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Design solutions to community health communication messages

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Design solutions to community health communication

Abstract

The aim of health communication campaigns is to effect a change in behaviour and attitude. These campaigns generally communicate a specific message regarding an epidemic or health-related issue. Health communication models can guide graphic designers to develop effective health communication messages. Some of these models, such as the Participatory Communication Model (PCM), suggest that involving the community in the communication process can produce clear and appropriate messages. The Extended Parallel Process Model (EPPM) maintains that a health message must have a threat element and an efficacy element in order to be effective in changing behaviour. The EPPM can also use persuasive messages that stimulate fear in order to encourage people to adhere or respond to the suggested options. The perceived threat element of the message makes the viewers feel prone to the risk, whilst the efficacy element makes the viewer feel that he/she will be protected from danger if he/she follows the recommended option. These theories developed by scholars in this field are not always applied by graphic design practitioners to design solutions especially in the field of health communication.

The aim of this paper is two-fold: Firstly to propose a health communication model for a developing country such as South Africa, and secondly to partly reflect on a survey conducted in Lesotho by the first author. The survey evaluated the efficacy of loveLife's outdoor visual materials. The proposed health communication model is based on existing health communication models (the PCM and the EPPM) and relevant results of the survey about loveLife's outdoor visual material.

The model proposes that a community health communication messages must follow a "bottom-up" development process; that it must ideally contain a threat element; that this threat element does not necessarily have to be intimidating in nature and that there must be an attainable efficacy element. The model further suggests that the development of the material must take cognisance of the cultural vogue of the audience; that the graphic imagery must harmonise with the efficacy element rather than the threat element; and that prominence can be given to positive graphic imagery. These strategies can enhance the comprehension of visually-based messages, which in turn could bring about the required positive health behaviour.

Keywords: self-efficacy, health communication models, graphic comprehension

Introduction

Health communication and promotion is about health information and awareness that can influence or help individuals make healthier choices about lifestyle or behaviour. Efforts in this direction have not resulted in a significant decrease in high-risk activities (Lynagh, Schofield & Sanson-Fisher, 1997). Research shows that health communication has witnessed several transformations during the past 50 years. Piotrow, Rimon, Merritt & Saffitz, (2003:2) mention that the first stage was a *clinic* era, based on a medical care model. The notion was that if people knew where medical services were located they would find their way there. The second stage was the *field* era, which was described as a more active approach emphasizing outreach workers, community-based services, and the use of a variety of information, education, and communication (IEC) products. The third stage, the *social marketing* era, was borrowed from the advertising arena and is based on the notion that highly promoted brands stimulate the demand side while convenient access through local shops and pharmacies expand the supply side (Andreasen, 1995; Rimon, 2001).

The fourth and current trend over the past decade has been era of strategic behaviour change communication, founded on behavioural science models for individuals, communities, and organisations. This trend emphasises the need to influence social norms and policy environments so as to facilitate and empower the individual and effect social change (Figuerola, Kincaid, Rani, & Lewis, 2002; Piotrow & Kincaid 2001).

Knowledge and insight are necessary in order to design effective health communication material. The process entails observation, and listening and talking to the target audience within the community. The process furthermore entails pre-testing the material before, evaluation during and post-testing after use in order to establish the efficacy of such material. Most importantly, the process requires following a certain communication model that will make all these steps easier.

What is Health Communication?

STD Communication (2007) provides a definition of health communication, appropriate to this paper, and it is as follows: *"Health Communication is the art and technique of informing, influencing, and motivating individual, institutional, and public audiences about important health issues. Health Communication theories identify important variables and specify how these variables work together to produce a desired outcome. The scope of health communication includes disease prevention, health promotion, health care policy, and the business of health care, as well as enhancement of the quality of life and health of individuals within the community"*.

The Horizons/Population Council (2002) states "... to achieve sustainable programmatic success, environmental-structural interventions must engage community members in the conceptualization, implementation and evaluation of policy-based initiatives to ensure their effectiveness as well as their acceptability and appropriateness in reducing health-related risk"

Different communication models have been used in different health risk communication campaigns. Some of the commonly used models are the *Health Belief Model* (HBM) (Murray-Johnson, Witte, Boulay, Figueroa, Storey, and Tweedie, 2001), the *Fear-Based Appeal Theory* which can be subdivided into three parts, namely the *Drive Theories*, *Parallel Response Model*, and the *Subjective Expected Utility* models (Witte, 1994). Furthermore, there are the *Participatory Communication Model* (PCM) (Health Development Agency (2000); Parker, Dalrymple & Durden, 1998; Smith, 2003) and the *Extended Parallel Process Model* or EPPM (Murray-Johnson, *et. al.*, 2001; Witte, 1992a) which are briefly discussed for the purpose of this paper.

The Participatory Communication Model

The Participatory Communication Model (PCM) suggests that involving the community in the communication process can produce satisfactory, simple, clear and appropriate messages. It entails reviewing the campaign framework and establishing the purpose and main problem(s) to be addressed by working directly with communities to help them define their own needs and develop their own solutions (HDA, 2000; Parker, *et. al.*, 1998; Smith, 2003). Parker, *et al.*, (1998) suggest that the model offers excellent opportunities for overcoming language and cultural barriers, since members of the target audience become active and are drawn into the message-making process, which maximises potential for behaviour change.

The benefits and challenges of this participatory communication model in health promotion are numerous. The active participation of beneficiaries in the planning and implementation of projects enhances their support and sustainability. It encourages the development of visualisation tools, promotes the formation of partnerships and creates a bond between professionals and planners and the target audience. Furthermore, it enhances the transfer of skills to local people.

In retrospect, it is possible to trace the failure of public health messages to insufficient pre-testing and/or insufficient reaction to pre-testing results.

The Extended Parallel Process Model (EPPM)

The Extended Parallel Process Model (EPPM) suggests that a health message must have a threat element and an efficacy element in order to be effective in changing behaviour. It explains when and why fear appeals work, as well as when and why they fail. The variable that tends to be most problematic in fear appeals is fear itself. Fear can be an obstacle to behaviour change, for example when people are so scared that they cannot act and they reject or defensively avoid a threat.

People who are threatened will take one of the following courses of action, namely no response, danger control, or fear control. If the threat is perceived as inappropriate or irrelevant,

then there is no motivation to process the message further, and people simply ignore the fear appeal (no response) (Witte, 2006). However, when the threat is portrayed and believed to be serious and relevant, subjects are motivated by their fear to take some sort of action (see Figure 1). This action can take one of two forms, namely, 'danger control' or 'fear control'. Danger control is externalised towards a solution. Fear control is internalised, ignoring a possible solution but focussing on evading the fear or danger control to be chosen, the viewer needs to feel that an effective response is available (*response-efficacy*) and that he/she is capable of utilizing this response to reduce the risk (*self-efficacy*). If danger control is not selected, then action defaults to fear control.

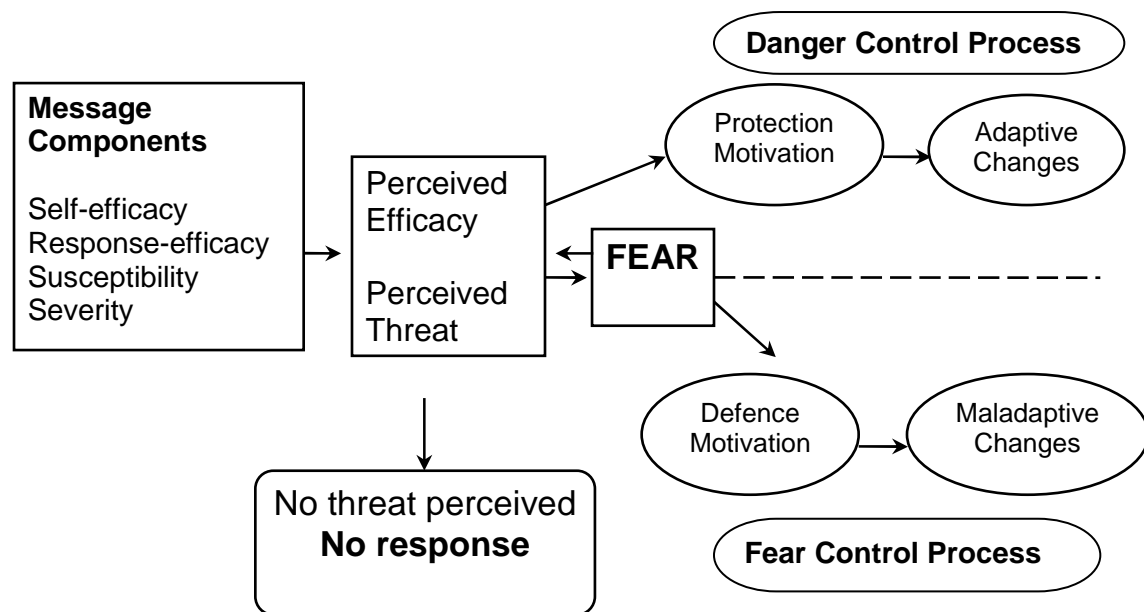


Figure 1: The framework of the *Extended Parallel Process Model* (EPPM) (Witte (1992).

In summary, Witte (2006) argues that the magnitude of threat in fear messages determines the extent of a response. Moreover, efficacy components in messages determine the manner of the response if either a danger or a fear control response is obtained (see Figure 1). EPPM proposes that if no information regarding the efficacy of the suggested response is provided, individuals will rely on their previous knowledge to react. If one wants someone to take action, then one should show him/her the threat, but also ensure he/she can see that there is a solution to the problem (i.e. recommended solution) (Witte, 1992a).

The EPPM also shows how, in some cases, messages arousing fear can lead to adaptive and life-saving actions (i.e., danger control processes) and in others they can lead to maladaptive and potentially life-threatening actions (i.e., fear control processes). As long as one perceives him or herself able to effectively avert the threat through the recommended response, very high fear levels can be induced. However, the moment a viewer begins to doubt his or her ability to engage in the recommended response and/or begins to doubt the effectiveness of the recommended response, fear appeals can produce strong maladaptive effects. For any community intervention to be effective, it has to be structured in this manner, with a balance between the vulnerability element and the efficacy element.

Reflections on a survey of *loveLife's* outdoor media

Visual messages are not always understood, particularly visual messages about health promotion targeted towards rural and low-literate communities. The positive change of behaviour and attitude that are expected from health promotion campaigns are not necessarily satisfactory. Possible reasons are that communicators use unsuitable visuals or no visual elements where necessary (Sims-Knight, 1992; Unnava and Burnkrant, 1991; Waddill and McDaniel, 1992).

Three-hundred and one learners in five high schools were initially used to evaluate message and image comprehension of 11 *loveLife* posters. *loveLife*'s visual communication material was chosen for this study because of its prominence as well as the media's criticism that the material is confusing. This reflection focuses on only two schools and two of the eleven posters that were used in the survey. The two schools and the two posters are not necessarily representative of the survey, but provide valuable parameters for the proposed model. The differences that can exist among teenagers from deep-rural and urban environments are highlighted. The two schools consisted of one hundred and nineteen learners (48 male and 71 female) who all spoke the same home language (Sesotho). The subjects were all in their tenth year (Grade 10) at a deep-rural and an urban school in Lesotho respectively. Their ages ranged between 14 and 23 years and their mean age was 17 years. These posters were put up on the walls in the respective classrooms and were evaluated by the learners. The learners in each school were asked to respond to a series of questions about the comprehension of the imagery (graphics) and to describe what they understood by the intended messages in each of the outdoor posters. This was done by means of a self-administered questionnaire based on open-ended questions. The subjects' answers were rated as correct, incorrect or partially correct. Images of the two posters are given below (see figures 2 and 3) and the results of the image and message comprehension are given in the tables below.



Figure 2: Poster 1 "love to be there"



Figure 3: Poster 2 "His & Hers"

IMAGE COMPREHENSION				
	School 1 (<i>Deep-Rural</i>) <i>n</i> = 79		School 2 (<i>Urban</i>) <i>n</i> = 40	
	<i>n</i>	%	<i>n</i>	%
Poster 1	7	8.2	32	80
Poster 2	58	73	38	95

Table 1. The number (*n*) and percentage of image comprehension of subjects in the deep-rural and the urban school

MESSAGE COMPREHENSION				
	School 1 (Deep-Rural) <i>n</i> = 79		School 2 (Urban) <i>n</i> = 40	
	<i>n</i>	%	<i>n</i>	%
Poster 1	7	8.9	33	83
Poster 2	63	80	39	98

Table 2. The number (*n*) and percentage of message comprehension of subjects in the deep-rural and the urban school

The *imagery* and *message* in the first poster, namely “Love to be there” (Figure 2) combines the dream of a positive lifestyle being achieved with a healthy and good lifestyle. This message encourages young people to “secure their future prospects” and to change their sexual behaviour in order not to be victims of HIV infection. Its intention is to encourage them to take concrete action (like staying in school and achieving good grades) to turn dreams into reality (loveLife, 2004:26).

Some subjects misunderstood the imagery and message as evidenced by the following responses: “*The other side is at night while the other is daylight*”; “*Aeroplane= travelling, Clouds= bond, Sun= happiness. I understand that they will convey people getting there*”; “*Love touring long distance*”; “*This means we have to love each other and to visit different countries*”; “*I see a police woman whose work is to prevent bad things and spread love among us*”.

Subjects who partially understood the message provided the following responses: “*The lady in the diagram used to draw aero planes when she was a kid because she dreams of flying one. She has grown up to become a pilot*”; “*When you’re a child, you have many dreams or aims in life. It shows that if you live a protected life you can live to the day your dream is fulfilled*”; “*Draw, learn and enjoy*”.

Subjects who understood the message typically provided the following responses: “*Someone wants to see a good future*”; “*We should live up to the dreams we had since we were little kids and make sure we fulfil them*”; “*I want to live to the point where I will reach my destinations*”.

Subjects from the deep-rural school with (8.9% and 8.2%) comprehension of the message and imagery generally misunderstood Poster 1 (“Love to be there”). This poster is one of three concepts of the 2004 loveLife campaign. The level of comprehension of this message was higher among the urban teenagers (80% and 83% for imagery and message respectively). When responses to imagery comprehension questions were examined in detail, it became clear that some subjects from the deep-rural school were unable to link the child-drawn picture in poster 1 with the photograph in the poster.

The imagery in poster 2 (Figure 3) depicts “His & Hers” fertilisation process. It is intended to increase awareness of the negative consequences unprotected sex and highlights the responsibility of men and women when it comes to having unprotected sex. The message aims to reduce teenage pregnancy amongst the youth (loveLife, 2001). The message achieved a high level of message and image comprehension in both the deep rural and the urban school. The majority of the respondents (both deep-rural and urban) understood the message, namely that unprotected sex leads to pregnancy. The symbolic representation of egg and sperm used in this poster was adequately comprehended by the respondents and thus aided their understanding. This imagery is therefore regarded as suitable and appropriate for the purpose of communication.

Subjects who showed complete and partial comprehension provided the following responses: “*Shows the fertilisation process in woman*”; “*Show how baby are made*”; “*Sexual intercourse is for males and females, people of different sex*”; “*I have to either abstain or have*

safe sex to avoid pregnancy”; “Unprotected sex leads to unplanned pregnancy”; “It means some one is getting into trouble and is going to regret it”; “Sexual intercourse is the responsibility of both male and female”.

To summarise, subjects from the urban school showed higher levels of comprehension, both with the image and message elements of the “Love to be there” poster, whereas the subjects from the deep-rural school had difficulty understanding the imagery and message of this particular poster. The subjects from the deep-rural and urban school showed adequate comprehension of the “His & Hers” poster. Neither of these posters has a threat element, nor a self-evident efficacy element based on the threat. The “Love to be there” poster does however, depicts a positive outcome and projects a child with a dream of becoming a pilot. This positive outcome or dream must be inferred by a reader and can create a sense of efficacy or self-worth, i.e. having a dream to pursue. The results in respect of Poster 1 are in partial agreement with the findings of Jordaan (2006:119-121) who also reported that his participants could not articulate the concept of the child’s drawing concept with other elements of the “Love to be there” poster. Jordaan in his study found the *loveLife* 2004 “Love to be there” concept contradictory and that it did not cater for South African language and cultural differences. He suggested targeting specific cultural groups, improving language and visuals to avoid misinterpretation (Jordaan, 2006).

The results in respect of Poster 2 are also in contrast with Delate (2001:14-23) who concluded that the ‘His & Hers’ billboards are confusing. Indeed, contrary to Delate’s findings, this particular poster was understood by both rural and urban teenagers (see Tables 1 and Table 2). Delate generalised his findings that meanings associated with the imagery in “His & hers” posters were not corresponding and inconsistent to the messages on the billboards (Delate, 2001).

The brief comparison of the two posters and the two schools highlighted several issues. Abstract imagery such as the “His & hers” poster are not necessarily inappropriate and can be understood by rural teenagers. This was unexpected, but it could be that the teenagers in question had already been exposed to such graphic imagery in some of their class subjects. Abstract and hidden messages and imagery, such as that used in the “Love to be there” poster, might prove problematic, but again this depends on the audience and their level of visual literacy and ability to decode graphic imagery. The contrast between the results of this survey and the work of Delate (2001) and Jordaan (2006) emphasises the need for pre-testing, and highlight the wide-ranging results that can be obtained through surveys of this nature and the fact that audience-specific message are important. Graphic imagery that is understood can contribute to message comprehension.

The ‘O’ communication Model, proposed model for design solution

The proposed ‘O’ health communication model is based on the EPPM and PCM and on the tentative conclusions of the survey in Lesotho. The ‘O’ implies a circular process whereby the phases in the model are sequential, leading to effective health communication material. The final phase re-informs the first phase and operates only amongst the end-users of the health messages. This model suggests that effective health communication can be achieved by using imagery and messages that conform to the norms of the society in question. The imagery and message must be developed through a community effort (“bottom-up” approach); it must depict that the community wants (it must address the group’s specific need) and how they want it (graphic presentation) in order to influence them positively. The ‘O’ model is participatory process in nature and identifies health promotions as social issues to be discussed by all the stakeholders. It involves community as a large circle within which other activities are built. The model acknowledges the community norms, literacy, as well as the overall indigenous identity, and must be created in collaboration with a community member or cultural insiders who know what, how, when and why it works, and what would appeal to the target audience.

The ‘O’ model proposes further that an element of threat can be depicted visually within a message and that provision must be made of how to deal with the threat (self-efficacy). This threat does not have to be a dangerous threat but can highlight the consequences or the outcome of the problem such as in the “His & Hers” poster. This model encourages a balance between the threat visual element and the efficacy element which can steer the individual to change their behaviour. A positive rather than a negative visual depiction of the outcome of a health communication message is desirable.

Local insights of the community with technical assistance from communicators, designers, and public health specialist will yield manifold benefits (Piotrow & Kincaid, 2001). Prominence of visual images can enhance message comprehension (Gaede, 1999 and Pauwels, 2000).

Sufficient time must be allocated within the framework of health message design for pre-testing all the components of communication as well as a process of post evaluation of the communication efficacy. The graphic representation proposes the steps of implementing the 'O' model (see figure 4). The model depicts six phases: The identification of the desired outcomes or goal of the health message; the "bottom-up" or audience research process; the concept development and pre-testing phase; the exposure of the material to the targeted audience (this can also be used as a pilot test in a pre-test phase); the evaluation of the results of the exposure. The evaluation of the material, either during a pre-testing or during a post-test phase must aim to determine whether the viewers perceive an efficacy element, a threat or no threat at all. Perceived efficacy will hopefully lead to desired behaviour, namely a danger control process whereby the viewer takes protective steps and modifies his or her behaviour. If the viewer perceives a threat without any measures to counteract this threat (no self-efficacy), or views the message to be without any benefits, then the message might lead to a defensive reaction and or inappropriate changes. If no threat or benefits are perceived, the viewer might show no response. The outcome of this phase leads to the final phase during which the material is evaluated, appropriate changes are made to the existing health communication material, and the results are incorporated in future communication material. The structure of 'O' model is given underneath.

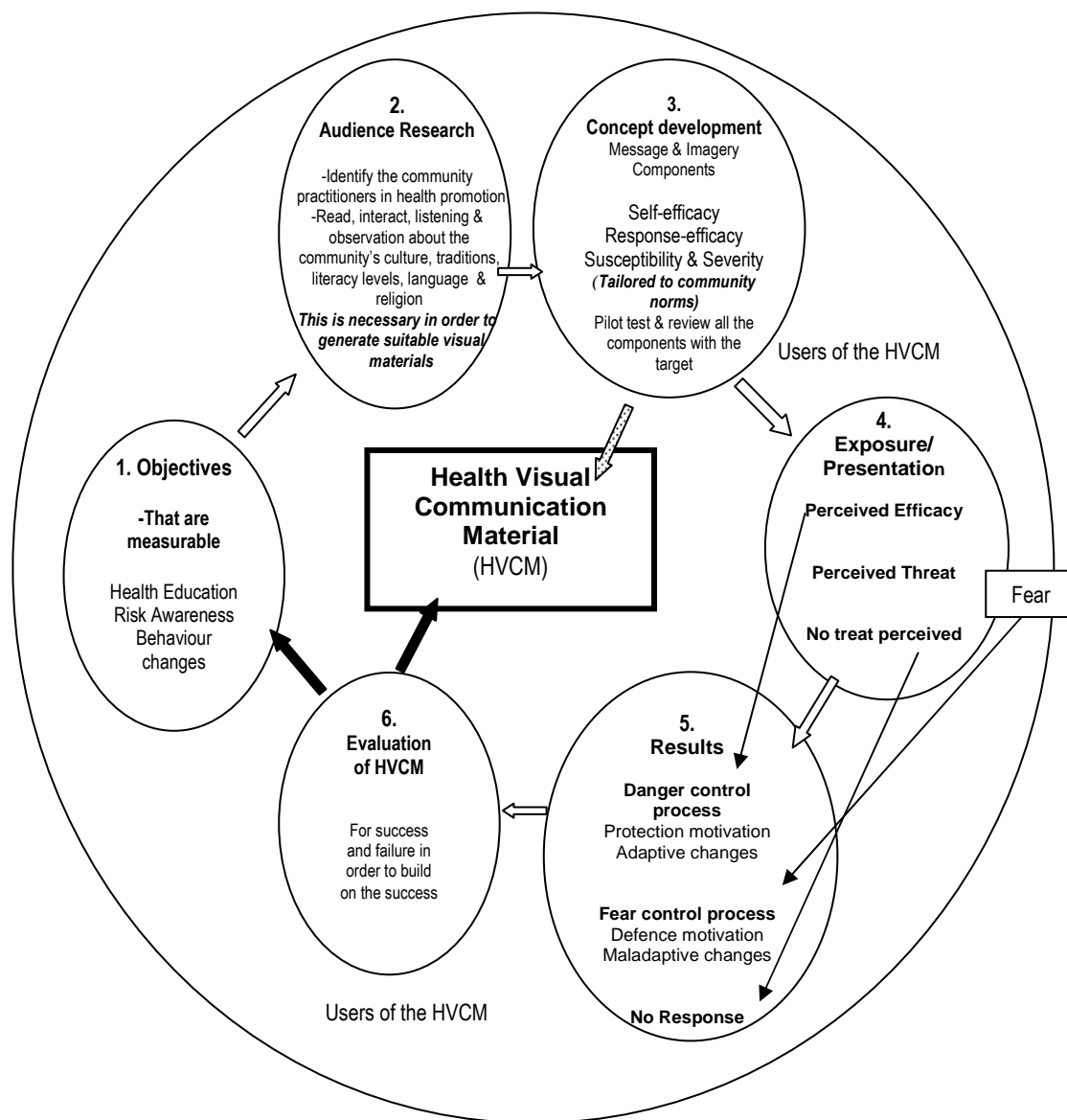


Figure 4. The characteristics of the 'O' model

Communication material is normally produced after phase 3 but the O model suggests that the health communication material must ideally be released after phase 6.

Conclusion

This paper highlighted two health communication models and reflected on part of a survey of *loveLife*'s outdoor media completed in Lesotho by the first author. It proposes the 'O' Communication Model, which incorporates the PCM, EPPM and tentative conclusions from the Lesotho survey. Community health communication messages must be created through a development process and must ideally contain a threat element plus an attainable efficacy element. The development of the material must take cognisance of the cultural vogue of the audience, while the graphic imagery must harmonise with the efficacy element rather than the threat element, with prominence being given to positive graphic imagery.

Urban teenagers might comprehend hidden messages better than rural teenagers. Rural and urban teenagers interpret health messages differently. Poor comprehension of imagery can contribute to poor comprehension of health messages. Rural teenagers should be approached differently (HDA, 2000; Parker, *et al.*, 1998), health communication materials can be more suitable and effective when they are written in the local language (PATH and Save the Children

2003:52). Community participation is a vital element of community health promotion solutions to bring about behavioural changes. The implementation of the 'O' model is envisaged to improve the communication of health messages. This however does not automatically ensure that appropriate action is taken by the community, and this is a possible area of further research.

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Conference and presentations

Experimental studies about learner's comprehension of *loveLife* HIV/AIDS prevention outdoor campaigns: Faculty of Engineering, Information and Communication Technology Research Day 2005

Learner's comprehension of health communication material: Faculty of Engineering, Information and Communication Technology Research Day 2006

Current research projects

Investigation into the effectiveness of HIV prevention messages

Articles in progress

Efficacy of *loveLife* outdoor media messages

Investigation into the use of visual communication materials to combat HIV/AIDS

Professional Association

Advertising Practitioner Council of Nigeria (APCON). -Member (1995)

Design Education Forum of Southern Africa (DEFSA) –Member (2007)

Awards

Best Graphic Design Student at B-Tech Level (2004)

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Design solutions to community health communication

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Content

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- The Participatory Communication Model
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Introduction

- **Health communication (art & technique)**
 - informing
 - influencing
 - motivating individual, institutional & public audiences about important health issues
- **Health information & awareness**
 - can influence or help individuals make healthier choices about lifestyle/behaviour

Introduction

- **Health Communication theories**

- identify important variables
- specify how these variables work together to produce a desired outcome

- **The scope of health communication**

- disease prevention & health promotion
- health care policy & the business of health care

Efforts in this direction have not resulted in a significant decrease in high-risk activities

Transformations during the past 50 years

■ *Clinic* era

- based on a medical care model
- location of medical services is important

■ *Field* era

- described as a more active approach
- emphasizes outreach workers & community-based services
- varieties of information, education & communication products used

■ *Social marketing* era

- borrowed from the advertising arena
- promoted brands stimulate the demand side while convenient access through local shops & pharmacies expand the supply side

Transformations during the past 50 years

- *Era of strategic behaviour change communication*

- founded on behavioural science models for individuals, communities & organisations
- emphasises the need to influence social norms & policy environments
 - > this facilitates & empower the individual and effect social change

Guidelines for Developing Health Communication Materials

Process entails observation, listening & talking to the target audience within the community to ensure:

- Message captivates the audience
- Medium are appropriate for the message & audience
- Information is from a credible source
- Messages & graphics are harmonious
- Messages are clear & comprehensible

Guidelines for Developing Health Communication Materials

- Materials must be pre-tested for reading level of the audience
- Be pre-tested with target audience to verify message comprehension
- Be evaluated during & post-testing after use
 - > to establish the efficacy of such material
- Most importantly, the process requires following a certain **communication model** that will make all these steps easier

Most commonly used theories and models

- Health Belief Model (HBM)
- Theory of Reasoned Action (TRA)
- Social-Cognitive Theory (SCT)
- Theory of Diffusion of Innovation
- Social Marketing Model
- Fear-Based Appeal Theory

(1) Drive Theories, (2) Parallel Response Model, (3) Subjective Expected Utility

Participatory Communication Model (PCM)

Extended Parallel Process Model (EPPM)

The Participatory Communication Model

- PCM suggests that **involving the community** in the communication process produces
 - satisfactory, simple, clear & appropriate messages
 - encourages development of visualisation tools
 - promotes formation of partnerships
 - creates a bond between professionals & planners as well as the target audience
 - enhances the transfer of skills to local people

The Extended Parallel Process Model

- Focuses on how to channel fear in a positive protective direction instead of a negative maladaptive direction



Reflections on a survey of *loveLife*'s outdoor media

■ Delimitation

- focuses on only two schools & two posters
- this reflections are not necessarily representative of the survey
- but provide valuable parameters for the proposed model

The problem

Visual messages are not always understood,
particularly visual messages about health promotion
targeted towards rural & low literate communities

Subjects

- 48 male and 71 female
- deep-rural vs. urban schools
- all in their tenth year (Grade 10)
- spoke the same home language (Sesotho)
- ages between 14 and 23 years
- mean age was 17 years

Material



Poster 1 "love to be there"

- combines the dream of a positive lifestyle being achieved with a healthy & good lifestyle
- encourages young people to "secure their future prospects" by changing their sexual behaviour

Material



Poster 2 "His & Hers"

- Fertilisation process
- Increases awareness of the negative consequences of unprotected sex
- Highlights the responsibility of men & women
- The message aims to reduce teenage pregnancy amongst youths

The rationale

- Prominence
- Media's criticism that the material is confusing

Method

- self-administered questionnaire
- answers were rated as correct, incorrect or partially correct
- posters were pasted on the walls
- series of questions about the comprehension of the imagery (graphics) asked
- describes what they understood about the messages in the posters

Results

IMAGE COMPREHENSION

	School 1 (<i>Deep-Rural</i>) <i>n</i> = 79		School 2 (<i>Urban</i>) <i>n</i> = 40	
	<i>n</i>	%	<i>n</i>	%
<u>Poster 1</u>	7	8.2	32	80
<u>Poster 2</u>	58	73	38	95

The number (*n*) and percentage of image comprehension of subjects in deep-rural and urban schools

Results

MESSAGE COMPREHENSION

	School 1 (<i>Deep-Rural</i>) <i>n</i> = 79		School 2 (<i>Urban</i>) <i>n</i> = 40	
	<i>n</i>	%	<i>n</i>	%
<u>Poster 1</u>	7	8.9	33	83
<u>Poster 2</u>	63	80	39	98

The number (*n*) and percentage of message comprehension of subjects in deep-rural and urban schools

Responses

Poster 1 was misunderstood in the deep-rural school as



“One side is at night while the other is daylight”

“Aeroplane= travelling, Clouds= bond, Sun= happiness. I understand that they will convey people getting there”

“Love touring long distance”

“This means we have to love each other and to visit different countries”

“I see a police woman whose work is to prevent bad things and spread love among us”

Discussion of the result

- subjects from the urban school showed higher levels of comprehension, both with image & message elements of the “Love to be there” poster
- subjects from the deep-rural school had difficulty understanding the imagery & message of this particular poster

Discussion of the result



- subjects from the deep-rural & urban school showed adequate comprehension of the “His & Hers” poster
- abstract imagery in this poster are not necessarily inappropriate & can be understood by rural teenagers
- this was unexpected, but it could be that the teenagers in question had already been exposed to such graphic imagery in some of their class subjects

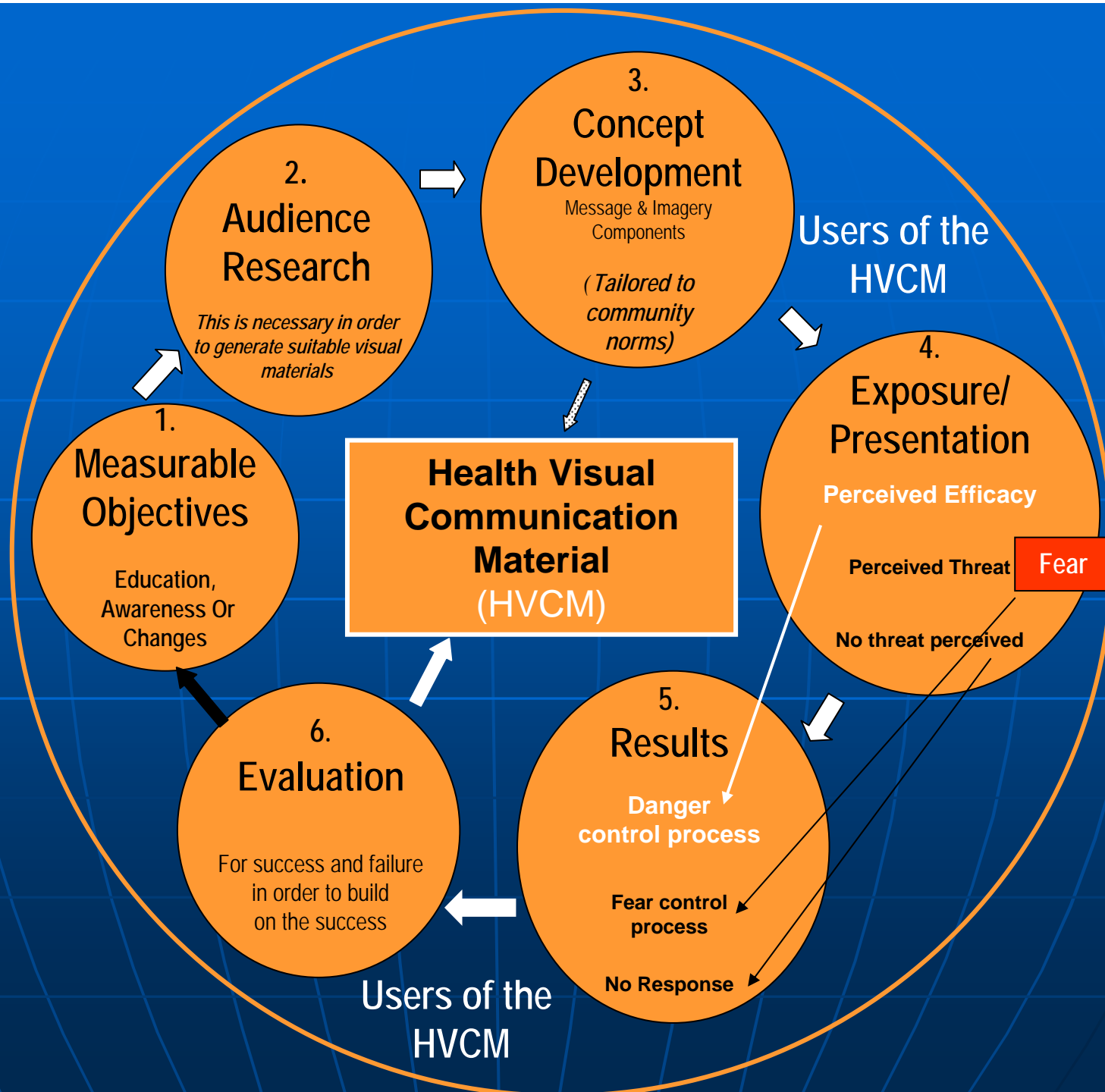
Discussion of the result

- abstract, hidden messages & imagery, used in poster 1, might prove problematic, but again depends on the audience & their level of visual literacy & ability to decode graphic imagery

The proposed model

The 'O' Communication Model

- Proposes that an element of threat can be depicted visually within a message & that provision must be made on how to deal with the threat (self-efficacy)



The 'O' communication Model

- Based on the EPPM, PCM & conclusions of the survey in Lesotho
- Phases in the model are sequential, leading to effective health communication material
- Suggests that effective health communication can be achieved by using imagery & messages that conform to the norms of the society in question
- The imagery & message must be developed through a community effort ("bottom-up" approach)
- Address the group's specific need

The 'O' communication Model

- Depicts what community wants & how they want it (graphic presentation) in order to influence them positively
- Participatory process in nature & identifies health promotions as social issues to be discussed by all the stakeholders
- Involves community as a large circle within which other activities are built
- Acknowledges the community norms, literacy, as well as the overall indigenous identity

Conclusion and Recommendations

To develop community health communication materials that are attractive, acceptable & effective in our community:

- incorporate **community participation** at every stage of development
- ensure materials are **readable** & **comprehensible**, as determined by community members
- materials contain a threat element plus an attainable efficacy element
- the cultural vogue of the audience must be respected
- the graphic imagery must harmonise with the efficacy element rather than the threat element, with prominence being given to positive graphic imagery

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The End...

Thank you