From Awareness to Action: Tackling HIV/AIDS Through Radio and Television Drama

Mary Myers

Benfield Greig Hazard Research Centre
University College London

February 2002

Introduction

Why do information campaigns often fail to change people's behaviour? Why do people persistently take risks, even when they know the consequences? These are perennial questions in disaster studies, and ones which are especially relevant to the study of HIV/AIDS. This discussion paper looks at psycho-social aspects of the AIDS pandemic in Sub-Saharan Africa, with particular reference to initiatives which use a combination of entertainment and education through the mass-media to promote awareness of HIV/AIDS and to encourage behaviour change.

Just as squatters in El Salvador or South Africa build and re-build their houses in flood and landslide-prone areas; and just as coastal dwellers in Bangladesh very often ignore cyclone warnings until the very last minute, despite knowing the risks; millions of couples worldwide continue to have sex without condoms, and risk contracting HIV. Is it any use telling them *not to*? Not usually. This is because, often for complicated reasons, they are compelled to do what they are doing; it is not within their power to change. The squatter builds by sheer necessity (there is nowhere else), and the coastal dweller guards his or her property against all odds. In the same way, but for different reasons, those at risk of HIV/AIDS in Sub-Saharan Africa continue with their risky behaviour because it is often not within their power to change.

The AIDS pandemic

Before we look at the reasons why people are trapped in risky behaviour patterns, it is worth reminding ourselves of the extent of the AIDS epidemic (ongoing disaster/ pandemic/chronic public health crisis, call it what you will) - and the reasons for its continued spread in Africa.

UNAIDS estimates that 60 million people have been infected with HIV since the epidemic began in the late 1970's. In 2001, three million people were killed by the disease. By far the greatest proportion (over 70 percent) of people living with HIV/AIDS are found in Sub-Saharan Africa, where they number 28.1 million,

compared with 6.1 million in South and South East Asia and only 560,000 in Western Europe[1].

Africans infected with the virus are far more likely to die of the disease than their counterparts in the developed world. In the United States there are close to a million people living with HIV, but in 2001 only 20,000 died of AIDS: a proportion of one in fifty. In Sub-Saharan Africa 2.3 million were killed by it: a proportion of nearly one in ten. This is due largely to the introduction of new drug therapies, which only the relatively rich can afford. In countries like Zimbabwe where 1,200 people are dying per week, AIDS is truly a natural disaster, requiring emergency response[2].

Circumstances affecting HIV/AIDS spread in Africa

It is only through transmission through heterosexual intercourse that HIV/AIDS can develop into a genuine epidemic, affecting a large part of the population[3 4]. This is precisely what has happened in Africa, and the reasons for this are at the root of the difficulties in bringing about behaviour change.

Perhaps more than any other behaviour, sexual conduct is not given to rational explanation or incentives - this is as true anywhere in the world as it is in Africa. But if we look more closely at what causes the disproportionate rates of HIV transmission in Africa we find a rather unique, and depressing, conjunction of circumstances.

Firstly, we find the high prevalence of untreated sexually transmitted diseases (STDs), which greatly increase the risk of HIV infection per sexual encounter[5]. Poverty and lack of health services mean that STDs remain undetected and untreated, and contribute significantly to the alarmingly rapid spread of the virus. Due mainly to the lack of testing facilities, over 90 percent of infected Africans are unaware they have HIV[6].

Secondly, Africa has extremely low rates of literacy and schooling. This lack of education has an obvious effect on the levels of awareness of how HIV and other STDs are transmitted, recognised and prevented.

Thirdly, levels of gender inequality are high in most areas of Africa, which means, among other things, that women find it much harder to control or negotiate sex (for example, insisting on condom-use) than do men. Studies have shown that infection rates among young women are significantly higher than young men[7]. This is because women (young ones especially) seem to be more physically susceptible to HIV infection than men[8 9]. Some common practices, such as young women having sex with older partners (for gifts or money); or men having sex with young women who they believe to be virgins, in the conviction that this will cure their STD, exacerbate the problem.

Fourthly, the cultural context mitigates against condom use, abstinence and faithfulness to one partner - the three most reliable forms of prevention. For

example, sexual taboos and conservative attitudes prevent couples and families discussing STDs, contraception or other aspects of sexual or reproductive health. Religious authorities in many countries have strongly resisted condoms[10]. The pressure to prove fertility is very strong in many cultures, thus attitudes to condoms are negative. High rates of migration tend to make male migrants (and the prostitutes they visit) more susceptible to contracting HIV than others. And polygamy is both common and a status symbol in many parts of the continent.

Finally, war, and the high profile presence of armed forces encourage the spread of the virus. The World Bank found that 'the size of a country's armed forces, as measured by the number of soldiers as a percentage of the total population, positively correlated with the prevalence of HIV.'[11] Some estimates put HIV prevalence rates among the armies of Angola and DR Congo as high as 60 percent. In conflict situations, law enforcement, judicial, religious, and other state systems that protect individual rights break down. Within this set of circumstances, the vulnerability of women to sexual intimidation is greatly increased. The incidence of rape and other forms of sexual coercion skyrockets in such conflict settings[12].

Reaching those at risk

Thus, many factors conspire to trap Africans in unsafe sexual behaviour. This makes the usual information, education and communications (IEC) channels much less effective than in developed or transitional-economy societies. For example, what use are information leaflets and posters if people cannot read? What use is, say, an awareness campaign among sex-workers when the real question for them is how they will feed their children if they lose clients for insisting on condoms? What use is a more open approach to sex-education in schools if high numbers of girls cannot/do not go to school?

It is interesting to note that while rates of transmission in Africa as a whole remain high, the rates are levelling-off among some social groups. For example, there is evidence that incidence of HIV is now declining among the better-educated urban dwellers in Africa, where once it was highest[13]. It is therefore not implausible to surmise that IEC strategies that have worked in the West (where rates of infection have also remained stable in the last ten years[14]) have also worked among the better-educated urban African population. This is, we presume, because these urban groups have been reached through conventional educational and print-based information campaigns, and - because they are better-off, better-educated and more able to access health care - they have been able to put those behaviour-change messages into practice[15].

Meanwhile, the rural, the poor, the war-affected - in other words the vast majority of the African population - remain acutely at risk from HIV. The question is, can their very hard-to-change behaviour be tackled, and if so, how? Although structural factors such as poverty, lack of health care, war and insecurity obviously need addressing urgently, it is education and communication which remain critical components of

what can be done overall[16]. And where conventional educational channels are no use, health communicators are increasingly saying that education needs to be combined with *entertainment*.

Entertainment-Education

Why combine education with entertainment? Firstly because entertainment is all-pervasive – from music played under a village tree, to a quiz on the radio. Everyone wants it, and (just about) everyone can get it. Secondly, and to put it simply, because the facts alone are not enough.

Pamela Brooke, an experienced entertainment-education writer and broadcaster, states the theory clearly:

> 'Before facts can take root in the human heart, they have to penetrate all the elusive psychological layers that are at work in our interactions with one another. Information is useless to us unless we are able to act on it without severely disrupting family and community norms.'[17]

For Brooke, the key is drama and storytelling. Thus, she and many other communicators like her, have developed soap operas, serial dramas and plays for live audiences, TV and radio, to show and tell the stories of fictional people struggling with the very real issues confronting ordinary Africans:

> 'story dramatisations [are] a meaningful way of linking[…]lifesaving facts[…] to the social interactions and emotional needs in every community[…]The different ways that story characters seek to expand existing boundaries, the laughter and tears that occur as they struggle with conflicting emotions and different social pressures are very powerful demonstrations of all the psychological steps involved in overcoming resistance as we change from awareness to action.'[18]

Live drama and radio are inexpensive ways to reach large numbers of people. Even TV, although not as widely available as radio, is still much cheaper on a cost-per-head basis than other media[19]. Live and electronic media solve the problem of reaching non-literate audiences. Radio is particularly effective, reaching, as it does, about 70 percent of African households.[20]

Successful Dramas

Drama makes possible the portrayal of all the psychological and social blocks to behaviour change and, through realistic characters, can model options and solutions to the barriers in question. For example, in a soap opera from Tanzania, *Twende na Wakati*[21], the wife of a womanising truck-driver shows strength and determination to withhold sex until her husband has an HIV test; and in a drama from Rwanda,

Urunana[22], a young man, learns to recognise the symptoms of an STD, gets it treated at a local health clinic and, while he is there, picks up a supply of free condoms.

Such dramas are often hugely popular, and are clearly compellingly entertaining, as well as informative. Soap operas have a special appeal – particularly for women - and are often the perfect vehicle for developing realistic storylines over time, as listeners or viewers tune in regularly to follow the trials and tribulations of their favourite characters, and remain hooked by means of the all-important weekly 'cliff-hanger'.

For instance, the South African TV series *Soul City* is watched by 70 percent of South African youth on a regular basis[23]. Soul City is a highly successful and long-running multi-faceted communication strategy which uses radio, TV, print, comics and awards to advance health and development, with a particular emphasis (in the most recently evaluated series) on HIV/AIDS, violence against women, small business development and hypertension. *Twende na Wakati*, a radio drama which models characters dilemmas and actions around family-planning and HIV/AIDS, was Radio Tanzania's most popular programme between 1993 and 1995[24], and reached 5 million people on a regular basis. Another educational soap opera on radio, *Zimachitika*[25], (concentrating on food security issues as well as HIV/AIDS) has been voted the number one radio drama in Malawi for three years running: it is listened to by 64 percent of the population (about 6 million), and 93 percent of listeners rate it as their favourite or second favourite show.

Not only are they popular, but they are having measurable effects. For example, in Tanzania, evaluators Rogers *et al*[26] designed an impact study for *Twende na Wakati* which compared listeners' knowledge and behaviours, with non-listeners' by means of isolating one broadcast region (Dodoma), from the rest of the country. They found that favourable attitudes to family planning increased by 5 per cent in the treatment area and decreased by 6 per cent in the control area; furthermore, 82 per cent of listeners in 1995 said that they adopted an HIV/AIDS prevention behaviour because of listening to *Twende*. In an evaluation of *Soul City*, in 1994, almost 1.2 million people said that they would change their sexual and health-seeking behaviour because of what they had seen or heard on the series. In Malawi, 71 per cent of listeners to *Zimachitika* said they had changed their agricultural practices based on series messages.

Why dramas work

The basic theory underpinning these projects is that audiences develop a strong sense of affective identification with characters and situations, and this kind of identification leads to discussion about issues raised and, eventually, to individual or even collective action[27]. The best dramas are written on the basis of solid and ongoing audience research, often modelled on Participatory Rural Appraisal-type focus groups and immersion in village life.

Good research questions and time spent with the audience by writers and actors will uncover the real blocks to behaviour change. For instance, in Kenya, research for *Tembea Na Majira*[28] revealed that many people believed that the lubricants in condoms were already infected with the AIDS virus – (some said as part of a 'Western plot' to limit African population size); and in Tanzania, a common belief is that heavy or 'fatty' people cannot be HIV positive, and therefore are 'safer' sexual partners. Such beliefs are a gift for a skilled drama writer, and can easily be turned into a dramatic – and educational - storyline.

Those working in the field of entertainment-education often find that they have more success if they combine drama with factual back-up. For example, in Kenya, the weekly radio drama *Tembea Na Majira* is followed by a magazine programme which runs interviews with doctors, phone-ins, and question-and-answer spots for listeners about issues raised in the drama. In Rwanda, the radio drama *Urunana* is followed by an 'agony-aunt' slot. Other projects, for example *Soul City*, produce comics, posters, leaflets and education-packs for adults and children drawing on the stories and characters in the radio and TV series. This sort of on- and off-air support ensures that the dramas are grounded in reality, are continually responding to the audience's real problems, and, crucially, are trusted for being factually correct.

Clearly, it is important not only for shows such as these to be trusted, but also for them to work very closely with actual health and social services on the ground. It is no use, for instance, advocating HIV testing by way of a radio drama character, if, in reality, testing is unavailable or unaffordable for any or all of the target audience. Thus, cooperation with ministries of health, and their HIV/AIDS departments, is vital.

Conclusion

The success of these dramas suggests that it might be possible to apply the same techniques in other contexts, in order to tackle hazards other than HIV/AIDS. This is already being done in one or two instances. For example a radio soap opera on disaster reduction has been started by the Pan American Health Organisation (PAHO) in Central America, in which 'the experiences of the characters will be used to instruct listeners on the measures they can take to prevent or reduce the impact of floods, earthquakes, and other emergencies.'[29] In Columbia, a local NGO, Viva la Ciudadania started a multi-media project, including a radio soap opera following the earthquake that hit the town of Armenia in January 1999. The aim was to help the reconstruction process and to counter the lack of information, the sensationalism and corruption stories running in the mainstream media[30].

Media-based public awareness on disaster prevention and preparedness has for too long been based on the old-school of informing and warning in a dry and unattractive style, without regard to the underlying reasons why people are trapped in the risky behaviours which make them vulnerable in the first place. Perhaps it is time that natural hazard warnings take a leaf from the book of entertainment-education projects dealing with HIV/AIDS?

This working paper is based on a report by the author for the Centers for Disease Control and Prevention, Atlanta, USA: Myers, M., 2002 *Institutional Review of Educational Radio Dramas*. Contact the author on marymyers@zoo.co.uk for further details.

Mary Myers is an Associate Member of the Benfield Greig Hazard Research Centre. She is an independent consultant specialising in the use of radio broadcasting for education, development, conflict resolution and disaster management in developing countries.

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[1] http://aids.oneworld.net/guide/front.shtml

[2] International Federation of Red Cross and Red Crescent Societies, 2000 *World Disasters Report*, Geneva, Switzerland

[3] Stefan de Vylder, 2001 *A Development Disaster: HIV/AIDS as a Cause and Consequence of Poverty*, Health Division Document 2001:5 SIDA, Stockholm, Sweden

[4] With Vylder, this is not to deny that HIV/AIDS has assumed dramatic proportions among homosexuals and intravenous drug users. Indeed, the disease has been a disaster for these groups. 'For example, in some cities in Asia and the former Soviet republics, the prevalence of HIV/AIDS has increased from virtually zero to well over 50 per cent of intravenous drug users in just a few years.' (ibid)

[5] World Bank, 1997, *Confronting AIDS. Public Priorities in a Global Epidemic*, Oxford University Press, Oxford, UK.

[6] International Federation of Red Cross/Red Crescent Societies, 2000 (above)

[7] eg. in countries such as Ethiopia, Malawi, Tanzania, Zambia and Zimbabwe, for every 15-19 year old boy infected with HIV, there are five to six girls infected in the same age group (World Bank, 1999, *Intensifying Action Against HIV/AIDS in Africa – Strategy Paper* Washington DC, USA)

[8] Glynn JR, Caraël M, Auvert B, Kahindo M, Chege J, Musonda RM, Kaona F, Buvé A, and the Study Group on Heterogeneity of HIV Epidemics in African Cities. Why do young women have a much higher prevalence of HIV than young men? A study in Kisumu, Kenya and Ndola, Zambia. *AIDS 2001;15 (suppl 4): S51-S60*

[9] M. Laga, B. Schwartlander, E. Pisani, P S Sow & M. Carael, 2001 To stem HIV in Africa, prevent transmission to young women, *AIDS 2001 15:931-934*

[10] See for example, BBC News 30 July, 2001 *Church rejects plea on condoms* (http://news.bbc.co.uk/hi/english/world/africa/): 'Roman Catholic bishops in southern Africa have condemned the use of condoms to fight AIDS…'

[11] World Bank quoted in Vylder, 2001 (above)

[12] United States Institute of Peace, 2001 *Special Report: Aids and Violent Conflict in Africa*, Washington DC, USA www.usip.org/pubs/specialreports/

[13] S. Gregson, H. Waddell & S. Chandiwana 2001, 'School Education and HIV Control in Sub-Saharan Africa: From Discord to Harmony?' *Journal of International Development Vol 13 No 4, May 2001*

[14] 'Aids deaths in Europe plummet' BBC News, November 27, 1998 http://news.bbc.co.uk/hi/english/health/

[15] Communications specialists do not always agree on why people change their behaviour, or exactly how. Another explanation for the fact that HIV/AIDS infection rates have not risen in the West is that about ten years ago the high-risk groups (homosexual men and intravenous drug-users) started to see their friends and acquaintances dying, and therefore started to change their behaviour as a result of what is known as the 'health belief model'. In other words, they started to perceive their own vulnerability and therefore started listening to HIV/AIDS warnings. In this case, the difference is that in Africa people may not perceive their vulnerability in the same way. For instance, in areas where mortality from malaria, TB, diarrhoea, etc. is commonplace, AIDS may be regarded as just another fatal disease among several, and may not inspire quite the same unique terror as it does in the West.

[16] Jose G. Rimon, II, (undated) *HIV/AIDS and Behaviour Change Communication* www.comminit.com/hotfive_joserimon.html

[17] Pamela Brooke, 1995, *Communicating through Story Characters* Institute for International Research, University Press of America, Inc., Lanham, New York, London

[18] ibid.

[19] Eg. in the Philippines, the cost of one radio-programme reaching one thousand people is just US$2.35. By comparison, 1 TV programme to 1000 people = $32.80
One thousand flyers = $38.50
Cinema-based film to 1000 people = $53.80
1 local newspaper to 1000 people = $86.70 (FAO)

[20] Source: BBC International Broadcasting Audience Research, quoted in Graham Mytton, 2000 'From Saucepan to Dish' in Fardon and Furniss, eds, 2000, *African Broadcast Cultures*, James Currey, Oxford, UK

[21] This soap is run by Radio Tanzania and supported by Population Communications International, with funding from UN Fund for Population Activities and the Tanzanian Government. For more details see Arvind Singhal and Everett M. Rogers, 1999 *Entertainment-Education: A Communication Strategy for Social Change*, Lawrence Erlbaum Associates, Mahwah, New Jersey, London

[22] This soap is run by Health Unlimited and is supported by DFID and the British National Lottery. For more details see www.healthunlimited.org/greatlakes/

[23] Soul City, 2001, *Social Change: the Soul City Communication Experience*, www.soulcity.org.za

[24] Singhal and Rogers, 1999, see above

[25] This soap opera is run by the Story Workshop Educational Trust, founded by Pamela Brooke. For details, see www.storyworkshop.org

[26] Everett M. Rogers, Peter W. Vaughan, Ramadhan M.A. Swalehe, Nagesh Rao, Peer Svenkerud & Suruchi Sood, 1999, 'Effects of and Entertainment-education Radio Soap Opera on Family Planning Behavior in Tanzania' *Studies in Family Planning Vol 30 No. 3*

[27] There are various different theories behind the social psychology of health behaviour, for which space here is too short. Some of the most important theories include the health belief model, the theory of reasoned action, social learning/cognitive theory, diffusion of innovation and social marketing. For a good summary see, for example, Collins O. Airhihenbuwa and Rafael Obregon, 2000 'A Critical Assessment of Theories/Models Use in Health Communication for HIV/AIDS' *Journal of Health Communication Vol 5 (supplement)*

[28] This Kiswahili soap opera, on national KBC radio, is run by the Mediae Trust, with funding from DFID and from companies such as Cadbury's. For further information see www.mediae.org

[29] Letter from Jacqueline Flentge of PAHO to the Communication Initiative website: www.comminint.com/

[30] DFID, August 2000 *Working with the Media in Conflicts and Other Emergencies*, Issues Paper, Department for International Development, London, UK