probably higher (Maw, 2000: 3). In 2001, it was estimated that 31% of Basotho adults of ages 15-49 were living with HIV and 8,200 children were living with the virus (UNAIDS, 2001).

Infection rates for women who attend antenatal clinics are also on the increase as shown by the following table:

Table 1: Infection rates for antenatal attendees

Sites	Area	1991	1992	1993	1994	1996	2000
Maseru	Urban	5.5%	5.1%	6.1%	31.3%	20.6%	42.2%
Mafeteng	Periurban	3.5%	5.0%	4.0%	10.8%	34.8%	18.98%
Leribe	Periurban	2.2%	1.8%	11.4%	8.7%	29.3%	26.03%
Quthing	Rural	0.7%	8.4%	3.4%	9.1%	15.8%	22.81%
Maluti	Rural	1.8%	1.4%	4.2%	5.0%	21.3%	19.04%

Source: HIV/AIDS Prevention and Control Program, MOHSW, Lesotho

In 2004, Maseru alone accounted for almost half (49%) of HIV/AIDS infected women visiting antenatal clinics (Bowsky, S, 2004). While these women have access to Nevirapine, which was introduced in 2002 to prevent mother-to-child-transmission, there is room for improvement in its administration (Kimaryo *et al*, 2004: 79). The epidemic is taking an increased toll on young people, especially young women.

According to the United Nations Development Project (UNDP) HIV/AIDS Focus for 2003, HIV/AIDS has become the single biggest threat to sustainable socio-economic development in Lesotho. This state of affairs is causing degeneration of households through poverty across the country. The situation has gained momentum and new infections are on the rise (UNDP, 2003). It is estimated that 350 000 people are now living with the pandemic and about 70 people are dying each day of AIDS related illnesses (Kimaryo *et al*, 2004: 20).

Statistics gathered from patients visiting government hospitals, expectant mothers and individuals submitting to voluntary testing point to the possibility that actual rates of infection and AIDS cases may be escalating to disturbingly high proportions. This is supported by the suspicion that there are great numbers of unreported cases. Over 80% of those dying of AIDS are productive and constitute a great loss to society and the economy. Most victims of this pandemic are women and children, who are victims but also backbones of their families and society. This is exacerbated by the fact that over 40 000[1] males are migrant workers in South Africa (TEBA Lesotho, 2004). Economic activities are generally left in the hands of women. When mineworkers are retrenched, they very seldom return to productive life. An inordinate burden is placed on women to provide for the family.

Mineworkers go home on average four times a year. Unfavourable living and working conditions in the mines contribute to their vulnerability to HIV/AIDS. Temptation to have extra-marital affairs is strong in single sex hostels where men are far from family support and security. This behaviour tends to be accompanied by unsafe sexual practices. It is implicit in this environment that upon their return home, spouses are subject to risk of infection (UNDP, 2003). This does not imply that women are innocent victims. It has been noted that there is increased likelihood of extra-marital affairs when spouses are geographically separated for long periods of time (Kimaryo *et al*, 2004: 55). Greater susceptibility of women to HIV

[1] TEBA, in 2004 report a figure of 41 462 males.

infection due to physiological factors (Singhal and Rogers, 2003; UNAIDS, 2004) heightens the desperate social and economic status of the country. UNAIDS reports that in Sub-Saharan Africa, women are 30% more likely to be infected with HIV than men (UNAIDS, 2004). It may be surmised from this that adolescent females are more susceptible to infection than adolescent males.

Lesotho, like other migrant sending countries in Southern Africa, continues to have higher HIV prevalence than South Africa. According to Barnett and Whiteside (2002: 153), this is because most of these countries are not well established in terms of effective AIDS control programmes. However, in recent years there have been major improvements and a considerable number of AIDS control programmes are in place in Lesotho.

While campaigns strongly advise monogamous relationships as advantageous in reducing risk of infection, marriage and monogamous relationships have not protected couples, especially women from HIV. On the contrary, they are potentially at greater risk because the perceived 'sanctity' of marriage gives a false sense of security. While women submit to partners' manipulation not to use protection, their partners might be engaging in sex with multiple lovers and/or sex workers without using condoms (UNAIDS, 2004). Most men are unwilling to use condoms with their spouses but are more likely to assent using it with a lover. This situation explicates to a certain extent why women are most likely to be infected by their husbands (Maw, 2000: 04; Melkote and Steeves, 2003: 44; UNAIDS, 2004). Housewives seem to be more susceptible to STI and HIV infections than other groups of women because of financial dependence on their partners.

Migration from rural to urban areas within Lesotho has led to increased risk of HIV/AIDS in urban areas. The majority of these migrants are in the textile industry. Approximately 50,000 Basotho, primarily women are employed in the textile industry (Lesotho National Development Corporation, 2004). This has resulted in the emergence of oscillatory migration patterns where workers move between urban workplaces and rural homes on a weekly, monthly or annual basis (Bowsky, S, 2004). This has been shown to be a major contributing factor in the spread of both HIV and STIs.

Singhal and Rogers (2003: 72) argue that poverty and commercial sex go hand in hand and commercial sex workers play an important role in the spread of HIV/AIDS. In the case of

migration to South Africa, migrants are easy targets for commercial sex workers. This is because migrants are far from home, lonely and easily accessible (Kimaryo *et al*, 2004: 70). On the contrary, most unemployed women in Lesotho get involved in commercial sex primarily for survival. Some of these are young girls who come from the rural areas to the capital, Maseru, in search of employment. The harsh reality of lack of employment in the city compels them to resort to prostitution. There is no law governing prostitution in the country, making it difficult to target this group for HIV/AIDS communication campaigns. This is despite the fact that government saw them as a risk population needing to be targeted (Government of Lesotho, 2000).

In a recent programme on Lesotho Television (October, 2004), it was reported that an NGO mobilising commercial workers was closing down due to lack of funds. The community and government equally, seek eradication of commercial sex. It follows that there is an expectation that NGOs advise commercial workers on alternative means of survival. It is not easy to escape the net of commercial sex because opportunities for a 'decent' living are scarce. Commercial sex workers are used to making quick money, thus challenging NGOs to offer interventions and support more substantial than communication interventions. It also requires great will and determination amongst sex workers to acquire skills for 'decent' jobs.

Affected families of victims of HIV/AIDS find themselves in desperate financial situations due to long illness and loss of income, compounded by the exorbitant costs around funerals. Purchasing power diminishes and this adversely affects the market as the number of consumers decreases. On this basis consumption patterns change because money has to be reallocated for the immediate needs of care and medication. Consequently, loss of a breadwinner impinges on the overall wellbeing of children because the opportunities for education and a decent standard of living are lost. In 2000, it was estimated that 29 469 children in Lesotho were AIDS orphans (UN report, 2000). Today more than 190,000 children in Lesotho under the age of 15 have lost one or both of their parents and 75 % of these orphans are as a result of AIDS (Bowsky, 2004: 8). By 2010, an estimated 206,000 children, 1 in every 4 children under 15 years old will be orphaned, more than 80% of them orphaned by AIDS (Bowsky, 2004: 8). The business community is also struggling because without sufficient spending money to keep the economy at a healthy level, business cannot provide more job opportunities.

The impact of losing parents to AIDS cannot only be measured in terms of monetary value. Children lose valuable moments, which are inherent in family life. Children also lose a sense of belonging because children's identity depends to a large extent on their parents' affirmed status in the community. The pain of such loses can only be felt by those experiencing them and are therefore not easy to measure.

Orphans are not the only dependent group greatly affected by HIV/AIDS. The elderly are also affected by HIV/AIDS as they also are dependent on the economically active adult population for care and support. Orphans and the elderly are not simply affected by HIV/AIDS; some become infected. The elderly usually have to take care of infected adult children without taking any precautions while orphans are more likely to be sexually abused. It is becoming increasingly common to find households headed by grandparents and children because the parents have died.

A major problem that Lesotho has to deal with is the persistent belief that AIDS is a myth. This is especially prevalent in rural areas. Even when people are dying in large numbers, some still associate illness and death resulting from AIDS with witchcraft (UNICEF, 2004). Lesotho has been involved in extensive awareness campaigns trying to address the spread of HIV/AIDS. As with many other campaigns in the region, there has not been a significant impact on rates of infection. The majority of campaigns were concentrated on prevention (Kimaryo *et al*, 2004: 79).

The major challenge facing Lesotho, beyond awareness of HIV/AIDS, is changing attitudes towards HIV/AIDS, and treatment and care for those infected with the disease. Measures are required to improve homecare and empower families with knowledge of caring for those who are sick. The Basotho people remain strongly 'anchored' in the belief in the family unit. However, the burdens of modern life, compounded by the effects of HIV/AIDS, encourage a shift towards people being less eager to assist or care for family members. This is because caring for the sick means frequent work absenteeism for caregivers, with the consequent fear of loss of employment. This hampers devotion to caring for the sick, and means more expenses in care and medication.

Cultural values, norms and sex

Traditionally, sex was primarily about procreation and pleasing men. Young Basotho girls were groomed at an early stage and in initiation schools skills, which were intended to make a woman a good homemaker. On the other hand, the emphasis on boys' initiation to manhood was predominantly focused on militancy rather than affection and/or sexuality (Kimaryo *et al*, 2004: 146). Patriarchal 'ideology' ensured that women pleased their husbands and not the other way round. From this perspective, it is assumed therefore that women experienced more pain than pleasure during sexual intercourse since both partners were effectively naïve concerning foreplay. Today, sex and its intimacies are increasingly de-linked from local cultural and social systems and new constructions of desire have replaced local values and norms (Barnett and Whiteside, 2002: 87). People are thus engaging in more sex because they have learned and acquired the skills to make sex more pleasurable. More importantly, they have the freedom to choose their own mates and act on this attraction.

HIV/AIDS and Youth

With globalisation and consequent demystification of sex, young people as well have learned the pleasures of sex through different kinds of media (Barnett and Whiteside, 2002). It is therefore unsurprising that young girls explore sex on a par with young boys. Most adults find this hard to comprehend because culture dictates that premarital sex, especially by girls is not allowed and has serious repercussions if discovered (Mturi, 2001: 2). Adults may also be at the attachment phase in their own relationships while adolescents are at the attraction stage[2]. These different stages may result in conflicting feelings about love and sexual relationships between adults and adolescents. Communication campaigns focusing on youth like *Choose Life* thus place emphasis on empowering girls to say 'no' to sex. Among other issues, the study will enquire whether or not girls really want to say 'no' to sex. Further factors such as accessible transport and communication, busy, lenient and overgenerous parents with pocket money; make it easier for young couples to meet frequently in their leisure time (Bowser and Wingood, 1992: 200-201, Mturi, 2001: 6). This scenario increases adolescents' chances of intimacy.

[2] Major drives in sexual relationships. See Helen Fisher (1992)

Traditionally, it was considered a source of pride for a Mosotho girl to be married a virgin (Mturi, 2000: 2). Most young people no longer value waiting until being married to engage in sexual intercourse. Messages that encourage abstinence are therefore not very effective as far as prevention of HIV/AIDS is concerned because the reality is that young people are already engaging in sex. It is thus unrealistic to assume that sexual relations can be effectively halted once commenced. It is likely that from the first time a young person falls in love to the time he/she becomes an adult, he/she will have had approximately 5-8 partners and had sexual relations with some. This makes youth more susceptible to HIV/AIDS because of increased likelihood of sexual experimentation at this stage. Youth fall in and out of love frequently and partners change from time to time (Lear, 1997).

Another major factor exacerbating the problem is reluctance by parents to discuss HIV/AIDS and sexuality with their children. This makes it difficult for other channels such as the public health system, churches, school and the media to reach the youth (Maw, 2000: 5). If information received from these channels is not reinforced in the family, it becomes divorced from family values. Adolescents thus grow up not associating sex and sexuality with other aspects of family life. Although some parents engage in dialogue about sex with their children, the vast majority of parents find it daunting to approach children on the subject (DiClemente, 1992; Ginott, 1973; Kimaryo *et al*, 2004; Lear, 1997).

AIDS and Government

Ministerial members of the Lesotho government have realised that HIV/AIDS is a threat to the existence of government itself. Government has become enormously committed in the fight against HIV/AIDS, as indicated by the following statements of the Prime Minister, Pakalitha Mosisili and Government Secretary, Tlohang Sekhamane respectively:

> I want to state categorically that we Basotho, the Government and the people alike, acting in unison and driven by a common commitment and shared sense of the utmost urgency, are irrevocably and indefatigably determined to fight the scourge of HIV/AIDS, whatever it takes, however long it takes...What is at stake here is the very future of the Basotho (Mosisili, 2004: xxi).

> For its part, Government...has fully taken up the challenge. For us in the Lesotho Civil service, especially for all of us Principal Secretaries, Deputy Principal Secretaries and Directors, we have already undertaken to rise to the

> challenge by leading the public sector response. We stand ready - all of us in the public service-to engage with equal courage in the fight for our own future. (Sekhamane, 2004: viii)

This political dedication came when the epidemic reached its peak; when death rates are enormous and infection rates at their highest. This setback has been experienced by most countries hit by the epidemic. One of the most important lessons of the past two decades has been the need for early and sustained political action to tackle AIDS head-on, before it begins to rage unchecked in the general population (Singhal and Rogers, 2003: 374). Had government commitment started at the early stages of the epidemic, that is, in the early 90's, the impact of the scourge would have been better contained.

Government is the major employer in Lesotho. The government is also responsible for the provision of social and welfare services. Government expenditure accounts for 40.6% of the Gross Domestic Product (GDP) (Barnett and Whiteside, 2002: 296). If the government loses most of its employees to AIDS, these responsibilities will be greatly compromised. Until recently, Lesotho has not been able to provide anti-retroviral drugs to HIV/AIDS patients.

This limitation highlights the plight of multitudes of individuals whose health was compromised because they could not afford private medical care and medication. The government of Lesotho has been advocating Voluntary Counselling and Testing (VCT) for public servants. Upon being diagnosed HIV positive, these public servants will be given all the necessary support in terms of medical care and support. According to Singhal and Rogers (2003: 74):

> Prevention activities and providing free anti-retroviral drugs can play crucial roles in controlling the HIV/AIDS epidemic [and] anti-retroviral drugs are still prohibitively expensive, far beyond what people in developing nations can afford.

This advocacy started with Cabinet Ministers and Principal Secretaries going for VCT. Each government Ministry was instructed to allocate 2% of its budget to HIV/AIDS activities. This is a commendable effort by government to retain members of its staff for as long as it can afford to.

AIDS and Industry/Labour

HIV/AIDS has adversely impacted economies, especially of disadvantaged countries with poor economies, and limited employment opportunities. HIV/AIDS may decrease employment as companies try to ease their dependence on labour by using less-skilled labour, which is cheaper to replace, and has poorer benefits packages (Barnett and Whiteside, 2002: 248). Further, HIV/AIDS raises costs, reduces the productivity of individual workers and alters the company-operating environment through: increased absenteeism, falling productivity, and replacement of staff (Barnett and Whiteside, 2002: 242). This is especially evident in the textile industry where there is a great turnover of workers.

A legal instrument has been drafted in Lesotho to protect workers in the private sector from HIV/AIDS discrimination in the workplace. This legal instrument is intended to ensure that employers are obliged to develop a workplace HIV/AIDS policy in consultation with workers. This policy would seek to prevent new infections, uproot discrimination and stigmatisation of workers, and provide care and support for employees who are infected and affected by HIV/AIDS (Draft Legal Instrument on HIV/AIDS and Employment, 2004). It would also impel employers to manage the impact of the epidemic in the organisation (Draft Legal Instrument on HIV/AIDS and Employment, 2004). For the rest of the population, this kind of support is still very limited and haphazardly done. The support is therefore diluted and not experienced by those who need it most.

Stigmatisation of people living with HIV/AIDS is one of the factors undermining efforts to deal effectively with the pandemic. Although stigmatisation of people living with HIV/AIDS is regarded as inhuman and barbaric, stigmatisation itself is not a new phenomenon (Barnett and Whiteside, 2002: 66; Singhal and Rogers, 2003: 243). It is an important part of the history of any epidemic. Lepers (Hansen's Disease) were isolated from the rest of the population. Stigmatisation is a social process: "a feature of social relations, reflecting the tension, conflict, silence, subterfuge and hypocrisy found in every human society and culture" (Barnett and Whiteside, 2002: 66). It is difficult to predict when HIV/AIDS stigmatisation will diminish to negligible levels, especially with perceptions about its contraction. Mandisa Mbali (2004: 19) states that several people in the 1990's spoke about AIDS in the third person of "those people", not in terms of "my status" or "my personal risk". Today, while many

have come out and openly disclosed their HIV/AIDS status; there are many more afraid to do so.

There have been a number of campaigns directed at the HIV/AIDS pandemic in Lesotho. Most of these campaigns have been on prevention, care and support. Little has been done regarding provision of treatment for the infected. It is worth mentioning some of the prominent campaigns to highlight the progress made so far to address the HIV/AIDS scourge.

The Lesotho AIDS Programme Coordinating Authority (LAPCA)

LAPCA is the national coordinating body established in 2001 to serve as a secretariat for a national AIDS Commission. It is tasked with updating national policies, strategic plans and guidelines in HIV/AIDS. Two documents have so far been produced by LAPCA, following consultations with Government, young people, NGOs and members of the public. These are the National HIV/AIDS Strategic Plan and the National HIV/AIDS Policy Framework, which were adopted by the Government of Lesotho in 2000. The following table highlights ongoing communication interventions in the country by different organisations.

Table 2.

Highlights of On-going Communication Interventions in Lesotho	
PREVENTION	
Project	**Implementing Organisation**
i. HIV/AIDS materials development	Positive Action, MOHSW
ii. Mitigation in HIV/AIDS in Lesotho	Christian Health Association of Lesotho (CHAL), Ministry of Agriculture, World Vision
iii. Information, education and communication (IEC) on HIV/AIDS and life skills training for youth	Lesotho Scouts Association
iv. IEC on HIV/AIDS for people with disability	Lesotho National Association for the Physically Disabled
v. HIV/AIDS awareness workshops and counselling training.	Lesotho Women's Institute
vi. Training of trainers of member organisations.	Lesotho National Federation of Organisations of Disabled

CARE and SUPPORT	
Project	**Implementing Organisation**
i. Improvement and extension of services in home-based care and counselling to People Living with HIV/AIDS (PLWAs) and their families	*Tšosane Tšosane Seli la Lefatše*
ii. Resource Centre for Maseru, Maputsoe and Mafeteng	CARE SHARP Project
iii. Nutritional assistance and establishment of self-help groups	Positive Action
iv. 24 hour toll-free HIV/AIDS helpline	Positive Action
v. HIV/AIDS staff development and community/capacity building	Lesotho Preschool and Day Care Association
vi. Home-based care and training	Thusanang Lifeline

Source: Kimaryo *et al*, 2004: 95-96.

Among the organisations mentioned above, Positive Action has been innovative in its production and distribution of posters with messages about HIV/AIDS throughout Lesotho. The organisation's creativity also saw the production of red ribbon safety pins, which have been sold to various organisations, including government. Furthermore, the organisation has a depot selling nutritional supplements for HIV positive people at competitive prices. It is the only organisation that has a 24-hour AIDS helpline in the country. The CARE SHARP project also can be singled out as the only organisation that is a cross-border initiative, focusing on the border towns of Lesotho and South Africa. CARE SHARP provides clinical equipment such as gloves, cotton wool and disinfectants for home-based care to the towns of Maseru, Mafeteng and Maputsoe. These are the busiest borders in the country; used by migrant labour to and from South Africa.

Like most communication campaigns, these interventions are based on behaviour change models; that successful delivery of messages will cause individuals to change their behaviour (Kimaryo *et al*, 2004: 95). It is therefore assumed that sexually active people, once they understand how HIV/AIDS is spread, would willingly change their sexual behaviour and protect themselves. The assumption that knowledge about the ill effects of a certain habit/behaviour leads to pro-social behaviour is gravely flawed[3].

[3] Discussed further in Chapter Two.

Soul City

Establishment, objectives and aims.

Soul City was founded by Dr. Garth Japhet, when as a young medical doctor in the late 1980's he was assigned to work in a rural clinic in KwaZulu-Natal. He realised that health promotion activities in the media were inadequate despite a highly developed mass media system. Most health messages were merely slogan based lacking meaningful health promotion messages (Singhal and Rogers, 1999: 213). Among the problems that Japhet noticed was lack of good indigenous drama on South African television or radio.

Dr. Japhet recruited partners from the entertainment and media industries, professionals, professors, medical doctors and international agencies. Together with another medical doctor, Shereen Usdin, in 1992 they established *Soul City*, a non-governmental organisation whose mission was to harness mass media for promoting health (*Soul City*, 2004[4]). The framework within which the rationale of *Soul City* lies is that for media based health promotion interventions to be successful, they have to be popular, attract the largest possible prime-time audience and be of very high quality. Japhet recognised that institutional partnerships with government, media, private corporations and donor agencies were required. This would ensure that commercial and public interests could be equally met (Singhal and Rogers, 1999: 213).

According to Tufte (2002: 172-173), the main principles that have driven and guided *Soul City* from its onset are the following:

1. *Soul City* is conceived as an ongoing vehicle, recurrent and building up a quality brand around the name of *Soul City*;
2. *Soul City* applies a multi-media strategy, combining TV-series with radio programmes in numerous languages, newspaper booklets, adult education material, etc;
3. *Soul City* emphasizes substantial formative research and summative research;
4. *Soul City* promotes community activism and enhancing strategic partnerships;

[4] Available at: www.soulcity.org.za

5. *Soul City* develops materials and courses, training and education, in the issues of concern;
6. *Soul City* works with advocacy both on community level as at national level.

The distinctive factor that differentiated *Soul City* from many other campaigns was that it not only responded to HIV/AIDS, but also confronted a variety of other prominent social issues. These included domestic violence; mother and child health issues; tobacco; tuberculosis; land; housing; alcohol and business management (Parker, Darlrymple and Durden, 2000: 28).

The *Soul City* edutainment model

Soul City is essentially a public health communication campaign that promotes health and development. It has incorporated Entertainment-Education (EE) as a tool to promote social change, dealing with a range of health and development issues. EE has played an important role in communication for development and has obtained widespread use in health communication (Tufte, 2002). It has been considered an important and powerful instrument to combat the HIV/AIDS pandemic. According to Tufte (2002: 159), the use of drama and education is often used by integrating instructive or best practices into fictional narrative, often radio drama or a television series. By so doing audiences are informed about how they can tackle specific issues in their everyday life (Tufte, 2002: 159).

In the realm of EE programming, *Soul City* pioneered several new directions, including the strategy of "on-going" multimedia vehicles addressing high priority national health issues (Usdin, 2002: 5). Each year a series of mass media interventions are implemented. Similar EE programmes on various social issues, especially HIV/AIDS began to emerge. Examples of these are the controversial *Yizo-Yizo* drama series, *Tsha Tsha Tsha* and *Gaz'lam*. These drama series have also been produced on an "on-going" basis.

The main principle of the edutainment model proposed by Japhet argues for a cyclical communication strategy (Tufte, 2001: 35). Inputs are fed into the media vehicle, resulting in a number of outputs. The whole process is subsequently evaluated and serves as a key input in the next phase of the "on-going" vehicle. A key input fed into the vehicle is formative research, which is audience and expert oriented. Key outputs emerging from the cyclical communication process are categorised into direct outputs. These are: changes in knowledge,

attitude, social norms and intermediate and direct practices including a supportive environment favouring these mentioned changes (Tufte, 2001: 35). The second outcome is the development of potential opportunities that are made possible due to the media intervention. These are educational packages, advocacy at both community and national level and the development of the *Soul City* brand name (Soul City, 2004[5]).

The cyclical communication process also involves forging partnerships with all stakeholders within civil society, government, private sector and international partners (Tufte, 2001: 35). By this Tufte implies that messages are formed in a participatory process involving all these stakeholders. However, Esca Scheepers of *Soul City* indicated difficulties with Tufte's interpretation and presention of *Soul City*'s work in terms of participatory approaches. Scheepers indicated that *Soul City* never claimed to follow a participatory approach or social marketing. Scheepers also comments that *Soul City* is best described by material generated by itself (Scheepers, comments on proposal, September, 2004). To *Soul City,* participation means engaging target audiences for the purpose of understanding the views generally present in a significant media audience. The goal is engagement of those interests that research indicates are potentially contradictory in the ways communities reason about health, sexuality, mortality and so on. Their goal therefore is to change the priorities people attach to their local interests, rivalries, grudges, attachments and taboos. The aim is to do this in ways that bring their practical reasoning about health and sexuality to be in line with the logic of HIV infection. It is important for public health campaigns to understand the underlying reasons for communities' point of view in order to design appropriate messages for them.

Tufte (2002: 170) summarises the process of the edutainment model into five phases:

Phase 1 Research and planning. This is topic research involving target audience and other stakeholders.

Phase 2 Development of the narrative. This involves message design, integration of message into chosen form of entertainment, pre-testing with target audience and other role-players. Finally it involves modification as a result of pre-testing.

[5] Available at: www.soulcity.org.za

Phase 3 Production. This involves the final preparations, shootings, and recording until the communication initiative is ready to be presented to the public.

Phase 4 Implementation and promotion. This includes promoting, popularising and getting the most out of the edutainment during implementation. Thus large parts of the advocacy take place at this stage.

Phase 5 Evaluation. The communication initiative is evaluated on an ongoing basis, and each final evaluation serves as input into the next campaign.

Soul City television series

The series consist of 13 episodes of prime time television drama, which are one hour long and have a slot on SABC[6] 1. *Soul City* has so far had seven series. The first series, first broadcast in 1994, dealt with issues related to mother and child health care issues. These included immunisation, breastfeeding, diarrhoea and dehydration, maternal health, HIV and AIDS, acute respiratory illness, paraffin poisoning and burns.

The second series dealt with issues including HIV /AIDS in the community, tobacco, tuberculosis, land and housing. The third series was about HIV and AIDS, land and housing, household energy, violence and alcohol misuse. The fourth series, aired in 1999, was the most successful of the *Soul City* series. It dealt with violence against women, AIDS, youth sexuality, small business development and personal savings, and hypertension.

The outstanding impact and success of *Soul City* series four was brought about by the fact that it was weighted towards a very emotional issue of violence against women. Domestic violence is a social reality in most households in South Africa and elsewhere in Southern Africa, where SABC, thus *Soul City* reached audiences. The series included a special partnership with the National Network on Violence Against Women (NNVAW), which is a coalition of 1500 activists and community organisations from rural and urban areas (Soul City, 2001: 4). This partnership helped *Soul City* to portray a vivid picture of the extent of violence and ways of dealing with the problem.

[6] South African Broadcasting Corporation.

The central issues on the fifth series of *Soul City* included care and support of people living with HIV/AIDS. It also focused on living positively, rape, disability and small, medium and micro enterprises. In the sixth series, the precedent issue was still HIV and AIDS, with a focus on children infected and affected by the pandemic, asthma, depression, Adult Basic Education and literacy.

The seventh series of *Soul City* deals with volunteerism/service, equity in South Africa's health system, HIV/AIDS and treatment, masculinity/manhood and cancer of the cervix. Although *Soul City* incorporates other aspects of social problems in its productions, sixty percent (60%) of *Soul City's* content has dealt with various aspects of HIV/AIDS (Soul City, 2002). The content of the television series is broadcast in a daily 15 minute, 60-part radio drama in ten most popular radio stations in South Africa using different languages. Although the message is essentially similar, the radio drama follows a different story with different characters, aimed at a rural population (Parker, Darlymple and Durden, 2000: 28).

Soul City also provides supplementary information in the form of booklets, carrying the same message as television and radio but in a more detailed form. The booklets are serialised through newspapers in the same three months that television and radio series are broadcast.

Soul Buddyz

Soul Buddyz is a multi-media edutainment programme also developed by *Soul City* in partnership with SABC Education. It is aimed at children aged 8-12 years and designed to cater for their health and well being (Soul City, 2004[7]). It was launched in 1999 to specifically target a young audience because although the *Soul City* series is popular with all age groups, its messages were not specifically designed for young audiences. The *Soul Buddyz* vehicle consists of four main parts, which are television, radio, life skills booklet for grade 7 and a parenting booklet. The series are very popular with children and together with the *Soul City* television series; they constitute the best products of *Soul City*. *Soul Buddyz* has so far had three series, dealing with issues including:

1. Children's rights and responsibilities;
2. Valuing and respecting other children;

[7] Available at: www.soulcity.org.za

3. Advocating respect and sensitivity for culture;
4. Creating a sense of history;
5. Role modelling good behaviour towards older people;
6. Promoting alternate values to the dominant individualist, consumerist set of values;
7. Encouraging exploration and interaction with the environment;
8. Encouraging a positive view of science and technology;
9. Viewing children as proactive, valuable and productive members of the community (Soul City, 2004[8]).

Beyond South Africa programmes

As its outreach to neighbouring SADC countries, *Soul City* developed a regional programme which aims to adapt *Soul City* media (television, radio and print) in eight Sub-Saharan African countries. The programme has entered into partnership with local partners in Lesotho, Swaziland, Namibia, Botswana, Zambia and Malawi. At the time of the study appropriate local partners were yet to be identified in Zimbabwe and Mozambique. *Soul City* aims to provide systematic training in the development of a multi-media health initiative in these countries. *Soul City* will provide training to build and empower local capacity to develop multi-media health communications. Local partners are required to identify core *Soul City* material, whether television, radio or print, that they wish to adapt in their country.

According to *Soul City*, it will provide capacity building among local partners to equip them with skills to do edutainment, develop media and do research and advocacy in a networked and sustainable fashion. *Soul City* also intends to provide product specific capacity in the media partners have chosen to use in their specific countries (Soul City, 2004[9]).

Choose Life

Choose Life is a *Soul City* product that has been adapted to four Sub-Saharan countries: Botswana, Lesotho, Swaziland and Namibia. It was developed prior to the regional programme and was initiated by the United Kingdom Department for International Development (DFID). *Choose Life* is an education booklet aimed at 12-16 year olds and addresses the HIV/AIDS pandemic in Sub-Saharan Africa. It does so by positively informing adolescent sexual behaviour with the aim of reducing teenage pregnancy, HIV and other

[8] Available at: www.soulcity.org.za
[9] Available at: www.soulcity.org.za

sexually transmitted diseases (Soul City, 2004[10]). *Soul City*'s rationale is that international and local research indicates that effective life skills/sex education helps delay commencement age of sexual activity. The result is an increase in safer sexual practices by adolescents. The implication is that educating young people to adopt safer sexual practices reduces the risk of HIV infection.

Choose Life is conceived in a different light from the *Soul City* and *Soul Buddyz* drama series, and other comic print material that have applied EE as a communication tool. *Choose Life* is a health communication initiative that has used limited aspects of EE in a strategic manner to create appeal for its target. However, this is not in the sense that it has been used in the drama series or other *Soul City* magazines or cartoons. In the drama series, radio and other magazines, *Soul City* has made use of theories that underpin entertainment. These include drama theory and play theory. Drama theory uses a storyline that captivates audiences (Kincaid, 2001: 137). The theory is used to explain how confrontation and emotion influence character change in a drama, which can influence change in real-life as well (Howard, 1999). Play theory on the other hand depicts pleasure as a legitimate form of escapism and provides people with information and para-social interaction, which may influence peer group behaviour (Coleman, 1999: 76). EE entails purposely designing and implementing a media message to both entertain and educate (Singhal and Rogers, 1999: 9). Entertainment is thus defined as a performance or spectacle that captures [and holds] the interest or attention of individuals, giving them pleasure and/or amusement (Singhal, 1990 in Singhal and Rogers, 1999: 10). Singhal also defines education as either a formal or informal programme of instruction that is meant to develop an individual's skill in order to achieve a particular end. *Choose Life* is distinguished from EE programmes by being a self-contained public health communication effort.

Approximately 1.3 million copies of the booklet have been distributed in the four countries in seven different languages (The Communication Initiative, 2004)[11]. According to *Soul City*, *Choose Life* was adapted for each country to ensure that its contents were appropriate for the country concerned. In each country *Soul City* forged a partnership with local NGOs to ensure effective adaptation, production and distribution of the *Choose Life* booklets (Soul City,

[10] Available at: www.soulcity.org.za
[11] Available at: www.comminit.com

2004[12]). Lesotho entered into partnership with *Soul City* through the Christian Council of Lesotho (CCL), and changed to Lesotho Network for AIDS Service Organisations (LENASO) in phase four of the project. It is assumed that due to the religious nature of CCL, the parties differed on certain aspects of the booklet. LENASO is a consortium of organisations working in the field of HIV/AIDS. *Soul City* presently works exclusively with *Phela* Health and Development Communications in Lesotho. Both organisations are presently involved in adapting other *Soul City* multi-media material to be broadcast in Lesotho. These include television, radio and print materials.

This chapter described the background to the situation of HIV/AIDS in Lesotho, and a brief discussion of the *Soul City* campaign. The next chapter looks at the theoretical framework and methodology applied in the study.

[12] Available at: www.soulcity.org.za

Chapter Two

Choose Life in Lesotho

The present chapter provides an outline of how the *Choose Life* project was developed; produced and implemented in Lesotho with a view to conceptually understand and explain the process. In his encoding/decoding model, Hall referred to 'moments' of a circuit of the communication process: production, circulation, distribution/consumption, reproduction, each of which is necessary to the circuit as a whole but cannot fully guarantee the next 'moment' with which it is articulated (Hall, 1980:128-129). These 'moments' explain the communication process of the *Choose Life* project and how these 'moments' were linked. The point of departure is a brief overview of public communication campaigns.

Public health communication campaigns – an overview

Public health communication campaigns (PHCC) usually involve one group's intention of changing another group's beliefs and behaviour. PHCCs tend to focus on promoting pro-social behaviour. Charles Atkin (2001) conceives that the initial step in campaign design is an analysis of behavioural aspects of a health problem to determine which actions should be performed by which people to improve what aspects of health status. A comprehensive plan is required to determine which mechanisms are most promising for campaigns to be successful. Most campaigns present messages that intend to increase awareness, informing and sensitising people about a particular health issue. They also involve instructive and persuasive messages which provide "how to do it" information and reasons why a certain behaviour should be adopted (Atkin, 2001: 56-57).

A number of heuristic factors elucidate the basis upon which recipients of messages accept or reject a message. Credibility, attractiveness and power of the message source, and message placement, are key indicators of how and why audiences will respond positively to one campaign and reject another (McGuire, 2001). Most campaigns assume that conducting formative research of target audiences to determine their knowledge, attitudes and behaviours for a particular health issue is sufficient to design an effective message. Audience participation in the construction of the message is not considered essential. Instead,

campaigns target to acquire support from policymakers and 'influentials', who subsequently influence adoption of the message. Brenda Dervin and Micheline Frenette (2001: 69) suggest that campaigns should go beyond a one way transmission of expert information and approach the campaign "in a position of self-imposed reflection, being open to disagreement, even coming to understand that one's well-meaning intentions may be mistaken and may foster unintended deleterious consequences".

Most HIV/AIDS-oriented PHCCs are guided by behaviour-change theories. These theories include the Health Belief Model (HBM), the theory of reasoned action, social learning theory, diffusion of innovation and social marketing; and emphasise individualism. While the health belief theory (Becker, 1974) predicts individual response to interventions according to an individual's perceived seriousness of the disease, the theory of reasoned action (Fishbein and Ajzen, 1975) anticipates individual behaviour by examining attitudes, beliefs and behavioural intentions. Both theories assume that individuals engage in rational decision-making processes. Social learning theory (Bandura, 1986) postulates that an individual's behaviour is influenced by modelling the behaviours of role models and the individual's perceived sense of self-efficacy to imitate such behaviour.

However, these theories are not adequate for HIV/AIDS prevention and care messages as the focus tends to be on individual rather than collective cultures of people. In the African context, family and community are more central to construction of health and well being than the individual (Airhihenbuwa and Obregon, 2000: 9). When culture is the focus, it is often for its limitations but almost never for its strengths in encouraging HIV prevention (Airhihenbuwa, 1995). Criticising cultural practices can result in alienating beneficiaries from interventions. Furthermore, AIDS related behaviours are heavily influenced by emotions such as love, desire, passion, care, which may not follow a linear path of awareness to attitude to action (Airhihenbuwa and Obregon, 2000). A further criticism of these rational theories is that sex is seldom a rational activity. The "heat of the moment" nature of sex, suggests that rational analysis and thought may not be as easy to practice as it is to theorise (Govender, 2003).

As indicated earlier, *Choose Life* is produced by *Soul City*: Institute for Health and Development and aimed at 12-16 year olds in Botswana, Lesotho, Swaziland and Namibia. The project is funded by the DFID and according to *Soul City*; the project was initiated by the

donors. *Soul City* further indicates that originally, the aim of the project was to print copies of *Soul City's AIDS in our community* for the four countries. The donors were however persuaded that the material needed to be tailored to a 12-18[13] year old audience and also suit local conditions of these countries (Scheepers, comments on proposal, September, 2004). A new book, *Choose Life* was therefore developed and tested in the four Southern African Development Community (SADC) countries, altered and distributed.

Based on comments from *Soul City* (Scheepers, comments on proposal, September, 2004), the contention is that the construction and design of *Choose Life* was determined by *Soul City* and DFID regarding the kind of message appropriate for target audiences in the four countries. This was influenced by the fact that DFID was the donor and *Soul City* the experts in the field of health communication. It is not clear which local conditions were taken into consideration at this initial stage because local people from the four SADC countries were not yet involved; and how *Soul City* came to the assumption that the information was appropriate for 12-16 year olds in those countries. This raises a major concern of why, if the booklet was not to be distributed to South African youth after all, beneficiary countries were not involved at this early stage. *Soul City* admits in its evaluation report that there was no initial in-depth needs analysis in the concerned countries (*Choose Life* evaluation report, 2001).

Partnership with LENASO

In Lesotho, *Soul City* forged partnership with LENASO; a consortium of NGOs working in the field of HIV/AIDS. According to Ranneileng (Interview, October 2004), LENASO's role in this partnership was to introduce the material to local people. Its responsibility was also to coordinate the whole process to determine which local actors would be included in the booklet. In addition, LENASO's task was to seek the views of all stakeholders, including the so-called gatekeepers such as religious leaders and the youth so that their views could be incorporated in the booklet. Some of these stakeholders were the Ministry of Education management, National Curriculum Development Centre (NCDC) and the National Curriculum Committee (NCC). However, the underlying objectives that drove the process were that of *Soul City*. This was because *Soul City* had expertise in terms of other aspects of

[13] The target audience of *Choose Life* in different *Soul City* material has been indicated as 12-16 year olds, while Esca Scheepers referred to it as 12-18 year olds. This creates a bit of confusion as to what exactly was their target age group.

the booklet and was funding the project, through DFID (Interview with Ranneileng, October 2004).

Melkote and Steeves (2001: 62) describe the role of a development support communication specialist as being to translate technical language into messages that would be comprehensible to users. Melkote and Steeves argue that the specialist's role should be to create conditions in which benefactors and their intended beneficiaries are able to jointly participate in "mutual co-equality" in making decisions (Melkote and Steeves, 2001: 360). Based on the above definition, it is assumed that the role of LENASO was at par with that of a development support communication (DSC) specialist for its role in facilitating the adaptation and translation of *Choose Life* to the Lesotho context. In contrast, *Soul City*'s role coincided with that of a DSC specialist because the content and design of the *Choose Life* booklet was exclusively determined by *Soul City*. The difference between these partners lay in the unequal power relationships with each other. However, the DSC specialist's role was not carried out in the manner in which Melkote and Steeves perceive it, wherein the specialist's active position becomes redundant as the process continues.

Advocacy with stakeholders

The initial South African version[14] of *Choose Life* was presented to LENASO and other stakeholders. This consultation was conducted with a view to solicit opinions from relevant stakeholders in Lesotho regarding the booklet. LENASO reports that it was not satisfied with some of the contents of the booklet, as indicated by the following statement:

> Some of the things we did not agree with, so we went to our constituency, and chose a representative sample of youth in Lesotho so that the book could be adapted. They indicated that they wanted their own actors and said even if they don't have television celebrities, we have radio personalities and football stars, even though they are few. They however said there were some people who did not matter if they stayed in the booklet. (Interview with Ranneileng, October, 2004)

Some stakeholders are reported to have disputed some of the content, which was regarded as inappropriate for youth in Lesotho, especially page 23. The page showed step by step how to use a condom and this, according to some adults was vulgar. Motemekoane (Interview,

[14] This version was incidentally never distributed in South Africa.

October 2004) contends that teachers indicated that page 23 exposed children to sex and ought to be omitted from the booklet. However, since the pre-test results of the booklet indicated that the youth, being the target group were satisfied with page 23, the criticism was overlooked. According to Ranneileng (Interview, October 2004), there were not many changes made to the South African version. The only major change made in the booklet was the change of celebrities. According to Motemekoane (Interview, October 2004), it was decided that some South African celebrities remain in the booklet as a symbol that the booklet was made in partnership with *Soul City*. Furthermore, it was their belief that Basotho youth are exposed to almost everything that South African youth are exposed to, therefore they would not consider South African celebrities as 'foreign'. In short, it is apparent that LENASO rationalised these views largely because *Soul City*, as the designer of the messages, was the more experienced and conversant partner with respect to health communication. The power to critique may have been constrained as a consequence of power-money relationships and caution with respect to expression of opinion in the light of donor ideology and/or policy.

Advocacy with the Ministry of Education

LENASO considered contacting the Ministry of Education (MoE) imperative as the booklet was targeted at the 12-16 year age group, the majority of whom were attending school. This was to ensure:

- Endorsement of usage of the booklet as a resource material in schools throughout the country;
- Support of the Ministry in order for the book to be seen in a respectful light both by parents and teachers and other stakeholders such as the church and the community;
- Good relations with the Ministry which would enable them to carry out necessary follow ups in the schools as part of monitoring, eventually evaluation (LENASO report, 2001).

It is indicated in the LENASO report that a meeting was set up for LENASO and *Soul City* to meet with the acting Principal Secretary of MoE at that time. The aim was to introduce the booklet and explain the intention to distribute the booklets to all schools in the country. At that juncture, only the South African version of *Choose Life* and the draft of the Lesotho edition were available. The most prominent comments from the Principal Secretary and his staff were:

- The booklet is a good initiative for the country, "while there are some materials being distributed among the youth, none is as comprehensive as this one";
- The booklet seems to address more than HIV/AIDS, it deals with other issues that are very important to the growth and well being of young people;
- The fact that it will be accompanied by a marketing and distribution campaign will enhance readership throughout the country, and hopefully this will make a difference;
- It would be great if the booklet could be written in Sesotho, to accommodate the youth who cannot read English;
- The pictures should be of Basotho youth to make it more attractive to other youth and to demonstrate that it is a Lesotho booklet;
- Content should include Basotho's moral traditional values and some Christian moral values as ways for youth to abstain from sex;
- The pictures demonstrating condom use must be excluded from the Lesotho edition (LENASO report, 2001).

Subsequent meetings were held, this time with a new Principal Secretary, whose positive dynamism and outlook on HIV/AIDS information dissemination indicated support for the project (LENASO report, 2001; Interview with Ranneileng, October 2004). He felt that the youth had been denied information pertaining to their sexual development because adults were too scared to discuss certain issues with them. His view was that people need to be shocked with facts so that the reality that people, especially the youth are dying because of ignorance, is recognized.

Contrary to this support by the Principal Secretary, the attitude of other management staff of the Ministry was negative and seemed to pose a threat to the success of the project. According to LENASO, the promotion of the Principal Secretary to the post of Government Secretary made things less easy. The fact that he had already signed a letter endorsing the booklet became a sore issue for some officials, who felt that LENASO and *Soul City* only involved them as an after thought (LENASO report, 2001).

According to the report, some of their comments were:

"Page 23 is so vulgar"

"The booklet is not gender sensitive, why have you not demonstrated the femidom as well?"

"Why haven't you included photographs of HIV/AIDS patients?"

"Why have you not included shepherds?"

The LENASO/*Soul City* partnership felt that NCDC and NCC officials were seeking fault instead of offering constructive criticism when considering the booklet. The comments following were regarded as constructive criticism and would have been welcomed earlier in the process:

"You are saying children can have sex when they are ready, yet among the questions you ask, there is no mention of age"

"You have written nothing on how to care for an AIDS patient"

"Why sperm, not semen?"

"Why HIV virus when the v in the HIV stands for virus?"

The *Choose Life* team pointed out that after the launch of the booklet, feedback indicated that some were excited about the book while others had mixed feelings about some of the content. Some felt 12 years was too young an age for some of the things contained in the book such as, "having fun without sex", the condom page and the nurses' stories (LENASO report, 2001; Interview with Ranneileng, October 2004, Interview with Motemekoane, October 2004). It is noted with some concern that some schools indicated the intention not to distribute the books to the children.

The above commentary highlights the need for change agents to be cautious of the possibility of being confronted with resistance by local communities. The fact that LENASO/*Soul City* felt that they were being attacked indicates that they never considered that their approach could have been flawed and might yield unintended negative consequences. *Soul City* did not expect this kind of resistance from stakeholders, especially because they (stakeholders) were

not the target audience. Melkote and Steeves (2001: 67) warn: "It is crucial to recognize that every development situation is unique and complex, and that the local level of the development project is ultimately inseparable from ... national political-economic structures and processes".

While the majority of adults consulted were opposed to the page showing condom use, the youth were said to have expressed their satisfaction with the page. *Soul City* /LENASO therefore disregarded the adult community's opinion and decided that 12-16 years olds were better judges of what is good for them. This assumption, drawing from the theory of 'another development' is relatively flawed and does not apply in all situations (Francis, 2002). Such issues therefore have to be dealt with great caution. In the Basotho culture, an adolescent cannot be left to make decisions about his/her life, especially regarding sex, which is still considered a taboo subject by most parents. It is contended that this is why some schools declared that they were not going to give their students the booklets.

Distribution

While Motemekoane (Interview, October 2004) believes that the marketing of *Choose Life* went very well, Ranneileng (Interview, October 2004) argues that the promotion of the booklet did not achieve satisfactory results and attributes this to lack of funds and infrastructure. Ranneileng argues that these constraints resulted in the team being unable to conduct road shows to promote the booklet, which she believes, would have sensitised people of the importance of the booklet whilst also distributing it.

Two editions of *Choose Life* were printed in Lesotho, in Sesotho and English. A total of 435 000 booklets were distributed in the country and this was the largest number of copies compared to those distributed in Botswana (400 000), Swaziland (116 000) and Namibia (380 000) (*Soul City*, 2004[15]). 1050 primary schools received the booklet and 154 high schools throughout the country. The remaining booklets were spread across NGOs (LENASO members), Lesotho Roller Mills, district hospitals and adolescent corners (*Soul City*, 2004[16]). The involvement of the Lesotho Roller Mills in the distribution of the booklet facilitated efforts for the booklet to reach remote places that it would otherwise not have reached. In this

[15] Available at: www.soulcity.org.za
[16] Available at: www.soulcity.org.za

way Lesotho Roller Mills was effectively promoting its product around the country. As Ranneileng (Interview, October 2004) adds:

> It [Lesotho Roller Mills] was very helpful because I was sure that the booklets wouldn't reach the people. Some of the schools as I talk to you now, I think they burned them, I don't know, but there are a lot of youth who didn't get these books from their schools.

The effectiveness of the use of Lesotho Roller Mills was confirmed by participants during the focus group discussions as a considerable number of them found the booklets in maize meal bags and not from their schools.

Evaluation

Although Lesotho received the largest number of copies than the rest of the other countries, *Choose Life* appears to have been more successful in Botswana because the bulk of its evaluation was conducted in Botswana. *Soul City's* justification for this is that there was no quantitative study conducted in the other three countries because of cost and logistics. Botswana was also chosen because it was the first country to complete the distribution of the *Choose Life* booklets (*Choose Life* evaluation report, 2001).

Only qualitative evaluation was done across all four countries. Group discussions were conducted at schools and partners in each country helped organise the groups. Ironically, Ranneileng, who was still a member of LENASO and was extensively involved in the development and implementation of the project, had no knowledge of any evaluation that was conducted. This brings to light the existence of a communication breakdown between *Soul City* and LENASO and between LENASO members themselves. Evaluation is a key phase of a project, which determines the success or failure of such a project. This lack of communication implies that there was some hidden conflict within the team if evaluation could be conducted without the knowledge of other members of the team. This was a sore revelation for Ranneileng, who claimed:

> As for the evaluation, they didn't tell us, well 'M'e Dolo [who became Chairperson of LENASO after Ranneileng] obviously did things her own way. Maybe she had her own reasons why she didn't involve us or maybe she didn't want to pay us. If there is already a report, it means the evaluation

> has long been done, and I was still a member of LENASO then. How could she not involve us, so that we could assess whether our efforts were successful or not?

The implication is that the evaluation was done under the banner of the newly formed partnership between *Soul City* and *Phela.* LENASO was hence no longer involved, although some of the *Phela* staff were recruited from LENASO, specifically the director[17] and the researcher who was interviewed. This created confusion in terms of differentiating between the relationship between *Soul City* and LENASO and its relationship with PHELA. The confusion arises because *Soul City* asserts that *Choose Life* is a different project from the regional programme and *Phela*, as a partner in the regional programme, is not part of *Choose Life*.

The qualitative evaluation was carried out using focus group discussions. 26 groups were interviewed in Botswana, 18 in Swaziland, 10 in Lesotho and 14 in Namibia (*Choose Life* evaluation report, 2001). It is reported that the intention was to conduct 16 groups in Lesotho but LENASO was unable to find sufficient schools willing to allow groups to be conducted during the period when the researchers were in Lesotho. According to *Soul City* the trends in impact from this evaluation indicated that *Choose Life*:

- Created an opportunity for communication and discussion amongst peers, and awareness around the need to communicate;
- Improved awareness and attitudes around the need to communicate;
- Served as a catalyst for assertiveness (girls);
- Improved awareness and attitudes around people living with AIDS, and stigmatisation (*Soul City*, 2004[18]).

The weaknesses that *Soul City* identified in its approach of the project included lack of a formal procedure to select a country partner, which was a risk because there was no track record of potential partners to determine whether they would be competent for the job (*Choose Life* evaluation report, 2001). There was also no initial needs analysis into the specific communication needs of the target audience to gain an in-depth understanding of their knowledge, attitudes and behaviour with regard to sex and health issues (*Choose Life*

[17] The Director of PHELA, Hope Dolo, was not available for an interview.
[18] Available at: www.soulcity.org.za

evaluation report, 2001). Strategies for marketing and distribution had to rely on limited information because in all the countries statistics were unavailable. This impeded effective distribution to adolescents out of school.

In Lesotho, a serious weakness that was identified was lack of infrastructure, which impaired communication between the project team and *Soul City*, leading to delays in the development of the local version of the booklet. The resistance of churches on certain aspects of the booklet was regarded as constraining the process. This is because in the initial stages of the project, *Soul City* had solicited the CCL's assistance, an organisation with a membership of church leaders. The organisation therefore felt that some content exposed adolescents to sex. It is also indicated in the report that LENASO did not have the capacity and resources to manage the implementation of the suggested trade exchanges and road show, to which Ranneileng admitted (Interview, October 2004).

Soul City's Partnership with *Phela*

Phela came as an initiative of *Soul City* following the *Choose Life* project (Interview with Motemekoane, October 2004; Interview with Ranneileng, October 2004, Scheepers, September, 2004). According to Ranneileng, Motemekoane and Scheepes, this was inspired by the success of the project and the cordial relations between *Soul City* and LENASO throughout the project. It is reported that *Phela* is not an affiliate of LENASO. However, some members of LENASO who were actively involved in the implementation of *Choose Life* were offered jobs in the new organisation and hence coordinated its establishment. *Soul City* wanted partnership with an organisation that would not only deal with HIV/AIDS issues, but also health and development issues. LENASO did not qualify in this regard because its endeavours were focused only on HIV/AIDS.

Although *Soul City* claims that there is no connection between *Phela* and *Choose Life*, Ranneileng (Interview, October 2004) pointed out that she was taken aback during the launching ceremony of *Phela*, because *Choose Life* was mentioned as a product of *Soul City* in partnership with *Phela,* and not LENASO.

The relationship between *Phela* and *Soul City* is that *Phela*, for two years, will adapt *Soul City* material that has been used in South Africa, and adapt it to the Lesotho context for Lesotho

audiences (Interview with Motemekoane, October 2004). This material may either be in the form of print, radio or television. At the time of this study[19], *Soul City* television series are being broadcast on Lesotho television. Print and radio are still in the process of being implemented. *Phela* claims to be an independent partner in its relationship with *Soul City*; however, *Phela* depends entirely on *Soul City* for funding and reports to the latter. Melkote and Steeves (2001) explain this scenario by pointing out that development agents as experts, inherently have an unwillingness to give up control over the development process and as such development agendas always remain with the experts.

Much of what happened during the implementation of the *Choose Life* project reflects the difficulties that public health campaigns are faced with. These complications include the expectation to accommodate reasoning arising from the interests, rivalries, grudges, attachments, taboos and so on of local communities in the face of the logic of an epidemic like HIV. The experience also reflects the rivalries that are inherent in peripheral regions, which obstruct their development (Melkote and Steeves, 2001). Lack of solidarity between NGOs in Lesotho adversely affects abilities to cooperate for the greater good of society. It may be deduced therefore that the inherent competition for funding results in further fragmentation amongst these organisations. As a result donors and experts are faced with the dilemma of deciding upon which organisation to partner with. Establishment of the new organisation (*Phela*) is evidence that *Soul City* wanted a partnership in which it would have substantial influence over, thus continuing the dependency cycle. On the other hand, without this link with *Soul City*, *Phela* cannot sustain itself and is still far from being able to build the capacity for an effective health and development communicator.

Role of NGOs

There are various NGOs working in various activities and aspects of HIV/AIDS in Lesotho. Although there are a number of these at the core of communicating about HIV/AIDS, these NGOs are independent of each other, each conducting its own activities, especially following the breakdown of LENASO. During its operation, LENASO was not well coordinated and therefore there was no synchronisation of activities and viewpoints between members. Consequently, while NGOs are doing commendable work, effectiveness is compromised. It is

[19] 2004-2005

also not easy for NGOs to influence national policy on HIV/AIDS as little solidarity and consistency of position is demonstrated. It is therefore a challenge for government and these organisations to be linked to the national response in order to bring about an HIV/AIDS competent society (Kimaryo *et al*, 2004: 28). In relation to the case of *Soul City* and its relationship with NGOs in Lesotho, the shift from LENASO to *Phela* has thus not had any significant influence over government decisions. *Phela* can only decide on its own activities regarding health communication.

This chapter discussed the implementation process of *Choose Life* in Lesotho. The next chapter discusses the theoretical framework and methodology applied in the study.

Chapter Three

Theoretical framework and Methodology

This chapter explores a theoretical framework in which it is possible to analyse the reception of the *Choose Life* booklet by youth in Lesotho to determine how appropriate it was to their context. The principal theories that informed the present research are Stuart Hall's (1980) encoding/decoding model, and Development Support Communication theory (Mowlana & Wilson 1990; Mowlana 1995; Melkote & Steeves 2001; Singhal & Rogers, 1999).

Encoding/Decoding

Hall's (1980) encoding/decoding model highlights the importance of active interpretation within relevant codes as an element of the study of mass communication. Encoding means the making of messages and the interpretation of these messages by the reader is referred to as decoding. Hall referred to 'moments' of a circuit of the communication process: production, circulation, distribution/consumption, and reproduction. Each of these 'moments' is necessary to the circuit as a whole but cannot fully guarantee the next 'moment' with which it is articulated (Hall, 1980: 128-129). Hall's model explains the fact that a given audience's decodings may not follow inevitably from a media producer's encodings. Thus there is no necessary correspondence between the encoded message and the decoded message, the former can attempt to 'pre-fer' but cannot prescribe or guarantee the latter (Hall, 1980: 135). These 'distortions' or 'misunderstandings' are attributed to the structural differences of relation and position between communicators and receptors of media messages and lack of equivalence between the codes of the source (encoding) and receiver (decoding) (Hall, 1980: 131). The making of meaning is seen as an interactive, dialogic process of translation, where the receiver of the message is an active participant in its decoding (Hall, 1997; Hall *et al*, 1980; Tomaselli, 1988).

One 'moment' in the circuit is the circulation of the message as it appears in its discursive form – which is the medium used to convey the message. This is the stage where production starts and the message is constructed. The discourses that are used in the construction of the

message frame the way in which the message is constituted. According to Hall (1993: 92), these discourses are:

> ...meanings and ideas: knowledge in use concerning the routines of production, historically defined technical skills, professional ideologies, institutional knowledge, definitions and assumptions, assumptions about the audience...

In another 'moment' of the circuit, the programmes are received by the audience, who decode meaning and later put those meanings into social practice. In order for a message to be decoded as meaningful, it must be encoded in a meaningful discourse. Both the encoder and decoder must realise it as meaningful. Hall argues that members of the same culture must share the same concepts, images and ideas in order for them to think and feel about the world in roughly the same way (Hall, 1997: 4). Thus, for one to decode a message meaningfully, it has to be within the confines of understanding of his/her culture. In this way culture and language are the means through which production and circulation of meaning takes place. This however does not mean that audiences cannot decode messages from other cultures as other signs are universal, particularly visual signs, and can be understood across borders.

In the next 'moment' of the circuit, the producer of programmes draws on social practices of the audience to produce further programmes. This is why the audience is seen as both the source and receiver of messages. For instance, *Soul City* sources material for its drama series from audience members through formative research. However, the material is reconstructed and shaped according to *Soul City*'s assumptions about how society relates to the specific material, anticipating their reaction to the material. It may be deduced from this point that production and reception of messages are not identical but differentiated moments that are related (Hall, 1993: 93).

Since 'moments' of the circuit are not identical, misunderstandings may arise. These distortions and misunderstandings arise from lack of equivalence between the two sides in the communication exchange. The codes used in the encoding of a message may not be the codes that are used by the decoder of the message. The technical infrastructure, relations of production and frameworks of knowledge of the producer of messages are not the same as those of the receiver of the message (Hall, 1993: 94).

Audience reception, argues Hall (1993), cannot be understood in simple behavioural terms. It is framed by structures of understanding and produced by social and economic relations, which determine how the audience realise a message as meaningful, permitting such meanings to be changed into practice or consciousness (Hall, 1993: 93). Fiske (1987: 14) supports this notion by pointing out that to understand both the production of programmes and the production of meanings from them; we need to understand the workings of discourse. Hall argued that the behaviourist approach failed to distinguish between real events and the signs produced by the media's representation of real events. The articulation of the sign, whether visual or verbal, is not purely simple and straightforward. It is a product of convention, not of nature and requires the support of codes.

To show how the varied ways in which signs are encoded and decoded can produce meanings, Hall (1993: 96), drawing from the lineage of semiotics, distinguishes between the terms denotation and connotation. Denotation is those aspects of a sign that appear to be taken in any language community at any point in time as its literal meaning. Connotation is the more associative meanings for the sign that it is able to generate. Connotative meanings therefore vary from situation to situation. Most signs combine both the denotative and connotative aspects.

Signs appear to acquire their full ideological value or appear to be open to articulation with wider ideological discourses and meanings at the level of their associative meanings. Here the sign enters fully into the struggle over meanings – what is called the class struggle in language. Denotation and connotation therefore are useful analytical tools for distinguishing the different levels at which ideologies and discourses intersect. In denotation, the ideological value is strongly fixed, because it has become fully universal and 'natural' (Hall, 1993: 97).

Hall's (1980) encoding/decoding model presents three scenarios to show how, due to the potential discrepancy between encoding and decoding patterns of viewer and programmer, viewers might not accept the intended meaning encoded. The reader can make a preferred, negotiated or oppositional reading to the encoded meaning intended by the producer of the message. Ideology plays an important role in the subjectivity of audience decodings. Preferred readings are produced by those who agree with and accept the dominant ideology and can therefore be said to be operating inside the dominant code (Hall, 1993: 101; Fiske, 1996: 121). Those who fit into the dominant ideology in general but inflect the preferred

reading to take account of their social position, produce a negotiated reading, as Fiske (1987: 64) states:

> The majority of viewers, however, are probably situated, not in positions of conformity or opposition to the dominant ideology, but in ones that conform in some ways, but not others; they accept the dominant ideology in general, but modify or inflect it to meet the needs of their specific situation.

Someone who puts himself in direct opposition with the dominant ideology produces an oppositional reading.

In reading a text, a reader places such a text in terms of his/her social position (Iser, 1978). Reception theory postulates that the meanings decoded by the message recipients are many and that the message itself (the *text*) is polysemic, and may hold multiple meanings. Hall argued that the dominant ideology is typically inscribed as the 'preferred' meaning in media texts; however, its readers have different ways of reading such media texts. It is argued that this is due to the fact that audiences decode messages for their own purposes in the same way producers encode the messages to serve their own interests (Strinati, 2000: 189). Hall attempted to retain the concealed and mystifying character of signs and codes, while including the discourses that determine the way producers and consumers of television messages encode and decode messages respectively (Strinati, 2000: 189). The concept of the subjective interpretation of meaning implies that without the cyclical free-flow of information between the communicator and receiver of the message, no agreement on meaning or the construction of a mutual reality can be arrived at.

Limitations of Encoding/Decoding

Hall's model has been criticised by writers such as David Morley and John Corner (Fiske, 1996: 128). Corner was of the view that too much emphasis was put on the polysemic qualities of the text, thus risking 'complacent relativism, by which the interpretive contribution of the audience is perceived to be of such a scale and range as to render the very idea of media power naïve' (Corner, 1991: 29, cited in Morley, 1992: 20).

Morley on the other hand was one of the writers who challenged the view that audiences were relatively powerless and inactive subjects. He differentiated between the socially and

textually produced subjects and argued that the audience is a social subject and has a history, lives in a particular social formation which is a mixture of class, gender, age, region to name a few. Morley argued that the social subjectivity is more influential in the construction of meanings than the textually produced subjectivity, which exists only at the moment of reading (Fiske, 1987: 62). In this way the social settings from which a viewer comes from determine the way he/she will construct meaning from a message, other than the text determining how he/she constructs the encoded meaning in the text.

According to Hall, class is a crucial factor in determining differences of reading messages (Fiske, 1987: 63; Fiske, 1996: 128; Morley, 1992: 104-111). Morley's study however revealed that class position does not in any way directly correlate with decoding frameworks (Morley, 1992: 118). Hall had overemphasised the role of class in the production of different readings and had also underestimated the variety of other factors that determined different meanings. The preferred reading also implies that the three types of reading texts are equivalent. In practice, there are very few perfectly dominant or purely oppositional readings, and as a result in reading a text, audiences enter in a process of negotiation with the text (Fiske, 1987: 64).

Circuit of Culture

Hall's later theoretical revision of the influence of media, the well-known `Circuit of Culture' model (1997), offers a greater level of abstraction, but does not present the same degree of clarity for the researcher, on the issue of discrepant/aberrant/alternative reception of media texts. Similarly, Eric Michaels (1990)[20] model of teleported texts does not offer clarity on the issue of discrepant/ aberrant/alternative reception of media texts.

The circuit of culture shares an interest in the way in which a viewer/reader/consumer receives and perceives text/products. Although the text influences how it is understood, and the reader contributes to the meaning making process, Hall (1997) argues that there are a number of processes at work. This therefore means that there is not one moment, which can be singled out in explaining the meaning that an artefact comes to process. It is argued that it

[20] Michaels identifies seven phases through which a text passes from the moment it is conceived in the mind of the producer to the moment when it returns to be reproduced by the producer. His emphasis is on the important role played by the technology in which a message is transmitted in meaning making.

is a combination of processes –in their articulation – that the beginnings of an explanation can be found (du Gay *et al*, 1997: 3).

The circuit is a non-linear process, which means that a cultural study could start anywhere. It should however explore how a cultural text is produced and consumed, what social identities are associated with it, how it is represented, and what mechanisms regulate its distribution and use. The five moments of the circuit of culture are representation, regulation, identity, consumption and production.

Development

Development put simply refers to the commission of improving the livelihoods of people and this means different things for different people (Melkote and Steeves, 2001). For the developing world, development theory suggests that target audiences need to play an active role in creating development strategies designed for their own benefit. This means people do things for themselves rather than having things done for them. Participatory models of development insist that a strategy adopted for development must come from the community and be relevant to their own experiences (Servaes, 1991). This discourages imposed strategies designed without consultation with the beneficiaries, as they do not address the problems pertinent to that particular community. Moreover, the imposed solutions are the property of the outsiders and normally this leads to unsustainable development projects. It is argued therefore that strategies which do not involve beneficiaries' participation become irrelevant and communities do not benefit from them. In the same manner, health communication messages intended for the benefit of target communities should follow the same route if they are to be successful.

Development Communication

Development communication can be categorised into four main paradigms namely: modernization theory, dependency theory, development support communication (DSC) and another development (Melkote & Steeves, 2001; Servaes, 1995, 1999). Defining each of these paradigms provides an indication of how the models of DSC and another development fit in with the history of the concept of development in order to make it possible to use them as a basis to analyse the data generated by the research.

The modernization paradigm emerged during the late 1940's and 1950's after the Second World War when Western countries saw the need to transfer technology to Third World countries in order to develop them. This paradigm emphasized a unilinear, capitalist-inclined, industrialized growth and production centred theory of progress that valued science, technology, consumerism, and a Western European urban culture as the goal and way to achieve development. The model as stipulated by Daniel Lerner (1958) and Wilbur Schramm (1964) was aimed to help Third World countries 'catch up' by providing them with technology and expertise. The assumption was that Third World countries were poor because of internal political, economic and sociological problems. Modern technology and expertise would be offered as a means of moving towards a better life. Apart from helping the Third World countries up to their level, the development of these nations was seen by the advocates of the model as providing and developing markets for their products, and also for providing unexploited sources of labour and raw materials.

The modernization paradigm considered mass media to be crucial in disseminating information from the source to the beneficiaries, that is, from Westerners to the Third World. The paradigm was seen to have grown from "a genuine wish to improve conditions in the 'underdeveloped world' and in a belief in the power of mass communication to teach and to lead by example and by the stimulation of consumer demand for industrial goods" (McQuail, 2000: 84).

This means the media would be used to both establish and to fulfil the need to modernise. Modernization assumes that the media is able to fulfil this role because of the paradigm's view of the communication process. According to McQuail, (2000: 85) the model of communication in the paradigm is a mechanistic one of transmission. Modernization views communication as a linear process where a knower and active sender transmits messages to the passive receiver. The communication approach was therefore a top-down one, with information flowing from the experts to the 'backward' beneficiaries. This top-down and unidirectional communication philosophy fractured fragile developing communities by undermining indigenous knowledge, beliefs and social systems. Tomaselli (1997) contends that in this paradigm the culture of target audiences is not taken into account in both message and campaign design, resulting in audience members being alienated from what they see. Dissatisfaction with the model led to the emergence of a new model, the dependency paradigm.

Dependency theory emerged in the late 1970s as a result of discontent with modernization theory by Latin-American theorists. The theory implies that the underdevelopment in Third World countries is a result of the so-called development introduced by the developed countries. The theory argues that their assistance has a negative effect on the ability of Third World countries to uplift themselves. Dependency theorists tend to think that for the Third World countries to overcome their poverty and technical backwardness, they should not adopt the mode of production of the advanced countries (Leys, 1996: 147). The main aim of this paradigm was to conscientise the masses to the ills of modernization. According to dependency theorists, developed countries exploited Third World countries to help their own economic growth and achieved this with the assistance of elite groups in these Third World countries (Melkote and Steeves, 2001: 170). The dominant paradigm was seen as failing to provide a framework for understanding the history of developing countries by assuming that Third World nations resembled the earlier stages of the history of Western countries and therefore needed to pass through similar stages in order to develop. 'Dependistas' argue that the underdevelopment in Third World nations is a product of past and continuing economic and other relations between the underdeveloped countries and the now developed countries (Frank, 1969: 4 cited in Melkote and Steeves, 2001: 171).

The dependency paradigm views international relations in terms of the centre and the periphery; corresponding to the First and Third worlds respectively. It further suggests that development at the centre implies underdevelopment at the periphery (Servaes, 1991: 58). Commenting on the issue John Thompson (1995: 150) argues that colonial power and industrialisation "created a new pattern of world trade based on an emerging international division of labour". Core countries imported raw materials from the colonies and exported manufactured goods throughout the world (Thompson, 1995: 150). As a result industrial production proliferated in the core countries and it became a source of economic and political power for core countries. This led to dependency of the periphery region. The paradigm therefore argues that the Third World nations had to dissociate from the First World. This meant that the national labour and raw material be used to develop the nation itself not the foreign countries.

While the modernization paradigm saw obstacles to development as internal and as a result of the traditional and backward attitude of the peasants (Melkote, 1991), according to the

dependency paradigm, the "most important obstacles to development are external to the underdeveloped nation" (Servaes, 1991: 70).

However, the theory ignored the benefits enjoyed by beneficiary societies and did not provide solutions to the problems posed by the modernization model of development (Leys, 1996). Servaes (1991: 59) argues that the dependency paradigm failed "to take into consideration the internal class and productive structures of the periphery that inhibit development of the productive forces" by opposing the suppression of the Third World by the First World. This means that the paradigm not only opposes the exploitation of the Third World by the First World, but ignores the exploitation of the rural periphery by the urban and the government centre of the same country (Wang, 2002).

The dependency theory advocates for dissociation of local communities from change agents. This implies that beneficiaries ought to do things for themselves without external assistance. It is argued close ties with 'experts' result in continued dependency.

In this regard, it is argued that LENASO was dependent on *Soul City* for both health communication expertise and funding. This relationship limited their independent development in the field of health communication. This is explicit in their subordinate position during the implementation of the *Choose Life* project. It is surmised that the dependency of LENASO on *Soul City* led to further dependence in the newly forged relationship between *Soul City* and *Phela*, an organisation that forms part of *Soul City's* regional programme. *Phela* was established after the LENASO/*Soul City* partnership. Its existence stems from *Soul City's* requirement to forge a partnership with an organisation that not only focuses on HIV/AIDS, but confronts other social and health issues. *Phela* enjoys both the expertise and funding that *Soul City* provides, and intensifies its dependence by using *Soul City's* material for a Lesotho based audience.

The above commentary supports the critique levelled against the dependency paradigm. It is argued that the theory ignores the benefits enjoyed by beneficiaries and the internal structures that inhibit their development. For instance, due to lack of organisation, expertise and infrastructure, small scale organisations like LENASO and *Phela* are inadequately equipped to secure funding from big corporations and organisations. *Soul City* on the other hand is well accredited in the field of health communication and is able to solicit and attract funding.

Furthermore, lack of solidarity among organisations working in the field of HIV/AIDS in Lesotho impedes on these organisations' ability to progress.

The DSC paradigm emerged as a response to the shortcomings of the development strategies of the dependency model. Through non-linear, horizontal communication between experts and beneficiaries, desired outcomes of DSC include honing of critical awareness skills and empowering local organisations and communities (Melkote and Steeves, 2001: 352).

DSC was a term coined by Western fieldworkers who were sent to Third World countries as development agents. It was a response to the realities they found in developing countries. The emphasis was to change the mode of communication as an input toward greater economic growth. Communication was seen as a tool to support people's self-determination, especially those at the grassroots (Ascroft and Masilela 1994; Jayaweera, 1987). The structure of communication would be semi-participatory in the sense that donors would still define projects and their objectives while communities would participate in the formulation of the message to suit the local context. The limitation of this approach is that, although participation of beneficiaries is encouraged and there is collaboration between experts and the people, there is no real empowerment because the design and control of messages is left with the experts (Melkote and Steeves, 2001: 350).

The paradigm of 'another development' drew its theoretical foundation from the work of Paulo Freire (1972). Freire suggested that for education to be relevant to the experiences of the students, they had to play an active role in creating their own education. The notion of Freire's work and its relation to Africa is discussed at length by Dominique Nduhura (2004)[21]. Freire argues that education without the participation of students fails, as the ideas given to them do not apply to the students' situations and thus cannot solve problems pertinent to them. Education, like development, is meant to improve lives. Full participation of people in the process is therefore necessary.

The paradigm of 'another development' as opposed to previous development strategies involves the full participation of beneficiaries. The key players in this paradigm are the people themselves, dealing with their problems in local settings and learning in relation to

[21] Masters dissertation submitted at the University of KwaZulu-Natal.

their experiences and realities. According to Keval Kumar (1994: 86), 'another development' assumes that there is no universal path to development, that it must be conceived as an integral, multidimensional and dialectical process which can differ from one society to another. However, it is also assumed that there are no countries that function completely autonomously and that are completely self-sufficient; nor are there nations whose development is exclusively determined by external factors (Kumar, 1994: 86). 'Another development' is the preferred model advocated by communication professionals in academic circles for development interventions. One of the critiques levelled against the theory is that it assumes that communities have the ability to articulate their needs and desires and have knowledge about what development means. The theory also assumes that communities are self-sufficient enough to advance their development free from external factors (Francis, 2002: 3; Lee, 1995: 4).

Audience research, needs assessment, and audience participation are crucial in influencing the effectiveness of messages intended for behaviour change (Singhal & Rogers 1999). Similarly, Mowlana and Wilson (1990) indicate that for development to be participatory, emphasis should be on communication as a process of sharing and dialogue, and popular participation in self-development planning and execution. The value of involvement of target groups in community-based forms of communication has been claimed to be essential, if these campaigns are to be successful. It has been argued (Servaes, 1999) that campaigns are unlikely to be accepted without the involvement of the target audience, failing because the audience does not feel obliged to contribute to the campaign's success. Servaes (1999) has argued that failure is the result of beneficiary communities' perception that they do not 'own' the outcomes of campaigns, perceiving instead that the latter belong to the 'experts'. These elements of DSC theory provide a framework for assessing the effectiveness of Hall's Encoding/Decoding model, by determining the extent to which the target audience found the messages in *Choose Life* appropriate for their context, and whether this reception has affected the outcome of the campaign.

Participation

Participation in development and communication is conceived as a normative principle to which to aspire. This is to such an extent that it has become a part of development jargon and

almost all development projects are proposed and funded on the basis of using the word (White, 1994).

Participation of target audiences in development projects can be classified into four different ways and according to (Uphoff: 1985) they are:

- Participation in implementation: People are encouraged and mobilized to actively take part in the actualisation of projects. They are given certain responsibilities and certain tasks, or are required to contribute specified resources.

- Participation in evaluation: Upon completion of a project, people are invited to critique the success or failure of it.

- Participation in benefit: People take part in enjoying the fruits of a project, whichever form it may take.

- Participation in decision-making: People initiate, discuss, conceptualise and plan the activities of their community. Some of this may be related to more common development areas such as building schools or applying for land tenure. Others may be more political, such as removing corrupt officials, supporting parliamentary candidates, or resisting pressures from the elites. Yet others may be cultural or religious in nature.

Few projects offer the opportunity for all of these types of participation but limit it to one or two. Earlier models of development saw participation of target groups in the stage of implementation only. The later model of development support communication has incorporated some of these types and 'another development' is the ideal model that integrates all four types. This maximum participation carries an assumed status of maximum benefits.

Soul City claims that its approach is not participatory but goal oriented and they never intended to adopt a participatory approach. They argue that the involvement of the target audience and stakeholders through formative research comes from an understanding of what is needed to make health communication effective; not from the empowerment paradigm that underlies community media. According to them, as a national mass media intervention, following a participatory approach is impossible.

DSC advocates for involvement of the target audience even though the driving objectives remain those of the donor. Involvement of target audiences in formative research is therefore still participation. That is if the health communicator can afford to accept the target audience's opinions and incorporate them in the messages the way they prefer them to be; even if they differ from those of the communicator. In this way the target audience is involved in the construction of the message and therefore target audiences' ability to voice their opinions on something that concerns them is participation. This participation is however semi-participatory because *Soul City* still defines the objectives of the project. This is not participation as conceived by 'another development', where communities define and control their own projects. It is seen in terms of participation as conceived by DSC, but characterised more by elements of the top down communication inherent in the modernisation paradigm.

Research methodology and methods

Triangulation

This study applies a triangulation of methods of inquiry. Triangulation involves the application of several research methods in the study of the same phenomenon with the hope of overcoming weaknesses and biases of a single method study. Triangulation serves to obtain confirmation of findings through convergence of results of different methods.

Methods and modes of enquiry are discussed in the next section.

Reception analysis

The study offers a reception analysis of the *Choose Life* booklet: both quantitative and qualitative methods which aid the interpretation and clear understanding of perceptions of both *Soul City* as the communicator; and youth in Lesotho as the receiver of the message. Both the focus group discussions and questionnaires provided the basis for interpretive and critical analysis of the study. Interpretive studies attempt to understand phenomena through the meanings that people assign to them while critical research assumes that social reality is historically constituted and that it is produced and reproduced by people.

Content analysis

A content analysis of the *Choose Life* booklet is used as a secondary method to provide a base line for whether the reception of the booklet was a preferred, negotiated or oppositional one. Content analysis consists primarily of coding and tabulating the occurrences of certain forms of content that are being communicated into manageable categories such as words, phrases or themes (Rubin and Babbie, 1993: 406). The advantage of this methodology is that it is objective and the researcher's biases do not enter into the findings; therefore similar findings should be arrived at should another researcher replicate the study.

The following units of analysis were used as elements of the content analysis of the *Choose Life* booklet: Pictures of people in the booklet in terms of whether they are Basotho or not, and which of those are celebrities or unknown actors; themes were HIV/AIDS, love/relationships, sex, violence, condoms, and sexually transmitted infections (STIs).

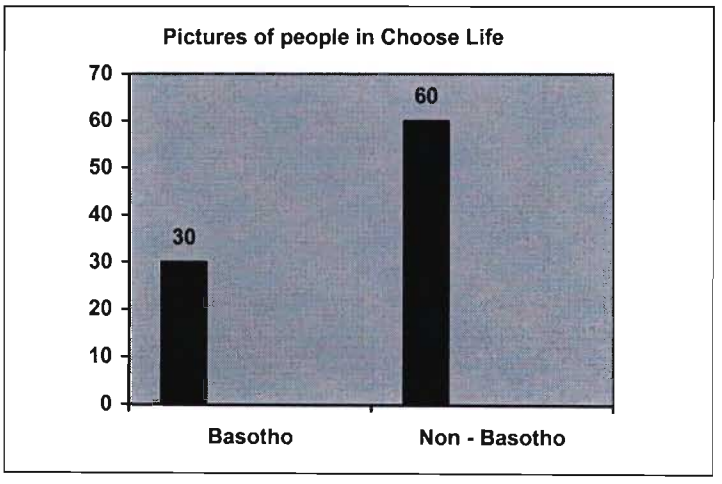

Figure 1

The *Choose Life* booklet is characterised by colourful pictures of youth portraying messages about various issues discussed in the booklet. Only 33% of the pictures were of Basotho while the bulk of the pictures were of South Africans and other faces not known to the researcher[22].

[22] For the purposes of the argument we will consider them South Africans or selected from the other countries where *Choose Life* was adapted and distributed. The faces of Basotho were identified with the help of the former Chairperson of LENASO.

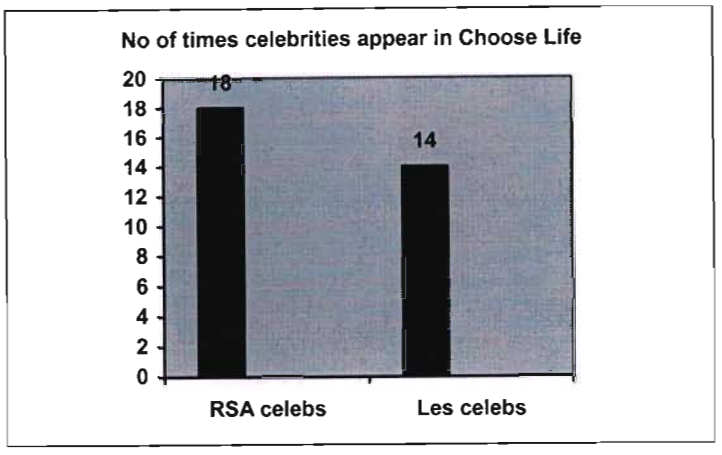

Figure 2

Out of these pictures, Basotho account for 44 % of the celebrities in the booklet while South African celebrities account for 56%.

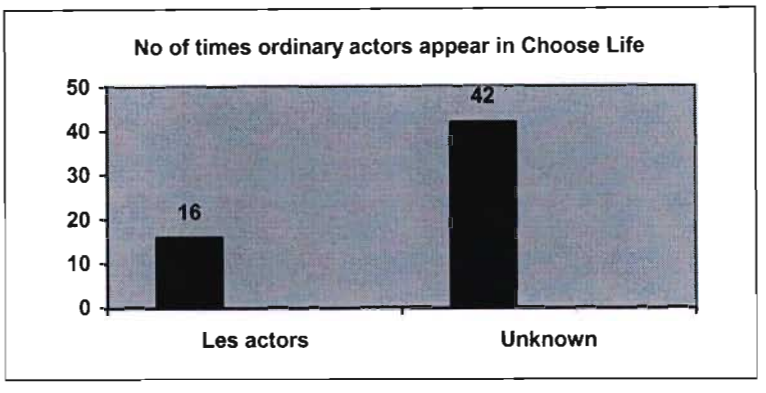

Figure 3

Figure 3 shows that the number of unknown South African actors in the booklet far exceeds the number of unknown Basotho actors. Figures 1, 2 and 3 all indicate that Basotho are underrepresented in the booklet. It is however indicated that formative research results showed that Basotho wanted to see their own people in the booklet (Interview with Ranneileng, October, 2004). The lower percentage of Basotho celebrities could be explained by the fact that there were a few well-known media celebrities in the country at the time. However, it is contended that unknown ordinary youth who would have liked to appear in the booklet could have been easily solicited. It is argued that inclusion of local ordinary youth would have increased marketing strategies of the booklet. This is because more youth would have been involved prior to its distribution with the advantage of word spreading to peers about the booklet. The non-inclusion of ordinary youth also implies that time logistics were a hindrance to the effective implementation of the project.

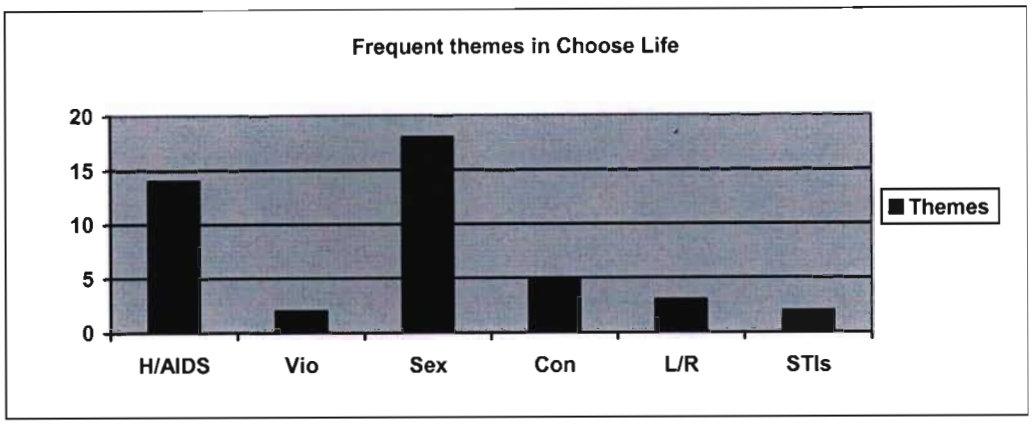

Figure 4

Table Keys

H/AIDS stands for HIV/AIDS
Vio stands for violence
Con stands for condoms
L/R stands for love and relationships
STIs stand for sexually transmitted infections

The theme that appears most frequently in the booklet is sex, appearing 18 times in the 45-page booklet. It is followed by HIV/AIDS, appearing 14 times; condoms, love and relationships, violence and STIs appear 5, 3 and 2 times respectively.

Interviews – Semi-structured interviews enable the researcher to probe specific issues as narrowly or widely as the context demands. According to Marlow (1988), in a semi-structured interview, the interviewer has more freedom to pursue hunches and can improvise with the questions. Bailey (1987) adds that a semi-structured interview might use a combination of open and closed-ended questions. These allow for the researcher and participants to clarify misunderstandings and allow participants to provide detailed explanations about certain issues.

An interview was conducted with a researcher at *Phela* Health and Development Communications, who was a volunteer working with LENASO during the implementation of *Choose Life*. Another interview was held with a former chairperson of LENASO, who was

actively involved in the development and implementation of the *Choose Life* booklet. The interviews were conducted with a view to obtaining insight into the operations and methods used to put the project in place. The interviews also provided information on the communication strategies that were applied in the development of the *Choose Life* project.

Focus group discussions – Focus groups have the flexibility to enable the researcher to elicit a wide range of opinions about a given issue (Gunter, 2000: 42). This methodology involves bringing together a small group of individuals to discuss an issue in the presence of a moderator and ensuring that each participant has a turn to stimulate discussion. Focus groups can be conducted in a short time, and because respondents stimulate each other's line of thought responses are often less inhibited than those obtained in formal individual interviews (Wimmer and Dominick, 1983: 100-101). The present project employed focus groups to determine the impact of the *Choose Life* booklet on the target group's attitudes, beliefs, and intention to change behaviour.

Five focus group discussions were conducted among a sample of youth who accessed the *Choose Life* booklet. The intention of the researcher was to conduct six focus groups among a sample of 12-16 year olds, divided equally between urban and rural areas. In each area, one group would comprise both males and females; the other two groups would comprise separate male and female participants, in order to observe the possible impact of gender relations on reception of the *Choose Life* message. However, only five focus groups were conducted, three in urban areas and two in peri-urban areas. The sample was drawn randomly from among youth making use of the *Choose Life* booklet's distribution points, which include Primary and High Schools and adolescent corners (based in hospitals).

Two focus groups comprised youth from adolescent corners based in government hospitals or clinics. One was in an urban area while another was in a peri-urban area. Two other focus groups were conducted with students from two high schools, one from an urban area and one from a peri-urban area. The last group comprised students from a primary school in an urban area.

Questionnaires – the application of this method was used to complement the focus group discussions, providing anonymity to participants who may provide information they would otherwise feel uncomfortable to reveal in face-to-face interaction, in the presence of recording

equipment, or under the influence of dominant respondents (Wimmer and Dominick, 1983: 102). This method also serves to balance the tendency for focus group participants (particularly dominant respondents) to provide responses which they assume the researcher/moderator wants to hear. The questionnaires were distributed to focus group participants to fill up in their own time and to return to the researcher.

Respondents both in the focus groups and to the questionnaires were allowed to use the language of their choice (English/Sesotho), allowing them better personal expression. Records were transcribed and translated into English where necessary. Although there is a formal system of requesting permission from the Ministry of Education to conduct research in schools in Lesotho, the present project made use of an informal version of this by negotiating with school principals and teachers to get access to the learners.

Sampling

Non-probabilistic sampling was used to draw the sample for the study. The advantages of non-probabilistic sampling lie in lower cost, fewer time constraints, and sampling errors being less problematic than probabilistic sampling (Wimmer and Dominick, 1983: 59). For the purposes of the study therefore an available and purposive[23] sample was used as subjects for the study. The sample was drawn in the following manner:

Focus group 1 – A youth club in Qoaling Maseru, was contacted. It was inquired whether or not club members received the *Choose Life* booklet. Upon getting a positive answer, an appointment was set up to conduct the focus group with members of the group. The focus group was conducted on a Saturday, when members met for their weekly gathering.

Focus group 2 – This was a group of primary school learners. An inquiry was made from a colleague of the researcher about whether her children's school received such a booklet. Her knowledge of the booklet encouraged the researcher to phone the school and an appointment was secured with the students. Standard Seven pupils were summoned and after they assembled it was inquired whether or not they knew the booklet. A random selection of five

[23] Subjects are selected on the basis of specific characteristics and the sample eliminates those who fail to meet these criteria. In this instance subjects were youth who accessed the *Choose Life* booklet.

girls and five boys was made from those who indicated that they knew the booklet and the rest of the class was dismissed.

Focus group 3 - This focus group comprised peer educators from Matsieng, which is a peri-urban area on the outskirts of Maseru. An enquiry was made from the local hospital about knowledge of youth who acquired *Choose Life* from the adolescent clinic at the hospital. The researcher was informed of this group of peer educators and an appointment secured for the researcher to meet with the group. This group met on a Tuesday, as it was their regular meeting day. The fact that there were more males than females in this group made the discussion appear mostly dominated by male respondents.

Focus group 4 – This was a group of High School students from Maseru. A list was made of a few schools within reach and each of them was called to inquire about *Choose Life*. The researcher was able to secure an appointment with one of the schools. Its principal promised to organise a group of students, with the understanding that the selection was not to be biased in terms of students who were held in high regard. On the day of the discussion the principal had forgotten to organise the group, and consequently ten students who were in the vicinity of the office were assembled and a focus group was conducted with seven of them as three of them indicated they did not know the booklet. This group was interesting in the sense that there were six girls and only one boy. The discussion was lively and respondents were comfortable in using English although initially, the discussion began in Sesotho.

Focus group 5 – This focus group were students from a high school in the outskirts of Mafeteng (a town South of Maseru). A teacher known to the researcher, after confirming that her school received the *Choose Life* booklet, facilitated meeting this group. The selection of participants was thus made by the teacher. More than ten showed up and three students had to be asked to volunteer to leave the discussion so that only ten students could participate. This group was shy at first and became more comfortable as the discussion took momentum. The discussion was conducted in Sesotho as it seemed they were more comfortable in the language than in English.

In all the focus groups participation was relatively high and interactive, although some respondents needed probing; while others decided not to respond to some of the questions. Responses indicated that adolescents are eager to talk about and learn about HIV/AIDS and

their sexuality. It was revealed that while HIV/AIDS information is important, its focus on the mass media and interventions override other pertinent issues adolescents need for their development. While adolescents get the least information from their parents, the overall feeling was that parents are the most suitable source to inform them about sexuality, followed by informed/trained peers. Discussions in the focus groups suggested levels of exposure to information about HIV/AIDS and sex were higher in urban areas than in rural settings. It also emerged that 'older' adolescents found the concentrated focus on HIV/AIDS in the media increasingly tedious than 'younger' adolescents.

Limitations of research

Problems of access – Problems were experienced in getting access to information about *Choose Life* from the Ministry of Education. All officials contacted were either absent when the project was implemented or failed to recall the entire process. Records were not available, either because they had not been kept or there was reluctance on the part of MoE officials to allow access. It was suspected the latter was the case. The researcher failed to secure a meeting with the Principal Secretary even after numerous attempts. It was indicated that permission was required from the Principal Secretary, in writing before access to schools could be granted. The reason put forward was that the Ministry management had to know what the research was about lest it put government in an embarrassing position.

Time – This lack of cooperation created a problem of delay in collecting data from the schools. This setback was further exacerbated by the fact that by the time the researcher decided to negotiate entry to schools informally, schools were closing for Independence break and data collection had to wait for schools to re-open. Upon returning, students were preparing for exams and Principals were not eager to allow their students to participate. The data collection was therefore further delayed until end of classes. The disadvantage of this was that students became impatient and fidgety after some time because of their eagerness to leave school premises. This resulted in discussions being hurried in order to finish and set them free.

Resources - Delay in accessing financial resources prevented the researcher from going into deep rural areas, requiring personal funding of transport and accommodation. Peri-urban areas were therefore selected to ease this restriction. Peri-urban settings are nearer to towns

but are characteristically regarded as rural areas in terms of the way of living of the people there and other factors such as infrastructure.

This chapter discussed the theoretical framework and methodologies applied in the study, in which it is possible to analyse the findings of the study. The triangulation of focus group discussions, questionnaires and interviews were used as methods of inquiry. Focus groups and questionnaires provided for a convergence of analysis of *Choose Life's* reception by its target audience. Interviews also provided a convergence of views from stakeholders and the target audience regarding the implementation of the *Choose Life* project. The findings of the research, with reference to the reception of *Choose Life* by its target audience are discussed in the next chapter.

Chapter Four

Research findings and analysis

Chapter Four analyses and interprets respondents' views in an attempt to explain how and why *Choose Life* was received by the target audience in Lesotho. The tenets of Hall's encoding/decoding model (preferred, negotiated and oppositional readings) form the basis of the analysis and interpretation. Reception is also analysed with reference to the participatory strategies advocated in the DSC model of development.

The use of content analysis, using both qualitative and quantitative methods, provided for the analysis of the reception of the *Choose Life* booklet. Five focus group discussions were conducted instead of the intended six. This was due to resources and time constraints. The focus groups explored the knowledge, attitudes, beliefs and behaviours of Basotho youth following their exposure to *Choose Life*. The broad issues that were discussed, comprising the content of *Choose Life*, included the use of celebrities, design of the booklet, love and sexual relationships, condom use and responsibility, and HIV/AIDS. These provided an indication of respondents' perceptions regarding the content of the *Choose Life* booklet. Respondents' general views about HIV/AIDS and the mass media, relationship with parents and the question around beneficiaries' participation in interventions were also explored.

Questionnaires, complementing the focus groups, explored more confidential issues. This was facilitated by the anonymity afforded to respondents by the questionnaires, valuable where respondents might be reluctant to disclose information on face-to-face interaction Wimmer and Dominick, 1983: 102). The questionnaires explored issues such as respondents' sexual behaviour and their views on Voluntary Counselling and Testing (VCT). Responses from the focus groups and questionnaires formed part of the basis for the argument of the research.

Respondents' profiles

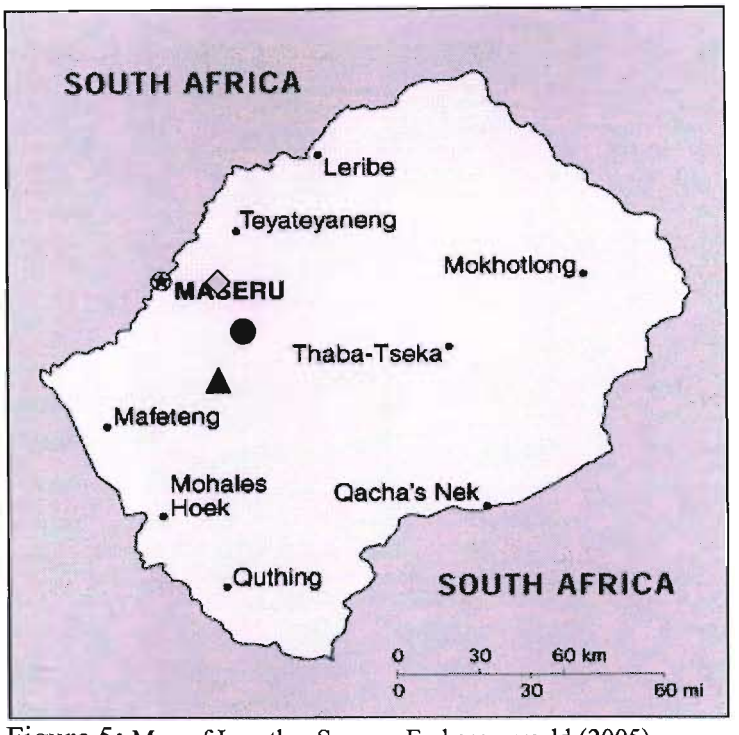

Figure 5: Map of Lesotho. Source: Embassy world (2005)

◇ Three of the focus groups were held in Maseru, the capital city of Lesotho.

● Another focus group was held in Matsieng, a peri-urban village on the outskirts of Maseru

▲ The last focus group was held in a rural village in the outskirts of Mafeteng, a town South of Maseru.

Of a sample of 45 respondents, 26 questionnaires were returned, representing a 57% response rate.

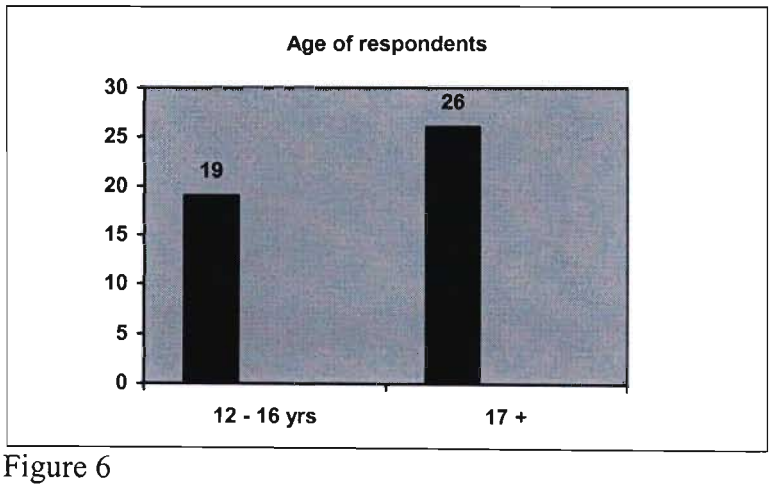

Figure 6

Out of this same sample, 58% were beyond the age group 12 – 16 and 42% were between the ages 12-16, the latter being the age group the *Choose Life* booklet was intended for. With most of them between ages 17– 19, it meant that they received the booklet (in 2001) when they were between 15 – 17 years old, an age where most adolescents are in secondary school. However, some students received the booklet even in subsequent years, because some schools kept stacks of the booklet in their offices and thus distributed the booklet to new learners. In this regard the distribution of *Choose Life* was a continuous exercise, not only confined to the year it was implemented.

The distribution of *Choose Life* was nevertheless not intended to be an on-going exercise. This unintended consequence yielded potential benefits for new students and new members to youth clubs, who would have otherwise not got access to the booklet. It is argued that the content was considered relevant by new comers because HIV/AIDS information has not changed much. The eldest respondent in the sample was 23, but still regarded himself as a youth and found the messages relevant for him. This implies that the booklet may have reached audiences beyond the intended age group. It shows therefore that there is need for further investigation as to who the target community, i.e. Lesotho regard as youth; whether adolescence is seen as including young adults; both in and out of school and those who remain dependent on parents despite the fact that they are beyond the 12-16 year age group.

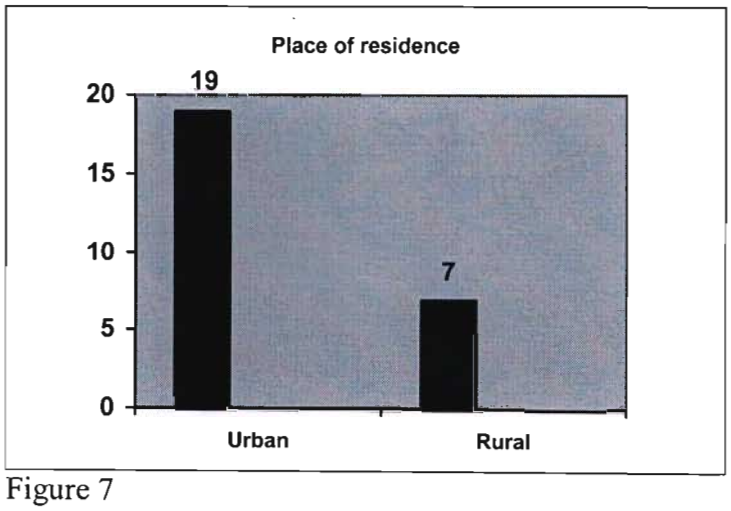

Figure 7

This study concentrated on urban respondents, with 67% of the respondents being urban. The remaining 33% were rural residents. It is noted that some respondents from the rural areas indicated that they resided permanently in urban areas but were in the particular rural area at the time of the research because of schooling.

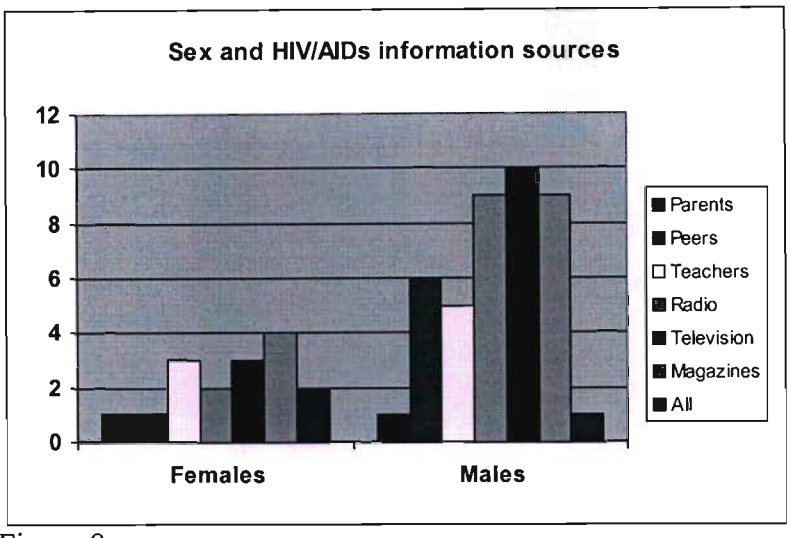

Figure 8

Most of the questionnaires that were returned were from male respondents; therefore there was no balance of responses in terms of gender. However, generally both males and females get most of HIV/AIDS and sex information from the media and the least from parents. From the findings of the study, males also seem to get a lot of information from their peers than females. This view is supported by (Lear, 1997: 38), who found that girls generally talked about relationships with friends while boys mainly talked about sex and were predominantly crude in their discussions. Most respondents indicated that this information is adequate but focus group discussions brought into the fore that adolescents would like to get more HIV/AIDS and sex information from parents.

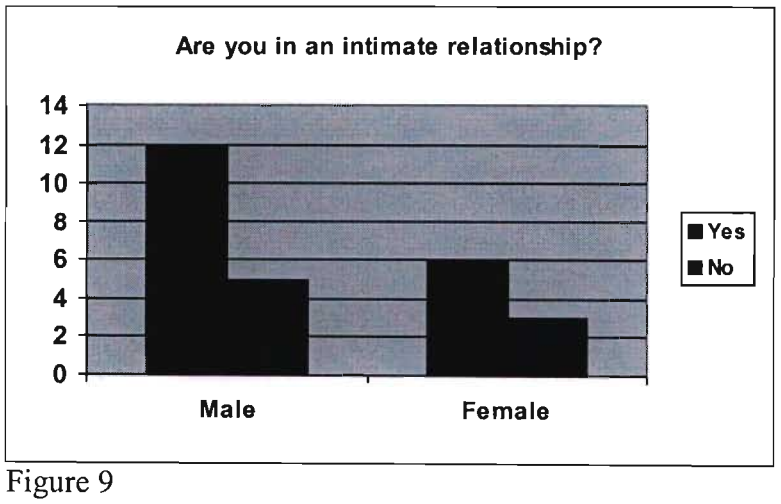

Figure 9

The ratio of male respondents to female respondents was approximately two to one. 68% of the respondents were in intimate relationships while 32% were not. From figure 8 it is evident that most of the respondents were in intimate relationships.

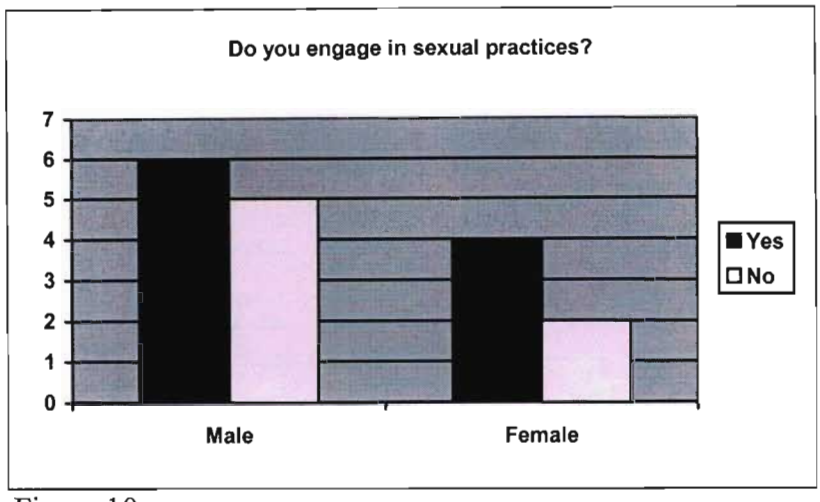

Figure 10

Out of 11 males who are in intimate relationships, 54% of them indicated that they engage in sexual practices while 46% said they did not. Of the 6 females who are in intimate relationships, 66% indicated that they engaged in sexual practices while 34% did not. Only one respondent was in the 12 –16 year age group (female) while the rest were 17 and beyond. This is indicative of the fact that *Choose Life* was intended for a young audience that possibly had not yet started sexual relations, but ended up getting a large audience of an older audience who were already engaging in sexual activities. It is notable that the focus group with the youngest respondents conveyed the impression that most of them were not yet sexually active. This group failed to return the questionnaires. This impression is illustrated by the following comments:

> (Urban) Right now as we are talking we are saying what we think is right because we are not yet in love because we are still very young... we don't know and we haven't experienced anything concerning love so I can't say, we can't say (FGD, 2004).

> (Urban) I think when two people have sex, it's about two people, that's what my aunt told me, someone you know and understand and whom you love and you know you'll spend the rest of your life with whether that person can give you AIDS or anything (FGD, 2004).

> (Urban) It's disgusting for young people to have sex at a young age. It's not good and they can get infected with AIDS (FGD, 2004).

> (Urban) On the question of whether condoms made sex less enjoyable, one participant said, "I don't think we can answer that question because it depends

if you have experienced that thing then you can answer it because maybe the first time you did it you used it, so maybe the second time you didn't use it, then you know the difference" (FGD, 2004).

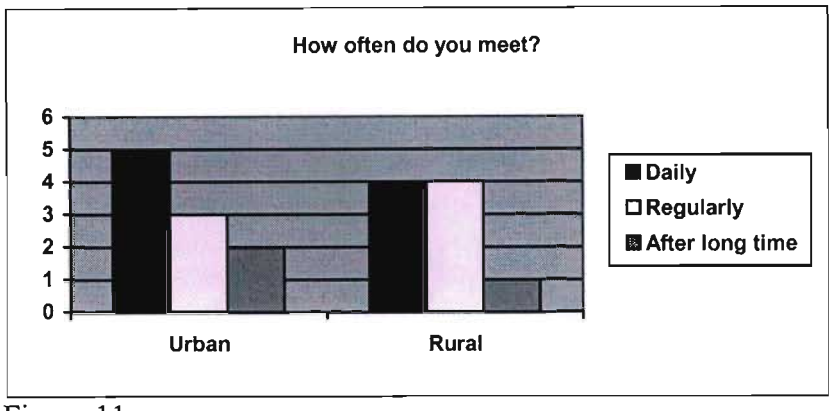

Figure 11

Out of 10 urban respondents and 9 rural respondents who responded to the above question, 50% of urban respondents met daily with their intimate partners while 44% of rural respondents met daily. 30% of urban respondents met on a regular basis while 44% of rural respondents met regularly. On average it can be deduced that adolescents from both the urban areas and rural areas met their intimate partners on a regular basis, therefore increasing chances of sexual relations of either group.

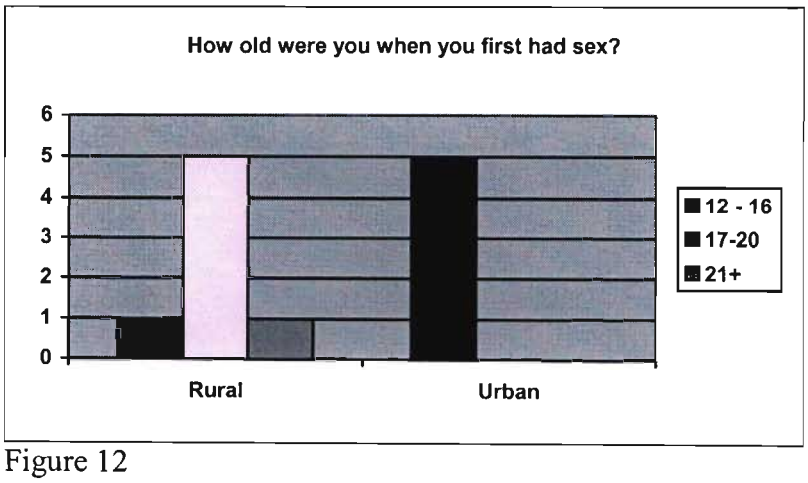

Figure 12

Out of those respondents who responded to the question, urban respondents appear to start sexual relations earlier, with 100% indicating their first sexual encounter having occurred between the ages 12-16. Rural respondents on the other hand reflected starting sexual relations later, with 71% having started between ages 17-20. Only 14% started sexual

relations between ages 12-16. It can be deduced that this scenario is a result of urban youth's exposure to more media and thus more sex information.

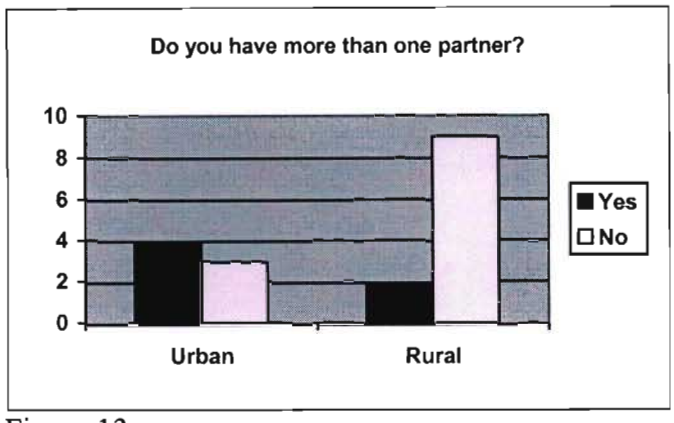

Figure 13

Out of 7 urban respondents who responded to the question, 57% stated that they have more than one partner, while 43% claimed they did not. On the other hand out of 11 rural respondents who responded to the question, only 18% indicated that they had more than one partner while 81% stated that they did not. From the above responses it can be implied that rural respondents are relatively engaged in monogamous relationships compared to urban youth, which increases the latter's chances of STIs and HIV.

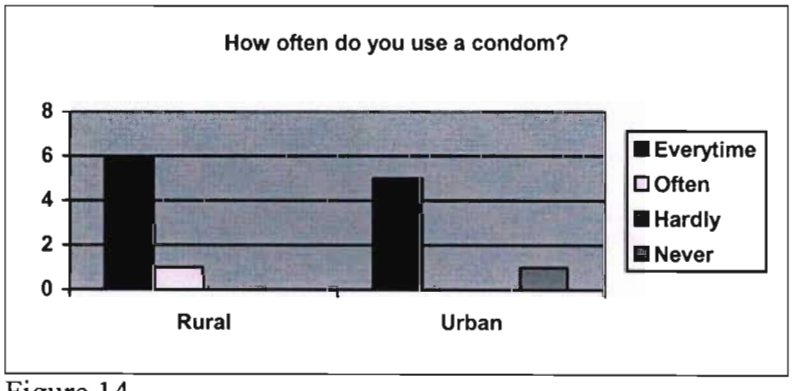

Figure 14

Out of 7 rural respondents who claimed that they were sexually active, 86% indicated that they used condoms every time they had sex. Correspondingly, out of 6 urban respondents who responded to the question, 83% claimed that they used condoms every time during sexual activities. This is despite the views that emerged from responses of some focus group participants, who claimed that condoms make sex less enjoyable.

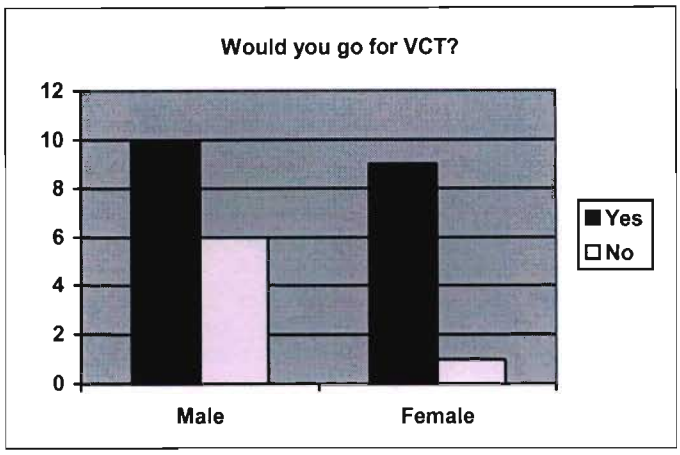

Figure 15

Out of 26 respondents, 73% of the respondents indicated that they would go for VCT, while 27% would not. A larger proportion of females, 90% would go for VCT while males accounted for 63%, showing an apparent reluctance for testing in males relative to females. It shows therefore that while respondents claimed that condoms were used at each instance of intercourse, respondents were afraid that the results might come out positive. Questionnaire responses indicated some reasons for respondents' reluctance to test:

"I will be afraid if I find that I have HIV/AIDS."
"I cannot stand the heat."
"I am afraid to find out my test results."
"I do not want to know my test results."

The responses may be indicative of respondents not trusting condoms, and/or not being consistent in their use of condoms.

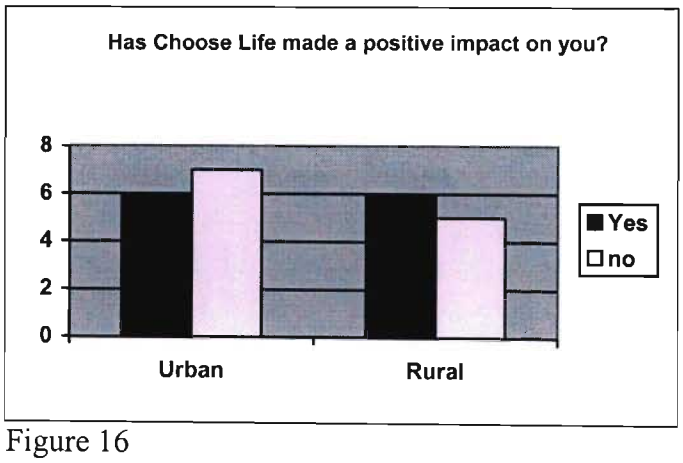

Figure 16

Of the 13 urban respondents who responded to the question, 46% indicated that *Choose Life* made a positive impact on them while 54% indicated otherwise. Of the 11 rural respondents, 54% indicated that *Choose Life* made a positive impact on them while 46% indicated that it did not. The above responses suggest that approximately an equivalent number of respondents from both the urban and rural areas had opposing views about the impact of *Choose Life*. However, those who indicated that *Choose Life* had a positive impact on them did not indicate what aspects of their behaviours, attitudes or beliefs had changed as a result of *Choose Life*.

Participation in implementation of *Choose Life*

Random sampling was used to select a group representative of the youth of Lesotho. Consequently, it was expected that very few or none of the selected sample would have overlapped with the LENASO *Choose Life* pre-testing sample. None of the selected sample indicated having heard of *Choose Life* prior to its distribution. An indication of adolescents who had been exposed to and/or had received the booklet was the main goal with this line of enquiry. On the issue of beneficiaries' participation in intervention programmes, participants were of the opinion that it was crucial that they be involved in interventions that are aimed at them from the initial planning stages up to the implementation stages. Servaes (1999) supports this belief by observing that beneficiaries know best where and how they need assistance. An evident shortcoming of *Soul City* in this regard is that it came with a finished product. The beneficiary country's role was only to adapt the packaged concept to the country's context, not having been involved in its planning and design. A stakeholders' workshop was held to brief country stakeholders about the booklet, with actual implementation being conducted by LENASO.

LENASO's participation was also relatively limited during the adaptation of the booklet. There were two people who consistently worked on the adaptation of the booklet, as other members of LENASO were not readily available when needed (Interview with Ranneileng, October 2004). Ranneileng attributes this shortcoming to lack of expertise and infrastructure on the part of LENASO. It is apparent that the lack of committed manpower limited the scope and reach of the pre-testing phase of the project. This scenario reflects again the difficulty faced by public health campaigns that are aimed at large audiences. On the other hand, participation of beneficiaries does not sit very well with donor agencies and thus they may be

expected to resist such efforts of reallocation of more power to beneficiaries (Lozare, 1994 in Servaes, 1996: 76).

Notwithstanding the above argument, participation is not always effective. Participatory theories are elaborated at a theoretical level and do not provide specific guidelines for interventions (Waisbord, 2003). Participatory communication further ignores the fact that practical and top down solutions may also positively contribute to the development and health of a community (Waisbord, 2003). Participatory models always assume that participants are cooperative and have the ability to reach consensus and articulate their needs and desires (Francis, 2002: 3). Research and experience (the researcher's) indicate a frequent inability to reach consensus. This inability to reach consensus may be detrimental to the overall success of a campaign. Participation can also be constrained by the fact that power is associated with money. Communities may censor or modify their reported opinions to enhance chances of receiving funding from donors (Arnst, 1996: 109-111).

Perceptions of youth on *Choose Life*

Design of the booklet

Respondents found the design of the booklet appealing in terms of pictures and its layout. It was indicated that the cover of the booklet, which showed a local soccer star and a local popular radio DJ allured one to pick it up and see what it was all about. This reflects good use of EE's ability to capture an audience's interest (Singhal, 1990). One respondent indicated that what fascinated him about the booklet were the quizzes and questions which the reader was required to answer, and tasks to do with peers and community. The quiz and question components were perceived as challenging as no other booklet had offered these. However, not all respondents actually did as recommended by the booklet. They simply read the booklet and digested the information but did not engage in any of the tasks that were recommended. *Choose Life* offered a new perspective on HIV/AIDS information because it did not simply inform. Tasks set in *Choose Life* presented respondents with reasons to think about dealing with challenges faced in life. Some respondents liked it for its title, because "It said to you, you must choose life and not death, therefore you should be responsible in the choices you make in your life" (FGD, 2004).

Use of celebrities

The Lord's path finders youth club (Urban) - This group, which comprised youth from a village in Maseru and its surroundings, mostly felt that the use of celebrities did not really make the messages more credible to them. This stemmed from the fact that they knew these celebrities and their behaviours. One participant stated:

> The people in the booklet we know their behaviour. So I get annoyed when I see them saying "do this" and "don't do that" because they themselves are not practicing what they are preaching. I just ignore such messages (FGD, 2004).

Some participants acknowledged that the reason behind use of celebrities could be the assumption producers of the booklet had about the celebrities being role models for the youth. The assumption was that the latter would consider information from their role models more credible. However, respondents felt that ordinary people in the community who are not famous are more credible and should be used instead. From these comments it can be argued that campaigns should consider use of a mixture of celebrities as well as local people. Celebrities would be useful mostly for their appeal, and local people for their credibility.

Seventh day Adventist primary school (Urban) - This group comprised primary school learners from a school in Maseru. The participants were between the ages 12 – 14. Most felt that celebrities on the cover of a magazine entice them to take it to see its contents. However, they indicated that when they read about what these celebrities are advocating while their behaviour is the exact opposite, they lose interest and ignore such messages. In this group some felt that ordinary people who are affected by HIV/AIDS should be used, not celebrities.

This view agrees with Bandura's notion of role modelling and how it influences self-efficacy. People judge their own capabilities in part from how well those whom they regard as similar to themselves exercise control over situations (Bandura, 1992: 102-103). Modelling influences should therefore be designed to build self-assurance, and to convey strategies for how to deal effectively with coercions for risky practices. The influence of modelling on beliefs about one's capabilities relies on comparison with others. The use of celebrities in *Choose Life* contradicts with this notion because they do not talk about their lives nor do they portray how they deal with a difficult situation, which the intended readers can model. For

instance, participants want to see people like Mothusi[24] telling them about sex and condoms because they talk from experience. They talk about their lives, how they got the virus and how they are dealing with it.

However, some felt that it is up to a person to take or ignore celebrities' advice. One participant observed: (Urban) "What if the person changes? People grow up and change, your behaviour changes" (FGD, 2004). This participant felt that one does not have to associate what the celebrity is saying with his/her behaviour. Rather, the message should simply be taken as it is.

Nevertheless, participants felt they would rather believe their own local celebrities rather than South African celebrities. This is because, they claim, at least they know their own celebrities but do not know the latter and how they conduct their lives. One particular participant[25], the only one pro South African celebrities, rebuked her fellow participants:

> I know why you are saying that, it's because you hear on radios and your parents always tell you that South African kids are spoilt. You know why? Because they are not punished[26]. That's the only reason they say that. So you don't know how those kids are raised. I know some of them are spoilt. But when they are put on the cover of magazines; while saying those things, giving advice, they also grow. (FGD, 2004)

Matsieng youth club (Rural) - This focus group was a group of peer educators from Matsieng, which is a peri-urban area on the outskirts of Maseru. In this group there were diverse opinions on the issue. Some felt that the use of celebrities made these messages more credible because whatever celebrities say attracts the youth. As a result, much as they will love a song advocated by the DJ, the message about sex will also stick in their minds in the same way.

Others felt that the use of celebrities in a booklet like *Choose Life* will only appeal to those youth who have access to radio and television and have seen and heard these celebrities before. By contrast, for disadvantaged youth, the use of celebrities does not have any

[24] Mothusi is an HIV/AIDS activist who is living with HIV/ AIDS. His story appears in page 38 of *Choose Life* where he tells his story.
[25] It emerged that this participant, although was now living in Lesotho, she was born in South Africa but had to leave with her parents when they came to Lesotho. She still misses life in South Africa and does not enjoy herself much in Lesotho.
[26] Corporal punishment; which is not uncommon in Lesotho and not a criminal offence.

impact in the way messages are read. It was indicated by rural respondents that inclusion of historical things that all Basotho could identify with, even those in the rural areas, would make the messages more credible.

This raises the argument that *Choose Life* as a product of *Soul City* would make more sense to a reader who has been exposed to other *Soul City* material, especially the *Soul City* television series. The reason behind this argument is that they would have been exposed to some of the actors and some of the messages before. However, most people in the rural areas do not have access to television. In the case of local DJs that appear in *Choose Life,* most radio stations are not accessible outside Maseru, the capital. This lack of television and radio exposure resulted in some respondents not even knowing who the actors were.

Other participants still felt that the behaviour of celebrities determines how the message will be received:

> Most of the time as people, we just don't accept what one is saying without the knowledge of how he/she conducts her life. For instance, I see Motlatsi Maseela[27] here; maybe I drink beer with him. When I see him here I just say, "Ag, I know this one, he is a drunkard"; When I see Counterforce[28] here, telling me to use a condom, I will say, "How can he tell me to use a condom, he even has AIDS". (FGD, 2004).

They therefore felt that the celebrity ends up clouding the message such that all they see is the celebrity and not the message. This group felt that the booklet was intended for an urban audience because some of the radio stations whose DJ's were in the booklet did not reach their places, and therefore they did not know them.

Lesotho high school learners (Urban) - This group comprised secondary learners from a school in Maseru. A significant number of these participants felt that since celebrities are their role models and aspire to be like them, they are more likely to listen to what they have to say than they would their parents or someone else. They felt that young celebrities in particular are able to include jokes with serious messages, thus making such messages livelier than if dryly presented from an adult perspective. Young celebrities, therefore, know the kind of language that appeals to them as youth. However, use of humour can be a two-edged

[27] A soccer star for the Lesotho national team, who is on the cover of *Choose Life*.
[28] A DJ for a local radio station.

sword as a threat reducing agent, if applied to excess. A young person might not know when humour should stop and serious issues begin, the result being serious issues taken very lightly.

Some still felt that the kind of person that a celebrity is plays a major role in how their message will be received, as indicated by the following statement:

> I think as youth we are very sarcastic because for me to adore a certain celebrity, it depends on what kind of a person he/she is; and the message, if passed by celebrities, you may find that Queen of Denver[29] is still a human being like me. But when they are put there, it is like they are superhuman or they don't make mistakes. She is still a human being and might end up doing unacceptable things. So even though she is a celebrity I won't take that message and will mock her because of the mistakes she can do as a person. (FGD, 2004)

On the issue of local versus South African celebrities, some indicated that the further they are from them the more they adored them. The majority still held the general view that local celebrities were much more preferred. Ironically, the number of times local celebrities appeared in the booklet was 44% compared to 56% South African celebrities. Even in the case of unknown actors, only 28% accounted for Lesotho actors.

St Thomas high school (Rural) - Some participants in this group were of the view that it was a positive approach to use celebrities as one participant indicated:

> I think it makes a big difference because as youth we do not like reading much, and are not easily attracted to simply picking a book and reading it. But if there is a picture of a celebrity, you want to hear what they have to say. (FGD, 2004)

While other participants agreed with this view, they indicated that they wanted to read about those celebrities' lives, not simply the messages without the celebrities focusing on their own lives. As a result the way in which the messages are portrayed in *Choose Life* did not create much appeal for them because they did not include celebrities' profiles. Others felt that because celebrities are more experienced in a lot of things, they are in a position to advise them because youth look up to them as trustable sources of wisdom. Others still felt that

[29] A DJ at a local radio station popular at the time the *Choose Life* project was implemented.

regardless of their celebrity status, they could not accept messages that are depicted by a person whose behaviour was unacceptable to them.
The overall view was that participants preferred their own local celebrities to South African celebrities to convey HIV/AIDS messages. Even then, the messages would be more credible if people who portrayed them were of acceptable moral behaviour to the target audience. This is why some participants appear to prefer ordinary people from the community, whom youth are not expected to adore; thus people do not have high expectations and are more forgiving regarding their behaviour.

The commentary on the above section brings forth the argument in the paradigms of DSC and 'another development' about the need to involve people at the grassroots. In developing regions, there is an evident existence of the 'core' and 'periphery'. The elite in the 'core' are usually beneficiaries of development interventions at the expense of the poor majorities, which further widens the gap between them and people at the grassroots level. Active participation of grassroots would ensure that fellow community members also appreciate development initiatives. The concept of 'them' and 'us' becomes irrelevant as people associate the messages with common people like themselves. Communication campaigns therefore stand a better chance of being relevant for everyone if they are culturally sensitive, multi-faceted, pay attention to all the political, economic and ideological structures and processes that comprise a beneficiary society (Melkote and Steeves, 2001: 38).

It is also evident from the discussion that the discourses that shaped the messages in the booklet were obviously in contradiction with the audience's sense of meaning. These discourses include professional ideologies, institutional knowledge and assumptions about the audience (Hall, 1993: 92). *Soul City* assumed that the use of celebrities would ensure the adolescents' acceptance of celebrities as credible sources. While this assumption was partially correct, it was flawed in the sense that while adolescents love celebrities, messages about HIV/AIDS and behaviour are considered credible if portrayed by celebrities who, according to them possess acceptable moral standards.

Participants' views on content

Participants' views were sought in relation to the content of *Choose Life* based on the prevalent themes that appear in the booklet[30]. The aim was to find out whether participants' views resonated with those advocated by the booklet, after having been exposed to it. In this instance, and in subsequent sections, responses were merged into a single narrative and stratified by urban and rural divisions.

Sex versus emotional involvement

Most respondents in the target audience of *Choose Life* (12 to 16 years of age) indicated that the booklet had a positive impact on their attitudes and beliefs, such as the meaning of love and alternative means for sexual release, i.e. masturbation. Most HIV/AIDS messages emphasise the simplistic argument of abstinence and that being in love does not mean one has to have sex. Most respondents described being in love as having trust, honesty, respect and the ability to share ideas and problems with a partner. The majority felt that being in love does not mean having sex and agreed that it is possible for a couple to take pleasure in each other's company without necessarily having sex. It was indicated that couples could still enjoy things like going for dates, studying together, talking and simply kissing. One respondent however, felt that love and sex could not be isolated:

> (Urban) To me it means when you love someone and you have lust and attraction towards them; when you love their whole being, the kind of person they are and you feel you can be anything and whatever you want when you are with them; when you feel you can give love and then you get love in return (FGD, 2004).

An interesting response came from a respondent from the youngest focus group:

> (Urban) I don't think when you are in love at a young age it's called love because you are going to meet new people and through those people you are going to meet new characters and you'll find someone else and you'll forget about the one you first met. So that's not love because you forget that person, you know this new person and you are already thinking "I'm in love"...I think people who can tell us are people who have met new people, people who are like married or who are grown ups, they will tell what love is

[30] Mentioned in Chapter Three.

> because maybe they will have many boyfriends or girlfriends and will know that the other person was cheating, the other I did not understand (FGD, 2004).

According to this respondent, one needs to experience the bliss and maladies of relationships before they can claim that they are in love. At a young age therefore, there is not enough experience to claim being in love. To this respondent, infatuation is an appropriate word to describe what adolescents feel for the opposite sex. Fisher (1992) suggests that love evolves through several stages: desire, attraction and attachment and that adolescent love centres on desire and attraction. While respondents agree with the dominant views in *Choose Life,* especially on the fact that love does not mean sex, it is argued that their experiences however showed some interference with the preferred meaning. This shared meaning therefore did not translate into similar behaviour because most were already engaging in sexual practices[31].

Views on fun without sex

Based on the responses and expressions of respondents, it was gathered that those who were already engaging in sex did not believe that two people in an intimate relationship could have fun without penetrative sex. These respondents unanimously agreed that it is not easy to abstain from sexual relations once they have commenced. One respondent stated: (Urban) "I think sex is part of the fun two intimate people can have, so I don't see why it should be excluded. It is the final step and I don't see why it should not be done." (FGD, 2004)

The younger respondents, who were probably not yet engaged in sexual relationships, were of the view that it is possible to have fun without sex:

> (Urban) I think it is true that people can have a lot of fun without sex, like kissing, doing a lot of stuff, talking to each other, getting to know each other, their personalities and everything but not sex (FGD, 2004).

> (Urban) Well, people can have fun without sexual intercourse. They can share a lot of things they have which are far away from the idea of having sex, kissing which has control, going out on dates and know that when you get physical with somebody, you know your limits; not this thing where you will let the guy to get really hot, and when he can't help himself, you feel sorry for him and he is pleading and you just do it because you feel sorry for him (FGD, 2004).

[31] See Figure 10

Perceptions about Condoms

Non-use of condoms is prevalent amongst most adolescents who are sexually active (Bissell *et al*, 2000; Mturi, (2000). This scenario suggests that educational efforts must move beyond simply imparting knowledge in order to achieve safer sexual practices in the target population(s). Most interventions provide individuals with information about specific means of viral transmission and about behaviours (e.g. condom use and abstinence) that can reduce AIDS risk, with the assumption that such information will increase HIV prevention (Fisher; Misovich; Fisher, 1992: 117-118). It has been demonstrated consistently that adolescents' high HIV knowledge has not generally translated into safer sexual practices (Diclemente, 1990; Fisher and Misovich, 1991a; Roscoe and Kruger, 1990; Ross and Rosser, 1989). HIV knowledge is therefore a necessary, but not sufficient, condition for adolescents' adoption of preventive practices.

Much as many people continue to smoke despite knowledge of the habit's adverse health effects, many teenagers continue to engage in unprotected sex despite knowledge of the risk behaviours associated with HIV transmission. Bandura (1992: 89) argues that information alone does not necessarily exert much influence on refractory health-impairing habits. Bandura points out that to achieve self directed change, people need to be given not only reasons to alter risky habits but also the means, resources and social support to do so.

All the participants knew the risks of not using condoms and agreed that it was essential for condoms to be used in a sexual relationship. However, a few felt that there was no need to use a condom if partners were faithful. They however pointed out that since faithfulness is hard to verify, condoms should be used regardless of how much a partner is trusted.

Contrary to the above views, there were participants who indicated that sex with a condom was less enjoyable:

> (Urban) Well, I think God meant for sex to be made naturally, not with a condom so that two people should feel as if they are one. So naturally sex without a condom is more enjoyable than sex with a condom. (FGD, 2004)
>
> (Urban) The truth is sex is more enjoyable without a condom. These messages they have written here like this one, is what they want us to believe.

> But because we are a generation that lives in the era of AIDS, we have to use condoms. There is no other way. (FGD, 2004)
>
> (Rural) Well, condoms are different. There are those that your partner will complain of pain when you use them, and there are those she will enjoy. So I think it depends on the kind of condom you use. I think these free condoms are the ones that are not right. (FGD, 2004)
>
> (Urban) They are too thick (FGD, 2004).
>
> (Urban) We have to use condoms to prevent HIV/AIDS, but you don't really feel the person you are having sex with (FGD, 2004).

These respondents took an oppositional reading to the picture that *Choose Life* and other campaigns portray that it is a myth that condoms make sex less enjoyable. These respondents accept the legitimacy of the dominant meaning that condoms prevent transmission of HIV/AIDS. However, on a personal level, they compromise this view with their own needs. This leads to the disruption of the preferred meaning that condoms do not make sex less enjoyable.

The above responses imply that respondents have experienced sex with and without a condom. It is evident from the preceding discussion that adolescents are not consistently practicing safer sex; even though they know the risks involved in doing so, and claim that they do. It would require extra willpower therefore for someone who feels sex is less enjoyable with a condom to actually use a condom consistently.

However, a considerable number of participants were of the view that it was not true that sex with a condom made it less enjoyable:

> (Rural) If a person is experienced in sex, they cannot say condoms make sex less enjoyable because a person feels sexual pleasure during orgasm; and if a person can do an experiment and penetrate without ejaculating, he won't feel any pleasure. Even with a condom it is still the same thing. It's like when masturbating, one feels pleasure when reaching orgasm. So whether you use a condom or not, sex will still be enjoyable (FGD, 2004).
>
> (Rural) I believe that for two people to find themselves having sex it is because they have sexual feelings. Using a condom is just a way of preventing diseases. So if these people have had sex and reached orgasm, it means the sexual feelings are no longer there, and the condom has done its job (FGD, 2004).

> (Rural) We have been taught that it is all in the head. It will depend on whether you want to have sex with this particular person or not. If you do it will be enjoyable whether you use a condom or not (FGD, 2004).
>
> (Rural) I think a condom is too thin to make a difference (FGD, 2004).
>
> (Urban) I think people who say that (*condoms make sex less enjoyable*) are less educated about sex (FGD, 2004).
>
> (Urban) Well, I think people just don't like the delay of putting on a condom. You have to put it on when the penis is still erect, and then you have to take it off while it's still erect. So that probably irritates people (FGD, 2004).
>
> (Urban) I think it's matter of what one wants to believe. If it's in your head that sex with a condom is less enjoyable with a condom, then you will feel that way when using a condom (FGD, 2004).

In terms of the perceptions about condoms, the above responses projected a preferred reading to the message encoded in *Choose Life* by most participants; and audiences who accept the preferred meaning are said to be operating inside the dominant code (Hall, 1980). Some of the responses however revealed an interesting perception that some males have about sex being enjoyable only at the moment of orgasm; an issue that requires further investigation.

Responsibility on use of condoms

The majority of respondents were of the view that it is the responsibility of both partners to have and use condoms. Generally girls expect boys to be the ones carrying condoms yet they (girls) are the ones expected to insist on condom use. In a situation where the boy does not have a condom, there is a possibility that they might engage in unsafe sex. Even with the introduction of female condoms, women in general do not carry condoms. This is due to the fact that society expects women not to anticipate or initiate sex and therefore it is embarrassing for them (Lear, 1997). Some respondents felt that girls should be responsible for use of condoms because they are at risk of falling pregnant. It is even more difficult to access the 'femidom' because unlike the male condoms, it is not readily or widely available. The researcher's observation has been that older women are more likely to acquire these condoms than adolescent girls.

However, even for adolescent boys it is difficult to access condoms from clinics. Respondents indicated that they were reluctant to visit clinics because nurses were very rude

to them. The picture portrayed by *Choose Life* on page 19 is that the atmosphere at clinics is adolescent friendly, whereas respondents indicate that the situation is quite the opposite. The following responses confirm this assertion:

> (Urban) "No, we don't go there because we are treated like sluts. We once went to a clinic and while we were waiting, one nurse remarked loudly, 'Even these kids also want condoms?' Remarks like that embarrass us and we stop going" (FGD, 2004).
>
> (Rural) The nurses really are very rude to us and make us feel like immoral kids. We end up not going unless one becomes sick and you have to go (FGD, 2004).
>
> (Rural) My friends who have visited clinics tell me that it doesn't mean that the nurses treat you badly. It depends on the kind of advice you seek there because they will ask you why you need that advice and why you feel you need to have sex (FGD, 2004).

This implies that when adolescents want advice on sexual matters, they are interrogated by nurses about why they want that kind of advice, which obviously adolescents resent. This situation is quite ironic when nations worldwide have realised that adolescents are at greater risk of contracting HIV/AIDS (UNAIDS, 2004: 15) and subsequently public health campaigns are desperately trying to promote safer sex and healthy habits to this population group. There is therefore no point in doing so if primary health workers are looking down at the "kids" who seek advice and condoms. This practice is in conflict with the rationale behind the Ministry of Health's decision to establish adolescent clinics where adolescents would be free and be treated in a friendly manner without fear of being judged.

A common problem that also emerged from the discussions was that clinics are usually manned by older people and it becomes hard to confide in them with sexual issues.

> (Rural) When you get there and maybe find that the nurse there is from your village, you will find that she will go and talk about you with her children or your parents, so we don't trust them (FGD, 2004).
>
> (Urban) I think at the clinic, this job should be given to people who are polite and young. So if a grandmother comes and does this work, people will say "I don't trust this person, maybe she doesn't understand what I'm talking about" (FGD, 2004).

> (Urban) As far as I'm concerned, it would be better if there were specific people in the clinics to deal with sex matters with the youth. So when you look at our community clinics, you find older nurses, who also deal with treating everyone with different ailments. So they think it's a waste of time to serve adolescents who want condoms and advice about sex. We are therefore reluctant to go there because it's like we prevent them from dealing with serious illnesses. (FGD, 2004)

A notable exception to the norm was found in an adolescent treatment section of the Scott Hospital in Morija. A young nurse was observed to be relating to teenage mothers with great sensitivity and skill. The teenage mothers appeared at ease with the nurse, as she was not judging them, as is the perception about older nurses. Unfortunately, adolescent corners are available only at government hospitals, and that means one in each of the ten districts of Lesotho. It is not established whether younger nurses also man the other adolescent corners or not. Most adolescents live far from hospitals and rely on community clinics, which are manned by older nurses who also cater for the health needs of the entire community.

Views on violence in relationships

Violence against women is an issue that is constantly discouraged on *Soul City* media. The series that dealt with domestic violence received a lot of media and community attention as women began to realise that they could put a stop to abusive behaviour by their partners (*Soul City, 2004*[32]). In the same manner *Choose Life* emphasised that violence was a crime and a violation of another person's rights.

Most respondents during the focus group discussions agreed that it was wrong to hit a girl, both males and females. Despite this view, some still believed boys were sometimes justified to use violence on their girlfriends, especially in a case where the girl is cheating on the boyfriend. This is done to show her who is in charge in the relationship. One reason put forward by respondents was that a girl would never say yes unless she got beaten. It was also indicated that in the rural areas girl battering is not considered violence because girls like it. To them, it means the boys really do love them. These opposing views to the preferred meaning indicate that the perception that women are subordinate to men still exists, and is inherited from generation to generation. Despite the advice and ideas advocated by *Choose*

[32] Available at: www.soulcity.org.za

Life about violence, respondents felt their reasons for their viewpoint were valid. It has been noted that culture can be an enemy and at the same time be an ally (Airhihenbuwa, 1995; Singhal and Rogers, 2003). This is an indication that it is crucial for campaigns to harness the positive aspects of culture. It is equally important that campaigns consciously avoid reinforcement of the negative aspects of culture. It also becomes important sometimes to focus on cultural norms that justify unacceptable behaviour in order to reverse such thinking. Such norms are deeply rooted and need to be dealt with at a cultural level and with caution.

Determinant factors on reception of *Choose Life*

The manner in which *Choose Life* was received by youth in Lesotho was influenced by a number of factors.

Perceptions of Lesotho youth about South African youth

In view of the fact that *Choose Life* was initially intended for youth in South Africa, it was important to find out how Lesotho youth related to South African youth, with the intention of trying to establish whether a book initially designed for the latter would be suitable for the former. Almost all respondents from the focus group discussions were of the view that South African youth behaviour was worse than their own. Most believed that South African youth start sexual relations at a very young age. It is argued that this is due to the kind of environment they grow up in. Environmental factors include economy, constitution, media, both local and international, and infrastructure. All of these factors influence the way youth behave. The above views contradict the perception that there is little behavioural difference between South African and Lesotho youth (Interview with Ranneileng, October 2004; Interview with Motemekoane, October 2004).

One respondent indicated that the fact that South African youth are free to go to clinics for contraception is one of the reasons why they start sexual relations at an early age, whereas Basotho youth are reluctant for fear of parents finding out. A national study in South Africa by Liberty Eaton, Alan Flisher and Lief Aaro (2002: 160) revealed that some parents, especially in the rural areas still try to control their daughters' sexual behaviour by forbidding them to seek contraception services. This however has not led to adolescents delaying sexual activity, but to less use of condoms (Eaton, Flisher, and Aaro, 2002: 160). Some participants

believe South African youth are spoilt because there is no corporal punishment and therefore do as they please. Some showed concern that Lesotho youth who study in South Africa acquire immoral behaviours, which they did not have prior to their exposure to South Africa. A few focus group participants indicated that these views are simply brought about by jealousy because Lesotho youth cannot afford to be like South Africans and because they do not understand the conditions they grow up in.

It is clear from focus group participant commentary that most respondents believe that South Africa has a bad influence on those exposed to it, while adolescents who still reside in Lesotho still behave comparatively better. One respondent stated:

> (Urban) A friend of mine who is studying in South Africa came back smoking and drinking. She asked whether I haven't tried doing a lot of things regarding sex; and when I said no, she told me I was still behind times and gave me tips on what to do and I was shocked. (FGD, 2004)

One (urban) respondent also proclaimed: "My sister is studying in South Africa, and she was a very shy person. These days she tells me stories about her boyfriends and what they do together and she has changed completely. She now wears make-up and all that stuff" (FGD, 2004). Although respondents feel that the acquired shocking behaviour of their friends and siblings is a result of being exposed to South Africa, observation and media reports have shown that even in Lesotho youth who find themselves away from parental control for extended periods of time, show a tendency to engage in social experimentation which their parents would not approve.

Perceptions about rural versus urban youth

The *Choose Life* booklet was intended for youth both in urban and rural areas; hence there was an English and a Sesotho version of the booklet with the same content, to accommodate even youth not proficient in English. However, all respondents pointed out that there is a big difference between urban youth and rural youth. The youth from the urban areas believe that they are exposed to more media and thus more sex than rural youth. Consequently, they are more knowledgeable about sex since a lot of information is available to them from a variety of sources, especially television. One respondent confirmed this view:

> (Urban) We in the urban areas are exposed to a lot of things; we are exposed to a higher level of media compared to them. They only receive magazines, even then they are not the ones we get here, and on television they don't watch the same programmes we do. We know a lot more and are exposed to sex more than they do. I think sex to them is just sexual intercourse; they just do it. I don't think rural people know things like foreplay etc. (FGD, 2004).

Urban participants also had a perception that rural youth were less educated about life in general and consequently had less knowledge about sex and HIV/AIDS. Although they acknowledge that rural youth are more respectful than urban youth, they claim that teenage pregnancies are rife in the rural areas than in the urban areas.

However, a large number of the urban participants argued that comparatively, rural youth behaved better. One of the reasons put forward for this was because "urban youth are party animals...They get drunk and they have sex; which is bad because most people have unprotected sex when they are drunk"(Urban) (FGD, 2004).

In essence, urban youth's perceptions of the rural youth are that they (rural youth) remain backward and lack knowledge about sex and their sexuality. They therefore engage in sexual intercourse without using any protection because they are ignorant of the implications of their actions.

In contrast, rural youth believe that urban youth have very low morals; evident in the way they dress. One respondent indicated that if a girl is seen wearing fashionable low cut pants; they immediately know that she is from the urban areas and is immediately shunned by other girls in the village, and given names like "slut"[33]. Traditional values still influence the way of living of rural people and the youth there still respect them. However, with easy transport, migration and modern communication, these values may not be maintained forever.

In terms of exposure to sex information, the rural youth acknowledge that they do not have access to a lot of media that is available to urban youth, and as a result there is a lot they do not know about sex and HIV/AIDS. It is evident that to a certain extent rural youth resent urban youth because of higher standards of living and aspire to be in a similar position. However, their poverty prevents them to bridge that gap. The only way to justify their misery

[33] The equivalent term in Sesotho is "Letekatse".

is to see them as the "other", who have abandoned their cultural values. This view parallels how Lesotho youth see South African youth. Discrepancies in the social position of the target group contributed to the way different readings were produced about *Choose Life*. In this instance class played a significant role in the reception of the messages.

In relation to the *Choose Life* booklet, the rural youth were of the view that it was intended for an urban reader because they did not find anything they could identify with. All the celebrities were urban people some of whom they did not know. One respondent pointed out that a traditional or cultural icon like "*Mosotho Chakela*"[34] in the booklet would have made them identify more with it. According to them *Choose Life* failed to recognise the differences between youth in urban areas and those in rural areas and therefore messages that are relevant for the former might not necessarily be relevant for them. The struggle over meaning and the resulting subjectivity over reception of messages imply that even people from the same culture will produce different interpretations about media texts. Construction of identity, which derives from a multiplicity of sources including social class and gender, leads to contradictory and fragmented identities (Hall, 1997).

Relationship with parents

Teenage behaviour is considerably more affected by emotion and hormonal drivers than is adult behaviour. It relies more on acceptance by peers, trust of friends, and affections of the opposite sex. Teenagers can thus reject their parents' notions of success. Ginott (1973: 91) points out that if parents undermine teenagers' viewpoint, they [teenagers] can strike back with awesome vengeance; they can become defiant and delinquent, or passive and neurotic. This indicates that parents and others trying to influence adolescents' adoption of pro-social behaviour cannot win by attacking the adolescents. A better option may be to try and win the adolescents over. This can only be done if adults are willing to stop doing all the talking and start listening to adolescents. This should be done in good faith, in order for adults to understand adolescents' point of view, which may not make sense to them.

A notable contradiction that society poses to teenagers is that adults and society preach values and norms to teenagers, which adults ignore. For example, some parents are very ethical

[34] Mosotho Chakela is a traditional singer whose songs are very popular in Lesotho.

about personal relations but are crooks in business. Some parents have extra-marital affairs known to their children yet preach honesty, loyalty, trust and 'fearing' God to their children. Children thus grow up thinking that it is acceptable to challenge and ignore those values.

A significant number of parents still find it hard to talk to their teenagers about sex. This is partly brought about by a conflict of values versus culture. While some parents feel that the time has come to accept the new reality of teenage sex and the need to talk to teenagers about it, some parents believe that sex talk will encourage license to sexual acts (Mturi, 2001: 4). Such parents believe that if good examples are set, their children will follow suit and maintain desirable behaviour.

If adolescents do not receive counselling about AIDS from important interpersonal sources of communication such as parents, the perceived importance of communications they receive from other sources may be undermined (Hingson and Strunin, 1992: 28). Adolescents therefore need to receive instruction on how to negotiate safety with a potential sexual partner from all stakeholders, including parents.

Teenagers are also often puzzled by a prevalent public paradox. On the one hand, society is sex obsessed and money motivated. Sex is all over television and used for commercial enticement for fun and profit. On the other hand, society says it believes in premarital abstinence. This creates conflict and tension among teenagers. It is imperative therefore that sex education is given priority in order to serve as an antidote to the sex propaganda that teenagers are exposed to, which is often sordid and vulgar. Society therefore should not allow the screen to set its sex standards. Ginott, (1973: 120) argues that sex education has two parts, namely information and values, and argues that values are best learned at home while information can best be given by experts.

It could be argued further that adolescents are not given clear alternatives on what to do when they are sexually aroused. This is a question teenagers would like to ask and parents would dread to answer honestly, if at all. While in *Choose Life* the message is that adolescents can masturbate to get sexual release, in general masturbation is frowned upon by the local society and is not encouraged by parents, the church or even local public health campaigns. This gives adolescents the impression that it is an immoral thing to do. Parents only want to emphasise abstinence. This message may foster tension between teenagers and parents.

Campaigns designed without reference to the target community's context may encourage individuals to adopt beliefs and behaviours that are in conflict with the dominant beliefs held by the rest of the society in which they live (Durden, 2003: 10).

Teenagers, especially girls feel obliged to pretend they do not want to have sex, while on the contrary they do. This is because they have been taught about the physical and emotional risks involved and the appropriate behaviour expected of young women. Because of this uncertainty, the perception is that girls succumb to boys' sexual demands because of the latter's persistence, not because of girls' own sexual desires.

Health messages often ignore the role of desire in sexual encounters and like society as a whole, put pressure on girls to refuse the advances of males. Lear (1997) contends that there is a continued construction in society of young women as sexual targets fighting off the uncontrolled and uncontrollable lust of young men. When women express their own sexuality, they risk censure (Lear, 1997: 74). When men have too may sexual partners, they are looked upon as 'studs' whereas women are looked upon as 'sluts'; ironically even by other women. These double standards have led to men, and consequently young men being erroneously marginalized in health communication messages.

Only a few respondents said their parents talked to them about sex. Most participants indicated that their parents do not talk to them about sex. Responses indicated that even when they talk about it, it is in passing general remarks, but there is no effective dialogue between parent and teenager.

> (Rural) I haven't talked with my mother or father about sex, never; and I think I would feel uncomfortable talking about it with them (FGD, 2004).
>
> (Urban) No I haven't talked with them and I think, but first of all I think my...I would say I would talk to my mother because girls are closer to their mothers than their fathers, but me and my mother we have very different views on almost everything, love, life, that includes sex and everything. But actually sitting down and talking about sex, no. But mostly I think she thinks I already know what there is to know about it and maybe she trusts that I can make the right decision. (FGD, 2004)
>
> (Urban) *Aek'hona*, I have never talked with my parents. I think maybe I will talk to them when it is time to talk with them because right now I can't say

> I'm having any sexual relationships, so it doesn't bother me much and it hasn't occurred to me to talk with them. (FGD, 2004)

Similar responses appeared throughout the different group discussions indicating parents' reluctance to talk and teenagers' embarrassment to ask parents about sex for fear of ridicule. One respondent who indicated that she talks with both parents about sex, stated:

> (Urban) Well, myself I do talk to both my parents, even though sometimes they ask me questions which are embarrassing to answer in front of parents. But many times, almost every time I'm alone with either my mom or dad, it's always the issue, about how I feel about my life and what I plan to do and am I having any sexual whatever with anybody. Again they ask whether I know about HIV and many things. (FGD, 2004)
>
> *Researcher asks*: Are you honest in your responses?
>
> Not always. Sometimes they stare at me too much and I become embarrassed. They ask embarrassing questions so I don't answer them. But we do talk, both of them (FGD, 2004).

One respondent also stated:

> (Urban) I talk a lot with my mom about sex, but in a way in which she doesn't ask me whether I'm sexually active or not. She explains her point of view regarding what sex is, how it feels and that it is great when you have waited; and she tells me about the consequences which follow sex, which are many. She doesn't only tell me about pregnancy because there are a lot of them (FGD, 2004).

These were the lucky few whose parents had the courage to face them and engage in dialogue about sex and sexuality, although some restraint is sensed. One respondent attributed this attitude to the Basotho culture, whereby it was not common for parents to engage in a discussion on any issue with children. He quotes an example about when a young man, in earlier times wanted to marry, instead of telling his parents, he would do something called *ho raha moritšoane*[35], to show that he was ready to marry, and his parents would find him a wife. Although times have changed and there is more communication between parents and children, there is still that apprehension regarding sexual communication. This is why parents will only pass remarks such as "You will get pregnant if you have sex", "You will get AIDS if you have sex", "Stay away from boys, sex is for adults" and many similar remarks that make it impossible for adolescents to probe for clarifications. Most respondents indicated that there

[35] The young man would wake up very early in the morning and go to the kraal. Instead of leading the cattle to the grazing fields, he would just open the kraal and leave them to go astray.

was no point in initiating dialogue with their parents because they are only going to tell them to abstain from sex.

However, the general view was that respondents want their parents to talk to them about sex because they believe there is a lot they can learn from their parents. While they claim that they might know a lot more about sex than their parents, they believe their parents can prepare them emotionally and mentally in terms of how to deal with their sexuality to avoid dangerous consequences.

While interventions like *Choose Life* encourage adolescents to strike conversations with friends, parents and the community as a whole, it becomes difficult to have any meaningful dialogue with the other sectors if that dialogue does not start and continue in the home. It will therefore not have much impact because the home is where values and attitudes that build a person are founded and moulded. Interventions that target youth and advocate dialogue with parents often fail to problematise the communication barrier between parents and adolescents.

Persistent communication barriers between parents and children created a setback on the effectiveness of the booklet. This appears generally true of intervention campaigns. This is in the sense that adolescents could not engage their parents on the issues in the booklet. Discussions were between peers and siblings, therefore even where parents could provide clarity, their assistance was not sought. For communication interventions to be effective, it is argued that community dialogue and collective, cooperative action is required (Figueroa *et al,* 2002). The individual change strategy is therefore insufficient and there is need to adopt a social change strategy as well (Figueroa *et al*, 2002: 3).

The concept of communication for social change entails:

> Moving away from people as objects for change, towards people and communities as agents for change; moving away from delivering messages, towards supporting dialogue and debate on key issues; moving away from a focus on individual behaviour, towards a focus on social norms, policies, culture and supportive environments; moving away from persuasion, towards negotiation and partnership; moving away from external technical expertise, towards integrating communities in assessing issues of concern at local level (Parker, 2003: 5).

Peer pressure

The theory of reasoned action (Fishbein and Azjen, 1975), asserts that beliefs about partner and peer preferences and desire to please partners and peers may also influence behaviour. This is also true in the case of adolescent sexual behaviour. Most respondents, especially boys, indicated that there is need to prove to other boys that they are having sex, hence their experimentation with sex. On further enquiry, it emerged that first sexual encounters were usually prompted by peer pressure, with subsequent encounters resulting from the pure pleasure of the act.

Q. Are you saying you are having sex because your friends are doing it, not because you enjoy it?
R. (Urban) (*Laughter*) Well, initially you do it because of peer pressure, but you continue to do it because you enjoy it. (FGD, 2004).
R. (Urban) Yah, once you start you can't stop because you enjoy it (FGD, 2004).

However, there were still those who differed from this view.

> (Urban) I think it depends on the kind of person you are, because for example, I associated with people who smoked and drank alcohol, but I never did those things. So this thing about peer pressure this, peer pressure that, I disagree with it totally (FGD, 2004).

The above participant possessed a high degree of self-confidence which most adolescents lack. When lacking a sense of self-confidence, thus lack of self-efficacy, individuals do not manage situations effectively even though they know what to do and possess the requisite skills. Self-inefficacious thinking creates discrepancies between knowledge and self-protective action (Bandura, 1992: 90). Belief in self-motivation and self-regulation play crucial roles in whether consideration is given to altering habits detrimental to health (Bandura, 1992: 93).

It is argued that people often seek friends with similar values, which they reinforce for each other and when friends do not practice safer sex; it becomes more difficult to imagine doing so (Lear, 1997: 37). Lear also contends that tensions may arise when an individual's values are in conflict with her friends', and they try to influence each other's values. Ironically, it is usually the risky behaviour that is easily incorporated into adolescents' values rather than pro-social behaviour. Sexual relationships are constructed with friends and lovers. Part of what is

important about the balance of power in a relationship concerns how friends perceive it (Lear, 1997: 75). It seems males are more likely to be influenced by their peers because male respondents indicated that peers were one of the prominent sources of sex and HIV/AIDS information for them[36]. Social norms, which are "expected modes of behaviour and beliefs that are established formally or informally by a group (Jones and Gerard, 1967) are important determinants of group members' behaviour. Individuals behave in a particular way to gain approval or to avoid sanctions from their reference group (Jones and Gerard, 1967: 121).

Contrary to the popular belief that boys are the ones that put pressure on girls to have sex, it emerged from focus group discussions that this is not particularly true. However, messages in health campaigns have been centred on equipping adolescent girls with skills to become assertive enough to rebuff advances of males. Both male and female participants were of the view that it is no longer true that boys are the ones who always want to have sex and that girls are the sex victims who always have to ward off the advances of boys' uncontrollable lust. This is evident from the following responses:

> (Urban) It is no longer true because these girls would tell you that you are sexy, the next thing they tell you they want you. What can you do as a guy? They tempt you into giving in to them even if it was not your intention. (FGD, 2004)
>
> (Urban) These girls if you don't visit them, they come to your place, pretend they want some help with homework, but they know very well what is going to happen there (FGD, 2004).
>
> (Rural) I don't think it's true that boys pressure girls into having sex because girls also have sexual feelings and they want to have sex (FGD, 2004).
>
> (Rural) Girls also do the pressuring (FGD, 2004).
>
> (Urban) When you don't have sex they (*girls*) say you are stupid (FGD, 2004).
>
> (Rural) Not all of them (*boys*). These days we are alike. There are things we do as girls to tempt a guy until he is so aroused he can't stop himself. (FGD, 2004).
>
> (Urban) I don't think it's boys. I think if one doesn't want to do something, no one can force you unless he puts a gun on your head. No one can force

[36] See Figure 8.

> you to do something you do not want. If one has sex with someone, it's because they both wanted to do it, it wouldn't be rape. (FGD, 2004)

A considerable number of participants held a different view and felt that boys did actually pressurise girls to have sex. One male respondent stated:

> (Urban) My view is that yes guys pressurise girls to have sex in a way that a guy, if there's something he wants desperately, he will find the best way to get it, in the sense that he will do the nicest things for the girl. Like when she has problems, he will be there for her so that the girl feels that this guy is the most amazing guy. So, after you have been treated like that, you have to show your gratitude. (FGD, 2004)

Some female respondents in this group held a similar view:

> (Urban) Sometimes yes, they are the ones who put pressure because he will be promising you heaven and earth. Or someone has done so much for you and they make you feel that the only way to repay them is to have sex with them to show your gratitude and that you love them and all that. (FGD, 2004)

> (Urban) Yes, guys pressurize girls financially on my side because sometimes you find yourself doing things that require money, which you can't ask from your parents. So you will want to repay this guy in some way and if he has spent lots of money on you, which you know there's no way you'll be able to repay, and you have something that will please him. That is when sometimes girls have sex. (FGD, 2004)

What these views indicate is that women have been socialised to ignore their own sexuality and reinforces the view that women are supposed to suppress their sexuality and only follow a man's lead. This assertion does not override the fact that some girls are pressurised to have sex for financial rewards. The argument is rather on the fact that women who act on their desire are regarded in a derogatory manner by society and called 'sluts' while similar behaviour by men will earn them names such as 'studs'[37] or 'players' (Lear, 1997: 69). It is assumed that this is why these girls cannot admit that one of the reasons they engage in sex is for the pure pleasure they get from doing it. A female adolescent in a television programme pointed out that if it is a girl who wants sex, she loses her dignity, but when a boy does not have sex with a girl, he loses his dignity (Future positive[38], SABC 1, 02/12/2004).

[37] The equivalent in Sesotho is "Poho", literally meaning bull.
[38] A television youth programme on SABC 1 about HIV/AIDS presented by Azania Ndoro.

Choose Life has attempted not to distinguish between males and females about pressure to have sex, their messages therefore accommodating both sexes. However, respondents were of the view that boys are consummate opportunists and rarely say no to sex. They claimed that they could only be deterred if the girl says no. It is suggested that health communication campaigns ought to focus on equipping adolescent boys with skills to shift the prevalent mindset that they cannot control their sexual feelings.

Media focus on HIV/AIDS

It became evident from the responses that the youth got most HIV/AIDS information from the media. In the focus groups that had younger respondents, their responses indicated that they were satisfied with HIV/AIDS being the focus of media messages. The following responses support this statement:

> (Rural) I am okay with that because maybe they know that nowadays people have AIDS and some might have it soon, so even if it does not concern you but in a few days you might be affected (FGD, 2004).

> (Urban) I think it is still a good thing that media focus is on HIV/AIDS because there are those people whose knowledge is still limited. Some people still think eating from the same plate with an infected person causes AIDS. Mostly messages are about abstaining from sex because AIDS kills. If the media can explain in a way that they tell people that you can share a plate with an infected person and not get AIDS and things like that. (FGD, 2004)

Others agreed that it was good for the media to talk about HIV/AIDS; but felt that some important issues were being neglected because of the focus on HIV AIDS:

> (Urban) I think the media is saturated with HIV/AIDS and other things are not discussed. We no longer know which paths to follow, besides sex and HIV matters. We no longer know what to do to grow up a healthy child who will be successful in life. Those issues have been left behind since the AIDS era...we are neglecting some parts of our growing up because everyone is like "AIDS this, AIDS that". But then what if I don't get AIDS and I get to live longer, how am I going to succeed in life because I didn't get the education I needed when the concentration was about AIDS and sex? Life is not all about that, not for everyone anyway (FGD, 2004).

Most respondents beyond ages 12-16 felt there was too much about HIV/AIDS in the media, and that they were weary of hearing about it all the time. They indicated that to them it

connoted that the youth were more promiscuous than the rest of the population. This attitude makes them change channels whenever anything about AIDS comes up on television or on radio. Some of their responses were the following:

> (Urban) The messages we get about AIDS only tell us how to prevent AIDS, but they neglect to tell us the effects of AIDS on the economy so that we know exactly how it will affect our future. It is like they are only concerned with our behaviour but we do not know how changing will help us besides not getting AIDS. (FGD, 2004)
>
> (Rural) I am not really happy about AIDS being the focus of every media message. A lot of things are being left out, for instance education. These days most international aid supports AIDS issues. No one says anything about school education anymore because everyone is concentrating on AIDS. (FGD, 2004)
>
> (Urban) I think it is good on one side but bad on the other because some people take advantage of the issue of AIDS. People think, "If I can start my own campaign on AIDS I will be making money, my own money, not for the people who are affected who need medication". On the other side when we are educated about AIDS, we therefore start to reflect that maybe we need to abstain, and if I'm sexually active, condoms are available. In that way they help. (FGD, 2004)

Relationship with other *Soul City* media

Other *Soul City* media that are likely to have filtered into Lesotho are the *Soul City* television series and *Soul Buddyz* and their radio versions. However, they did not seem to have had any significant impact on the reading of *Choose Life*. Respondents did not associate *Choose Life* with *Soul City*. This refuted the researcher's expectations that adolescents who were exposed to the *Soul City* television series would associate more with *Choose Life* and thus find it credible. Respondents indicated that they were not aware that *Choose Life* was a *Soul City* product. Most who reside in the urban areas were exposed to the *Soul City* series broadcast over the years on SABC television. The general feeling was that the series dealt with important and realistic issues and provided valuable information. Ironically, a connection was not made between the *Soul City* logo and the fact that most of the actors in the booklet were the same ones from the *Soul City* series. Few respondents were aware that the first *Soul City* series that were broadcast on SABC television were being broadcast on Lesotho television. The reason behind this is that with the spill over of SABC television to Lesotho, almost everyone who has a television set can access SABC and e tv channels. Lesotho television

does not offer the kind of quality television that is offered by SABC. Consequently, viewership rates for Lesotho television are minimal, especially in the case of adolescents. Against their will, adolescents may be compelled to watch Lesotho television on the insistence of parents.

Furthermore, even those who watched Lesotho television indicated that they would not be interested in watching the same series they had already watched on SABC when there are new exciting dramas on the SABC channels. The only difference on the *Soul City* drama series presently being broadcast on Lesotho television is that at the end of an episode, there is footage of Basotho discussing issues related to the episode (Interview with Motemekoane, October 2004). It is argued therefore that even though the *Soul City* drama series were very good, their being broadcast on Lesotho television will not have much impact, largely because only a small sector of the population watches Lesotho television. In the same manner that respondents did not relate to South African celebrities in the *Choose Life* booklet, it is expected that the same response from the Basotho population would be found, especially when *Soul City* is being broadcast on Lesotho television. By so saying the implication is that they might adore the celebrities when they see them on SABC television but when on Lesotho television they see them as invading their territory and some issues not related to their context.

This chapter analysed and discussed the reception of Choose Life by the target audience in Lesotho. A summary of the discussion and conclusion is provided in the next chapter.

Chapter Five

Summary and Conclusion

The initial hypothesis was based on participatory models of development communication - that audience research, needs assessment, and audience participation are crucial in influencing the effectiveness of messages intended for behaviour change (Singhal & Rogers 1999). This was based on the view that when beneficiaries are not involved, the tendency is that such interventions are not taken seriously. There is no responsibility on beneficiaries to ensure that they succeed. In essence, they do not own up to such interventions (Servaes, 1999). The study tried to find the level of participation of the beneficiary country (Lesotho), including the target group of *Choose Life* and how their involvement or lack of could have influenced the reception of the booklet in Lesotho. This reception was analysed based on Hall's (1980) encoding/decoding model, which provides for preferred, negotiated and oppositional readings of media texts. The reception was analysed based on respondents' views on the content of the *Choose Life* booklet. 'Other' determining factors that influenced its reception were also explored.

During the pre-testing of the booklet in Lesotho, adolescents were asked to comment on the booklet and its content (Interview with Ranneileng, October 2004; Interview with Motemekoane, October 2004). This procedure was meant not to discuss adolescents' general views on HIV/AIDS, health and relationships, but on content that was already decided on by *Soul City*. The research argues that this limited the scope of adolescents' views. *Soul City's* argument is that *Choose Life* was not intended to be participatory, and therefore it (*Soul City*) did not place much effort on formative research prior to the intervention. Contrary to this position, it is argued that indigenous culture is very important to understand in order for interventions to have a positive impact. Culture is defined as "an ensemble of social practices through which defined groups within and sometimes across classes, industrial societies and other kinds of non-industrial groupings express themselves in unique ways in their dynamic encounters with material and non-material circumstances" (Tomaselli, 1996: 44).

Different cultures have positive aspects that public health campaigns can tap into to make their interventions more efficacious. While it is true that youth culture can cut across

different societies; the diversity of culture points towards the notion that there is always something distinct in a society's culture that will differentiate, for example, between South African and Lesotho youth, and in the same manner differentiate between youth in Swaziland, Botswana or Namibia. This is evident in the perceptions both urban and rural youth have about each other. General health messages cannot be expected to incorporate such diversities, but in a specific campaign like *Choose Life*, it is argued that this is an oversight.

Notwithstanding the proven advantages of participation (Freire, 1972; Mowlana and Wilson, 1990; Servaes 1999; Singhal and Rogers, 1999), the varied and oppositional views of the subjects of the project reflect a problem with participation. People always have differing viewpoints and this can create conflict among participants. Public health campaigns therefore are faced with the difficulty of accommodating reasoning arising from the interests, rivalries, grudges, attachments, taboos and so on of local communities, which differ from community to community. Nevertheless, the fact that HIV/AIDS infection mainly occurs in the intimate realm, and involves emotions, it is important to conduct extensive formative research to understand local reasoning and norms. Sexual interactions are influenced by emotional, psychological and physiological factors that may overwhelm a rational approach (Parker, 2003: 2).

The use of celebrities in public health communication campaigns has been used to influence audience members to change attitudes and behaviours. By modelling the good behaviours of models and being exposed to the consequences of unacceptable behaviour, audiences may copy the good traits of the model or avoid their bad ones (Singhal and Rogers, 1999: 148). While local celebrities on the cover of *Choose Life* fascinated respondents, they were not impressed about the messages these celebrities portrayed. Respondents also felt that the messages lacked celebrities' own experiences about love, relationships, sex and HIV/AIDS, which they could learn from. The basis of the respondents' argument is the essence of role modelling as conceived by Bandura (1992).

The risks associated with non-use of condoms have been made widely known by almost every media message and campaign. However, it has been demonstrated through numerous studies that this has not translated into consistent use of condoms, especially by adolescents. Despite conflicting views about whether condoms make sex less enjoyable or not, most respondents indicated that they used condoms every time they had sex. The problem with this assertion is

that with the expected social/health responsibility exerted on people to use condoms, it is possible for respondents to give the researcher such responses. This view is supported by the fact that respondents indicated that lack of support from health facilities prevent them from seeking services from such facilities. It is evident that condoms are not readily available for adolescents except when purchased. Reluctance of parents to discuss sex with their children and their emphasis on abstinence also restricts the freedom of adolescents to visit health facilities. It is therefore not enough to simply convince people to alter risky habits. Most of them also need guidance on how to translate their concerns into efficacious actions and the means to do so through availability of resources and support (Bandura, 1992: 101).

The media, with its focus on HIV/AIDS has played a crucial role in disseminating information about the pandemic. While this is necessary, the research found out that adolescents have become weary of hearing the same messages over and over. It is argued that other issues also considered important by adolescents such as career guidance have been sidelined. It is argued that *Choose Life* did not have much impact to most respondents who were beyond the target age group because most of its content was about what they already knew. The messages were clearly monotonous for them. This could be explained by the fact that most people try to adopt pro-social behaviours recommended by most health communication messages but find themselves failing to do so consistently. Behaviour changes are therefore not necessarily sustainable, even if they are consciously made (Parker, 2003: 3). To be most effective, Bandura (1992: 97) contends that health communications should:

> [I]nstil in people the belief that they have the capability to alter their health habits and should instruct them on how to do it...success usually is achieved through renewed effort following failed attempts. To strengthen the staying power of self-beliefs, health communications should emphasize that success requires perseverant effort, so that people's sense of self-efficacy is not undermined by a few setbacks.

The findings of the present study have to be seen as influenced by a number of factors. Firstly, the booklet was intended for 12-16 year olds but also reached an audience aged beyond that age group. There is a possibility that only a minority of the target audience was reached even though 1050 primary schools received the booklets. It is believed that the booklet reached more adolescents who are in high schools and youth clubs, where the age of the adolescents is higher than the intended target group of the *Choose Life* project.

The research findings indicate that the oppositional readings evident from most of the responses are the result of the sample being mostly adolescents older than the target age group. At that age adolescents are rebellious and oppose adults' point of view of what is acceptable and unacceptable behaviour (Ginott, 1973). On the other hand, those in their early teens, i.e. 12-16 year olds seemed to portray a more preferred and negotiated reading of the *Choose Life* booklet since they are at an age where parental influence is still high and they fear ridicule from parents. From the above point, it can be inferred that had *Choose Life* reached only the intended target group, it would have had a more positive reception than it did.

In its evaluation of the *Choose Life* project, *Soul City* indicated that general responses from the four countries revealed that the booklet:

- Created an opportunity for communication and discussion amongst peers, and awareness around the need to communicate;
- Improved awareness and attitudes around the need to communicate;
- Served as a catalyst for assertiveness (girls);
- Improved awareness and attitudes around people living with AIDS, and stigmatisation (*Soul City*, 2004[39].)

While the research does not negate these assumptions, the research also revealed that boys do not necessarily coerce girls to have sex; that both sexes put pressure on each other. It is argued that awareness around the need to discuss and communicate with peers issues about health and sex was increased, not created since other communication initiatives in the country have also been promoting communication between peers tremendously.

In conclusion, *Choose Life* was not a worthwhile exercise. Credibility was lost through lack of adequate formative research. Lack of target audience participation prior to design and execution was a significant additional factor in the loss of its effectiveness. Involvement of the target audience in the initial stages of the message design may have shed light on young people's perspectives about HIV/AIDS, relationships and life in general. Further, effective message design would have been facilitated by such involvement. One example may have

[39] Available at: www.soulcity.org.za

been exploration of other means of communication. It is suggested that this would have gone some way to maximising use of limited resources and infrastructure, mentioned by *Soul City* as constraints to the success of the project.

Alternatively, the target group's involvement would have shown that while Basotho youth wanted to see their own local celebrities in *Choose Life*, acceptable moral behaviour would be an important selection criterion for such celebrities. Most of the oppositional readings observed during the research could be explained based on the experiences of youth as opposed to recommended and expected behaviour, which are often in conflict.

Furthermore, communication campaigns that target only adolescents, but do not incorporate other members of the community will not be efficacious in the long run. The reason behind this assertion is that young people do not live in an island and their views about life are influenced by a number of factors including cultural norms. It is therefore futile to equip teenagers with information while social influence is non-supportive of such information in terms of behaviour, attitudes and lack of communication. Community sub-groups that encourage interpersonal communication using guiding material would encourage dialogue between adults and teenagers instead of a booklet that a teenager reads on his/her own or with his/her peers. Airhihenbuwa *et al* (1999) have noted that the influence of culture...has been disregarded because the assumption has been that individuals have total control over their behaviour. This viewpoint is based on the fact that behaviour is not simply an individual choice. Multiple forces such as families, social networks, workplaces, schools, religious affiliations, or community and societal structures shape how an individual makes health decisions. Based on the report on the Radio research process on *Soul City* Series 1 (2004) to be produced in Lesotho, extensive formative research has been conducted. It is expected therefore that this campaign unlike *Choose Life* may yield more positive results.

It shows therefore that there is need for public health campaigns to take into consideration the following factors:

- That proximity should not be the basis upon which messages can be assumed to be appropriate for different populations, therefore the need to involve beneficiaries in order to understand their way of thinking;

- That youth and adolescence can have varied categories in different societies, therefore material appropriate for a particular age group in one society might not be appropriate for the same age group in another society;
- That while HIV/AIDS education is important, there are other important issues concerning other aspects of life that adolescents want to learn about, and these should be included.

Choose Life has brought forth the problem of rolling out existing projects into similar but different settings with limited resources. Messages need to be designed with the specific target group, in their own context, if they are intended to meet their immediate needs, particularly interventions that require behaviour change.

Further research may shed light on the following questions:

- What are the positive and negative cultural attributes of the local community with respect to HIV/AIDS?
- How can communication programs tap the Basotho people's cultural domain to prevent HIV/AIDS?

Based on the findings of the study, to account for the conflicting interests of respondents in their reception of *Choose Life*, Hall's Encoding Decoding model provided the ground to argue that encoded messages might not be accepted as intended by the decoding audiences. The three scenarios that Hall presents are the dominant, negotiated and oppositional readings. While Hall implies that these types of reading are roughly equivalent, in practice there are few purely dominant or oppositional readings. This is evident in the reception of *Choose Life* because there were no perfectly dominant or preferred readings. While there were those who were totally negative about some of the content of the booklet, most responses indicated that there was a lot of negotiating with the text that was going on. Encoding therefore is able to construct some limits and parameters within which decodings will operate. This implies that there is always some degree of reciprocity between encoding and decoding. Without this 'correspondence' there would not be an effective communicative exchange at all (Hall, 1980: 135-136).

Furthermore, while Hall emphasised the role of class in the production of different meanings, class was not the main factor that influenced the reading of *Choose Life*. Instead, factors such as age, gender, urban versus rural, relationship with parents and peer pressure were more prevalent in accounting for the different readings by the respondents of the study. It is argued that the *Soul City*/LENASO partnership underestimated the role these factors could play in the reception of the *Choose Life* booklet by the target audience.

In terms of the DSC model, specialists support the projects and activities of local people through participatory approaches. Communication is supposed to be horizontal knowledge sharing between participants. The findings of the study indicate that LENASO played the role of the DSC specialist in the project, whose role was to bridge the communication gap between the technical specialists (*Soul City*), and the potential users of *Choose Life.* However, not much knowledge sharing occurred in the implementation of *Choose Life* because not enough effort was made for the target audience to make any meaningful contribution to the final version of the booklet. While the DSC models suggests that the role of the DSC professional is to eventually empower the local people to participate in the economic and political processes in the societies, it is argued that this is not essentially relevant to a target age group of 12 – 16 year olds. Their immediate need in relation to HIV/AIDS is information and the means and support to deal with the challenges they are faced with. However, this can be effectively provided only if both external and internal organisations do not act in their own interests and involve the youth in their endeavours.

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Appendices

Questionnaire

I would like to thank you for your participation in this study because it is for the benefit of us all. Your responses will be kept confidential and will not be used in any way other than for the purposes of this study. I therefore implore you to be honest in your responses. Please fill in your answers in the space provided and circle/tick your answer where applicable. Please be free to elaborate on your answers.

1. Age: .....

2. Gender: Female/Male

3. Level of education: Primary/Secondary/High School

4. Grade/Class: .....

5. Live in urban or rural area?.....

6. Do you live with your parents?.....

7. If not, state reasons and whom you are staying with:

.....

.....

.....

.....

8. Where do you mostly get information about sex and HIV/AIDS? Parents, peers, teachers, radio, television, magazines? Is it adequate?

.....

.....

9. Do you have a girlfriend/boyfriend? .....

10. What activities do you do when you are together?

.....

.....

11. How often do you meet? .....

12. Do you engage in sexual practices? .....

13. How old were you when you first engaged in sex?

.....

14. Was it an informed decision?.....

15. Was it your choice?.....

16. How often do you practice safer sex (use condom)? Everytime/often/Hardly/Never

17. Do you have more than one intimate partner? .....

18. If yes, why do you prefer having more than one partner?

.....

.....

19. Would you go for a voluntary AIDS test? .....

20. If no, why?.....

21. Do you think Choose Life has made a positive impact on you? .....

NGO Interview questions (Guideline)

1. What is your organisation about?
2. What activities/interventions are you involved in?
3. What led you as an NGO to form a partnership with *Soul City*?
4. What role do you play in this partnership?
5. What was the role of DFID?
6. How did *Choose Life* come about?
7. Who were involved in its making?
8. What were the major changes that were made from the original South African version? On what grounds?
9. How did the target group access *Choose Life*? Did they get involved before it was distributed? In what way?
10. Did you do any pre-testing of *Choose Life*? What were your findings?
11. What about evaluation of the campaign?
12. Who did the evaluation of *Choose Life*? What were your findings?

13. From your experience as an NGO, what works in Health communication campaigns?

14. Where parents involved in the campaign?

Focus Group discussion questions (guideline)

1. Do you remember this booklet? How many of you still has it? Can you remember its contents?
2. Do you remember how you got into contact with the book? Do you know where the book came from?
3. What does being in love mean to you?
4. Do you enjoy your youth? What makes you enjoy it and what prevents you from enjoying it?
5. Violence in relationships. Do you think it is okay to beat a girl? On what grounds?
6. Do you talk about sex with your parents? What do you think you can learn from them? Do you ask for information or wait to be told about it? Is it easy to talk to adults about sex? What is their attitude towards you?
7. Page 16 – What do you think of these phrases? Is it possible to have fun without penetrative sex?
8. Why do you think young people are having sex?
9. Do you think boys are the only ones who pressure girls for sex?
10. Why do you think it's hard for girls to say no?
11. Page 19 – Is this the kind of treatment you get at clinics? What service do youth usually seek in clinics –advice, contraception, treatment of STI's or testing
12. Do you think the use of celebrities make messages more credible, does it make you want to do the things they are saying? Why? What about South African celebrities? Are they your role models?
13. What do you think about condoms? Do they make sex less enjoyable? Are they easily accessible? Whose responsibility is it to use condoms? Does using a condom mean you don't trust your partner?
14. Is there any difference in behaviour among youth in rural and urban areas? What are your perceptions about South African youth?

15. What are your perceptions about South African youth?

16. What do you think makes people stigmatise people with AIDS? What do you think about VCT?

17. What kind of messages would you, as youth would like to hear concerning your lives?

18. Are you happy with AIDS being the focus of almost every media message?

19. What are your general views about *Choose Life*?