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DECODING THE PUBLIC SERVICE ANNOUNCEMENTS of HIV/AIDS: EVALUATING
BOTSWANA's AIDS MESSAGES AND THEIR IMPACT ON 15 - 24 AGES

by

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A Dissertation

Submitted in Partial Fulfilment of the Requirements for the
Doctor of Philosophy Degree

College of Arts and Media
in the Graduate School
Southern Illinois University Carbondale
May 2023

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DISSERTATION APPROVAL

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BOTSWANA's AIDS MESSAGES AND THEIR IMPACT ON 15 - 24 AGES

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A Dissertation Submitted in Partial

Fulfilment of the Requirements

for the Degree of

Doctor of Philosophy

in the field of Mass Communication & Media Arts

Approved by:

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March 27, 2023

AN ABSTRACT OF THE DISSERTATION OF

Enole Ditsheko, for the Doctor of Philosophy Degree in Mass Communication & Media Arts, presented on **March 27, 2023**, at Southern Illinois University Carbondale

TITLE: DECODING THE PUBLIC SERVICE ANNOUNCEMENTS (PSAs) of HIV/AIDS: EVALUATING BOTSWANA'S AIDS MESSAGES AND THEIR IMPACT ON THE 15 to 24 AGES

MAJOR PROFESSOR: Professor William Freivogel

The study is grounded in the concept of “Start where the people are” (Nyswander, 1956) which suggests that effective health campaigns that promote prevention strategies to enhance the quality of life for those targeted must be rooted in the prevalent cultural practices and religious values of the receivers of the slogans, themes, and taglines. Health campaigns that superimpose the values of the outsiders promoted as universalized solutions have limited effectiveness.

Sub-Saharan Africa has only 1.3 billion people out of an estimated eight billion of which China and India each recording above two billion, cumulatively accounting for more than half of the world population. Yet sub-Saharan Africa is the epicenter of HIV infections with more than 68% (avert.org), or nearly 26 million out of almost 38 million people living with HIV, globally. This scenario demands that global citizens should foster effective collaborations to end human suffering. Among the ten nations in the world hardest hit by HIV, seven of them are in the southern African region where Botswana, in position three at 18.6% is trailing her next-door neighbors, Lesotho (20.9%) and Eswatini (formerly Swaziland) which leads the pack with 27.9% (UNAIDS Report 2022).

This study, therefore, focuses on children and adolescents between 15 and 24 in Botswana. According to a surveillance report (Botswana AIDS Impact Survey 2021) covering the period from March to August, adolescents and youths in Botswana are a source of concern. The report puts the national prevalence at 20.8% or 329,000 persons of the reproductive

population (15-49 ages) are living with HIV. This sobering picture is despite the free availability of treatment drugs at no cost since 2002, when Botswana became the first African nation to roll out antiretroviral treatment (HAART interchangeably called ARVs) that was adapted as *Masa* – ‘a ray of hope of a new dawn’ in 2002. Further, the continued increase in new HIV infections among people of ages 15 to 24 since 2010 is recorded amid major prevention campaigns sponsored through global health partnerships, translating into billions of U S dollars. Numerous HIV prevention strategies developed in the West using empirical data and technology include condom use, antiretroviral regimens known as pre-exposure prophylaxis (PrEP), and treatment as prevention popularized as undetectable equals untransmissible (U = U).

Social media channels like Facebook, TikTok, YouTube, Snapchat, and Instagram are awash with these HIV prevention strategies, and the adolescent population of Botswana consumes information about everything, including these HIV prevention campaigns. These mentioned strategies seem to provide effective barriers against the intrusion of HIV in the “key populations,” a United Nations preferred term to refer to members of the lesbian, gay, bisexual, transgender, queer and intravenous drug users (LGBTQI) communities in the Western nations. However, these strategies require major adjustments when launched in sub-Saharan Africa, this study’s results show, or they are the right message targeted to the wrong audience, mainly because of a lack of cultural representation in the nuanced taglines, headlines, slogans, and themes.

The study suggests that for HIV to be eliminated, participatory research and co-learning where Western science and technology on one hand, and African indigenous knowledge, on the other hand, can fuse in the design of strategies should be prioritized as an emergency.

Key terms: HIV Prevention. Culture. Religion. AIDS epidemic. Communication campaigns. AIDS Drugs. Condoms. Major Campaigns. Medical Circumcision. U = U. PrEP. Treatment as Prevention. Anthropological Studies. Beliefs. ABC Campaign. Key Populations. LGBTQI. HAART. ARV. STIs. STDs. Cultural Imperialism. Decolonial Theories. Decolonization. Content Analysis. Textual Analysis. Media Theories. Health Communication Theories. Globalization. Universality.

DEDICATION

To my dear wife, Wazha and our children (Mogolodi, Pholo, Linda-Joy and Bogolo) this degree is meant to improve the quality of life for all of us. Leaving a plum position in Government to uproot you and live on half the earnings might have been the toughest decision. But I made the move with you all in mind and it was a risk worth taking. We all know the biggest pie that mommy deserves from this degree – yes, she is rightly Mrs. Dr. Ditsheko! She kept the entire family together throughout the journey of four years, while we cruised smoothly in our scholastic pursuits. In all, your limitless support to complete this program in eight semesters is highly cherished. It is, therefore, proper that we all share this Doctor of Philosophy Degree!

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The completion of this rigorous program would not have been successful without the backing of many players who contributed psycho-social guidance, emotional support, and financial sponsorship. The generous fellowship received from Southern Illinois University Carbondale has been the central bedrock of the pursuit of my long-held ambition. The American taxpayers have funded my tuition across the four years I have been at this university, allowing me to focus on academic rigour while my family's welfare was maintained from the assistantship. I will forever be indebted to the American people, particularly, the southern Illinoisans. The College of Arts and Media has never failed me during hardships by doling out emergency scholarships through the SIU Foundation. Thank you for holding my hand.

After the roughest five hours of the general records examination, admission was not guaranteed without glowing references praising my abilities to handle doctoral studies. I am thankful to my undergraduate professors for supporting my application, unreservedly.

Two distinguished scholars in HIV prevention strategies deserve accolades because they set aside time during the preparatory stages to steer me in the right direction. Dr Sheila Dinotshe Tlou and Dr Bagele Chilisa, I cannot think of a greater way to describe patriotism. Thank you, my mentors, I will forever be grateful that you are in my circle.

The Chilisa clan has had significant contributions to the realization of this dream, from ideas to material support and emotional encouragement before my flight out, and throughout my studies. You are not just friends, but dependable ones qualified by "A friend in need, is a friend indeed" proverb.

Throughout my studies, the anchor of support to the general welfare of my family has been the family of Norm and Linda Yoder from Henderson, Nebraska where I lived as a 21-year-

old exchange trainee between 1994 and 1995. Over three decades of our friendship, our bonds have stretched far beyond friendship to treating one another as family. Words are beyond me to express gratitude to you, your children, and your grandchildren. Your genuine belief in me and trust are humbling.

The Government of Botswana has truly exemplified its will and commitment to end HIV/AIDS through its generous investment in my research study, and I am proud to be its citizen. The ministries of Health and Wellness and Education and Skills Development issued permits to access the selected 20 schools that were the study sites. Given the long distances between the districts piloting the PrEP prevention strategy from where I collected data, logistical arrangements would have been impossible without the benevolence from the National AIDS and Health Promotions Agency (NAHPA). Here is to a collaboration to end this nation's misery and anguish.

Many prayers and kind thoughts have been spared for me over the course of my program by friends near and far, and if I don't mention you by name, it is because you are very special to believe that this PhD was my destiny. Some of you went to lengths to source data from reliable think tanks all over the shore. Thank you for the optimism.

The dissertation committee held me by the hand to light up the pathway. In a special way, my chairman walked an extra mile to exhort me to go to the finish line whenever I felt overwhelmed. Prof. Freivogel, thank you is not enough. I knew nothing about quantitative research, so Dr. Ryoo, thank you for designing the online study and hosting it on Qualtrics. Fr. Brown, you have been the "go-to" person for confessions every time I felt the odds were stacked against me. Dr. Karan, your last-minute comprehensive feedback has given the paper depth. Dr. Myrick, resting in the assurance that I was in the great company of a renowned health

communication expert was priceless. Prof. Thompson, your respect for graduate students as offering something to teach professors makes you the rare kind.

Let me acknowledge the powerful women who shaped me into the resilient person I am. I have been immensely blessed to be born into a family of matriarchs, from my recently departed grandmother, mother, sisters, and aunts, African feminists in their own rights and carers and nurturers of HIV/AIDS patients who succumbed to the condition across three decades. I have counted every finger on both hands to represent the losses suffered by the family between 1993 and 2019. I have always been cared for by big sisters who saw me as the leading light. They put their lives on hold for my success. There is no doubt that I owe every accomplishment to these women. Glory be to God for matching me up in heaven with another amazing woman, Wazha.

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TABLE OF CONTENTS

<u>CHAPTER</u>	<u>PAGE</u>
ABSTRACT.....	i
DEDICATION.....	iv
ACKNOWLEDGMENTS.....	v
LIST OF TABLES.....	x
LIST OF FIGURES.....	xii
CHAPTERS	
CHAPTER 1 – INTRODUCTION TO THE STUDY	1
CHAPTER 2 – LITERATURE REVIEW.....	15
Health Communication Theories in International Advertising....	15
Relevant Texts.....	25
CHAPTER 3 – RESEARCH METHODS.....	41
CHAPTER 4 – DATA ANALYSIS.....	54
CHAPTER 5 – DISCUSSION OF STUDY.....	78
CHAPTER 6 – CONCLUSION OF STUDY.....	94
Implications of Study	103
Limitations of Study.....	142
Recommendations of Study.....	143
REFERENCES.....	148
APPENDICES.....	154
APPENDIX A – PMTCT CAMPAIGN.....	154
APPENDIX B – ABC CAMPAIGN.....	155

APPENDIX C – ABC CAMPAIGN.....	156
APPENDIX D – MEDICAL CIRCUMCISION CAMPAIGN.....	157
APPENDIX E – PrEP CAMPAIGN.....	158
APPENDIX F – TasP CAMPAIGN.....	160
APPENDIX G – BOTSWANA IRB APPROVAL.....	161
APPENDIX H – SIUC IRB APPROVAL.....	163
VITA.....	165

LIST OF TABLES

<u>TABLE</u>	<u>PAGE</u>
TABLE 1 Demographic Metrics of the Participants.....	56
TABLE 2 Familiarity with full-blown AIDS Patients.....	57
TABLE 3 Extent of Concern about AIDS.....	58
TABLE 3.1 Justification for Level of Concern.....	59
TABLE 4 HIV Prevention Campaign Awareness.....	60
TABLE 5 Major HIV Prevention Campaigns in the Media.....	61
TABLE 6 Likely HIV Strategies among Youths.....	62
TABLE 7 Preferred Use for AIDS Drugs.....	63
TABLE 8 Ads for AIDS Drugs as Preventatives.....	64
TABLE 8.1 Taglines from Drug Commercials.....	64
TABLE 9 Clear and Plain Content in Drug Ads for Prevention.....	65
TABLE 10 Media Exposure on HIV Prevention Slogans.....	66
TABLE 11 Role-playing Drug Ads for Prevention.....	67
TABLE 11.1 Association and/or Disassociation from Models.....	68
TABLE 12 Mirroring Local Environment in AIDS Drug Commercials.....	69
TABLE 13 Age, Religion and Culture in Messaging Prevention.....	71
TABLE 13.1 Slogans Suited for Adolescents and Youths.....	72
TABLE 14 Effective Strategy to Eliminate AIDS.....	73
TABLE 15 Availability of AIDS Information across Mass Media Channels.....	74
TABLE 15.1 Ideas on Best Channels to Spread HIV Prevention Messages.....	75
TABLE 16 Radio Jingle about Medical Circumcision as a Prevention.....	76

TABLE 17 Impact of Taglines for Behavior-Change.....77

LIST OF FIGURES

<u>FIGURE</u>	<u>PAGE</u>
FIGURE 1 Encoding and Decoding the Message.....	19
FIGURE 2 Two-Way Communication.....	22
FIGURE 3 Information to Impact Behavior.....	38
FIGURE 4 Sender-Channel-Receiver Process in Communication.....	124

CHAPTER 1

INTRODUCTION TO THE STUDY

Botswana is a multi-party democracy, landlocked country with a mass almost the size of the state of Texas and a climate similar to Arizona (the Kalahari Desert occupies about two-thirds of the surface). Its people are Batswana. The country is found in the southern tip of Africa, sharing its borders with Zambia in the north, South Africa, Namibia in the west, and Zimbabwe in the east. According to the UNAIDS Report 2022, the region has seven out of the ten countries in the world hit hardest by the high prevalence of double-digit HIV rates, and Botswana's 18.6% infection rate is the third highest worldwide, trailing Lesotho (20.9%) and Eswatini (formerly Swaziland at 27.9%) while South Africa at 18.3% trails Botswana. The rest of the southern African nations in the red include Namibia, Zimbabwe and Zambia, each recording a range between 10.8% and 27.9% placing them among "high burden, and severe HIV epidemic". The remainders are Kenya, Mozambique, Malawi, and the Democratic Republic of Congo—all these are found in sub-Saharan Africa.

Botswana is a predominantly African Protestant Christian nation with more than half of the population subscribing to Judeo-Christian practices, one-third practicing African traditional religion whose leaders the "Western emissaries" have labeled "witchdoctors" and one-fifth representing different faiths (Islam, Bahai, Buddhism, Hinduism, and Sikh).

Health campaigns are messages meant to influence attitudes and behaviors in target audiences, usually for products meant to promote the enjoyment of a higher quality of life than consumers would have without the advertised products and services. Public Service Announcements (PSAs), therefore, are a form of campaign. They are effective if they achieve behavioral change that transitions from the familiar to the new and desirable culture that is

sponsored in the ads. Change and communication experts ask crucial questions about the message in a campaign before it is placed.

Thus, this study focuses on the PSAs that Botswana has promoted between 2002 and 2023 to prevent further transmissions of Human Immuno-deficiency Virus (HIV that causes Acquired Immuno-Deficiency Syndrome (AIDS)). Mainly, these strategies are prevention of mother-to-child transmission (PMTCT), abstain, be faithful, or use a condom (ABC), treatment as prevention (TasP) interchangeably called undetectable equals untransmissible (U = U), pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), and lastly, safe medical circumcision (SMC), all of which will be discussed in detail including visuals and taglines that accompany each campaign.

AIDS is a global epidemic and the worst health challenge in sub-Saharan Africa in contemporary history. By the end of 2021, over 26 million HIV-positive people (or 68%) were from sub-Saharan Africa, 38.4 million people worldwide were living with HIV. Another 1.5 million contracted new HIV infections, and more than 0.65 million died from AIDS-related complications, globally within the same period (UNAIDS Report 2022 “AIDS by the Numbers”).

Hence a review of the PSAs about preventing a health catastrophe is the essence of this research project. Since Botswana is the setting of this research study, it is worth situating the project on what scholars in HIV-prevention have done in the past and critically look at strategies that have been thrust wholesale on Botswana from the West.

Ntseane and Preece in their article “Why HIV/AIDS prevention strategies Fail in Botswana: Considering Discourses of Sexuality” (2005) underscore the feminization of HIV

prevention messaging by the West as a disempowerment tool that alienates men from supporting women and fulfilling their roles as protectors and providers.

Across the border in South Africa, Segopolo and Tomaseli (2017) buttress Ntseane and Preece's assertion regarding HIV prevention strategies that exclude men in the advancement of women's progress to embrace the ABC campaign in the "I will not share my Partner" discussed in the article. Such a campaign boldly projected on the campus of the Kwa-Zulu University in South Africa is devoid of consideration for the prevalent polygamous setting, where women are treated as subservient in the pecking order. It is a proclamation reminiscent of a rights-based Western feminist who is emancipated. Is this (dis)-empowerment program a universal message to prevent HIV in sub-Saharan Africa where thousands of females die at the hands of their jealous lovers, thousands more are maimed permanently because males see campaigns to pit them against each other?

Therefore, where HIV prevention is concerned, Ntseane (2015) is sounding a horn that in conservative societies like Botswana, it defeats the purpose to isolate women in the guise of empowering them to insist on their male partners wearing condoms and remaining faithful in monogamous liaisons so long as these interventions leave out the men. Perhaps the failure of Western campaigns explains why all 10 nations hit hardest by HIV are in sub-Saharan Africa where the place of men and women is predetermined at birth by the socio-political systems that marginalize females.

In "Theorizing African Feminism – the Colonial Question" (2006), Pinkie Mekgwe debunks the Western empowerment program in these words: "African women's writing...mainly set out to dispel mal-representations of African womanhood...it sought to demonstrate that they

were relevant to the African context and in particular that they did not simply seek to emulate their Western feminist counterparts,” (p. 13).

Further, Bagele Chilisa in her article “Educational Research Within Post-Colonial Africa: A Critique of HIV/AIDS in Botswana” (2005), decries the universality in HIV prevention strategies that do not respect the practices and beliefs of the host countries where Western-centric messages are launched with no or little adaptations, save to translate to local languages, while carrying the import of themes that are dominant in European cultures.

Further, Tlou and Phaladze (2006) lament the inequalities that exist between males and females in Botswana that skew bias against women being infected with HIV worse than their partners. They identify poverty as a major contributor to fueling the spread of the virus, and that to ignore it in drumming up prevention campaigns is to lose touch with the reality of sub-Saharan African women whose challenges are in no way closer to what Western women deal with daily.

Africa’s most lauded champion of the HIV/AIDS war, and Botswana’s former president (1998-2008) Festus Mogae when appealing to the world community, used the following descriptions: “We are threatened with extinction. People are dying in chillingly high numbers. It is a crisis of the first magnitude,” (*Los Angeles Times*, 2001).

The adolescents and youth populations (ages 15 to 24) are the hardest hit by HIV, says a surveillance report (Botswana AIDS Impact Survey V Report 2021). This sobering picture is despite the free availability of condoms and prevention drugs since 2002 when Botswana became the first African nation to roll out antiretroviral treatment to HIV-positive sufferers. Further, these new infections are amid major campaigns bankrolled using the global health partnerships that the Government of Botswana fostered with Western biotech giants, philanthropic foundations and research institutes seeking a lasting solution to AIDS. These major campaigns

have seen joint ventures of public-private partnerships that include but are not limited to the Bill and Melinda Gates Foundation and Merck and Co., Bristol Myers-Squibb Foundation, United States President's Emergency Plan for AIDS Relief, Global Fund to Fight AIDS, UNAIDS, Harvard, University of Pennsylvania, Johns Hopkins University, and the University of Maryland, all who left a footprint in Botswana's fight against AIDS at one time or another.

For HIV-positive women planning to give birth to HIV-free new-borns, PMTCT has given them a ray of hope. Couples living with HIV and in relationships where their partners are negative have relied on TasP to exercise their rights to procreate. Moreover, PrEP has become fashionable among adolescents and youths as a high-risk population who tested negative but are sexually active. It is accessible through public schools. Meanwhile, the ABC campaign was ramped up in schools with a significant focus on the proper use of condoms by teenagers much to the chagrin of parents who felt family values were corrupted by introducing sex to their "impressionable" children who were being asked to believe in a man-made latex.

Condoms, which have traditionally been marketed for heterosexual couples, have now provided a barrier for men who have sex with men (MSM), a phenomenon that is frowned upon but which came to light in the last decade when more young men in urban centers came out of the closet to declare they were gay. During the same period, 'straight' young men have shown an increasing appetite in SMC to provide them guaranteed protection against HIV while enjoying the bliss of unprotected sex with HIV-positive female partners.

HIV prevention strategies developed in the West, including antiretroviral regimens known as PrEP used by people with high-risk behaviors to stay negative, U = U among those living with HIV to reach a stage where their blood samples test negative, and condoms all seem to provide effective barriers against the intrusion of HIV in the key populations, which is where

the epidemic is concentrated in the West which is sometimes referred to as the Global North. However, these clinically backed-up interventions might require major adjustments when launched in sub-Saharan Africa before they can be hailed for the same success to impact mainstream populations where the disease is concentrated unlike in the developed nations.

The key populations are moved to the head of the table as the central focus for chief campaigners in major HIV strategies, who take evidence supported by empirical science in the efficacy of the medicines that can block the transmission of the virus from an infected person to an uninfected partner whenever exposure occurs and attempt to shape campaigns to fit this evidence.

Botswana is a signatory to the “United Nations 2021 Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030,” which exhorts sub-Saharan Africa to design deliberate strategies to highlight “key populations” as central players to influence the end of AIDS. Freeman (2020) in a news article headlined “Gilead says ‘Step up for PrEP’ in Descovy’s first HIV Prevention Campaign” shows how they have creatively come up with the under-represented people to push forward the message of preventing HIV because of how, traditionally, they were pushed to the margins of society because of their association to AIDS.

Placing minorities in the lead in the prevention of HIV is a conscious step to include these marginalized people and to give them the confidence to step out of the closet, which is, commendable. No one should be discriminated against—neither stigmatized nor denied medicines that could save them from the debilitating conditions caused by AIDS.

HIV-positive people used to be depicted as living on borrowed time with no chance of survival because of opportunistic diseases that would kill them. Eventually, the news article

headlined “Graphic HIV/AIDS Horrifies Gay Community” (2020) would encapsulate the fear-arousal advertising by the New York Health Department.

In their paper “Can Fear Arousal in Public Health Campaigns Contribute to the Decline of HIV Prevalence?” (Green & Witte 2006) persuasively show that while American health professionals no longer support the use of fear incitement in HIV prevention, because they learned of its counterproductive effects, under the global health partnerships in Botswana and the rest of sub-Saharan Africa, the ABC campaign capitalized on arousing fear to change sexual behaviors of the African populations in associated slogans. By in large, the ABC was too preachy in its promotion of abstinence and monogamous relationships so much the messaging condemned those who ended up HIV-positive as having chosen their destiny.

Sub-Saharan Africa is expected to push to the head of the table these key populations in HIV prevention messaging across cultural and religious spaces dominated by heterosexuals in the transmission of the virus, despite the WHO bulletin published in August 2002 that claimed that “more than 99 percent of HIV infections in sub-Saharan Africa were attributable to ‘unsafe sex’...” in the heterosexual population (Flint & Hewitt, 2015 “Colonial Tropes and HIV/AIDS in Africa”).

Therefore, this study seeks to test the effectiveness of these hailed strategies when they are uprooted to Africa and launched with the expectation to leave a lasting impact in mainstream society—do they make a persuasive case? This “effective” HIV prevention approach: arguably mirrors the AIDS situation in the Global North, yet it is expected to eliminate transmissions that have spiraled out of control among the adolescents and youth populations in Botswana since 2010 with annual 13,000-plus new cases of HIV averaging 4% out of the national HIV

population. Behind these whopping numbers are the faces of our children, siblings, nephews, and nieces whose future hangs by a thread unless proper messaging takes place sooner than later.

The online study I created and launched on Qualtrics contains 22 questions measuring the knowledge about HIV prevention that males and females aged between 15 and 24 in Botswana have and how this information translates into positive sexual behaviors to eliminate the transmission of the virus that causes AIDS. The urban and rural centers were covered to determine where the disease is concentrated and whether economic or social elements might be contributing to the rise in the new cases of HIV across Botswana. The capital, Gaborone, peri-urban Molepolole, and rural villages of Kanye, Serowe and Bobonong served as the study sites in July 2022.

The results from this study reveal that the vast majority of the 15 to 24 age population in Botswana have displayed a high knowledge of preventing HIV and overwhelmingly affirmed having been exposed to major campaigns where HIV interventions are circulated for their daily consumption from credible sources, including social media platforms such as Facebook, YouTube, SnapChat and WhatsApp. But the study also found many respondents were offended by the lack of representation of their backgrounds in the ads and infomercials meant to benefit them with HIV prevention information.

This study about communicating HIV/AIDS prevention campaigns finds credence in the model espoused by an American health educator, Dorothy Bird Nyswander, who said, “Start where the people are” (1956), meaning that strategies should be coined from within, designed with the local people’s involvement, and launched using their familiar channels of communication.

Take, for example, the success rate that an AIDS doctor in New York had, which were career experiences that he was taking with him to Botswana in 2002 to reverse the tide by relying on the familiar health theories to fit a distinct group of people identified by a physical place different from New York. Baxter (2018) enjoyed a decade-long phenomenal success keeping his patients on Truvada as one of the triple-drug therapy combinations to allow his HIV-positive patients to enjoy a high-quality life. This treatment became popular among at-risk populations and those who might have been exposed to contracting HIV in the initial 72 hours to stay negative.

The lived experiences of Daniel Baxter, an AIDS doctor at Ryan Health in New York City who worked with key populations and significantly eliminated the HIV burden among his patients were mostly needed by Botswana. In 2002, Baxter was hailed an HIV “messiah,” in Botswana. Almost immediately, he came face-to-face with the menace of African AIDS that debunked the universality themes in addressing AIDS as an epidemic with the exact same responses to counter its effects. Baxter, while in Botswana, where he remained for nine years, Baxter learned these strategies were failing. He applied common strategies of condoms and AIDS drugs to curb further transmissions of HIV among HIV-positive patients, including prescribing condoms for anal sex, only to be dismissed as promoting a “Western disorder that is not present in Botswana,” (2018, p. 65) during a *kitso* training session.

Hence, the universality of HIV prevention strategies has become the sobering experience recorded in *One Life at a Time: An American Doctor's Memoir of AIDS in Botswana* (Baxter, 2018). This text is the primary source for the research study on AIDS in Botswana and sub-Saharan Africa in general concerning the roles played by cultural institutions and religious

centers as integral components in target campaigns for specific populations to influence positive behaviors to reduce new infections.

Given the cultural practices and religious customs that are central to the regulation of sexual relationships and behaviors in the sub-Saharan African context, before these Western-centric strategies can be lauded as universal, focus on dominant values and widespread mores should guide the theoretical frameworks in health communication to address these beliefs and to influence positive change in behaviors before adopting the strategies to end AIDS by 2030.

The people who are in a specific geographic expression with unique cultural, religious, and social experiences make sense of health and its associated meanings based on the surrounding as elaborately explained by Kevin Bradley Wright et al. who write that “The term health is a complicated concept to define, due to multiple interpretations based on individual experience and culture,” (2012, p. 3).

Several studies situating culture at the center of AIDS prevention have been undertaken. Scholars including Green and Ruark (2006), Elizabeth Onjoro Meassic (2018), and Airhihenbuwa and Obregon (2000) spring to mind as advocates against cultural imperialism. For instance, culture is foregrounded as effective in risk avoidance rather than in a campaign promoting a risk-reduction approach in HIV prevention according to *AIDS, Behavior, and Culture: Understanding Evidence-Based Prevention* (Green & Ruark: 2011).

Meanwhile, Meassick (2008), as a medical anthropologist is interested in participatory research projects where African societies’ input regarding what they have identified as their needs to address HIV are taken onboard to produce effective strategies. Meassick (2008), denounces universal HIV prevention strategies and makes a convincing case to recognize African institutions of culture as integral in shaping such messages. She declares early on:

I want to convey my sense of how urgent it is today to work toward a dialogue that moves beyond opinion and personal agendas, toward a course based on what different people understand to be their true needs and reflecting what works and does not work to prevent HIV/AIDS.” (2008, p. 170)

Similarly, Airhihenbuwa and Obregon (2000) lament the absence of African cultures in designing and implementing HIV prevention strategies using Western-centric health communication models that disrespect the prevalent customs. Care should be taken that these powerhouses are anthropological scholars and not in the field of communications, and as such, their contributions to HIV prevention are on-point to foreground culture as critical in conceptualizing these taglines and implementing them for effective impact.

Still, none of these studies have reviewed the efficacy of HIV prevention strategies by comparing the AIDS situations in the Global North and in sub-Saharan Africa against the backdrop of major campaigns to contrast appropriate taglines and phrases suited to the prevention messaging. By closely analyzing the major campaigns that seem to falter after 20 years against the war waged by AIDS upon the youth population in Botswana, the need to place these major campaigns against the backdrop of culture is not just important, but rather necessary given the staggering numbers of new HIV cases recorded annually.

Comparatively, across the same period in the United States, the incidence rates have dwindled steadily, resulting in a national prevalence of 0.36% (CDC: 2021), implying that messages are tailored for homogenous audiences, members of the LGBTQI communities can resonate with the HIV/AIDS major campaigns, and the audiences can retain the slogans and positively influence behavior change. The exact same messages are what have been universalized to achieve similar results in Botswana and the rest of Africa.

Riding on the great works of these anthropologists who place a premium on culture as a central component in HIV prevention, this study expands the scope by assessing how widespread the knowledge about major campaigns from the West reach these societies, which channels of information are easiest to access, and which motifs are employed for clear, crisp, and plain messages for lasting impact and a positive change of behavior.

No study has had its objective to compare the AIDS situations of the developed nations against what is common in sub-Saharan Africa about coining prevention slogans. Hence, it remains important that more work in intercultural communication for HIV prevention should be undertaken to stem the tide of the disease infecting millions of Africa's populations including 330,000 HIV-positive Botswana citizens.

Thus, this research study recognizes the fact that, where HIV prevention is concerned, the universal strategies promoting "one-size-fits-all" solutions do not appeal to homogenous audiences if they do not take into consideration peculiarities prevalent in different geographic settings. How HIV is transmitted, and the population demographics among which it is concentrated, calls for tailor-made messaging to target homogenous rather than heterogeneous audiences if a lasting impact should be felt in reversing the tide in Botswana and, to a large extent, sub-Saharan Africa.

Therefore, it is the crux of this study that an effective HIV prevention campaign that can significantly reduce the effects of, if not eliminate AIDS on sub-Saharan Africa's populations should be grounded on intercultural communication techniques (as discussed by Samovar & Porter, 1972) that crystallize the need and relevance of paying close attention to the cultures receiving benevolence wrapped in the guise of health promotions developed in the West with the intention to save lives or secure the posterity of the African people. The importance of probing to

know what works best for the receivers of such communication, and how synergies between equal partners can be created for the message's efficacy for behavioral change cannot be overstated.

Given the background explained about the two AIDS epidemics broken down into geographic locations due to the prevalent lifestyles among those living with HIV, there is a need to open new ways for such modifications in HIV prevention strategies that resonate with the cultural and religious realities of sub-Saharan Africa. Particularly important is to focus attention on the ages 15 to 24 with the view to:

RQ1. Review all AIDS campaigns and determine whether there is a correlation between the availability of HIV prevention information and the increasing rates of new infections among the 15 to 24 age population in Botswana.

RQ2. Test the suitability and appropriateness of the campaign content to determine whether HIV prevention strategies resonate with the cultural and religious contexts of the target audiences.

RQ3. Determine the effectiveness of the channels of communication where campaign messages are placed for accessibility to the target audience.

RQ4. Gauge the level of knowledge the target audience has about HIV prevention campaigns to influence sexual behaviors that prevent and/or expose them to HIV.

Therefore, the study sampled 247 online participants to show their level of understanding of life-saving messages by reviewing HIV prevention campaigns and taglines to determine individual abilities to interpret the messages and embed them into behavioral practices that can protect them against the disease. Their responsiveness to the questions probing the level of

comprehension also reveals the suitable communication platforms that these young people prefer and the frequencies by which content played across the mass media channels can penetrate their psyche to impact positive sexual behaviors.

Unless African scientists, medical anthropologists, and health communication scholars pay attention to the dominant cultural and religious realities of Africa to prevent HIV, the grand goal of eliminating AIDS by 2030 as envisioned in the third United Nations Sustainable Development Goal is likely to fail badly in sub-Saharan Africa. Against this backdrop, the hypotheses tested by this study are outlined below:

H1. The extent of concern about HIV/AIDS is significantly and positively related to the effective and/or impactful level of awareness in preventing HIV among the 15 to 24 age population in Botswana.

H2. The extent of clarity in eliminating the spread of HIV/AIDS as regards prevention messages is significantly and positively related to an effective and/or impactful level of awareness in preventing HIV among the youths in Botswana.

H3. Accessibility of information across mass media channels is significantly and positively related to an effective and/or impactful level of awareness among the youths in Botswana.

H4. The extent of advertisement content whether informative or ambiguous is significantly and positively related to an effective level of awareness among Botswana's youth.

CHAPTER 2

LITERATURE REVIEW

The review of these campaigns assumes that the dominant health communication theories are universalized, and therefore, can fit into how adolescents and youths in Botswana hear messages, decipher jingles, and understand promotions across mass media channels. Therefore, these prevention strategies to curb HIV as they appear in the ads are retained in their brains, and the youths translate the slogans into positive behaviors to prove the effectiveness of social psychology models easily understood in Western populations affected by the AIDS epidemic.

Health Communication Theories in International Advertising

In this study, the social science theories that are commonly used in health communication campaigns, chiefly, the *Health Belief Model* (Becker, 1974), the *Social Cognitive Theory* (Bandura, 1986) and lastly, the *Knowledge Gap Theory* (Tichenor, Donohue & Olien, 1970) are assessed to support the position that messages travel in a linear direction from the source to the channel and then to the target audience, resulting in the desired impact of behavioral change necessary to eliminate new infections of HIV.

To better grasp the disproportionate imbalances in the rates of HIV between the peoples of the Global North (Western nations) and sub-Saharan Africa, this study seeks to assess general premises or propositions against cultural and religious practices to determine how different cognitive theories commonly used in health communication account for levels of prevalent perceptions among a distinct people to be good indicators to determine the outcome of behaviors in HIV prevention communication campaigns.

HIV prevention campaigns in sub-Saharan Africa are accompanied by these social psychology theories that lend themselves to positive exploitation in designing appropriate

vehicles through which life-saving messages can reach the targeted audiences and influence desired behaviors. These social psychology theories are described as ‘cognitive’ because the decoding of the slogans and taglines takes place in the brains of the listeners (radio jingles), readers (print media advertisements), and viewers (television commercials), promoting specific health messaging to earn a higher quality of life that otherwise is ruined if the target audiences ignore the content.

These cognitive theories work best in health communication because they consider how the receivers of useful information will likely process and decode the message, given adequate attention paid to their beliefs in the campaign. After all, the language employed in the advertisements is assumed to be accessible, precise, and plain after being tested over and over, and it is assumed to incentivize the action required on the audience’s part for behavior change to happen. Experts postulate that the theoretical frameworks are adjustable to suit unique people from a certain region in a specific way that is different from the next group in a totally different region regarding the same disease.

The *health belief model* explains why there might be different reactions to a health campaign that seeks compliance with certain prevention protocols, and it argues that the perceptions of reality that individuals have about the disease that influence their behaviors. People are constantly weighing advantages and disadvantages, risks against benefits, opportunities, or threats in a health message, all as variables that suggest to them how close or far they are from danger. If the people being targeted in the campaign hold the view that they may catch the illness if they do not act, then they are likely to take a step in the way the campaign is influencing behavior and the reverse would happen if they were convinced that the likelihood is low. G. M. Hochbaum (1958) explains that:

The combination of perceived susceptibility and seriousness is termed a perceived threat. The perceived threat has a cognitive component and is influenced by information. It creates pressure to act but does not determine how the person will act. That is influenced by the balance between the perceived efficacy and cost of alternative courses of action...the beliefs will reflect social and cultural influences. (2)

Particularly critical in the application of these cognitive theories is how communication reinforces the level of understanding that the local people have about the disease or debunks their knowledge to influence a new comprehension that they are comfortably willing to accept and to adjust their habits. Outbreaks by nature, whether they originate from within or without, appeal to the senses of the local environment for common awareness and understanding to position the individuals to tackle it using available resources and practical solutions. The possession of knowledge that those targeted in health messaging can change their behavior to favor the uptake of services and products being marketed in the campaign, therefore, means abandoning the familiar behavior to improve their quality of life after weighing the risks against the benefits in order for them to embrace the new lifestyle.

The *social cognitive theory* (SCT) on the other hand, boasts its greatest strength in observation, to hear and make sense of the activity on display before the brain tells the heart what to do—either accepting or rejecting what the eyes or ears encountered in the campaign. Hence it also recognizes people's lived experiences and their physical environments as critical elements in influencing desired behaviors while observing the rewards that may accrue to the people if there was a shift to embrace a new order and conduct. Because campaigns are assigned a period during which they run before outcomes in behaviors can show, they usually set their

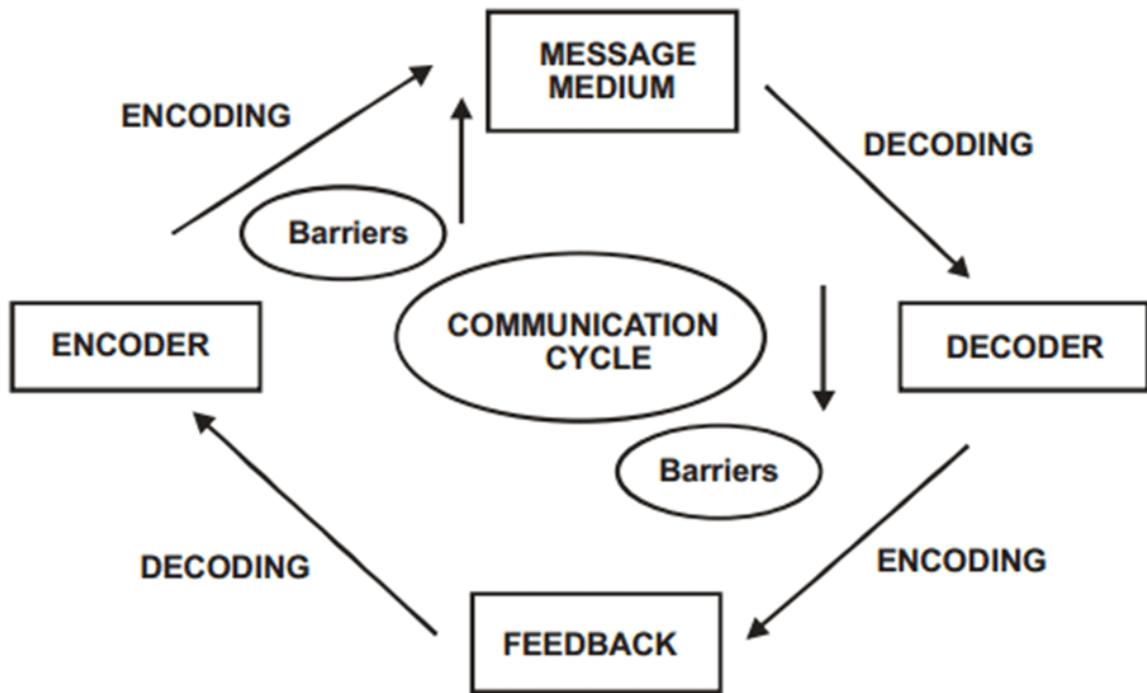
goals and objectives clearly right at the beginning, because a positive change in conduct is the cornerstone of successful campaigns.

Hence the triangulation of SCT appeals to personal cognitive factors, and socio-environmental factors acting together to affect behavioral outcomes in the target population. At the personal level, the cognitive influences result in “self-efficacy,” “outcome expectations,” and “knowledge” (Glanz, Rimer & Viswanath, 2015) about the behavior being promoted in a campaign, while the socio-environmental factor refers to the cultural beliefs and level of acceptability if certain roles were played by certain individuals as opposed to others, and lastly, a behavioral factor is the action individuals are required to adopt once they have observed the campaign. Because SCT appeals to the brain cells to break down information, “self-efficacy is an internal mental process...defined by a person’s level of confidence in his capability to control behavior...people select tasks and activities in which they feel competent,” (p. 162) but also consider the sender and channel of the behavior message to predict its likely outcome, “either positive or negative (e.g., pleasure, pain, or change in disease symptoms)” (p. 165).

The assumption that HIV is transmitted in the same way across diverse age groups might catch some targets and leave out others in a campaign designed for heterogeneous audiences instead of a homogenous audience that decodes the nuances and lexical content meant for their age or gender, even if the topic is AIDS. This is one sure way of determining cognitive theories and their suitability for health promotions. Leslie B. Snyder (“Health Communication Campaigns and Their Impact on Behavior,” 2007) crystalizes this point in the following words:

“The justification for targeting is that messages crafted to be successful with a homogenous group are more likely to have an impact on that group than messages designed for a heterogeneous population with varied concerns, values, and behaviors,” (S35).

Therefore, campaigns targeting general audiences are not the best when it comes to influencing positive behavior because of variables such as gender, age, level of education, ethnicity, religious convictions, and so forth. Snyder (2007) reinforces the need for appealing to the cognitive abilities of the targeted audience by removing possible ‘noise’ accompanying the encoded message from the ‘sender’ via a channel or platform where it is launched to be decoded by the receiver on the other side, before returning the feedback in a changed and positive behavior as illustrated in **Figure 1** below is “Encoding and Decoding the Message”.



Campaign designers should consider targeting by behavior, actual and perceived risk, misinformation and beliefs, environmental barriers, and communication patterns because these factors affect the nature of the messages produced for the campaign and the ways to communicate them. If the population has been grouped by how close they are to changing their behavior (unaware of the behavior, contemplating changing it, made a decision to change it,

trying it, and maintaining it), then the campaign goal can be to help each group move to the next stage, and messages can be designed accordingly. (Snyder, S35).

Hence, our interactions with the environment and people familiar to us, shape our cognitive abilities and affect individual behaviors regarding the disease and its ramifications because “humans are social beings, and the power of social connections to influence health is one of the most pervasive, consistent findings in the public health literature,” according to Glanz et al., (p. 150). AIDS is a health risk but one that is understood differently, as demonstrated in the introduction of this study, and how one group of people perceives the degree of risk to life is indeed the perception that these social sciences theories are based on. Glanz et al. expound on the familiarity with the environment and people in the following passage:

Transportation may encourage consumers of messages to identify with characters, may reduce counterarguments, and may provide vivid exemplars for the real world, thus leading to behavior change. While the theory of narratives does not replace SCT’s hypothesis about observational learning, it offers a greater elaboration of how observation may work and delineates mechanisms that lead to behavior change. (p. 152)

In short, people should buy into the prevention campaign for behavioral change by identifying with those characters’ role-playing life-saving messages to bring the reality closer to home to affect individual and social change “because sources of self-efficacy include personal experiences, persuasion and vicarious experiences learned from observing others, or modeling” (Glanz et al., 2015, p. 152). Otherwise the campaign seems far-fetched and fictitious, and to believe it may have an impact in real life situations. Unless those being targeted by the campaign are incentivized to see the old behaviors as dangerous and self-destructive, the campaigns that do not employ familiar faces and environments to influence behavior change do not appeal to the

cognitive senses of those listening or watching the performances, and as such, it is difficult if not impossible to sell them the new campaigns that force them to abandon their old habits.

Snyder (2007) elaborates on the need to be intentional with the selection of the communication strategy by choosing:

Activities and channels to be used in a way to reach a high percentage of the target population multiple times in a given period of time...The number of times a person is reached by a campaign is called frequency, and greater frequency of exposure may help people remember the campaign messages more accurately. Using multiple communication channels may also increase the frequency of exposure to campaign messages when people see the messages across different channels. (S36)

Because campaigns should make sense to those they are targeting, such health communication taglines must be coined in ways that these people located in a particular region and with unique cultural practices, nuances, and religious beliefs as well as educational levels, are brought to a standard where they can see the suggested themes mirroring their everyday experiences. The lack of understanding of such important messages as avoiding the spread of HIV might be due to an exotic value system in the characters role-playing the central message or the language that is not decoded to send a clear message because it was not constructed in the local environment using dialects and nuances that are prevalent. See the next figure for emphasis.

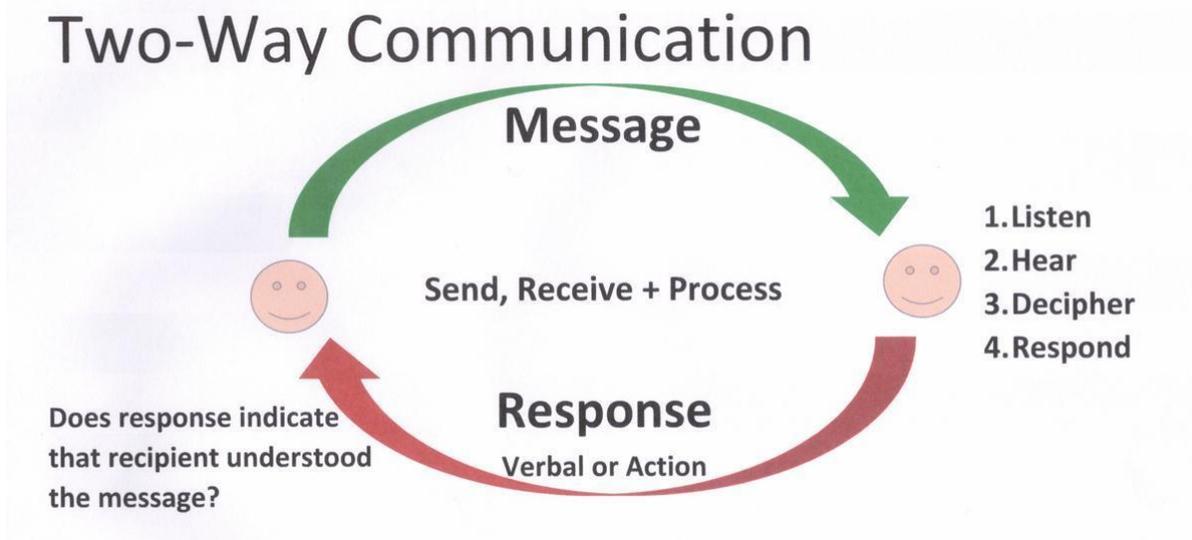


Figure 2 “Two-Way Communication”

Either way, this phenomenon manifests as the *knowledge gap theory* whereby useful information leaves out a good chunk of its targeted audiences due to unfamiliar communication tools being preferred in the place of local techniques. Snyder (2007) breaks it down this way: “However, people do not always act on what they know—a phenomenon known as the knowledge gap or the communication effects gap—so even when campaigns include knowledge, awareness, or belief change goals, they should also include behavior goals,” (S34).

Brent D. Ruben in “Communication Theory and Health Communication Practice: The More Things Change, the More They Stay the Same” (2016), wades into the crosshair that is the cognitive theory, arguing that it is central to recognize that individuals make sense of what appeals to them, while anything that achieves the opposite is not their concern to engage their minds. Ruben (2016) remarks that daily:

An individual is being bombarded with various messages that compete for that individual’s attention. When applied to health communication, this means that communication outcomes are not easily shaped or controlled by message senders, but

rather are more fundamentally guided by the predispositions and the ‘susceptibilities and take-into-accountabilities’ of the receivers. (p. 3-4)

It should be simple to note that these social psychology theories are relying on the mental experience of everyone to come up with a picture of what is being described to them at that particular moment, and if it sounds like something the person had encountered, perhaps once in life but retained in the brain, the campaign might just rekindle that image of love or hate to be accepted or rejected immediately. The dynamics of who comes up with the message, what vehicle they are using to launch it for impact, and whom they have selected to lead the activities that influence behavior are all necessary and critical in health promotion because, as lucidly explained by Nova Corcoran (2007), communication is “content and relationship” (6).

Ruben (2016) makes no room for ambiguity in health campaigns because they offer a life-or-death choice to be made by the one receiving the message. It is the primary role of this research study to ensure that all HIV prevention campaigns in Botswana are clear and specific and have their target audiences defined by streamlining content in the language and nuances that resonate with the demographics being addressed. As stated already, further research into the cultural, political, and social contexts of the ways in which AIDS is understood and tackled would have allowed someone in Geneva or New York to let the local experts decide on the tools of information dissemination in their dialects and local languages to embrace the science and technology behind the prevention and treatment of the epidemic. Ruben (2016) sums this concept up in these few words:

In many respects, health communication interactions are most appropriately viewed as cross-cultural encounters. When traveling to a foreign country where the language, monetary system, and geography are unfamiliar, there is no mistaking the fact that one is

engaged in an intercultural experience that requires careful observation, listening, and care in translation. (p. 5)

He concludes his discussion of health communication theories with candidly bullet points summarizing the complexity of influencing positive behaviors through campaigns, which is much worse when such health promotions are carried out by outsiders who have no clue about the local environment and its varied rhythms and heartbeats. Ruben makes a distinction between a “clear and compelling message” (2016, p. 7) and the actual transformation from old habits to newer behaviors contained in the campaign. Furthermore, he demonstrates that acquiring knowledge from the campaign is not synonymous with behavior change, which is known as the *Knowledge Gap Theory*.

Critiquing social psychology theories discussed earlier in this chapter, the *social cognitive theory* has significantly contributed to the framework used in anchoring this study because of its intersection with the culture of a unique society to target different populations. Therefore, I place culture at the intersection of source, sender, and content as the best model for coming up with an effective disease prevention campaign. To arrive at the destination safely, I discuss sex and sexuality in general and how Batswana (the people) understand and treat these topics. Hence, the culture-centered approach (Dutta, 2008) argues that communication theorizing ought to locate the people at the heart of the campaign process such that the theories are contextually embedded and co-constructed through dialogue with the cultural participants. That is to say that health communication takes place within local contexts by looking at the identities, meanings, and experiences of health among members of the community and understanding it from their cultural point of view. It gives the local people a voice in the co-constructions of

health and the articulation of health problems facing their communities, rather than for outsiders to inscribe their knowledge as superior.

RELEVANT TEXTS

Cultural theorist—Stuart Hall, widely respected in media studies, has long recorded that, using what he refers to as the “four-stage theory of communication”, it is likely that a well-intended message can “be used or understood at least somewhat against the grain,” depending on many factors (1973, p. 477). I suppose Hall recognized the possibility of a duality in the message to those it targets, allowing them the chance to interpret it in the opposite meaning or, even where there might be a plain and simple message, the target audience could respond negatively if they felt it was confrontational and invasive to their cultural beliefs.

Hall’s line of thinking has to a great extent been supported in the data I collected from fieldwork in Botswana regarding the negative perceptions of the young people regarding major HIV prevention campaign strategies involving the application of technology, including condoms, AIDS drugs, and medical circumcision as protection mechanisms, despite empirical science backing them up as credible barriers against invasion by HIV into the human body.

The article by Wamai et al. (2015), “Male circumcision for protection against HIV infection in sub-Saharan Africa: The evidence in favor justifies the implementation now in progress” is from a study supporting the latest HIV prevention strategy launched through global health partnerships across sub-Saharan Africa. The strategy is hailed as achieving a risk-reduction by 60% for males having vaginal sex to contract HIV from an HIV-positive partner. Government ramped up a campaign that saw positive results in Uganda in the past decade without recognizing that a vast majority of Botswana’s ethnic groupings do not practice circumcision either at birth or as a rite of passage.

The adaptation of the medical surgery campaign “Rola Kepese” loosely translated as “take off the cap/hat” is accompanied by blissful sentiment during unprotected sex once healing has taken place following the procedure because male partners are insulated against infections from their female partners living with HIV. Whatever the science behind medical circumcision as a bulletproof protection which has been replicated across African nations, such a campaign promoting bliss and high standards of hygiene while downplaying the high risks of exposure to an incurable disease is reprehensible and irresponsible, especially when targeted to the adolescents who experiment with casual sex whenever their hormones are aroused.

However, the results from the research study have shown that instead of the dominant models in health communication, attention should be paid to the prevailing culture in general, to make messages that appeal to the cognitive abilities of these youths in order for them to embrace positive behaviors around sex and reduce risks of getting infected from HIV rather than blindly following science. The social psychology theories are valid to work in specific settings where they originate, but they have blind spots that hinder health communication experts to implement campaigns based on well-known models because the problem in different cultures often includes many layers concealed from their knowledge.

In an international bestseller, *Factfulness* (2018), Hans Rosling shows the tendency among mass communications scholars to miss the built-in factors of unknown societies when good intentions lead their steps to different cultures where they apply these same theories that end up achieving poor results. The implementers of interventions are stuck with the problem because it does not go away, leading to frustrations of muttering under their breaths as to what might be wrong with the African people because the plan is perfect. Even scholars have not avoided the pitfall of stereotyping Africa’s HIV crisis and all sorts of negativity that has formed

the discourse around why the problem was not getting under control despite massive financial resources and technical assistance that the Western superpowers have channeled into them as a sign of benevolence across two decades.

Thus, health communication campaigns featuring certain lifestyles are believed to extend great dividends to those targeted by promotional material in the form of ads, public service announcements, jingles, television spots, infomercials, and commercials are under discussion in this study. It is imperative to heed the counsel of Marshall McLuhan in the first of his book *Understanding Media: The Extension of Man*, (1964), where he states that “the ‘message’ of any medium or technology is the change of scale or pace or pattern that it introduces into human affairs” (p. 1). This is so because, through the channel of communication, audiences decipher ideas that introduce them to new ways of behaving. No greater is the power of the medium and the message it broadcasts for impactful behavioral change than it is in the field of health communication because failing to persuade and introduce themes that support life yields death and despair all around us.

Therefore, this study is premised on the assumption that the same disease manifests differently from one region to the next and is influenced phenomenally by the cognitive positions prevalent in those communities that serve as catalysts or barriers to the rates of transmission. These social, environmental, and religious realities merit completely different approaches to be designed by unique societies to take advantage of those vehicles of communication best suited to connect with their cultures and to save lives.

According to this study among Botswana’s youths, the theme from McLuhan’s “The Medium is the Message” chapter (1964) is instructive in how the study participants responded to the specific questions dealing with AIDS drugs as preventatives against the transmission of HIV

among the young people in Botswana who are targeted by the advertisements on social network sites, including Facebook, TikTok, YouTube, and Snapchat as well as traditional mass media including television, radio, newspapers, and billboards. Like youths elsewhere, they spend hours daily on these social media channels. Communication is about connecting to the communities where these campaigns are launched. Campaigns end up bearing no impact if the target audience denounces them because prevalent customs and beliefs have been ignored.

For the mainstream population in Botswana, sex as a phenomenon has sustained communities over centuries where it was had primarily for procreation and lastly for pleasure and was considered especially a display of masculine potency that earned men who sired many babies with multiple women as being endowed with the “seed” that perpetuated lineages. Unlike in Western societies where parents participate in the co-creation, raising children only to become “empty nesters” one day when the children have forged ahead with their own lives to continue the cycle, African children, on the other hand, are the biggest investment their parents count on, with the surety that when they are old, parents would *transform* into “children” needing the care and support. The absence of brick-and-mortar care institutions makes the love of their next of kin indispensable.

My grandmother died in July 2022 at 101 years, and for the past 10 years, my mother who is the eldest child, took her mother in and had been caring for her even when our mother, herself an octogenarian, couldn’t have done a sterling job if it were not for my elder sisters who surrounded her every day to nurse our grandmother until her last breath. It is why, in African communities, it is not encouraged for a woman to pass her prime without bearing a child, married or unmarried because in the place of brick-and-mortar institutions, family relatives exist for that support network in a collectivist setup.

Hence, the ABC campaign, which preceded all major strategies, was caught in the crossfire of being “preachy” in its exhortation for abstinence in unmarried but mature couples without understanding the customs that relaxed the rules when women reached a certain age without bearing children. Further, the promotion of fidelity attached to monogamous relationships mirrored in holy matrimony and anchored on Western-centric Christian values that frowned upon polygamy and polygyny unions, introduced AIDS as “a disease of choice” (Flint & Hewitt 2015), infecting those who decided their fate by refusing the born-again American Evangelical-Pentecostal bible-preaching gospel to the *Heart of Darkness* (Conrad 2003) that cannot defeat the crisis without the civilizing enterprise of Western medicine and technology.

The irony of the ABC was that condoms were not readily welcomed because they were viewed to impede the progression of life from its natural course and were considered, therefore, an alien concept associated with spreading HIV. The widespread dissent stemmed from the reality that the ABC campaign placed sex in the public discourse. Instead of being a private affair between mature adults whose time was ripe to perpetuate lineages, sex was discussed in schools in front of children, became topical at national events with politicians’ speeches, and even the sermons were preached using HIV/AIDS and how it spread from one person to the next.

Someone might want to challenge the basis upon which condoms were sneered upon by a nation that did not know the technology and science behind its effectiveness against HIV, except that some fair-minded AIDS expert from the United States expounded on the losses of sexual morality that Africans had prior to the ABC campaign. According to Edward Green (2009) “The Pope was Right about Condoms” article, the anthropologist argues that condom distribution to Africans has worsened the AIDS situation because with it came based upon some sexual

practices that were common in the West including homosexuality which pose a higher risk of getting HIV.

E. Green (2009) builds his argument around a model known as *risk compensation theory* to say that, when people rely too much on technology and the safety net it grants them, they let their guard down, and he concludes that is what has happened with sub-Saharan Africa since the introduction of condoms as 99% safe against HIV. Green argues that “Africans have become sexually reckless” like in Western societies where technology and science are held in deference and relied upon unquestionably.

Earlier than Green’s study about condoms and higher transmission rates of HIV among African heterosexual populations, former president of South Africa, Thabo Mbeki asked the world an unpopular question regarding seemingly immoral sex habits that could have been viewed worse among Africans for HIV cases to swirl in figures they were reported when compared to other continents, ultimately arguing that it was poverty that “caused” AIDS. The West blasted Mbeki for this sentiment and labeled him a denialist. Beneath that literal meaning of “cause” AIDS, poverty fuels the rates at which HIV is spreading in sub-Saharan Africa (Tlou & Phaladze, 2006).

Instead, Green reminds African nations to return to their ‘lost paradise’ and regain social graces that have sustained communities across centuries where matters of sex were mentioned. He calls this “mobilizing indigenous resources” (2009, p. 394) to foster partnerships with cultural and religious institutions to play strategic roles in coming up with solutions instead of bypassing these leaders to launch Western-centric methods of prevention which would likely be rejected.

Meanwhile, medical doctors Norman Hearst and Sanny Chen (2004) whose study about the effectiveness of condoms in HIV prevention in developing nations was commissioned by the UNAIDS proved that condoms as a method of prevention were ineffective among heterosexuals. It failed to curb unplanned pregnancies and sexually transmitted infections including HIV, contrary to highly acclaimed success in the West. The higher the distribution of condoms, the higher the rates of pregnancies and incidences of STIs, their results show. The contexts for the two geographic areas as well as the demographics proved that the sub-Saharan population is constituted mainly of heterosexual couples who probably conduct multiple concurrent partnerships deserving behavioural-change communication interventions that study the sexual patterns of these individuals with the aim to positively influence their attitudes, not a one-size-fits-all approach.

Assuming condoms are an effective prevention strategy against HIV, for it to be recorded as failing to yield similar results in sub-Saharan Africa as in the UN-commissioned study can mean only one reality—failure to observe inter-cultural communication in how the benefits of science and technology could best be communicated to the extent that communities reciprocate the message with higher levels of acceptance as a prevention strategy. Samovar and Porter (1972) crystallize the need and relevance of paying close attention to the particular cultures that are alien to those from where communication that is meant to save lives or secure the posterity of a people originates. Their book, *Intercultural Communication: A Reader* (1972), is adequate to bring out the successful impact of intercultural communication and in how it advances the survival as well as coping mechanisms of those different cultures because the communicator, who is also the helper, seeks to ask important questions to appropriately assist where there is a need. The book not only presents a theoretical approach to solving problems but also raises

practical issues once communication crosses the cultural barrier, and this technique is critical in HIV/AIDS prevention.

These inter-cultural communication sensitivities are the hallmark of Roger Myrick's work, whose HIV prevention studies render advice to the states and federal government to tailor-design strategies that would address a plethora of layers driving high incidence and prevalence rates among the African American populations. In "Speaking from the Margins" (1996), Myrick examines the communication strategies in Alabama that embrace minority-sensitive communication in HIV-prevention literature.

In the article "In Search of Cultural Sensitivity and Inclusiveness: Communication Strategies Used in Rural HIV Prevention Campaigns Designed for African Americans" (1998) Myrick recommends changes to the campaign and for the target population. He underscores the need for campaign planners to be conscious enough to scope out the environment they are launching these prevention strategies in to determine the buy-in of those targeted by the taglines, mainly because of different cultural lifestyles.

In addition, Murphy and Greene (2006) in the article "Was the ABC Approach Responsible for Uganda's Decline in HIV?", discount the argument that those prevention strategies that are preachy like the ABC make an impact in sub-Saharan Africa. They argue campaigns like the ABC ignore the realities of power relations that exist between men and women in sexual relationships. They say that behavior change under the ABC campaign requires acknowledging that women don't have the same rights as men to decide how sex is conducted in these heterosexual relationships.

Similarly, Mbizvo and Phillips. (2014) "Family Planning: Choices and Challenges for Developing Countries" buttress the point about inequalities. They argue that attaining the 1994

Cairo International Conference on Population and Development (ICPD) goal for achieving universal access to reproductive health remains elusive for many developing countries. However, women in Africa are valued among others, by their capacity to bear children, and women in marriages, in particular, are by obligation expected to birth heirs to family dynasties. Introducing family planning methods like condoms, which is also prevention against HIV, is thus an important undertaking that should consider the social status of those involved, lest what is intended to improve the quality of life becomes a scourge of domestic violence and unstable relationships. Mbizvo's paper discusses the current landscape of contraception in developing countries, including options available to women and couples as well as the challenges to its consistent provision.

Thus, the devastating effects at the peak of HIV/AIDS deaths posed serious challenges to how life is viewed in a society that treats sex as an act to progress lineages, whose descendants always carry the responsibility to care for the next person rather than self and therefore, promote a collectivist approach in care and support of the weaker ones in their midst. The "ABC" campaign that littered the billboards, jingled on radios, and in print media, and textbooks was a revolution taking place. If it were not used to preach morality stemming from "personal responsibility" that Western societies promote as a lifestyle, the ABC campaign might have taken a leaf from censored ads (Boodman, G. S. 1988) that American mainstream society promoted until recently. Meanwhile, this ABC approach ignored a collectivist model that did not favor condoms for prevention much as they were initially frowned upon by American mainstream society to stigmatize AIDS sufferers.

In a similar light, the more the denial grew regarding the ABC tagline in Botswana, the worse the effects of the epidemic hit the core of society with one in every seven living with HIV

(15-49 ages) before the availability of the medicines that significantly reduced the rates of infection. Thus, we should ask the question: Why there would be some resistance by the target audience to make sense of the prevention messages and translate them into positive steps that can reduce their risk of getting infected if the social psychology theories appeal to the cognitive abilities of the target population and aiming at altering behaviors and attitudes? Despite these theories being dominantly used in health communication, the 20th-century was the deadliest in contemporary history, amidst distribution of condoms at no cost to the end-user.

In the new millennia, the “Get tested for HIV and enroll on ARV” slogan was not only understood, but many AIDS patients lined up at public health facilities to receive lifesavers in AIDS drugs treating the effects of the condition in those living with the disease. If health communication theories concern themselves with the “sender,” the “message,” and the “receiver” for positive behavior to take place in reducing the risk of infection, then it must follow naturally to explain how, culture sits at the center of these relationships.

Cognitive theories impact behaviors and attitudes for a positive outcome and are best positioned to be applied in bringing down the infection rates of a highly transmissible disease like AIDS, providing the baseline for the research questions to get us to the results that might offer solutions for Botswana’s situation, or even the southern Africa region to some extent, and by considering these prevalent beliefs and dominant cultures.

The unintended and undesirable outcomes of PrEP have shown an increase in new HIV infections among Botswana’s youth population, particularly those who got on the pill for prevention ended up developing drug resistance complications to Truvada (now Descovy)—a licensed drug for the treatment of AIDS patients as part of a daily triple-drug cocktail. How was it that those who were on Truvada for prevention were still getting infected? Baxter (2018), in

his memoir about AIDS in Botswana confesses that universalizing AIDS solutions without closely studying the cultures where science is applied is as destructive as not collaborating with these nations to pull them out of the death throes.

Baxter's assertion is poignantly summarized in an anthropological medical study by Elizabeth Meassick regarding HIV prevention strategies in Africa, when she says:

The main reason for HIV/AIDS programs' failures in Africa is embedded in the direct importation and imposition of a Western health development model as the solution to the health problems of African nations...Western models by design tend to ignore the cultural realities and strengths, history, and philosophical reality of African people.

(2001, p. 182)

So much about cultural sensitivity is stressed when global marketing communication is discussed as a component in international advertising. Alon et al. (2017) highlight that "international advertising traditionally has required different strategies than domestic advertising, because of the differences in culture," (p. 517). They explain that gaining insights into the nuances of exotic cultures is imperative, depending on the cultural symbols that have been pulled into the campaign to provoke reactions of the same audience.

It has been proven that prophylactic drugs eliminate the risk of contracting HIV and with consistent adherence, Truvada or Biktarvy could keep the virus at bay. However, those on the pill who might get exposed to a strain that quickly mutates could render Truvada useless and ineffective to fight the virulent HIV-1 that causes AIDS, unless there was a vaccine (for which AIDS has none to date) according to Sather (2016).

This research, as already stated, spotlights Botswana in the region of southern Africa therefore, her peoples, religious beliefs, history, anthropology, and cultures prevalent right across

the desolate countryside remain integral in the perception of pandemics and what risks they pose to the survival and sustenance of life if there was no shift in behavioral and attitudinal paradigms for positive impact. The epidemic of HIV/AIDS is placed under the microscope, applying these theoretical frameworks to harness Western strength in her sciences to collaborate with all the elements that define Botswana and southern Africa to some extent.

Hence Snyder (2007) helps us to appreciate the need to present a persuasive message in health promotion geared towards behavior change by stating that:

How the message looks and sounds can mean the difference between messages that are accepted and those that are rejected by the target population. Messages need to capture the attention and be easily remembered by each member of the target population by being creative and novel; refreshing media messages often; depicting people who are clearly members of the target population, keeping messages of high quality, using explicit, intense, emotional, or entertaining messages; and by creating logos, slogans, or jingles.

As much as possible, messages should be kept simple, because complicated messages are more likely to be misunderstood and misremembered...In many circumstances, messages that evoke positive emotions may have a greater impact with the target group than those evoking negative emotions like fear. Another aspect of a message is the information sources and their credibility and consistency. To increase acceptance of the message, the campaign must select credible spokespeople that balance trustworthiness and expertise.

(S37)

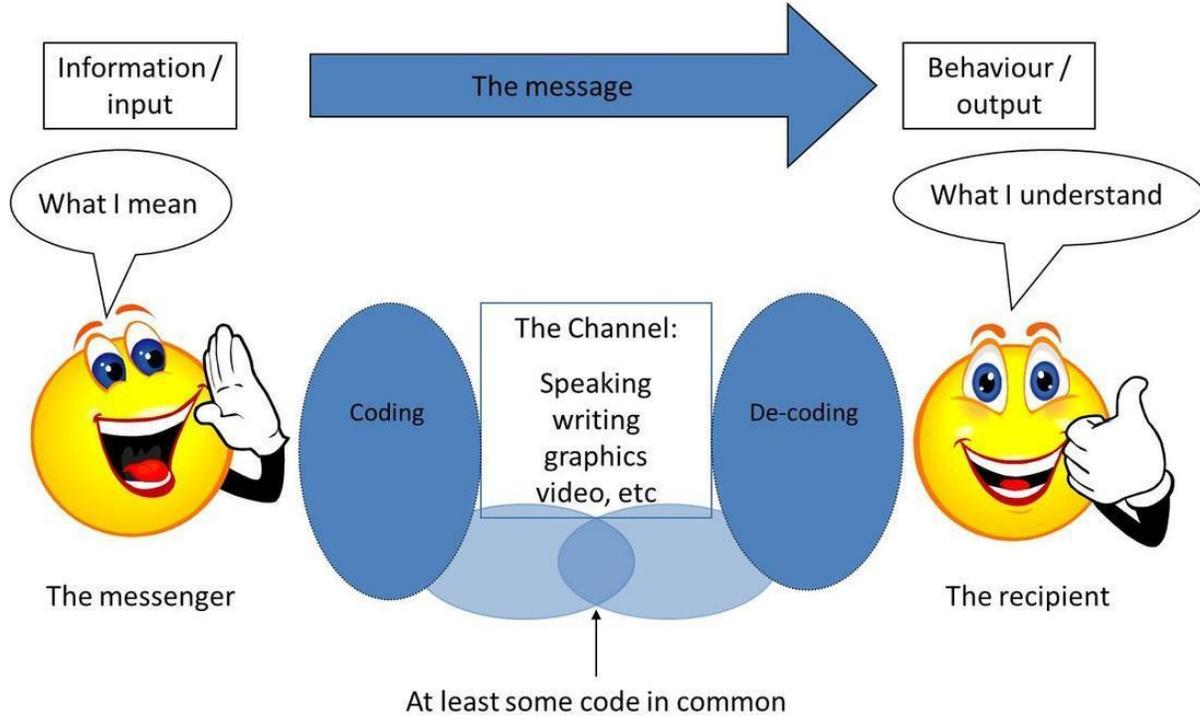
From the above, a health campaign sets out to accomplish behavior change and for that to happen, it requires ensuring consistency in the message, the vehicle and the characters and ensuring that the individuals projecting the themes are in sync with the recipients who should

find the content useful and achieve the desired outcome. In essence, Snyder (2007) states the need to seek the answer to the question: What impact does the campaign have on the listener or the one watching the commercial on television? It is a very crucial question to pose because human beings are born with cognitive capabilities that can tease out even the subtlest themes not intended to come out of the campaign. Health communication campaigns should be clear, crisp, concise, and coherent without creating any duality in the mind of the hearer, and it is those ambiguous messages that Snyder says the target audience usually rejects.

By assessing health communication theories against the widespread cultural practices, the study seeks to dig deep into how this specialized field of mass communication and media studies has evolved and developed its concepts, hypotheses, and theories about saving human life against diseases and epidemics such as AIDS. This explores the conceptualization, development, and launch of health campaigns exploiting the mass media as public channels to influence behavior change, as well as the evaluation of their efficacies and effectiveness after 20 years since the fostering of global health partnerships.

By employing a comparative analysis of the existing HIV prevention campaigns and seeking out their suitability across Botswana, the health communication theories discussed in this section, compel the campaigns to connect with the cultures and societies for them to be relevant and beneficial. Hence there is a need to sync the messenger (Sender), with the message (Content), and the target (Receiver) by selecting qualified characters that the targeted audiences identify with in role-playing, exploiting suitable channels that can move messages for impact to the masses, and launching the themes using nuances that resonate with the local environment to persuade the receivers to change their behaviors to embrace new HIV prevention strategies. This effective way of communication is modeled in the next pictorial.

Figure 3 “Information to Impact Behavior”



If communication travels in a linear direction like the social psychology theories that have been discussed in this chapter suppose, which provide the frameworks for HIV prevention campaigns launched in sub-Saharan Africa, perhaps there won't be misunderstandings that are common among people in relationships because what the speaker is saying is exactly what the listener is hearing. But we know that is not true for any situation.

If you take the message “undetectable equals untransmissible” as an example, the immediate impression that one listening to the slogan can catch is that, if the laboratory test for HIV cannot detect the virus in the bloodstream of an infected person, there is no virus that they can pass to an uninfected sexual partner during unprotected sexual intercourse. This understanding from the U = U campaign is factual. But it is also a wrong understanding that HIV-positive patients who have tested negative after staying on the pill might have the illusion that they are cured of the virus since it is undetectable. There is only one way that the virus that

causes AIDS cannot be spread to another person and that is when both partners are HIV-free. U = U might mislead HIV-positive people into thinking that they are HIV-free and therefore, are able to stop taking treatment, during which time the virus mutates, and they develop some drug resistance when they get sick again.

Noah Sather (2016) sheds light on AIDS drugs and why it is important for those using them as preventative to be extra careful not to engage in risky behaviors that will expose them to worse complications than before they started the regimen, be it PrEP or TasP.

Expounds Noah Sather (2016) in a news article on wired.com that “A person is at greater risk of infection if they miss even one in twenty doses. It is important to remember—HIV-1 is so devastating because it attacks the immune cells meant to keep us healthy. The virus also demonstrates the highest reported mutation rate of any biological entity, allowing it to quickly develop new defenses against drugs and host immune systems.”

Therefore, if the campaign sells “U = U” without foregrounding an explanation that, even at the stage when they have tested negative, patients should continue to adhere to the regimen like before, it may lead to complications when patients discard their medicines. The after-effects of abandoning AIDS drugs for treatment (not prevention) would be catastrophic because they are not cured of the disease since AIDS has no cure, only therapy to suppress the virulence of the condition. Therefore, treatment as prevention or U = U might mislead HIV-positive people into complacency, only for them to die when they could have lived longer.

Janes et al., in “Weighing the Evidence of Efficacy of the Oral PrEP for HIV prevention in Women in Southern Africa” (2018), show that the estimates of the efficacy of oral pre-exposure prophylaxis (PrEP) regimens containing tenofovir have varied widely across trials that enrolled women, “with some studies reporting high efficacy and others reporting no efficacy at

all among women in several southern African countries,” including Botswana. The meaning is that science does always work with the precision it is promoted in these health campaigns.

CHAPTER 3

RESEARCH METHODS

This mixed methods research employs a quantitative approach of collecting data using an online survey platform called Qualtrics to export raw data to a statistical analytical tool called SPSS to chart and graph the data for interpretation in a qualitative study. The interpretation of the data results significantly follows the qualitative method of descriptive narratives to depict the HIV situation among the Botswana youth population between the ages of 15 and 24. The impact of the campaigns on the actions that can reduce risky behaviors of the participants is tested using the hypotheses to prove whether the target populations make sense of these prevention taglines, given their peculiar identities, dominant beliefs, and prevalent customs.

The major PSAs already discussed include PMTCT, PrEP, treatment as prevention (TasP) or U = U, Abstain, Be Faithful, or use a Condom (ABC), and medical circumcision (SMC). The content analysis of these campaigns is carried out using intercultural communication to determine the impact of HIV prevention strategies that can leave a lasting impact on Botswana's youths.

Upon approval by the Southern Illinois University Human Subjects Committee in the spring 2022, the study envisaged sampling of 250 participants, surveyed across the winter months in Botswana. This target assumed that the Government of Botswana's IRB protocols would approve the study immediately. However, due to the red tape synonymous with central governments elsewhere, especially when licensing researchers dealing with human subjects, the permit was issued on May 16, 2022. Even then, the Ministry of Health approval was the first hurdle as the schools which are run by the Ministry of Education issued a separate approval after a back-and-forth. The five educational districts include the capital city of Gaborone, which was

the base from where travels were coordinated to hundreds of miles to Bobonong and Serowe in the central parts of the country, Kanye (Southern district) and Molepolole (Kweneng district), requiring adequate resources to enable the collection of data.

Instead, a total of 247 respondents participated in the study. Still, each prompt elicited a different reaction from each participant whereby some questions were overwhelmingly answered while others had as low numbers as 43 and yet in others, the possible number of 247 did respond. This could mean that unanswered questions were difficult, or unclear or the participants ran out of time before they got to them. In a cross-sectional analysis, it is normal that the respondents to a survey leave some questions unanswered, and even the prompt on the questionnaire gives them the leeway to answer to the best of their ability.

Daylight is required to travel between Gaborone and Bobonong which was the furthest district. With limited resources, only 20 government schools (ages 15 to 19) were approved as study sites. These included Gaborone, Marang, Matlala, Maikano, Ledumang, Seepapitso, Tlhomo, Ntebogang, Kgari Sechele, Dithejwane, Masilo, Boitshoko, Tshegetsang, Motswasele, Moruakgomo, Metsimasweu, Kgalemang Tumediso, Bobonong, Matshekge, and Mosetlha. To each school, 20 consent forms for students aged 18 and above and 20 assent forms catering for the below 18 ages were distributed to a minimum of 20 participants before the students could be enrolled in the study.

These five districts were targeted because there already exists an HIV prevention strategy using the Truvada pill for pre-exposure prophylaxis (PrEP). This intervention is a partnership between the United States and Botswana Government. The pilot project involves mainly girls aged between 13 and 19 whose families are concerned that they might become infected with HIV because of their sexual activity levels. However, since the focus of this particular study is on

youths aged between 15 to 24 that are identified in the Botswana AIDS Impact Surveillance Report 2021 (BAIS V) as the focus of concern and who are already experimenting with PrEP, it excluded the under-15 adolescents both male and female.

Therefore, from a target of a possible 400 participants from 20 schools including ages 20-24 staff workers, only 12 schools being Gaborone, Marang, Ledumang, Ntebogang, Mosetlha, Bobonong, Metsimasweu, Kgalemang Motsete, Kgari Sechele, Masilo, Boitshoko and Dithejwane ended up participating in the actual study that wound down on 31st July 2022.

The focal persons in each school were the pastoral care teachers who collected the forms from the students when they were completed satisfactorily consenting to their participation before the research commenced. The rest of the participants older than 18 did not have to come to the study site to complete the questionnaire. However, they gave informed consent online before proceeding with the survey. In total, there were 247 participants who responded to the online questionnaire. They were not required to record their names or provide any identifying information because the human subjects' protocol was that it remain an anonymous study, and no participant was to be quoted using his or her real names or distinguishing marks that could make him or her vulnerable or exposed.

There were inordinate delays in processing consent as, in some cases, students were interested in the study while their caretakers or parents were unwilling or did not see the benefit of the study to them. At other times, participants lost the consent forms, yet were adamant to participate in the study, leading to the issuance of more forms and dealing with one site over a long period. While there was an agreed calendar spelling out times for the study to take place at specific sites, dates and hours, the repeated scenario was that plans changed because of a host of reasons. In some schools, teachers felt indifferent to organizing the participants because they

understood the study to benefit the researcher and not them, much less the students, and were not keen on keeping the appointments by laying the groundwork per agreed timelines. The researcher did not have control over such attitude and behaviors since facilitating independent research is not what teachers are hired to do in Botswana.

The other challenge that was recurring throughout the 20 approved schools, even including five in the capital, was the intermittent connectivity to the internet. In some cooperative schools with all groundwork laid, the study could not happen on the slotted dates because that particular day or week, there were power outages, and nothing could be done within a desirable turnaround to bring the situation back to normal. Eight of the identified 20 schools experienced this challenge which resulted in non-participation by their students. Thus, 160 participants were denied the opportunity to respond to the questionnaire.

The financial support from the AIDS agency which helped in offsetting expenses associated with travel, accommodation, printing and photocopying, telecommunications, and so forth was only made available during the first week of July when the study was left with exactly three weeks to wind down. This severely hampered progress, and in earnest, the study that was meant to cover 90 days lasted only three weeks amidst all the enumerated challenges that the dissertation committee was regularly kept abreast of.

Some participants showed interest or knowledge in some questions more than in others; therefore, it is not consistent to expect all the 247 participants to have responded to each prompt on the questionnaire. Thus, the correct percentile of each question cannot be worked out of the total 247 participants. Rather, it should be based on the actual number of participants for that specific question and/or prompt to maintain consistency in the outcome of showing the

knowledge the youths have about HIV prevention strategies promoted in the major campaigns throughout media channels.

The online study collected individual responses to the questionnaire by measuring their cognitive abilities to decode the prevention campaigns as one of the important factors that contributes to the outcomes of the high rates of HIV among the youth population in general. Botswana as a conservative society does not discuss sex publicly, let alone imagine adults exchanging ideas on sex and sexuality with adolescents. Personal responsibility, which is celebrated in Western societies to mean that the individual is looking out for his or her interests and how to safeguard them, is sneered upon in Botswana where a collectivist sense teaches the individual to care about what the rest of the community thinks about his or her actions and their impact on the next person. Reviewing the PSAs that promote personal responsibility over what they are accustomed to, offered an opportunity for the participants to display their knowledge about preventing new HIV infections.

Instead of merely reducing the risk of HIV transmission, this study posits that it is possible to avoid risky behaviors that expose adolescents and young people by engaging them in the conceptualization of the taglines, involving them to role-play the messages, and allowing them to select appropriate media channels to place these campaigns for impact—all steps that will yield participation in breaking down the meanings of the campaigns. Hence “risk avoidance” instead of “risk reduction” should be considered as an effective strategy if the war against AIDS is to be won by 2030 as envisioned in the United Nations Sustainable Development Goal. Risk avoidance should be adopted as a practical solution because social responsibility is a key factor in determining life choices involving how sex is to be conducted in mainstream societies of sub-Saharan Africa.

This study explores the environmental levels of tolerability, acceptability, and suitability to communicate messages on sex which is a topic that is never discussed publicly between adults, adolescents, and youths. To determine the levels of sensitivity and appropriateness in the campaigns, the participants were asked about their beliefs surrounding sex as a “taboo topic” versus the highly transmissible disease that commands a nation to adopt pragmatic prevention strategies that offer life-saving solutions. The study is premised on the fact that HIV prevention campaigns are all about communication, and as both an art and science, messages must be constructed from within (“start where the people are” (Nyswander, 1956)”) by using a common language that connects the target population to the themes because of its accessibility, engaging credible figures, and utilizing popular channels.

If campaigns employ unfamiliar language and metaphors that alienate the receivers of information, then campaigns are failing the task of communicating clearly and plainly. If campaigns are first and foremost created in a foreign tongue and translated or adopted, they may not always retain meanings for effective strategies that can bear a positive impact on the needed behavioral change. Evidence of this assertion is provided by Ruben (2016), who reminds us that “In many respects, health communication interactions are most appropriately viewed as cross-cultural encounters...that requires careful observation, listening, and care in translation” (p. 5).

Such an assessment takes into consideration the role-playing, nuances, motifs, and metaphors in the prevention strategies to conjure up familiar personalities and localities, including the channels used to disseminate the messages to the target populations.

Capitalizing on the “Start where the people are” model, how can we tap into the collectivist value of Setswana to overcome this adversity? African nations should co-create HIV prevention taglines that move away from Western “personal responsibility” to embrace the

African sense of “communal duty” where an infected individual is part of a community that mobilizes all its resources to care for one another. Finding solutions resonant with their positive cultural beliefs of prioritizing the “other” over “self” and promoting inclusiveness in “we” rather than “I,” prevention taglines might begin to resonate with the target populations. The study requires Africa to re-examine her attitudes towards sex and AIDS as a public discourse that can’t be avoided any longer.

This study follows a quantitative methodology to harness information about the target population (ages 15 to 24 of infected and uninfected youths) of different sexes polled randomly to test out cognitive responses regarding the major campaigns explained previously. This research study evaluates how the public service announcements (HIV campaigns on radio, television, print media, and billboards) appeal to the cognitive senses of the youth population in Botswana—and how the assumed understanding plays a role in their decision-making processes on matters of safe sex to reduce new infections.

The survey contains general questions regarding the suitability of the HIV messages or slogans in the advertisements, including the accessibility of the language to the target population, to assess the cultural sensitivity regarding the topic of sex and role-playing in these life-saving messages. There are a few demographic questions (gender, age, class, education, and family income) and very few open-ended questions where participants are asked to express their opinions or expand on the answers they have given in close-ended questions.

Any content or direct quotations are anonymized so that participants cannot be identified, and care has been taken to ensure that other information that could identify them is not revealed. Where necessary, numbers and letters were assigned to address the demographics. Participation

in this study was completely voluntary, and the participants were able to discontinue while the study was ongoing, and their responses would not form part of the collected data.

The following is the exact format in which the online questionnaire appeared: Please answer the following questions closest to your information and opinions. All information will be confidential and only cumulative information will be used for the analysis.

Q1. Indicate your age

15-17 (1)

18-20 (2)

21-24 (3)

2. Indicate your gender.

Male (1)

Female (2)

Rather not say (3)

Q3 Indicate your highest level of education.

Lower than Middle School (1)

Middle school (2)

High school (3)

Undergraduate (4)

Postgraduate (5)

Q4 Indicate family income (per year).

up to 9,600 (1)

up to 18,000 (2)

- up to 48,000 (3)
- up to 90,000 (4)
- up to 144,000 (5)
- above 145,000 (6)

Q5 Which district do you come from?

- Gaborone (1)
- Kanye (2)
- Kweneng (3)
- Serowe (4)
- Bobirwa (5)
- Others (6) _____

Q6 Have you seen someone living with full-blown AIDS?

- Yes (1)
- No (2)

Q7 Please answer the following question.

	Least (11)	Less (12)	Somewhat (13)	Enough (14)	Extremely (15)
To what extent are you concerned about AIDS? (1)					

Q8 If you answered "least" in the above question, explain your reasons.

Q9 Have you seen or heard about any of the HIV prevention campaigns?

- Yes, a lot (1)
- Yes, a few (2)
- Not at all (3)

Q10 Which of these major HIV prevention Campaigns across mass media channels

(television, print media, radio, billboards, social network sites) have you seen or heard about?

(Answer all that apply)

- AIDS drugs (1)

- Condoms (2)
- Safe medical circumcision (3)
- Abstinence and faithfulness (4)
- Other campaigns (5)

Q11 Which of the prevention strategies are you and your peers likely to use?

- Undetectable = Untransmissible (1)
- Pre-exposure prophylaxis (2)
- Condoms (3)
- Abstinence and faithfulness (4)
- Safe medical circumcision (5)
- Post-exposure prophylaxis (6)
- Other strategies (7)

Q12 What do you think AIDS drugs should be used for?

- Treatment (1)
- Prevention against new infection (2)
- Prevention against infecting others (3)
- Prevention after likely exposure (4)
- Other: (5) _____

Q13 Have you seen some of the advertisements for HIV drugs as a preventative strategy?

Yes (1)

Maybe (2)

Not at all (3)

Q14 If "Yes" or "Maybe," can you recall some of the advertisements in terms of the message (slogans, taglines, headlines, etc.)?

Q15 Watch the following commercials for AIDS drugs. The survey will auto-advance once it is completed.

Q16 Please watch another video. The survey will auto-advance once it is completed.

Please answer the following questions.

	Strongly disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Strongly agree (5)
Q17 Are HIV prevention messages clear and plain in eliminating the spread? (1)					
Q18 Do you find HIV prevention campaigns and slogans clear and accessible? (2)					

Q19 Do you identify with the people in the commercials?

Yes (1)

No (2)

Q20 Explain your response to your association or disassociation to the characters in the commercials promoting AIDS drugs as a prevention strategy.

Q21 Explain whether the examples of these commercials mirror your social environment concerning attitudes and behaviors necessary for prevention of AIDS as a sexually transmitted disease.

Q22 Are HIV Prevention messages designed to suit specific ages?

Yes (1)

No (2)

Q23 Are HIV prevention messages designed to suit specific beliefs?

Yes (1)

No (2)

Q24 Are HIV Prevention messages generalized or do they suit specific cultural values?

Yes (1)

No (2)

Q25 If you answered YES to the previous three questions that messages are suited for specific groups, give one example that is suited for 15 to 24 ages in Botswana.

Q26 Of the major prevention campaigns mentioned below, which do you believe can effectively eliminate AIDS? (Answer all that apply)

- Undetectable = Untransmissible (1)
- Pre-exposure prophylaxis (2)
- Condoms (3)
- Abstinence and faithfulness (4)
- SMC (Safe male circumcision) (5)
- A combination of all the above (6)

Q27 Please answer the following question.

	Extremely unlikely (6)	Somewhat unlikely (7)	Neither likely nor unlikely (8)	Somewhat likely (9)	Extremely likely (10)
To what extent do you agree that AIDS information is accessible across mass media channels? (1)					

Q28 Please, share your ideas to improve how AIDS information can reach the 15-24 ages for impact. Here, think of the correct and suitable media channels for this group.

Q29 Click [this link](#) and listen to the radio jingle (Friends Radio Advertisement / Clearinghouse on male circumcision) and review the print ad below. Please answer the following question.

	Extremely confusing (6)	Confusing (7)	Neutral (8)	Informative (9)	Extremely informative (10)
To what extent are the ads informative or confusing? (1)					

Q30 Answer to the following question

	Extremely difficult (6)	Difficult (7)	Vague (8)	Clear (9)	Plain (10)
How impactful and effective are the taglines in preventing HIV? (1)					

CHAPTER 4

DATA ANALYSIS

A total of 247 respondents in the study broken down in the following tables shows how the young people performed in answering each question. In a cross-sectional analysis, it is normal that the respondents to a survey leave some questions unanswered, and even the prompt on the questionnaire gives them the leeway to answer to the best of their ability. There are some instruments that did not elicit responses, whereas others seemed to interest the participants more.

The missing data might mean they misunderstood the question or had some level of discomfort, or they ran out of time, or any other reason that we might never know. The following research questions and hypotheses help the reader to appreciate the intent of the study in contributing to the prevention of HIV among Botswana's adolescents.

RQ1. Review all AIDS campaigns and determine whether there is a correlation between the availability of HIV prevention information and the increasing rates of new infections among the 15 to 24 age population in Botswana.

RQ2. Test the suitability and appropriateness of the content to determine whether HIV prevention strategies resonate with the cultural and religious contexts of the target audiences.

RQ3. Determine the effectiveness of the channels of communication where campaign messages are placed for accessibility to the target audience.

RQ4. Gauge the level of knowledge the target audience has about HIV prevention campaigns to influence sexual behaviors that prevent and/or expose them to HIV.

In addition to the research questions, there are claims about HIV/AIDS and pundits have made postulations as to why the rates are out of control in sub-Saharan Africa, including low levels of information dissemination channels and poor telecommunication bandwidth. This study

has gone to the heart of testing whether the adolescents in Botswana have access to media channels where HIV prevention information can reach them, and the following hypotheses were tested against the presumed knowledge or a lack of which they might or might not be used optimally to protect themselves against the disease. These hypotheses are outlined below.

H1. The extent of concern about HIV/AIDS is significantly and positively related to the effective and/or impactful level of awareness in preventing HIV among the 15 to 24 age population in Botswana.

H2. The extent of clarity in eliminating the spread of HIV/AIDS as regards prevention messages is significantly and positively related to an effective and/or impactful level of awareness in preventing HIV among the youths in Botswana.

H3. Accessibility of information across mass media channels is significantly and positively related to an effective and/or impactful level of awareness among the youths in Botswana.

H4. The extent of advertisement content, whether informative or ambiguous is significantly and positively related to an effective level of awareness among Botswana's youth.

DESCRIPTIVE STATISTICS:

Q1

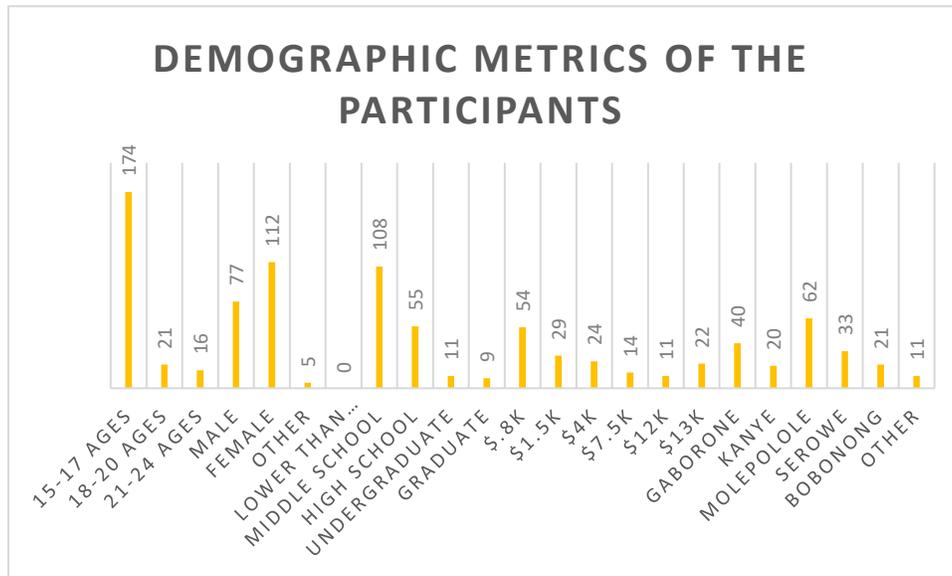


Table 1 “Demographics for Participants” breaks down the participants according to their ages, sex, educational level, family income, and rural versus urban dwellers to determine the concentration of the disease. Given the controlled environment of school classrooms, the students are the majority of the participants in this survey, recording 174 out of a possible 211 or 82.46% of the sampled population. Females registered 112 out of 194 or nearly 58% compared against 77 respondents, or almost 40% of males, while the remainder preferred not to indicate their gender. Junior high school tallies with the ages 15 to 17 to account for the largest number of 108 participants out of a possible 183 or 59% while the remainder is split among high school, undergraduate and graduate students.

Furthermore, family income shows the dynamics in terms of understanding the importance of a study like this one on the lives of individuals and the nation at large, possibly suggesting that the poorer families are, the harder they have been hit by HIV and this has caused them to want to participate in finding probable solutions to ending the suffering they are

accustomed to daily. Consequently, families making under \$4000 a year make up 69% or 107 out of the total 154 participants.

Lastly, the districts include the capital Gaborone, peri-urban Molepolole (Kweneng), and three rural areas of Kanye (Southern district), Serowe and Bobonong, which are hundreds of miles away from the capital. It is shown in the responses that greater participation is from urban centers, scoring 102 out of 187 or 54%. The many channels of information reaching the target audience and/or the swirling rates of the disease among urban dwellers probably make HIV a challenge here worse than in the countryside.

Q2

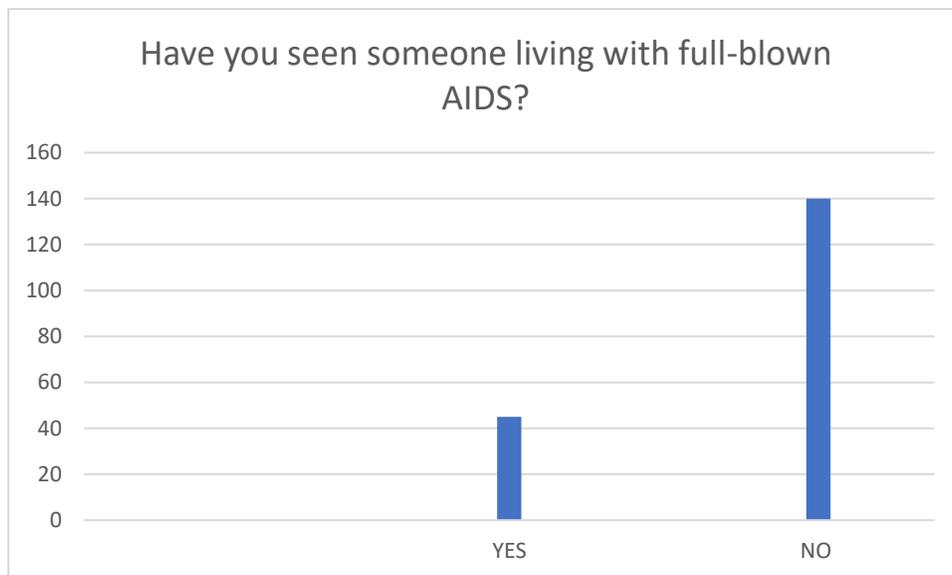


Table 2 “Familiarity with Full-Blown AIDS Patients” shows a staggering 140 out of 185 or almost 76% of the respondents have never seen a full-blown AIDS patient, thanks to the game-changer in the medicines and therapy borne out of the anti-retroviral drug treatment known by the local brand *Masa* which means a new dawn bringing hope in the rays of the sun – quite a well-thought-out noun to inspire an afflicted population.

Q3

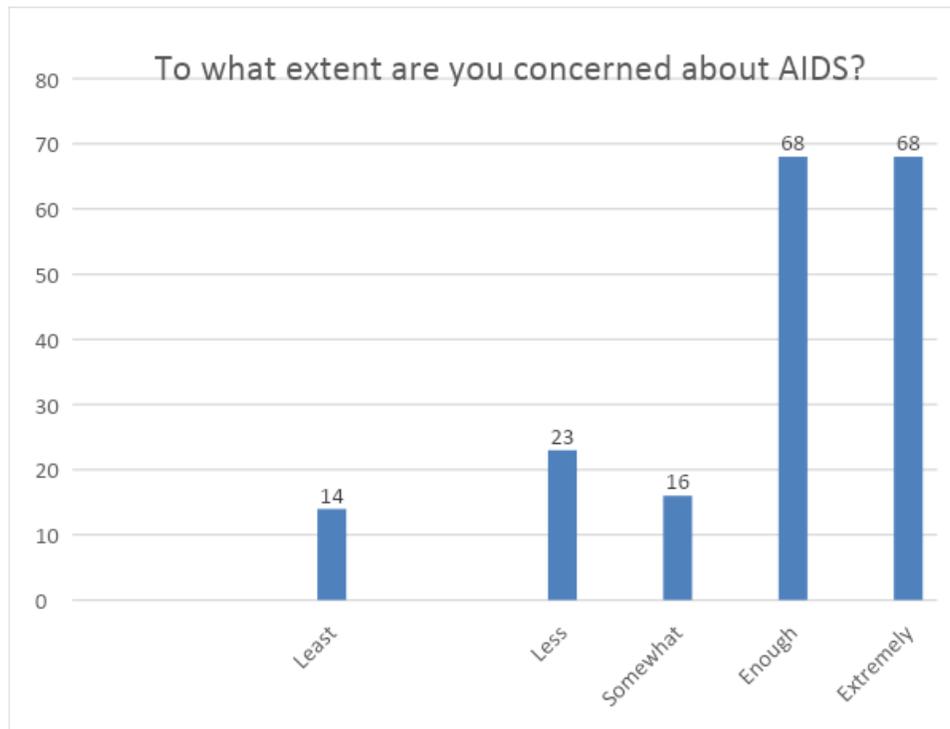


Table 3 “Extent of Concern about AIDS” Because of the availability of medicines to treat AIDS in patients with the full-blown disease, it might be assumed that the younger generation would not care about the devastating effects of the epidemic. However, it is apparent that an overwhelming number of 136 out of 189 respondents or 72% of the sampled participants are concerned about HIV/AIDS.

Q 3 a) If you answered “least” in the above question, please explain your answer.



Table 3.1 “Justification for Level of Concern” is by far, the most telling chart regarding the extent of concern HIV/AIDS is for the young people of Botswana. Despite the new infection rates (incidence) averaging 4% annually since 2010, out of 247 respondents, an overwhelming majority of 240 (97%) of the young people share deep fears and worry about the epidemic, and only seven participants (3%) say they are not worried. There might be a disconnect between what they know regarding the prevention of HIV from the major campaigns and how well such themes are integrated with their daily lived experiences for conducting sexual relationships.

Those that have answered that they are least concerned have stated their reasons, which range from “I have been taught enough about HIV and AIDS and how to live with it positively,” to “There is no one I know who is living with HIV,” or “AIDS deaths have become rare ever since ARVs have been developed. In addition, methods of protection have been introduced, thus AIDS is my least concern,” or “I am not exposed to anyone who may have AIDS, so I feel safe,”

or “I am having protected sexual intercourse,” to saying, “AIDS never came to my attention ever since the outbreak of Covid-19, which I am extremely concerned about right now.”

Q4

Have you seen or heard about any of the HIV Prevention Campaigns?		
		103
	74	
		14
YES A LOT	YES A FEW	NOT AT ALL

Table 4 “HIV Prevention Campaign Awareness” The young people reveal their awareness and knowledge about preventing HIV with 177 from 191 participants (above 92%) who answered admitting to having seen or heard major prevention campaigns across mass media channels to equip themselves with choices to make regarding their HIV status.

Q5

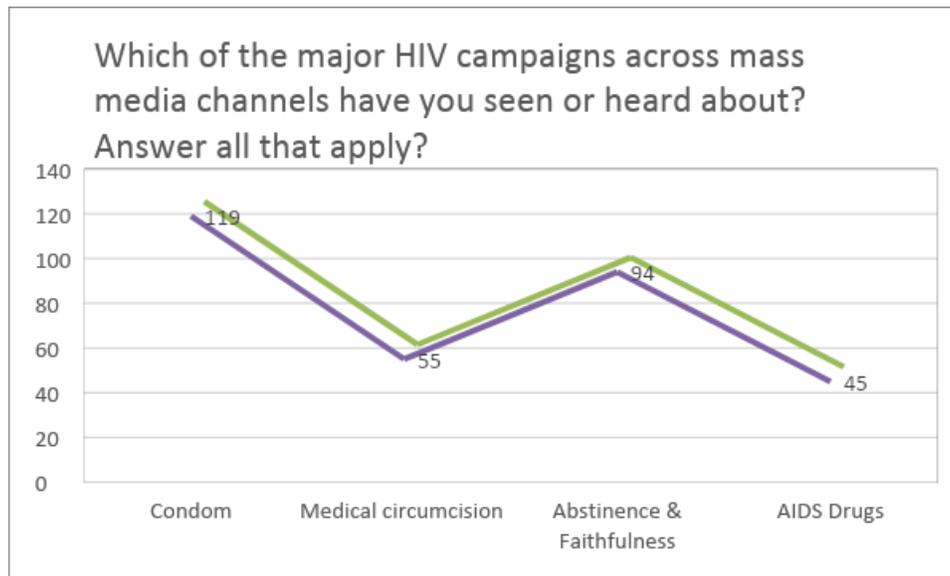


Table 5 “Major HIV Prevention Campaigns in the Media” This question hogged the most responses with a total of 313. Tallying with their level of knowledge and information about prevention campaigns, in Table 5, Botswana youths consider condoms, delaying sexual debut, and monogamous relationships as popular strategies. Between these two strategies, a cumulative score of 213 (68%) knows about “Abstain, be Faithful and/or use a Condom” (ABC Campaign). The third popular strategy is medical circumcision, while AIDS drugs as a preventative trail the list with only 45 responses (14%).

Q6

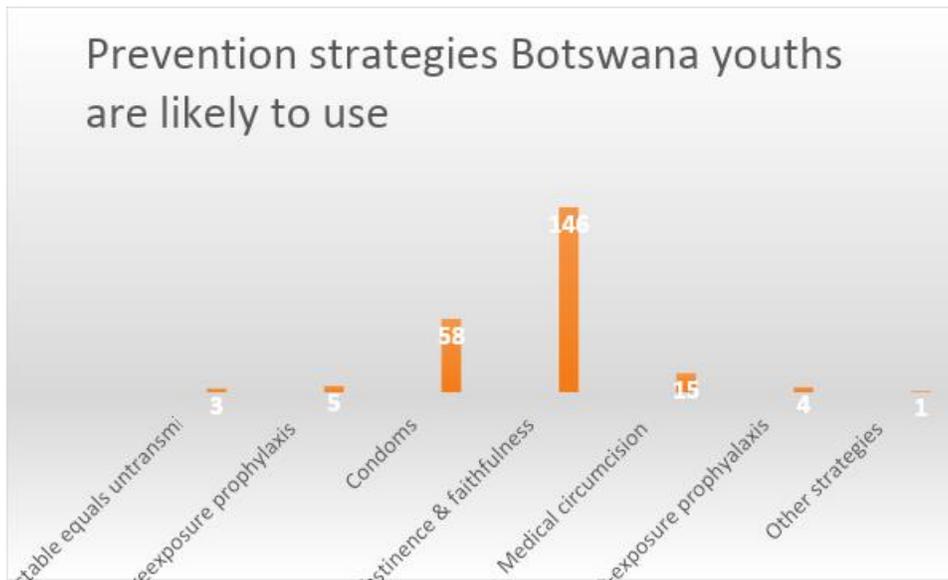


Table 6 “Likely HIV Strategies Among Youths” is consistent with the general response that the Botswana youth population views condoms and delaying sexual debut and staying faithful as effective strategies to lock out HIV. Out of a possible 232 participants, we see the youths recording 204 or (83%) of the responses favoring these two methods of prevention as safe ways to protect themselves against the transmission of HIV. AIDS drugs as a preventative record single digits each, and even when they are put together, drugs trail medical circumcision by 3%.

Q7

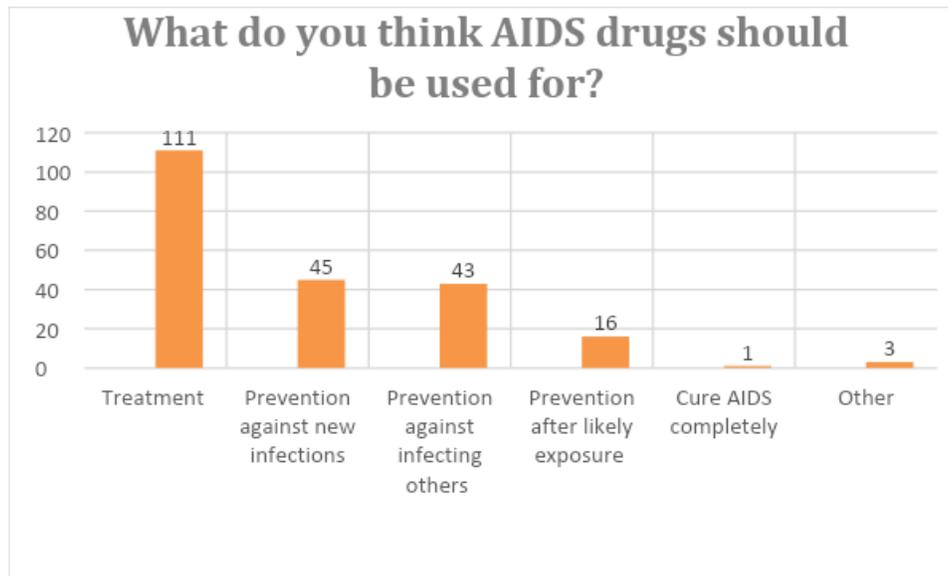


Table 7 “Preferred Use for AIDS Drugs” shows that, while the youth population is fully aware of the benefits that AIDS drugs have brought to their parents’ generation, which was faced with the possibility of “extinction” before the dawn of the new millennia, the youths are knowledgeable that these drugs are not a cure and nor can they be relied upon as a bulletproof prevention strategy against HIV encroachment. All forms of prevention using the drugs are not favorable among the youths who base their argument on the fact that drugs are good for therapy and managing the extent and impact of the disease on those who are HIV-positive to get them to a stage where they are not sick.

Treatment using drugs scored 111 from a total of 219 (50.6%), while pre-exposure prophylaxis (PrEP), Undetectable = Untransmissible and Post-exposure prophylaxis (PEP) put together, registered 104 (47%). This is quite revealing about their beliefs and level of comfort in the drugs as a preventative.

Q8

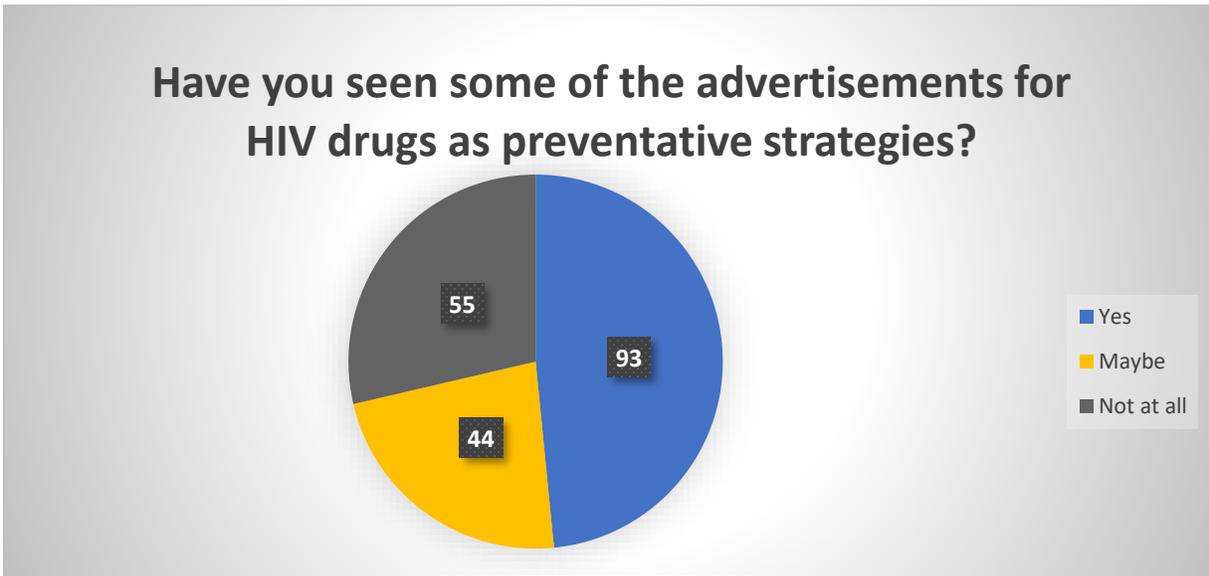


Table 8 “Ads for AIDS Drugs as Preventatives” From 192 participants, 93 of them or almost half (48%) admitted to have seen or heard commercials advertising AIDS drugs as a preventative and they were able to recall some of the popular taglines and slogans. Meanwhile, 44 others (23%) percent might have known the slogans and a further 55 (29%) have never heard or seen the ads.

Q8 (a) If yes or maybe, can you recall some of the slogans or taglines, headlines etc?

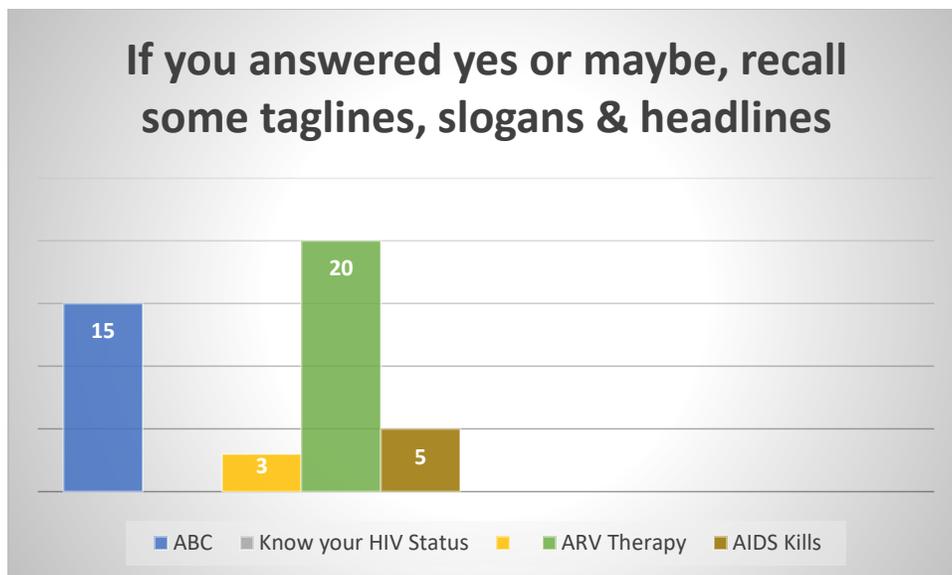


Table 8.1 “Taglines from Drug Commercials” This question is probably the one that drew the least number of respondents totaling 43. who responded to this question displayed their knowledge regarding major campaigns that Botswana has launched since 2002, and they depict the reality as one may guess about a nation that was on the brink of “extinction” by the dawn of the millennia. The Masa (ARV Therapy) campaign to treat AIDS patients recorded 20 out of a possible 43 respondents (47%) and was followed by the ABC campaign with 15 participants (35%) of the total. Completely, they distanced themselves from commenting on the drugs as preventatives.

Q9

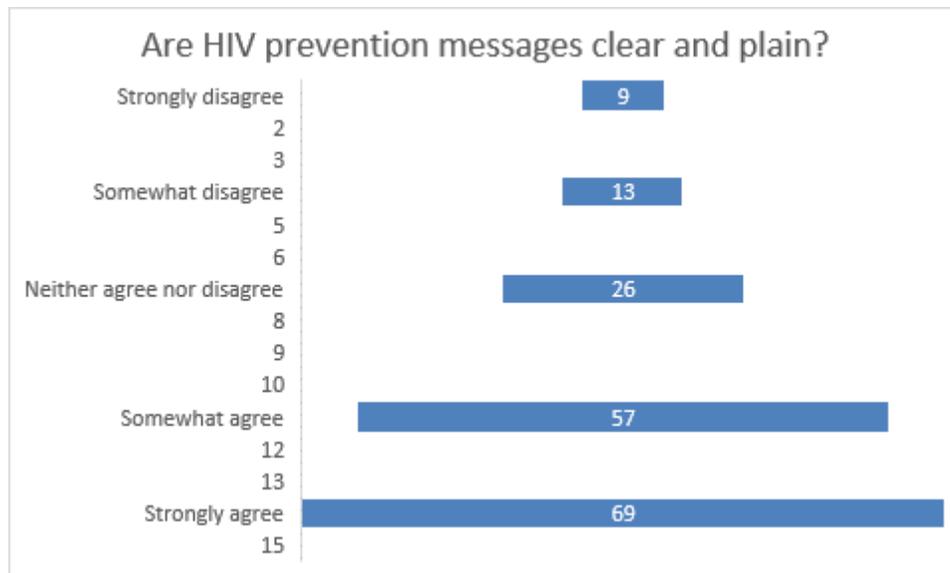


Table 9 “Clear and Plain Content in Drug Ads for Prevention” Out of 174 participants to this question, the results show that prevention taglines, slogans and messages are clear and plain enough to appeal to the cognitive dispositions of the young population in Botswana. With 126 participants (72%) affirming the prompt and 22 individuals (12%) disagreeing, there are no serious language barriers in the campaigns.

Q10

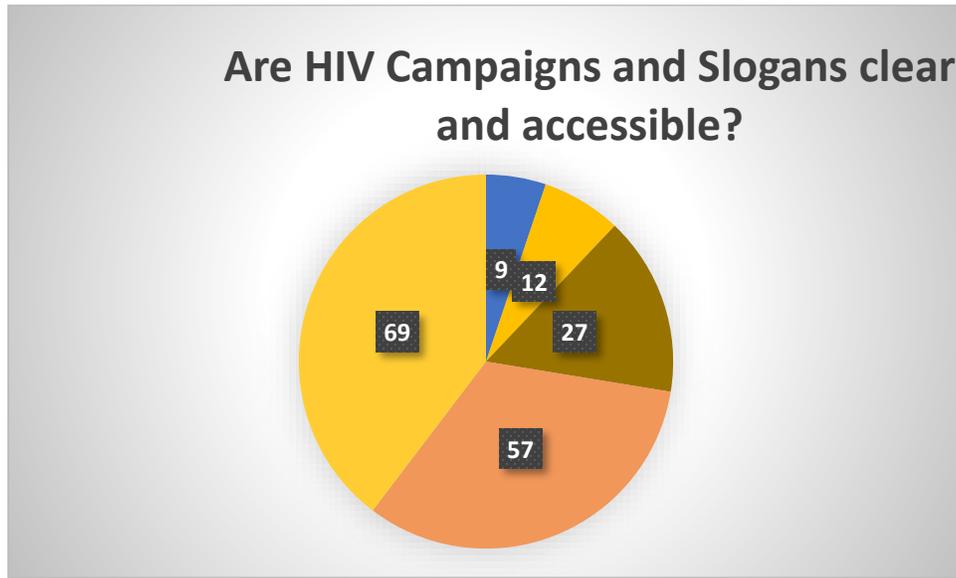


Table 10 “Media Exposure on HIV Prevention Slogans” Supporting the earlier assertion that slogans, themes, and taglines are clear; and plain the table shows that the prevention messages are also placed in mass media channels where the youths can access them easily. Of a total of 174 participants, 126 (72%) agree with the prompt against 21 (12%) that disagree with the assertion. Those who neither agree nor disagree total 27 (15.5%) of the respondents.

Q11

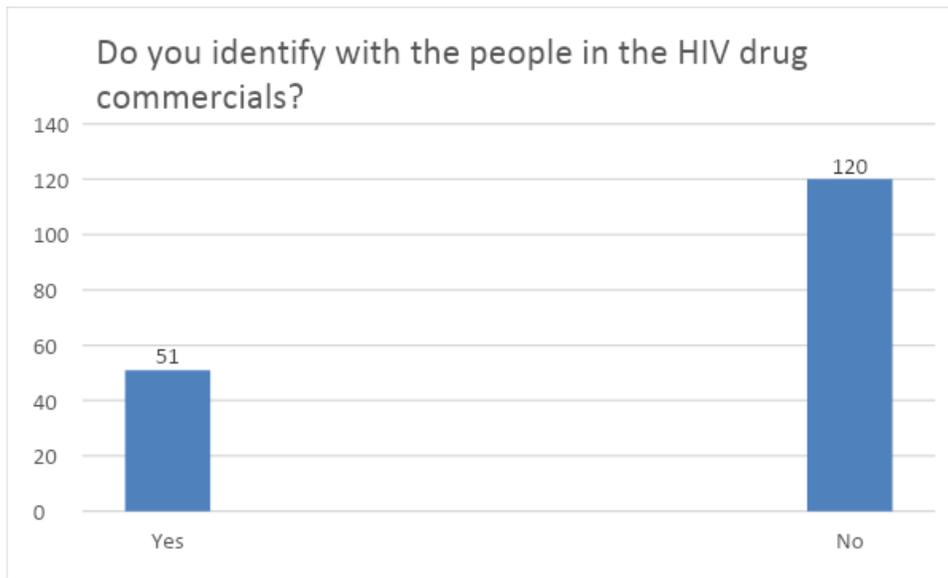


Table 11 “Role-Playing Drug Ads for Prevention” shows that the clarity of the messages and their accessibility is not the only combination by which they are deciphered for positive impact in keeping the virus that causes AIDS at bay. The young people are not seeing themselves in these drug commercials influencing positive change expected of them, therefore, it is possible to infer that the plain language and mass media channels used to place these messages might be targeting a different audience altogether. A total of 171 participants responded to this prompt, and 120 (70%) disapproved while 51 (30%) affirmed it.

Q11 (a) Explain your association or disassociation from the characters in the commercials.

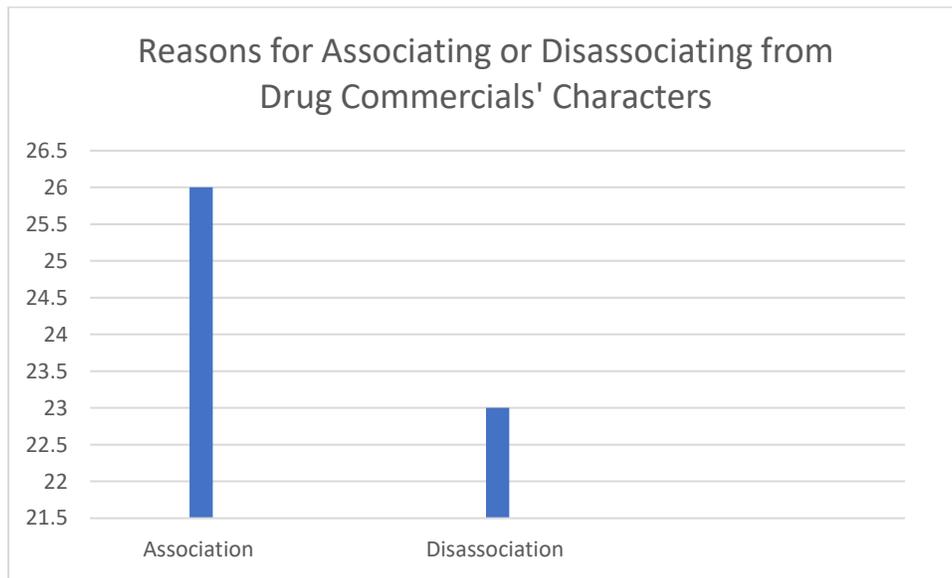


Table 11.1 “Association and/or Disassociation from Models” Out of 49 participants, above half, (53%) or 26 participants distanced themselves from the characters in the AIDS drug commercials, while 23 of them (47%) found some common features in the people role-playing the prevention messages in the PrEP and U = U drug campaigns. Reasons for associating with the characters included some of the following statements: “Because they teach people that the drugs are given for prevention and not a cure” “They put confidence in victims of HIV/AIDS,” or “I am quite pleased by the commercial because the message is clear and quite understandable. It definitely brightened my mood,” to something like “They are black like me.”

On the other hand, participants showing disassociation have stated that “I do not find anyone familiar because I do not know them,” or “Because the message is not clear,” or “I think the only effective drug is abstinence and be faithful,” to something like, “In our village, most of the advertisements I see are in books, magazines and written sources that’s why I don’t associate more with them but I prefer face-to-face.”

Q12 Explain whether the examples of these commercials mirror your social environment concerning attitudes and behaviors necessary for the prevention of AIDS as a sexually transmitted disease. The individual responses mirror thematic areas that are dominant as categorized below.

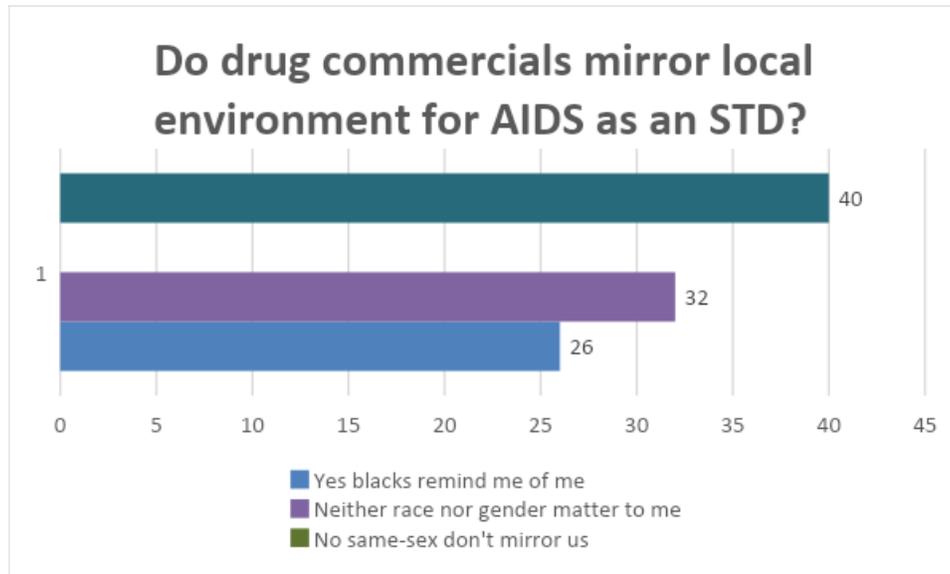


Table 12 “Mirroring Local Environment in AIDS Drug Commercials” Out of the 98 respondents who explained themselves, 32 could not be bothered either way by the content of the commercials or the characters role-playing HIV prevention messages targeting them, while 26 agreed that the commercials were spot-on and mirrored their lives and social environment.

Examples of those similarities are found in the black characters in whom they see themselves mirrored, the trust in the drugs as a game-changer, fighting stigma attached to those living with HIV, and generally, the characters as agents of influence to share useful information about staying healthy by engaging in routine physical fitness. Examples of their statements include:

“The examples in the commercials relate to my social environment because even in the real world, HIV/AIDS positive people are stigmatized,” or “There are many young and black people in the commercials,” to “Yes they really do because those people who undermine, criticize and

mock HIV-positive people must stop doing that to them and accept and tolerate them with wide open arms.”

On the other hand, 40 participants raised disapproval ranging from nationalistic sentiments that these were not Batswana to racial identity for those whose skin color is not black. A greater majority criticized the manner in which homosexual liaisons are widely accepted and promoted in the commercials teaching HIV-prevention messages. They decried that it was against their prevalent attitudes regarding sex and sexuality. Some of the strong sentiments are captured as: “No, the sex being described is not what is prevalent in mainstream Botswana where HIV is hitting the hardest,” or “They do not mirror my environment because they do not really promote faithfulness or abstinence because one can use the drugs for prevention. So having sex without using a condom is not a big problem as long as you are taking AIDS drugs because you will not get it,” to “Because the message is not clear whether they are promoting same-sex relationships or AIDS drugs. And I do not know who these people are.”

Q13

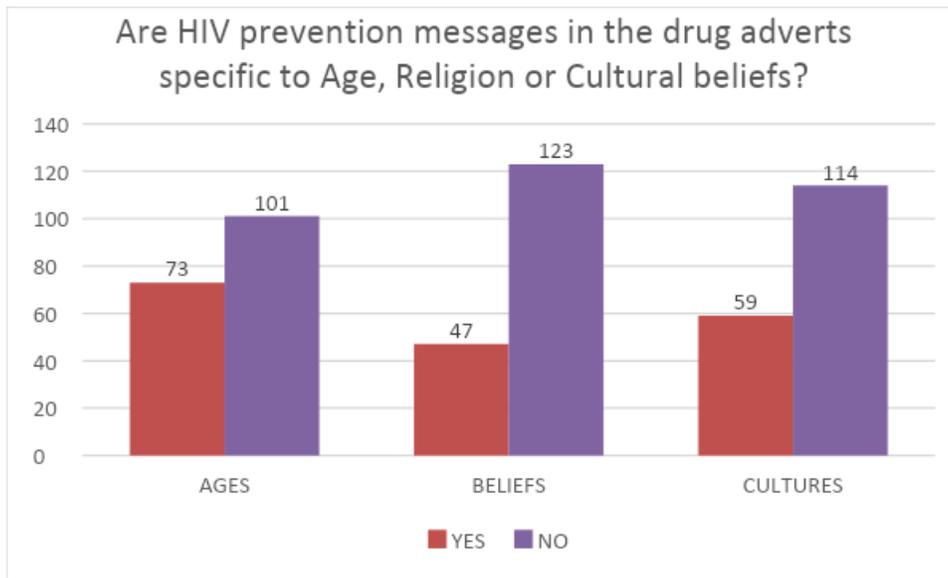


Table 13 “Age, Religion, and Culture in Messaging Prevention” is quite revealing in that we appreciate why the youths in Botswana do not identify with the characters role-playing HIV prevention, especially in the drug campaigns. An overwhelming majority of the respondents denied that the commercials represent their age population, neither their religious beliefs nor cultural practices in matters of sex and sexuality which drive the transmission of HIV in Botswana’s mainstream population. At least 101 participants out of a possible 174 (58%) of the respondents said commercials did not represent the youth population, another 123 from a total 170 (72%) said drug ads did not respect their religious beliefs, while 114 out of 173 participants (or 66%) responded that their cultures were not considered by the commercials.

Q13 (a) if you answered yes to any of the three questions above, give one example of a message that is suited to the 15-24 age population in Botswana.

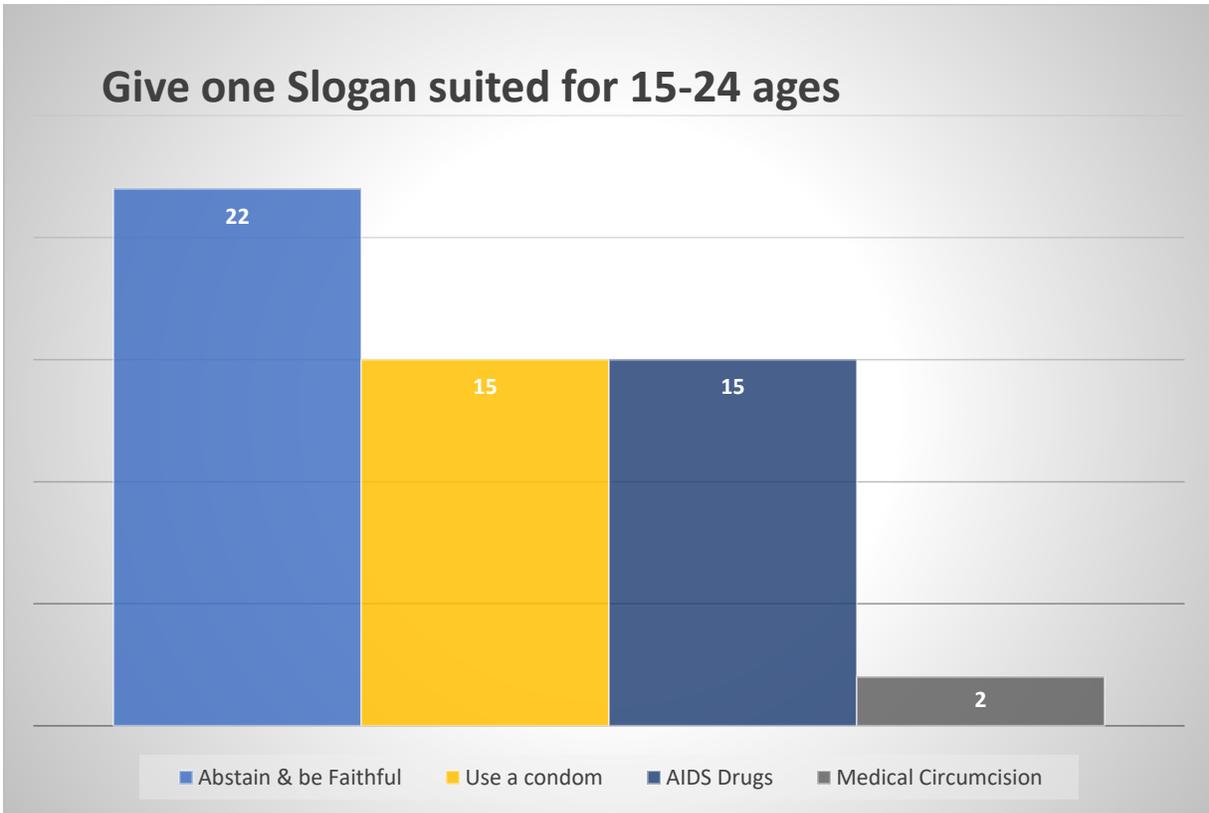


Table 13.1 “Slogans Suited for Adolescents and Youths” The 54 youths who responded to this question showed their knowledge about HIV-prevention campaigns and slogans. Two said, “Get circumcised,” while 15 each supported the use of condoms and AIDS drugs to prevent HIV. The “use a condom” tagline was consistent among the 15 respondents, while a mixture of “PrEP,” “U=U,” “Post-exposure prophylaxis (PEP), and “Drugs are not a cure” were shared by those remembering the drug promotional campaigns. Meanwhile, 22 resonated with the “Abstain and Be Faithful” message, placing it ahead of all strategies.

It can be seen even from such a low number of participants who recalled the taglines that there is consistency with the question surveying preferential methods of prevention among this demographic that a majority of Botswana young people place their lives on cultural values that

are largely influenced by their religious beliefs to delay sexual debut and, when ready to engage in sexual activity, to remain in monogamous sexual relationships. It is also very pronounced that they disapprove of the reliance on technologically designed methods of magic pills, such as Truvada and Biktarvy, and they disdainfully reject medical circumcision to provide them bulletproof mechanisms against the invasion of HIV.

It might be surmised, as had already been demonstrated overwhelmingly in another qualitative question, that these technologies and the employ of foreign faces, motifs, language, and nuances that do not speak to the idiosyncrasies of their environment make it harder for them to embrace these strategies to fight HIV.

Q14

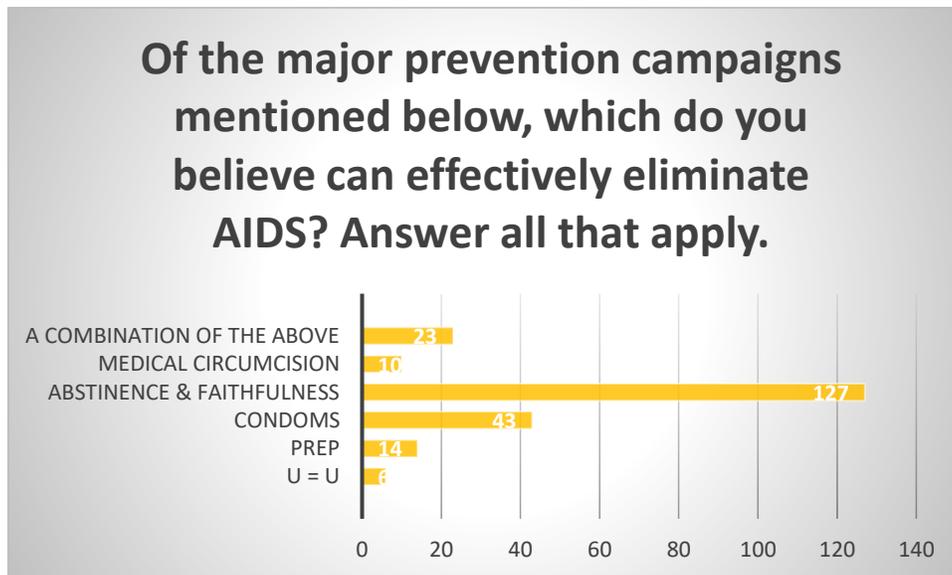


Table 14 “Effective Strategy to Eliminate AIDS” is another evidence that the Botswana youths understand the plain language of the campaigns in saving lives and that condoms, abstinence and faithfulness are the favored interventions that can eliminate HIV with a cumulative score of 170 out of 223 respondents (76%) against 20 participants (9%) choosing drugs as a line of prevention, while 10 participants (or less than 5%) said that medical circumcision could

eliminate AIDS. With abstinence and faithfulness recording the highest number of 127 out of 223, which translates to 57% before adding condoms that recorded 43 participants (19%) to complete the ABC campaign, there is hope that the youths can be saved if messages feature the people that youths can identify with, who represent their cultural practices, and whose role-playing respects the dominant religious beliefs of the Botswana people. There is no denying whether the ABC is the practical approach to preventing HIV if it is contextualized to suit the local cultures.

Q15

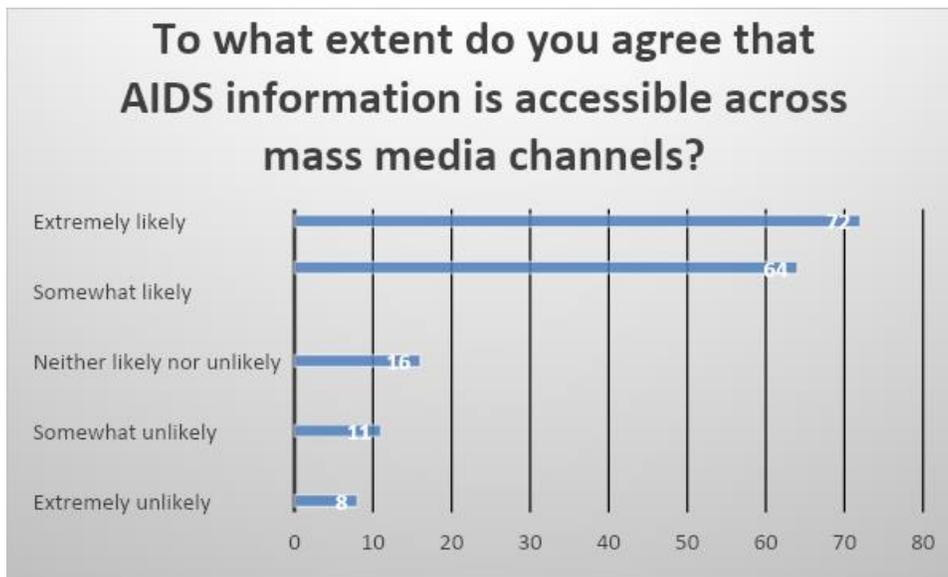


Table 15 “Availability of AIDS Information Across Mass Media Channels” Above 79% or 136 respondents out of a total of 171, said information is available versus 11% or 19 respondents who disagreed that they can easily access HIV prevention information.

Q15 (a) Share ideas on how HIV prevention messages can reach 15 to 24 ages for impact. Think of the correct and suitable media channels for this group.

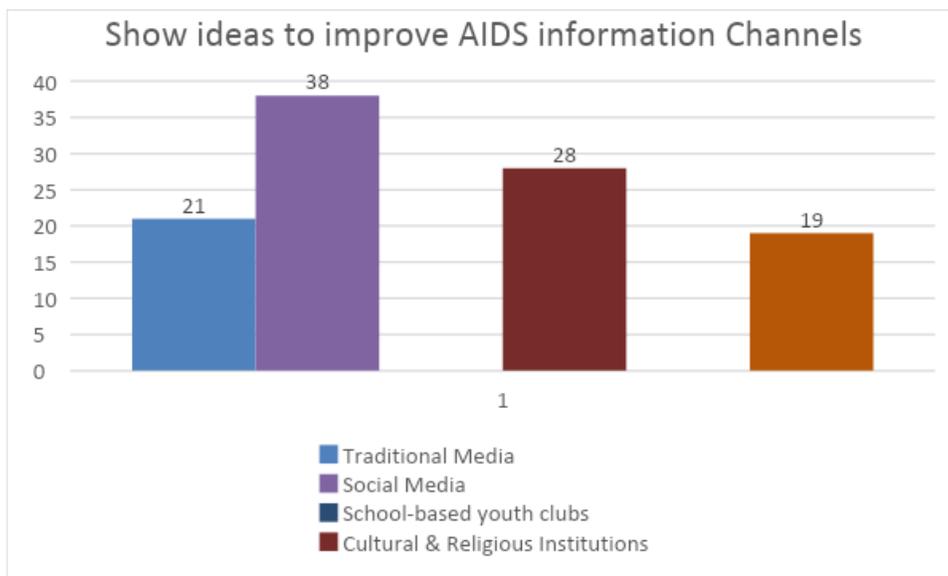


Table 15.1 “Ideas on Best Channels to Spread HIV Prevention Messages” This is one open-ended question to which the participants responded overwhelmingly, signaling the need to get involved in designing their channels of information or expressing their preferences in the order of popularity and frequency with which they patronize such media outlets. A total of 106 youths shared their channels, and quite honestly, there is a healthy competition between the first two and the last two options, which can be summed into the suggestion of adopting all four platforms as reliable sources that the youths can trust to learn about HIV.

It is not surprising that the traditional media of newspaper ads, television commercials, radio jingles, or highway billboards have been overtaken by digital online media of all sorts and school-based youth clubs. Traditional media occupy third place with 21 participants (23.5%). About 38 respondents (36.8%) prefer digital online media, while 28 who responded (27%) chose

school-based peer education clubs, and in fourth place are the cultural institutions with 19 participants (18%) advocating for moral regeneration. While corporate mass media have dominated HIV-prevention advertising as reliable sources of accurate information about AIDS in the past, this diagram shows that the young people in Botswana are tech-savvy and exploit social media sites for information about HIV prevention strategies.

Q16

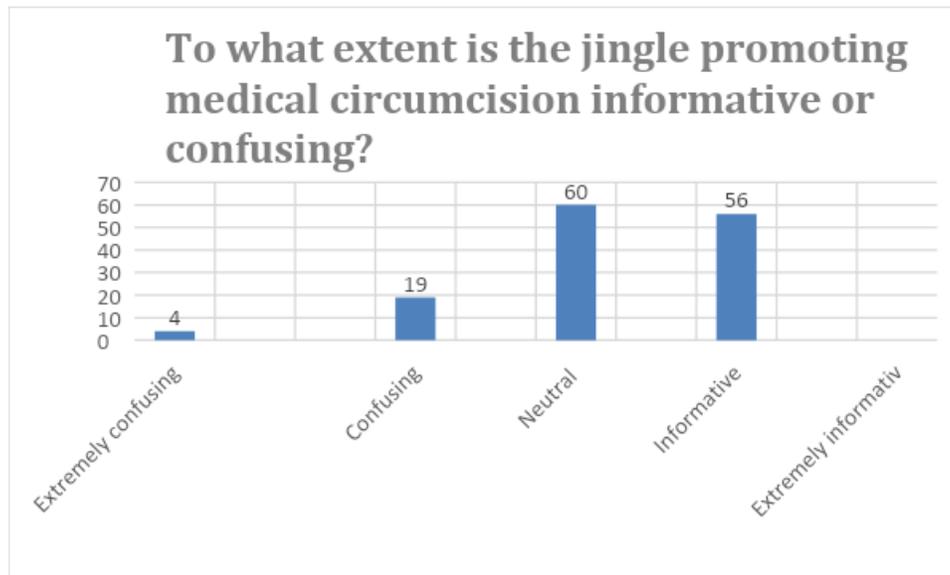


Table 16 “Radio Jingle about Medical Circumcision as a Prevention” Among 161 participants, 78 affirmed the prompt (48%) that the prevention messages are clear, plain, and accessible, therefore, they are not confused about content when compared against 23 respondents (14%) who reported some ambiguity in the campaign.

Q17

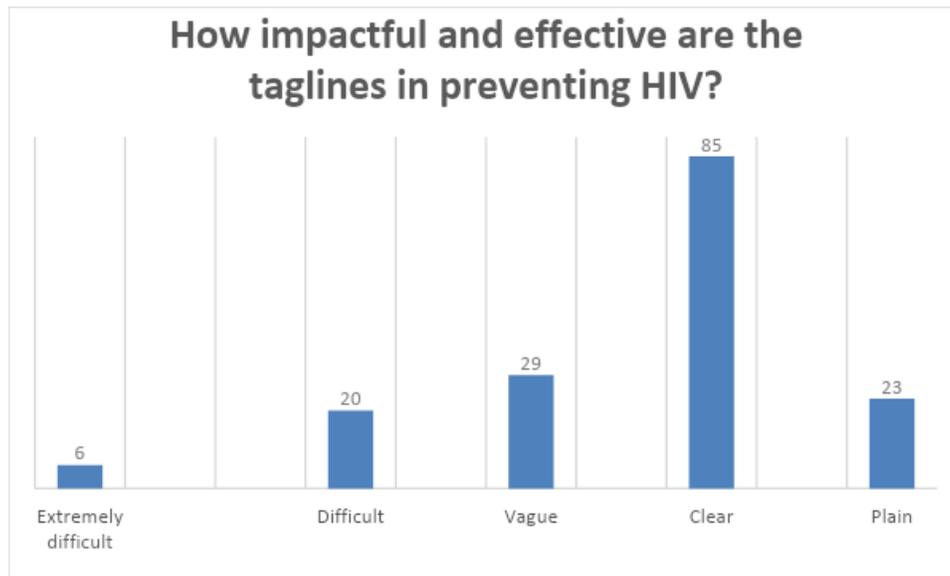


Table 17 “Impact of Taglines for Behavior-Change” The effectiveness of the HIV prevention taglines, slogans and messages can be gauged by how crisp and concise they are to those consuming them, and Botswana youths have overwhelmingly responded that prevention strategies and their themes are making a lasting impact with a score of 108 from a possible 163 (66%) against a mere 26 participants representing almost 16% who said the campaigns left no impact on them.

CHAPTER 5

DISCUSSION OF STUDY

To better grasp the outcomes of this study, we return to the four research questions to measure the impact of the health communication models imported from the West to the sub-Saharan African context in HIV prevention in general and specifically to the Botswana AIDS crisis. The results of the data have tested the hypotheses that assume a correlation between the possession of knowledge and information about HIV prevention strategies on one hand, and the positive behavioral change of those who have been exposed to the taglines, headlines, themes, and slogans. In the major campaigns involving condoms, drugs as a preventative in all its forms. Situating the AIDS crisis in Botswana by applying Western popular health communication models, including the Health Belief Model (HBM), Social Cognitive Theory (SCT) and the Knowledge Gap Theory (KGP) has rendered these HIV-prevention strategies (prevention-of-mother-to-child-transmission—PMTCT, Pre-exposure prophylaxis—PrEP, post-exposure prophylaxis—PEP, treatment as prevention—TasP, and safe medical circumcision—SMC) ineffective, according to the results of this study.

Except for the safe medical circumcision first piloted in Uganda, resulting from the global health partnerships with sub-Saharan African nations, the rest of the HIV prevention strategies were coined in the West and exported to these hardest-hit nations as ready-made panacea only to be adapted in the local languages, while sometimes losing the message in the translation process. All these HIV prevention campaigns dominate mass media channels and, even more so, the traditional chambers of broadcast (television and radio) and print (newspapers, magazines, and highway billboards), and in recent years, the digital media, which are almost exclusively packaged in European tongues. But such efforts have soberly reminded a besieged

people about the long distance we have travelled with condom promotion at the height of AIDS deaths in the mid-1990s as the sole layer of protection and the short but arduous distance ahead amidst new technologies at our disposal, including AIDS medicines.

Therefore, the four research questions and four hypotheses have been answered by the study as summarized below:

RQ1. Review all AIDS campaigns and determine whether there is a correlation between the availability of HIV prevention information and the increasing rates of new infections among the 15 to 24 age population in Botswana.

This has been disproved in that young people are not denying that information on how to prevent HIV is readily available in the mass media channels at their disposal, yet the rising incidences show that this information is not translating into positive behaviors.

In several tables showing the rate of responses to exposure to HIV prevention information, the young people reveal their high level of awareness and knowledge. The young people answered Table 4 prompt: “Have you seen or heard about any of the HIV prevention campaigns?” by revealing their high awareness and deep knowledge about preventing HIV with 177 out of 191 participants or above 92%.

Table 5 supports the result from the above with Botswana youths admitting to have knowledge about the ABC campaign so much that 213 out of the 313 respondents or 68% affirmed the ABC message as best suited among all other interventions in answer to the prompt, “Which of the major HIV campaigns across mass media channels have you seen or heard about?”

Table 8 asks “Have you seen HIV drug advertisements as prevention strategies?” and the youths recorded almost half of the sampled respondents at 93 from 192, while those denying ever seeing ads or others who were not sure share the remainder of the 52%.

In response to Table 9 prompt “Are HIV prevention messages clear and plain?” 126 out of the 174 or 72% who affirmed the statement. Another 72% of the respondents or 126 from a total of 174 participants affirmed Table 10 which seeks to establish whether they have seen or heard these taglines, headlines, and slogans promoting the prevention of HIV in the mass media channels. This, therefore, means that the youths possess some level of information about how to protect themselves against the intrusion of the virus that causes AIDS. The youths responded overwhelmingly that they have seen all the major HIV prevention campaigns.

RQ2. Test the suitability and appropriateness of the content to determine whether HIV prevention strategies resonate with the cultural and religious contexts of the target audiences.

Tables 11, 12, and 13 offer insight into why it is imperative for Botswana to invest in homegrown HIV prevention solutions that can address various populations by paying close attention to age, religion, and dominant customs that are not necessarily applicable to all ethnic groupings found in the country. From a total of 171 who answered the question “Do you identify with the people in the HIV drug commercials?” 119 or 70% said they did not see any resemblance between them and the characters in the ads promoting drugs as a preventative. When asked in the sub-set of the same question to proffer an explanation for associating or dissociating from the models used in HIV-prevention, more than half (53%) or 26 out of 49 respondents pointed out the stark differences that made the ads out of sync.

Further, in answering the prompt “Do drug commercials mirror local environment for AIDS and STD?” the youths were vehement that they do not come close. Out of 98 participants,

40 of them (41%) disagreed while the remainder of the percentage was split between those who were not sure to pick a side and the smallest minority of 26% who agreed.

The disapproval of content regarding the life-giving messages when using AIDS drugs to prevent HIV is important feedback for biotech and pharmaceutical companies from the West to heed because of the deliberate choices they made about the inclusiveness of the marginalized populations dominating the paid ads across mass media channels. At the back of their minds, these health communication scientists in collaboration with biotech and pharmaceutical giants including Gilead Sciences whose ads promote two major medicines Truvada for PrEP on the one hand, and Biktarvy for TasP or U = U on the other hand, may mean well to bring on board the marginalized people and situate them in the forefront of the AIDS war so that they dismantle the stigma that led many sufferers to hide in the closet during the early years. But these are medicines that should work in human beings no matter where they are located, and if provable science is perceived to be pushed forward by the marginalized populations, it already carries the stigma from where these people originate, contradicting the ad's purpose of having prevention strategies accepted and embraced. Thus, the intended objective does not yield the desired outcomes.

When the ads are transported halfway across the world and launched in societies where the disease is ravaging the mainstream population, the unintended consequences of stigmatizing the medicines as belonging to those marginalized populations become even more amplified because the disease has been given the face from where the commercials originate. It is easy, therefore, for AIDS sufferers to be repulsed by what is the only lifesaver in the drugs just because members of the LGBTQI communities are prominent characters in the commercials,

thus polarizing the general population between “us” and “them” sentiments and/or reactions instead of embracing the science.

Such a manifestation of attitudes is suicidal because people who need the therapy the most might opt out on those grounds of intolerance, spiking new HIV infections and deteriorating conditions among those living with the disease to a point of high mortality across the mainstream population, when they could have been saved. No one in sub-Saharan Africa can discount the dividends that have been reaped from AIDS drugs. However, the tables about “identity,” “social context,” and “association” in the AIDS drug commercials as a preventative strategy are critical when conceptualizing health messages, especially themes with universal value as medicines to save lives. Medicines cannot afford to be given faces that stigmatize the condition affecting people, lest they are resisted by those who see themselves as not mirrored in the marketing communication of the finished product they might have to spend their hard-earned cash to purchase.

The place of culture in health prevention communication strategies cannot be overemphasized. This study clearly shows that an effective HIV campaign should be grounded in the customs influencing how sex is had and the role families, faith institutions, and traditional leadership play to galvanize support for avoiding the risk associated with contracting the virus.

When family members or friends have trust in the relationships, they exchange ideas and beliefs they have about a disease without holding back because they count on the support of their friends and relatives to ease the pain of dealing with the illness if they faced it alone. As a result, these relationships can “enhance the chances of behavior change” (Glanz et al., 2015, p. 244), mainly because they are tied to the physical and emotional environments where the individual is deserving of love, kindness, compassion, and mercy from those around them acting as their

social support to pass “information that one is cared for, esteemed, and part of a mutually supportive network,” (Glanz et al., 2015, p. 186). In communities like Botswana where the social fabric is based on a collectivist value to rally relatives to stick together through thick and thin, (Baxter, 2018) has recorded this accurately in the following descriptions.

He finally confided in his grandmother, who told him to go to the ARV clinic at Marina. Grandma went with him as his adherence partner. The side effects went away, and several months later he was feeling much better. He told his family and girlfriend, who accepted him. His job was not affected, and when he finally told his coworkers, some of them came forward to be tested and to get into treatment (69)

Here we see how interpersonal relationships contribute significantly to spreading useful information about HIV prevention, and it is a powerful testament to social support dynamics shaped by the dominant culture that might not be applicable in the United States or Europe. From this snapshot by Baxter, we also appreciate the level of collectivism as opposed to individualism in building and maintaining links with one another in a web of these relationships that summon the community to get engaged, involved, and participate in caring for the next person, rather than oneself. It should be enough evidence from this description, that for HIV to disappear in Botswana, and to a large extent; sub-Saharan Africa, messages of prevention should put ‘another’ person ahead of ‘self’ and coin themes that tell of the strength, courage and resilience of community instead of the individual: hence “we-focused” should replace “I-centered” prevention taglines.

Therefore, the insignificant rates (both incidence and prevalence) in the United States are consistent with the Global North, whereas the high figures registered in Botswana represent a disturbing pattern of the devastating impact of HIV across Sub-Saharan Africa. It is no wonder,

therefore, that since 1981, when the United States registered the first AIDS case, to date, the national prevalence stands at 0.36% according to the Centers for Disease Control and Prevention (CDC) out of a national population of 330 million compared against the staggering 20.8% recorded in the 2021 Botswana's AIDS Impact Survey.

According to the CDC, in 2019 alone, a total of 34,800 new HIV infections were recorded across the national population, whereas in the same year, Botswana registered above 13,000 new cases, contrasting the disproportionate rates in how the virus is transmitted in the two types of populations discussed earlier being the LGBTQI in the Western nations versus heterosexual couples in sub-Saharan Africa.

Consequently, an 8% decline in new HIV infections was recorded between 2015 and 2019 in the United States. Human behavior, therefore, analyzed through unique lenses of cultural nuances and religious attitudes regarding practices that fuel the transmission of HIV becomes the central focus for how social environments play pivotal roles in the cognitive abilities of the target audiences to embed health promotion campaigns as desirable lifestyles to secure their futures.

Thus, Western AIDS is concentrated in the key populations whereas, in sub-Saharan Africa, AIDS is the disease of the majority population; therefore, there are two AIDS epidemics, distinct and contextual to deserve solutions tailor-made to address specific, prevalent behaviors that fuel the transmission of HIV. The top-down corporate advertising campaigns from the West to Sub-Saharan Africa miss the realities of social, interpersonal, and cultural contexts to effectively communicate such that HIV prevention is understood clearly and plainly using vocabulary and motifs suited for the homogenous audiences and taking advantage of media channels that reach the target audiences for positive impact in behavioral change communication.

Responding to the question “Are HIV prevention messages in the drug adverts specific to age, religion or cultural beliefs?” the results spoke loudly about the bias that is skewed against African populations in the commercials. Overwhelmingly, respondents denied that the ads represented their age in any way, with a score of 101 against 73 who confirmed, another 123 who said their faiths were not taken into consideration, and 47 who said yes; meanwhile, 173 against 59 denounced the ads as respecting the local cultures in any shape or form.

It can be surmised that these denunciations are at the root of why, amidst robust campaigns, there are swirling rates of new HIV infection among the youth in Botswana. Again, in conceptualizing these adverts, big pharma might benefit from the knowledge that the similarity between Western marginalized populations and citizens of developing nations is that both are disadvantaged groups and must overcome hurdles for them to be welcomed at the table as contributors if not role-players in messaging HIV prevention. While they seek to promote the marginalized populations from the West in these commercials, it would bode well for the citizens from the sub-Saharan region to see themselves represented adequately in these commercials, mainly because that is where the biggest share of the market is concentrated. In a television spot on NBC News, the first-ever 30-second ad promoting PrEP is unpacked by Fitzsimon (2018) as depicting “a gay couple, a transgender woman and young people of color – groups disproportionately affected by HIV.”

As is, the pharmaceutical companies are seen to be exploiting an already under-developed, under-represented people who contribute significant portions of the profits that are taken back to be invested into foundations and philanthropic ventures benefiting Westerners to carry out more research on vaccines and therapeutic medicines that they will ship out to the biggest market—perpetuating the cycle of poverty in sub-Saharan Africa because there is no cure

in sight. Some of the responses hinted that the characters in these commercials are disguised because “They do not have the faces of sick AIDS patients, but of those who make money as agents of influence to sell the drugs.” This would mean that not associating with the role-playing in the commercials is multi-faceted to include all the dynamics so far discussed in the responses, but more importantly, lamenting some expropriation.

In “Speaking from the Margins” Roger Myrick (1996) says:

To address this situation, HIV prevention education, which in many cases has evolved into an institutionalized, white-dominated effort, must be re-evaluated regarding its relationship to marginal communities, especially those of color...redesigning HIV communication strategies to make them more culturally sensitive to and relevant for marginal populations who are currently hardest hit by HIV/AIDS. (244)

Unless and until this idealized world envisioned by Myrick becomes a reality in the discourse of AIDS, the marginalized populations of Sub-Saharan Africa will continue to suffer the consequences of the imbalances. Africans are not allowed at the discussion table; their indigenous knowledge is marginalized as myths, abstractions, and superstitions; they are not allowed in the Ivy League institutes for participatory research that can yield a cure; nor are they considered in the commercials to send sensitive, suitable, and appropriate messages that strike the right chords with their audiences out of respect for the customs, beliefs, and age to receive crucial information to save lives.

“In fact, designing a culturally relevant program and communicating messages in small groups are two critical factors reported to influence positively the outcome of 37 community-based HIV/AIDS prevention programs evaluated in the United States,” (Myrick, 1996).

Discussing culture as integral to the conceptualization of health communication campaigns and launching them with its backdrop is the thesis of an article co-authored by Collins O. Airhihenbuwa and Rafael Obregon (“A Critical Assessment of Theories/Models Used in Health Communication for HIV/AIDS,” 2000) who are unapologetic that disregarding dominant cultures to spotlight health communication theories in foreign contexts only yields disaster in that:

“Moreover, the role of cultural contexts in the successful implementation of programs often is omitted, even though evidence abounds that culture is a central feature in health behaviors and decisions particularly in the context of behaviors that may predispose people to HIV/AIDS.” (p. 6)

AIDS as a global crisis has affected the Global North and Sub-Saharan Africa regions disproportionately with the former registering negligible numbers of those living with the disease, while Africa is the epicenter of AIDS. In the developed nations commonly referred to as Western societies, HIV has spread largely among minorities or, in the preferred language of the United Nations, among – the “key populations” which include as Lesbians, Gays, Bisexuals, Transgenders, Queer people, and those who use intravenous drugs (LGBTQI). Meanwhile, in Sub-Saharan Africa, the epidemic poses the worst catastrophe in the mainstream population, leaving behind a trail of destruction in families, villages, communities, and societies where procreation is happening unabated, according to the WHO bulletin (2002) that nearly all transmissions in Africa take place during ‘unsafe sex’ between heterosexuals (Flint & Hewitt, 2015) which suggests that in the Global North, HIV transmission occurs widely through other means besides male and female intercourse.

Edward C. Green et al. (“Mobilizing Indigenous Resources for Anthropologically Designed HIV Prevention and Behavior-Change Interventions in Southern Africa,” 2009) observe that “HIV prevention programs are often implemented as if African cultures and leadership structures are non-existent...” (p. 390), hence the rejection of culture as the center-stage in health communication campaigns for HIV prevention strategies in Botswana.

Therefore, after two decades of full-blown AIDS warfare in this under-developed region through well-resourced global health partnerships worth billions of dollars in HIV prevention campaigns accompanied by highly trained professionals in HIV/AIDS management, strategies have tended to falter, save for the phenomenal success stories in the treatment of full-blown AIDS via therapy that revived millions of patients who were written off, and in the hailed prevention of mother-to-child-transmission (PMTCT) that resulted in almost an HIV-free generation (9.6 out of every 10 new-borns) since the advent of AZT and other cocktail drugs in 2002 and afterwards.

All these interventions have the scientific backing and assume a universal approach will fit sub-Saharan African contexts, mainly because they have seen huge successes within the “key populations” infected and affected by HIV and AIDS in the Global North. Thus, this study attempts to find practical strategies in the prevention of HIV transmissions in sub-Saharan Africa, particularly in Botswana, by closely studying these public service announcements (PSA) that go to the heart of the universal public health messaging that has informed the discourse of AIDS and prevention campaigns around the world.

In analyzing the PSAs, this research study emphasizes the central role of health communication to promote positive behaviors that can bear a lasting impact on the general well-being of individuals because there should be harmonious, seamless synergies involving the

sender, message, and receiver in the process. As Corcoran (2007) suggests, communication is “content and relationship” (p. 6) in which negative or positive language might be employed to affect the outcome of behavior in the targeted individuals. The slogans and phrases coined to influence desirable behaviors that could keep the infection rates low cannot escape the intertextual analysis to determine their suitability; therefore, critical discourse analysis of the major campaigns is necessary and important.

RQ3. Determine the effectiveness of the channels of communication where campaign messages are placed for accessibility to the target audience.

Given what has been discussed thus far regarding adolescents’ exposure to mass media channels of all kinds, it is difficult to pin down a specific channel that is influencing positive behaviors regarding sex and choices that put youths at risk of contracting HIV, given the consistent rates of new infections witnessed across a decade’s period. What is evident, though, is that while the traditional mass media played a significant role in the first decade of the advent of AIDS drugs to halve the prevalence rate of HIV by promoting “Masa” (“a new dawn”) ARV for treating the effects of full-blown AIDS patients who were extended a new lease on life, the respondents have shown favor towards social digital media and school-based peer clubs, in that order, accounting for a cumulative 62%. Traditional media’s popularity is dwindling according to the results of the study, standing at 21 and trailed by cultural institutions that recorded 19 out of a total of 106 respondents.

Meanwhile, the youths are extremely likely to find HIV/AIDS information easily, across mass media channels with at least 55% of 136 out of 171 affirming the statement regarding accessibility. But accessibility does not seem to suggest effectiveness in influencing the adolescents to adopt positive sexual behaviors that can reduce the risks of getting HIV.

RQ4. Gauge the level of knowledge the target audience has about HIV prevention campaigns to influence sexual behaviors that prevent and/or expose them to HIV.

Similar to the previous question, it is difficult to find linkages between high knowledge about HIV prevention that is shown in the responses regarding the youths' ability to understand the slogans and taglines in the plain language used in the ads, their savviness to navigate different types of media channels for information, and the annual increase in new HIV infections, on the other hand. A total of 78 participants agreed with the informative campaign promoting medical circumcision compared against 23 who reported being confused by the import of its message, suggesting that if the bigger number embraced whatever prevention strategy, positive sexual behaviors would follow. The reality on the ground does not depict this correlation, though. Furthermore, there is a tremendous affirmation for HIV prevention strategies in general with 108 or 66% against 22 participants who said the campaigns were not effective and therefore, not impactful in adopting certain lifestyles that can save them against HIV.

This assumption has been disproved because Table 3 shows that 136 out of 189 who responded said that they were concerned about AIDS, which translates to 72%, quite telling about their knowledge regarding the devastating effects of the epidemic. Further, a whopping 97% or 240 participants showed they are deeply concerned about HIV, which bears no correlation between the rising numbers of new infections since 2010 on the one hand, and their level of awareness to embrace positive sexual behaviors, on the other hand.

H1. The extent of concern about HIV/AIDS is significantly and positively related to the effective and/or impactful level of awareness in preventing HIV among the 15 to 24 age population in Botswana.

The hypothesis has been disproved because despite deep concern about the disease by registering above 71% or 136 participants out of a total of 189, being aware that AIDS is a threat to their existence has not translated to reductions in new infections. In fact, only seven people out of a total of 247 participants who overwhelmingly responded to the question of why they are concerned about AIDS showed indifference to the crisis. It is evident from this slide that the adolescent people share fears and concerns about the devastation caused by the disease, yet the annual new infections of more than 13,000 HIV cases do not speak to the recorded 97% who said they were concerned and aware that AIDS kills. Therefore, having knowledge about the disease cannot be equated to saying they are empowered enough to practice safe sexual habits that can keep HIV away.

H2. The extent of clarity in eliminating the spread of HIV/AIDS as regards prevention messages is significantly and positively related to an effective and/or impactful level of awareness in preventing HIV among the youths in Botswana.

This hypothesis has been disproved because the youths in overwhelming numbers have shown that they get the value in the HIV slogans, and campaigns are generally considered to be plain, accessible, effective and impactful. Still, even after being informed, there is no evidence of behavioral change that protects them against the disease. Representation, identity, and familiar motifs surrounding sex all seem very important in how adolescents have distanced themselves from scientifically supported prevention strategies involving AIDS drugs compared to medicines marketed for treating the disease and improving the quality of life. It cannot be ignored that seeing the medicines flickered hope of a new dawn by referring to the drugs or HAART as *Masa* thus resonating with the general population including the young people.

The adolescents have tremendously responded that AIDS medicines should be to treat those living with HIV, with a score of 111 or 50.6% while drugs as a prevention line in all forms share the remainder of 49.4%. It might be guessed that adolescents are engaging in unprotected sex or using AIDS medicines for prevention but without consistency or, as it has been unbundled elsewhere by experts, that these medicines do not always work the same in every human body to provide insulation. In any of these situations, HIV cannot be prevented.

H3. Accessibility of information across mass media channels is significantly and positively related to an effective and/or impactful level of awareness among the youths in Botswana.

This assumption has been demystified by the results from several prompts asking whether the adolescents are confused by the taglines, whether mass media channels containing HIV prevention information are at their disposal, the level of impact and effectiveness of the campaigns, or their mental power to recall HIV slogans that have accompanied major campaigns. They responded overwhelmingly to display a higher understanding of how to prevent HIV from infecting them because of AIDS information placed across these media channels.

Further, this claim has been disproved; it has been shown that, when information is readily available to young people, it means that their awareness has increased to make choices that can safeguard their lives from HIV. Given the dynamism that the world is going through and the overwhelming support for social media channels and youth-friendly AIDS education clubs, Botswana young people have demonstrated that cultural and religious values are integral for survival. Table 13 in which an overwhelmingly big number denounced that the drug commercials showed any cultural and religious considerations for the local people targeted by those messages is a case in point. In favor of social media outlets, some of the sentiments

included statements like: “TikTok, Facebook, YouTube, and Instagram. Through social media outlets this can help the youth to access the messages as they take a lot of time on social media channels,” or “Since children are nowadays always on social media, there should be more ads supporting or encouraging them about preventing AIDS.”

It is evident that young people believe they have the power in their hands and can relate to one another if there is peer education within and among themselves possibly with a greater impact than when it is top-down from corporate mainstream media telling them what to do when they do not necessarily understand their landscape. Respondents remarked upon this peer education with statements like: “Relevant education and participation by young people in AIDS education and mobilization. Usage of youth-friendly and easily accessible platforms,” or “Forming fun associations in schools and campaigns that can help spread the message in a most fun and entertaining way,” to “Giving students opportunities to research about HIV and AIDS in computer science labs.”

H4. The extent of advertisement content whether informative or ambiguous is significantly and positively related to an effective level of awareness among Botswana’s youth.

This also has been disproved in all but one diagram where the youths have shown that the AIDS drugs might be sending messages of duality in what they understand the medicines to be doing in their system to block HIV from being transmitted. This study has revealed that it matters not whether the ads are informative or not; there is more about campaigns that need adjusting to appeal to the ages, cultural practices, and religious beliefs that can leave a lasting impact than to come up with an informative tagline that is foreign to the local social environment.

CHAPTER 6

CONCLUSION OF STUDY

The comparative study between the AIDS situation in the Global North, and sub-Saharan Africa contexts is crucial for many reasons, particularly that, after 40 years since the first registered case of the human immunodeficiency virus (HIV) that causes AIDS, out of 75 million people who have become infected with HIV, over 32 million people have died from AIDS-related illnesses, and sub-Saharan Africa has constantly remained the epicenter of the epidemic.

To put in place strategies that can effectively respond to the epidemic, “Therefore, the first stage of any communication campaign is to analyze the behavioral aspects of the health problem,” as Corcoran mentions (2001, p. 9. Suffice it to state from the above that it is necessary to study the pattern of the disease in relation to the prevalent culture in a particular region—that way, individuality rather than universality in coining prevention messages is the approach and focus.

Green and Ruark in *AIDS, Behavior, and Culture: Understanding Evidence-Based Prevention* (2011) offer an insight into the importance of anthropological investigation of the epidemic in sub-Saharan Africa in the following passage:

A 10-country research report on multiple and concurrent sexual partnerships in southern Africa did not mention positive cultural practices that might mitigate the spread of HIV. Thus, even good studies fall back into the habit of seeing African culture only in a negative light almost any time that AIDS and African cultural practices are discussed together. (47)

Further, the evidence regarding the stereotyping in framing HIV prevention that is alluded to in the book dates back to ancient times when the Greeks first encountered the great

cultures on the African continent, quite a disturbing phenomenon that the European societies have sustained across generations. According to the combination of research efforts between an anthropologist and a public health specialist that bore the book, understanding the relationships between the dominant practices surrounding sex and sexuality by Sub-Saharan Africans, on one hand, and the need for people to change behaviors on the other hand can guide those designing health communication to target their message for impact because “This allows identification of the actions needed to change that behavior and highlights the pathways of influence that hinder (or promote) that behavior,” (Corcoran, 2001, p. 9).

Avert is an international non-governmental organization that collects the world’s HIV data, and on its website, it shows that about 68% of the global active HIV cases (25.6 million) are in sub-Saharan Africa, while a negligible rate of 0.36% is recorded in the United States among ages 13-24, whereas Botswana’s national HIV prevalence (15 through to 49 ages) stands at 20.8%. With the annual 13,000-plus new HIV infections recorded constantly covering the period 2010 and 2020 in the target population for this study, it begs the question of why there seems to be a gap between mass-mediated HIV campaigns and the behavior outcomes.

From the health communication theories, failing to learn about the audiences targeted in the messaging—including general behaviors, attitudes, social and physical environments, cultural and religious beliefs, and the conceptualization, packaging and presentation of the campaign are all in vain. Glanz et al. (2015: p. 129) state “Behavior change is a process that unfolds over time through a sequence of stages” (129) once people are informed “enough about the consequences of their behaviors,” which should be abandoned to embrace suggested ones contained in the taglines. The epidemic of HIV/AIDS has remained the 20th and 21st-centuries’

sub-Saharan Africa's biggest challenge and continues to be a threat to its populations. AIDS is unlikely to be waning ahead of the goal year 2030.

Therefore, the scholarly research is grounded in the concept of "Start where the people are" (Nyswander, 1956), which suggests that effective health prevention strategies must be rooted in the prevalent cultural practices and religious values of the people being assisted and never in the values of the outsiders. Botswana boasts the best model in prevention and treatment for the whole continent with a sterling performance of 95-98-98 against the UN Sustainable Development Goal of 90-90-90 that was set to have been achieved by every nation in the year 2020 (UNAIDS) that every nation would have tested and diagnosed 90% of its HIV-positive people, 90% of HIV-positive people would be enrolled on AIDS treatment and that 90% of those on antiretrovirals would have suppressed the viral load to an undetectable level in a laboratory test not to be transmitted to a sex partner.

The concept of "Start where the people are," therefore, needs homegrown HIV/AIDS prevention solutions wherein Western science and technology strengthen the strategies in collaboration to end the epidemic that has beleaguered her societies in four decades, and surprisingly amidst the availability of medicines to suppress the virus since 2002.

Particularly after AIDS drugs and advanced technology increased the quality of life for those suffering from the disease, Western superpowers and their HIV/AIDS forays into sub-Saharan Africa have relocated effective prevention strategies. Much to their dismay, there seemed to be resistance to behavioral change interventions contained in the mass-mediated HIV/AIDS campaigns, going by the unintended outcomes of rising new infection rates in the general population, and even more so, among young people ages 15 to 24.

Especially for AIDS drugs as prevention against the transmission of HIV among sexual partners, the major, mass-mediated communication campaigns using television, radio, newspapers, magazines, billboards, social network sites and online channels including pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), and treatment as prevention (TasP), have significantly featured the key populations (LGBTQI) characters roleplaying prevention messaging. It is not the goal of this study to downplay the inclusivity of the key populations in lead roles to promote the medicines for treating AIDS to be made accessible to them as marginalized populations. However, for a region that is predominantly heterosexual like Sub-Saharan Africa, such important science needs to be leveraged using familiar partners in these relationships that have fueled the transmission of HIV by “99%” if there should be any credence to the 2002 WHO bulletin. The shocking figures mentioned earlier should elicit some desire from within these diverse cultures to harness cultural and religious values that address the epidemic using nuances, motifs, and role-playing familiar to the intended audience.

Rather than transfer pre-packaged strategies touted for their efficaciousness from the developed nations, particularly the Western world and launching them wholesale in European tongues, an equal partnership that recognizes Nyswander’s (1956) wisdom to co-create health promotional campaigns which the intended audience can identify is the answer to ending AIDS by 2030 as envisioned in the United Nations’ Sustainable Development Goal. In a few instances, the universal HIV prevention strategies are adapted but only limited to the dominant languages that exclude a greater majority of people who cannot speak, read, or write them since they are acquired through formal education, much like Setswana as the national language, is preferred over tens of ethnic languages and dialects.

This study makes no attempt to dispute the empirical science behind condoms, AIDS drugs, and medical circumcision as effective HIV prevention strategies, as there is evidence that they have rolled back new infection rates among unique populations around the world. While it is important that “Anti-retroviral drugs like those used in pre-exposure prophylaxis are the best tools we have to treat and prevent HIV-1 infection,” (Sather, 2016), empirical science like AIDS drugs and what they can do for people planning on prevention against HIV can yield disastrous results if they are misunderstood for a cure.

In the Botswana context, the sad reality of the HIV prevention campaigns in the past two decades has yielded rising new infection rates, suggesting that some gaps need to be closed, ranging from the creators of the content and their familiarity with the landscape, the characters in the commercials and their credibility to connect with the target audiences, to the channels where content is placed for consumption to affect behavior. Between the creator of the message, who is not always the sender, the channel transmitting the message, and the intended audience, it is possible to communicate but fail to connect the behavioral-change message to the end-user for a positive impact in a health campaign. When communicated badly, even the best strategies can leave behind a trail of destruction and no intended, tangible, and desirable outcomes.

To better appreciate the imbalances in the rates of HIV among Western citizens versus sub-Saharan African populations, the epidemic should not exclusively be treated as a viral disease whose cause is known to scientists, but rather whose driving factors are not universal to every place on earth for which the same solution can be prescribed uniformly to bring about desirable outcomes. The lifestyles, content in the prevention messages, linguistic barriers as well as media where they are launched, all combined, appeal to the cognitive abilities of those targeted to make the right choices.

These AIDS drugs supplemented the use of condoms that Baxter's patients used in anal sex for men-having-sex-with-men and among prostitutes and commercial sex workers, according to his confessional tale (2018). Condoms, like the AIDS drugs, are touted to prevent HIV with up to 99%. But the celebration of the effectiveness of the drugs and condoms as bulletproof protection against HIV lasted Baxter only before his arrival in Botswana in 2002 under the auspices of the Bill and Melinda Gates Foundation to share efficacious HIV prevention strategies that he had successfully used in New York.

With a provable track record, Baxter (2018) embodied the 'saving grace' that the West benevolently ushered to a besieged nation at 24% prevalence back then. The landlocked country in Southern Africa is one of the world's highest HIV prevalence. And Baxter means well to put his expertise to serve and save humanity. He openly details the repeated failures to prevent further transmissions of HIV by applying the exact, same, tried, and tested strategies in the United States, which significantly stemmed the tide in New York City and replicated the success story across major American cities with a high concentration of the key populations who benefited from these interventions.

In Botswana, however, Baxter spent nine years on the frontlines of AIDS warfare, but but the battle was completely different from what he was accustomed to in his practice among the minorities. It is this sobering discovery that there are two types of AIDS epidemics caused by the same virus that this study supports individual and specific solutions influenced by social environments to back up conceptualization of the content, selection of the characters to roleplay the message, and choice of the medium to place the message for a homogenous audience rather than heterogeneous audiences.

This “single perspective instinct” (Rosling, 2017) is the reason the former President of South Africa, Thabo Mbeki, was caricatured as the worst fool for misunderstanding the cause of AIDS because he blamed poverty for it. The Western nations missed appreciating the truth in President Mbeki’s statement that, in mainstream sub-Saharan Africa, those who were living in abject poverty were disproportionately infected by AIDS, leading to reason that their economic power did not allow them to negotiate safer sexual relationships because of the existing imbalances, an assertion which Hall (1980) echoes in the discussion of the superstructure of these relations. HIV and not poverty causes AIDS, it is scientifically known. But poverty drives the rates of HIV, and whether it is in the developed nations of the West or sub-Saharan Africa, economically deprived members are worse exposed to contracting HIV than well-to-do counterparts.

Therefore, it is not entirely wrong that “poverty causes AIDS” in the context that President Mbeki put it. Those who depend on economically stronger sex partners almost always have no means to reject “unsafe” ways to have sex with their partners, and nearly all of them are females, who suffer double the effects of AIDS in heterosexual relationships because of cultural prejudice that compels them to procreate or carry the stigma of being “barren” in addition to having the weaker economic power. Mbizvo, Phillips and Sharon. (2014) in their article demonstrate the role of an African woman in a predominantly patriarchal society:

Family Planning: Choices and Challenges for Developing Countries” demonstrate that Women in Africa are valued among others, by their capacity to bear children, and women in marriages, in particular, are by obligation, expected to birth heirs to family dynasties. Introducing family planning methods like condoms, which is also prevention against HIV is thus, an important undertaking that should consider

the social status of those involved, lest what is intended to improve the quality of life, become a scourge of domestic violence and unstable relationships. (1)

The reality that we are dealing with two types of the same epidemic that identifies by a geographic expression in the Global North and in sub-Saharan Africa is the premise of this scholarly investigation into HIV prevention – that unique, peculiar, distinct, specific, and different interventions must be conceptualized with the Sub-Saharan African region in the foreground and the cultural and religious contexts at the center of the AIDS messaging. Unlike in New York, HIV in Botswana started and spread in the mainstream society, and therefore, strategies targeting people outside this orientation were always likely to be outrightly rejected or bear no impact because they didn't convey sensible messages needed by the intended audiences due to their unfamiliarity with cultural and religious environments. Baxter (2018) discovered sooner than later in his altruism that “They resolutely insisted that homosexuality was a Western disorder not present in Botswana” (p. 65), suggesting that the doctor was miscommunicating the intent of his ‘saving grace’ by promoting the use of condoms for anal sex among people who considered such an act as an abomination, unnatural, unculturable, and therefore, inappropriate to be part of the AIDS discourse.

Furthermore, this study makes no attempt to marginalize LGBTQI members in the prioritization of condoms as an HIV prevention strategy, except to reveal the mismatch to focus a lifesaving message to a minority population in a cultural environment that is predominantly heterosexual, whereas the same message is well-focused on the minorities in the United States and Europe appealing to them because they are hit the hardest. Hence, Baxter failed to “start where the people are” in promoting condoms as an effective, scientifically backed-up strategy against HIV in a predominantly heterosexual society.

But there is an even deeper problem that is revealed in Baxter's (2018) daring attitude to put it out in plain language to the beneficiaries of his service without sparing a thought to the sensitivity and suitability of such a promotion in a conservative society like Botswana. Did Baxter study the environment before his arrival to know what was culturally and religiously acceptable regarding sex in general and HIV prevention in Botswana? What about scoping the environmental landscape upon arrival concerning the attitudes towards AIDS, HIV-positive people, and those who died from the disease to be able to strike the right chords with his audience? As it happened with colonial missionaries, Baxter's bold declaration about anal sex epitomizes the Western rigidity to accept that the developing nations deserve equal partners to co-create knowledge about the human condition – not for the AIDS emissaries to carry a torch to light up the *darkness* by mismatching strategies with the intended audience.

However, even institutions headquartered in the West have not avoided this pitfall of prescriptive solutions to local problems because they assume authority over epistemological realities in these foreign lands (Spivak, 2008). For example, the referenced WHO bulletin (2002) in the introduction which reported that HIV transmissions in sub-Saharan Africa were spreading at “an alarming rate of 99%” among heterosexual couples, implied that Sub-Saharan Africa was on the brink of extinction resulting from AIDS because of promiscuous, reckless, and unsafe sex between males and females. However, when the West should address the insatiable appetite for vaginal sex that is apparently decimating Africa's populations, experts such as Baxter prescribe condoms for anal sex among heterosexuals, begging the question, how will that strategy bring down incidence [rates] among these couples?

Therefore, from the controversial WHO report (2002), it can be deduced that there are two HIV epidemics classified according to distinct locations between the Global North and sub-

Saharan Africa. In the Western nations with high HIV prevalence, they tend to have the epidemic concentrated among the key populations. The annual average of 4% HIV incidence experienced by Botswana between 2010 and 2020 HIV incidence among the 15-24 ages is validation that AIDS is a venereal disease and “unprotected” sex fuels its transmission just like other sexually transmitted infections (STIs) that are common.

Implications

Therefore, coming up with pragmatic solutions to address the epidemic requires a proper contextualization of the ways through which HIV is transmitted across these populations in unique geographic expressions with specific cultural values and religious practices that influence the attitudes towards sex and HIV. The Global North nations tend to be liberal in many ways where the topic of sex and sexuality is brought up, especially in North America and Western Europe where they can openly discuss it without cringing or blushing, whereas it is a taboo to talk about sex and sexuality openly across Sub-Saharan African societies, much less to imagine a conversation between parents and children or community leaders and their followers on a matter so private and intimate.

Rather than prescribe a universal solution, the tested and provable science and technology would encounter few to no roadblocks if knowledge about the disease was co-created and practical HIV prevention strategies were developed from within these communities. Epistemological development around pressing challenges including HIV/AIDS demand participatory research techniques using indigenous knowledge preserved within these communities about diseases and health overall that has been acquired over centuries of observing

the cosmos to build upon such body of knowledge with the breakthroughs recorded in the sciences, technology, engineering, and mathematics arena to benefit humanity.

Intrinsically, HIV/AIDS in the Global North has remained a disease of the minority. These people have been in the margins of mainstream society that seemingly dictated mores and values deemed to be civilized and upright – and as such, public service announcements tended to be moralizing and didactic to the extent that they were conceptualized with the fear-arousal factor. Therefore, it is unlikely that prevention strategies pushing the key populations' themes or even just their connotations could appeal to the sub-Saharan African communities because their AIDS is a whole different epidemic widespread among heterosexual couples.

The HIV incidence among the ages 15-24 population is a disruptive and disturbing phenomenon considering that since 2002, Botswana became the first African nation to supply antiretroviral AIDS drug therapy free of charge to its people over and above the availability of condoms that had been the first layer of protection against HIV since the height of AIDS deaths in the last decade of the 20th-century. The science and technology of drugs as suppressants to manage the effects of AIDS on the sufferers surely extended a lease of life to millions in sub-Saharan African populations. As technology peaked, then came a cocktail of AIDS drugs touted to eliminate HIV from the bloodstream of an infected person to the point that if HIV is undetectable, it is, therefore, untransmissible during “unprotected” sex. This is a dangerous tagline because AIDS has no cure. But the ambiguity in the message may result in HIV-positive people misinterpreting it to mean they are cured of HIV to not spread it or those following PrEP as insulation against being infected might hold the belief that it is guaranteed. Both campaigns are misleading because HIV gets passed from one partner to the next while using the drugs in some cases that science has not been successful to explain.

The latest medical strategy launched right across the sub-Saharan African continent is medical circumcision popularized as safe male circumcision (SMC), which assures male partners a safety net of about 60% protection during “unprotected” sex with HIV-positive females. Despite these hailed prevention strategies, sub-Saharan Africa remains the AIDS epicenter, recording above two-thirds of the world’s population, which translates to above 26 million people living with the virus that causes AIDS. Meanwhile, foundations and wealthy nations are placing little if any premium on character-virtue development by pairing with cultural and religious institutions as agents of change and influence to direct HIV strategies that can combat and defeat AIDS by 2030.

The disturbing trends with new HIV infections are taking place amidst these robust campaigns, where Botswana’s HIV prevention and treatment strategies are lauded as the best models for the whole continent of Africa. In contrast, Baxter (2018) sums up the AIDS epidemic in the United States this way:

The stark terror of AIDS in New York was magnified by the guilt and shame attached in those days to homosexuality. Coming down with AIDS meant you were gay or a drug addict or both...Early on in America, many people regarded AIDS as a just punishment for people whose sexuality they despised—AIDS sufferers got what they deserved (7)

Hence this study has established that these high numbers of new HIV infections among 15 to 24 ages in Botswana signal sexual behaviors prevalent among teens and young adults resulting from inappropriate information that is missing its target for impactful, positive behavior. Furthermore, the new HIV rates mean that wrong channels to disseminate useful and relevant HIV prevention information has resulted in missing the target audience, mainly because prevalent cultural and religious practices have been disregarded in the campaigns.

The future of every nation is guaranteed in its children and youth. After the clarion call President Mogae made to the international community (2000), a year later, one-third of HIV-positive people out of the then national population of 1.5 million were receiving AIDS medication free of charge from the government, a move that earned Botswana accolades as the first African nation to tackle the AIDS pandemic head-on as a national security threat. Granted, Western medicine is the sure game-changer to bringing down the debilitating effects of HIV/AIDS, but could the Global North at the least acknowledge that it has been coining the right messages but targeting the wrong audiences, or that it created the wrong content and delivered it to the right people suffering from AIDS but who cannot resonate with it? Because these HIV prevention campaigns succeeded in the United States, should that universalize them?

Therefore, the focus of this study is on the dominant cultural and religious practices of the *Batswana* (people of Botswana) and how they intersect with health promotion campaigns against HIV to initiate for behavioral change towards sex and AIDS. It is the objective of this study to improve health messaging around HIV prevention to blend with the cultural idiosyncrasies of the dominant population affected by the epidemic of HIV/AIDS. These life-saving messages are packaged as informational content using mass-mediated platforms like television, billboards, print ads and radio jingles, while the new media of social networking like Facebook, YouTube, blogging, TikTok, WhatsApp, and other channels have become popular in the last decade to transmit important facts to stay safe. It is for this reason that Wright et al. (2012) note that “Many health communication researchers are interested in the role of the mass media in helping to shape our understanding of specific-related issues and our more general conceptions of health and illness,” (p. 6).

The mass media are a strategic partner to send the user information that is beneficial, and when it is consumed, there is an expectation to impact behavior of those reached by the message. It is thus extremely important that conceptualization of the message is not only limited to who the ads affect (including their race, class, gender, economic/educational backgrounds), but also the physical place from where such a theme is originating as well as its destination (target population). In the context of HIV/AIDS in Botswana, which is out of control among the 15-24 ages, this study seeks to establish more effective means of communication that not only appeal to the youths, who are technologically savvy and live off their handsets and dominate the social networking nodes daily.

Coming up with a solution in the communication campaigns that may impact positive behavior, we should ask “Who is doing this searching, why they are using the internet to find health information, and where they are searching?” (Harrington, p. 341). Then we must avail it on those channels that they frequent like YouTube, Facebook, TikTok and other social networking sites (SNS). Especially with the stigma that has always accompanied HIV/AIDS, “Although tremendous advances have been made in treating this disease, it is still frightening, causes patients to have a lot of uncertainty...So in the case of this disease, patients will often rely on searching online for information,” (Harrington, 343) because the platforms allow for information sharing that respects the privacy of the individuals.

Health campaigns thus should pass the litmus test in community engagement concepts and principles as Nyswander (1956) advises about “starting where the people” targeted by the message are located.

Coercing communities that have different value systems to adopt new, outside interventions that did not respect their nuances, disregarded their public opinion, and whose

decision-making rejected their input, inevitably, is a recipe for disaster because there is likely to be no social action on the part of the target audience. In fighting an infectious disease like AIDS, one whose historical origins in the United States squarely blamed, demonized, and condemned the sufferers, most of whom were Black heterosexuals, white gays, intravenous drug users, vagrants, and commercial sex workers, and populations that the privileged white Americans considered the earth's scum, the United States should have avoided the pitfall of moralizing in her HIV prevention upon entering the Black continent under the ABC campaign.

America should have remembered the resentment that its minorities felt against the so-called mainstream society that thrived on the "holier-than-thou" attitudes. The United States should have embraced an equal partnership with the cultures of sub-Saharan Africa to co-create practical solutions to help her rise above the worst health crisis in contemporary history. Recognizing the indigenous knowledge about AIDS and combining it with the science that America brought would have been complementary, and preferable to denigrating every practice while inserting the technology of condoms and drugs as the only choice between panacea or gnawing at death throes of Africans perishing from the AIDS epidemic. This is why, in 2011, an American AIDS doctor returned home a humbled expert to have assumed the "one-size-fits-all" approach in HIV prevention, resulting in his exhortation that every AIDS case should be treated as unique because of different factors as mirrored in the title of his memoir: "One Life at a Time" (2018).

Indeed, University of Botswana professor Bagele Chilisa decries this universality alluded to by Baxter and supports her argument in the article "Educational Research Within Postcolonial Africa: A Critique of HIV/AIDS Research in Botswana" (2005), explaining that "The error of sameness or universalism is that it can only proceed by massive domination and silencing of the

less powerful,” (p. 671). By this, Chilisa is lamenting the tendency to dismiss the plight of the Africans when they narrate their experiences and understanding of diseases including HIV/AIDS—that is, indigenous knowledge is often dismissed as mere ‘myths,’ ‘superstitions,’ ‘assumptions,’ and ‘abstractions’ to engender the hegemon of the superpowers even in their acts of altruism depicted through global health partnerships like the President’s Emergency Plan for AIDS Relief (PEPFAR).

The superpower nations like the United States disregard and disparage Africa as an unequal partner who cannot create knowledge about the diseases and how to prevent their transmissions, nor can co-create solutions unless it was told what was appropriate for its settings.

Nyswander’s (1956) model, “Start where the people are” harmonizes with the confession in Baxter’s AIDS book about Botswana, and the prevention strategies conceptualized outside and implemented in an African setting. Therefore, the major campaigns, including the ABC (abstain, be faithful, or use a condom), the SMC (safe medical circumcision), and AIDS drugs as PrEP (for HIV-negative, high-risk populations) and lastly, the U = U (undetectable equals untransmissible for HIV-positive people) are the focus of this research study to establish their efficacy and effectiveness in Botswana as funded through global partnerships and the Government of Botswana that started in 2002. These programs extend financial and technical assistance to the developing nations, and the United States’ PEPFAR accounts for two-thirds of the HIV prevention footprint in sub-Saharan Africa, where the strategies are replicated across these nations.

For health campaigns to reach target audiences for impact, their messages are mass-mediated using the radio, television, newspapers, magazines, billboards, and online social marketing channels. Therefore, the main campaigns are analyzed against the backdrop of these

mass media channels to determine the suitability to deliver information that can alter behavior of the target audiences.

Since 2010, new HIV infections have been spiraling out of control from the national 17.1 percent in 2008 to the current 20.8%. More disturbing is the increase the Botswana youth population (ages 15-24) have been registering at an annual 4% between 2010 and 2020. There is a need to summon the courage to face the challenge of the epidemic head-on to result in pragmatic prevention strategies that complement the AIDS drugs which have alleviated pain and suffering that used to befall those sick from the disease in the previous decade.

The AIDS reality in Botswana regarding the science and technology that were launched outside the cultural contexts that influenced the spread of the disease became the source of pain and frustration for the internal medicine doctor whose memoir depicts humility and sobriety upon return to the United States. Corroborating Baxter's (2018), Sather (2016) remarks in a news article that the "one-two punch" of the prophylactic drugs "means the virus is extraordinarily difficult to wipe out once the infection is established."

From the above explanation, even as Truvada or other PrEP medicines are touted as preventative strategies against HIV, there are individuals who by their genetic makeup have resistance to drugs that are meant to insulate them against infectious diseases, including AIDS. Despite the hailed success in the United States where doctors like Baxter observed great results, they were hoping to share as best lessons from the science with besieged nations of sub-Saharan Africa, the patterns of transmission of HIV in these communities should have become the entry point of the clinical trials before any health campaign promoting the drugs as prevention could ever be launched.

On the other hand, Baxter and fellow American AIDS experts were dispatched as emissaries of altruism, Botswana's 24% national prevalence back in 2002 meant it was among the world's top three nations hardest hit by HIV after Swaziland (now Eswatini) and Lesotho, her neighbors to the south, a decline from the 30s percentile before the distribution of antiretroviral drug treatment to its citizens. Out of almost eight billion of the global population, sub-Saharan Africa has less than 1.1 billion citizens, or just slightly under 14%, yet it carries the heaviest burden of active HIV cases and highest mortality rates from AIDS. More than 25.6 million out of the global 36.83 million HIV-positive patients are in the Sub-Saharan Africa region, suggesting a disproportionately unbalanced burden from the pandemic, begging the question – why has this reality been constant in the last two decades since the forays into the sub-continent in 2003 under the United States PEPFAR program to alleviate suffering and pain?

The rhetoric of power in universalizing Western messaging about HIV prevention strategies that have made it into the cultures of sub-Saharan Africa thus sits at the intersection of this research study. Especially with science-backed interventions such as PrEP, PEP, and U = U, this posture for inclusion is made clear in how AIDS drugs that are meant to work effectively in a predominantly heterosexual region are promoted exclusively by the key populations from the United States.

Television commercials in major cable networks with an international reach, for example, Cable News Network (CNN), British Broadcasting Corporation (BBC) and Sky News, or popular social network sites like Facebook with its 2 billion users, TikTok, YouTube and Twitter, all promote the efficacy of the AIDS drugs such as Biktarvy or Dovato in the campaign U = U (also Treatment as Prevention or TasP) and in the PrEP campaign using Truvada or Descovy medicines to give patients a good quality of life. These commercials predominantly use

the members from the key populations for a universal message about the prevention of HIV. The tagline in the Biktarvy drug campaign, for example, is “Keep being You,” essentially encouraging gay couples to remain proud of their sexual identity because they are safe if they adhere to the use of the antiretroviral drug. How sensitive is such a communication campaign in sub-Saharan Africa with its religious and cultural values that shun same-sex relationships, where anal sex is viewed as a “Western disorder...and an abomination” (Baxter, 2018, p. 65)

The same narrative is repeated in drugs that are meant to save tens of millions, including Truvada or its successor Descovy (which appeared after Truvada lost its United States patent in 2021) whose campaign targets people within “key populations” to take AIDS drugs and engage in unprotected sex to prevent HIV, or Biktarvy or Dovato, which promote U = U. Members of the “key populations” are roleplaying the science behind the drugs manufactured by these biotech giants to benefit humanity, yet packaging life-saving messages by exclusively promoting the minority populations of the Western nations to target the rest of the world audiences including sub-Saharan Africa’s heterosexual populations in these television spots launched on these major news networks as well as major entertainment channels including MTV, and BET for global audiences.

However, the big pharma companies, in embarking on their global communications about messages of hope to treat and prevent an epidemic that is devastating the majority of sub-Saharan Africa, should have been culturally sensitive to the extent that they engaged the communities to input how the campaigns should look and feel before the target audiences infected with HIV from different ways because of their social, educational and age backgrounds. Assuming that sub-Saharan African nations would see and hear the science behind the role-playing has been a miscalculation by these global companies and their advertising firms.

No one captures the truth about adapted advertising better than Gilead Sciences' Vice President of U. S. sales and marketing for HIV treatment and prevention, Chris Freeman in a news article headlined; "Gilead says 'Step up for PrEP' in Descovy's first HIV prevention Campaign" (2020) by stating that:

"Gilead wanted to make sure many different populations of people at risk for HIV were represented. Across most consumer media, people want to see representations of themselves in advertising before they start to think this could be something for me or this is relevant to me."

This same awareness of employing the most appropriate characters to forward the message should not have eluded Gilead when it took its campaigns to different cultures where HIV/AIDS is not a disease of the minorities but has hit the core of existence and spread at "alarming rates" (WHO, 2002) across heterosexual couples for reasons that are not similar to what the company has experience of in the United States. Indeed, as Marshall McLuhan has counseled before that, "The medium is the message" (p. 1) because, through the channel of communication, audiences decipher ideas that introduce them to new ways of behaving.

Because of the myths surrounding AIDS in the United States, prevention communication campaigns traditionally heightened fear while castigating behaviors and attitudes of these marginalized populations because it was widely accepted that they chose their fate. Baxter's (2018) assertions in his 'confessional' can be bolstered by some of the media campaigns that dominated the billboards, television spots and newsprint across America's major cities, where these minorities to this day experience the disease burden. For example, the New York City Health Department, in promoting condom use as a prevention of HIV/AIDS designed a campaign that "aired on cable networks including the gay and lesbian channel Logo, Bravo, and the Travel Channel that: 'When you get HIV, it's never just HIV. You're at a higher risk for

dozens of diseases even if you take medications, like osteoporosis, dementia, and anal cancer” (James, 2010). In response, a news report headlined “Graphic HIV/AIDS Video Horrifies Gay Community” circulated as the ad attracted a barrage of hostility from the gay communities (James, 2010).

Members of the gay communities had to fight hard to be recognized as humans with intrinsic rights enjoyed by “straight people,” bearing pressure on the government and individual states, including every municipality to recognize their fundamental rights to stop demonizing their sexual orientation as deserving punishment from an incurable disease. Because they were being denigrated, they tended to show disinterest in the ‘wear a condom’ campaign, forcing authorities to withdraw such judgmental ‘scare tactics’ to influence positive behaviors in the prevention of disease.

The moralists were from outside the circle looking inside and seeing filth that had to be condemned because those infected with HIV had deviated from the norm, and thereby, drawing conclusions regarding their morality as a promiscuous and loose population. Across the minorities, the effects of AIDS had been widespread among African American people with more than 30% of reported HIV cases, despite contributing only 12% to the national population, a similar scenario to the global HIV pattern of Sub-Saharan Africa’s AIDS situation versus the world population. Corneille et al., (2015) in “There's more to us than this: A Qualitative Study of Black Young Adults' Perceptions of Media Portrayals of HIV” stress that:

It is critical to analyze these perceptions within a historical and cultural context.

Participants’ perceptions of messages exacerbating negative stereotypes about Black people as ‘overly sexual’, ‘dirty’ or ‘careless’ is consistent with the long history of negative representation of Black people. (p. 76)

It might have seemed insurmountable in the beginning for these minorities to have their voices added to the war against AIDS, but ultimately, they bore pressure on policymakers and got involved in designing PSAs promoting “safety and solutions, rather than stigma and stereotype,” reads abcnewsradioonline.com report (Dec. 15, 2010) “Always use a condom,” might have the good intentions of speaking inspiringly, but from an already judged community, the PSA lends itself to a preachy tagline, where the reaction is to lock the defense mechanism. The African-American men and women are seven times worse off than their white counterparts where HIV infection rates are concerned, according to the abcnewsradioonline.com report (Dec. 15, 2010). The designers of the campaign defended their content and characters that projected it as being without judgment, besides stating scientific evidence.

However, health communication experts have consistently demonstrated that, while fear-arousal might in the immediate future, bear a positive impact, it will not in the long run once people settle themselves into the condition of the disease. It follows instinct to repel the prescriptive approach that treats others as sub-human to be frightened by judgmental themes. Mass media pundits say that mass-mediated messages might trigger public debate around the health campaign yet end up not bearing any positive effect on behavior because they recycle stereotypes that serve as reinforcement for stigmatization. In making a case for the involvement of minorities in his article; “Speaking from the Margins” (1996), Roger Myrick states that:

The most effective campaigns use the personal, interpersonal, social, and political contexts of target populations as a basis for health communication strategies that encourage behavior change through the promotion of self-efficacy or belief on the part of the audience that it has the power and need to enact behavior modifications...In short, effective health communication designed for African American populations must be

based within those populations. To achieve this goal, target communities must be actively involved in all phases of HIV prevention campaigns. (pg. 243-4)

Myrick's insight is precisely the foundation upon which this study involving the 15 to 24 youth populations of Botswana is built. The point is also important in informing policy direction for HIV prevention campaigns, and it rhymes with the model espoused by the American health educator Nyswander (1956) in "Start where the people are."

Similarly, Green and Witte (2006) in their scholarly article titled; "Can Fear-Arousal in Public Health Campaigns Contribute to the Decline of HIV Prevalence?" say that such campaigns are ineffective as they succeed best at entrenching stereotypes and stigma, and never about bringing down rates of infections. They state that "A gay actor recently admitted in a *New York Times* op-ed that something is not working with the message to which the gay community is exposed, in fact, they might even be contributing to higher infection rates" (Green & Witte p. 248).

Four decades after the early discoveries regarding the transmission of HIV from one person to another, the Global North nations have moved to the extreme end of the spectrum to fast-track inclusion of these marginalized populations in the fight against AIDS, rallying them to the head of the table as agents of change to view the disease and its sufferers from a different and positive light. In contrast, the AIDS situation in sub-Saharan Africa has from the beginning, been about the mainstream society, spreading among heterosexual couples "at an alarming rate" (WHO 2002) because partners did not have protection during sex, and whose purpose for intercourse was always two-pronged: procreation and pleasure. The AIDS situation in the Global South was never like what the developed nations were experiencing; as such, these societies should have designed their prevention strategies informed by the realities of the disease and how

it was spreading from one community to the next resulting in a health crisis it has become. These nations should never have based prevention interventions on the assumed universal messaging coming out of the Global North that already had innuendoes, connotations, and judgments.

Such a disposition assumes that the local communities have no capacity to demonstrate their “strengths” because they are defunct of moral values that outsiders consider as necessary experiences for equal strategic partnership in promoting co-learning and cultural humility to integrate knowledge and action. Because they are deemed irrelevant in participatory research that can “facilitate equitable involvement of all partners;” the local cultures remain insignificant for “recognition of inequities as the major target of change,” (Glanz et al., 2015, p. 283) in launching health campaigns.

That way, sufferers of HIV in sub-Saharan Africa caved into denial much the same way as their counterparts in the Global North, except that heterosexual intercourse is unavoidable to be stigmatized no matter where one goes around the world. The argument to be made about the ABC campaign in Botswana and the rest of sub-Saharan Africa is that it refused rigidly to appreciate the need for scientific research to converge with indigenous knowledge where

Recognizing the importance of cultural and implementation contexts within diverse communities and increasing the external validity of research...in community-based participatory research supports bidirectional learning...in the cultural and social contexts of the health issue and potential solutions that may work locally. (Glanz et al., 2015, p. 291)

Thus, in the sub-Saharan African context, AIDS spread and became a disease of the majority with every nation including Botswana, recording double-digit percentile in their national prevalence because of the power dynamics playing out in a supposedly benevolent

partnership between the Global North foundations and African governments. Health promotion strategies that recognize the engagement by communities have their origins in the 1948 constitution of the World Health Organization which states “Informed opinion and active participation on the part of the public are of the utmost importance in improving health...with a call for participation by community members in the planning and implementation...” (Glanz et al., 2015, p. 280), as such, the PEPFAR interventions that have received enormous collaborations from the United Nations agencies (WHO, UNAIDS, UNICEF, and UNFPA) should have ticked the boxes of the blueprint before implementation.

The stigma the ABC campaign perpetuated in Botswana and across sub-Saharan Africa disregarded the cultural beliefs prevalent in the communities where men dominate sexual relationships. By staying fixated on HIV spreading because of immoral sexual behaviors and unwise actions, the ABC campaign denied itself the opportunity to learn that what is enforceable against perpetrators of ‘marital rape’ in the United States is not always a black-and-white dividing line in Botswana because husbands are entitled to the enjoyment of conjugal rights anytime without conditions advanced by their wives, unless during menstrual periods.

Furthermore, the campaign disregarded to appreciate that certain cultural practices that have sustained communities for centuries, and contributed positively to strong, closely knitted families, such as polygamy, might need to be abandoned in the age of HIV, and that it might take another generation before there was a complete revolution and acceptability for monogamous relationships. Even young girls who might have delayed their sexual debut until they were married and stayed faithful to their husbands were still not immune against future HIV infections from their partners because it is permissible for men to conduct extramarital relationships for many reasons, including but not limited to when the woman was incapable of conceiving.

Therefore, a campaign that preaches fidelity and chastity and whose taglines place premium on these approaches as insulation against HIV is shortsighted because it is not immersing itself in the dynamics of culture and beliefs that are widespread in these communities.

Murphy and Greene in their paper “Was the ABC Approach Responsible for Uganda’s Decline in HIV?” (2006) shed light on these power relations.

Although ABC behaviors have been credited with Uganda’s dramatic decline in HIV rates, questions remain as to whether the ABC-related behavior changes are attainable in other developing countries, given many women’s relatively limited control over their sexual relationships. Influential AIDS policymakers have expressed doubt that ABC-related behavior changes can take place in settings where women seem to have little control over their sex lives. (1)

Such a campaign might mean well, but it bears undesirable outcomes when those infected with HIV are labelled as having failed to restrain their sexual appetite or did not wait to get married to have HIV locked out of their bloodstream. The campaign succeeds in the unintended goal to pile up blame, condemnation, reprisal, and fear on the AIDS sufferers as ones who did not heed the Christian message about what God planned for sex between married couples. But if the designers of the ABC campaign had studied the cultures of sub-Saharan Africa and the place of men in sexual relationships, it might have added value to ensure their inclusion in driving prevention strategies and with significant role-playing to communicate the themes. Across these societies, a campaign that excludes men who are the decision makers and influencers of policy is a failed intervention before it even takes off.

Just across the border in South Africa, a replica of the ABC campaign intended to empower women in sexual relationships screams omnipotently, “I will not share my partner”

(Segopolo & Tomaseli, 2017) on the billboard erected on the grounds of University of Kwa-Zulu-Natal. UKZN is among the top nationally ranked institutions of higher education in South Africa. Natal is the capital of the kingdom of the Zulu nation, the roots of the departed King Goodwill Zwelithini, and it is also the home of former President Jacob Zuma. Both these public figures are proud Zulu patriarchs who celebrate centuries-old customs of masculinity that is demonstrated in the potency to sire children with different women. Polygamy is expected of Zulu men, and women know right from when they become aware of their surroundings that they are subservient to their male counterparts in sexual relationships.

But the ABC campaign with an image of a female uttering such a statement is meant to give the girl children hope for a better tomorrow where they can negotiate sex in relationships with male partners and choose their destiny where sexually transmitted diseases including HIV are concerned. It is not impossible to achieve such an admirable goal in this generation. However, such an authoritative, bold, and daring proclamation by a female in the most conservative part of the country risks unintended consequences should the female stand her ground to not lie down with a male who conducts culturally sanctioned multiple concurrent relationships by the Zulu customs.

It is imperative that if the model “Start where the people are” is observed in creating and launching campaigns, this study pushes us towards considering these cultural differences before splashing slogans that might bring about unintended outcomes such as sexual assault and physical violence. The ‘UN Women’s HeForShe community-based initiative in South Africa,’ advocate for HIV prevention programs. They do so by carrying on board their male partners to bring down cases of sexual assault, physical violence and other vices that have stemmed from the imposed empowerment programs employed by the HIV prevention strategies from the West like

the mentioned billboard erected on the campus of the University of Kwa Zulu-Natal. The young women leading HIV and Violence prevention strategies say it is in vain that there should be programs to empower the girl-children and young females about HIV prevention strategies when such initiatives exclude their partners, who should share in the understanding of their customs and beliefs, and how they shape the understanding of the disease and ways to curb its spread (UN Women, 2020).

The common denominator, therefore, between the Global North and sub-Saharan African nations became the stigma surrounding the disease that continues to frustrate concerted efforts to roll back its devastation throughout campaigns, which have deliberately ignored how social systems operate, “how change occurs within and among communities and how ideas and information spread,” (Glanz et al., 2015, p. 272), which campaigns have consumed billions of American taxpayers’ dollars being doled out to Sub-Saharan Africa as acts of benevolence and altruism, often accompanied by hordes of experts to end AIDS under the PEPFAR collaboration.

These conservative cultures must, as a matter of fact, create enough space for the minorities’ voices to be heard in rolling back HIV because, burdened by the virulence of AIDS in its mainstream populations, yet without the resources to bring it under control, Sub-Saharan Africa finds itself welcoming the dominance by the key populations from the world’s superpower in championing HIV prevention campaigns that disrespect the target communities. The inequalities that the UN is advocating against to end AIDS ahead of 2030 are being entrenched in the majority of sub-Saharan African nations that might not have known lesbianism or homosexuality had it not been introduced to them. Indeed, as McLuhan (1964) succinctly states that:

Today when we want to get our bearings in our own culture and have [a] need to stand aside from the bias and pressure exerted by any technical form of human expression, we have only to visit a society where that particular form has not been felt, or a historical period in which it was unknown. (p. 9)

In combating the epidemic 20 years later, it is this study's central thesis that context is not just important but necessary as the health campaign partners should acknowledge mutual interplay in health promotions to the extent that even basic interpersonal relationships can become effective ways in which life-saving messages can reach those often missed by the prevention campaign in the mass media. Glanz et al., (2015) show these interconnections and the roles they play from a mere expression of the tagline to its interpretation across personal relationships because they "are interconnected with the goals and tasks associated with healthy behavior change...a foundation of trust and rapport can promote disclosures about illness behaviors, and a lack of trust and rapport can inhibit these disclosures," (2015, p. 244).

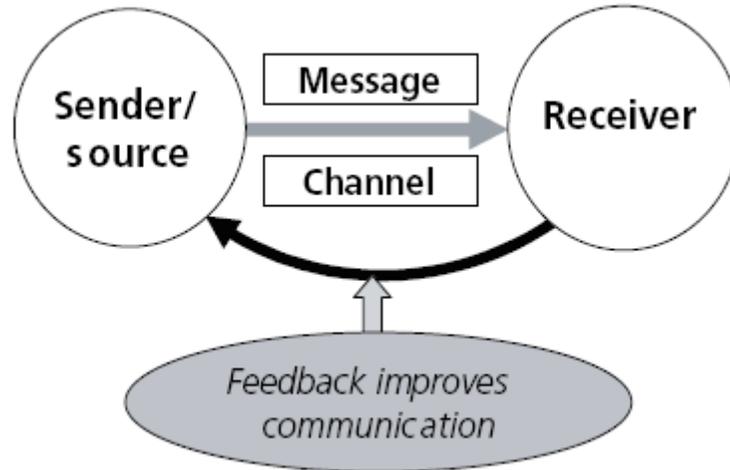
In recent years, some of the life-transforming scientific breakthroughs in AIDS medicine as prevention of HIV have pushed exclusive role-playing as the preserve of the key populations in the campaigns that have penetrated the sub-Saharan African region intended to influence positive behavioral-change among the predominantly heterosexual communities. Therefore, the question as Baxter discovered during his stay in Botswana remains: What cognitive imperatives do the local people have regarding the sender of life-giving messages with whom they have categorically denounced as "a Western disorder not present in Botswana" (Baxter, 2018, p. 65) among them? The AIDS drugs are the solution to the crisis to suppress the virulence of the virus in infected persons, and before gays, lesbians, transgenders, bisexuals, prostitutes, and commercial sex workers could be lauded as the champions to influence positive behaviors and

attitudes towards the science, there was a significant majority of sick people in Botswana enrolled in therapy with high adherence rates.

The patients that Baxter encountered who were straight with him in their repulsion of anal sex represent the average AIDS sufferer in Botswana who cannot countenance lesbianism or homosexuality, let alone when role-playing is their exclusive preserve to drum up the message of hope found in the science. But AIDS campaigns are supposed to elicit behavior change or they have failed in their objective. There are two probable scenarios that can come to bear from such a campaign: either to penetrate the minds of impressionable, gullible youths, who might see lots of potential in making wealth by embracing the identities of the characters sending the message to them, or the other group that believes in their gender as male and female might shut their minds to receiving the important message behind the role-playing they might protest its import.

Both these perspectives are unhelpful to address HIV/AIDS and its ramifications in Botswana; a smoldering population of the “minorities” targeted by the ABC, SMC, PrEP and U = U campaigns championed by the American activists might lead not only to the crisis of identity among the youths but AIDS may become concentrated in this group that never was, while “straight” people may reject the sender in the campaigns confuse role-playing for a failed science and thus waste their lives away. The below illustration might help to appreciate the importance of effective communication across relationships, particularly where feedback is necessary, and which might take the form of embracing a new behavior because, indeed, communication is a transactional process between partners who send messages back and forth to acknowledge an understanding of what they are discussing.

Figure 4 “Sender-Channel-Receiver Process in Communication”



To plead with governments of sub-Saharan Africa to adopt the inclusivity to tailor-make HIV prevention interventions to target the key populations might be the West admitting, finally, that its minorities matter and should play meaningful roles in rolling back new infections, albeit promoting the strategy across a seemingly conservative region, and one in which the same WHO, in its 2002 report (p. 9) stated that unprotected sex in Sub-Saharan Africa was the exclusive reason for the widespread pandemic spreading disproportionately among heterosexual couples. Flint and Hewitt in their article (2015) bring out the complexities of tackling HIV and AIDS by applying universal strategies espoused by the Global North across sub-Saharan Africa.

The established narrative of uncontrolled sexual appetites in Africa dovetails with the view, in some quarters at least, of HIV/AIDS as a ‘disease of choice.’ According to this perspective, the fact that HIV/AIDS in Africa is overwhelmingly sexually transmitted means that those who have been infected have become so on the basis of their decision to engage in sexual behavior that has put them at risk. Within this perspective, there is a hierarchy of victimhood; infections as a result of rape, mother-to-child transmission, and infection from contaminated blood products are morally differentiated. A World Health

Organization bulletin in 2002 fanned this perspective (albeit unwittingly) with the claim that ‘more than 99 percent of the infections in Africa are attributable to unsafe sex,’ substantially higher than other regions of the world like Europe and North America. “Colonial Tropes and HIV/AIDS in Africa: Sex, Disease and Race” (Hewitt & Flint, 2015, p. 307)

Hence, health promotions targeting sub-Saharan Africa to push back HIV should focus on strategies that can yield positive behavioral changes in matters surrounding sex and sexuality among heterosexual couples for the messages to resonate with the receivers, and in return, for them to respond by embracing healthier behaviors after having weighed the pros and cons. Leslie B. Snyder “Health Communication Campaigns and Their Impact on Behavior” (2007), demonstrates the aspects of effective campaigns:

For new topics, it is possible to anticipate relative success rates by examining characteristics of the behavior. Across health issues, campaigns promoting the adoption of a behavior that is new to the individual or replacement of an old behavior with a new one have a greater success rate than campaigns aiming to cease an unhealthy behavior people are already doing or prevent commencement of a risky behavior. (S33)

It can be deduced from Snyder (2007) that communication campaigns that use misplaced information that the target audience might not understand readily or struggle to relate to immediately are likely to fail in their persuasion for positive behavior.

For example, the campaign promoting Truvada as a panacea to preventing the transmission of HIV from infected people to uninfected partners having unprotected sex is a classic example of how the cognitive theories have disregarded cultures in the conceptualization

and selection of credible characters for role-playing, to elicit positive behavior on the receivers of such life-giving messages.

Michela Tindera reporting in *Forbes* (Aug. 7, 2018) follows Truvada's "I'm on the pill" HIV campaign that exclusively features the key populations probably in the quest to meet the policy-making requirement as engendered by the United Nations for these minorities to lead from the frontlines of the AIDS war. Truvada, which was first approved in the United States in 2004 as the first once-a-day drug to treat AIDS, has now become synonymous with PrEP among high-risk populations to reduce infection rates by 92 to 100% since its second approval in 2012 as a preventative. It is exclusively used to promote the rights of key populations against being infected with HIV despite the risky behaviors that expose them to higher levels of contracting the disease.

The PrEP campaign has hailed Truvada as a success story among the key populations in the mass media platforms including primetime viewing on major cable news networks with an international reach like CNN on one hand and entertainment channels like MTV on the other hand, carry campaigns selling drugs as a preventative strategy against intrusion of HIV. How do cognitive theories speak to a campaign that exploits significant scientific breakthroughs in medicine to promote the rights of exclusive minorities about a disease that is decimating the mainstream society in sub-Saharan Africa?

Hence the results of this study are impressive in that the young people have displayed a high knowledge of preventing HIV and overwhelmingly affirmed having been exposed to major campaigns including the ABC, PrEP, U = U, PEP, prevention-of-mother-to-child-transmission (PMTCT), and medical circumcision (SMC). They also admitted easy accessibility to the mass media channels (television, radio, press, and internet social network sites popular among them

including Facebook, TikTok, Instagram, YouTube, and social texting apps like Snapchat and WhatsApp) where these interventions are circulated for their daily consumption from credible sources because “Knowledge is power” as the saying goes.

Despite this exposure to all the major campaigns that Botswana has launched since 2002 in the global health partnerships is not showing desirable outcomes. The country fostered collaborations with Western foundations like the Bill and Melinda Gates, biotech giants such as Merck and Bristol Myers-Squibb as well as research universities including Harvard, University of Pennsylvania, University of Maryland, and Johns Hopkins University (all which opened shop in the landlocked southern African country), this knowledge has not shown in positive sexual behaviors given the rising numbers of new infections.

To address the discrepancies between young people’s knowledge and accessibility of information on the channels at their disposal amidst a grim situation, I critique the theoretical frameworks discussed in Chapter Two by relying on what other theorists in mass communication and cultural studies have posited. Communication scholars have expressed discomfort with social psychology theories being relied upon exclusively by planners of health communication advertising to place campaigns in alien cultures using the same approach. These theorists, scholars, and thought leaders challenge such a disposition that does not respect the cultures where campaigns from outside are launched with the aim to prevent diseases from spreading.

To wrap up the discussion of the results that have been presented in chapter four, I find Hall (1973) to offer useful insight in his famous essay, “Encoding, Decoding” (1980) where he deals with the way messages travel from sender to receiver. Hall foregrounds culture and advocates that cultural theory should sit at the intersection of mass communication because of the power dynamics that come into play when messages are sent (encoded) to when they are

received (decoded). It is this superstructure of relationships that complicates the linear direction common among the social psychology theories that are preferred in communicating health messages.

If we were to reflect that HIV prevention campaigns are designed in the West, tested according to Western social sciences, and proven to work effectively among Western citizens, then transporting such strategies wholesale and launching them in Sub-Saharan African societies should not surprise us when they seem to falter. But it is the “complex structure of dominance because at each stage they are imprinted by institutional power-relations,” (Hall, 1973, p. 477) where it is obvious that the West is also the global power influencing the direction the entire world is going.

Here, we are dealing with neocolonialism at another level of the scale, where the dominant partner in these “complex” relationships will always carry the day by disregarding wise counsel by Nyswander (1956) that we should always “start where the people are” by imagining life from their personal point of view. Hall (1973) persuasively shows that communication between the “encoder-producer” and “decoder-receiver” there does not necessarily require a dividing line of halves to understand or misunderstand the intended meaning of the message in mass media channels, except to base it on how the message mirrors the two codes—and this explanation comes out lucidly in the AIDS drug commercials more than in other interventions. By denying any similarities between the characters in the life-saving drugs and the participants in the study, it lends credence to Hall’s (1973) argument about the two codes and how their “symmetry/asymmetry...depends on the degrees of identity or non-identity between the codes which perfectly or imperfectly transmit, interrupt or systematically distort what has been transmitted...to do with the structural differences of relation and position...”

(480), an argument which holds water because efforts to adopt healthy behaviors can be made if one is persuaded only.

Further, Hans Rosling in his internationally acclaimed book, *Factfulness* (2018), shows us why some of the world's major problems do not seem to get resolved, and he does so with evidence-based research he has broken down into "instincts" for each chapter he explores. This study has paid particular attention to three of those instincts: "the generalization instinct," "the single perspective instinct," and "the blame instinct," to shed light on the problem of HIV/AIDS prevention strategies in sub-Saharan Africa.

Rosling (2018) reminds us that human beings are bereft of the ability not to generalize knowledge about anything. The problem with generalization is that our knowledge has taught us that if it is this way, it ought to be just this way and whatever else presents differently is weird. The earlier chapters of this study dealt with the origins of HIV/AIDS in the Western nations and how Western citizens perceived its transmission. First off, the West proved that AIDS as an incurable disease is caused by HIV, and therefore, the virus could exclusively lead to one suffering from the condition and ultimately dying of it. Because AIDS affected minorities in the West, Blacks even more so than other populations in the United States, fell under the "generalization instinct" when forays into Africa through the U. S. PEPFAR in 2003 started. This instinct was the natural disposition of the Western campaigners and scientists because Black Americans are of the same stock since they were extracted from their motherland and shipped away into slavery. Therefore, we shared similar idiosyncrasies in transmitting HIV, hence the heaviest burden of the disease was in sub-Saharan Africa.

Failure to scope the local environment to get to the level where they saw beyond the skin pigmentation and stinking poverty, the only two similarities between us and the deprived Black

Americans, misled the “fountains of knowledge” about AIDS to launch tried, tested, and effective HIV prevention strategies that they know best just in the same approach, save for adaptation in Setswana—the national language assumed to be spoken by everyone in Botswana.

Advocating for condom use in anal sex as an HIV prevention strategy blew the AIDS crisis out of control when same-sex relationships were not generally part of the equation in the transmission of HIV. The approach to HIV prevention in sub-Saharan Africa did not consider the peculiarities that there was a different epidemic among heterosexuals that was decimating mainstream societies at alarming rates and that prevention had to concentrate right there.

Rosling (2018) teaches us that “Everyone, everywhere knows that people from different tribes have different customs,” (p. 146) and if such diversities can be found among tribes of the same nation, how much worse can the differences be between Sub-Saharan Africans and Black Americans when it comes to the transmission methods of HIV? But the generous assistance amounting to billions of American dollars could afford a holistic approach to HIV prevention that the Government was already sponsoring in the United States and nothing new and nothing different.

“The generalization instinct,” instead of solving a problem that already existed, was now exacerbating the crisis by introducing a complex layer of alien behaviors that made HIV transmission easier than what was originally known. There was no humility with which to pause and ask what the problem was, how the local people saw it and perceived it to be spreading so fast: the general knowledge they had that HIV causes AIDS and anything else is the behavioral factors taught the implementers that strategies had to be applied uniformly. This understanding is what Rosling (2018) dubs “the single perspective instinct,” and it dovetails with “the generalization instinct” because it finds its premise on what is familiar to the individual who is

standing outside the circle and looking inside but sees nothing except what he believes and holds to be infallible.

Mass communications and media studies as a field of study is important in part because it is also put out for those consuming its products (news, commercials etc.) to ask who informs them to make all of us trust what they tell us. Instead of swallowing everything from the mass media 'hook, line, and sinker,' we can afford some skepticism if not some degree of cynicism about what they tell us. "Forming your worldview by relying on the media would be like forming your view about me by looking only at a picture of my foot... Where, then, shall we get out information from if not from the media? Who can we trust? How about experts?" (Rosling, 2018, p. 185)

When I first visited the United States in 1994, it was a common refrain to get asked if Nelson Mandela was still the president of Africa by people regarded as schooled enough to know that mainland Africa is a continent made up of 54 nations before South Sudan joined in 2011. The place and influence of South Africa on the continent should not be understated, but at the same time, it is an overkill to reduce the whole region to a single nation. This "single perspective instinct" did not just form impressions in the minds of millions of American people who admitted to having heard something about Africa and Mandela.

The media pushed the discourse about Africa as a place devoid of resources other than wildlife and that there existed an iconic figure in Mandela who was different from other political leaders, and therefore, he was the president of a single country called Africa, they assumed. Even if the journalists would have been accurate in drumming up support for Mandela and South Africa, it would have been the emphasis on Africa as a whole that the Mandela magic might have that the listeners or readers misconstrued him to be the leader of one huge country, in many ways

similar to the president of the United States. “The single perspective instinct” like “the generalization instinct” is too alarming because it offers no alternative to learning and embracing new knowledge from and by others on matters that one considers to be knowledgeable about, like AIDS, for example. It simplifies everything around us into a single solution whereas the HIV/AIDS problem demands a multi-layered approach before it is addressed. Rosling (2018) sums it up aptly in the following statements:

All problems have a single cause—something we must always be completely against. Or all problems have a single solution—something we must always be for. Everything is simple... Being always in favor of or always against any particular idea makes you blind to information that doesn't fit your perspective.

This is usually a bad approach if you like to understand reality...Be humble about the extent of your expertise. (186)

The next issue Rosling discusses which I find applicable to the AIDS crisis in Sub-Saharan Africa is called “the blame instinct,” which is the way of escaping from the responsibility of why things are not working well as planned by applying health communication models that have yielded positive results among the key populations in Western societies and disaster in Africa. Because Truvada has been hailed as the magic pill that transformed lives among members of the LGBTQI communities in major cities across the United States, its dismal failure to contain the spread of HIV among those who participated in the clinical trials in Botswana resulted in frustrations. Perhaps, there was something else about Africans that they were doing outside “normal” sexual relationships which complicated a simple solution.

Stigma such as high intensity for sex, out-of-control rates of promiscuity, and bordering on barbarism among African people found their way into the discourse of AIDS with some of the

weirdest slogans meant to chide the target audiences of these HIV prevention strategies. “Don’t be stupid, use a condom!” or “Are you careless, ignorant and stupid,” to “Avoiding AIDS is as easy as ABC” are some of the featured prevention strategies that clearly laid the blame on the target audiences for their painful situation and ignored the fact that the health communication models were not effective in this different environment.

Rosling (2018) explains that “It seems that when things go wrong, it must be because of some bad individual with bad intentions...To understand most of the world’s significant problems we have to look beyond a guilty individual and to the system,” (pp. 206-07) which reminds me that after two decades of vigorous HIV prevention campaigns, health communication experts by now should have abandoned the Western-centric social psychology theories to embrace one that situates the people and their cultures right at the center.

Having discussed Rosling (2018) and the “instincts” he adequately expounds upon; I now pull Corcoran “Theories and Models in Communicating Health Messages,” (2007), when he addresses the language and its employ in slogans to influence negative or positive behavior change among those being targeted by the health promotions. “Language and lexical content of the message is also important. Lexical content, which literally means the words, can be used positively or negatively” (Corcoran, 2007, p. 7), and in the earlier paragraph where I gave examples of “blame slogans” to amplify Rosling’s instinct, it might be good guesswork to suggest that those feeling insulted, judged, and disparaged in the ABC campaign will not heed the steps to prevent HIV. It is why theoretical frameworks only ground the study but should not be too rigid to shift if it runs into resistance, especially culture because with this reality, a community or society is anchored and cannot be separated.

“The role of cultural contexts is missing and in non-Western populations these theories may be less culturally sensitive, especially if they promote individualism and remove emphasis on family or group behaviors” (Corcoran, 2007, p. 17) which is a recipe for disaster for theories to ignore fundamental blocks upon which sub-Saharan societies are built.

In their article, “A Critical Assessment of Theories/Models Used in Health Communication for HIV/AIDS” (2000), Airhihenbuwa and Obregon lament the absence of cultural considerations when designing prevention campaigns tailored to Sub-Saharan Africa, “A critical point in this debate about relevant health communication theories/models is the recognition of culture as central to planning, implementation, and evaluation of health communication and health promotion programs in general.” (2000, p. 6)

The authors foreground culture as integral in designing an effective campaign by targeting a homogenous audience whose practices are different from the next group even if they belong to the same nation. They are in support of fieldwork over superimposing theories on the existing problem, and I resonate with their line of thinking because the results from this study in many areas contradict the health communication models that I relied upon to ground the research:

Although these theories (social psychology) and models have proven effective in certain societies for addressing certain diseases, they seem to be inadequate for communicating HIV/AIDS prevention and care messages in Africa, Asia, Latin America, and the Caribbean. In fact, the assumptions (such as individualism as opposed to collectivism) on which these theories and models are based are foreign to many non-Western cultures where these models/theories have been used to guide communication strategies for HIV/AIDS prevention and care. (pp. 8-9)

The above statement lends credence to the earlier assertion that, instead of the “I” (personal responsibility) messages targeting Sub-Saharan Africa, more campaigns should move towards “We” (communal responsibility) because what is widely regarded as the African proverb “It takes a village to raise a child” means exactly that everyone contributes to the upkeep and care of everybody. In short, the collectivist approach to relationships demands a collectivist solution to HIV prevention strategies because in Africa, truly, “No man is an island,” as the saying goes. While in the West it is common and acceptable to describe an individual as “self-made,” in Africa it is not realistic for one person to climb the rooftop and scream his lungs out that he made it alone because family members, villagers, and even strangers would have paused their lives for the sake of this successful individual to thrive.

I am a classic example of one who has been made by the family and community I was born into. Born the sixth out of eight children, my elder siblings who were not intellectually endowed like me saw my gifts early on and literally paused their lives to put me through school. I have set a record of many “firsts” that would take another generation or several generations to break, thanks to the support and care system borne out of a collectivist belief. It is why privileged Africans always carry the sense of responsibility to pay back by adopting their nephews and nieces to push them through hurdles in life, even as we are also paying forward by investing in the new generations. It seems that many Western people do not resonate with this sense of duty to one another and treat the responsibility we embrace with pleasure as burdensome. Real Africans would find proponents of “self-made” people to be self-effacing and too conceited about their worth and capabilities to flourish on their own.

The two scholars conclude their discussion with a profound statement:

That knowledge is not a sufficient condition for behavior. Our analysis of survey data rarely found a close correspondence between changes in knowledge and changes in behavior...Campaign planners need a greater understanding of their target audiences which often belongs to a culture and a social class different from theirs. Culture should become a pivotal domain in the new era of HIV/AIDS prevention and care...Such a strategy should locate culture within a theoretical framework that will allow flexibility for regional and national differences in communicating HIV/AIDS prevention and care messages. (pp. 12-13)

The results of my research study speak to the above truth where the participants display a high level of knowledge and information about HIV prevention and admission that the campaigns are crisp, clear, and coherent about what is available to protect themselves against infection, yet the rising cases do not speak to this level of understanding by the young population. It cannot be overemphasized that health communication models are important in planning HIV prevention campaigns, but it is also vital to recognize that where these theories are inadequate, health communication experts should not find it impossible to locate culture at the intersection to influence the conceptualization of slogans, headlines, and taglines best suited for Africa.

One of the pillars of culture in Africa is the recognition of traditional leadership and its pivotal role in influencing the values of communities because the people put leaders into those positions and roles without the Western concept of the ballot where there is a section that might not necessarily prefer the politician who garnered a simple majority in the outcome of the election process. These traditional leaders must come on board to play a significant role in preserving customs that can bring down new HIV infections. Green et al. "Mobilizing

Indigenous Resources for HIV Prevention in Southern Africa” (2009) have recognized the significant contributions these leaders can make to designing practical interventions, as they observe succinctly that “Traditional leaders have the potential to play a positive role in addressing the socio-cultural factors that can either fuel or mitigate the spread of HIV in Southern Africa” (p. 390).

This recognition of the traditional leadership in Africa is the sure way to arrest the out-of-control situation where the youths are described to have derailed from the moral code that African cultures promote and have preserved over centuries regarding sex and sexuality in general that forbid public displays of affection for the opposite sex. For Africa’s young population to have crossed this bar to even fondling in public between people who appear to belong to the same sex has been a phenomenon described by and large as immorality by traditional leaders who blame homosexual practices on the Western human-rights approach to HIV prevention imposed on its societies without seeking the opportunities that African value systems provide in designing behavioral-change interventions to defeat AIDS. Green et al., (Mobilizing Indigenous Resources for Anthropological Designed HIV-Prevention and Behavior-Change Interventions in Southern Africa, 2009) article shows how traditional leadership, in general, has been disregarded by Western prevention strategies implemented across communities where tribal chiefs and spiritual leaders are models and influencers on matters of sexuality.

Behavior-change communication interventions in Africa have typically been implemented without regard for local perceptions, knowledge, beliefs, or customs relating to sexual relations, marriage, and related areas of human experience. The opinions and experiences of Africans are assumed to be the same as those of Americans or Europeans...African culture is almost always depicted in a negative light, as

something that constrains a modern, enlightened, individual rights-based approach to HIV prevention. (Green, 2009, pp. 391-392)

This is what neocolonialism has achieved – to undermine the cultures of the developing nations and inscribe Western technology as superior, relegating indigenous knowledge to the periphery while promoting research laboratories and their findings as the supreme knowledge without which human survival is impossible. There is no acknowledgement that these so-called primitive societies have been sustained across centuries because of the indigenous wisdom that the elderly people passed down to the younger ones. At the appropriate time for young people to engage in sex, elders using rites of passage, taught them how to care for people suffering from infectious epidemics like AIDS.

Green et al. (2009) show that the traditional leaders across the four surveyed counties of Botswana, Lesotho, South Africa, and Swaziland (now Eswatini) expressed a desire to be invited to the table where big debates surrounding HIV prevention are held so that they can inform prevention strategy planners about the needs that are unique to their settings, mainly by reviving the institutions that sustained their communities about the impartation of moral values to young ones.

Like the other scholars thus far discussed who fault the health communication models that are not adjustable to unique cultural settings, Meassick (2008) cautions that repeated failures with HIV prevention strategies are obvious if these tried and tested theoretical frameworks are uprooted to Africa and expected to perform miracles without any adjustment made to them. For a public health specialist to loudly declare that ignoring “empirical evidence of African philosophical beliefs that drive health behavior and healing practices” (p. 182) has been the biggest affirmation of cultural practices prevalent across sub-Saharan Africa. She lambasts

Western cultural practices to influence programs in HIV prevention in Africa, suggesting that the distribution of condoms or alternative technology should not be relied upon exclusively as an effective intervention to curb the problem of AIDS because all steps attempt to bring down and not eradicate the disease.

Meassic (2008) also says that “There is no question that safer sex should be promoted among truck drivers and sex workers; however, I see the most at-risk group in Africa as the heterosexual family in both polygynous and monogamous marriages” (p. 182) proving the earlier assertion I made that, instead of introducing alien ways surrounding sex such as indiscriminate distribution of condoms in schools and advocating for distribution of condoms in prisons where males are incarcerated separately from females, HIV prevention campaigns should be sensitive to the cultural dynamics present in each society. This disposition is too common where HIV prevention strategies from the West inscribe themselves as the ultimate solutions despite repeated failures with the rising new infections among the youth population in Botswana—a reality known as “the epistemic violence” that was alluded to by Gayatri Spivak in her essay *Can the Subaltern Speak?* (2008).

In closing, it is not that the social psychology theories embraced by health communication experts planning and launching these HIV prevention campaigns do not work altogether; rather, when they are uprooted from their place of origin to work as effectively in other places around the world, they will always miss the boat! I agree with the theorists and scholars who have criticized health communication theories that are common in international health campaigns to influence positive behaviors that, if they are adjusted to accommodate the ramifications of culture and religion in those societies, there would be noticeable differences.

AIDS is acknowledged in sub-Saharan Africa by relying on the observance of the cosmos, and the changes of season—a practice from time immemorial where sages are recognized to share indigenous knowledge of how their ancestors used to tackle and address crises that plagued them in the past. Natural disasters including diseases have been understood and were tackled using indigenous approaches to sustain communities over centuries before the European encroachments in the 18th and 19th-centuries when most of Africa became under colonization.

Herpes is among the common symptoms of AIDS or late-stage HIV infection, and, as such, the disease has been widely acknowledged as “ancestors curse fires” through which their displeasure was made known to the sick patients. Sub-Saharan Africa acknowledges the accompanying spirits of the dead in daily life experiences and that the living should conduct themselves in ways that show respect for the sanctity of life for fellow humans, render unequivocal deference to the elders, and demonstrate generosity to the less privileged members of the community through kind deeds like plowing their fields, or supplying milk to the orphans as a manifestation of collectivism that defines communities. Any omission or departure from these standard behaviors is firmly believed to trigger the displeasure of the ancestors to unleash their wrath in the most debilitating force, resulting in the “ancestors’ curse fires” or the conditions widely known as HIV and AIDS in the scientific world.

Therefore, it is true that Africans see AIDS as a disease that came about because of wrong choices in behavior, attitude, and practice. The main contrast is that the other perspective exclusively treats the transmissible disease to be the result of sexually immoral behaviors that should be regulated, whereas the local cultures explain AIDS as a disease stemming from defiance of authority. Both perspectives share a need to alter behavior to make a positive change

and prolong the lives of individuals; therefore, behavioral-change-communication sits at the center in the prevention of HIV/AIDS.

Failure to recognize the regional idiosyncrasies, cultural intricacies, and religious imperatives in the way an infectious disease like AIDS could be spreading from one individual to the next has snowballed into a major health crisis that has decimated Sub-Saharan Africa's populations, and shows no signs of waning even after decades amidst technological and scientific advancements with medicines to treat the outbreak and increased knowledge regarding safe means by which those uninfected can lock out the virus that causes AIDS.

For example, apart from the key populations in the Global South, under the PEPFAR partnership, the United States railroaded the ABC campaign (abstain, be faithful, or use condoms) that promoted in the main, Christian, conservative values of chastity (delayed sexual debut) and monogamous, vows-founded holy matrimonies, or if both these strategies fail, to fall back on the technologically backed-up insulation from latex material. The PEPFAR-funded ABC taglines marketed to the nations of sub-Saharan Africa including Botswana early in the partnership entrenched a stereotypical equivalent to suit the moralistic agenda regarding the disease to condition the inhabitants that AIDS was indeed a "disease of choice" among the sexually loose, promiscuous people with insatiable and uncontrollable libido (Flint and Hewitt, 2015, p. 306) who should be moralized to embrace sexual restraint and desirable behaviors.

In restraining the sexual tendencies that the United States saw as fueling HIV from its experience with the minorities in major American cities, the ABC campaign was prescriptive and preachy to the target audiences in Botswana and across sub-Saharan African nations, whose cultures and beliefs were never considered in creating the health campaign. In coming up with a

solution for sub-Saharan nations, the ABC campaign failed the litmus test in community engagement concepts and principles of “start where the people are” (Nyswander, 1956).

Limitations

Obviously, this study has been undertaken over a very short period of time and with financial constraints to cover the breadth and width of the vast land of Botswana. It has limited the scope to focus on specific towns and villages where the collaboration between the governments of Botswana and the United States are piloting PrEP among female adolescents. It is assumed for the most part that both male and female participants from these districts would have an increased knowledge about HIV prevention over the other major campaigns that are applicable to all other districts where PrEP has not been introduced as a strategy.

It would be a good undertaking for researchers to further this work in the future by launching countrywide HIV-prevention research to determine the knowledge among adolescents as a demographic that is hit the worst by the disease by widening the scope to conduct it over a longer period of at least six months. That way, if the project is well resourced, there should be at least 1,000 participants or twice that, to give a fair representation of the general population. More so, such an undertaking might favor employing an ethnographic study that would cover one half of the country while the other half of the study would use quantitative approach so that in the end, the results from the separate projects can jell to explain why the numbers suggest what they are communicating. As it is, there is so much information that is provided by the quantitative method in this study that is not explained clearly unless by inference, whereas an anthropological study seeking to understand the dominant beliefs, customs, nuances, and motifs around sex and sexuality would uncover why there might be new cases of infections among the adolescents

amidst major campaigns. We might never know the underlying reasons in a scientific study that works largely with numbers and less with explanations of what is prevalent in each society.

Recommendations

Primarily, this research has focused on the impact that HIV prevention advertisements in newspapers and magazines, television spots and commercials, radio jingles, and online media containing messages about HIV prevention play on the cognitive abilities of adolescents and young adults aged between 15 and 24 in Botswana. Participants in the study responded to how they make sense of these slogans, taglines, and messages echoing in the media chambers to determine the clarity of language to communicate to them in ways that bore positive impact on the target population. Health communicators would have us believe that precise and well-understood slogans, taglines, and headlines promoting a healthy lifestyle automatically cause humans to adopt what they see, hear, and watch; therefore, in the context of Botswana youths, when exposed to such media, they should make the right choices about sexual behaviors and reduce the rates of HIV.

However, the fieldwork has turned up evidence that, while the youths express no confusion whatsoever about the major HIV prevention campaigns on different media channels, they have not embedded the themes into their lifestyles surrounding sex in general, given the rising rates of HIV among this age group spanning longer than a decade. Indeed, HIV prevention strategies should “start where the people are” (Nyswander, 1956) as the introduction of the research study emphasizes. These HIV prevention campaigns should by now have given impetus for lasting impact in changing sexual behaviors that might eliminate new HIV infections.

It is imperative to revisit the discourse around AIDS as a disease that Africans know nothing about and that Western theoretical frameworks have tried to fit themselves into by using faces of people the target audience cannot associate with or identify common features between them, the meanings, metaphor, and nuances brought to life by their role-playing of important messages of life and death. Like communication scholars who have provided detailed critiques of the theoretical frameworks used in health advertising, the Global North should acknowledge that, given the billions of dollars and varied expertise that have accompanied HIV prevention in sub-Saharan Africa, there had been some losses to count in the intended impact for tangible outcomes because of the Western ways pushing forward their familiar strategies without any adjustment to accommodate the cultures where they have launched these campaigns meant to communicate life-saving messages to the African people.

Health communication experts should plan prevention campaigns alongside Africans who themselves are not native speakers of European tongues, even if they may have inherited them from colonialism. Allowing Africans to think of AIDS from their cultural point of view in the discourse to construct the “form” (structure) these HIV prevention campaigns should take, and how the rhetoric as a form of narrative is conceptualized, packaged, and launched using the local languages (instead of adaptation), and engaging credible faces they are familiar with that can hit the chord for impactful messages, sub-Saharan Africa might experience a significant decline in new HIV infections among its specific, homogenous populations.

The conclusion, therefore, is that the communication strategies should go to the heart of the matter by recognizing the cultural contexts of Botswana and other sub-Saharan African peoples as occupying the center stage in co-creating slogans and taglines. Campaigns must resonate with their beliefs, practices, and nuances and behavioral communication strategies that

target homogenous audiences with specific messages rather than a general tone targeting heterogeneous groups. Only those campaigns applying cultural theories can influence positive behavior and significantly reduce new infections, evidence from the study tells the story.

AIDS is an infectious disease, highly transmitted through vaginal sex in mainstream societies of Africa, and the relevance of this study is to contribute to the body of knowledge on how science needs to communicate in a clear manner that leaves no risk of duality in messaging or outright rejection of important messages that have used unwelcome faces to convey them, resulting in undesired outcomes. By foregrounding African cultures, communications will encapsulate important themes that are already missing the target in generalized HIV prevention grounded on Western theoretical frameworks. When all these are aligned, the desired behavioral change to stem the tide will be noticed.

Could there be an opportunity to revisit the conceptualization of AIDS messages that might resonate with the cultures and people of Botswana and other sub-Saharan African nations? Yes, by designing culturally sensitive HIV prevention campaigns that will support Western science because there is no denying that the West has handheld Africa in the fight against the epidemic since the early 2000s, availing her technology of drugs, condoms, and medical circumcision. But like a mechanic who attempts to milk a cow with a spanner, the West has been wrestling to solve the crisis by experimenting with its theoretical frameworks to fit into a complex problem of an epidemic that is ravaging mainstream society and not members of the LGBTQI communities as is the situation in the Western societies.

Thus, the solution that worked effectively for a minority in the West is a misfit for a majority in Africa's population. This study has shown that knowledge and behavior change are

not necessarily intertwined until the right approach has been adopted to turn them into practical solutions. Therefore, the following are recommendations that emanate from this study.

- Start where the people are—learn about whom you are dealing with. Ask questions rather than bring solutions to a problem. Assume the student’s role, not the teacher’s.
- Employ participatory research—include the local people to contribute to the body of knowledge on HIV prevention by tapping into what they know is available from their surroundings. Co-create solutions together as equal partners.
- Adjust theoretical frameworks—where possible, do away with Western theories and try something new that the local contexts may supply you to work with. A culture-centered approach is the surest way to arrest HIV/AIDS.
- Embrace intercultural communication—by all means, unless communication respects the other person and their cultures, what has proven effective in one part of the world might dismally fail in the other part.
- Forge strategic collaborations with cultural and religious institutions to ride on the influence of tribal leaders and spiritual lords to drum up support for HIV prevention campaigns to sway their followers in the right direction.
- Prioritize collectivist “We-centered” slogans promoting communal duty over “I-centered” taglines that promote an individualistic worldview where the self is more important than any other around him. These interpersonal communication values are important in the support system for adherence to drugs that prevent or treat HIV.
- Push heterosexual couples and give them prominence in the ads rather than havinb gay couples send out lifesaving messages about prevention because HIV is decimating

mainstream society and LGBTQI members are not the drivers of the transmissions. It is a question of the “right message to the wrong audience.”

- Instead of a “one-size-fits-all” approach, campaign planners should design tailor-made slogans for homogenous audiences considering age, cultural, and religious factors in health ads.

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APPENDIX A

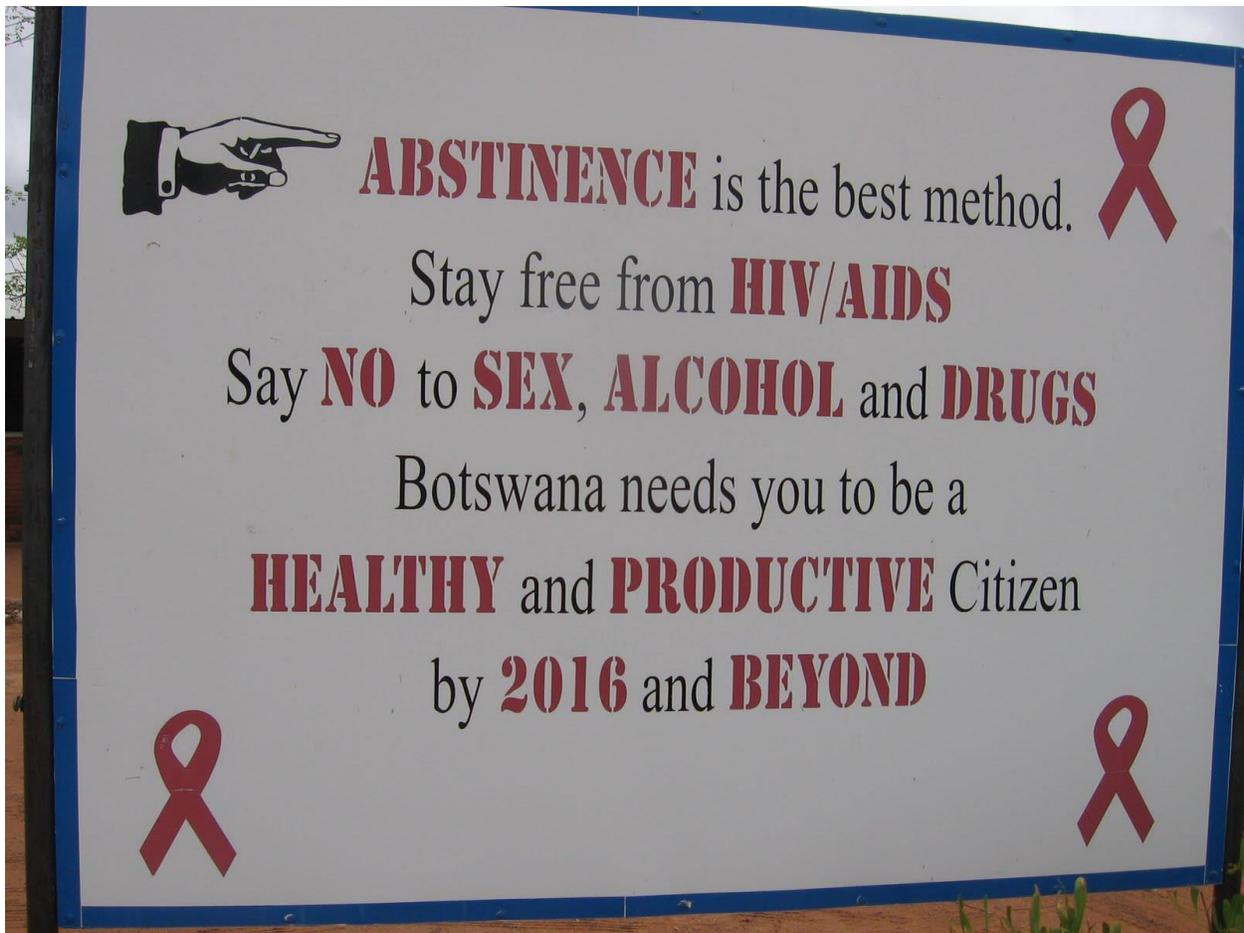
PREVENTION-OF-MOTHER-TO CHILD-TRANSMISSION CAMPAIGN



This healthy-looking toddler is one among the success stories of a hailed campaign known as Prevention-of-Mother-to-Child-Transmission (PMTCT) that HIV-positive mothers have embraced in Botswana.

APPENDIX B

ABSTAIN, BE FAITHFUL OR USE A CONDOM (ABC) CAMPAIGN



Making choices to abstain from sex is associated with sobriety because the campaign emphasizes personal responsibility to stay HIV-negative.

APPENDIX C

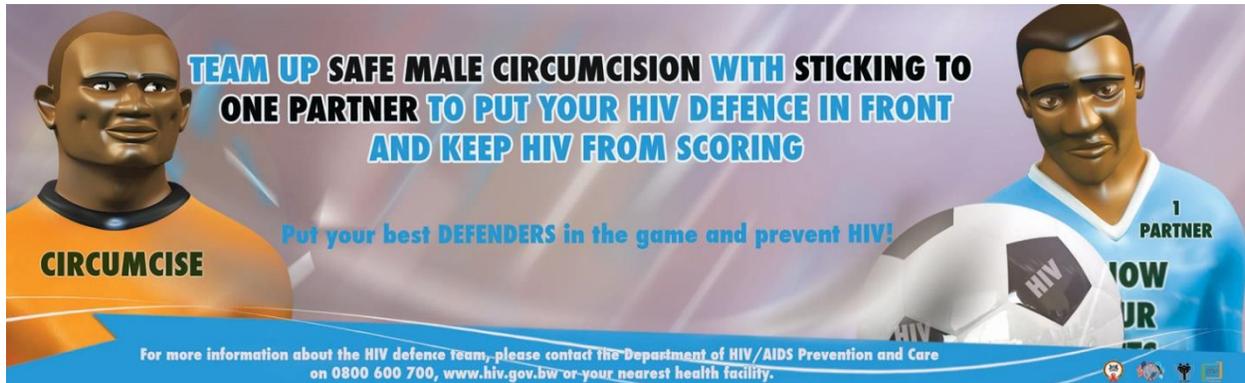
ABSTAIN, BE FAITHFUL OR USE A CONDOM (ABC) CAMPAIGN



Condoms have been part of the layers of protection against AIDS since the 1990s, and billboards promoting condom use were a common sight before drugs were available after 2002.

APPENDIX D

SAFE MEDICAL CIRCUMCISION CAMPAIGN



In the last decade, males in heterosexual relationships have nipped their foreskins primarily to ringfence against the intrusion of HIV and simultaneously enjoy the bliss that comes with unprotected sex promoted in the message of medical circumcision as an HIV-prevention strategy.

APPENDIX E

PRE-EXPOSURE PROPHYLAXIS (PrEP) CAMPAIGN



A partnership between the United States and Botswana to prevent the transmission of HIV enjoys a female-focused program that uses the popular PrEP strategy woven into an acronym “dreams” for Determined, Resilient, Empowered, AIDS-free, Mentored and Safe intervention targeting 13 to 19 ages.

PrEP

THE PILL TO PREVENT HIV

PrEP is for people who do not have HIV and want added protection. When taken as prescribed, PrEP is highly effective in preventing HIV.

Most insurance, including Medicaid, covers PrEP. If you don't have insurance, there are options.

Find Out More!

EndingHIV.org

WE
AIDS

APPENDIX F

TREATMENT AS PREVENTION (TasP and/or U = U) CAMPAIGN



This young couple seemingly in a quandary over one another's HIV-positive status is encouraged to not give up the relationship because HIV drugs for treatment can enable discordant couples to have HIV-negative babies. The Campaign is known as treatment as prevention (TasP) which has evolved into a popularized campaign known as Undetectable equals Untransmissible (U = U).

APPENDIX G

BOTSWANA HUMAN SUBJECT COMMITTEE APPROVAL

TELEPHONE: 363 2500
FAX: 317 0155
TELEGRAMS: SABONGAKA
TELEX: 2818 CARE BD



MINISTRY OF HEALTH
PRIVATE BAG 0038
GABORONE

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REFERENCE NO: HPRD 6/14/1 16 May 2022

Health Research and Development Division

Notification of IRB Review: **New application**

Enole Ditsheko
P. O. Box 46705
Gaborone Village

Dear Enole Ditsheko

PROTOCOL TITLE:DECODING THE PUBLIC SERVICE ANNOUNCEMENTS (PSA) OF HIV/AIDS: EVALUATING BOTSWANA'S AIDS MESSAGES AND THEIR IMPACT ON 15-24 AGES

Review Type: Expedited
Review Date: 10 May 2022
Approval Date: 16 May 2022
Effective Date: 16 May 2022
Expiration Date: 15 May 2023
Risk Determination:No greater than minimal risk

Thank you for submitting new application for the above referenced protocol. The permission is granted to conduct the study.

This permit does not however give you authority to collect data from the selected sites without prior approval from the management. Consent from the identified individuals should be obtained where applicable.

The research should be conducted as outlined in the approved proposal. Any changes to the approved proposal must be submitted to the Health Research and Development Division in the Ministry of Health for consideration and approval.

Furthermore, you are requested to submit at least one hardcopy and an electronic copy of the report to the Health Research, Ministry of Health within 3 months of completion of the study. Approval is for academic fulfillment only. Copies should also be submitted to all other relevant authorities.

Continuing Review
In order to continue work on this study (including data analysis) beyond the

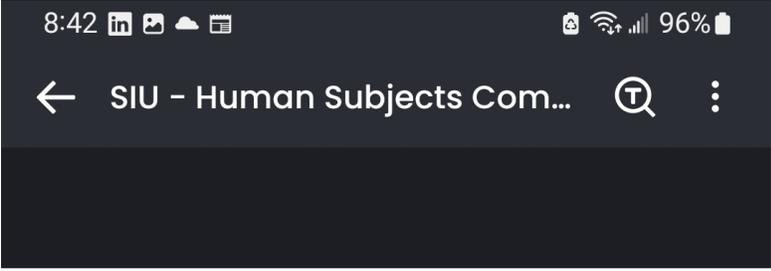
[#] Page [book icon] View mode [pencil icon] Edit [share icon] Share

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[hamburger icon] [home icon] [back icon]

APPENDIX H

SIUC HUMAN SUBJECT COMMITTEE APPROVAL



SIU Southern Illinois University
CARBONDALE

INSTITUTIONAL REVIEW BOARD
OFFICE OF RESEARCH COMPLIANCE
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To: Enole Ditsheko
From: M. Daniel Becque
Chair, Institutional Review Board
Date: April 9, 2022
Title: Decoding the Public Service Announcements (PSA) of HIV/AIDS: Evaluating Botswana's AIDS Messages and their Impact on 15-24 Ages.

Protocol Number: 22059

The above referenced study has been reviewed and approved by the SIUC Institutional Review Board.

This approval expires on **April 9, 2023**, one (1) year from the approval date. Regulations make no provision for any grace period extending beyond the above expiration date. Investigators must plan ahead if they anticipate the need to continue their research past this period. The application should be submitted 30 days prior to expiration with sufficient protocol summary and status report details, including number of accrued subjects and whether any withdrew due to complaint or injury. If you should continue your research without an approved extension, you would be in non-compliance of federal regulations. You would risk having your research halted and the loss of any data collected while IRB approval has lapsed.

Also note that any future modifications to your protocol must be submitted to the Committee for review and approval prior to their implementation. When your study is complete, please fill out and return a study close-out form. A study is considered complete when you are no longer enrolling new participants, collecting or analyzing data.

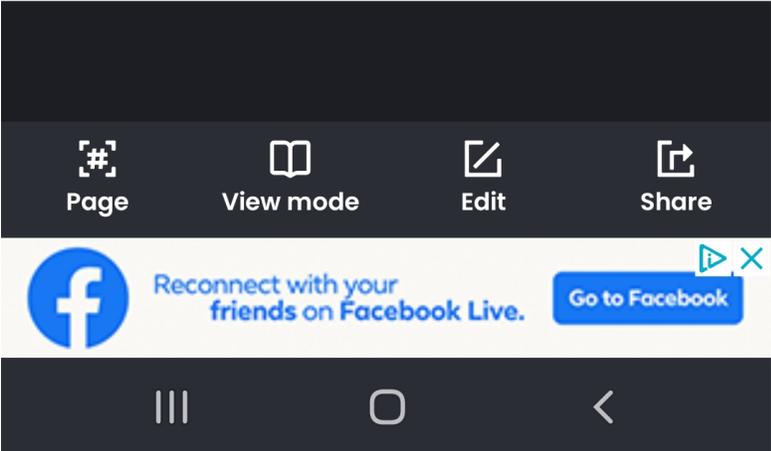
Best wishes for a successful study.

This institution has an Assurance on file with the USDHHS Office of Human Research Protection. The Assurance number is 00005334.

MDB:sk

Cc: William Freivogel

SIU.EDU
Revised 11-24-2021



VITA

Graduate School

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Enole Ditsheko (editsheko@gmail.com)

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Creighton University
Bachelor of Arts, Journalism & Mass Communications, December 2000

Creighton University
Bachelor of Arts, Creative Writing, December 2000

Honors and Awards:

The International English Honor Society (Sigma Tau Delta)

Dissertation Paper Title:

Decoding the Public Service Announcements of HIV/AIDS: Evaluating Botswana's
AIDS Messages and Their Impact on 15 - 24 Ages

Major Professor: William Freivogel

Publications:

Wrestling Botswana Back from Khama (2019)

My White Grandpa – Memoir of Enole Ditsheko (2008)