

An Education Entertainment Approach to HIV/AIDS Education for Adolescents In
Ethiopia, Washington DC, and Brazil

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Abstract

This thesis begins by taking an in-depth look at the current status of healthcare, education, socioeconomic factors and overall quality of life for adolescents in three jurisdictions: Brazil, Ethiopia, and Washington DC. Using this lens, it will become evident that HIV/AIDS is an imminent threat to the health and future prosperity of these adolescents. The pervasiveness of this disease, accompanied by inadequate education systems, creates adolescents who are in desperate need of HIV/AIDS education but cannot rely on the written word to absorb the necessary information. This gap is the focus of my work. I will examine the theories behind entertainment education, looking specifically at the benefits of theater, song, interactive games, television and radio shows as effective communication tools for health education. My aim is to devise three programs that are tailored to the specific needs of, and use the resources available to, adolescents in Brazil, Ethiopia, and Washington DC. This can serve as the basis for a broader education entertainment HIV/AIDS prevention program that will prove effective to a global adolescent audience.

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D) Introduction/Why this cause?

In a worn-down classroom in Anacostia, Washington D.C, 15 fidgety fifth graders sit in their marked-up chairs. The classroom has a faint scent of mold and the walls are bare except for the water stain in the left corner. The students are huddled in their separate cliques and are joking and laughing to themselves. The students look up when the classroom door opens and five boisterous Georgetown University students donning grey t-shirts and navy blue sweatpants walk in the door. “Hi guys! We are *Grassroot Hoyas* and we are really excited to be working with you today!” exclaims the head coach of the group. The 11-year-olds are not convinced, but they are interested by the new faces and slowly tuck their cell phones back into the pockets of their jackets. First on the agenda is the process of introducing one another. The cheery Georgetown student athletes introduce themselves one by one using their nicknames, many of which make the students laugh. Then, the students are given time to make up their own nicknames, which we will use throughout our time with the students. Names like DJ Free Weezy, Glitter Girl, Brace Face, and Master Flex appear on crisp white name tags stuck to the varied attire of the students; this gives an added sense of fun and levity to some heavy subject material.

Next up is assessing the information they already have concerning HIV/AIDS with some pre-education quizzes printed on bright orange paper. The light-hearted mood shifts and a look of disdain floods the students’ faces as they are handed what looks like another test. At the persuasion of the Georgetown athletes, they begrudgingly begin. Ten minutes later, one of the Georgetown students sweeps up the tests and realizes that a boy in the back, “Young Guns,” as his nametag reads, has not filled out a single word. “Don’t worry, it is all confidential and it is not graded, just put down whatever you know,” says the Georgetown student trying to reassure

him. “It’s not that, I just can’t read English,” responds the boy in a hushed tone. The student, after shaking off the initial shock, sits down and translates the questions verbally into Spanish for the boy and marked down his answers. “Gracias,” he says as he hands the paper over.

Fortunately for “Young Guns” and many others who have participated in this student athlete run HIV/AIDS education program known as the Grassroot Hoyas, there is not an emphasis placed on reading information. Instead, the focus is on interactive games, open discussions, and creating a comfortable learning environment.

a. Trying to Correct a Gap in the Health Education System

Unfortunately, programs like these are not widespread in the fight against HIV/AIDS; literacy rates in communities across the world are far lower than those in Anacostia. Still, in ward 8 Anacostia, the reality is not encouraging; 48.9 percent of residents in 2007 functioned below basic literacy levels. This is in sharp contrast to ward 2, where Georgetown is located, with 20.8 percent functioning below basic literacy levels in 2007. (DCPS watch) In Ethiopia, the literacy rate among adolescent males in 2010 was 56 percent with the female adolescent literacy rate at thirty three percent. (Unicef, statistics by country: Ethiopia) In Brazil in 2010, the adolescent literacy rate was significantly higher, reaching 97 percent for males and 99 percent for females. (Unicef, statistics by country: Brazil) However, there are target populations in Brazil who need this information delivered in a visual and engaging manner. The *favelas*, or shanty towns, in Brazil are the lowest rung on the socioeconomic ladder. Along with reduced accessibility to quality education, these poor urban adolescents suffer higher rates of health problems, violence, and infant and child deaths as compared to their more affluent peers. (Unicef, UN Secretary General and Brazilian Adolescents Discuss Challenges in Urban Life) It is in the

high-risk areas of all three of these jurisdictions that visual, tactical, and interactive learning can have the deepest and most widespread impact on preventing future HIV/AIDS infections.

Washington DC fares better than the previously mentioned countries in terms of literacy rates, but worse than other developed countries. In 2007, 36 percent of DC residents were functionally illiterate (meaning there is some ability to read and write, but it is insufficient to fully function in everyday life). (DCPS watch “State of Adult Literacy in DC”) In 2009, 43 percent of students in 3rd, 4th, and 5th grade were at or above proficiency as tested by the DC Comprehensive Assessment System. (DC.gov, DC CAS results) These shockingly low numbers demonstrate that the DC public school system is failing over half of its students. As a result, children like *Young Guns* are unable to read or write English, although they are within a strictly English-speaking school system.

b. Universal Right to Education

Across all three jurisdictions— Brazil, Ethiopia, and Washington DC—children who are not literate, or who are functionally illiterate because of lack of access to adequate education, are *de facto* being denied the following human rights, as stipulated by the United Nations Declaration of Human Rights (Article 26, UN):

1) Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory. Technical and professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit.

(2) Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship among all nations, racial or religious groups, and shall further the activities of the United Nations for the maintenance of peace.

(3) Parents have a prior right to choose the kind of education that shall be given to their children

Countries have devised approaches to adhering to this mandate. In the United States, for example, it is illegal to not send your children to school under a certain age (this varies by state). Brazil has introduced programs such as “Bolsa Familia”, whereby school attendance is awarded with a monetary reward credited to a debit card. (World Bank, Bolsa Familia) The latter type of program is designed to lessen the appeal of child labor for poor families by providing financial freedom to let their children study regardless of their economic situation. However, economic hardship, poor accessibility, and poor to non-existent educational resources plague the majority of the globe. Most countries have not been able to pool the resources and support for innovative programs to help alleviate these problems. As a result, millions of children are uneducated, or undereducated, and are forced to work at increasingly younger ages.

c. Education Disparity Linked to Health Disparity

This lack of general education is a tragedy in itself because it inhibits both individual and population development and diminishes economic and social possibilities for future generations. Educational disparities are closely linked with health care education and health literacy. This is a part of adolescent education which, if neglected, can have devastating, life altering effects. While there is usually a barrage of barriers to proper sex education such as cultural norms, stereotypes, and lack of resources for necessary supplies, knowing the facts about how to prevent HIV/AIDS infection is the best tool that these adolescents can be provided in helping them protect themselves through informed decision-making.

Sadly, because of the lack of education globally, skills that most of us in the United States would take for granted, such as the ability to read and comprehend text, cannot be assumed when thinking about teaching adolescent populations about HIV/AIDS. Given the low

rates of literacy in many countries, educational programs related to HIV/AIDS should not rely on reading material, posters, pamphlets, or hand outs, but instead should focus on getting the messages across in a more dynamic, interactive, and engaging manner so that the literacy barrier can be overcome and crucial information provided. Use of these educational approaches can reduce the prevalence of HIV/AIDS in populations with low literacy levels. It is this disparity that makes this subject of research a Justice and Peace oriented topic; the next generation should not be deprived of crucial health information simply because of the impoverished and violent communities into which they are born and in which they grow up.

d. Defining Adolescence and Why Adolescents are an Important Target Group

An adolescent is defined by the WHO as a young person between the ages of 10 and 19 years; in 2009, there were approximately 1.2 billion adolescents worldwide. (Unicef, Demographic Trends in Adolescents) The period of adolescence is characterized by major physical and psychological change, accompanied by significant changes in social interactions and relationships. (WHO, Child and Adolescent Health Development) Adolescents are often thought of as a healthy group, but there are many who die from entirely preventable and treatable afflictions such as accidents, violence, and communicable diseases. Adolescents also take the greatest risk with their health in terms of practicing unsafe sex, drug use, tobacco and alcohol abuse, and eating poorly; the consequences are significant. Sexual risk-taking alone can result in unwanted pregnancy and sexually transmitted disease, the most life threatening being HIV/AIDS. In 2009 alone, 40 percent of new HIV infections occurred among those between 15 and 24 years of age. (WHO, HIV and Young People)

It is crucial that education about HIV/AIDS begin at the very outset of adolescence, between ages 10 and 14, so that changes in the lives of these young people can be handled with

knowledge of the facts and risks involved. Since HIV/AIDS does not show symptoms for years, adolescents may feel they can engage in risky behavior without immediate affects. As long as we remain without a cure, the infection of HIV during adolescence will prove to be a serious threat to the well-being of that individual further down the line, as an adult. (WHO, HIV and Young People) According to unicef, “The HIV/AIDS pandemic has reached catastrophic proportions in several parts of the world, unraveling decades of hard-won gains in child survival and development, especially in sub-Saharan Africa.” (Unicef, Adolescent Health, The Big Picture) Adolescent risk-taking behavior also has an intergenerational effect; babies born to adolescent mothers are more likely to be born premature and underweight and statistically are at a greater risk of death. (WHO, Young People, Health Risks and Solutions)

From an economic standpoint, there are compelling arguments for investing in the health and future of adolescents. By improving the health of adolescents who are of school-age, enrollment and retention will increase. Better health among adolescents will allow them to flourish academically and will lead to greater productivity for not only the population in question, but for the future workers of their country.

e. Meeting the Stipulations in the Convention on the Rights of the Child

Document

The Convention on the Rights of the Child is a document, signed by virtually all countries in November 1989, that stipulates the various needs (and an obligation to fulfill them) that children and adolescents have while growing up. (Convention on the Rights of the Child, United Nations) Article One defines a child as a person below the age of what??, so the majority of the adolescent population is included under this convention. (Unicef, Summary of the Rights Under the Convention of the Rights of the Child) Article four stipulates the following:

“When countries ratify the Convention, they agree to review their laws relating to children. This involves assessing their social services, legal, health, and educational systems as well as levels of funding for these services. Governments are then obliged to take all necessary steps to ensure that the minimum standards set by the Convention in these areas are being met. They must help families protect children’s rights and create an environment where they can grow and reach their potential.” (Unicef, Article 4)

As will be further described throughout this thesis, Ethiopia, Washington, DC, and Brazil all face challenges in meeting this goal. In Brazil, the extreme economic disparity and oppressive conditions of the *favelas* keep thousands of adolescents in poverty, in danger of gang violence, and without an outlet to education. In Washington, DC, there are schools in the less affluent parts of the city that have deteriorating physical infrastructure, damaged and inadequate educational equipment, too few educators, and insufficient books and learning tools. In Ethiopia, despite the past year of economic growth in Addis Abbaba (BBC News, Ethiopia, 2011) millions continue to face chronic food and water shortage and much of the population lacks access to education and health care. (Unicef, Ethiopia)

Article 6 of the Convention, entitled “Survival and Development,” states that “governments should ensure that children survive and develop healthily.” (Unicef, Article 6) Part of healthy development is an understanding of impediments to health, which broadly encompasses nutrition, exercise, tobacco and alcohol use education. However, emphasis should be placed on HIV/AIDS education because it is the least discussed of the aforementioned topics and it is an area in which one decision can have lifelong consequences.

Article 17 stipulates that children have the right to information that is important to their health and well-being. Governments should encourage mass media, radio, television, newspapers, and internet content sources, to provide information that children can understand and to not promote materials that could harm children. (Unicef, Article 17) This article makes an important point, that adolescents should be given the most opportunity to learn and educate themselves on a broader level to avoid potential or eliminate current risks to their health and well-being and their ability to prosper as an adult. The component stressing that children understand the information is also a key concept in this study, because for some children, access to a newspaper or text on the internet may not be helpful at all if the child is not sufficiently literate enough to understand the material as result of poor education.

II) Global History of HIV/AIDS

a. Overview of the start of HIV/AIDS

The very first case of infection of HIV-1 in a human being was traced to a man who resided in the Democratic Republic of Congo in 1959. (HIV/AIDS Basics, Center for Disease Control, 2006) In June of 1981 the CDC published a report about five cases of pneumocystis carinii pneumonia (PCP) in healthy men living in Los Angeles. (MMWR weekly, CDC) At this point in time, there had been no known cases outside of the American male homosexual community. This changed quickly with the disease spreading beyond the American border and across populations, indiscriminate of sexual orientation.

The origins of the disease are important because this casts some light on the stereotypes that are still believed to this day. In 1982, the disease acquired the name GRID, or gay related immune deficiency. (Oswald, “Attempted immune stimulation in the ‘gay compromise syndrome’”, BMJ 1982) This early, and others similar, label provided ammunition for the still-

held stereotypes that HIV/AIDS affected only the gay male community. In 1982, the CDC first used the term Acquired Immune Deficiency Syndrome (AIDS). (MMWR weekly,1982,CDC)

Early work in HIV/AIDS prevention focused on teaching safe sex methods to the homosexual community, which would quickly prove to be the best place to start until further information about the transmission of the disease was uncovered. The risk groups were broadened by the CDC to “sexually active homosexual or bisexual men with multiple partners, Haitian entrants to the U.S, present or past abusers of IV drugs, patients with hemophilia, and sexual partners of individuals at increased risk for AIDS.” (MMWR weekly, 1982) It is easy to see how this early classification would create potential for a hostile and exclusionary environment for these listed populations. In American society, the “4-H club” identified those at risk of HIV/AIDS: homosexuals, hemophiliacs, heroin addicts, and Haitians. (Callen, M 1983) As one might expect, this had serious implications for the homosexual and Haitian communities within the U.S , creating a stigma, which led to absurd “preventative” behaviors, such as that of the San Francisco Police; they issued masks and gloves when dealing with a ‘prospective AIDS patient’. Increased reports of HIV/AIDS in central African countries raised concern because there was little awareness of homosexuality and IV drug use. By the end of 1983, the WHO had begun to track the disease and a global forum was held. (MMWR weekly,CDC,1983)

In 1984, the virus was believed to be identified and the Secretary of the U.S. Department of Health and Human Services, Margaret Heckler, announced that there would soon be a test available to the general public that would yield “100 percent certainty.” (Review of Public Health Service’s Response to AIDS, 1985) This was much-needed good news amidst a slew of tragedy, death, and confusion concerning the disease on the global spectrum.

Studies conducted on the spread of HIV/AIDS within Africa yielded the results that an urban environment, heterosexual promiscuity and relatively high income may also be risk factors for HIV/AIDS. (Van de Perre,P, Rouvroy,D, Lepage P, 1984) The stress on heterosexual promiscuity was an important change from the information on transmission in the U.S because homosexual transmission had represented the highest percentage of new cases. This information would influence important changes in the way that organizations addressed the HIV/AIDS crisis in Africa.

In 1985, the first blood tests were successfully implemented to detect the antibodies associated with HIV/AIDS. There was an onslaught of ethical issues that came with the institution of the HIV/AIDS blood test in which gay men in particular insisted that utmost confidentiality be held. People who tested positive for this antibody were no longer allowed to donate blood. (Krieger,N, Appleman R,1986)

In the mid 1980s, the dichotomy with respect to perceptions of “innocent” victims like hemophiliacs versus those who were believed responsible because of personal behavior (e.g., gay men and IV drug users) became more pervasive. This concept of innocent and guilty victims of HIV/AIDS is important to understand and actively avoid because it excludes and places unnecessary blame on HIV/AIDS victims.

In 1986, crucial advances were made with a medication called AZT, which seemed to prolong the life of HIV/AIDS patients. (Fischl, M. A., Richman D., Grieco M.,Gottlieb M., Volberding P. 1987) In 1987, the FDA approved AZT as the first antiretroviral drug to be used as a treatment for HIV/AIDS. In the year previous (1986), the WHO Global Program on AIDS developed a Global AIDS strategy, which established the principles and objectives for nations to

prevent and control HIV/AIDS. It stipulated that countries must have a 'supportive and non-discriminatory environment.' (Mann,J, 1989)

The emergence of AZT and continued research into effective HIV/AIDS treatment, together with the initiative among several global governments and non-profit agencies to promote a supportive and informed community, were two crucial steps in the history of HIV/AIDS treatment and prevention. From that point on, HIV/AIDS was, for the most part, addressed not as a deadly killer, but as a disease that the global community could fight through education and treatment. However, there was still no significant progress in ways to support victims. This changing tide varied greatly by country and, within country, by geographic regions. In general terms, though, the 1990's and the 2000's were decades marked by innovations and increased awareness in the fight against HIV/AIDS and not a sense of doom and anger.

B) Region-Specific History of HIV/AIDS

In order to encapsulate the global response to HIV/AIDS, the remainder of this section of the paper is presented by global region and focuses primarily on modes of transmission, because that is most pertinent to prevention programming. There are several factors that should be kept in mind, in particular cultural factors related to increased rates of transmission in different parts of the world and transmission modes. Understanding these factors will inform what cultural elements need to be incorporated when attempting to format prevention programs for the adolescents of Brazil, Ethiopia, and Washington, DC.

i. Industrialized European Countries

In this region, the beginning of the epidemic was characterized by transmission between homosexual men and injection drug users. (UNAIDS, WHO, 2003 pg3) In Spain and Italy, the

most prominent form of transmission was seen in intravenous drug users, whereas in France, Germany, and the UK, the most common transmission is through male to male sex. (UNAIDS, WHO,2003,pg 4) Thanks to this region's dedication to provision of proper health care to all of its citizens, Europe was the first continent to see true progress in combating HIV/AIDS after the discovery and widespread use of AZT. The number of AIDS cases diagnosed in 2001 was a mere one third of the rates that were reported in 1995. (UNAIDS, WHO, 2003,pg 4)

ii. Eastern Europe and Central Asia

Eastern Europe is an interesting case because this region seemed relatively unaffected by the disease early on. Cases of HIV began to appear more frequently in the second half of the 1990's. (UNAIDS, WHO2003,pg.4) The great majority of these new cases was due to intravenous drug use. This is a region that would benefit greatly from government subsidized needle exchange programs. The key to success with needle exchange programs is not setting out to correct deviant behavior such as drug use, but instead aiming to inform. It hinges on a realistic view of society and the pervasive drug use of the region. Providing clean needles attempts to minimize the damage done to drug users by not coupling dangerous drugs with contracting a fatal disease.

iii. Latin America and the Caribbean

Latin America and the Caribbean is another region that was hit hard by the epidemic in the early 1980's, with the main means of transmission being sex between men and intravenous drug use, predominately in the urban areas. (UNAIDS, WHO2003,pg.5) Fortunately, the spread of this disease has been slower compared to other developing regions. (UNAIDS WHO,2003,pg 5) However, what will become evident in the next section is the stark differences between the

response and state of the epidemic among different Latin American countries, with Brazil being a standout in terms of response and programming. Today, the epidemic in the region can be characterized as being low level and concentrated in urban areas. (UNAIDS WHO,2003,pg 5) However, there is an unfortunate spike in HIV prevalence among pregnant women - around 1 percent. (UNAIDS WHO,2003,pg 5) This would indicate that Mother-to-Child transmission is not only a focus area for health officials in the region, but be an important element to incorporate when proposing future educational programs, especially because of its potential for prevention.

iv. South and Southeast Asia

In this region, Thailand and India had the highest case rates of HIV/AIDS, perhaps because of the great number of sex workers in those countries who were infected and not using proper protection. (UNAIDS WHO,2003,pg.6) Intravenous drug use was another common means of transmission. Thailand experienced a similar surge to Ukraine in infection rates, with less than 1 percent of IDU drug users with HIV in 1987, soaring to 50 percent in 1990. Thailand has done an excellent job in documenting the epidemic and is often the model for condom distribution programs, although recent progress has been rather stagnate. (UNAIDS WHO,2003,pg.6)

v. Sub-Saharan Africa

By the late 1980's it became apparent that HIV/AIDS had moved from a concentrated issue to a full blown epidemic in Africa. (UNAIDS, WHO,2003) South Africa currently has the largest number of HIV positive people living within its borders, with the prevalence being 17.8 percent as of 2009; this brings sub-Saharan Africa to the forefront of the HIV/AIDS epidemic today. (UNICEF, South Africa Statistics) Historically, HIV spread rapidly through this region because of several risk factors such as poverty, low status of women, cultural norms and lack of

education. (A History of HIV/AIDS in South Africa, sahistory.org) As mentioned previously, HIV/AIDS is commonly passed through unsafe heterosexual sex. This, coupled with culturally-embedded myths and practices, has led to an HIV/AIDS crisis in Africa that is unparalleled by any other experience globally. As a result, it is one that demands country specific attention.

III) Case Study Jurisdictions

a. Overview

For this thesis, I wanted to ensure that three different cultures and political and economic environments were incorporated to ensure that the usefulness of edutainment could be seen across borders. Brazil is the first jurisdiction I focused on. I chose this country because of its interesting and impressive history battling the HIV/AIDS epidemic, its unique culture and economic disparity, and a personal interest in the presence of favelas and the adolescents that live in them. Washington, DC is the second jurisdiction I focused on because of my familiarity with the region and work in HIV/AIDS there and because of the city's alarmingly high HIV/AIDS rates as compared to the rest of the United States. It is a jurisdiction with many impressive qualities, however there is much room for improvement with respect to HIV/AIDS education among D.C adolescents. The third jurisdiction is Ethiopia. I chose this country because it was important that I represent an African nation. Additionally, there is a strong presence of Ethiopians in Washington, DC so I have some familiarity with the culture. Ethiopia is a jurisdiction that is making strides in the right direction in terms of HIV/AIDS education and awareness but there is a lack of formal education, information technology, and health care access that makes Ethiopia a country that would most profit from an edutainment program for their adolescent population.

b. Brazil

i. Brazil Governance Structure and Jurisdiction

Brazil is a Federative Republic, which means the citizens democratically elect their leaders. It has seen strong political stability since the military coup d'état in 1964 and successfully switched to a popularly elected government in 1989. The current president is Dilma Vana Rouseff, the first female to hold this position. She took office in January of 2011 and, since then, has focused on growth and equity policies in order to alleviate the widespread poverty throughout Brazil. (Department of State, Brazil) Rouseff is an avid defender of human rights and gender equality. This type of leadership should provide the structural support for changes in HIV/AIDS reform to get Brazil to even more impressive heights in the fight against HIV/AIDS.

Like the United States, Brazil's government consists of three branches the executive, legislative and the judicial. It has a population of 190 million, the largest in Latin America and fifth largest on the global scale. The majority of Brazilians reside in Sao Paulo, Rio De Janiero, and Belo Horizonte. After a period of rapid urban growth in the last two decades, 81 percent of the population was residing in urban areas. While this facilitates economic development in the country, it also causes strains on the social, environmental and political factors within major cities. (State Department, Brazil)

ii. Education System in Brazil

The education system in Brazil is impressive for the rates of attendance it boasts. However, due to the size of the country and the wealth and health disparity, schools range from being productive places of learning and preparation for university to poorly-funded, ignored schools that are often unattended by the children in order to make money for their families instead, President Lula de Silva started an innovative and effective program titled 'Bolsa

Familia.’ This program allows for upwards of 12 million families to get a monthly payment that ranges from 12 dollars (22 reais) to 116 dollars (200 reais) with the only stipulation being that their children attend class. This program helps poor families resist the temptation of child labor by alleviating economic pressure among poor Brazilian families. It also aims to promote the importance of education above all else. (Cabral,P, Throssel L,Brazil’s Education Challenge in bid to be World Player.)

Among males age 15 to 24 years of age, the literacy rate is 97 percent and among women, an even more impressive 99 percent. (UNICEF, Brazil) It is clear that illiteracy will not be a significant hurdle in Brazil. However a different approach to HIV/AIDS which emphasizes student interaction, games, and theater will prove to be enlightening and hopefully more engaging, promoting absorption. Primary school attendance for males is 95 percent. The survival rate to the last primary grade is 76 percent, though. Females, on the other hand, start off with the same primary school attendance but their survival rate to the last primary grade is 88 percent. Although their literacy rates are high, once the children get to secondary school, attendance dips considerably; for males it is 74 percent and for females it is 80 percent(. UNICEF, Brazil)

iii. **Brazilian Economy**

Brazil’s economy is on the upsurge and has been for the past couple of years thanks to its well-developed agriculture, mining and manufacturing. Brazil has an increasing presence in the global market plac; it bounced back quickly after the 2008 recession due to the strength of its commodity-based exports. (World Factbook, Brazil) Brazil’s GDP, or purchasing power parity,

is at 2.172 trillion dollars, making it the 9th highest in the world. It is important to keep in mind, however, that their GDP per capita is 10,800 dollars, which is 102nd in the world.

Brazil currently has an unemployment rate of 6.7 percent, which has been steadily decreasing since 2008. However despite its relatively low unemployment rate, the jobs that many Brazilians are taking are not sufficient to pull them out of poverty because the country also has 26 percent of its population below the poverty line. (World Factbook, Brazil) This economic setting is a reason for hope for Brazilian adolescents; although there is a huge disparity between wealthy and poor Brazilians, their economic surge and increased respect among the global community is setting the foundations for increased success and economic growth. Adolescents in Brazil today make up 17 percent of the population. (UNICEF, Brazil)

iv. **Brazil's Health Care System**

Brazil's health care system, known as Sistema Unico de Saude (SUS), has several problems, but as a system, it prioritizes quality health care provision to the millions that need it most. Up until the 1970's there was a running joke in Brazil that suggested you had to die before the authorities paid any attention to you. During this same time period, there was an actual position titled Death Secretary in city governments; this person was in control of organizing and administering funerals. (WHO, Flawed but Fair) Now the picture is much less grim, thanks in great part to the political changes and agendas after the 1964 coup which focused on access to health. This was cemented in the 1988 constitution which labeled health a citizen's right and a responsibility that fell on the government in terms of provision. (WHO, Flawed but Fair).

One of the key components to the continued success of Brazil's system is primary health care. Due to this dedication to the 'health for all' mantra of the Alma-Ata declaration, Brazil has

impressive statistics compared to its Latin American neighbors; about 70 percent of the population receives its health care through these free of charge medical services, whereas the remainder who are wealthier pay to see a private doctor in order to avoid lines. (WHO, Flawed but Fair)

v. History of HIV/AIDS in Brazil

Brazil is seen as a model country in Latin America because of the efficiency, quick response, and social movements that sprung from their campaigns to tackle the disease. (Frasca, T pg.37) Due to these unique factors, the history of HIV/AIDS in Brazil will be explored in greater depth than in the other two jurisdictions because there is an abundance of effective programming and decision-making that can serve as models for the responses in the other two sectors.

The gay male community was the first to respond to the emergence of HIV/AIDS in Brazil. Brazil had its first documented case of HIV/AIDS in 1980. (Frasca,T, pg. 187) By 1983, the Sao Paulo gay rights group titled “Outra Coisa” had already developed informational pamphlets and sessions for those affected and by the end of the year, the government of Sao Paulo had established an AIDS program. (Frasca,T,pg.188)

By 1985 the first non-governmental organizations were set up to deal exclusively with HIV/AIDs. At this point in time, none of Brazil’s neighbors had acknowledged the disease as a cause for concern. This acknowledgment of the seriousness of the disease back in a time when the entire world did not have a firm grasp on what HIV/AIDS was or how it was transmitted is prophetic in nature. This jump start allowed Brazil to take opportunities to establish not only a

prevention and medication program, but spark a social movement to promote understanding, comfort and breaking down of stigmas within the Brazilian population.(Frasca, T pg.195)

In 1985, Brazil emerged from a period of military rule that started in 1964. With the removal of the dictatorship and that start of a democracy, Brazilians could finally voice their opinion. This atmosphere of human rights, and a fight to restore equality that had been stripped from them by the previous regime actually aided to the comprehensive manner in which HIV/AIDs was tackled in Brazil. It gave AIDS activism a whole new meaning. (Frasca,T,pg190)

A key difference in Brazil's approach was their inclusion of education and space for dialogue about sexuality, an aspect left untouched by surrounding countries like Argentina.(Frasca, T pg.195) Educating about HIV/AIDs only slowly emerged as a way to tackle the growing problem. However constructing these early 'educational messages' produced by the governments did not involve any element of sexuality.

Unlike the start of the epidemic in the United States, HIV/AIDS spread quickly from homosexual males to heterosexual male and female Brazilians. (Frasca,T pg. 47) It also became evident that the disease was being transmitted at frightening speeds through intravenous drug use. This was addressed with the establishment of needle exchange programs which yielded positive results especially in the port of Santos, where IV drug use was at a high. (Frasca,T, pg.208)

Brazil also had, and continues to have, a type of socioeconomic apartheid, where the difference between the extremely rich and devastatingly poor seems to never diminish. This disparity along with other cultural factors that will be highlighted further on will prove to put Brazilian adolescents at heightened risk for HIV/AIDS infection.

In the early 1990's, Dr. Ricardo Ayres expanded the notion of preventative public health in the field of HIV/AIDS by popularizing the use of the term vulnerabilities versus the commonly used term risk. He explains his quest for change as the following: "Prevention work needed more operational concepts and there weren't any." (Frasca, T pg.206) This step away from terms like 'risk group' and 'high risk behavior' took into account the cultural elements of this movement and made the language sound less accusatory and more informative. This is a change that has global resonance because of its consideration for the psyche of victims and those being informed of HIV/AIDS. This concept has gained traction through global programs combating HIV/AIDS because of the manner in which it combats structural violence in the world of HIV/AIDS by placing emphasis on rationality and modification of behavior.

Another watershed moment for the HIV/AIDS prevention world that can be traced to Brazil is the full inclusion of sexuality in their work. This type of openness and honesty in the public and private sectors was simply not found in some of the more religious neighboring countries. A parish priest in Sao Paulo who runs two hospices for patients suffering from AIDS has on his wall a 'break glass in case of emergency condom display' which would be a death sentence for a priest in neighboring Chile. (Frasca, T, pg.107) Brazil was also one of the first countries to pro-actively seek out the financial assistance of the World Bank for funds to further their programs. In 1996, thanks in part to World Bank assistance, Brazil signed a law which ensured universal and free of cost access to AIDS treatment. (Nunn, pg.ix) One third of all people living with HIV/AIDS in Latin America reside in Brazil. Luckily, because of the aforementioned law and an abundance of support programs and proper government funding for those in need of testing and treatment, the prevalence rate has remained stable since 2000 at .61,

with Brazilian women having a prevalence rate of .42 and Brazilian men having a rate of roughly double, .82 percent(. USAID, Brazil HIV/AIDS)

Today in Brazil, the rates vary by region, with the northern and northeastern areas having the highest prevalence and the southern and southeastern regions having the lowest. (USAID, Brazil HIV/AIDS) Brazil's population is 192.8 million, with the estimated population living with HIV/AIDS at 730,000, which yields a prevalence of .6 percent. (UNAID,Health Profile) Currently, the most at risk populations include female sex workers, of which 34 percent are infected. A distant second is men having sex with men, also known as MSM, with a prevalence of 5.5 percent. (UNAID, Health Profile) The third most affected group is female prisoners, with 14 percent being infected with HIV/AIDS, followed by female injecting drug users at 2.4 percent and male injecting drug users at 6.3 percent. (UNAID, Health Profile)

vi. Cultural Factors and Challenges for Brazilian Adolescents

The United Nations estimates that in the year 2000, there were 250 million more urban children in the 5 to 19 year old age range as compared to during the mid 1980's. It is also evident that 90 percent of these children and adolescents were living in developing nations. In Latin America alone, there were 100 million indigent urban minors and in Brazil it is almost certain that the majority of them lived in the streets or the urban *favelas* (Inciardi, pg.101). It is this population that needs to be honed in upon because they face the greatest challenges among the Brazilian youth, they lack general education, they live in areas of extreme violence and temptation to enter the drug world, and they often lack the family structure necessary to adequately support them in their pursuits.

It is often in these impoverished communities that health risks, and knowledge of/protection from them, fall second to the concern of daily survival within the violence and dangers of their community. One important aspect of the youth living in these areas is the pervasive drug use as depicted in a study conducted by the University of Brasilia with three different groups of youths: those with no schooling or family ties, those who received social welfare who were often delinquents, and youths who were enrolled in school. A shocking 100 percent of the adolescents interviewed admitted to drug use; the most commonly used drugs were inhalants, such as glue, but 32 percent reported to using marijuana and cocaine. (Inciardi, pg.108). While these drugs do not directly put the youths at greater risk for HIV/AIDS contraction, because they are not intravenous, it is a very important cultural factor to take note of when working within these *favelas*. The street children of Brazil, regardless of drug use have always reported very high risk sexual behaviors.

Prostitution is a very common practice among males and females looking to make any kind of money in poverty-stricken areas. Rape is also a common occurrence by older street children, adults of the *favelas*, and the police force and it moves beyond the common male perpetrator and female victim scenario. (Inciardi, pg.109) In a study conducted by Einstein and De Aquino in 1992, 98 street children were interviewed; 53.1 percent were sexual active and 44.9 percent reported being forced to have sex. (Inciardi,pg.109) A similar survey of 52 HIV-positive youths under 16 years of age showed that 28 percent had had anal intercourse, and 57 percent had been forced to have anal intercourse. (Inciardi,pg.109) Condoms are almost never used in these acts of violence. These terrible realities of the everyday lives of adolescent living in the *favelas* need to be addressed and if at all possible remedied when conducting HIV/AIDS prevention programs.

c. Ethiopia

i. Governance structure and political stability

Ethiopia is the oldest independent country on the continent of Africa (with the exception of an Italian rule from 1936 to 1941); it has never been colonized (Country Watch, Ethiopia). This means Ethiopian history has taken a very different path from its neighbors, the majority of which have been colonized by another world power. (BBC, Ethiopian Profile) Ethiopia is also the second most populous country on the continent of Africa, with over 76.5 million inhabitants. (New York Times, Ethiopia) It is located on the horn of Africa, neighbored by Eritrea to the north, Djibouti in the northeast, Somalia to the east, Kenya in the south, and South Sudan to the west. (Britannica, Ethiopia, Land) Ethiopia, much like the United States is made up of a smattering of languages and cultures. In the north, semitic languages are spoken such as Ge'ez, Tigrinya, and Amharic (which is recognized as the 'working language'). Oromo is spoken mostly in the western, and southern areas of the country. (Country Watch, Ethiopia.)

Ethiopia's first democratic constitution was adopted in 1994 with multiparty elections held right on the heel of that landmark historical moment. Ethiopia, however, has not known peace for long, with a very costly war with Eritrea from 1998 to 2000, and tensions still exist to this day despite the peace treaty of 2000. (Country Watch Ethiopia) Thanks in part to this war, Ethiopia is one of the poorest countries in the world today. The economy relies heavily on agriculture and, as such, is very susceptible to the extreme fluctuations caused by droughts, floods, and natural disasters. In recent years, Ethiopia has seen times of progress fueled in part by loans from the IMF and changes to its economy to provide a more stable system. (Country Watch, Ethiopia) Yet the past decade has not been a smooth ride for Ethiopia.

Following the war with Eritrea, 2002 brought a steep decline in international donations and support. This factor in conjunction with a severe drought resulted in a desperate food shortage, which could not be remedied. This drought affected 14 million people in Ethiopia alone and it caught the attention of the UN World Food Program due to the widespread need; 7 million Ethiopians, to be exact, in need of immediate emergency food (Country Watch, Ethiopia).

While Ethiopia does have one of the largest armies in Africa it is important to note the state of violence that the country seems to fall in and out of, especially when considering stresses on the Ethiopian adolescent. (New York Times, Ethiopia) Today, the country is run by president Girma Wolde-Giorgis and Prime minister Meles Zenawi following a significant win, though not legitimized by the international community, for the Ethiopian People's Revolutionary Democratic Front in May of 2010. (BBC, Ethiopian Profile)

ii. Ethiopian Economy

Ethiopia has a gross national income per capita of 870 U.S dollars, with a total expenditure on health per capita of 40 dollars. In Ethiopia, 4.3 percent of GDP is spent on health. (WHO, Ethiopia) Ethiopia has . (BBC, Ethiopian Economy)

The country's main focus is the agriculture industry, however, as previously mentioned, natural disasters such as droughts and floods cause a constant sense of uneasiness for Ethiopians, with thousands not knowing from where their next meal will come. The recent new growth is promising but there are serious roadblocks to pulling Ethiopia into the developed world. Millions of Ethiopians rely on food aid and it well documented that basic human rights of Ethiopians and those that visit are commonly ignored. (BBC, Ethiopia) The unstable economy mixed with the low priority of healthcare in the political sphere, Ethiopia is left with some grim health statistics.

iii. Ethiopian Health Care System

The health care system of Ethiopia is not on par with the development that the country has undergone in other sectors and because of their significant population, the health care system does not effectively manage the needs of its people. (Center for National Development in Ethiopia) The current health policy was put into effect in 1993 and it focused on a decentralized approach of primary health care in order to reach as many Ethiopians as possible. The current system is functioning as a four-tier system which is comprised of the following segments: a primary health care unit, composed of a network of one central health building and five smaller health posts, the hospital at large, the regional hospital, and the specialized referral hospital. (Center for National Development in Ethiopia)

The current strategy is to strengthen primary health care and increase the availability of health services, a tricky promise in a rural country. (Center for National Development in Ethiopia) Partly due to this access of healthcare services and information, the HIV/AIDS rate in the country is at a staggering 3.5 percent. (IPAC, HIV/AIDS Ethiopia) The Federal Ministry of Health in Ethiopia has reflected on this serious problem and has set out to aggressively combat HIV/AIDS and set up the proper channels through which those affected can get the medical attention and prescription they require.

Malaria is also a pressing concern in Ethiopia and should be taken into account when conducting disease prevention programs. In total, 80 percent of the countries health problems are due to preventable communicable diseases and nutritional issues. (Center for National Development in Ethiopia) The life expectancy in Ethiopia is 57 for males and 60 for females, figures just above the continent's average, but still low on a global scale. Another important

indicator of health is the under-five mortality rate, which in Ethiopia is 104 children per 1,000 live births. (WHO, Country Fact Sheet, 2010)

iv. **Ethiopian Education**

Sadly, education in Ethiopia pales in comparison to Brazil, with a youth literacy rate of 56 percent for males and 33 percent for females as of 2010. (UNICEF, Ethiopia) This can be traced back to the lack of attendance among Ethiopian children at primary schools, with only 45 percent of both female and male children attending the most fundamental years of their education (UNICEF, Ethiopia). As can be expected, the numbers deteriorate as the grade level increases. Adolescents make up 24 percent of the Ethiopian population and of them, 28 percent of the females gave birth before the age of 18. As of 2010, another red flag exists, with only 32 percent of male Ethiopian adolescents having a comprehensive knowledge of HIV/AIDS, followed by 21 percent of Ethiopian female adolescents. (UNICEF, Ethiopian Statistics)

The literacy rate combined with the great need for increased education in the HIV/AIDS arena makes Ethiopia a country that can benefit greatly from an HIV/AIDS education program that does not rely on the written word. One of the most significant challenges to proper HIV/AIDS information dissemination is the rural landscape, a common challenge in the health promotion and disease prevention world. Ethiopia presents another layer of difficulty because of the lack of proper health care infrastructure. Although there is a revamped effort to provide health care to spread to the corners of the country, it seems to be too little effort too late in the progression of communicable diseases throughout the country. Another hurdle in assessing the needs and education levels concerning HIV/AIDS of the adolescents of Ethiopia is finding an

effective way to pull together the adolescents in the area. The school system is not successful in bringing together this specific population.

v. History of HIV/AIDS in Ethiopia

The first case of HIV/AIDS was reported in 1984 and since then has been a terrible and overwhelming problem for the country. (USAID, HIV/AIDS Ethiopia) Consistent data for information on the history of HIV/AIDS is hard to come across thanks to the obstacles in data collection that come with being a predominately rural and poor country paired with general mistrust of the government. (Barz, G, Cohen J, pg.328)

However, in broad strokes, the epidemic devastated both the population and the economy, leaving thousands of AIDS orphans to fend for themselves. The country declared a public health emergency because of the rampant cases of HIV/AIDS in 2002. (USAID, HIV/AIDS, Ethiopia) Today, the epidemic is at a stable point, meaning the infection rates are not rising, but as it stands, it is a huge burden on not just the health of the population but the future growth and success of the country. Today in Ethiopia, an estimated 1.3 million people are living with HIV/AIDS; women and the younger generation are disproportionately affected. (ICAP, HIV/AIDS Ethiopia) It is important to note that stable rates of HIV/AIDS are not seen as success; there has to be increased effort made to educate those that are not infected and provide the proper medical care to those that are affected so that the number of deaths decreases steadily.

HIV transmission in Ethiopia occurs primarily through heterosexual contact with a small portion of transmission resulting from mother-to-child transmission, a risk that is completely preventable with the proper resources. (ICAP, HIV/AIDS Ethiopia) In 2009, the national prevalence was 6.6 percent, with the breakdown of percentages of those that are HIV positive are

similar to Brazil, in that the urban areas are a hotbed for disease transmission with 14 percent of Ethiopians being HIV positive compared to 3.7 percent in rural areas (WHO African Regions, Ethiopia, 2009). It is also important to note that while the prevalence rate of the country as a whole has leveled off, the rural areas of the country are reporting a gradual but consistent increase in HIV rates. (ICAP, HIV/AIDS Ethiopia) This will become important when formatting an HIV/AIDS education program for Ethiopian adolescents because the scope must be pushed beyond the busy streets of Addis Ababa and into the countryside.

vi. Ethiopian Adolescents and cultural factors

In order to provide the country with a new generation of educated, productive and healthy adults, one must target the current adolescents. Issues such as internal migration (which is often triggered by droughts), widespread poverty, and low education levels especially among adolescent females are the main components that fuel the HIV/AIDS epidemic in Ethiopia. (ICAP, Ethiopia HIV/AIDS) While they may already feel the effects of the poverty ridden surroundings, teaching them about HIV/AIDS and how to prevent it will be crucial.

Another cultural factor that needs to be taken into consideration is the prevalence of female genital mutilation. This is also known as female circumcision and it is practiced in 25 African countries, one of them being Ethiopia. A study conducted by the IAC on harmful traditional shows that in 1989, 85 percent of women in Ethiopia were being circumcised. (11th International Conference of Ethiopian Studies, 1994) It is estimated that 74 percent of Ethiopian women have undergone this life threatening and traumatizing procedure. (Eradicating Female Genital Mutilation, 2009, populationmedia.org) A cultural factor to take into consideration in Ethiopia is the young age at which females get married. Marriage brings with it a couple of

vulnerabilities to HIV/AIDS, firstly that these adolescent females are having frequent unprotected sex. In Ethiopia, like many other countries, male infidelity is quite common. In Ethiopia, 19.1 percent are married by fifteen, 49.1 percent by 18 and 64.7 percent by 20. (11th International Conference of Ethiopian Studies, 1994) Also, married female adolescents have less access to education and media than their peers who are unmarried. They are assumed to have familial responsibilities and education is often a low priority. On the global spectrum, two demographics have been targeted as consistently rising in HIV prevalence and those are adolescents and females. Therefore, it only makes sense that in a culture that promotes early marriage, HIV/AIDS programs understand the increased vulnerability that adolescent females are in.

In a study conducted on Campaigns Against female genital mutilation, Pamela Nichols said: “Discussing traditional practices, whether harmful or beneficial, is a challenging task. Using Theater as a tool for communicating sensitive messages is an effective approach, especially in many parts of Rural Africa, where there is a strong oral tradition. In dealing with such issues (the status quo and women’s role in society) education is fundamental and different communication techniques must be used to strengthen the message and increase the level of awareness” Here we see the edutainment method put to use in areas of education that cannot be broached under normal circumstances, the theater becomes a tool for dialogue and further understanding.

d. Washington, DC

i. Political Structure

Washington, DC is the capitol of the United States, making this territory different from the previous two countries examined. In order to understand how DC functions it is important to look at the governing structure in place under the United States Government. The current president of the United States is Barack Obama and the country runs under a constitution-based federal republic with a deep rooted tradition of democracy. (Country Watch, U.S) The current mayor of Washington, DC is Vincent Gray, who was elected in 2010. The population of Washington, D.C. was 617,996 in 2011 (U.S Census Bureau, District of Columbia, 2011), of whom 50.7 percent were African American, 38.5 percent white, and 9.1 percent Latino. (U.S Census Bureau, District of Columbia 2011)

Washington, DC is home to the heart of the United States government, although interestingly enough, Washington DC is the only region that does not have a voting representative in the national legislature and that lacks statehood. Nationally, the United States has a very stable political atmosphere, ranking 9.5 out of 10 in Political Stability. (Country Watch, United States) Thus far, the U.S is the most politically stable country to be examined in comparison with Brazil's 8.5 score and Ethiopia's score of 4. (Country Watch) One would hope that this level of democracy and free and fair elections would allow all segments of the U.S government to function with relative ease, however in DC there are numerous issues with the city's education system, its lack of congressional representation, poverty, and most importantly for this piece, the staggeringly high HIV/AIDS rates.

ii. Washington DC Education System

In Washington the compulsory ages of school attendance are 5 to 18. According to the latest survey done by the National Center for Education Statistics, attendance starts at age 5 with 98.2

percent and slips to 95.2 percent by the time they reach high school (14-17). (National Center for Education Statistics,2009) This is the worst percentage in the United States second only to West Virginia.

One of the challenges that I often face when coming into these schools is the false assumption that everyone in a 7th grade classroom will have around a 7th grade reading level. In majority of the cases, I have found that certain children do not read or understand English well because they primarily communicate with their families and friends in Spanish. These problems with having to sit and translate quizzes, or, for some English-speaking students, read them and explain them in English, creates a serious roadblock when a program is built under the assumption that children in these classrooms can not only read, but read and understand material in English. While in our programs this is easily corrected, because I also grew up speaking Spanish, it has much more serious implications for the lack of cohesiveness and progress in DC classrooms.

When you look at data for Washington, the disparities found between DC and other states are nothing short of alarming. For public school students in the 8th grade, the percentage of students that are at or above proficient is 14 percent. This is half of what almost every other state in the United States is reporting. (NCES, 2009)

iii. **Washington DC Economy**

Washington, DC has an unemployment rate of 9.8 percent as of March 2012. (District of Columbia, Economy at a Glance, Bureau of Labor Statistics, 2012) As of February 2012, The recent increase in unemployment has most affected the D.C population that have a high school diploma, but no higher education. (DC Fiscal Policy Institute, 2012) In general, the city has not

made an even recovery from the recession, for example D.C's African American resident have seen the largest increase in unemployment over the past few years, with the unemployment rate more than doubling from 9.4 percent in 2007. (DC Fiscal Policy Institute, 2012) Furthermore, teenagers and young adults have seen high increases in unemployment since 2007 and are now the age group with the highest unemployment rate, at 17.4 percent. (DC Fiscal Policy Institute, 2012) This means that in Washington, DC those affected the most negatively by the economic hardships are African American teenagers and young adults. This is an important consideration when you are developing a HIV/AIDS education program because you cannot take such things as transportation, and health insurance for granted.

As of April 2012, DC could potentially endure the loss of millions of dollars in revenue and spending capacity as a result of proposed budget cuts. (Sequestration a 'major issue' Washington Post, 2012) Washington, DC is a unique American city because it is home to the federal government, which has provided a solid source of steady jobs through the past four years of the American recession. (Sequestration a 'major issue' Washington Post, 2012) However, this benefit comes with a price, the D.C economy is unusually vulnerable to the budget cuts and changes in economic policy that are made on Capitol Hill.

iv. Washington DC Health Care System

The economic disparity within DC that was mentioned earlier creates problems for the poorer populations of the city in terms of access to quality health care. The health care system in the United States is unique because instead of having a combination of public and private sectors, like most other countries, the private sector in the United States is the dominant force in health care. This becomes a serious problem when discussing access to healthcare because today, nearly

45 million Americans are uninsured. (Garson, A U.S Healthcare System 2010) The topic that has proved most decisive in the political sphere is concerned with fixing this discrepancy and providing universal coverage to Americans. In terms of HIV/AIDS work, a full implementation of this universal program would help significantly with being able to get those who need medical attention most to the proper doctors without being restrained economically. While the United States is home to the absolute top doctors, technology, and well-equipped hospitals, there is a significant and alarming drop off when you focus on the populations who cannot afford health insurance. As a country, we fall short in our commitment to provide health to all of our citizens ranking 37th in the world(WHO,Health Systems).

v. History of HIV/AIDS in Washington, DC

Washington, DC has been one of the most perplexing cities in the global fight against HIV/AIDS. Washington, DC is the capitol of the United States, a country much admired for its wealth, military strength, health care, and broadly speaking, its established and efficient infrastructure. Moreover, DC is the undisputed capital of health policy and international public health centers(Greenberg, A, Fighting HIV/AIDS in D.C) However Washington, DC has a prevalence rate that between 2009 and 2012 has ranged between 2 and 3 percent (Washington Post, At Least 3 percent of DC residents have HIV or AIDS, 2009), a rate that is on par with developing countries. (Greenberg, A Fighting HIV/AIDS in D.C). The question that begs to be answered is how can a city that is responsible for making many crucial health policy decisions that not only affect Americans, but the global community, be so irresponsible in their own local fight against HIV/AIDS? Some risk factors that are intrinsic parts of the DC community include a high level of population of individuals who are at an increased vulnerability towards

HIV/AIDS such as intravenous drug users, men who have sex with men, and heterosexuals with multiple partners. [Greenberg,A).

Washington, DC has also struggled with significant levels of poverty and similar to Brazil, a significant economic disparity between its residents. As of 2012, The top fifth of earners in the District make an average of 29 times the incomes of the bottom fifth.(Washington Post Local,Income Inequality,2012) Today, there are several gaps in Washington's response to the epidemic, some of the most significant being the frequent changes in the leaders of HIV related work within the DC department of health, HIV testing and condom distribution programs that are too narrow in scope, and inadequate education concerning HIV/AIDS within DC schools (Greenberg, A).

There have been some steps in the right direction, however in the history of HIV/AIDS in Washington DC. In 2006, the city started a campaign entitled "Come Together DC-Get Screened for HIV" to provide easy access to testing, educate on HIV/AIDS and related stigmas, and give those who are HIV positive the medical assistance and medication necessary(Greenberg,A). This was a first program of its kind in the U.S and it was made possible because of D.C's small and urban population. One element of policy change that came from this campaign was a shift from providing HIV/AIDS testing to promoting it and making it a routine part of DC healthcare. This kind of blanket decisions to incorporate testing is so effective in removing stigma or fear concerning the HIV test itself, and they aid greatly in informing HIV positive patients of the options available and the precautions that are necessary to lead a productive and full life.

In 2007 in Washington DC, one person for every twenty was diagnosed with HIV/AIDS.(ABC news,1 in 20 DC residents is HIV positive, 2007) This is a staggering number

for the capitol of a country considered to be the wealthiest and most technologically advanced country in the world. In 2009, surveys showed that Washington DC had 3 percent of its population infected with HIV/AIDS, a 22 percent increase from the figures in 2006(Washington Post, Vargas). While 3 percent may seem not so alarming to some, it is important to put it into context. If a country or city has 1 percent HIV/AIDS prevalence amongst their population it is considered a generalized and severe epidemic, and here in the nation's capitol, that has tripled. Shannon L. Hader, director of the District's HIV/AIDS Administration, who once led the Federal Centers for Disease Control and Prevention's work in Zimbabwe, stated "Our rates are higher than west Africa, they're on par with Uganda and some parts of Kenya."(Washington Post, Vargas)

At the center of what can only be classified as a severe health epidemic, there are some considerable issues to be corrected. The first is that D.C does not have an efficient system in place to systematically collect and analyze data pertaining to HIV/AIDS patients which in turn efficient planning for patient care difficult. Secondly, Washington, DC is not involved enough in the efforts of government agencies as well as non-profit organizations in their efforts to help those that are HIV positive The third problem which is evident in the lack of knowledge among D.C public school children, is the widespread lack of prevention programs and the necessary funding and staff to keep them running.

vi. DC Adolescents, Cultural Factors and Personal Observations

Today, rates of sexually transmitted infections are high among Washington, DC youth, which is a clear indicator that they are engaging in unsafe sexual acts. While they are not the group that has the highest HIV prevalence (most new diagnoses occur in people in their thirties and forties),

(D.C Department of Health, HIV/AIDS), the rates of STI's should serve as a serious warning to health educators about the need for a more effective sex education program in schools.

An intriguing program that is running currently is called 'Real Talk DC' and it is a social media program that uses text messaging to spread news about testing and HIV/AIDS events and also to answer questions about HIV/AIDS(RealTalk DC). This notion of using social media as a tool in health education is very intriguing when working with DC adolescents and it will be delved into further when constructing a program.

IV) Edutainment-An Introduction to Theory and Application

a. What is it and How it is used in Public Health

Edutainment, or entertainment education, is defined by Arvind Singhal as "the process of purposely designing a media message to both entertain and educate, in order to increase audience members knowledge about an educational issue, create favorable attitudes, shift social norms, and change overt behavior."(Singhal, pg.4) There is an important distinction made that edutainment is not a theory of communication, it is actually a communication strategy that relies on various communication theories to achieve the desired social change.(Singhal, pg.5) The prominent communication theories that are involved will be discussed further on in the work.

When edutainment is used, the goal is to create awareness, knowledge and shift the attitudes and behaviors of those watching(Moyer, E, Communication Theory). "The purpose of entertainment-education programming is to contribute to directed social change, defined as the

process by which an alteration occurs in the structure and function of a social system. This change can occur at the level of the individual, community, or some other system.”(Singal, Rogers pg.9) This method of information dissemination at different levels is so effective for HIV/AIDS work because it works on two different planes. Firstly, to inform the viewer and promote behavioral shifts, but also to create a surrounding that is more educated and understanding to what it means to be living HIV positive. To educate on the nuts and bolts of the disease is crucial, for example means of transmission, how to protect yourself, where to get tested, and what medications to take if HIV positive. Secondly, the work done to create a culture of support and comfort for those living with HIV/AIDS is an aspect that is sometimes overlooked. This is also of the utmost importance so that you have a population who can both protect themselves, share their knowledge and be part of a community that respects others regardless of their HIV status (Moyer, E, Communication Theory).

There are three main reasons for the use of edutainment that Arvind Singhal and Everett Rogers outline in their book “Entertainment-Education- a Communication Strategy for Social Change” They are as follows:

1. There are development problems all over the world, no country is exempt.
2. Leisure and entertainment represent one of the most significant trends of recent decades, they reach expanding audiences worldwide, even hard to reach rural areas.
3. The entertainment media needlessly suffer from the stigma of being a ‘mindless’ genre. Audience research shows that carefully designed entertainment media messages can help educate audiences, promote pro-social behavior, and be economically profitable.

b. Theory of Edutainment

i. Albert Bandura's Social Learning Theory

A significant portion of Edutainment is grounded in the work of Albert Bandura and his Social Learning Theory. Bandura essentially believed that individuals learn not only in classrooms but also by observing role models in everyday life, including characters in movies and television programs(Bandura,A, pg.vi).

Bandura highlights three main components of his theory that are worth noting. First, that vicarious and self regulatory processes play prominent roles in psychological functioning. Secondly, that humans have a remarkable capacity to use symbols in order to represent events, analyze their conscious experience, communicate with others, and engage in foresightful action. Thirdly, social learning theory place utmost importance on self-regulatory processes. In other words humans do not just automatically respond to outside stimuli and pressure; they can construct constraints and rules that in turn impinge on their behavior, therefore asserting influence over their own behavior(Bandura, A,pg.vii).

This theory is crucial to HIV/AIDS education because the crux of educating adolescents is so that they may incorporate facts and certain precautions, such as always using a condom, and that idea has an effect on their behavior. The best case scenario being of course that they take this idea and make it a habit, where a condom is used in every instance of sex without exception. "This conception of human functioning then neither casts people into the role of powerless objects controlled by the environmental forces nor free agents who can become whatever they choose. Both people and their environments are reciprocal determinants of each other."(Bandura, A, pg.vii) I find this quote appealing when thinking about HIV/AIDS education because it enforces the idea that if you put adolescents in an environment of learning, understanding, and

enjoyment (even if it is for a couple hours a week) that will be reflected in their person and their conduct.

Modeling is another central concept in social learning theory, and it is one that edutainment relies heavily on with its use of positive role models. Modeling is a phenomenal education tool because it surpasses the idea of imitation. Bandura defines it as the psychological processes in which one individual matches the actions of another, not necessarily closely in time. Modeling extends beyond the psychological components of identification and it also is more complex than a mimicking of actions, sets a precedent for patterned change.”(Bandura,A,pg.42)

Once again, it is clear to see how important Bandura’s theory is when thinking about HIV/AIDS education. By providing an educated and approachable teacher, students can be infused with the teacher’s notion of HIV/AIDS whether that be preventative measures, breaking down of stereotypes, or creating a respectful and helpful environment for those who are HIV positive. When you start discussing edutainment through television, theater and radio channels you have an even more extensive opportunity to flesh out characters that are ‘the ideal educated citizen.’ Another way to educate and portray difficult cultural issues very effectively is through theater.

ii. Miguel Sabido and Past Success in Edutainment

To understand the power of edutainment, it is important to look at a past campaign. Miguel Sabido is a writer-producer-director of television and theater in Mexico. He is a pioneer in the world of edutainment, and he worked to create an intellectual basis for the entertainment-education strategy in television (Singhal, A, Rogers, E pg.10). Miguel Sabido found that the soap opera format was an ideal fit for the Mexican culture and an extremely effective means of

educating the vast numbers that watched soap operas. Soap operas air 5 times a week which provides massive ongoing exposure to an educational message, they provide characters (which in edutainment programming exhibit good behaviors) which populations will mimic, and they are the perfect basis for conversation due to their dramatic events and plot turns(Singhal, A, Rogers, E pg.53)

Sabido's soap opera entitled 'Ven Conmigo' did all the above and also made a point to incorporate the rich Mexican history and culture. The Soap Opera's educational goal was to promote literacy, a problem that Mexico and all three of my jurisdictions struggle with. With an estimated 8 million Mexicans illiterate, there was plenty of room for improvement(Singhal, A, Rogers, E pg.53). Throughout the series, there was research conducted and the results were very promising, with 9 times the number of Mexicans enrolling in literacy classes in 1975, the year Ven Conmigo was broadcast. This kind of powerful effect on the Mexican population to act on their illiteracy was unprecedented in previous government campaigns and it encapsulated a quote from Albert Bandura "The worth of a theory is ultimately judged by the power of the change it produces(Singhal, A, Rogers, E pg.47)." Ven Conmigo solidified the edutainment strategy as an effective and inspired education strategy.

c.Edutainment and the Adolescent

What is remarkable about edutainment as it is classically defined is that it takes an element of the adolescent life that can be destructive in terms of portraying unrealistic, corrupt or unreachable role models and uses the power of television, radio and mass media at large as a source for truth and understanding. "Entertainment whether it is over radio airwaves, a television screen, glossy magazine pages or newspapers is the most pervasive mass media genre; it tells us

as a member in a specific society how to dress, think, act, and behave. We are ‘educated’ without realization even if its unintended from the source and unrealized by the audience.”(Singhal, A, Rogers, E pg.19) This kind of outreach and almost daily connection to the ‘viewer’ sets up a structure which is already so effective and popular that as a strategy it has limitless untapped potential, with only very little being utilized today(.Singhal, A, Rogers, E pg.10) For an adolescent age group whose minds are constantly wandering and always over stimulated by media and technology it proves to be an especially helpful way to go about things. By fusing entertainment and education the hope is that the most benefits can be drawn by using them in conjunction. Education ceases to be boring and dull and entertainment ceases to be mindless serving no cognitive function.

d. Practical Considerations in Application of Edutainment

i. My Take on Edutainment

For the purposes of my work, I will be expanding upon the common understanding of edutainment to include interactive games, theater, music and art. I will be proposing three country specific programs that combine media techniques and programming as well as on site edutainment tactics. By expanding the scope, I will be able to construct programs that use an array of cultural elements from Brazil, Ethiopia, and Washington, DC to come up with a program that best suits those specific adolescents. It is evident thus far that there is a need for a more comprehensive and adolescent specific HIV/AIDS education program in Brazil, Ethiopia, and Washington, DC. However the following section will determine what edutainment brings to the table that can help fill in the holes of HIV/AIDS awareness.

ii. Creating your own edutainment program

When creating a new edutainment program there are some key factors that need to be involved and they are as follows: firstly, there needs to be a moral framework that is directly associated with the specific educational messages that the creator wants to put across. Secondly, understanding your audience and having research in place to know what is the issue that most needs intervening. Third, there needs to be positive and negative role models for the issue that is being dealt with. While this element is tricky because you do not want to incite the Archie Bunker effect (where viewers mimic bad behavior), it is important to have a realistic portrayal of the issue and that cannot be done if every character is making educated and informed decisions. Lastly in order to prove the success or determine the errors, research must be done with the a segment of viewers after the show has aired (Singhal, A, Rogers, E pg.15)

iii. Augusto Boal and the Importance of Theater in Edutainment

To understand the historical use of theater as a tool for change it is crucial to look at the writings of Augusto Boal who first came up with the theatrical form known as the *Theater of the Oppressed*. To begin, a quote from Aristotle: “All theater is necessarily political, because all activities of man are political and theater is one of them. Those who try to separate theater from politics try to lead us into error-and this is a political attitude.”(Boal,A, pg. 7) Here Aristotle touches on one of theaters most common uses-to articulate a voice and opinion of characters under oppressive political forces. While politically charged theater is more famous on a global scale, there are several elements that make up the happiness or well being of a character-safe surroundings, political voice, and fair rulers being important but economic security, education, and access and status of healthcare being just as important. All these elements work together to comprise a fully functioning adolescent and when one or several are amiss, there is a need for

people to take a stand against it and draw attention to the problem. This is done very effectively on stage and through other art forms.

Another Aristotelian inspired quote that shows the rich and lively tradition of theater's power throughout history is the following: "Nature according to Aristotle , tends to perfection, which does not mean that it always attains it. The body tends to health but it can become ill. Thus nature has certain ends in view, states of perfection toward which it tends- but sometimes nature fails. From this follows the purpose of art and science: by 're-creating the creative principle' of things, they correct nature where it has failed."(Boal, A,pg.9) I admire this concept of human-created elements that work to combat the intricate faults of nature. Of course, this is why medicine emerged in the first place. As a framework for HIV/AIDS work it is a very powerful message- that through art and expression we can attempt (and hope for success) to fill in the gaps of nature and use creativity and communication with the audience to create a shield against what can seem like the harsh realities of nature and disease.

The final Aristotelian take that Boal has as it pertains to this subject is the following on the habits of man; "Nature, according to Aristotle, gives us faculties and we have the power to change them into actions(passions) and habits..he who practices justice becomes just, he who practices wisdom becomes wise...(Boal, A, pg.16) When I read this line my automatic addendum was "...he who practices health becomes healthy." However even without this health focus I believe this message is powerful because it places a sense of agency in the everyday person. Every individual has the faculties within them to create their own habits (as we have seen through Albert Bandura) and hopefully therefore exuding virtue. This concept of taking justice and wisdom in as not only important attributes, but making them habits of your everyday life is a powerful message because the exact same can be done though personal faculties in keeping

oneself healthy. Theater is also a helpful tool for adjusting to cultural norms, especially when you set up a performance to have audience involvement and feedback. This way actors can present their piece but can work off the suggestions of audiences. On one hand, this opens a dialogue between actors and viewers that is rare and exciting. It also informs the players as to what changes can be made to make the performance the most educational and effective as it pertains to the reality of their audience.

Early on in the battle against HIV/AIDS, health educators became aware of the potential education power of media and tools of communication to disseminate information. In a discussion on the use of audiovisual tools for HIV/AIDS education, the following criteria was noted “the selection and evaluation of audiovisuals for HIV/AIDS education and prevention should be based on a sound knowledge base that also accommodates the variables that shape individual attitudes and beliefs about a stigmatized disease such as AIDS.(HIV/AIDS in Public Schools)” This second component I believe is crucial when looking at possibilities to implement into programs. You need a video or clip that will highlight some of the most common misconceptions that adolescents hold about the disease and break it down through a character and a story, while still retaining perfect scientific accuracy.

iv. Peer Leadership in HIV/AIDS education

One of the methods for HIV/AIDS education that I most believe in, apart from the obvious utilization of outside the box techniques, is the idea of peer leadership. In Grassroot Hoyas, we do a version of this in the sense that we come into schools with the mentality that while we are trained and informed individuals, we are also students and should take every opportunity we can to engage with the students on a friend level, and create a forum for open

conversation and learning, and not adhere to the archaic norms of silent student and droning teacher. I believe that when working within all three jurisdictions, especially if you are in an urban setting, this idea of peer leadership in HIV/AIDS intervention could be extremely effective. Studies on peer education in HIV/AIDS have shown some promising results, with statistically significant intervention effect on HIV/AIDS awareness, attitudes concerning risky sexual behaviors, and resistance to peer pressure concerning condom use (Pearlman, D, Journal of Adolescent Health pg. 31).

Considering the previously mentioned theory of modeling presented by Bandura, I strongly believe that this tactic will prove effective in several ways. First, it is a way to eliminate tension between the common scene in health education of outsider teacher and native student. Secondly, if the training of the peer is done effectively, it creates a model for the students that they can automatically relate to, and they understand that educating themselves and possibly sharing important facts with others is a role they can easily step into. Third, peer educators in Brazil would have information about societal norms and pressures that no amount of outside research could uncover. I believe it is important to work together with the coordinators of the HIV/AIDS education effort and the peers who are picked to be trained as educators so that the adolescents can have a say in the implementation of the program and adjust or add to the content accordingly.

From a coordination standpoint, special attention would have to be paid to ensure that you are not taking advantage of the youth who volunteer to educate their peers. Most importantly, the program could not interfere with school. In previous studies, the average rate of pay for the student is 6 to 7 U.S dollars per hour of training and educating so the equivalent pay

should be given in Brazilian reals and Ehtiopian birrs(Pearlman, D, pg. 32). Parental consent in the native language should always be required and necessary meals should be provided.

In a specific study conducted in the United States, concerning the effectiveness of peer leadership and education, the findings showed that there were significant differences in the groups in two areas: knowledge about HIV/AIDS transmission and high-risk behaviors, and perception of self as a change agent for HIV education and prevention(Pearlman, D, pg. 33). Both of these elements are very important, but the second aspect is quiet a breakthrough when working with adolescents because it enables those educated to become educators themselves, spreading the world to other adolescents. When working with the poor populations of the jurisdictions, for example in the favelas of Brazil, the ominous parts of Anacostia, and the dangerous sections of Addis Abbaba, this chance to be a leader and an educator could be a once in a lifetime opportunity. In my experience in one jurisdiction, when this tactic is coupled with strategies that are interactive and fun, the response from the adolescents in that community has potential to be really transformative.

v. Practical Application of hybrid edutainment program

Now that the framework is in place, and the usefulness of an education entertainment based program is made clear beyond the obvious benefits to adolescents, it is time to envision what country specific programs might look like. Here, I try and take into consideration the previously discussed history (both political and HIV/AIDS related), the current structure of the education and health system, the current political climates, and most importantly for the adolescents of these jurisdictions, what resources do they or don't they have at their disposal. The ultimate goal is to create programs that are not only sensitive to cultural issues but take

advantage of some of the richer traditions, for example the importance of storytelling in Ethiopia or the pervasive influence of social networks among Washington, DC adolescents. Poverty also plays a large role in making these proposed programs as realistic as possible. In all three regions, we may encounter adolescent females who have children and care for them as a single parent. This requires planning and understanding the full scope of issues at hand, and then preparing to alleviate or solve them so that this education entertainment program can be as useful and accessible as possible before a dry run.

So what is the logical next step? Here we have encountered three jurisdictions which are failing to meet the educational, safety, and health needs of their adolescents. In Brazil, Ethiopia, and Washington DC we have segments of the population that are extremely behind academically and with no legitimate safety net in place to get them up to date. HIV/AIDS pamphlets, factbooks, articles, research, and even online links will do nothing for these young men and women if reading is an act is a source of frustration and difficulty. As is made evident, these jurisdictions lack the educational infrastructure to provide the majority of their adolescents with a sharp and critical eye. Nothing less is needed when reading on a subject so important, and even then it is difficult to get the full message across.

When you are dealing with sensitive material, material that is both personal and deeply important to the future of the global adolescent, it is not enough to have them read the information. Of course, any information far surpasses no information but with a complex subject such as HIV/AIDS it is difficult to retain and fully understand the complexities of the disease, the treatment, and the steps towards prevention. This is where education entertainment comes in.

At the beginning of this work, the argument was made that this is the solution for dissemination of crucial HIV/AIDS information among illiterate adolescents and I still firmly believe that. However, seeing the efficacy of the edutainment programs across various populations, regardless of educational level and being equipped with a fuller knowledge of the educational and health gaps, I have come to the conclusion that this is really the best answer for all adolescents. Moreover, adolescents are the focus of my work, but I firmly believe interactive educational HIV/AIDS programs are the best path for all age groups. Boredom and confusion with health education material are traits that go beyond any age range, but luckily so does love of music, television, games, and theater. Using alternative creative techniques is not just an answer for those who can't read the information but it is an answer for populations who are in need of a deeper understanding of the many forms HIV/AIDS can take.

The following sections will be comprised of suggestions on how to construct an effective edutainment program for adolescents in the three jurisdictions. Country profiles have been established earlier in the work, which will aid in producing an informed and appropriate strategy. However, the programs will not be area specific, rather they will be recommendations for the jurisdiction that are shaped by cultural factors or adolescents and the strengths and weakness of each jurisdiction. By keeping the programs broad, I will be able to incorporate strategies and recommend tactics that have been the bulk of this work, without being hindered by the step-by-step process involved in proposing one specific program.

V. Building on Strengths: Recommendations for Edutainment to address HIV/AIDS in Ethiopia, Brazil and Washington, DC.

a. Ethiopia and Edutainment

In Ethiopia I believe the peer leadership and education aspect will prove to be quiet effective considering the considerable culture clash, for example between American volunteers and Ethiopian students. Also, because of the cultural practices such as female genital mutilation and high prevalence of young brides, it is important to work with someone who is in touch with those issues and can think of ways to effectively address them.

In terms of edutainment techniques I believe Ethiopia would be a prime candidate for a radio program that had a strong and consistent HIV/AIDS awareness message. Perhaps it could also address the alarmingly high fertility rate of 5.9 children born per mother (CIA, Ethiopia). The series could involve all the necessary elements as outlined by Singhal, making sure to include positive negative and transitional role models (those who start off making poor decisions but become educated and change). In order to see whether or not this would be a helpful addition to an edutainment program for adolescents, it is important to reflect back on past programs in Ethiopia. In November of 2001, a radio drama entitled *Journey of Life* first aired in Ethiopia (Journal of Health Communication, Ethiopia,pg.226)

The series which ran six months focused on family planning, HIV/AIDS awareness and prevention, and general methods of avoiding sickness(Journal of Health Communication, Ethiopia,pg. 227). The first promising indicator that came out of this study was the percentage of 100 people questioned who owned a radio, 87.6 percent(Journal of Health Communication, Ethiopia,pg. 230) This is good news for future campaigns because it is a channel of communication that is relatively cheap and accessible, a factor that is very important in a poor, developing country. When questioned whether they felt strongly about making changes in their behavior to protect their health after listening to *Journey of Life* 92.8 percent responded yes

(Journal of Health Communication, Ethiopia,pg.231) This is an example of a resoundingly successful campaign.

My suggestion would be (because of the popularity in Ethiopia of listening to radio shows) that specific programs should be written to target different age ranges. The successful techniques and writing methods of *Journey of Life* should serve as a model, however I do think making generation specific shows would result in even more listeners and if the programs gained popularity, it would create an easy talking point within those communities. For example, Ethiopian adults may be interested in a higher maturity level of content, while adolescents are still captivated by the trials and tribulations of being young. These small adjustments could potentially provide more specific health information (for example a series written for adolescents could focus on empowering young women), and it would potentially be easier to relate to, and therefore provide better ‘models’.

Another important element that can be used to the advantage of HIV/AIDS educators is Africa’s rich history with storytelling. The use of performance, especially in Ethiopia (an area that has been hit so hard by the disease) is a way to “reinforce the connections between human activity, medical research and health care- forging public opinion, lobbying for research funding, recreating the meaning of being HIV positive from within the community , and demanding access to available treatments(Barz, G,Cohen J, pg.4)” This sense of agency that performance and interaction allows for is absolutely essential to long lasting progress. More than likely, in whatever region you travel to in Ethiopia there will be few books, the education system is broken and underfunded, and computers are not the everyday object they are in the U.S. There will always be adolescents who are exceptions but what is most commonplace among Ethiopians is a rich and proud history, and generations that have shared their experiences and wisdom through

stories. Therefore for Ethiopian adolescents, we need to remove HIV/AIDS from the realm of technology and go back to human connections and communications.

There is so much of the Ethiopian population that is HIV positive, or as it sometimes referred to 'living positively', there needs to be an increased effort on the part of HIV/AIDS educators to foster a health and informed community. The question remains however "how can artistic performance restore a sense of order to the chaos and destruction wrought by an incurable and ultimately fatal virus?(Barz, G,Cohen J, pg.4)" Ethiopia has seen success with previous campaigns to educate about HIV/AIDS in a theatrical manner, one strong example being the circus play "The Grave Digger" which was put performed in Addis Ababa. It was a huge success, filling the stadiums where they performed. The play was overwhelmingly hopeful, colorful and upbeat with a serious message that informed the public of HIV/AIDS awareness but also made sure to highlight the strength an individual can take through information and friendship(.Barz, G,Cohen J, pg.323) The circus is an event that has plays an important role in Ethiopian entertainment and by combining crowd drawing performances with an upbeat and informative play, this circus troop was providing enjoyment and happiness in the present and the tools for future enjoyment of health.

My suggestion for Ethiopia would be to create a program which functioned as a summer camp of sort. Ethiopian adolescents are faced with the most challenges in terms of societal pressures, poverty, political instability and violence, and pervasive health issues. This kind of setting is destructive for cultivating informed and productive future members of society. The arts could be a main component, and Ethiopian adolescents when not in school could come and be with their friends and a safer, more stable environment and play sports, undergo peer training to educate friends who might not have been able to join them, and participate in circus acts which

could be performed at the end of sessions and hopefully throughout the school year to other adolescents. This ‘summer camp’ would have to be completely funded or else it would not be a realistic option for the vulnerable adolescent population of Ethiopia, but if the resources were available it would be an innovative way to educate consistently, provide an escape from their often dire realities, and teach them to be future educators.

Another important aspect of teaching HIV/AIDS education in Ethiopia is putting emphasis on the empowerment of women, because they live in a society where they are not treated as equals and this automatically makes them increasingly vulnerable to HIV/AIDS. Today, adolescent women are 1.6 times more likely to be HIV positive than compared to adolescent men and globally, 20 percent of women report that their first sexual encounter was forced (Empowering Female Youth to Lead, UNFPA, WorldYMCA, pg.33). In places like Ethiopia where the poor infrastructure leads to rampant violence and crime the figure could very easily be higher. This grim reality can only be combated through extensive empowerment workshops which serve to both inform Ethiopian women of their rights but also educate them about the health risks that surround them. It would be challenging to gather a group considering many young Ethiopian women don’t go to school but perhaps you could tap into the powerful church culture and find a progressive church community that would be willing to host these seminars. An excellent guide for this work is entitled “Empowering Young Women to Lead Change” and can be found on the UNFPA and World YMCA site.

b. Edutainment in Brazil

Brazilian adolescents have the benefit of living in a country which has always promoted open and honest dialogue concerning HIV/AIDS and has taken decisive action against it. It is

also the only jurisdiction in which treatment prescriptions for those living HIV positive is completely cost free. The first step in my eyes would be ensure that the adolescents you were working with were aware of the abundant services available to them throughout Brazil.

You could do this effectively through a game that we play in Grassroots entitled 'My Supporters.' The goals of the game are to understand the importance of social support and services and identify those that provide them for us. Also to become aware of stigmas associated with HIV/AIDS, and finally to commit to and identify methods of supporting people living with HIV/AIDS (Grassroot Hoyas Manual, pg. 68). An ideal group size is 7 to 12 and what the participants do is they stand in a tight circle with their palms held up facing one person who is standing in the middle. Each participant is wearing a nametag or card with labels such as sister, friend, religious leader, doctor, counselor, parent, and several others. The person in the middle wears the name tag that says HIV positive person. When working in Brazil, you could include nametags that had the names and locations of non-profits, organizations that do free testing, hand out condoms, or give out medication. It is important that they be specific to the region that you are working within because many cannot travel or will not travel far.

The game itself involves the person in the middle asking "My supporters, are you ready?" the group responds "Yes!" and the person in the middle sways side to side with their eyes closed being held up by the group of hands. After one round it is helpful to go around the circle and have a discussion about who are people who would always support you and why, what are some of the figures who might not support an HIV positive person, and when playing in Brazil, spend time explaining the benefits of certain programs or outreach groups. In my experience, the circle then becomes smaller when people like 'religious leader' or 'boyfriend' often step out. You are then to play a second round to see how it is significantly more challenging to support the center

person when someone from their support system backs out. It is always fun and often sparks interesting debate among students when they are asked to decide who they believe would stick with them if they were HIV positive.

Another method that I believe would be extremely effective is using Brazil's obsession with soccer as a tool to lure adolescents into a HIV/AIDS programs and providing them with a fun team experience, but also consistent HIV/AIDS education messages. This kind of program has been conducted most successfully in South Africa and was actually the inspiration for the Grassroot Hoyas program. Grassroots Soccer uses the powerful draw of soccer to reach large numbers of youth and incorporates games, team building exercises and challenges along with the best available information to provide a hands on and wildly entertaining HIV/AIDS education program(Grassroots Soccer Mission). The tactics they use are as follows, "to improve upon their culturally sensitive and fun 'skillz curriculum', to effectively share the curriculum with local implementing partners allowing for sustainability, and lastly to empower local community role models such as professional soccer players or youth sport coaches with the proper tools to educate the youth in their communities." This program, like Grassroot Hoyas, hinges on the idea that "kids learn best from those they respect, learning is not a spectator sport, and it truly does take a village.(Grassroots Soccer Theoretical Approach)"

On the implantation side of this you could ask for support from this very program because they are well funded, and are always looking for areas to expand. It would be important to find an area that was relatively safe and away from the violence and drug-ridden favelas (but make sure to provide proper transportation). You could promote the program in schools, because Brazil's attendance rate is high thanks to recent government initiatives and conduct it as an after school program. This would give Brazilian adolescent males an alternative to the gang life and

peer pressure that is part of the favela community and it would provide adolescent females with a safe haven from the common sexual assaults. Also, by team building with both genders you would create an atmosphere of friendship and understanding so that the adolescent males would respect the females more as one of their own and become educated in what is safe and respectful behavior.

I believe the aforementioned peer leadership initiative would be very enlightening when working with urban poor youth of Brazil. While modeling as a theory can be used as an agent for changing social behavior for the better, it can also go in the exact opposite direction when Brazilian adolescents only see role models in form of violent and power hungry males. Due to the pervasive gang culture in poor areas of cities like Sao Paulo and Rio De Janeiro, this is the tragic reality for adolescent males. It is important to understand the cultural dynamic and possible gang affiliations of participants and create an open dialogue as to why these young men feel pressured to join these gangs, and what could be alternative lifestyles or safe ways out of what is almost always a path of destruction. Also, there should be extra attention paid to drug use and how intravenous drug use can place you at a very high vulnerability for contracting HIV/AIDS. It is of utmost importance that facilitators try and be realistic in their goals and do not cast judgment or shame concerning the lifestyle choices of the adolescent participants whether it be a drug dealer or a prostitute. This is an aspect that goes beyond Brazil and applies to HIV/AIDS education at large.

c. Washington, DC and Edutainment

One of the most alarming aspects of youth culture in DC that I have observed through my work with Grassroot Hoyas is the interest and involvement in sexual acts at very early stages in

child development. What I have observed working with varied cultures within these classrooms is that this is not necessarily an intrinsic quality of DC adolescents, but an unfortunate trend in adolescents in general. While I know that many stories are just talk and to build up their ‘cool factor’, the pure presence of wildly inappropriate conversations like that outline a very different atmosphere and awareness of themselves as sexual beings compared to myself and my peers at that age. This needs to be taken into consideration when working with the younger age groups, such as fifth, sixth and seventh grade, because the more information they have access to, the better choices they will be able to make in the future. I do not believe there should be unnecessary cuts made to an HIV/AIDS educational curriculum because of a younger age group.

Something else I have observed without exception in the males in my classrooms has been the use and discussion of violence, especially against other male classmates. When we are conducting our programs we like to not have the typical ‘adult supervision’ because we find it allows the students to be more honest and open with us. However, it is appalling at how out of hand simple altercations can get- with the male students often resorting to violence and the females often resorting to verbal abuse. I can only believe that this is the product of a destructive atmosphere within poor areas in DC, where children become frustrated with the lack of opportunities, rates of violence and often times terrible home lives that shapes their reality. As a response, many become jaded, resistant to outsiders (such as ourselves) and turned off from the world of learning.

In DC there are some important cultural differences compared to Brazilian and Ethiopian adolescents. In the United States, even the poorest people have access to technology such as cell phones and computers through public libraries and schools. The society they live in is less lawless than Brazil and Ethiopia, thanks to a well funded police force and effective judicial

system. That is not to say violence is not an issue, but it is not rampant and unpunished like in Ethiopia and Brazil.

Female empowerment, although just as important, needs to be shifted dramatically to teach confidence, provide resources for help with abuse, and breakdown the devastating culture of ‘perfection in women’ as seen through American media. What have historically been the biggest wake up calls for American adolescents in HIV/AIDS awareness was the affect that it had on popular figures, or its appearance in popular music, movies, or television. We are a generation that feeds off our computers, iphones, televisions and celebrities and HIV/AIDS educators in this capitol should not only be aware of that, but take steps to incorporate those communication means into their work.

What I believe would be a popular initiative is creating a web series that was targeted at poor adolescents in the D.C area. There is a severe need for a widespread and popular means of edutainment among D.C’s urban youth, this can be seen in the fact that 81 percent worry about HIV/AIDS but only 40 percent feel they are at risk (Snell, Cudore “Help Seeking and Risk-Taking Behavior Among Black Street Youth,pg.28). The cast would have to be a health mix of African American, Latino, and white to provide an accurate portrayal and create a suitable ‘model.’ By making it a web series versus a television series, adolescents could watch it at their convenience and it could be a talking point that is separate from the adult and school realm.

The writing would have to extremely well-done in order to provide the drama necessary, the cross gender appeal, and the likeable characters necessary for a considerable following. It would also be difficult to advertise because the HIV/AIDS education piece would have to be fairly covert, or is it would be unappealing. I do believe however that if there were a list of

important issues to be tackled such as teen pregnancy, bullying, body image, homosexuality all coupled with a strong undercurrent of accurate and intriguing information, the series could gain a following out of pure curiosity.

Reflecting on my experience, I also think that programs such as Grassroot Hoyas and Metro Teen AIDS that come into schools once a week, and target specifically lower income communities need to start broadening their scope both in the frequency they visit and in the communities they target. Public Schools across DC were given a C- by the DC Appleseed report card in their ‘ability to adopt system wide health standard that includes HIV/AIDS prevention and develop and implement a plan for enhancing HIV/AIDS policy for DC schools.’ (DC Appleseed Report Card) While HIV/AIDS is a disease in the district that disproportionately affects African Americans, it is important to educate the city as a whole on not just the facts, but what you can do to help out, and breaking down stigmas that are just as present in wealthy, predominately white communities as they are in poor predominately black communities.

I also believe that D.C would benefit greatly from a ‘summer camp’ type proposal that is seen in the Ethiopian section. Although the focus of the camp could be culturally adjusted to include classic summertime activities such as swimming, camping, canoeing, arts and crafts etc. Another positive is that the U.S has programs in place like Camp Kindle (www.campkindle.org) that provide free spots to youth that are affected by HIV/AIDS. In this city, there are a shocking number of children that would qualify for that and I know that they would benefit greatly, it is simply a matter of spreading the word and working to set up similar camps close to the D.C area. An important element of this kind of camp would have to be creating future educators because another jarring realization when working with DC adolescents is their feedback after we ask them to share what they have learned. It never ceases to surprise me to hear how unaware and

uninformed their parents are but it is encouraging to know that these children are understanding the material, and able to inform their parents or siblings.

Another aspect of DC adolescent culture that I believe is an untapped channel for HIV/AIDS education is the unprecedented power of facebook, while it is an unbelievable waste of time for many adolescents, the fact that almost every Washington, DC teen signs in at least once a day is a channel for education that is unmatched in American youth culture. HIV/AIDS educators should reflect on the recent popularity of the KONY 2012 video (which reached 90 million views and counting on youtube) and come up with a similar initiative that informs, educates, and moves people to join the fight against HIV/AIDS in the United States. The most effective way to do this is to rally celebrity and political supporters and if possible have them appear. The video must be constructed with a proper balance of information, storytelling, shock and celebrity appeal to bring it to the level where it could spread virally across Facebook. If a campaign like this were successful it would reach millions of adolescents at a rate that the education and health sector could only dream of. There is a trend in the past decade among American youth that being intelligent, politically aware, earth and health conscious is no longer nerdy but can potentially garner respect and friends. While that is a broad trend with exceptions across the board, it is however a uniquely western ideal and this notion should be used and explored when approaching HIV/AIDS work.

VI. Re-examining Edutainment through a Global Vision

There are certain aspects of adolescents that hold true no matter what language they speak or where they grow up. It is a time of learning but also one that is filled with societal pressure, hormonal influxes, and confusing shift from childhood into adulthood. It is a period in

life where there seems to be so many factors in the air and so much that can go wrong. However, there are elements of similarity especially when it come to adolescents and education. Any method that can step away from the archaic scene of the teacher droning to the silent student is always welcome, no matter your geographic location. Engaging with them through the use of culturally appropriate tools for example a proposed soccer game in Brazil, an interesting youtube clip in D.C, and a funny story in Ethiopia. These are methods that adolescents will be drawn to because it will give them a place at the table, an opportunity to engage in a dialogue about what actually matters to them and what issues they deal with on a daily basis. Without this feedback and the use of tactics that help us get to that, HIV/AIDS education would remain stagnate, and the prevalence rate in countries would simply plateau instead of drop down. Edutainment is a way to set your student in their most comfortable and ‘guards down’ environment so that their openness can translate to being a receptive and engaged learner. While it is important to be culturally specific, there are elements of my idea of edutainment that are universal such as peer leadership, open and honest communication, using love of music, film, television and radio to your educational advantage, and creating an educational atmosphere that depends on the comfort and enjoyment of the adolescent.

Presentation:

For my presentation portion of my thesis I decided to try and implement some of the new strategies that I had uncovered within the Grassroot Hoyas Program. I went about this by asking to meet with the creator of the program, Tyler Spencer, and present my findings to him. I have worked with him before and I knew that he would be open to suggestions, because he went

through months of research and compiling of effective programs to come up with the current curriculum we have now in our Grassroots programs. The program that he created was my inspiration for this work, because I was able to see first hand how effectively this knowledge could be spread to D.C adolescents through employing more exciting and engaging tactics. While I noted that the current program is very efficient and effective in its use of interactive games and educational team building exercises I thought that a couple elements could be included to make the Grassroots curriculum even better. My suggestions came from my findings in writing this work, and before my presentation I sent him what I had of my work in early March, which included almost all of my theoretical base and in country examples. From this research I advised that if we could find a way to involve the children more in their own education. For example, we might ask for volunteers to help us lead a session the following week, and have a quick meeting with them about our game plan and the messages we could get across. Based on my research and my experience, having a peer in front of the classroom would really help us get the full attention of students, and it would bridge the any slight cultural gaps that we might be overlooking. Also another suggestion that derived from my work was to take time before a session, perhaps the night before, to put together a play that acted out a scenario that pertained to HIV/AIDS education, or perhaps the realities of life with HIV/AIDS. While I knew this would be a little trickier, because it involves the creativity of the coaches, the children would really benefit from it. At first, it would probably be a point of humor but if the coaches were committed to their messages, the kids would get to see a real life scenario played out, and questions would be bound to arise after. Tyler agreed that my suggestions made sense and he said that they were in the midst of reworking and updating the curriculum currently and that he

would seriously consider some of my proposed changes. I was very excited to get the chance to improve on a program that I have loved and learned so much from.