

AIDS awareness programmes and health literacy

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Abstrak:

VIGS bewustheid en gesondheidsgeletterdheid. Die artikel bevestig die effektiwiteit van AIDS boodskappe en voer aan dat die aannames van boodskapontwerpers van onder andere ontwikkeling in gesondheidsintervensies; die vlak van gesondheidsgeletterdheid, die gesondheidstatus, die seksuele identiteit en gedrag en die inligtingsbehoefte van die teikengemeenskap die effektiwiteit van die AIDS boodskappe ondermyn. Die artikel voer aan dat programme alleen die deelnemers na die bereiking van kritiese gesondheidsgeletterdheid kan bring as die aannames/konstrukte van die program ontwerpers krities ondersoek word, die doelstelling van die intervensie deur beide die partye onderhandel word en 'n gelyke deelname in 'n diskoers gerealiseer word waar elkeen hulle betekenis in vryheid kan konstrueer en boodskappe kan beleef of skep volgens 'n meer aanvaarde wyse van aanbieding. Dit impliseer dat 'n digotomie op 'n globale vlak tussen die sogenaamde ingeligtes en oningeligtes, die ontwikkelde en onderontwikkelde of op 'n plaaslike vlak (soos die skoolgemeenskap), tussen die onderwyser/program aanbieder/boodskap ontwerper en die leerder/gehoor/ontvanger opgehef word. Huidige geletterdheid in gesondheid moet versterk word binne 'n konstruktivistiese (Vygotskianse) leeromgewing, wat bydra tot en die sin van koherensie versterk deur die inhoud en metode van inligtingsaanbieding en die bevordering van die gesondheid van 'n skoolgemeenskap.

Research problem and point of departure

Research in AIDS programmes in South Africa has mainly focused on efficient ways to change high-risk sexual behaviour and to prevent infection (Harrison *et al.*, 2000). This type of focus assumes that high risk sexual behaviour is the problem and the objective of the research is to find the best ways to change behaviour. Melkote *et al.* (2000) indicate that sociopsychological theories and models have frequently been used in AIDS prevention campaigns, like the health belief model (HBM), the theory of reasoned action (TRA) and the SCT (social cognitive theory). These theories are employed with the question in mind of how to best alter behaviour and try to understand why individuals fail to make the behavioural transition.

This article argues that understanding of health constructs has to forego AIDS programmes and does not focus on what is regarded as being high-risk and unhealthy. A salutogenic and not pathogenic approach lies at the basis of the type of research and interventions this article supports.

The assumption is found in AIDS awareness programmes, that "high-risk" behaviour defines the problem and the prevention thereof motivates and directs the interventions. Consequently the health needs of a community are assumed and an uncritical choice of certain information and a preference of the way it should be conveyed follows. The focus on visual material in the form of pamphlets and posters which plead condomisation, faithfulness and restraint can be viewed in this context of uncritical choice.

The efficiency of AIDS programmes can be undermined due to a misfit in constructs of

both parties which leads to the fact that messages are neither integrated into the existing conceptual framework of the target community, nor accepted, but rather met with resistance. The disturbance in the sense of coherence in a rural community, after the intervention, was noted in the pilot study, which actualised conflicts between teachers and learners and a discomfort with and suspicion of the content of the programmes. The way the intervention was directed also led to feelings of unease. The details of the pilot study are explained later.

The article argues that the attainment of critical health literacy implies more than a situational empowerment of a community, or the compliance of the community to a given situation, the accommodation of health messages and the mere acceptance of the problem posed as a problem of the community. A reformulation of focus is necessary, which does not have a pathogenic focus, but is rather aimed at the promotion of health. This pathogenic approach in AIDS awareness programmes leads to the representation and experience of health as being HIV-negative. The shift of paradigm towards health promotion and integration of holism in health would focus on positive lifestyles and an enhancement of existing strengths in the community. The argument of this article is that a constructivist approach to communities in AIDS intervention campaigns will not be an imposition or in conflict with current conceptual frameworks. The attainment of critical health literacy will lead to both a symbolic (being an equal participant in the discourse and constructing the terms of reference) empowerment and, as Nutbeam (1999) describes, a structural empowerment, which refers to the ability to change social and economic determinants on a communal level and to improve resilience to social and economic adversity on an individual level.

A further critical stance is taken towards the notion of development in the motivation to launch health interventions, seen against the stereotyping constructs of what is scientific, accepted, proper, informed, developed, healthy and civilised concerning an African's sexual behaviour. The critical question to be asked is which constructs on both sides need deconstruction.

The interrelatedness of health and literacy

Definitions and constructs of literacy and health both refer to the attainment of specific abilities, with the common objective in both to cope with or change the environment (Ottawa Charter, (1986), Vygotsky (referred to by Ewert, 1990) and Bhola (1992). Health literacy, as a congregate of the two constructs, would refer to the ability to acquire information which is relevant to the fulfilment of health needs (physical, intellectual, psychological, spiritual, vocational and emotional) which arise in the interaction with the environment, with the objective to cope with or change the environment. Health literacy can also refer to existing levels of knowledge, skills and behaviours about health which are beneficial in living optimally.

In a constructivist learning framework, literacy would refer to the ability to make changes to current knowledge systems and to act according to the acquired level of cognition. The environment can also be represented in the form of symbols, and literacy then refers to the ability to negotiate and change meaning which leads to improved functioning within or change of the represented environment. There are multiple forms of information presentation and literacy would mean the ability to make sense of all the forms in which information is presented (visual, oral, textual).

Definitions of both health and literacy refer to abilities and within these definitions the notion of development is implicit. The Ottawa Charter's (1986) definition of health promotion refers to the

process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical well-being, an individual or group must be able to identify

and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is therefore seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.

The ability to develop needs to be recognised and the objective of development needs to be determined in a discourse of equal participation. It is however true that current messages represented in health interventions form part of a discourse which has already been determined, and often, one-sidedly. These terms of reference as the terms of the discourse and the way of presentation have already been chosen.

It was part of the preparation of this article to ascertain the reaction, level of acceptance, and accommodation of teachers in rural South African schools to these messages and programme interventions. The question to be asked is whether the messages lead to an improved coping and toward a change in knowledge structures which benefited coping. In short — did the interventions lead to empowerment or disempowerment?

Health literacy and empowerment

Elements of development and empowerment are contracted, as shown above, into the field of meaning of both health and literacy. Habermas (1971) differentiates between different levels of literacy which are related to specific knowledge interests and subsequent different levels of empowerment. The technical and practical (interactive) knowledge interests are usually linked to situational empowerment, while the emancipatory interest in information leads to critical empowerment.

It can be seen in two cases, the San (Bushmen) in South Africa and the gay community in the USA, that the participation of people within a discourse is an imperative for empowerment on any level. As the San (Bushmen) in South Africa had no political rights since the colonisation of the continent, they were excluded from any type of discourse in which they could have debated their power. The denial of structural power (economical, political) also implies within Habermas' framework a denial of situational empowerment (communicative, interactive). One can then understand that a structural or political disempowerment led to the fact that the San's medicinal knowledge was not respected or even acknowledged. No discourse existed between the westerners who took over the San's medicinal inventions, and no demands were met which could have equalled the scale. A broadcast on the SABC on the 13th of August 2002 reported their case: for hundreds of years the San were able to cure themselves by their medical knowledge. As the San had no voice of power within colonial ruling, their medicinal knowledge had been taken over by medical or pharmaceutical practitioners in the last 200 years. No acknowledgement was given concerning patent rights, as the San were not operating within the discourse, or the narrative defined by westerners. This inability to maintain themselves in an alien system led to the exploitation of their knowledge. The Hoodia Cactus for instance, used by the San to stave off hunger, has been patented by an international pharmaceutical company as a diet drug. The rights to the drugs were granted to the drug company by South Africa's Council for Scientific and Industrial Research (CSIR).

Bhola (1992) defines power as the universal human need and the differentiated individual capacity to make an impact on both the material (structural) and symbolic world. Power also refers to the symbolic transformation of reality. To be involved in symbolic transformation would therefore mean to experience power. Changing health-related knowledge, or knowledge that has a bearing on health, is possible as it has come to a symbolic realisation. Power is a combination

of psychological and structural processes — on the one hand, empowerment is the process through which those, who are powerless in the face of people who have control or power over them, gain a critical consciousness about their individual reality. Empowerment is also a structural process, where the disempowered organise themselves to multiply individual power to collective power and to demand changes in their environment (Bhola, 1922).

In the following case, the power to change symbolic meaning was preceded by the gaining of political power. Castells (1997) refers to the fact that the gay community of San Francisco was able to transform the dominant society's stigmatization of AIDS as a gay disease and consequently was able to overcome and prevent the plague. The gay community was able to transform meaning, or become symbolically empowered, as they had the power to organise themselves structurally and to gain political power. They were therefore actively making themselves equal partners within the discourse on HIV/AIDS, a place from which they had been excluded.

Nutbeam (2001) links the attainment of critical health literacy to improvement, on an individual level, as the improved resilience to social and economic adversity and on a communal level as the improved capacity to act on social and economic determinants of health. He regards interactive literacy as the dominant level of literacy and critical health literacy as the exception, or the ideal. It is the point of view in this article that an intervention to promote the health of a community should view the attainment of critical health literacy, not as exceptional or ideal but as an imperative. The attainment of functional health literacy as such leads to a situational empowerment, which Kickbusch (2001) refers to as compliance, which is not the focus of health literacy. She also indicates that the failure of large-scale literacy efforts world-wide can be ascribed to a lack of concern with empowerment.

Within the context of this article, where the appropriateness of information is investigated, the focus is on symbolic empowerment. Symbolic empowerment can be explained as the critical awareness of the suitability of the information to the own context and the ability to transform meaning. The symbolic level refers to symbols and terms of reference and the discourse itself. Symbolic empowerment would refer to the opportunity to negotiate meaning within the discourse. Equality of members within the discourse is essential, as inequality within the discourse makes empowerment impossible. Habermas (1989) states that the discourse is only possible if everyone is allowed equally in the discourse, considered as equals, and can participate in the discourse in freedom.

In the case of AIDS intervention programmes, equality within the discourse is essential for participation where the needs, arguments and views of everyone can be expressed. The distinction between the teacher and learner, the programme presenter and participant, on a local level, but also on a global level between the developed and underdeveloped, the scientific and the lay community, the informed and the uninformed, needs to be sublimated.

As efficient messages are assumed to be representative of a dominant symbol system, their meaning in the case of AIDS is not the same for the recipients as for those who designed them. If messages reflect a holistic understanding of health and are contributing towards the promotion of health of a certain community, they can be considered successful and on target. This is however not true, as the way and content of presentation alienate teachers and disturb the coherence of the school community. The attainment of critical health literacy in HIV/AIDS programmes makes certain demands on the programme developer's constructs of development, sexuality and health and the information needed to help people promote health within a debilitated community.

Development

"Development is fundamentally about mapping and making, about the spatial reach of power and the control and management of other peoples, territories, environments and places" (Crush, 1995).

It is against this statement that development in health programmes should be critically investigated. The term "development", especially, has been part of colonial discourse. The history of development in South Africa for instance has, up to the 1990s, separated the indigenous, so-called underdeveloped people from those who were regarded as the developed Europeans. Each group had to develop separately according to objectives which were, in the case of Europeans, negotiated but in the case of the indigenous people were to serve the objectives of development of the Europeans. Constructs of development and civilisation have strong colonial links and it has been demonstrated that the objective of the so-called "developer" has set the rules. Mutwa (1968) explains that interest in the African was only in terms of what they could mean to the developer. "Many have studied the African only to compare him with the white man — intellectually for instance. Many more have studied the African in order to find justification for the policies of the ruling group they work for and support."

It seems that development interventions concerning Africa have failed, as the GDP per capita has fallen and welfare gains achieved since independence in areas like health and education have been reversed. Levels of inequality have increased dramatically worldwide. The disparity between the income of the top 20% and the lowest 20% increased by a factor of 44 from 1960 to 1997. The assets of the top three billionaires are more than the combined GNP of all the least-developed countries and their 600 million people. Development organisations, like NGOs, co-operated in Europe's control and colonization of Africa. Their work contributed marginally to the relief of poverty, but significantly to undermining the struggle of the African people to emancipate themselves from economic, social and political oppression. (Manji & Coill, 2002).

Messages in AIDS awareness programmes reflect constructs about the target audiences — not sensible, not careful, not restraining, not faithful to one partner, etc. The history of strong stereotypes concerning the African's sexuality, may also form the "hidden text" in approaches which are focused on condomisation, restraint and faithfulness. The so-called ABC's — abstain, be faithful, use a condom — is a favourite slogan. Africans are generally described in terms of what they are not, chaotic not ordered, traditional not modern, corrupt not honest, irrational not rational, lacking in things the west presumes itself to be (Manji & Coill, 2002).

In this respect, it is illuminating to see the correspondence in stereotypes formed in colonial and modern times. The focus on restraint, condomisation and faithfulness in modern day AIDS messages serves as an example of the modern narrative.

A link in 1866 between consumption (tuberculosis) and the Africans' sexual practices is made by the missionary, Reverend William C Holden (1866):

One great source from which (consumption) springs is their night orgies, in which singing, dancing and adultery are often carried on to great excess. Their dances are often long continued, in which the physical effort is intense; profuse perspiration follows. This is kept up until a late hour, until the body becomes exhausted; the pores are thrown open, and a chill ensues, which entails disease and death.

A further construct with strong moral undertones is in the following remark, made by the same person

...general uncleanness abounds, the gratification of the sensual passions being allowed and encouraged, without the influence of any public sentiment to check and retard it.

Hence, disease, as a natural consequence, must follow. Probably this is the only consideration which weighs with them, in helping to moderate their lustful practices.

About forty years later the Englishman Dudley Kidd says the following:

... so long as the animal and sexual nature of the natives absorbs all their thought, and fills all their conversation, progress is impossible ... The natives must be taught the lesson of restraint; and, of course, this work is the special care of the missionaries (Kidd, 1905).

These quotes may seem out of context today, if not for the racist and judgemental attitudes of many moving in clerical and academic circles. The 100- and 140-year-old constructs, which are shown here, are put into context by the remark of Gesheker (1999), who indicates that Victorian ideas of sexuality were affronted by the African's unashamed display of nakedness and implicit sexuality. This uncivilized behaviour justified the need for colonial social control, spurred on by Christian views on promiscuity. Clumeck claims that "sex, love, and disease do not mean the same thing to Africans as they do to west Europeans [because] the notion of guilt doesn't exist in the same way as it does in the Judeo-Christian culture of the west." Thus, AIDS "educators" counter "shame" in African sexuality through conservative appeals to restraint, empowerment, negotiating safe sex and a near evangelical insistence on condom use (reference by Gesheker, 1999).

Apart from the disempowered position of Africans concerning their colonial past, an empowerment within the discourse on health and AIDS, or a symbolic empowerment in general, is now difficult to attain. Except for the fact that health beliefs about the Africans are formed by strong stereotypes, health beliefs of Africans are regarded as unscientific while an adherence to orthodox or scientific views of medicine and healing is regarded as signs of development and sensible thinking.

An equality in the discourse on health and development is further hampered when taking into account the hidden agenda that Africa could be made a laboratory of biological experimentation, as the African population does in any case not have a high life expectancy. The export of genetically modified grain to African countries serves as an example — a venture that moves control of food consumption from land communities to multinational corporations (Stober, 2002). A refusal to prolong these imports goes hand in hand with concerns about environmental and health safety. Any discourse on development seems futile if capitalist interests still paralyse the local economies of Africa.

The African has further been denied for a long time his preferred ways of expression. Textual literacy has always been a western preference, while the African has a strong oral tradition (Brown, 1998). Belief in messages which are conveyed orally is stronger and a focus on other ways of presentation deflects the impact of the message. It has been found by researchers that folk media, drama, theatre, and radio soap-operas are more successful in conveying the AIDS-message (Vaughan *et al.* 2000; Panford *et al.*, 2001).

Within the negation of preferred way of expression and the negation of health beliefs (and more broadly, cultural beliefs) a dichotomy in codes arises which makes equality within any discourse impossible. In this respect, Bernstein (1990) refers to restricted codes (those of the disempowered) and elaborated or sophisticated codes (those of the empowered). The African, who is regarded as unsophisticated, underdeveloped and unscientific, would refer to medical matters in a restricted code (which is made restricted by those in power), while the westerner, who regards himself as sophisticated, developed and scientific, would refer to medical matters in an elaborated code. The elaborated code can also be compared to orthodox views, while the restricted code can be likened to dissentients' views. In this respect the debate can be referred to about the nature of the HI-virus, the issue that it is sexually transmissible, the link between HIV

and AIDS, the social profile of the disease, etc.

Given the consciousness of the systemic view of health promotion (Levin, 2002 — referring to the Ottawa Charter) and the multiplicities of literacy (Sensenbaugh, 1990) a promotion of health literacy within this broad, inclusive conceptual framework can theoretically be critically empowering. Multiple ways of understanding and expression are recognised which lead to critical symbolic empowerment. Physical, emotional, social, mental, vocational and spiritual aspects of health set a multidimensional stage and make the promotion of health multifaceted and enlarge the possibility for empowering health interventions. But, against the background of development, which has left the African more destitute than before, the question has to be asked why it would be different now. In which way will health interventions not be another form of colonisation?

Global voices, local echoes

One notes similarity in the HIV/AIDS discourse on global and local levels where the approach to reporting on AIDS in the mass media is echoed in reports by local AIDS awareness workshops. It seems that global paranoia concerning AIDS is sustained by dire statistics and descriptions of HIV/AIDS in the mass media such as "global pandemic", "holocaust", "plague", "apocalypse", "ground zero" (Moeller, 2000). By creating fear with a certain choice of terms and statistics, the message of restraint and condomisation is presumably sold. In research, fear or threatening are not even critically regarded in the prevention of high risk sexual behaviour that leads to HIV/AIDS, as can be seen in the following statement: "A poster threatening the family or other close-in group members may be more effective than threatening the individual" (Murray & Johnson, 2001:338)

A report from *Newsday.com* follows the same pattern by creating a fearful awareness and instilling trust in the US citizens that their government will come to the rescue of mankind by changing their foreign policy and donating millions of dollars more: a report issued at the Barcelona conference reveals that "by 2010, 25 million children around the world will have lost one or both parents to AIDS, up from 13.4 million last year. Even more alarming, African children — 20 million — will constitute the vast majority of these so-called AIDS orphans." Early this month, an article published in the medical journal *Lancet* predicted 45 million new infections around the world by 2010. It said more than 60 percent of those cases can be avoided if the world increases spending on AIDS prevention by \$5 billion a year.

Bush signalled a major shift when he proposed an additional \$5 billion over three years in development assistance to poor countries, an increase of about 14 percent in what the United States spends on foreign aid.

Even if the terms of reference change, the discourse on development seemingly stays the same — if political gain was the motivation for development, in this case, the fight against AIDS, like the fight against terrorism, becomes another way to promote political interests. Therefore interventions in Africa are well documented on the Internet — like the replacement of a shipment of faulty condoms to Tanzania by the United Nations Population Fund early in August 2002, the donation of millions more than what was originally decided in middle August 2002. The caption of this report needs no comment: "The Strength to Kill AIDS Lies Within U.S".

Locally, AIDS awareness workshops follow the same strategy and are usually introduced by a setting of the scene, or a description of the background. Statistical data are given and quotes from scientists and media are given, painting a sombre picture, e.g. "The only sure thing about HIV/AIDS in Africa is that the worst is yet to come" — Reuben Sher. "HIV/AIDS was responsible for one third of all deaths in South Africa in 2001 and will rise dramatically to almost

66 percent in nine years — MRC Report.

Military terms of reference in the case of AIDS, as seen in this quote from the same article, "We cannot afford to lose the war against AIDS. The world looks up to us to bring to the war against AIDS and poverty the firm commitment we have shown in the war against terrorism ...", defines the discourse and creates the mentality that those at risk have to be informed at all costs. Ways to present information in the media globally, and locally, to targeted communities can be likened to a hard, rationalistic, bombardment approach (as in the case of the eradication of terrorism), where no respect for existing structures of meaning or internal coherence is shown, as shown in the next section.

In the following sections, reactions of teachers who formed part of the first pilot studies are presented and discussed.

Constructs of teachers — a preliminary pilot study

A pilot study was undertaken in August 2002. The group that participated in the study consisted of undergraduate black teachers from remote rural schools in the North West Province in South Africa. These teachers attend classes in education monthly during the academic year for the completion of their teacher's diploma. During one of their class periods, four questions concerning the efficiency of Aids Awareness Programmes were set to the class and the responses of 15 teachers were analysed and coded. The questions were:

- a) What do you think of the AIDS programmes at your school?
- b) Can the existing programmes be improved? In which way?
- c) What is the most important thing young people must know/learn/hear/experience about AIDS?
- d) Why do you think AIDS messages/programmes work/do not work?

Responses of the teachers indicated their needs and problems with AIDS awareness programmes. These responses were also indicative of what intervention programmes can focus on. The responses were analysed by descriptive codes, following the qualitative research method as proposed by Miles and Huberman (1994). The following subsections provide a descriptive analysis of the responses of the teachers.

Morality

The teachers feel that cultural sensitivities are not respected in conversations about AIDS. The focus should be on a reinstatement of morality. In this respect, they feel that the country's leaders should be exemplary. They feel that the discussion of safe sex with children is improper, as it is something which belongs to married people. Teachers do not think that children are ready to have sexual relationships. The use of condoms should also only be an issue for married couples. Teachers feel that if abortion is legalised, there should not be a fuss about promiscuity, which leads to AIDS. On moral grounds abortion and promiscuity are therefore regarded as equally offending. They think that the discussions create a chance for children to "go and try" what has been talked about and consequently lead them to promiscuity. As the illness is regarded as a sin and as illegal, those who are inflicted with the illness are stigmatised. Learners have to realise that compromising morality could cost them their lives.

Information

Teachers feel that the reality in programmes is lacking, as they need proof to show children that the disease really exists, for instance, video material of people suffering from AIDS, AIDS activists who share real experiences and who make the message authentic and convincing. Nurses

are needed in schools for information. Information about the disease is complex: simplistic, exact information, which is understandable, is needed. The messages should also be user friendly for those they are intended — the levels of comprehension of children should be taken into account by those presenting the information. Information is needed which explains the cause of the disease and why it is contracted. Children should know that AIDS is killing. Many times AIDS is not accepted as the cause of death. Learners should understand that the illness is not discriminatory and not like other illnesses. It is more deadly than TBA and no medication exists. Teachers indicated the need for a structured, compulsory integration of AIDS awareness in the formal curriculum, although it might be difficult to realise. Aids awareness programmes are unsuccessful, because schools are under-resourced and remote. Media are also needed to convey the message. Remote communities are not reached.

Incomprehensibility of the disease

Due to the doubt that AIDS exists, people believe those who are dying in hospital are being killed by something in the hospital. The fact that people fear the disease, leads to their denial of its existence. Messages about AIDS are inefficient because people basically believe that it does not exist. People doubt the existence of the disease, as it is in contrast with logic. The fact that the illness has not existed for ages makes it difficult to grasp its present existence. The fact that something (sex) which leads to procreation, now leads to death, is not understandable.

Relationships of trust

Children are fearful of the disease, or fearful of telling or sharing, because they fear victimisation. People should be allowed to talk and they need people in positions of trust to talk to, like the teachers themselves. Teachers should be present in the workshops, as they have a level of trust with the learners.

Involvement of community

Programmes presented at schools should involve the whole community. All the role players in the community need to be contracted. Families should be included in the awareness programmes and the information shared, as they are ignorant about the disease. Parents should be included in programmes. More teachers should be involved in the AIDS workshop training, as only a few are selected and sent. The message does not reach everyone, as it is not regarded as a priority. Not only learners should be trained, all the teachers should be involved in training too. If they are also informed, persuading the children will not be so hard. Many adults do not have information about the disease and they need to be informed. There are also adults who do not understand the illness as such. It is necessary for the message to reach ordinary people, as only the professionals (teachers, health workers) are informed.

Change of focus demanded

Programmes should deflect their focus from condoms and restraint towards a positive lifestyle and physical fitness. Programmes should focus on the care for AIDS sufferers and mutual support in this regard. Learners should be prepared to care for those who are afflicted.

Practice informs theory

From a rationalistic to a constructivist approach

The fact that the messages were complex, superfluous and not contributing to understanding, supports the assumption that a rationalist approach was chosen and the community bombarded

with information. No respect was shown for existing moral codes, cultural sensitivities or preferred ways of presentation. The way the intervention was conducted created conflict in the school community. A disturbance of the coherence in the school community can be explained in the distrust and suspicion of teachers about the content of the programmes. The teachers were left with a general feeling of confusion and the division between teachers and learners was widened further.

Within a social constructivist learning environment, which is here regarded as in opposition to a rationalistic approach, the construction of meaning schemes does not happen by imposition, people themselves realise that existing meaning structures need expansion or adaptation and in common sense new structures are adopted. An imposition of thoughts or understandings will be experienced as contradictive in the demands of the Vygotskian learning environment. Current understanding is therefore not passively changed. People have to play an active role and must feel a need to expand structures of knowledge. No imposition of new thoughts happens, as a cognitive need is felt and with guided learning a new concept is assimilated. As seen in the reactions of teachers on programme interventions, constructs on both sides, which prevent health, need to be redefined. If the objective in determining the constructs happens only for the sake of judging them as wrong and deficient, then the intervention does not meet the requirements of a salutogenic learning process. It is in determining people's constructs concerning their health, that appropriate messages and interventions can be developed which acknowledge, respect and build upon the structure of current understandings towards the objective of promoting health. Existing health literacy has to be established, which refers to an individual's existing ability to understand information and uses it to change or to cope with his environment.

Symbolic empowerment would mean that the signs and symbols which make up the messages are re-defined and reconstructed to give expression to new understandings. If the focus of AIDS programmes is on AIDS prevention, the message cannot include anything more than condomisation and the elimination of risk behaviour. Through language, reality is reconstructed and the terms of reference can contribute to either disease prevention or health promotion. As language is an important tool for social development (Donald *et al.* 2002), one can understand why teachers fear children becoming promiscuous, as the terms of reference are focused on sexual behaviour.

If pre-judgements concerning healthy behaviour and the conviction of where the health promoting process must lead is not shared by programme participants and presenters, the intervention is futile and the objectives of only one party strived for. A new dichotomy then arises.

Existing strengths denied

The fact that teachers, family members and the "ordinary" people in the community are excluded from the AIDS awareness programmes, undermines the credibility of the programme. Health beliefs and customs, cultural traditions and the high moral standards of the community — those things which can be referred to as existing strengths, have to be contracted and built upon. The fact that teachers are excluded from the programmes, misses an opportunity to pull on existing strengths within the school community. Their exclusion leads to suspicion and creates conflict. In this way the sense of coherence of the target community is violated.

Those allowed into the discourse are chosen selectively. It is as if the programme presenters do not want to complicate things. One can understand the dynamics behind the selection of those allowed into the sessions against this remark:

It seems as if health interventions are aimed to convince people that knowledge of com-

plex illnesses resides with expert others ... Within the dominant discourse or narrative, the medical and health care system forms partnerships with education and the other message carriers including the media. These cultural sub-systems are designed to reinforce and complement each other in order to effect control and order (Fitzclarence & Dellit, 2002).

From disease prevention to health promotion

The interventions described by the teachers cannot be regarded as salutogenic. At this stage the messages seem to be directed to restraint, change of sexual behaviour and the propagating of condomisation. The teachers themselves indicate a need for a shift towards salutogenic interventions and the change of focus towards positive interactions, care, support and the rebuilding of the country.

If AIDS intervention programmes take AIDS as an entry point to promote health, the focus shifts and the construct of health is enlarged. At this stage, the construct of health which is formed by interventions is defined by being HIV-negative and the bio-physical level of sexuality and sexual behaviour remains the only level which is contracted in the programmes. If the focus shifts to health promotion, or if the pathogenic paradigm is sublimated by the concept of health promotion, the focus of the programme shifts from a pathogenic regard of health as being HIV-negative towards a salutogenic regard of health in the enhancement of existing strengths and literacies. Within such an approach, the sense of coherence of a community is strengthened, as they are not unequals within a narrative, which refers to them as ignorant and unhealthy.

A general over-presentation of condomisation and restraint makes teachers want to see something more in the programmes, focusing on healthy lifestyles, the rebuilding of the country, the support to AIDS victims, the breaking down of stereotypes concerning AIDS victims, etc. These needs are apparently not met in the AIDS awareness programmes they have seen or attended.

Conclusion

It is possible that the new interest in Africa — especially since the World Summit on Sustainable Development the first week of September 2002 in Johannesburg — will indeed lead to sustainable development in health interventions.

Commitment to African epidemics and AIDS, especially, may create a new chance for political gain. Given the global paranoia about AIDS and motivated by self-interest (the disease as seen in the context of the global village), a new political playing field is created. Health development interventions can be harmful and just as detrimental to global health if a discourse is not realised whereby the terms and objectives of development are negotiated by equal partners. As has been demonstrated in this article, harming stereotypes and political gain will leave the continent poorer than before.

Health Promoting Schools do and will definitely have to cope with communities debilitated by AIDS. If HIV/AIDS is taken as the "in-road" to promoting health, the needs as well as the existing strengths (the health literacy) of a school community must be contracted into the programme. A health promoting intervention should have as its objective the attainment of critical literacy. This implies that a deconstruction of hindering knowledge structures on both sides should happen. Holistic health promotion should not become a new "healthy" colonisation.

Following the Habermas model (1989) of free participation in a free discourse, it is necessary that the so-called informed should also be demythologised concerning their own constructs of what needs to be known and become equal partners in the fighting of HIV/AIDS.

A further frugalisation, of health being HIV-negative, is in effect an insult to the humanity of the community. A programme which is articulated by terms referring to restraint and condomisation, is in effect a debasing of humanness. As soon as communities are basically respected, harming stereotypes and assumptions will not have a role to play. As soon as those who do the interventions want to hear the needs of the communities, harm will be prevented.

HIV/AIDS will then be effectively countered in the achievement of critical literacy by both the message designers and the target audience. The current model of health promotion within a holistic framework can serve to counter the disease effectively.

Feelings of trust and security within the neighbourhood in which one lives can make a significant difference to health status (Kickbusch, 2001). Acknowledging existing strengths will contribute to the feeling of trust in own literacies and wisdom. This will be a positive step in enhancing health literacy and in line with the capacity-building aspect of health promotion.

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