The HIV/AIDS Pandemic: Examining a Global Health Problem from Intercultural Communication Perspectives

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With about 20 million dead from HIV/AIDS and an estimated 38.6 million people infected with the virus, HIV/AIDS is a global problem (UNAIDS, 2007). Communication is of vital importance in preventing further spread of the virus. In this article, we analyze two successful, though widely different, health communication approaches to HIV/AIDS prevention—one in Belize and one in India. These efforts were selected because they took place on different continents with people of different cultural backgrounds for different lengths of time; however, each was creative in its approach to addressing this public health problem. By examining such efforts, scholars, researchers, and practitioners can begin to learn from programs across the globe, assess utility, and compile best practices.

Despite advances in treatment, the HIV/AIDS pandemic still rages. In 2003 in the United States alone, it was estimated that 1,039,000 to 1,185,000 individuals were living with HIV/AIDS (Glynn & Rhodes, 2005). With an estimated 38.6 million people infected with HIV and at least 20 million dead from the infection worldwide, HIV/AIDS is a colossal problem, one with serious public health implications (UNAIDS, 2007). In addition, estimates suggest that approximately 3.8 million additional people will become HIV positive and 4.3 million will die of AIDS each year (AVERT, 2007).

HIV/AIDS spreads for many reasons. For example, in Eastern Europe, infection occurs mainly through intravenous drug users (IDU) sharing and reusing needles (International AIDS, 2006). In Southeast Asia, the virus is predominately spread by men who have sex with men and IDU (International AIDS, 2006). In India and Southern Africa, most transmission occurs through sex between men and women (International AIDS, 2006). Regardless of the means of transmission, communication is of vital importance in preventing further spread of the virus.

As such, health communication scholars are challenged with researching the communicative nature of HIV/AIDS—and with this focus come issues of culture. For example, health communication scholars are faced with uncovering strategies to talk about HIV/AIDS within romantic, family, and sexual relationships. However, romantic, family, and sexual relations are practiced differently in different cultures. In addition, prevention efforts must take into account culture and intercultural differences in attempting educational and behavior change efforts. Cultural, social, and economic differences need to be considered in the development and execution of prevention programs. Practitioners must consider the most useful methods of conveying information and reducing the rate of infection. Clearly, what works in one location with one group of people may not work in another location with another group of people. Thus, successful practices need to be chronicled so that others may

assess what might be useful in future efforts. In short, there are knowledge gaps and too many studies and prevention efforts have employed "one size fits all" approaches.

Further, attention needs to be given to integrating prevention strategies—there are serious limitations to employing only one approach and much stands to be gained from combined efforts (International AIDS, 2006). As Gita Ramjee proclaimed at the International AIDS Conference (Wells, 2006), prevention needs to move beyond ABC (abstaining, being faithful, and using condoms) to ABCDEFGHI, which includes, for example, using diaphragms and exposure prophylaxis. Across all prevention efforts from A to Z, communication is vital in raising awareness and addressing potential behavioral adaptations.

This article examines two successful, though widely different, health communication approaches to HIV/AIDS prevention: one in Belize and one in India. These efforts were selected because they took place on different continents with people of different cultural backgrounds for different lengths of time; however, each was creative in its approach to addressing this public health problem. By examining such efforts, scholars, researchers, and practitioners can begin to learn from programs across the globe, assess utility, and compile best practices (although simultaneously recognizing these are always variable based on culture).

The Belize program is a combined effort of university faculty and students and is centered in two rural communities: Gales Point and Red Bank. These communities differ in a number of respects, such as cultural heritage and communication practices. The program's focus is on designing and delivering health education programs to primary school children, teens, and adults. The overarching goal is to raise awareness of HIV/AIDS, especially in terms of transmission methods. Our second example examines the use of folk theatre and art to inform audiences in India about HIV/AIDS. India is multicultural and has rich heritages in these art forms; thus, it is not surprising that health workers would employ theatre and art in entertaining and educating people. Through entertaining media, educational points can be more easily made and are more easily remembered.

Belize

Belize, Central America, is a relatively small Caribbean country. It borders the Caribbean Sea and is located south of Mexico and east of Guatemala. Despite its relatively small size, Belize is populated with numerous cultures (e.g., Creole, Mestizo, Garifuna, and Mayan). Throughout the country, English is spoken, as it is the national language, but many ethnic groups speak Spanish or Creole.

With nearly 300,000 people living in Belize, health care continues to be a major concern (Government of Belize, 2007). More specifically, Belize is at a critical point in regard to the HIV/AIDS epidemic. Within Central America, it has been reported that Belize has the highest adult HIV prevalence rate (UNAIDS, 2006). In 2005, it was estimated that 3,600 people age 15-49 years old were living with HIV/AIDS in Belize (roughly 2.5% of the population) (UNAIDS, 2006). Of those infected with HIV/AIDS, only 31% were receiving anti-retroviral treatment (UNAIDS, 2006).

Various factors perpetuate the HIV/AIDS problem in Belize. For example, the predominant mode of transmission of HIV/AIDS in Belize is through sexual intercourse (Global Health Reporting, 2006). Many adults, especially men, have multiple sexual partners

without the use of condoms. Young adults also engage in sexual activity without contraception (Global Health Reporting, 2006). Moreover, many men cross the Guatemalan border to engage in unprotected sexual activities with commercial sex workers (Global Health Reporting, 2006). Given the stigma and discrimination surrounding those infected with HIV/AIDS, the World Health Organization (WHO) reports more programs and services need to be in place to help curtail the growing infection rate of HIV/AIDS in Belize (WHO, 2005).

Understanding the need to increase prevention efforts in Belize, in 1998 the Belizean Ministry of Health asked representatives from the University of Louisville (UofL) to help with healthcare and health education. Initially, UofL participants were asked to develop a health education and medical project that could continue over time for one village, Gales Point. Based on project success, in 2003 the Ministry of Health asked that another village, Red Bank, also be included in UofL's efforts. As a result, in 2004 UofL began working in Red Bank. Both Red Bank and Gales Point were underserved in their healthcare needs due to their remote geography. They are difficult to access and the closest health service beyond first aid is more than two hours away by bus from either village.

Gales Point is a coastal village on a peninsula with undefined boundaries at approximately the 23-mile marker of Manatee Highway. The population is estimated to be 334 residents (55.6% female and 98.1% Creole in ethnicity). However, some estimates put the population as large as 500 or as small as 250. There is one primary school with approximately 120 students and no secondary school.

Red Bank is a small Mayan community located in the Stann Creek District (the second highest district for HIV prevalence). The population is estimated to be 700; however, some estimates put the population as large as 1,475 or as small as 650. There is one primary school with approximately 180 students and no secondary school.

As noted above, since 1999 faculty and students from UofL have taken part in a health-centered, service-learning program in Belize. An interdisciplinary group of faculty and students from Communication, Medicine, Dentistry, and Nursing created a Health Education Awareness Team (HEAT) to educate, treat, and increase prevention efforts for myriad health issues, including HIV/AIDS.

For approximately four to eight days each March, HEAT sets up and runs free medical, dental, and health education clinics in Gales Point and Red Bank. Not turning anyone away, the clinic is usually open 8-10 hours a day. While the Medical, Dental, and Nursing faculty and students deliver care to the residents, the Communication faculty and students interview residents on their current health beliefs and practices. In these interviews, we explore the residents' knowledge of HIV/AIDS, risks associated with HIV/AIDS (and other sexually transmitted diseases), and prevention efforts associated with HIV/AIDS in Belize.

After analysis of the interview data, HEAT focused efforts around health education to help increase awareness of HIV risks and prevention methods. For example, in Gales Point an annual young adult/teenager health evening was established in 2004. In this evening program, teenagers and young adults engaged in games, activities, and information sessions about HIV/AIDS. The first year the program was established over 100 young adults attended (statistically nearly all the young adults and teenagers of the village). Keeping focused and entertained with the activities and games, the young adults were informed about many health issues associated with unprotected sex. As a marker of the evening program's success, every

year since 2004 the village governing council has enthusiastically asked for the young adult evening to continue.

In Gales Point, another effective method of educating residents about HIV/AIDS was the "Ask the Doctor" question-and-answer event. In this program, HEAT arranged an educational question-and-answer session in the community center so residents could ask HEAT participants general questions about health. During this event, health education materials pertaining to HIV/AIDS were dispersed. By providing the HIV/AIDS information in a relaxed, noninvasive, and fun atmosphere, HEAT encouraged residents to freely and frankly ask follow up questions about sexually transmitted diseases. Village governing council members reported later that many residents who felt shy in the clinic to ask about HIV/AIDS and/or sexually transmitted diseases benefited a great deal by hearing the information and answers presented at the "Ask the Doctor" event.

In Red Bank, analysis of interview data revealed the residents wanted more health education in their school. As a result, since 2005 HEAT has led health education programs for three days in the primary school. The programs are held in three to four classes (i.e., different class grades), and the material presented is reformatted to match the learning and cognitive skills of the students. In what is equivalent to eighth grade, students are given a lecture and learning activities associated with puberty and sexuality. At the end of the lecture students are given the opportunity to ask questions of the presenters. Knowing the embarrassment that often is associated with puberty and sexuality at this age, questions are gathered by having every student anonymously write a question on a piece of paper, fold the paper, and drop it in a box as a presenter walks around the room. The presenters then read and answer the questions in front of the entire class.

Presenting material about puberty and sexuality to students around the age of nine is a bit more difficult. The material presented is reshaped into a more basic human biology lecture. Allowing students the opportunity to learn about their bodies and learn correct anatomical names for different parts of their bodies sets the foundation for future lessons on human sexuality. There has been great teacher and community response to these health education events. In 2006, community leaders of Red Bank told several HEAT members that children were going home after school and telling their parents what they learned in school. As a response to those interactions, the community leaders asked HEAT to create future educational events in the evening so that adults could also have an opportunity to learn about health.

In short, HEAT has made strides in preventing the spread of HIV/AIDS in Gales Point and Red Bank. By creating programs that are culturally appropriate, HEAT is taking a necessary first step in reducing HIV/AIDS infection rates—educating the people of Gales Point and Red Bank about HIV/AIDS. By combining efforts to increase healthcare services and disseminating information about health issues, specifically HIV/AIDS, HEAT hopes to lessen HIV infections.

India

India is the seventh largest country in the world. As a peninsula, it is surrounded by water on three sides and shares borders with Bangladesh, Bhutan, China, Myanmar, Nepal, and Pakistan. Diverse in religion, ethnic groups, and communities, the people of India speak

several languages; 112 mother tongues are recognized by the Indian government. With a population of about 1.1 billion, India is one of the most populated countries of the world.

Of this population, an estimated 2.5 million are currently living with HIV (UNAIDS, 2007). The revised lower estimate from the previous five million is a result of improved monitoring and data collection methods. Surveillance reports from the National AIDS Control Organization (NACO) set up by the Indian government indicate a reduction in infection rates in South India. The reports, unfortunately, also indicate a gradual and slow increase in infection rates in certain populations, such as injection drug users, as well as in certain states of North Eastern India (WHO, 2007). In 2006, it was estimated that almost 90% of all infections occurred in the 15-49 age range (NACO, 2006). Most infections occurred through heterosexual sex.

India's efforts to prevent the spread of HIV/AIDS occur at multiple levels. Although NACO was established at the national level to monitor all matters related to HIV/AIDS, India's diversity demanded extensive efforts at the state and local levels. Hence the government established the AIDS Prevention and Control Society in each state to carry out regional prevention efforts, such as HIV testing and information campaigns to create awareness. Augmenting government funding for these prevention efforts are a host of other sources including private corporations, the World Bank, and the Bill and Melinda Gates Foundation.

Regardless of the funding source, any effective measure to communicate about AIDS requires a culturally appropriate strategy. In India, as in several other cultures, AIDS is a highly taboo topic. Talking about AIDS is embarrassing and uncomfortable, and therefore rarely occurs. Discussion of AIDS can be less taboo only if the "silence [is] broken at the individual, community and national level" (Singhal & Vasanti, 2005, p. 2). In order to break through this silence, information campaigns sponsored by different agencies and geared to prevent the spread of HIV/AIDS have used a variety of entertainment media.

Most of India's citizenry live in villages where, although the use of modern entertainment media such as movies and television has proliferated, centuries old forms of entertainment, such as folk theater (although slightly modernized), continue in a limited way to amuse audiences. Below we describe the use of folk theatre, engrained in India's cultural heritage, to educate and inform audiences about a modern disease. With spirited dialogue, dancing, and music, Indian folk theater is an aural and visual feast. Regional differences, however, abound both in the form and content of folk theater. Two examples, Banthara and Yakshagana, that convey AIDS messages through their performances are described here. The former is from Himachal Pradesh, North India and the latter is from Karnataka, South India.

Himachal Pradesh, a state in the shadows of the Himalayas, is known for its lush forests and stunning scenery. After fleeing Tibet, the Dalai Lama made his home-in-exile in this state (Tashi Jong, n.d). The Buddhist monks are part of the diverse people and culture of this region. Folk theater and music are part of the mountain tradition of Himachal Pradesh.

In Himachal Pradesh, Banthara, a satirical theatre, is used to make people aware of AIDS. Banthara is a synonym for Bhand or jester, who in ages gone by amused royalty; now Banthara artists appeal to everyday people. Banthara blends "three arts—music, dance, and gestures" (Jerath, 1995, p. 57). The artists use song, dance, and humor to ridicule misdeeds and hypocrisies.

Banthara perfomances incorporating HIV/AIDS in the song and dance are delivered using witty dialogue and have garnered audience attention where previous methods failed (Tribune News Service, 2005). Description of the disease and how it spreads is woven into the performance. The information about AIDS is explicit and clear. However, rendering this information through folk drama allows the painful reality of AIDS to be more easily absorbed by the audience. These folk dramas were performed at camps over the course of a fortnight and attendance at these camps increased steadily. Older adults tended to be the most receptive to these performances.

Likewise, in the coastal region of Karnataka in South India, Yakshagana is utilized for a similar purpose: to inform the audience about HIV/AIDS (The Hindu, 2006). Located by the Arabian Sea, the region is populated by Hindus, Christians, Jains, and Muslims who speak Konkani, Tulu, Kannada, and Hindi among other languages. Churches, temples, and mosques dot the area. In particular, Hindu temples from the 13th century draw modern day tourists. Yakshagana, with roots in Hindu myth and legend, is folk entertainment for the residents of the villages and small towns.

Like Banthara, Yakshagana is folk theater involving song and dance (Hapgood, 1980). Yakshagana is the dance of the yakshas or spirits (fairies or giant demons). The dance is visually powerful with the artists dressed in bright masks, costumes, and headgear. Engaging the audience through a spirited exchange of questions and answers, the witty artists perform from dusk until late in the night. The plots are complex, often based on Hindu mythology. Although the origins of the dance form are unclear, Yakshagana was an established form by 1600 A.D. when the Hindu epic Ramayana was written in Yakshagana.

To inform the audience about HIV/AIDS, Yakshagana artists from the region wrote and performed a play with a complex plot involving health, disease, and AIDS (The Hindu, 2006). In keeping with most Yakshagana plays, the story is located in a distant time when kings ruled Ananthapura. Princes and princesses, and their Swayamvara (betrothal) and marriage (an ancient theme), are the focus of the play. Some of the events, however, have been modernized to include a discussion of HIV/AIDS. The play was pivotal in creating awareness of the disease among a previously ill-informed audience, who may not have known about how HIV/AIDS is transmitted and what can be done to prevent its spread.

Although the effectiveness of folk theater is yet undocumented, audiences are certainly exposed to information through an evening's entertainment. Previous research on the use of entertainment education programming in India (see Singhal & Vasanti, 2005) encourages the continued use of folk theater to create audience awareness about AIDS.

Conclusion

Much work remains to be done to reduce the spread of HIV/AIDS. Clearly, effective communication approaches will take into account culture and audience. In this article, we have examined two recent approaches to educating rural villagers about HIV/AIDS—one in two rural villages in Belize and one in two regions of India. The Belizean efforts were interdisciplinary, using a team of students and faculty interested in health, and employed a relatively traditional approach to education (e.g., lectures, activities, question-and-answer sessions). The Indian efforts centered in folk theatre, using an age-old entertainment practice to inform villagers about a new health issue. Initial data suggest that each approach secured

audience attention and participation; however, long-term outcome research remains to be done. Through such activities, best practices can be compiled so that they may be useful to prevention efforts in a number of regions across the globe.

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