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A CRITICAL ANALYSIS OF REPRODUCTIVE HEALTH INFORMATION IN SOUTH AFRICA

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Abstract

The aim of this paper is to examine Reproductive Health Information (RHI) designed for communities in South Africa. The Social Construction of Reality (SCR) theory (Berger and Luckmann, 1967) is employed as a tool of examination. This paper attempts to answer questions which emerged from the results of the study conducted by the author. The findings of this study revealed that RHI is not understood by the target community (Mbananga & Becker 2002). Also several studies conducted in the country have shown that despite high levels of knowledge (98%) about HIV/AIDS amongst community members, this knowledge does not translate to sexual behavioural change. The increase in HIV/AIDS and STDs rates in the country have been used as a proxy measure for poor translation of RHI into sexual behavioural change. Consequently, questions were asked: Why RHI is not understood by the target community? and Why this information appears to be failing in transforming sexual behaviou!
r? An analysis of RHI within SCR provides three answers to these questions. Firstly, RHI is void of the everyday reality of reproductive activity, concepts and knowledge of target communities. Secondly, RHI construction focuses mainly on the nature of reproductive health problems rather than the presence of these problems. Thirdly, RHI development neglects typificactions which are progressively anonymous in the "here and now" (moral values) daily discourse and yet acceptability and utilisation is defined and scrutinised within their parameters.

Key words : Social Construction of Reality, Reproductive Health Information (RHI)

Paper

Background

South Africa and Southern African Countries are faced with a growing HIV/AIDS pandemic despite the presence in communities of information aimed at changing sexual behaviour in order to prevent the rapid spread of the HIV/AIDS scourge. According to demographic projections by Dorrington et al., (2001), the HIV/AIDS epidemic will be the primary cause of death in South Africa in 2010. Department of Health antenatal surveys (2000) also reveal growing annual incidence rates of HIV since the early 1990s. The National Department of Health and its provincial units have for more than a decade embarked on strategies aimed at curbing sexually transmitted diseases (STDs), including HIV/AIDS.

The Department of Health's main strategy has been to disseminate information about HIV/AIDS and studies conducted in South Africa reveal that 98% of the population in South Africa is aware of HIV/AIDS. Despite this knowledge, people have not changed their sexual behaviour, as illustrated by the low rates of condom use and the increase in HIV prevalence rates (Department of Health, 1999). This paradox inspired a study that examined why the information disseminated to communities failed to change people's sexual behaviour (Mbananga, 2002) The information examined by Mbananga covered family planning, STDs, HIV/AIDS, sexuality and reproductive cancers. The collective term given to this information was Reproductive Health Information (RHI will be used throughout this paper) as it addresses core reproductive health issues.

The study revealed that the information disseminated to local communities in South Africa, particularly impoverished areas, was not understood by residents. In fact, poor understanding of RHI, mainly visual information (health posters) was gross (Mbananga & Becker,2002). Another important finding was that RHI, at development stages, did not take into consideration the norms, values, language or culture of the target community (Mbananga, 2002). The fact that RHI posters were generally misunderstood or not understood at all raises three questions. Firstly, why is RHI

not understood by community members when it is developed for them? Secondly, how is a lack of cultural awareness and sensitivity in the development of RHI responsible for misunderstanding? Thirdly, why does RHI fail to change sexual behaviour? This paper will take a critical-explanatory position and employ the Social Construction of Reality (SCR) theory in order to deal with these questions. The SCR argues that! reality is the subjective world which human beings are biologically endowed to construct and 'inhabit'. This world is commonly constructed by the self and others into a subjective world. The subjective world created by everybody becomes the dominant and definitive reality. Although there are natural limitations in the process of constructing the subjective world, once created this world acts back upon the creator, thus determining which socio-cultural aspects will be considered and protected. In the dialectic between nature and the socially constructed world, people are transformed and produce reality which produces them (Berger and Luckmann, 1967).

The SCR theory indicates that people are socialized into cultural species representing specific communities or societies. They perceive, relate to, process, think about and assimilate knowledge or information in relation to their own cultural aspects. People living in impoverished, deprived and underdeveloped areas can construct very rigid subjective worlds because of their environment which is not conducive to change. These people are able to learn and institutionalize knowledge if it is branded within familiarity and cultural relevance of their own. This means that whether people will learn and change their sexual behaviour on the basis of RHI will depend on the cultural relevance of this information to them. Therefore, the SCR theory is summoned to testify on whether RHI constructed outside the reality of target community can be effective or not.

The Social Construction of Reality (SCR) theory developed by Berger and Luckmann (1967), relates neatly to a critical analysis of RHI: its development, dissemination, communication, interpretation, understanding and utilisation at both institutional and target community levels. As far as Wisdom (1973) is concerned, SCR is important because it explores ideas that are central to the course of knowledge, and the relationship between subjective and objective realities. SCR appeals to RHI analysis due to its inclusiveness of philosophical sensitivity to issues of ontology (the nature of reality) and epistemology (the nature of knowledge: in this instance RHI) (Wisdom, 1973). Also, the significant realisation of the importance of everyday life (in the context of RHI, socio-cultural aspects), a central focus of SCR, makes it an appropriate and useful perspective in finding answers to the prevailing problems associated with RHI.

Despite criticisms that SCR is weak in addressing cognitive and emotional aspects of every day life (Hunter & Ainley, 1986; Lichtman, 1970; Wisdom, 1973), it is argued that it remains the best approach to the critical review of RHI. SCR is relevant in this analysis because it deals with the reality as experienced by people beyond cognition and emotion. Both cognitive and emotional aspects of people are determined and influenced by their socio-cultural environment. In the framework of this enquiry, the information in question is RHI but the term 'knowledge' will be used interchangeably with RHI in this paper. This paper will only focus on the aspects of RHI that demonstrate the relevance of SCR in understanding why target communities fail to make sense of RHI and why RHI does not translate into change of behaviour. SCR will bring in-depth knowledge and highlight radical suggestions about how RHI should be constructed and disseminated at the institutional level. It wil! l also provide clarity to problems related to RHI understanding, interpretation, communication, understanding and utilisation at the target community level.

This paper will be structured on the three pronged framework of SCR, and relate each section to RHI. The three sections are: the Reality of Everyday Life; Social Interaction in Everyday Life; and Society as Subjective Reality.

The Reality of Everyday Life

In South Africa, RHI is developed away from the target communities and those who develop it do not consider the cultural diversity of the audience. Participation by typical community members in

the development of RHI is erratic. Pre-testing and post-testing are conducted remotely from a typical audience (Mbananga & Becker, 2002). This paper brings forward the argument that RHI, in its conceptualization and construction, is void of the reality of everyday life in target communities. Some communities, particularly those in remote, underdeveloped and impoverished areas of South Africa have cultures and knowledge systems, about reproductive health and sexual activity, different to those of the developers of RHI. Local culture and knowledge systems are protective mechanisms against social disintegration, deinstitutionalisation and perceived decay of cultural moral values. Definitions of knowledge and what makes it acceptable are subject to and defined within local cultural rele!
vance and scrutiny.

According to Berger and Luckmann (1967) knowledge is what the 'man in the street' understands as the real world in which he lives. Therefore, information that is not regarded as 'real' by the ordinary members of the community is not considered knowledge. The SCR approach, indicates that knowledge is only what people know as reality in their everyday life and concentrates on the relationship between human thought and the social context in which it arises. This perspective suggests that RHI construction fails to first establish the relationship between people's socio-cultural environment and how they think about issues of reproduction and sexual activity. The 'natural world view'claims that society determines the presence of ideas and engineers them socially but does not determine the essence of ideas, which are natural. Reproduction and sexual activity are both facets of the biological nature of human beings. Although sexual activities are biogenic in nature, how people engag! e in them is socially determined. A more radical approach holds that no human thought is immune to the ideologizing influences of its social context. In South Africa RHI is developed by health professionals who are, socially, physically (geographically), culturally and linguistically different from the target communities. This information is mainly developed within the strong biomedical model of disease aetiology, which is primarily concerned with the cause of disease, and RHI is coined using biomedical and health concepts and terminology that are not understood by the target audience. This bio-medical approach to RHI construction does not consider the culture and lacks relevance and experience of target audience (Mbananga, 2002)

Berger and Luckmann (1966) contest that "common sense" or everyday knowledge, rather than ideas, should be the central focus when analyzing knowledge. RHI constructors must first determine the "common sense" understanding of reproduction and sexual activity of its target community. To understand what is a sexual activity in a particular community is important as such an activity may be conceived and defined differently from community to community. For instance in the culture of the community studied (Mbananga, 2002) sexual activities differ conceptually and morally. People do not talk about sex but they engage in sexual intercourse and sex organs are not to be seen as if seen they become a source of embarrassment and shame, this means that sex and sexual activities are taboo. If ever, or whenever, people talk about sex they use acceptable metaphorical language. RHI with explicit messages and or pictures of genitals create a barrier to learning and change. According t!
o Pitt-Rivers, (1965) honour and shame are crucial elements in small societies where face to face relations are dominant. In these societies certain people have to protect the honour of the family from shame. This means that it is vital that aspects of RHI are examined within the context of target communities. People will avoid RHI that brings shame to them and their families. RHI that is constructed after careful analysis of the culture of the target community can be better used by that community because it is familiar in every aspect. People will be better equipped to interpret, understand and utilise RHI if it makes sense within the context of their everyday lives. The reality of grass roots diversity in South Africa must play a key role in RHI development.

Any disease, especially those that are stigmatized such as sexually transmitted disease including HIV/AIDS, for instance, must be understood within its social construction and reality from the point of view of communities before RHI is constructed by health professionals. It is important to investigate the layman's definition of these diseases. Ordinary members of the community become sick and ill without a diagnosis. What is important to them is the illness and the sickness

not the diagnosis. For many families who take care of AIDS patients, illness and sickness are more important than the diagnosis: HIV/AIDS. Therefore, RHI construction should understand the psycho-socio-economic impact of illness and sickness (the burden of the disease) to target members. The understanding of information about HIV/AIDS and other reproductive health problems are socially constructed first before they are medically diagnosed. It becomes pivotal to understand the epidemic amongst co! mmunity members.

Some rural communities have not yet grasped the name of the bacteria that causes TB (Micobacterium Tuberculosis), yet TB has been a health problem in South Africa for at least a century. It is submitted in this paper that in the development of health information in general a lot of energy is spent on describing the nature of the disease rather than the presence of it . As highlighted earlier, society relates more immediately to the presence of the disease, not the nature of it. For instance, people do know about the presence of TB and AIDS as they are able to feel and see the signs and symptoms, deaths , orphans and economic loss as part of their everyday reality. The fact that mycobacterium causes TB is merely academic in the process of understanding the nature of the disease and is imbued in a pathological explanation that goes beyond the understanding and reality of ordinary members of rural communities. The use of academic and scientific jargon in RHI construction lead! s to confusion amongst communities, impedes utilisation and distracts from the reality: the presence of the problem of TB and HIV/AIDS.

For Berger and Luckmann (1967) consciousness is capable of moving through different spheres of reality and the world consists of multiple realities (such as everyday diversity and cultural diversity). Health professionals understand the diversity in the different strains and clades of the virus (for instance HIV-1 and HIV-2 in different countries and continents) in the ordered reality of bio-medicine and biotechnology. This bio-medical culture cannot be regarded as ordered by ordinary members of rural communities. Common sense knowledge is popular knowledge that people in the same community share as part of everyday life. It is this common sense knowledge that is vital in RHI construction and is neglected. The popular knowledge that people share about reproductive behaviour is the very information that needs to be clarified and improved by professional RHI rather than ignoring it. In the culture of the reference community (community studied) there are underlying assu!
mption about reproductive health problems. For these people sexually transmitted diseases are associated with promiscuity and shame and the victims are ostracized and ridiculed. When popular knowledge is neglected, more problems are created at the stage at which RHI is meant to communicate with the audience and bring about transformation, meaning and comprehension amongst the target community. This problem does not cause meaning gap it develops a conflict of ideas about the reality of everyday life.

Everyday life of RHI target communities is too complex to develop any information or knowledge without prior examination of it within the socio-cultural environment of targeted members. If everyday life of target communities (culture) is not analysed prior to RHI construction and dissemination, the information will always encounter problems of misunderstanding, misinterpretation and utility at the level of target community. It becomes imperative to know how a sense of reality is constructed around HIV/AIDS, STDs and reproductive cancers by ordinary members of the community, regardless of whether it is considered invalid by developers of RHI. Any type of reality is valid to those who live it and hence it needs to be examined so that it can be infused in RHI construction.

Social Interaction in Everyday life

A major part of reproductive health concerns social interaction, relationships and sexual relationships. Social interactions and relationships play a major role in effective communication. Relations between people are based on face to face situations and all other cases are derivatives of this. "In face to face relations, the other's subjectivity is available to 'me' through a maximum of symptoms" (Berger and Luckmann, 1967:12.) In any kind of communication, different methods of sending and receiving are available to the senders and receivers of messages. The availability of

verbal plus non-verbal cues of communication maximise meaning by adding expressions and gestures to enhance meaning in the topic of communication. RHI disseminated in posters and written material is limited in its potential to maximise meaning as it lacks aspects of non-verbal behaviour. Some topics such as HIV/AIDS and STDs have been stigmatized, have become taboo and are not easily opened to discussion! in South Africa. They are evaded and repressed by some people. In such cases, typical RHI (posters/pamphlets) fails to make an impact in change of behaviour. It is important to explore whether or not complex and sensitive aspects of reproductive health, such as HIV/AIDS and STDs are not best communicated with face to face communication. An understanding of what can be best communicated orally should not be disseminated in posters or pamphlets. However, it should be noted that it is difficult to impose rigid patterns on to face to face interactions even if they are designed within the routines of everyday life (Berger and Luckmann, 1967). While there is a general theory that people living with HIV/AIDS can be used to disseminate HIV/AIDS information, there are problems associated with this approach. This difficulty is a result of the fact that the social reality of everyday life is apprehended in a continuum of typifications (norms, values, belief system and culture).

These typifications become progressively anonymous as they are removed from the "here and now" of face to face situations. Society is the sum total of these typifications and current patterns of interaction are established by means of them. Typifications inherent in different cultures are not always "here and now", meaning that are not recognised easily. Moral values are not discussed in conversations but they are recognised and maintained through conversations. When people engage in conversations they do not remind themselves consciously about the regulating values and norms related to their topic of discussion. If RHI is communicated and typifications in a certain culture are not understood by one party to the communication, that communication fails. Some of the moral representations of sexual activities that exist in different cultures are removed from HIV/AIDS and STDs communications in everyday discourse, yet they continue to exist because they are progressively anonym! ous. This anonymity of sexual typifications could be a problem for somebody who communicates them without knowing, it may not be acceptable to community members. In other words, even at the face to face level of communication, stranger to stranger communication remains problematic. This means that if HIV/AIDS and STDs communication is to be based on the face to face paradigm it must be derived from familiarity and commonality. If RHI is constructed by people from a cultural system different to the target community's, such information will encounter problems related to acceptability and utilisation.

Another important element in RHI development is participation. Interaction with others in everyday discourse is constantly influenced by the common participation of those involved in the available stock of knowledge. A major aspect of knowledge in everyday life is the knowledge of the relevance structure of others. Knowledge in everyday life is socially distributed. In small communities, people know everything known to fellow community members and how it is disseminated includes acceptable language. According to Grice, (1975) language is defined and regulated by the norms, values and culture of the people who use it. It becomes necessary to understand the syntactic and semantic laws of the language used by the target community of RHI before construction and dissemination. As indicated earlier, this is not the case in South Africa. RHI is developed in English and translated into the other 10 official languages. Translation is not a solution as the translated versions continue! to retain the rules of the original language (Shresta, 1979). According to Harraway (1985), human knowledge articulated through language is essentially metaphoric in nature. Knowledge about knowledge is therefore a question of which metaphors one chooses to express one's knowledge. Professional health knowledge about reproductive health and sexual activity chooses metaphors that are conceptually and culturally different from those of the target community in South Africa. These metaphors are articulated in a language that is not of the RHI target community. This does not cause tension, but it does breed ignorance in the presence of knowledge.

Using the language that is regarded as taboo in RHI cannot be accepted by the target community There are specific social sanctions against cultural disintegration and one of them is ridicule (Berger and Luckmann, 1967). In other words if RHI communication is alien to the culture of the

target community it raises doubts about sexual activity, which is very real for community members. It then becomes perceived as ridiculous for raising doubts about the structure of reality. This means that it is not taken seriously in informing decisions towards changing reproductive and sexual behaviours that are considered risky by medical and health definitions.

Thus, knowledge about the socially available stock of knowledge and the language in which it is distributed are important elements in RHI construction and dissemination. Participation of typical target members of the community in RHI development is the kind of contribution of the available stock of knowledge about reproductive health and sexual activity amongst community members. It is the community participation in RHI development that will help to balance the distribution of knowledge between RHI developers and target communities and will help to generate acceptable and useful information and change of sexual behaviour.

In conclusion it appears from this analysis that RHI cannot change reproductive and sexual behaviour and cannot be understood by target community members even in the presence of information because of poor integration of culture in its construction. Poor integration of everyday life (culture and knowledge) with the professional knowledge can be regarded as a barrier to sexual behavioural change, acceptability and utilisation in the presence of RHI in South Africa.

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