

One Sound Bite at a Time: Examining the Discourse of the Representation of People Living with HIV/AIDS on an Entertainment-Education Drama RockPoint 256

Tina Kawooya

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Department of Communication
Faculty of Graduate and Postdoctoral Studies
University of Ottawa

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ABSTRACT

The objective of this thesis is to examine the meaning of the language used in an Entertainment-Education (E-E) radio serial drama *RockPoint 256 (RP256)* and its representation of People Living with HIV/AIDS (PLHA) and HIV/AIDS. The theoretical framework that is used to guide this study is the Cultural Studies perspective. Using Cultural Studies is instrumental to a study such as this that looks to find the source of meaning in *RP256*'s discourse (Hall, 1993, 105).

The methodological research design used is discourse analysis that examines the oral and written data of *RP256*. Discourse analysis “focuses on the way language is used, what it is used for, and the social context in which it is used” (Punch, 1998, 226). There were two types of discourse analyses used. Gee's (1999) discourse analysis is used to analyse the linguistic nature of the texts at a micro level while, Fairclough's (1989) discourse analysis is used to observe the overarching meaning of the discourse found in *RP256* at the macro level.

The analysis of the data indicates that the representation of PLHA is a product of the societal and cultural markers that are a result of ideological labels given to HIV/AIDS and PLHA. The study concludes that PLHA are ostracised, stigmatized, live in poverty and are mostly women. The societal and cultural markers indicate that HIV/AIDS is still viewed as a plague and as a result PLHA are often silenced, marginalized, and discriminated against in Uganda.

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DEDICATION

I dedicate this thesis to my family: my mother Berti Nsereko Kawooya, my grandmother Hajati and my siblings: Sheila, Tessa, Lisa, Eddie, and David. My family has always inspired me to excel in all formats of my life; they have loved me through my ups and downs and have never given up on me. It took me three years to finish a two-year journey but throughout my whole journey they stood by me and never once told me to throw in the towel. Rather in their own exemplary accomplishments I have learnt to: ***NEVER EVER EVER GIVE UP on a dream and life itself!***

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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARVs	Antiretroviral Treatment
HCP	Health Communication Partnership
CCP	Center for Communication Partnership
CDFU	Communication for Development Health Uganda
E-E	Entertainment Education
HIV	Human Immunodeficiency Virus
PEPFAR	The United States President's Emergency Fund for AIDS Relief
PLHA	People Living with HIV/AIDS
PWA	People with AIDS
RP256	Rock Point 256
SCT	Social Cognitive Theory
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
USAID	United States Agency for International Development
YEAH	Young Empowered and Healthy

Chapter 1: Introduction

Background of Uganda and HIV/AIDS

Uganda is recognized as the African nation that has successfully dealt with the HIV/AIDS epidemic for a number of years (Low-Beer & Stoneburner, 2003, 11). It was in the 1980s that Uganda witnessed its first cases of AIDS and the disease has continued its reign of devastation into the 21st century (Kisekka Nakaterregga, 1990, 35).

Uganda is a country located in the Eastern part of Africa, neighbouring Kenya to the east, Tanzania, and Rwanda to the south, Sudan to the north and the Democratic Republic of Congo to the west (Barlas & Yong, 2000, 7). Uganda is known as the Pearl of Africa, a name given to the country by Winston Churchill during the British colonial rule. This name was based on Uganda's geographical location and vegetative environment which is fertile and green as well as the beauty of Lake Victoria- the source of the Nile River (Boardman and Ovuga, 1997, 649). Uganda was known for its peaceful tourist livelihood for many years until political warfare heightened in the 1980s, leaving Uganda as a shell of what it once was. It was during this period that the first cases of AIDS surfaced in Uganda (Kisekka Nakaterregga, 1990, 35).

Political warfare led to widespread rape, increasing poverty levels, and the disintegration of family structures. These factors, coupled with the high mobility rates among military personnel moving from one part of the country to the other led to a rapid spread of HIV/AIDS during the 1980s (Okuanzi & MaCrae, 1995, 125).

Globally, HIV/AIDS has affected millions around the world. In 1995, 1.3 million people from 193 countries were living with AIDS (Quinn, 1996, 99). It was also noted that women seemed to be infected at a much higher rate, with as many as 9 million women suffering from HIV/AIDS, a number which rose from 25 percent in 1990 to 45 percent in 1995 (101).

HIV/AIDS infection rates seem to be higher in women who are commercial sex workers. In a study released in 1994, it was observed that Indian women working as sex workers in Bombay had a 20 percent infection rate in 1992. By 1997 that number had increased to 40 percent over a two year span (Stanecki & Way, 1996, 52). India's HIV/AIDS prevalence rate among sex workers is extremely high but, Sub-Saharan Africa remains the greatest affected region with "more than 16 million individuals-almost 3 % of the population of the subcontinent –hav[ing] been infected" (Quinn, 1996, 102). Yet HIV/AIDS seems to have taken effect in Western countries as well, as it was documented in the 1990s that the United States of America had one of "the highest number of reported AIDS cases in the world-over 500,000 cases and over 300,000 deaths as of late 1995" (104). By the end of the 1990s AIDS was the number one killer of men and women aged 15-49 years of age (100). By early 1999, there were reportedly 10,000 cases of HIV/AIDS in Russia, and in 2000 it was estimated that 25.3 million people worldwide were infected with HIV/AIDS. Sub-Saharan Africa has remained, worldwide, the most infected "1.1 million children under 15 [who were] living with HIV [and] over 90 percent of whom acquired infection from their mother" (Piot et al, 2001, 2). In 2000, Western Europe had an estimate of 30,000 people and an estimate of 45,000 in North America (1). HIV/AIDS has globally taken a toll on nations, both developing and developed, with the loss of lives "by the end of 2000, over 36 million people were living with HIV/AIDS" (Lampsey et al, 2003, 178: Valdiseri, 2003, 4).

Some nation states have been hit harder than others on both personal and community levels, economic levels, with loss of labour, and political levels with conflict and migration at a higher rate than ever. In Uganda specifically, HIV/AIDS has had the following impact:

The number of people living with HIV: 940,000; Adults aged 15 and up living with HIV: 810,000; Children aged 0 to 14 living with HIV: 130,000; Death due to AIDS: 77,000; Orphans due to AIDS aged 0 to 17: 1,200,000 (UNAIDS, 2009).

In 1995 it was documented that out of the population of 17 million Ugandans, 1 to 1.5 million had HIV/AIDS (Bayer, 1996, 122). Uganda's first HIV/AIDS case was documented in 1983 in Rakai district which was purportedly the "epicenter of the epidemic" (Kisekka Nakateggera, 1990, 37; Kiweera, 2008, 54). Prior to 1983 there was a well-known disease commonly referred to as SILIMU (SLIM), whose most noticeable symptom was weight loss of its victims. It was later discovered that this disease was actually HIV/AIDS (Kiweera, 2008, 53). During the early 80s and 90s many Ugandan youth were killed, leaving the old to care for their grandchildren (Low Beer & Stoneburner, 2004, 165). By 1986, it was said that 900 HIV/AIDS cases had been reported and only two years later in 1988, 6000 cases had been reported of HIV/AIDS (Slutkin et al, 2006, 352). In a study conducted by Schopper et al (1995) they found that by 1987, "1 out of 4 [Ugandan] women attending a prenatal care clinic was infected with the human immunodeficiency virus [while in the following year] 1988, a national seroprevalence survey found that the adult population (age 15 and above) infected with HIV in the central region was estimated to be 21% in urban areas and 12% in rural areas" (171).

The 2010 Ugandan progress report at the Special Session in the United Nations General Assembly (UNGASS) mentions that the HIV/AIDS pandemic mainly affects those men and women who are commercial sex workers, those who live in fishing communities, displaced people, refugees, persons in uniformed services, and persons with disabilities (31). The report also noted that women were more at risk of being infected with the disease whether in urban or rural areas (17). UNAIDS data show that in 2003, Uganda counted about 4.1% of adults with HIV/AIDS (UNAIDS, 2009). Since the 80s, it is believed that 900,000 people have died due to

this disease (UNAIDS, 2009). In 2003, there were an estimated 1 million orphans in Uganda and 840,000 of them living with HIV/AIDS (Henry L. Kaiser Family Foundation, 2005). However between 1990 and 2003, there was progress that showed HIV prevalence amongst pregnant women had decreased from 31% to 6.2% as well as, in army soldiers whose HIV prevalence rates decreased enormously by a percentage of 12 over the 5 year gap (Otolok-Tanga et al, 2007, 55). The data produced by UNGASS (2010) shows that over 1,101,317 people were living with HIV/AIDS in Uganda by December 2008, and that about 10% of this number (110,694 people) were new infections (21).

The Ugandan government has tried to solve the problems of the HIV/AIDS pandemic through constant cooperation with local government officials in carrying out policies with educators , religious institutions, by working with International organizations such as UNICEF, UNAIDS and by carrying out BCC campaigns (Allen & Heald, 2004, 1149).

Statement of the Problem

This thesis illustrates the ways in which a model of BCC campaign in the context of Uganda, functions to construct the identity of PLHA and HIV/AIDS. A BCC is a campaign tailored to change and affect people and their surrounding environment, to act upon positive attitudes and behavior changes as opposed to the risky attitudes and behavior they exhibit (Cassell et al, 1998, 72). BCCs are mainly popular in health communication or education sectors and various BCCs have been conducted to help reduce risks of diseases such as HIV/AIDS, diabetes, cervical cancer, cardiovascular disease and obesity to name a few (Liu & Chen, 2010, 1).

This study focuses on a radio drama entitled *RP256*, which is a media strategy of the 2005 national BCC campaign YEAH (YEAH, 2012). YEAH, as a BCC, works to communicate, promote and educate the Ugandan public on the different social and health issues in a manner

that will change their behaviors and attitudes to employ better lifestyles of living. It does this through various media channels such as radio, comic books, newsprint, and posters (YEAH, 2012).

I shall analyze *RP256* an Entertainment-Education (E-E) drama that informs and creates awareness of HIV/AIDS, gender inequity, transactional sex and others in order to change the attitudes and behavior of their target audience, 15-24 year-olds (YEAH, 2012). The theoretical framework and methodological posture that have guided this study emerge from the field of Media and Cultural Studies. Using a Cultural Studies approach will help in examining Uganda's past strategies with HIV/AIDS and how it has dealt with educating and creating awareness in its different communities.

Media and Cultural Studies involve the process of representing and learning the aspects of our lived environments as both play a vital role in how we as human beings interact with one another. Media studies in particular, involves the study of content and the ways in which this content is used by an assortment of media such as radio, television, and the internet, as well as the effects of this content on audiences and societies (Baldwin et al, 2004, 193). With media studies, radio programs like *RP256* in Uganda are examined for the type of content they communicate to their audience whereas, Cultural Studies examines the ability a reader has to engage his or her "text" through the lens of those represented, objectified, or subjected to the ruling ideology and power struggles that exist in that time and space (Storey, 1996, 3). Therefore the use of a Cultural Studies perspective will investigate the representation of PLHA in *RP256*, the oral and written text contain discourse that is produced by a governing ideology and power struggles of what HIV/AIDS is and who PLHA are, how they live and with whom they interact. Cultural Studies "[draws] on social and cultural theory, [and is] useful in broadening the

scientific basis of E-E investigations”, the approach will mediate on the articulations that *RP256* professes about PLHA and HIV/AIDS (Tuffe, 2004, 408). The following research questions that will direct this study are as follows:

1. What are the cultural and societal markers that are used in *RP256* to represent the life and experiences of PLHA and HIV/AIDS?
2. To what extent does the narrative found in *RP256* communicate Ugandan societal beliefs and ideologies toward PLHA and HIV/AIDS?

In order to answer these questions this study will use a qualitative research design to investigate the representation and identity of PLHA and HIV/AIDS on *RP256*. The purpose of using a qualitative approach is to understand how Ugandan society, culture and people articulate and produce meaning about HIV/AIDS and PLHA. The qualitative research design that will be used is discourse analysis.

The use of discourse analysis in this study will be resourceful in understanding the language used that identifies and represents HIV/AIDS and PLHA through the written and textual data of *RP256*. Gee (1999) and Fairclough’s (1989) examination of discourse analysis will be used to investigate the meaning of the texts in relation to the portrayal of PLHA in the fictional rural and fishing community of *RP256* - which is a reflection of any community in Uganda (YEAH, 2012).

Discourse analysis views the use of ‘language as a social practice’ therefore to understand the discourse; one has to understand the context of the language spoken, whether in written or oral text. It is only when one recognizes the ideology governing the context of that particular text that the formation of the social practice will be retrieved. Therefore, in order to understand how and why PLHA are represented the way they are in *RP256*, one has to

understand the ideology of HIV/AIDS and PLHA in Uganda and the sites of struggles found in this discourse that manifests itself as social practice in people's behavior towards PLHA and HIV/AIDS.

Importance of the Study

This study will investigate the degree to which, constructing the identity of PLHA in Uganda, is communicated by *RP256*'s socio-cultural behavioural change messages. The findings of this study will be beneficial to the Ugandan communication academia and public communication campaigns such as YEAH. That is, the outcome will assist decision makers to better articulate new models of health communication campaigns insofar as the re-strategizing the construction of the language used in creating E-E dramas that disseminate societal and health issues. The outcomes should be instrumental in two ways.

First, a Cultural Studies perspective is useful in analysing the level of representation that PLHA in Uganda receive from their local media and examining how radio narratives work to influence Ugandans' view on HIV/AIDS and PLHA. Radio in Uganda is among the most commonly used and affordable modes of communicating content to Ugandans in both rural and urban areas (Amienyi, 1996, 149). Second, this study will endeavour to advance the discourse of social stigma associated with AIDS in Uganda in order to begin the discussion of the effects of representation in the media, specifically radio.

Limitations of the Study

One of the limitations of this study on the outset is that I only examined the first three quarters of *RP256* which had a total of 39 episodes whereby the show has 23 quarters and 282 episodes to date. I chose to analyze the first three quarters of *RP256* chronologically to follow the narrative of the story and have a better understanding of the show and its representation of HIV/AIDS and

PLHA . As a result, I concentrated on the first three quarters as I was unable to study all the 23 quarters and 282 episodes in a two year thesis time span and a 100 page limit requirement.

Therefore, the findings of this study cannot be generalized to all quarters of the show but only to those that were analyzed.

Chapter Organization

Chapter 1, the Introduction, gives a background of Uganda and HIV/AIDS and gives an overview of the study, its importance and the purpose and the limitations of the study. Chapter 2 deals with the literature review and it will cover theory such as BCC theory and Cultural Studies in relation to the analysis of the representation of HIV/AIDS and PLHA on *RP256*. There will also be concepts such as that of ideology, identity, representation, E-E and stigma that will be discussed. The literature review will examine the history of radio in Uganda and its importance, and the ABC Strategy and *Straight Talk*, the predecessor of *RP256*. Chapter 3 will look at the methodology, that is, the research design that will be used. Gee (1999) and Fairclough's (1989) discourse analysis will be used to analyze the three quarters of *RP256*. Gee's discourse analysis will be used to linguistically explore the scripts of *RP256* at the micro level and Fairclough's discourse analysis will be used to examine *RP256* at the macro level, to draw upon the overriding meanings of the cultural and societal markers and ideology of HIV/AIDS and PLHA. Chapter 4 will deal with the analysis of the findings and results. Lastly, Chapter 5 will conclude the study and provide limitations as well as recommendations based on the findings of this study for future research.

Chapter 2: Literature Review

This literature review will explore five sections. The first section will explore media and Cultural Studies as well as the concepts of ideology and representation. The second section will look at BCCs- what they are, and the different kinds that were successful in Uganda such as the ABC campaign, *Straight Talk* and YEAH. This section will also discuss target audiences and youth and media. The third section will examine what E-Es are and provide examples of E-Es that have been employed around the world. The fourth section will introduce and discuss radio as a medium and its history in Uganda. The last section will discuss stigma specifically that faced by PLHA and identity formation in reference to the object of this research, *RP256*'s identity construction and representation of PLHA.

What is Cultural Studies Theory, Ideology and Representation?

Media and Cultural Studies involve the process of representing and learning about aspects of our lived environments. Both play a vital role in how we, as human beings, interact with one another. Media Studies in particular, involves the study of content and the ways in which that content is used by an assortment of mediums (such as radio, television, and the internet) as well as the effects of this content on audiences and societies (Baldwin et al, 2004, 193). Barker (2000) understands cultural studies as “a body of theory generated by thinkers who regard the production of theoretical knowledge as a political practice. Here, knowledge is never neutral or objective but a matter of *positionality*, of the place from which one speaks, to whom, and for what purposes” (5).

Cultural Studies is “concerned with describing and intervening in the ways ‘texts’ and ‘discourse’ (that is cultural practices) are produced within, inserted into, and generate in the

everyday life of human beings and social formations, so as to reproduce, struggle against, and perhaps transform the existing structures of power” (Grossberg, 1996, 180). Cultural Studies is based on defining and retelling a story from multiple perspectives (Steedman, 1993, 52). It aims to critique and analyze that which is historically, socially, politically and economically represented as truth and fact in the discourse found in various texts such as that of a book, television, radio, an educational or religious institution (Hall, 1993, 107). The meaning of a text is understood differently by every reader due to their interaction with their historical, political, economic, racial, and religious and gender based experiences. As a result a person’s understanding of a text is based on the way they have been socialized in their immediate surroundings (Storey, 1996, 4).

Cultural Studies approach works as an enzyme, a catalyst so to speak. It reacts with existing knowledge, and how that knowledge is represented, to produce ways in which one can codify that represented truth objectively depending on the perspective that one uses to approach that particular discourse (Johnson, 1996, 75). Cultural Studies is functional to many as it has the ability to encompass multiple positions due to the nature of “negotiating its identity and repositioning itself within changing intellectual and political maps” (Grossberg, 1996, 181). Thus, it is most effective in its analysis of discourse that is language spoken, written and represented.

“Discourse refers to the production of knowledge through which language gives meaning to both material objects and social practices” (Barker, 2000, 56). Language has the ability and power to represent a people, race, and histories (94). Cultural Studies plays a vital role in examining the language or texts used in the representation carried out in mediums such as radio, television, the internet and in films (Hebdige, 1993, 448). The discourse produced in media texts,

and the meaning constructed by the reader is vital due to the fact that the message understood by the reader has the ability to turn that meaning into a social practice that is reinforced into people's lives, their lived environments and cultural and social practices as status quo (Hall, 1993, 508).

Cultural Studies is a perspective that deals with how and why we speak about others and how we speak to ourselves (Couldry, 2000, 5). The field of Cultural Studies is where the “cultural production [this could be a written text, song, film, and idea] is the result of what particular people have done at particular times and places, and under particular constraints and limitations” (11).

The Cultural Studies' perspective has evolved from culture as viewed from an ordinary standpoint to culture and its social practices as the producers of meanings, producers of life experiences and hierarchal orders that a particular group is composed of based: on race, gender, sex, tribe, religion, nationality and ethnicity (Hall, 1996, 34). Culture is a way of understanding the varied:

Meaning and values which arise amongst distinctive social groups and classes, and the basis of their given historical conditions and relationships, through which they ‘handle and respect the conditions of existence’ (28).

Cultural Studies poses the five Ws: who, what, where, when and how, in order to assist the voices of those silenced, long forgotten, and thus represents territory of equality, articulation and freedom (Couldry, 2000, 2). This suggests that people in their varied interactions participate in the making of meanings and fixing definitions of whom and what ‘others’ in society are or ought to be (Johnson, 2004).

Consequently, Cultural Studies deals with the ideology of people and their societies. An ideology is presented through the knowledge of the things people care to know and understand. There are two types of this knowledge; existing and appropriated knowledge (Kuhn, 1996, 51). The foundations of ideology are built upon how people come to understand themselves and the immediate surrounding environment. These occurrences take place by the existing knowledge they were socialized in from birth or that which they have appropriated from experiences in school and religious institutions (9).

An ideology has the power to produce, create and act as an interpretation of meanings towards people in society (Cormack, 1992, 17). Ideology therefore reinforces itself in linguistic and social practices which provide the means by which a person from a particular community can produce meaning and is able to communicate that particular meaning with other people in his or her own community. The language used in this ideological communication is spoken through a particular social context (12).

Ergo, ideology is practice, it is produced and reproduced with no fixed meaning, and there are three characteristics of ideology (Hall, 1990, 161). First, an ideology can be used and expressed in a multitude of ways. Second, ideologies have been in existence long before we were born, we find them and situate our lives within or around them. They are transformed as a collective and through an individual. Lastly, an ideology has the power to define and represent a people and profess “ideological truths” that may not always be the real representation of reality (161). It can be deduced that ideologies are a natural process of “social life” they start out of human rationale (Boudon, 1986, 11).

Ideologies “are often based on a realistic interpretation of interpretations or explanations which are themselves removed from reality” (9). For instance, the colonial ideology of early 20th

century that represented Africa as a void and uncivilized continent that needed to be saved by Western civilized nations (Dunn, 1996, 163).

Ideologies are generated from false concepts of truth that are represented through various ways in society such as learning institutions, the media, religion (Boudon, 1986, 18). An ideology's usefulness does not depend on the truths it represents but on the meaning it tries to fix with the false concepts of truth that are represented (18). Thus, ideologies are judgments of fact of a group or a person's belief system in effect this judgment of fact divides those who are the owners of the ideology and those who will learn to practice the ideology, an "Us versus Them" narrative comes into existence (19).

For an ideological narrative to manifest itself it has to be tested and proved to stand on its own merit, and if it does so, it is further reproduced into the historical, political, social and economic realities of people's daily lives (31). Taking this into account, Glapka states that "[an] ideology [is] a practice of meaning production and interpretation" (2010, 47). Hence ideologies are social, in the way they are acquired, constructed and changed; it is a social process and involves shared group knowledge (Van Dijk, 1998, 49). Ideologies therefore have the power to label, and represent "...who we are, what we stand for, what our values are, and what our relationships are with other groups...." (69).

The dissemination of an ideology into society begins with the ideas that take root from a shared belief system of a group of people, and then communicated into society through means of oral tradition, the use of media such as radio, print, television, the internet and learning institutions. An ideology is the representation of the truths it attempts to articulate about people and society. The ability an ideology has to produce and reproduce a perception of something and naturalize

that perception, is at times detrimental or advantageous depending on who is doing the representation and what is being represented.

Representation is defined as “the meaning given to the images that are viewed and depicted in the various media such as radio, film, television and the internet” (Jhally, 1997). Meaning depends on what one makes of it and this always depends on how people are represented. In other words “representation (of an object or person) has no real meaning until it has been represented” (Jhally, 1997).

Stuart Hall notes that there is a four part process of how a person receives and understands a message communicated to them visually or orally (1996, 41). The first part of the process would be the production of the message that is packaged and transmitted to the audience. Second, is the circulation of the message to the intended target audience. The third process involves the consumption of the message, and fourth, the reproduction of the meaning of that message by the audience viewer; at this point in time the message is transmitted by that audience viewer directly to the community and society they live in.

Therefore, meaning is based on the interpretation of what has been represented by that media or communal channel (Jhally, 1997). It is important to note that meaning of a representation is not fixed, however ideologies aim to fix meanings to images, a group of people, culture, religion and languages. This results in the existence of power struggles that includes or excludes a group of people through the use of ideological representation. The included group is characterized with positive traits whereas, the excluded group “the other” is found to have negative traits. ‘The other’ is a marginal group that can be blamed or scapegoated for a societal problem” (McCormick, 2010, 100). Indeed “it is important to ask who has the power to name, to

represent a display, and to see how the thing is named, represented and displayed” (De B’béri, 2006, 77).

The social construction of representing something is an institutionalized ideal that whoever is in control of the product or message is outside the lens (78). Therefore analyzing the language used to communicate the societal and cultural markers of PLHA and HIV/AIDS in Uganda on *RP256* will result in finding out the ideological truths that are represented or not represented of rural life in Uganda.

The History of BCCs in Uganda

BCCs are campaigns that are conducted to communicate a favorable change in behavior, usually health behavior (Liu & Chen, 2010, 1). Behavior is defined as:

A product of an individual’s learning history, present perceptions of the environment, and intellectual and physical capacities. Thus behavior can be changed through new learning experiences, guidance in the adjustments of perceptions and support for the development of capacities (MacAlister et al, 2008, 176).

BCC campaigns mostly deal with the concept of health behavior change. Their goal is to improve upon, and have positive effects on, health risks of a particular population, community, and country that will reduce mortality rates in the long run (Liu & Chen, 2010, 1). Such health issues that BCCs are involved in are HIV/AIDS, diabetes, cardiovascular disease, polio, fistula, cholera and sexually transmitted diseases (STDs). BCCs also deal with social issues that affect the overall level of wellbeing of individuals such as family planning, gender equity, and transactional sex. Noor et al (2009) find that BCC campaigns;

Aim to generate specific effects in large numbers of individuals, typically with a specified period of time, and through a coordinated set of communication activities. They employ single or multiple media at the national, regional, and local levels, either as stand – alone efforts or as part of multicomponent programs (16).

Therefore, BCC campaigns employ a strategy or an approach to better affect the behavior change of a geography and people. In order for any BCC campaign to have an impact on its targeted audiences, two measures need to be present. The messages need to be informative and well packaged about a particular issue (Abrams & Maibach, 2008, 221). The messages are transmitted through multiple media channels that disperse of the information to the intended audience members (221).

The health of a community is affected by the attitudes and behaviors of its people and the interaction between the people and their environment (221). For a BCC campaign to garner any type of success, its message has to aim at behavior change towards the social system of the lived environment instead of aiming at the individual alone (225). Messages aimed at the social system involve community members working together to bring about favourable change whilst, a message catering to the individual alone would mean that there would be no communal support, thus making it hard for any change in behavior to take place. Cassell et al (1998), state that:

For a health communication to be persuasive, it must be both transactional and response dependent. Communication is transactional when it allows for give and take between [the] persuader and persuadee and allows both parties to bring something to the exchange. Thus, to be persuasive, a communication must (a) motivate the receiver to actively attend to messages and perceive and interpret their content, (b) include iterative

and transactional solicitation of feedback from audience members, and (c) activate elaboration of message arguments and counterarguments to encourage individuals to move through the process of attitude change (73).

In terms of HIV/AIDS, BCC campaigns have been used to create positive behavior changes in the populations where HIV prevalence rates and rates of mortality are high.

HIV/AIDS took a major toll on Uganda during the 1980s. In 1986, the government of Uganda formed a National Committee for the Prevention of AIDS (NCPA) to look into the AIDS crisis and possible prevention methods (Slutkin, 2006, 352). By 1987, Uganda had established a national AIDS control plan and its mission statement was to “mount an educational campaign to inform the public on the modes of transmission and ways to avoid infection” (Uganda AIDS Control Programme, 1989). During the 1980s, a lot of internal and local based agencies such as The AIDS Support Organization (TASO), People Living with AIDS (PLWA) and Phily Lutaya Initiative played various roles in informing the public about HIV/AIDS and offering services to those affected by HIV/AIDS (Nassanga, 2000, 110). External agencies, for instance, the Joint United Nations Programme on AIDS United Nations (UNAIDS) and the World Health Organization (WHO), also provided services (110).

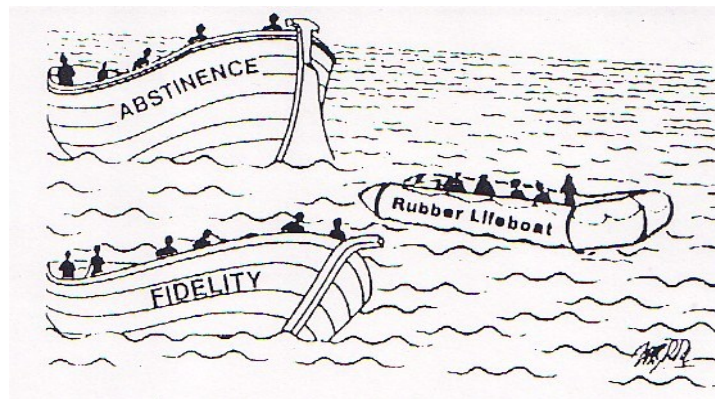
From 1989-1992, the Ministry of Health stepped up its initiative in the fight against AIDS and started a health education campaign known as Information, Education and Communication (IEC) (Slutkin, 2006, 354). Its three main objectives were to mobilize all sectors of Ugandan society, provide Ugandans in the different districts with information related to IEC and also decentralize training at the local district level (354). IEC’s message was to encourage fidelity, and delay of sexual relations, in other words, to encourage Ugandans to practice “zero grazing”

(356). Zero grazing is a practice used in herding cattle that entails deterring cattle from grazing outside its own pasture by use of various techniques such as fencing (356). The message advocated Ugandans to 'stick to one partner', 'love carefully', and 'choose a partner carefully' (356).

In 1992, the Uganda AIDS Commission (UAC) was created in order to "closely co-ordinate and monitor the national AIDS strategy" (Green et al, 2006, 338). Within a decade in 2001 there were 700 agencies in Uganda that were government or non-government based that were working towards HIV/AIDS epidemic (338). By the end of the 1990s, there was a blueprint for health BCC campaigns to develop in order to continue the discourse on HIV/AIDS and sexual behavior. BCCs in Uganda have now become common practice and are usually implemented by local and International NGOs that work hand in hand with government agencies, women's groups, and Faith based Organisations (FBOs) to help solve health and other issues affecting Ugandans. In Uganda, BCCs' "ultimate aim of AIDS preventive interventions has been to further halt the spread of HIV" (Wellings, 2002, 132). There are three Ugandan BCC campaigns that have had a significant impact with HIV/AIDS in Uganda and they are as follows:

The ABC campaign is among Uganda's most successful BCC to date due to the rapid decrease of HIV -1 prevalence rates in the country that resulted from the campaign messages (Parkhurst, 2011, 240). The origins of the ABC strategy originated from Bernard Joinet a Catholic Chaplain in Tanzania at the University of Dar-es- Salaam in the 1980s (Mulwo, 2008, 39). The idea behind the ABC strategy was inspired by Joinet in the 1980s comparing the Biblical story of Noah's Ark to HIV/AIDS. Joinet believed that the flood of AIDS was a danger to the livelihood of many and in order for people to survive they would have to seek refuge in life boats of 'Abstinence', "Fidelity" and "Rubber life boat" (condoms) (39).

Figure 1: Joinet's Flood of AIDS poster



Source: Fleet of Hope

The ABC strategy then took its first life cycle in the Philippines in 1992, where a BCC campaign launched the slogan “ [ABC] Abstain from sex, Be Faithful if you do not abstain [and] Use a condom if you are not faithful” (Avert, 2011). Later in 1992, the ABC campaign was adopted in Uganda and was used in three different ways as a message, policy or approach and an outcome (Parkhurst, 2011, 244). In its message the campaign targeted certain groups in order to achieve a particular outcome for instance, Abstinence message in the campaign targeted youth or young adults who were not sexually active, encouraging them to delay sexual activities for marriage (246). Whilst Be Faithful message targeted those who were married, encouraging them to zero graze, that is, to practise monogamy and lastly, the Condom message targeted the group that was sexually active and not in a committed relationship encouraging them to practise safer sex (246). In the 1980s there was a culture of fear towards HIV/AIDS because very little was known about it at the time. This led to earlier communication campaigns’ use of fear to ward off people from engaging in risky sexual behaviors and prevent further HIV/AIDS infection (247). As a result,

the ABC approach was a message that did not use the fear strategy and urged Ugandans to practice better sexual practises.

Although many critiqued the results of the ABC campaign, claiming that the campaign was not the sole reason for the success in the reduction of the low prevalence rates of HIV-1 in Uganda (Parkhurst, 2002, 78). However it was found that other policies and messages that were in place at the time in institutions such as schools, places of worship, family, businesses, local and international NGOs and the government all worked to reduce the impact of HIV/AIDS in the country (Mulwo, 2008, 41). By the mid 1990s Ugandans were beginning to educate themselves about HIV/AIDS, what it was, whom it affected and prevention methods that needed to be taken. Therefore, the ABC campaign only reiterated that same information tailoring it to specific target audiences.

Straight Talk is another BCC that has had significant and continuous success in Uganda. *Straight Talk* is meant “to analyze the behavioral aspects of the health problem to determine which actions should be performed by which people [and] to improve what aspects of [the] health status” (Atkin, 2001, 50). *Straight Talk* Uganda was initially run as a field test newsprint in 1993 to discuss HIV/AIDS the epidemic and the prevention methods (Straight Talk Foundation, 2006).

The *Straight Talk* campaign is funded by the United Nations International Children’s Emergency Fund (UNICEF) (Straight Talk Foundation, 2006). It is a BCC campaign that caters to the age group of 10-19 year-olds (The World Bank, 2004, 219). This proved to be too large an age group and so it was divided into two sub groups; catering to 15-19 year-olds and Young Talk 10-14 year-olds (The World Bank, 2004, 219).

The aims of the *Straight Talk* campaign are to:

1. Increase the understanding of sexual issues amongst adolescents
2. To introduce reproductive health in the dialogue of young Ugandans, and
3. To promote safer sex and abstinence that would decrease the levels of HIV/AIDS infection among adolescents (Straight Talk, 2006).

The broad aim of the campaign is to create a safe and healthy environment for young Ugandans by introducing sex and health issues into the community. The *Straight Talk* campaign has a health and social motivation aspect since it was aimed at using health education to reduce the rates of HIV/AIDS infection as well as create life skill choices with its intended target audiences.

The objectives of the *Straight Talk* campaign are:

1. To increase understanding of adolescent sexual and reproductive health (ASRH)
2. To promote safer sex, life skills [,] child and adolescent rights (The World Bank, 2004, 221).

Straight Talk's mission statement is geared to improve the lives of Ugandan adolescents and change sexual behavior tendencies that were termed risky behavior (Straight Talk, 2006).

Straight Talk communicates its messages in three ways. The first is a newsletter insert placed in one of the country's leading newspapers and government owned *The New Vision* and the second is through a radio syndicated show (The World Bank, 2004, 223). Third, the community channel, using the oral traditional way of gathering and disseminating information to *Straight Talk* school clubs that were oriented around primary and secondary school students (225).

Most public communication campaigns use three types of messages to reach their targeted audiences; awareness, instruction, and persuasion (Atkin, 2001, 55). A study conducted in 1991 showed that young adults in Uganda made up 40 percent of the population affected by HIV/AIDS, thus a need for the *Straight Talk* message of prevention and safer sex (The World

Bank, 2004, 228). There is a culture of silence that exists in Uganda, whereby adults rarely discuss sexual matters with their children, and this played a pivotal role in the type of strategy *Straight Talk's* would adopt to tailor its message to its target audience. *Straight Talk* is used as a tool to facilitate discussions about sex among young people as well as encourage discussion with parents (228). *Straight Talk* works as a means of helping youth realize the role and positive changes sex education has in a society (228).

Straight Talk relies on messages that create awareness and advocate the dangers of HIV/AIDS, what can be done about it, and how this should be acted upon (Atkin, 2001, 55). The campaign also uses instruction messages which entail a “how to do it” ethos, a type of information that generates knowledge and contributes to the learning of life skills and sexual health issues (Atkin, 2001, 54). The *Straight Talk* radio show was established in 1999 to reach potential audience members that could not read or write and had no access to the *Straight Talk* newsletter in *The New Vision* (Straight Talk, 2006). The thirty minute radio show is entitled “Enter Educate” and is broadcasted in English as well as eleven local languages (Straight Talk, 2006). The show is hosted by young radio broadcasters, includes call-in sessions to discuss certain topics, and each segment had an expert who is able to answer questions or give advice about sexual and health issues (The World Bank, 2004, 225). Topics discussed on the radio show concern HIV/AIDS stigma, transactional sex, peer pressure and negotiating safer sex with a partner (225). To summarize, *Straight Talk* set the foundation for YEAH and its E-E drama *RP256* to be built upon.

YEAH is a BCC campaign that was established to cater to the youth demographic in Uganda (Uganda AIDS Commission, 2010). It was initiated by the Uganda AIDS Commission, that wanted to bring about “sustainable and coordinated behavior change in youth” in order to

reduce HIV/AIDS, as well as to discuss teen pregnancies and high school dropout rates among youth in Uganda (Uganda AIDS Commission, 2010). YEAH is structured and therefore able to function with the help from the Communication for Development Foundation Uganda (CDFU) and Health Communication Partnership (HCP) (Y.E.AH, 2012). CDFU is an NGO that concentrates its efforts on BCC campaigns in Uganda; to manage, create and promote them, as well as financially support them via the different media channels (Nombuso, 2006). CDFU's mission statement is to “ help, individuals, families, and communities adopt practices that lead to healthier and more productive lives, and to influence social norms, attitudes, and values that enable people to adopt improved social practice” (Nombuso, 2006).

HCP is an NGO that works with developing nations to “create an environment that supports individuals, families and communities to act positively for their own health and to advocate for and have access to quality services” (HCP, 2011). HCP is operated under two American run organizations; The United States Agency for International Development (USAID), which works in nations across the globe to further U.S. foreign policy of providing aid, economic, humanitarian and development relief to regions in need (USAID, 2011) and the Centre for Communication Program (CCP), an organization that uses all types of channels to communicate better health and living conditions of people in developing countries (The John Hopkins University, 2011).

YEAH receives its funding from USAID and U.S. President's Emergency Fund for AIDS Relief (PEPFAR) (YEAH, 2012). YEAH operates and partners with local and international NGOs such as HCP, AIDS Information Centre, Save the Children in Uganda, Students' Partnership Worldwide, Uganda Red Cross Society, Reproductive Health Uganda, UNICEF,

and Save the Children U.S. in order to dispense its message on health messages in and around Uganda (YEAH, 2012).

YEAH's end result in all its BCC campaigns is to serve Ugandan youth and create services that will educate, increase dialogue and support the youth with matters concerning gender equality, sexual and reproductive health such as HIV/AIDS, legal rights, health services among others (YEAH, 2012). YEAH's mission statement is to: "simulate dialogue and action among communities, families, schools and health institutions and model positive practice through local and national media" (YEAH, 2012). YEAH sets out to do this with its E-E radio drama *RP256*. *RP256* is about the struggles and dilemmas of Ugandans in a fictional fishing and farming community in rural Uganda (YEAH, 2012).

The underlying meaning behind the title of *RP256* stands for the rocks which are a landscape feature of Uganda that represent strength, while 256 is the national area code of Uganda "indicating the national identity of the series" (YEAH, 2012). *RP256* is produced, written and acted by Ugandans for Ugandans. For this reason it is broadcasted to the five main regions of Uganda: Central, East, South, North and South West (Y.E.A.H, 2012). It is produced and acted out in nine languages that is English, Luganda, Luo, Ateso, and -Runyankole, Rukiga, Runyoro, Rutooro (the 4 Rs) and is meant to cater to all Ugandans (YEAH, 2012).

The radio stations that air *RP256* in English are the following: Rock Mambo 93.3 FM, Voice of Teso 88.4 FM, Radio Parcis 90.9 FM, Radio Uganda- Red Channel 98FM, and Radio Uganda- Magic 100FM (Y.E.A.H, 2012). Those that air the drama in Luganda include: Radio Simba, Bukedde 100.5 FM, Kiira 88.6 FM and Buddu 98.8 FM and 95.5 FM. The stations that air the 4Rs are: Radio West 100.2 FM, Voice of Kigezi 89.5 FM, Hoima 88.6 FM and Voice of Kamwenge 87.9 FM. Lastly the stations that air Lwo are Mega 102 FM and Voice of Lango 88.0

FM (YEAH, 2012). In order to get a good understanding of who and what they are scripting, the team of *RP256* writers are given opportunities to go out into the community and learn more about real life situations of those who live in the fishing and farming communities where they talk and discuss issues with the residents who have been affected by HIV/AIDS, domestic abuse, alcohol abuse and gender inequality (YEAH, 2012). *RP256* writers are educated on HIV/AIDS, anti- retroviral drugs, maternal health and legal and gender rights by medical physicians, experts in law, and women's rights (YEAH, 2012). All of this is done in order to ensure that *RP256* strikes a chord with the intended audience who live in rural Uganda.

RP256's target audiences are 15-24 year-olds. In targeting this specific demographic *RP256* is "segmenting the population into unique and distinguishable groups to which specific products, services or messages are directed" (Karlyn, 2001, 439). This particular age set is targeted as audience members because those highly affected and infected by HIV/AIDS in Uganda are those in the age set of 15-49 (Bayer, 1996, 123).

Factors that influence the reason as to why Ugandan youth are targeted by *RP256* is because they are "marginalized and disempowered" in their immediate surroundings, youth are at a stage in their lives of engaging in and developing personal relationships, attitudes, values, behaviors and belief systems (Hoffman & Futterman, 1996, 237). Youth are always conflicted with obstacles that lead to decisions that may or may not affect their freedom of choice, will and their roles in their families and intra families are in a constant state of change therefore this is a period in their lives to seek guidance and advice (237).

HIV/AIDS messages communicated to young adult audience members of *RP256* are beneficial for youth in acquiring knowledge, informing opinions on life experiences such as sex, money, education and disease. The concept of childhood is a social construct therefore if

“childhood and youth are characterized as innocent and premature and adulthood is constituted as knowing, civilized and mature both constructions are affected through a range of discursive practices both representational and material” (Prinsloo, 2007, 26). Youth undertaking activities that involve having sex, drinking, and drugs is deemed an unfit set of behaviors that warrant caution (26). Thus targeting youth through BCC campaigns about HIV/AIDS and STDs is advantageous because a presence of a strong and well received mass media campaign results in an increased awareness and knowledge of the message that is discussed and taught at large such as HIV/AIDS (Sood & Nambiar, 2006, 145).

When targeting an audience, channel selection is of importance due to the fact that this shows who is being targeted (Myhre & Flora, 2007, 38). Channel selection also dictates how broad or narrow the message will be depending on the medium used such as traditional media; radio, television, print or using new interactive media such as twitter and Facebook. For instance in South Africa, HIV/AIDS mass media campaigns such as *LoveLife*, *Y6664* campaign and *Youth 4 Life* mainly target young adults through social activities such as song, dance and street theatres (Colete & Simbay, 2006, 60). In turn, this has increased the rates of youth activism in South Africa which has also been symbolic to that of the youth activism during the apartheid era (59). Precaution must be taken when targeting youth as the issue of HIV/AIDS should always take precedence in the BCC campaign, that is a balance of information and entertainment is needed. Understanding and knowing HIV/AIDS revolves around the premise of “knowing the facts” about HIV/AIDS and the prevention methods (Gavin, 2001, 87; Paxton, 2001, 56). Targeting youth also helps in breaking the barriers of a culture of silence that encourages youth to teach themselves rather than talking to their parents or guardians about such issues pertaining to sex, HIV/AIDS, STDs (Temin et al, 1999, 189).

For many youth, sex is viewed as coming into adulthood while for others; premature sex is the result of attraction, material/ monetary gain and peer pressure (189). Youth who have sexual relations with adults on the primary basis of having a favour returned is known as transactional sex. This phenomenon has been practiced in different cultures since the beginning of time and occurs when “sex [is] used in an instrumental manner to secure relationships that are financially rewarding” (Leclerc-Madlala, 2008, 220). There are two types of transactional sex. First, ‘survival sex’, which is based on a person’s poverty level and economic dependence on their partner, whether female or male (215). ‘Informal sex’ is consensual sex for the exchange of a ‘want’ or a ‘need’ (217). In such sexual relations, sex is perceived as having commodity value that is measured according to one’s cost of living and lifestyle (220). With transactional sex there are particular ‘needs’ and ‘wants’. Leclerc-Madlala finds that these ‘needs’ or ‘wants’ are essential for one party at a lower socioeconomic bracket. The ‘needs’ are “food, rent/services, essential clothing, school fees and basic transportation” [while the] ‘wants’ are cellular phone/ jewellery, entertainment/ travel, fashion clothing, tertiary education fees and luxury transportation” (224). However, transactional sex has led to many people contracting HIV/AIDS or STDs due to the multiple partners that people have, the virus is then spread through a cycle of concurrent sexual partners (218).

Therefore, targeting youth in BCC campaigns such as *RP256* is an effective way of discussing issues of sex, and disease that are not discussed privately. In African culture, specifically in Uganda, many parents fail to discuss these matters because of a culture of silence, a result of being shy and timid and not knowing how to broach sex and sexual health matters with youth (Nassanga, 2000, 113). For example, within the Baganda tribe in Uganda, advice on sexual matters has traditionally been passed on before a child gets married by either the Ssengas

(paternal aunt), for women, or the Koojas (paternal uncle), for men (Norton & Mutonyi, 2010, 53). This is a cultural tradition among the Baganda that assumes most children, or young adults, do not engage in pre-marital sex (Nassanga, 2000, 113). The tradition still continues yet sex education has moved into the core public discourse and therefore out of the comforts of a home. This has often led to many Ugandan parents objecting to sex education being taught elsewhere in fear of it increasing promiscuity among youths (53). As a result, crafting a message to target any demographic is not always easy and one cannot predict the outcome of how the message will be received, yet Uganda has been able to craft such media campaigns since the late 1980s.

The negative cultural and societal beliefs that have existed over the years about what HIV/AIDS is and what it means to have AIDS or be HIV positive has led to challenges in communities (Singhal, 2003, 231). These challenges include silence, denial, blame, stigma, prejudice and discrimination. E-E programs such as *RP256* have been created in order to break the culture of silence, blame and discrimination among others about HIV/AIDS. Even in Uganda's political discourse; President Yoweri Museveni has been an enthusiast advocator of safe sex campaigns: "When a lion comes to the village, you don't make a small alarm. You make a very loud one. When I knew of AIDS, I said we must shout, and shout, and shout, and shout" (Singhal, 2003, 231). *RP256* shouts loud to inform Ugandans about the risk of HIV/AIDS.

It's Entertainment...Its Education...no....It's Entertainment-Education

Entertainment-Education (E-E) is not a new concept; it has been referred to as "info-tainment", or "enter-educate" (Papa et al, 2000, 32). An E-E is communicated through the use of a specific medium such as radio to promote and inform an audience about the dire health or social calamities they face and how to bring about a better and positive outcome through social

and behavioral change (32). *RP256* is an example of an E-E or edutainment program that Singhal and Rogers (1999) define “[as] the process of purposely designing and implementing a media message both to entertain and educate, in order to increase audience members’ knowledge about an educational issue, create favorable attitudes and change overt behavior” (9). E-E is “the intentional incorporation of educational messages into entertainment formats with the purpose of changing audience members’ behavior” (Karlyn, 2001, 441). An E-E is not a communication theory but a strategy “to bring about behavioral and social change” and social change can occur at the level of the individual, community and society level (Singhal & Rogers, 2004, 5). E-Es are effective because “[they] can influence members’ awareness, attitudes, and behavior toward a socially desirable end [as well as] influence the audience’s external environment to help create the necessary conditions for social change at the system level” (5). Furthermore E-Es assist in delivering health messages to target audiences that may or may not be knowledgeable of particular health issues such as HIV/AIDS and prevention methods, they are able to communicate emotional reactions from audience members and lastly E-Es have “a lasting impression that can change [a] viewer’s behavior” (Piotrow & De Fossard, 2004, 40).

The nine factors that an E-E incorporates in its message are as follows ; **P**ervasive, the message has to be broadcasted and placed everywhere to reach as many of the targeted audience as possible; the message should be **P**opular, modern and keeps up with the times; the E-E should be **P**assionate that is emotional; it may at times be **P**ersonal to the targeted audience; it is **P**articipatory form that is having audience members participate with feedback via mail; it is **P**ersuasive the message is catered to entice as well as educate the viewer; it is supposed to be a **P**ractical form where props are used to the realistic nature of the drama; it is **P**rofitable for the specific media channel through advertising and promotions during that allocated time of the

featured E-E drama and lastly it is **Proven effective** , messages reach the audience and they may change their attitudes whereby audience members become more informed about a particular issue such as condoms, abstinence in reference to HIV/AIDS (Piotrow et al, 1997, 78).

However, E-Es run the risk of having too much educational material that may not attract youth or may have too much entertainment that does not cater to educating the masses therefore a balance is needed in crafting a message that serves to educate and entertain the targeted audience (Piotrow & De Fossard, 2004, 44). E-Es need to be fine-tuned in order to make the quality of the message believable to the targeted audience (45). Depending on the cultural, religious and tribal controversies at times the drama, the characters and words used may be changed to suit and tailor the particular population and environment the message is targeted to (45). For example *RP256* is broadcasted in 8 local languages including English and the drama has to cater to the social and linguistic culture of the different regions in which this information is disseminated.

Overall, there have been more than 75 dramas of this kind worldwide in Asia, Latin America and African countries that have been geared around HIV/AIDS, family planning, adult literacy, gender equality, dowry and others (Rogers et al, 1999, 194). Elkamel (1995) found that the E-E programs have existed since the 70s, in Latin America between the period of 1976- 1983 there were six programs that were forms of E-E, in 1984 India there was *Hum Log* based on television documenting family planning and in 1987-1991 Egypt there was *The Family House* based on family planning and health issues (226).

In the early 90s and into the 21st century we have the following examples of E-E shows in Africa and India:

In 1993, there was *Twende na Wakati* (Lets go with the times), which focused on family planning methods in Tanzania, as population growth was at an all-time high (Rogers et al, 1999, 193). *Twende na Wakati* was successful in that there was an increase of the use of contraception practice among couples (202). In a survey carried out the results confirmed that through listenership there was an increase in interpersonal communication about family planning, determining family size, and an increased support for determining the ideal age for marriage among women (205). *Twende na Wakati* was successful with its message content due to the five evaluation guidelines of the content in *Twende na Wakati*. They were as follows:

1. Use formative evaluation to facilitate the design of the radio messages;
2. Use of a values grid to structure the educational content of the episodes;
3. Focus on the entertainment element to draw a large audience;
4. Explicit use of role models for behavioral change and its consequences; and
5. The [use of] long running soap opera format to allow the audience to identify with the characters and allow listeners time in which to change their behavior” (207).

Twende na Wakati was designed to draw the Tanzanian population into hearing messages of family planning and as a result through the fictional characters of the show would advocate change in family planning practices.

Another example of a successful running E-E is South Africa’s *Soul City* which has resulted in increasing knowledge about HIV/AIDS in the rural and urban areas through the use of media campaigns on television and radio (Goldstein et al, 2003, 194). *Soul City* has helped change attitudes, practices and social norms concerning HIV/AIDS in South Africa (194). *Soul City* allows for interpersonal interaction which is a key component to E-E projects being successful since the content and message they incorporate to be listened to on the radio or watched on

television by the intended viewer has the power to change the way one perceives the concept of something or someone (Rogers, 1995, 277). *Soul City*, was created at a time when South Africa had high rates of HIV/AIDS infection, with more than 4.7 million of its population infected in the 90s (196). In order to curb the spread of HIV/AIDS *Soul City* television and radio dramas were created to portray “realistic” situations so that audiences could identify with the characters and the stories in order to impart knowledge of prevention, condom use, and attitudinal change (196). *Soul Buddyz* was a spin-off of *Soul City* that was targeted to reaching out to adolescent children in South Africa. It too garnered success as it has slowly encouraged a means for children, their elders such as teachers and parents to engage in conversations of health and body issues at a communal level (199).

In Zambia, *Nshilakamana* (*I have not yet seen it*) was another entertainment education radio drama about AIDS (Yoder et al, 1996, 190). This program was meant to tackle, and provide incentive for AIDS discussion amongst communities in Zambia. Although it aired for a year, *Nshilakamana* was successful only to a point, because during its transmission between 1990-1991, there were a lot of other channels educating the masses about what AIDS is, as well as prevention and treatment of AIDS, such as government services, NGOs, schools (201). *Nshilakamana* was the foundation of other entertainment education programs in Zambia and a reminder that in Africa there are many mediums used to transfer information about HIV/AIDS other than radio.

Lastly, *Tinka Tinka Sukh* (*Happiness lies in Small Pleasures*) was an E-E that aired between 1996-1997 and was meant to cater to people living in the village of Lutsaan (Pape et al, 2003, 33). *Tinka Tinka Sukh* dealt with issues of dowry, and family planning. It too was successful in India as it encouraged the community of Lutsaan to discuss openly about issues like

dowry, early bridal marriage and family planning. *Tinka Tinka Sukh* resulted in engaging the people of Lutsaan village in collective action to solve community problems.

Twende na Wakati, *Soul City*, *Soul Buddyz*, *Tinka Tinka Sukh*, *Nshilakamana* and *RP256* are produced to incite social behavioral and attitude changes among its audiences. Most of these E-
Es were mostly broadcasted over radio airwaves while a few such as *Soul City* used television. Therefore radio in developing nations is used by BCC campaigns to channel their messages to their target audiences in rural or urban areas.

I hear a tune, the weather report, my favorite show *RP256*....on the Radio!

Mugambi Nabasuta (1994) finds that radio in Uganda is an essential medium of communication because:

Uganda as a whole has a primarily oral culture. Being exclusively aural, radio broadcasting more than any other medium of communication unites the entire population as it blurs boundaries between literate and non literate members of the society.

Additionally, the radio audience is vast since most urban and rural homes own transmitter radio as their main source of information and entertainment (48).

Nabasuta acknowledges that radio in Uganda is a powerful medium, because it imparts powerful messages and ideas. For example, radio is used to voice the struggles of those oppressed. In Uganda, female musicians use radio as a means to communicate their equality rights and independence in songs transmitted on the local stations (44- 63). Radio as a medium transmits content which has the ability of creating or adding onto existing hierarchy of power struggles and relations with the content it broadcasts. Radio in modern day Western societies is often referred to as a “secondary medium” since it has been displaced by television, the internet and even mobile phones (Berland, 1990, 179). Yet radio continues to thrive as the primary medium in

developing countries such as Uganda. In Uganda, radio is an extension of cultural, social and political interactions among Ugandans. It is that medium that has been able to reach the urban and rural populations, the literate and illiterate because it is cost effective in monetary terms of producing content and buying the actual medium as a commodity (Amienyi, 1996, 149). Radio runs on battery life and is not affected by the means of having or not having electricity (149). Radio is that “blind medium: you cannot see with your eyes, like you can television, a movie or newspaper. You can only see the pictures in your mind” (Vivian & Maurin, 2009, 79). Radio is a medium that is assisted by the content of its message in four types of aspects that speak to imagery: words, sounds, music and silence (75). It is devoid of visual appearance but has the power to create mental representations of people and places (Posetti, 2008, 161). As a medium of communication, radio has the ability to act as a protagonist, antagonist or social actor towards a particular cause, ideology, and calamity (Montanari, 2003, 139). Due to the fact that its mode of communication is through spoken and lyrical content, radio has the ability to frame reality through its own lens (Posetti, 2008, 165). Consequently two types of experiences take place; that of the listener, who absorbs the content and the broadcaster, who produces the message and controls the type of content listened to (Patnode, 2011, 170).

In Uganda, radio was used for the first time in 1954, when Radio Uganda started broadcasting on airwaves for 2 hours but it was not until 1956 that Radio Uganda broadcasted for 6 hours in the local vernaculars (Amienyi, 1996, 156). Radio Uganda is Uganda’s main source of public broadcasting and has always had a “variety of programs broadcast in 28 languages including English and Swahili” (Nassanga, 2000, 110). It has also had the means to reach Ugandans in all districts with the help of its wide coverage and is a major source of information to most Ugandans (111). The national policy for all broadcasting mediums in Uganda such as

radio, and television is to “educate, entertain, inform and mobilize the people of Uganda” (Amienyi, 1996, 157). Radio in Uganda has always been used as a tool for learning purposes, when it was introduced in Uganda by the British Colonial government of the time (Kiwanuka-Tondo, 1990, 54). The three reasons as to why radio broadcasting was introduced in Uganda was: First, for the colonial government to keep in touch with what was going on elsewhere in around the world especially in Europe; Second, the need to propagate colonial national rhetoric, and lastly to educate Ugandans (Kiwanuka-Tondo, 1990, 54).

In the context of Uganda, radio programming integrations started in the 1960s as a form of public education. The goal was to either educate the students and colleges or to raise awareness on agricultural farming. Since then, radio has evolved in Uganda to contain persuasive messages about health, sex, HIV/AIDS, plays music and music countdowns. In the 21st century, radio in Uganda has evolved and has become a space for public debates on politics, religion, laws among others and this has given voice to those who could not previously voice their opinions (Mwesige, 2009, 221). For instance, political radio talk shows in Uganda allow listeners to call in and speak to their local politicians about issues that concern them (221).

The success of radio in today’s 21st century Uganda has allowed the country to operate “42 radio stations (the most in East Africa): 7AM, 33FM, 2 shortwave. Another 100 broadcast licenses have been issued but are yet to be put to use” (Otiso, 2006, 44). Uganda’s most popular radio stations are Sanyu FM 2000 (Kampala), Monitor FM (Kampala), Impact FM (Kampala, Mable and Masaka), Radio Simba FM (Kampala); Radio Maria Uganda (Mbarara); and Radio Apac (Apac) (44).

RP256 as a media channel for YEAH and the programming content provided is geared to educate, inform and entertain the Ugandan audience about HIV/AIDS and is transmitted on 15

local radio stations (YEAH, 2012). For that reason the ‘radio format’ of *RP256* contributes to effectively disseminating content about social and health issues specifically HIV/AIDS that have been discussed on the airwaves in Uganda since the 1980s.

The Impact of Stigma on Identity formation

In 2005, there were 915,400 PLHA in Uganda, 79.8%, (775,000) were from the rural areas (Hladik et al, 2008, 505). Uganda has disclosed of its HIV/AIDS crisis publically and internationally, however in the cultural and social settings, most individuals and communities associate HIV/AIDS with a social stigma of moral standards (McCombie and Eshel, 2008, 203). Stigma “refer[s] to an attribute that is deeply discrediting but it should be seen that a language of relationships, not attributes is really needed [to reinforce it]” (Goffman, 1963, 3). Stigma comes about through three visible and non-visible ways: physical deformities such as being handicapped, blind; through immoral character flaws such as prostitution, drug or alcohol addiction and lastly through tribal stigma of race, and religion. Negative attitudes and mindsets of HIV/AIDS mostly stem from ignorance and fear of the disease itself. HIV/AIDS stigma is further reinforced by the social attitudes of the people of the community (Letamo, 2003, 348). The following are three reasons as to why PLHA are stigmatized. First, there is a lack of education on the matters of how people contract HIV/AIDS, the types of ways it is transmitted and the prevention methods, therefore people believe the false myths about HIV/AIDS (348). Second, HIV/AIDS has no cure to date; therefore it is an illness that inevitably leads to death, and most people who are uneducated on HIV/AIDS are afraid this impact and as a result reject those with HIV/AIDS (348). Third, HIV/AIDS is thought to be contagious through the act of daily activities and it is associated with deviant behavior and viewed to many as immoral and a

curse (348). For instance people in certain labour forces are stigmatized for the belief that they have HIV/AIDS for instance medical practitioners who treat PLHA.

PLHA are stigmatized and viewed as abnormal, and lacking from the rest of society at large thus discrimination and prejudice ensue (5). Stigma creates false entitlement for the “normal” to bully those people that are viewed as “abnormal” due to having contracted the disease. Vulgar language is used as a weapon of stigma (5). Goffman argues that in society there are two types of social identities; the first being a virtual social identity, defined as that which a person ought to be or thought of to be and then there is the actual social identity, that which a person is (2). The stigmatized person has to juggle these two identities in order to fit into society and in doing so they become isolated due to the limited interaction caused by the condition that led to the original stigmatization. These two identities play a vital role in how a person views themselves as well as how they interact with their immediate environment. When someone is looked at from the lens of his or her social role and identity, they become multiplicities of selves and identities (63). A stigmatized person’s identity is governed by the information and control that individual or society has over their identity when represented (64). On account of PLHA, Tewksbury (1994) finds that:

Stigma associated with HIV disease focuse[s] on the idea of “otherness”, blame, dread. HIV disease is established as something brought to the good people of society by those who are devalued to being with [or who are]: gays, drug users, and foreigners. As a consequence, little empathy is generated, except for the “innocent victims” (338).

Innocent victims are those that contracted HIV/AIDS “accidentally” for instance, through a debacle medical procedure (Jones, 1998, 312).

HIV/AIDS is an acronym and yet it also signifies a label that is socially constructed to induce feelings of “fear, revulsion, anger, contempt, self-righteousness, sympathy, pity and shame” among a community (Devine et al, 1999, 1212). AIDS stigma has two effects; personal and social effects (1213). The personal effects deal with PLHA’s physical and psychological wellbeing, whereas the social effects are the interactions with society (1213). The personal and social effects of AIDS stigma also in turn have a resounding effect on the actual and virtual social identities of a person. HIV/AIDS stigma not only affects those who are infected but also those related to them such as partners and spouses, nuclear and extended family members as well as those who aid PLHA with social assistance and health care (Holzemer et al, 2007, 543). In a study conducted by Duffy (2005), it gave testimony of a health care worker who discovered “that it is easy to talk about malaria or tuberculosis, but with AIDS, we feel we should not mention it. When it comes to HIV, it’s [called] a ‘long illness’” (18). As a result of stigma PLHA are ostracized and forced to live a life of secrecy which inevitably creates anxiety, depression, low self-esteem, physical disorders, and prejudice (Duffy, 2005, 16; Green, 1995, 558).

HIV/AIDS stigma is produced by fear: a fear of the unknown outcome that is of dying, or contracting the virus (Brown et al, 2003, 50). These fears are based on the lack of understanding of what HIV/AIDS is, its transmission and preventative methods (50). Consequently, fear triggers stigma which in turn leads to three types of stigma; received, associated and internal stigma (Holzemer et al, 2007, 547). Received stigma “refers to all types of stigmatizing behavior towards a [PLHA] as experienced or described by themselves or others” while internal stigma refers to a person’s perception of themselves that takes on a negative thought process of how they speak about themselves and what they do is centered on their HIV status (547). Associated stigma refers to stigma that often stems from a person’s or peoples’ association with a PLHA

(547). Those people that face associated stigma through relation or by any other interaction are termed as secondary stigma recipients (Brown et al, 2003, 51).

Stigma and discrimination have always been linked to HIV/AIDS creating a social practice of silencing the disease and PLHA in speech and day to day activities (Finn & Sarangi, 2009, 48). In the context of Uganda, PLHA are stigmatized through the process of naturalized social and narrative contexts of the “self” the actual social identity and the “other” the virtual social identity (51). This implies that through the social interaction with others, PLHA are alienated and considered different from someone who might be considered “normal” or HIV negative (51). PLHA in Uganda are defined by the social constructs of the disease in their immediate surrounding community and culture. This could be found in the local terminology of a person with HIV/AIDS as they are termed “*Kakokoolo* –scarecrow, *Yamira akaveera*- one who swallowed a piece of polythene bag, *K’amuyoola*- was caught in a trap” such labels connote a negative attitude towards PLHA (Muyinda, 1997, 144). Their identity is one that takes shape when the disease’s symptoms are evident and test results come back as HIV positive thus power relations at play in HIV/AIDS stigma are found in the social, historical and economic fabrics of Ugandan society (51).

An example of stigmatization of PLHA in Uganda is observed with how Faith based Organizations (FBOs) reacted to HIV/AIDS in the 1980s and 1990s. The notion endorsed at the beginning of the HIV/AIDS epidemic in Uganda by FBOs was that of a negative attitude towards those diagnosed as HIV positive or having AIDS (Otolok-Tanga et al, 2007, 57). FBOs discriminated against PLHA as an interviewee found that “ in the beginning it was rather not very kind because whoever was found HIV-positive was looked at as a sinner and I think-faith based organizations have played a big role in enhancing stigma which was unfortunately very

bad” (57). Such stigmatization created a culture of silence whereby PLHA did not want to disclose of it to anyone nor get medical help, they lied and made excuses about their condition and tried to avoid everyone (Muyinda et al, 1997, 144). Stigmatization also led to external fears whereby the community would avoid those with HIV/AIDS (144). An example of external fear carried out would be fear of buying produce from a person in the local market who was suspected of having HIV/AIDS, and this in turn would economically affect the person (146). However with time the FBOs approach to PLHA improved in that FBOs now act as a social channel to fight against stigma and discrimination faced by PLHA in the community (59).

When there is a presence of stigma it detracts on the progress of work done to spread awareness, information and aid on issues of HIV/AIDS (Paxton, 2001, 71). Disseminating information is one of the solutions to eradicating HIV/AIDS stigma, and media is a channel that is commonly used to educate people about HIV/AIDS. However the use of media can be detrimental in terms of the portrayal of HIV/AIDS because “illness[nes] are stigmatizing because they represent potential or existing physical limitations, they are associated with particular negative images and myths and therefore they take on symbolic meaning (Fife & Wright, 2000, 51). Representation plays a key role in enhancing or diminishing stigmas specifically those attributed to PLHA.

Different cultures react differently to AIDS based on the social practices in place (Jones, 1998, 330). For example, in Hong Kong, people living with AIDS (PWA) were categorized into two types: (1) the innocent victims who were either children or blood transfusion patients, and (2) the dangerous victims who were prostitutes, drug users, and promiscuous individuals (312). Therefore PWA were ostracized and perceived as outsiders and outcasts, and AIDS was a disease that brought about shame and guilt among PWA, their families, community and nation

(310). So there is a common thread that PLHA are stigmatized due to societal and ideological beliefs about HIV/AIDS, these general beliefs are reinforced in lived environments or institutions such as schools and the family. It is in these lived environments and institutions where the production and reproduction of ideologies, identities, behaviors and attitudes are learned, appropriated, and reinforced into society (Reddy & Dunne, 2007, 161; Kimmel, 2001). Therefore the creation of a person's actual identity is linked to their interactions with society; the two are interdependent on each other (Reddy and Dunne, 2007, 162; Ybema et al, 2009, 302). Moreover if identity is socially constructed, then it is always in a state to be continuously "contested and negotiated" (Ybema et al, 2009, 306).

Identity is composed of shared histories common in people and it can be expressed as an emotional bond and can work as an attachment among individuals and the community (Hall, 1996, 34). Identity is always in a state of becoming something other than what it is at that present time such that the definition of identity varies by the mere fact of the differences in discourse systems, cultures, races, ethnicity and religion (Jones, 1998, 315). Due to its constant state of becoming identity changes its meaning with time, space and experience of the author in control of it or social and political institutions in control (Cerulo, 1997, 386). For this reason, the struggles that exist within different discursive and cultural conceptualizations of identity mainly occur because these struggles are constitutive to the politics of representation, or between 'the self' and 'the other' (Grossberg, 1996, 89). The self and the other are brought about by an identity consisting of multi-layers of constructs, which are fragmented into different pieces. Here each layer plays a pivotal role in who we become, how we are represented or how we represent ourselves as individuals, and communities (90). It should be noted that these layers of constructs are made up of differences, in gender, class, race, religion, tribe and language that are present in

the self and the other. We define ourselves not in terms of self but ‘selves’ of a community (Potter & Wetherell, 1987, 102). There are three types of self-identity: the individual self that is defined by your personal character traits; the relational self defined that is linked with others in society, and the collective self that is defined by group differences that enforce an “us versus them” rhetoric (Gomez, 2010, 140). One’s identity is therefore a multiplicity in itself for instance a young lady may identify herself as being athletic which is a personal character trait and yet at the same time identify herself as Ugandan a relational self that has ties to her lived experiences socially, historically and politically. Lastly, her collective self may be the tribe or religion to which she belongs that creates a narrative of her belonging to a particular group of Ugandans that “the others do not belong to”. In order for people or groups of people to know themselves they have to “announce” their identities (Hermanowicz & Morgan, 1999, 198). The process of announcement evolves through past history, it means an identity is processed and acknowledged through continual practice of everyday rituals which could be someone’s values or belief system (198). Identity affirmation is only obtained when certain practices of belief systems, values and rituals became an inherent part of life or an institution and are innate to that social community (200). However if that practice is not performed this leads to the disintegration of that identity and institution because identity cannot exist without it being practiced in a community by way of upholding political, social, historical and economical values in its surrounding community or public space. The media play an important role in the production and construction of social identities, the media such as television or radio at times create an identity that often represent one’s race, cultural practices, ethnicity and religion, this identity is then placed into identity hierarchies where the “us versus them” arises (Ebanda de B’Beru and Middlebrook, 2009, 33). Identity is not universal rather it is cultural and “specific to particular times and places”. In other

words, identities “are discursive constructions which change their meanings according to time, place and usage” (Barker, 2000, 166). It would therefore be right to state that *RP256* is a medium that communicates Uganda’s production, construction, and articulation of the identity of HIV/AIDS and PLHA. However, in so far, as *RP256* deals with the representation of PLHA, it also runs the risk of producing and reinforcing stigma and stereotypes about HIV/AIDS and PLHA.

To summarize analyzing *RP256* texts from a Cultural Studies perspective to identify the representation of PLHA on a 30-minute serial broadcasted over most regions in Uganda. Examination of the ideology and mentality Ugandan society has of PLHA, the stigma they face, and the power struggles they face socially will be observed.

Chapter 3: Methodology

The method that will be used to examine the ways in which PLHA are represented on *RP256*, will be carried out using a qualitative research method. Qualitative research is defined as:

A means for explaining and understanding the meaning individuals or groups ascribe to a social or human problem. The process involves emerging questions and procedures, data typically collected in the participant's setting, data analysis inductively building from particulars to general themes, and the researcher making interpretations of the meaning of data (Creswell, 2009, 4).

Qualitative research analyzes “the study of social life in natural settings” (Punch, 1998, 199). Therefore it “allows for [the] participant's perspectives and understandings of a phenomenon to be revealed” (Merriam, 2006, 36). Qualitative research will play a pivotal role as the primary research design for analyzing *RP256* because it is the most suitable design that would be able to study the narrative Discourse found in the E-E drama (Peshkin, 1988, 416). The use of a qualitative research design will allow us to better understand the phenomena at hand since this is the first study analyzing the discourse embedded in *RP256*, and how it represents HIV/AIDS and PLHA in Uganda.

The qualitative research method, of discourse analysis will be used to examine the “constructs” of the identity and representation of PLHA and HIV/AIDS on *RP256*. As a radio serial *RP256* is meant to target smaller groups of audience members, this is because radio transmits its programmes to a tapered audience unlike mediums such as television and the internet (Hausman et al, 2000, 4). The formatting of radio programmes such as *RP256* is important since it is in the art of formatting that the programme runs smoothly from the music it plays, the sound effects used, the message acted out by the actors, these all work to “attract and

hold the segment of the audience a station is seeking” to attract (5). For instance *RP256* begins with a theme song that alerts the audience member that the show has started before the prologue of every episode (208). To make a successful radio programme such as *RP256* the end goal is to produce an effect, so that the programme emotionally holds the listeners attention and will make them listen to that particular programme every day or every week when it is broadcasted (209). The four factors that play a role in enhancing radio production are music, sound effects, colouration of sound, timing and pace (Hausman et al, 2000, 210). Music is used “to [create] a mood and has the ability to “reinforce a theme”, while sound effects are the use of any sound component to add onto the programme - for example, a door slamming in a scene (211). The colouration of sound is a “nebulous quality that cannot always be singled out” for example the degree of cultural difference and uniqueness of a radio programme in Uganda as compared to one in Canada (212). Lastly, time and pacing mostly deals with the decisions involved in airing a particular clip onto the airwaves, it is the how and when something is aired that affects the mood and message of a show (213). *RP256*:

Is a composition that tells a story through action and dialogue. It generally involves a conflict; person versus person or person versus society. A drama in its broadest form has a plot, usually the plot has a beginning, middle and an end. A drama includes dramatic techniques such as suspense and exposition (223).

The content of *RP256* constitutes; sound effects, spoken word, music, voice quality, timing and pace in order for the target audience to relate, understand and be entertained with the messages being broadcasted (224).

The two research questions that will help in analyzing *RP256* narrative are as follows:

1. What are the cultural and societal markers that are used in *RP256* narrative to represent the life and experiences of PLHA and HIV/AIDS?
2. To what extent does the narrative found in *RP256* communicate Ugandan societal beliefs and ideologies of PLHA and HIV/AIDS?

These questions will be answered methodologically through the use of Gee's (1999) Discourse Analysis method and Fairclough's Critical Discourse Analysis (1989).

Research Design

The data collection and analysis procedures will follow Gee's (1999) Discourse Analysis as well as Fairclough's Critical Discourse Analysis theory. Discourse has two types of definitions; the first represents discourse as dialogue and dialogue maybe aural in nature or a written text. That is to say "discourse embraces all aspects of communication- not only its content, but its author (who says it), its authority (on what grounds?), its audience (to whom?), its objective (in order to achieve what?)" (Woral, 1990, 8). There are three guiding principles that inform discourse; it is governed by rules in its internal structure, discourse is a social practice that is produced by human dialect and the surrounding environment and discourse is made up of ideologies and aspects found in the "socio-historical matrix" that it creates (Punch, 1998, 227). However, discourse is not restricted exclusively to verbalized propositions but can include ways of seeing, categorizing and reacting to the social world in everyday practices" (Jupp, 1996, 300). It is a way of communicating between and among people; it is the way language is used as a tool to tell a story or narrative. Narratives are "the primary genre of oral discourse"; therefore the history of a people or culture is learned from studying and understanding its narrative in the form of stories (Graesser et al, 2002, 229). A story "is a

structured, coherent retelling of an experience or a fictional account of an experience” a story is meant to inform, teach or convey something to its audience (Schank & Berman, 2002, 288). For instance, *RP256* is a fictional story or narrative that is constructed around the understandings of experiences and history of people that live in rural areas of Uganda (290). A person meaning from narratives found in a story through the “mental representations” or “scripts” that have been stored about a particular emotion, experience, or societal and cultural marker of the past and is brought back into existence when the audience member hears, sees or reads a narrative that relates them back to that specific “mental representation” (301). A person’s culture, race, gender, tribe and social experience will determine how they interpret a narrative (Polichak & Gerrig, 2002, 80). As a result, through the use of narrative, language is understood as a “...privileged medium in which we ‘make sense’ of things in which meaning is produced and exchanged...Representation through language is therefore central to the processes by which meaning is produced” (Hall, 1997, 1).

Discourse analysis is “concerned with talk and texts as social practice [as well as] with the rhetorical or argumentative organization of talk and texts” (Potter & Wetherell, 1994, 228). It focuses on “what is said or done in the text, a text’s subject matter, and on how something is said[,] that is the total of the language mechanisms and strategies that operate in discourse” (Georgakopoulou & Goutsos, 1997, 8). Discourse Analysis is ambiguous as it could either work as a methodology or theory or as both and has multitudes of different disciplines that echo the same thoughts such as Critical Discourse Analysis which we shall discuss later. Discourse analysis is principally the *who-doing-what* because it studies the language in use as a social practice and the functions it carries out in identifying, communicating and creating identities in the social reality or context that it is situated in. As a result, Gee (1999) finds that there are seven

building tasks that are needed to understand the importance of language in use and they are as follows: significance of the language; the activities that take place in the dialogue; the identities created in the language; the relationships signified; the politics or perspectives (distribution of the social goods) of the language in use; the connections inherent in the dialogue and lastly the sign systems and knowledge of what is being spoken about (11-13).

With each building task there is a question that Gee formulizes to help in identifying a specific building task in the language used. The seven building tasks will be of guidance when analyzing the narrative of *RP256*, and the questions are:

1) **How** is this piece of language being used to make certain things significant or not and in what ways?

2) **What** activity or activities is this piece of language being used to enact (i.e., get others to recognize as going on)?

3) **What** identity or identities is this piece of language being used to enact (i.e. get others to recognize as operative)?

4) **What** sort of relationship or relationships is this piece of language seeking to enact with others (present or not)?

5) **What** perspective on social goods is this piece of language communicating (i.e. what is being communicated as to what is taken to be “normal”, “right”, “good”, “correct”, “proper”, “appropriate”, “valuable”, “the ways things are”, “the way things ought to be”, “high status or low status”, “like me or not like me”, and so forth)?

6) **How** does this piece of language connect or disconnect things; how does it make one thing relevant or irrelevant to another?

7) **How** does this piece of language privilege, or disprivilege specific sign systems (e.g. Spanish vs. English, technical vs. everyday language, words vs. images, words vs. equations) or different ways of knowing and believing or claims to knowledge and belief? (11-13).

Gee differentiates “discourse” and “Discourse”, he recognizes the difference between the two and finds that “Discourse”(with a capital D) in language is always the addition of the “other stuff” meaning the “action, interactions, values, beliefs, symbols, objects, tools, and places together in such a way that others recognize you as a particular type of who (identity) engaged in a particular type of what (activity), here- and – now, then you have pulled off a Discourse” (27). Whereas “discourse” (with lowercase d) is just the language in use found in stories, and conversations (26). To distinguish the two is important because it enables one to understand the relations and effects language has when used and the underlying meanings found in a particular utterance. In order for Discourse to take place there are three components that are involved in analyzing the meaning of the language in use and these are; the situated meaning, the context and cultural model. A situated meaning is when a particular word or groups of words takes on a new meaning when used in a particular context (57). The context refers to an array of factors that come with the language in use such as the seven building tasks (57). Lastly, the cultural model of the story line explains the relationship of the situated meaning and the context of the narrative. For this reason Gee’s Discourse analysis method will be used to analyze the dialogue and language used in *RP256* at the micro level. While Fairclough’s Critical Discourse analysis will be used to add onto Gee’s methodology.

Critical Discourse Analysis (CDA) defines language as a construct of experiences that involve institutions such as the family, educational and religious places of worship; hence a person or groups of people may identify themselves within the struggles and conflicts taking

place in society overall (Wodak, 2001, 2). CDA examines texts, that are either spoken or written, and the prominent concepts found in CDA are power, history and ideology (2). CDA views language conventions as diverse however composed with power struggles (Fairclough, 1989, 22). Language is a social practice that goes through a process before it becomes a textual product of society (24). Fairclough argues that a text is produced into a product or resource through the social interpretation and production of the people that engage in this Discourse. The social relations found in the Discourse matter since they articulate language as “ a site of and a stake in class struggle and those who exercise power through language must constantly be involved in struggle with others to defend (or lose) their position” (35). Fairclough’s CDA will examine the power struggles in the narrative of *RP256* that is the ideology that articulates and naturalizes HIV/AIDS and PLHA in the drama (84). Naturalization to Fairclough is when:

A discourse type so dominates an institution that dominated types are more or less entirely suppressed or contained, then it will cease to be seen as arbitrary (in the sense of being one among several possible ways of ‘seeing’ things) and will come to be seen as natural, and legitimate because it is simply the way of conditioning oneself (91).

Naturalization is the process of an ideological truth that is socialized and practiced by people that it becomes the appropriated truth and status quo, and it is only when the ideological truth is challenged that the social practice is halted. Naturalization takes place in various forms such as aural and written form. Therefore using CDA, *RP256*’s narrative Discourse will be examined in three different ways; text description, interpretation and explanation.

Text description is the element that speaks to the “formal properties of a text”, whilst the interpretation is the element that speaks to the “relationship between the text and interaction” and explanation is the element that speaks to the “relationship between interaction and social

context” (26). For instance the text description of *RP256* will focus on the scripts and sound bite of the drama, the interpretation will study the scripts, sound bite and how the researcher interprets and perceives the narrative discourse in *RP256*. Lastly the explanation will relate to Ugandan society and how the societal and cultural markers of HIV/AIDS and PLHA are produced and reinforced into the social order.

Three values need to be analyzed in discourse in order to situate the ideologies and power struggles within a society. These values are (a) experimental, (b) relational, and (c) expressive (112).

Diagram of Formal Features: experimental, relational and expressive values

Dimensions of meaning	Values of Features	Structural Effects
Contents	Experimental	Knowledge/beliefs
Relations	Relational	Social Relations
Subjects	Expressive	Social identities

An Experimental value “is a trace of and a cue to the way in which the text producer’s experience of the natural or social world is represented” while relational value is “a trace of and cue to the social relationships which are enacted via the text in the discourse” and expressive value is “a trace of and a cue to the producer’s evaluation (in the widest sense) of the bit of the reality it relates to” (112). This is vital in the analysis of *RP256* Discourse because with every scene, setting, and character there will be experimental, relational and expressive features that will analyze the ideology of HIV/AIDS and PLHA, their portrayal in the drama at the macro level.

Narrative Discourse is an important element in an E-E it acts as a means of escapism for the audience member, and allows them to reflect on their lives and surrounding environment as well as to distinguish behaviors that are negative and positive in the narrative and compare it with their own lived experience (Hutto, 2007, 2). *RP256* is fiction and therefore it is socially constructed and geared to have “artistic purpose and internal connectedness” among its audience viewers (Lamaraque, 2007, 130). Its narration plays an important role in the message it conveys about HIV/AIDS and PLHA since “a narrative is an artefact, wherein the maker seeks to make manifest his or her communicative intentions. When the audience grasp those intentions, they have a grip on what the events of the narrative are, and how they are related” (Currie, 2007, 18). The narrative of *RP256* is composed of “connected events” or story lines that allow characters, their behavior and attitudes to grow or to recede in order to receive the intended emotional response from the targeted audience (19). In order for the target audience to have the emotional response from *RP256* narrative Discourse that seeks to promote positive behavior and attitudinal change will depend on that target audience’s belief systems, moral principles, culture, tribe and social up-bringing (Zahavi, 2007, 181). Audiences will receive the message codes of *RP256* differently and there are three types of codes or positions that the audience lean towards; the dominant-hegemonic code, the negotiated code and the oppositional code (Hall, 1993, 514). The dominant-hegemonic position is where the audience member absorbs the message exactly the way the producers and writers produced it; it is termed as the “ideological reproduction” of the status quo (515). The negotiated position is where the audience member understands what is being communicated to him or her however they know that they have the choice to incorporate that message into their lifestyles or reject that message, in essence they are not restricted to any one position (516). Lastly, the oppositional code is where the audience member completely

rejects a message that is communicated and interprets the message through their own lens (517). Audiences interpret the three codes differently depending on their lived experiences and knowledge about particular issues and that is why “narratives are considered mental representations” (Koutsoubou, 2010, 229). All narratives are set to be interpreted differently by their intended target audiences, so “...the story of any individual life is not only interwoven with the stories of others (parents, siblings, friends etc.) it is also embedded in a longer historical and communal meaning-giving structure” (181). This means that the ideological struggles inherent in a narrative or Discourse are attributed to the author of the text or narrative, those represented in the text and lastly those that are tuning in to hear the narrative in the case of *RP256* (Whooley, 2006, 299). Narratives are rooted in the social and cultural aspects of a society and therefore when produced by a media channel and further reproduced into society by the audience of that media channel, the process of naturalization occurs depending on the meaning found in the text (Bruner, 1986, 12).

RP256 is an interpretation of the lived experiences of PLHA and HIV/AIDS in rural areas of Uganda, thus Gee’s Discourse analysis method and Fairclough’s Critical Discourse analysis will be able to study the Discourse of HIV/AIDS and PLHA present in the drama.

Data Collection and tools of inquiry

Three quarters of *RP256* were analyzed, there were thirty seven episodes in total however the data of this research was obtained from quarter 1 that had 8 episodes and 11 scenes containing narrative Discourse on HIV/AIDS and PLHA; Quarter 2 had 8 episodes and 13 scenes; and Quarter 3 had 5 episodes and 7 scenes. Scripts of the episodes can be found in Appendix 1.

Only episodes, scenes and characters that participated in narrative Discourse about HIV/AIDS, either with or about PLHA, their extended family or in community settings were considered and analyzed.

Synopsis of RP256

RP256 is based on a rural community in Uganda where most of its livelihood is centered around farming and fishing activities. Rock Point has social, economic, cultural and medical dilemmas that affect the society at a micro and macro level. The characters interact with one another in private and public settings, the private settings are usually their homes and the public areas and they are as follows : the Rock Point Bar, is a hub for most of the adult males in Rock Point, Topi's Salon, a hub for older married women, Foundation High School is where the youth of Rock Point go to school, Rock Point Club where youth entertain themselves, the Football Pitch where young males go to play football, the hospital and Health Centre is where Rock Point citizens seek medical assistance.

The narrative centers around five families and the supporting characters. The first family is that of Solomon and Nana, who are the moguls of Rock Point and own various businesses within the community. They have three children and are taking care of an orphan Lillian from the North of Uganda whose parents died in the war but knew Solomon. Solomon is Lillian's guardian, Solomon also has another son with his first wife who passed away, and his name is Matata (reasons for Solomon's first wife's death are not elaborated upon in the 3 quarters). The second family is Monday and Judith who have two children; Robert and Rebecca. Monday is a mechanic at the Rock Point garage while Judith is a teacher and School counselor at Foundation High School. Monday also has a second wife Mille. The third family is that of Don Guma,

Nana's cousin who is a radio DJ from Kampala but has come back to settle in Rock Point to start up a Radio Station. He is married to Amelia and has two children. The fourth family is Lisa and Debra. Lisa is unemployed and married to a teacher but he is never mentioned in the three quarters that were analyzed. Their daughter Debra has HIV/AIDS and works as a health counselor at the Health Centre. The fifth family is Steve, Steve's mother and Betty. Steve's mother is a widow who has HIV/AIDS, she is unemployed and Steve is the breadwinner of the family and provides for the family as a fisherman, a trade he learned from his father who passed away. Steve also has a "sugar mummy" Stella who provides for him financially. The supporting characters that interact with the 5 families are Sister Aisha a nurse or doctor at the Health Centre (her medical title is not indicated), Pastor Paul the religious figure of Rock Point, Petero and Jackson squatters on Guma's farm, Alphonso, Guma's right hand man, Afande, the Police Officer, Remy the town Lawyer and teacher Mark and the Headmaster who are Judith's colleagues at Foundation High. Akonyo, Vicky and Flower are students that attend Foundation High School. And lastly Steve's fishing buddy of John.

The characters and scenes that will be examined in this study will be based on the narrative discourse that involves PLHA, issues pertaining to AIDS, HIV+, STIs or STDs, condoms and sex. The tables of Quarter 1-3 detailing the, episodes, scenes and characters that will be studied can be found in **Appendix 2**.

The primary data of this research, were the transcripts and audio of *RP256* episodes, that were easily accessible online from the YEAH website and as well as on the Health Communication Program (HCP) online website (online addresses can be found in the references). Both of these sources played an instrumental role in collecting all the necessary data for this research. The scripts of *RP256* had already been transcribed in English. It is important to

note that only the English version of *RP256* was transcribed and available in audio-visual material and all the other local languages were not. This could be attributed to the fact that English is the first mode of communication in Uganda for educational purposes (Hasaba & Grant, 2010, 4). Also the audio for episodes 1-26 were available online however 11 episodes of quarter 3 were unavailable.

Collecting the data online was advantageous because, I did not have to travel back and forth from Canada to Uganda to obtain access to the bulk of information as a result this saved on time and eliminated any financial constraints.

Online documents in the form of scripts and audio-visual are advantageous as they “represent data [that is] thoughtful” and gives the researcher all the available information needed (Creswell, 2009, 180). Since the scripts were easily accessible online this also helped in saving time and expense costs of transcribing (180). With documents and audio visual material collected online the researcher has to make sure that the data is accurate and not outdated as well as ensuring that all the information is made available. This limitation was minimized because the data was collected on reliable stakeholders websites such as YEAH and HCP therefore this diminished the risk of analyzing misinformed data (180).

The Social Cognitive Theory and Stages of Model Theory embedded in *RP256*

RP256 episodes follow the design path of Modeling and Reinforcement to combat AIDS (MARCH), which was designed and created by The United States Centers for Disease Control and Prevention (CDC) (YEAH, 2012). In this type of approach MARCH follows the Sabido methodology design whereby there is an incorporation of the Social Cognitive theory (SCT) of

Bandura and the Stages-of-Change model, both are a strategic way to incorporate the messages of HIV/AIDS into an E-E (Barker, 2005, 128).

The practice of E-E dramas became popular in the 1990s and these dramas were used extensively by health communicators in their work on particular diseases (Kincaid, 2002,136). The theory of drama model is articulated with six elements: (1) the plot or action that makes up the blueprint of the drama; (2) the thoughts or ideas in the message of the drama; (3) the verbal expression and language used; (4) the music or song in drama that is attention grabbing and (5) the characters used to relate to the audience; and (6) the spectacle of the drama (137: Labov & Waletzky, 1967). These six elements of drama must engage the audiences, because of the spellbinding plot that allows the target audience members to identify with the characters in the drama. For that reason, dramatic stories are meant to be a reflection of the audiences' lived experiences or have a relation to societal and cultural problems the audience can easily identify with (150).

Albert Bandura's SCT shows how the content of *RP256* increases the target audience's cognitive awareness about the HIV/AIDS pandemic. According to Bandura (2004), E-Es use social settings such as people, places, and cultural or societal markers that enable audience members to relate to the lived experiences that are represented in a drama such as *RP256*. In this model the community and individual values' and belief systems play a vital role in motivating behavioral change (80).

SCT can be defined simply as a theory based on understanding and learning how humans interact and behave in their immediate surroundings (McAlister et al, 2008, 170). SCT emphasizes how human beings relate, react, perceive and articulate meaning with each other and with their immediate environment (170). "SCT seeks to provide a comprehensive understanding

of both why and how people change individual health behavior and the social and physical environments that influence them” (McAlister et al, 2008, 185). SCT is also “[a theory that] provides an agentic conceptual framework within which to analyze the determinants and psychosocial mechanisms through which symbolic communication promotes personal and social changes” (Bandura, 2004, 76). The two ways in which change occurs is through a direct pathway such as using a media channel to influence, and inform people whilst the other way is through socially mediated ways such as local networks in the community and society, the latter is more effective in informing and enabling change to take place (76). People learn from their experiences and the experiences of others that is social modelling and in order for change of behavior and attitude to occur in a person or community a modelling process takes place (78). This is where “instructive, motivational, social prompting and social constructions...” are formulated in a model to emulate “knowledge, values, cognitive skills, and new styles of behavior. [The] observers also acquire emotional proclivities toward people, places, and objects through modeled emotional experiences” (78). The modelling process of change through the media channel or social network is secondary to a person’s change in behavior, the primary factor in enabling change is one’s own ability to want to change, that ability that drives and exercises change is self-efficacy (78). A person’s self-efficacy is tailored to four aspects that is their mastery of life experiences, the amount of social persuasion they adhere to, the social modeling and lastly their physical and emotional state of mind (79). Self-efficacy beliefs are then strengthened by the collective efficacy of the immediate environment that is the belief system of the social network a person may relate to and interact with for instance education and religious institutions, or immediate and extended family members (80). Collective efficacy of a shared group has the power to solve a lot of societal and health problems that people face such as

violence against women, HIV/AIDS, fistula, cholera, rape, and gender inequity. The type of efficacy whether self or collective impacts a person's goals and aspirations, the way they observe their strengths and weaknesses, their expected outcome of goals and the projection of their lives in the future and lastly the received outcome, that is how they will be treated by others (81).

RP256 using SCT identifies and defines HIV/AIDS and this is pertinent to how the audience relate to or is educated on safe sex practices, abstinence, HIV/AIDS prevention and antiretroviral drugs, knowing and understanding this information will in turn affect the behavior and attitude changes of the targeted audience (Finnegan & Viswanath, 2008, 366). As a result when one uses SCT there are four measures that are considered; firstly the sender who writes and produces the serial; secondly the content of the message diffused; thirdly the channels used to communicate the message which could range from using radio, and television; and lastly measuring the results of the impact of the message effects on the audience (364).

The process of implementing SCT into an E-E drama such as *RP256* is facilitated by the use of five elements. The first is differential modeling, this is where three types of modeling influences are created in the characters of the serial, and they; are the positive, negative and transitional models (Bandura, 2004, 82). The positive models or characters exhibit good examples and inspirational lifestyles that result in rewards and negative models or characters exhibit dangerous, carefree lifestyles that result in punishment or death (83). Transitional models or characters exhibit stages of change through the experiences that result in them becoming a positive or negative model (83). The second element used is vicarious motivators and these are the rewards or punishments that the models receive from an expected outcome (84). The third is the "attentional" involvement such as sound effects. The fourth element is the symbolic coding that is the use of prologues or epilogues and lastly environment support this examines the

resources given to the production of the serial, as well as the promotion and advertising that is involved in its production (84). **Appendix 2** presents the modelling of the characters found in *RP256*.

The other model that is used in the production of *RP256* is the Stages- of- Change Model, this approach uses 5 Stages-of-Change that human beings go through they are; pre-contemplation, contemplation, preparation, action and maintenance (Sood et al, 2004, 124). The pre-contemplation stage is the stage where individuals are in denial or are unaware of the need to change their behavior to those that will be a benefit in the long term (124). Contemplation stage is where a person starts to realise that their present behavior and actions are a disadvantage for them in the long term and they begin to think about changing their ways (124). Preparation is the stage where the individual is certain and makes a “commitment” to work to change their present behavior (124). The action stage involves the individual incorporating the new learned behaviors and attitudes in their day to day activities and the last stage of maintenance is when the individual turns away from their old behaviors and takes up their new learned behaviors (214). It is at this point that the individual has to incorporate steps that will enable them to avoid relapsing (214). Overall *RP256* is developed on a moral framework and values grid where messages of the drama are based. Barker defines moral framework as “a document that summarizes the existing legal and policy framework underlying the topics to be addressed in the serial drama” (135).

A value grid is defined as “a compilation of positive and negative values that will be promoted (or negated) in the serial drama” (137). An example of this can be viewed in the **Appendix 2**, this value’s grid specifically was designed in 2004 for Sudan serial dramas but can be appropriated into any behavioral communication campaign such as *RP256* (137). The moral framework and values grid allow messages to have positive and negative values where a good

action leads to good consequences and a bad action leads to bad consequences. *RP256* uses the moral framework and values grid in order to have a projection of how the characters are to transition and what the audience is to take away from the serial (137).

Process of Data Analysis

In this study, the data was analyzed manually and there was no use of computer software. The primary sources of *RP256* audio and written transcripts found the stakeholder's websites YEAH and HCP were the sole documents used to guide the data analysis process. Specific societal and cultural markers were coded and analyzed to study how they represented PLHA and HIV/AIDS. Coding is a "process of organizing the material into chunks or segments of text in order to develop a general meaning of each segment" (Creswell, 2009, 227). The type of coding that is used to analyze the text is termed as theoretical coding it is defined as "the procedure for analyzing data which have been collected in order to develop a grounded theory" in this case theoretical coding will be used to analyze data that have been collected to observe the representation of PLHA and HIV/AIDS on *RP256* using discourse analysis (177). Coding is important to use because it helps "break down and understand a text and to attach and develop categories and put them into an order in the course of time" (178). Punch (1998) identifies coding as "the process of putting tags, names or labels and coding against pieces of data" (204). This is also termed as code notes and they "[are] produced for explaining and defining the content of codes and categories, and a multitude of memos which contain striking observations or the material and thoughts that are relevant to the development of the theory" (Flick, 2002, 180). Coding is breaking down text into specified portions in order to deduce any meaning from the gathered information of the study (Creswell, 2009, 186). The written and audio transcripts of

RP256 will act as a resource to identify the societal and cultural markers that acted as codes and that represented HIV/AIDS and PLHA. To achieve this goal, Gee provides a model of coding that fully fit with the segmentation of the scenes that will be analyzed in this study.

The segmentation of *RP256*'s episodes and scenes will follow Gee's 7 building tasks; significance of the scene, the activities taking place in the scene, the identities of characters in the scene, the relations or relationships of the Discourse, the politics or perspective of the Discourse, the connections the Discourse engages with the text reader and lastly, the sign systems and knowledge the Discourse communicates to the text reader (1999, 11-13). In each episode and scene there will be specific language used that will focus on the social and cultural markers to understand how the Discourse produced within *RP256* reproduces and represents the societal ideology of PLHA and HIV/AIDS. Fairclough's experiential, expressive and relational values will further analyze the overarching meaning of the language used.

Table 1 illustrates the societal and cultural markers in the episodes and scenes while Table 2 and figure 3 illustrate the frequency of the societal and cultural markers used by the characters in the episodes, respectively. All tables and figures can be found in **Appendix 2 and 3** respectively.

The validity of the analysis depends on the convergence, agreement, coverage, and linguistic detail embedded in *RP256* Discourse (Gee, 1999, 113-114). Convergence is when "the analysis of the study offers compatible and convincing answers to many or all of the findings" (113). Whereas agreement is when the various "Discourses in the data agree that the analysis reflects how such school languages actually function in such settings" (113). Coverage is when the analysis and data fully support all the findings of the study; and when the linguistic details is when the linguistic structure is accurately explored and examined in the "grammatical devices"

(114). As a result, convergence and linguistic details is the key for a discourse analysis to remain valid, both these factors have to be carried out at great length and thoroughly examined to ensure trustworthiness.

Role of the Researcher

As a Ugandan my national origin plays a vital role in this study as well as my educational interests. That is to say, the use of societal and cultural markers has been part of my socialization growing up in Uganda in reference to the message of HIV/AIDS, STIs/STDs, condom use, and abstinence. In conducting this study I wanted to understand and examine the way language is used in reference to HIV/AIDS and PLHA in Uganda and the meaning of this language at the micro and macro level in Ugandan society. That is my educational interest in Communication and media and identity increase my desires to want to know more about how Uganda and Ugandans communicate and relate to the topic of HIV/AIDS and AIDS, a disease that has been present in the country since the 1980s (Kisekka Nakaterregga, 1990, 35).

RP256, is a constructed narrative of life in rural areas in Uganda, it sets itself out to be the mouth piece of providing stability and reinforces Ugandan ideals and national identity (YEAH 2012). Rock Point stands for the rocky landscape of the country that identifies Rock Point as the drama that provides stable reliable and information (YEAH, 2012). 256 stands for the international area code of the country, hence *RP256* is the stable and reliable information that represents the national identity of Uganda. Therefore studying the aural and written scripts of *RP256*'s representation of HIV/AIDS and PLHA will work to identify societal and cultural markers that are used to label HIV/AIDS and PLHA. It will also work to identify the ideological beliefs in Uganda about HIV/AIDS and PLHA. The use of Gee's seven building tasks will be

resourceful as “ a discourse analysis is more trustworthy the more the answer to the question asked about the building tasks of language converge in the way they support the analysis, or the more the analysis offers compatible and convincing answers to many or all of them” (Wheeler, 2010, 45). In using Fairclough’s experiential, relational and expressive values, I will demonstrate the impact the language used in *RP256* Discourse not only informs views of sexual and health matters but also carries with it “ideological truths” falsehoods about PLHA and HIV/AIDS.

Chapter 4: Findings and Discussion

Question 1: What are the cultural and societal markers that are used in *RP256* narrative to represent the life and experiences of PLHA and HIV/AIDS?

The Discourse of PLHA and HIV/AIDS is situated within the interactions of particular characters and their immediate surroundings. The findings have been grouped into the following categories:

The first category analyzes the Discourse of Steven, Betty and Steven's mother who is a PLHA, Steven is one of the transitional characters in *RP256* that goes through changes from the experiences he faces at home, with his peers and sexual relationships. The first category will include four sub- categories: Steven and his mother, Steven and peers; Matata, Vicky and Rebecca. As well as Steven and his relationships with Stella, Vicky and Rebecca and lastly, Steven and the adults in his life such as Coach Tito, the doctor, Sister Aisha, Pastor Paul, and Traditional Healer.

The second category will focus on Debra the second PLHA in Rock Point, her mother Lisa and Judith, and the way they relate to one another in dialogue about sexual and health issues. The third category will examine the interactions amongst Rock Point youth; Rebecca, Akonyo, Flower and Lillian. The last category will study the communications among the women of Rock Point; Topi, Nana, Lisa and Judith.

The meanings produced about PLHA and HIV/AIDS will be examined at the micro level with Gee's Discourse analysis as well as using the theoretical framework guiding this study Cultural Studies. Using Gee's Discourse Analysis the selected episodes and scenes that contained Discourse about HIV/AIDS and PLHA in *RP256* were examined using the seven

building tasks: significance, activities, identities, relationships, politics or perspectives, connections, sign systems and knowledge. Gee's building tasks will help draw out the cultural and societal markers of HIV/AIDS and PLHA present in *RP256* in order to understand the context and situated meanings of the Discourse. (See the scripts in Appendix 1)

Category 1 (A): Steve, Steve's mother and Betty (Episode 1, Scene 2)

The significance of the Discourse in this context is that it takes place in Steve's home in the village between Steve and his mother. Steve is a 19-year-old who is attending his last year at Foundation High School. Steve has been the breadwinner of the family since his father died as his mother is unable to provide financially for the family. The audience is not given any indication of the cause of Steve's father's death nor his mother's illness but there is a lot of foreboding in the scene about HIV/AIDS symptoms.

This Discourse spoken by Steve's mother signifies that she is facing a disease that killed her husband and she is worried about her children especially Steve who goes to school and works as a fisherman to care for the family. Steve's mother uses the words "tired", "dizzy", "bothered", "illness" to explain her health condition. The words used by Steve's mother differ in meaning depending on the context in which they are applied (Gee, 1999, 53). Steve's mother has HIV/AIDS but is unable to express that openly with her children and so she prefers to indicate her symptoms through the use of words like "tired", "dizzy", "bothered" and "illness". Steve's mother is never referred to by her own names but rather in reference to Steve, this is a cultural norm in Uganda whereby a mother is referred to as her first born's name. In this particular instance Mama Steve can be translated in to English to Steven's mother. However, there is also

an underlying meaning as to why Steve's mother's name is unknown - her namelessness represents the plight of many PLHA in rural areas and she speaks to these individuals by signifying their dilemma. Steve's mother is represented as an individual living in poverty and unable to care for her children or herself. The activities in this Discourse that illustrate the poverty in which Steve's family lives in is illustrated when Steve's mother, in line 20, says, "Oh, thank you dear. It is just not right. You're only 19 and already supporting a family. You father's death and my (SLIGHT PAUSE) illness have..."

In this scene, the Discourse represents Steve's mother social identity as a poor, and this "illness" that is indirectly spoken about is the cause and consequence of her poverty. This social Discourse of Steve's identity represents him as a young, hardworking boy who juggles school, work and caring for his family. The social relationship present in the scene is that of a family that is striving to survive in Rock Point. (See line 21, episode 1, scene 2.)

The politics and connection of the interaction draws a correlation between the fishing community and poverty. The sign systems and knowledge that are present in this scene link Steve's mother's illness to her husband's passing, and lead us to understand that the disease Steve's mother has led to her husband's death. We also observe a culture of silence in this scene whereby the disease that killed Steve's father is not talked about, yet this is known to both Steve and Steve's mother privately. The use of societal and cultural markers such as "tired", and "illness" are indications that someone has HIV/AIDS and in this context used as a situated meaning to signify Steve's mother as a PLHA.

Episode 5 Scene 7

The significance of this scene is that Steve's mother acknowledges to Steve she is "sick" (line 24 of episode 5 scene 7). In this Discourse Steve's mother chooses to use to speak about her HIV/AIDS status using the cultural marker "sickness". The audience does not know what she suffers from but based on the language used, her "sickness" is terminal as she warns Steve she will not "live long enough". Steve also speaks indirectly about his mother's "sickness" by wanting to take her to the hospital. The hospital is another cultural marker that connotes the urgency of Steve's mother's "sickness" to be treated by a medical doctor.

The action that is taking place in this scene shows Steve's mother addressing her "sickness" to her son in a private conversation, where she is counselling Steve to make the right choice with the women he has relationships with. (See line 26)

The social identity represented by Steve's mother is that of a widow whose husband died unexpectedly. She does not disclose what her husband died of and so a culture of silence persists whereby she does not tell her children the truth that her husband died of HIV/AIDS, or that she has HIV/AIDS, out of shame and fear of the reaction from her children and the community. Steve is represented as a womanizer who may fall "sick" if he continues to "run around with women" in the village. There are three relationships that are singled out in this scene; the relationship between Steve and his mother, and Steve and Stella (a woman who used to be Steve's mother's friend as well as Steve's Father's associate and mistress). Stella's relationship with Steve's father is revealed to the audience member when the mother warns Steve about Stella: "she might soon start showing sickness like me if I know her well enough. Look after yourself." (See line 32)

The death of Steve's father represents a 'womanizer' who contracted HIV/AIDS (e.g., he infected both his wife and mistress Stella). The social perspective of this scene illustrates the fact that HIV/AIDS, in the language used, is not a medical concept, but rather cultural marker linked to deceases: i.e., "hospital" and "sickness"... The audience member understands the context of the meaning of the "sickness" that Steve's mother is referring to because this is a "sickness" that kills those who have it. Another perspective is that fishermen from rural areas are philanderers and are prone to contracting HIV/AIDS, so Steve is prone to contracting HIV/AIDS just as it is assumed that his father did. The Discourse connects Steve's father to having had HIV/AIDS, and as a result Steve's mother and Stella also have the "sickness". Through the use of the cultural markers Steve's mother is trying to warn Steve about the "sickness" and death that comes with HIV/AIDS as she mentions to Steve in line 26: "Your father died unexpectedly, remember?" The sign systems and knowledge are the societal and cultural markers of HIV/AIDS in this scene, which are: "hospital", "sickness" and "death".

Episode 8 Scene 6 (a)

The significance of this scene outlines Steve's mother's health condition. We observe Betty, and Steve's dialogue about their mother's deteriorating health. Steve's mother's "sickness" has worsened and she has no medication and no type of transport to get her to the Health Centre, where she can receive medical attention. The activity of the language used in this Discourse draws the audience to the pain and worry Steve and Betty feel about their mother's situation. The identity represented by Steve's mother is that of a poor widow while the identity represented by Steve is that of a bread winner and family patriarch as observed in line 20 of the episode.

The young take care of the elderly if the elderly are PLHA. The relationship in this Discourse revolves around Steve as the man of the household, and his authority over Betty and his mother. For instance, Steve has the responsibility in buying his mother's medication and this is observed when he asks his mother (lines 14), "When did your medicine get finished?"

The politics of the Discourse articulates the poverty most families face when both parents have HIV/AIDS or have died as a result of HIV/AIDS. The fact that Steve's mother has no medication and does not tell Steve who is currently providing for the family shows the imbalance of responsibility children are faced with when a parent has HIV/AIDS. The language used in this scene speaks to the impact HIV/AIDS has on people as words such as "medicine", "medication" and "Health Centre" are used in the context of articulating HIV/AIDS that is they are societal and cultural markers that are used to speak to a person's health condition. Steve's mother has been taking medication for her "sickness" and if this "medication/ medicine" is not taken then Steve's mother's condition worsens to the point where the "Health Centre" is the last resort. The sign systems and knowledge in this scene show that Steve's mother has HIV/AIDS and is described as "weak" and in "pain" these are also cultural markers of signifying the symptoms of HIV/AIDS. Steve's mother needs medication, and medical treatment from the Health Centre, yet her HIV/AIDS status is not disclosed to her children, or the audience, reinforcing a culture of silence.

Episode 9 scene 6

The context of the scene takes place when Steve's mother has returned from the Health Centre and is at home and the significance of the Discourse of this scene is that this is the first

time the word AIDS is used in the private conversations between Steve, Steve's mother and Betty.

In line 13, Betty is the first to speak boldly about AIDS in the home setting, when she inquires about her mother's health because the community, namely her friends, seem to know about their mother having HIV/AIDS and Betty does not know what to believe since her mother's illness is not a matter that is discussed in the home. Their mother ignores Betty's inquires, silences her and changes the subject in lines 14 demonstrating that HIV/AIDS is not a subject broached by many parents in rural areas of Uganda.

The activities taking place in this scene include Betty's understanding that her mother is not well, seeking confirmation from her mother, whilst her mother and Steve ignore the topic and discuss school matters instead. Betty represents the innocent yet modern child who wants to openly discuss matters such as AIDS, whereas her mother and Steve represent the traditional way of life in Uganda where issues of sex and HIV/AIDS are not discussed in the family home but rather in the public institutions such as schools and health centres or hospitals. The relationship in this scene is that of a mother who adheres to tradition and does not discuss sexual health matters choosing instead to focus on educational matters with her children, lines 14- 18. The perspective demonstrates that there is stigma associated with HIV/AIDS in Uganda whereby having AIDS is viewed as something negative because Betty's school friends were gossiping about her mother's health condition and their mother does not answer Betty for fear of shame and guilt that is associated with AIDS. The Discourse connects AIDS to the overall society that is AIDS may not be discussed in the home however it is discussed among peers at school. The signs and knowledge present are the societal and cultural markers that Betty uses to refer to her mother: "pain", "sick", and "AIDS". "AIDS" is used as a medical term whereas "pain" and

“sick” are the Ugandan societal and cultural markers that connote symptoms of someone having HIV/AIDS in this context.

Episode 19 Scene 2

Steve and Steve’s mother are home alone and are discussing Steve’s personal life and relationships. His mother is questioning and giving him counsel. The Discourse is significant because this is the first time Steve’s mother proactively advises Steve on his sexual relations with the women in the village especially Stella. Steve’s mother advises Steve traditionally without mentioning sex and HIV/AIDS but uses societal and cultural markers to get her message across. For instance, instead of sex, Steve’s mother uses the terms “playing with girls”, “relating” and refers to HIV/AIDS as to “fall sick” in lines 12-35.

The action that is taking place in this scene shows Steve’s mother advising him to recognize the dangers of having multiple sexual partners. Steve’s mother represents wisdom and old traditions when she gives counsel to her son to avoid making the same mistake and getting “sick”. At the same time, she illustrates old cultural practices of advising a child in an indirect manner. Steve is represented as a womanizer. The relationship in this context is that of a rural traditional mother trying to raise a son in modern times. For instance Steve’s mother tells him: *to be careful while relating with her [Stella]* and Steve replies, “Oh mother there is nothing wrong in using that magic word”, the magic word meaning sex (line 32).

The politics of the Discourse presents the differences in rural versus urban and traditional versus modern, Steve’s mother is rural and traditional whereas her children who are influenced by peers and are urban and modern in terms of how they relate and articulate themselves. The scene makes the connection with Ugandan parents advising their children about

sexual health matters in order to avoid “falling sick”. The sign systems and knowledge are the societal and cultural markers of HIV/AIDS: “sick”, as well as the societal and cultural markers of sexual behaviour: “playing” and “relating”.

Episode 32 Scene 1

This scene is significant because this is the first time in the Discourse that Steve’s mother tells her children directly that she has AIDS, the scene takes place when Betty, Steve and their mother are at home. Steve’s mother starts to hallucinate and they prepare to take her to the Health Centre, however their mother repeats that she is going to die and finally tells her children the truth in lines 17-33. In the narrative Steve’s mother confirms that she has AIDS and reveals that Steve’s father was not the only one who was unfaithful in the marriage, she too had an affair which resulted with Betty and Steve having different fathers and may have contracted AIDS from the affair (lines 33). The activities in the scene involve Steve’s mother predicting that she is dying multiple times while Steve and Betty try to rush her to the Health Centre. Steve’s mother is identified as an adulteress is identified as a PLHA. This implies a general belief that all PLHA are promiscuous. The relationship this Discourse seeks to enact is that most PLHA do not disclose of their status or tell the truth about them having HIV/AIDS for fear of rejection. Steve’s mother only told her children she had AIDS because she thought she was dying and would not be around to face the stigma of shame and guilt. The politics communicates AIDS as a disease that often kills parents and leaves children orphans, a fate which is the status quo of village and rural life. The connections of this Discourse is that AIDS is used as a medical term and marker in order to educate the audience members about it for instance Steve’s mother tells her children that

AIDS is a disease that kills and “wiped out villages” (lines 31). The Discourse also connects Ugandan rural or village areas as being adulterous.

The sign systems and knowledge illustrate AIDS as a disease that kills, as Steve’s mother mentions dying or how she is going to die five times in the scene. Steve understands AIDS as a disease that makes one suffer as he says: “Mama you don’t deserve to suffer like this” (lines 32). “AIDS”, “disease”, “die/dying”, “Health Centre” are words whose situated meanings are understood as societal and cultural markers of HIV/AIDS. “AIDS” is the medical term that classifies the disease but is a cultural marker in terms of it being naturalized in society, while “disease” and “die/dying” are results of having HIV/AIDS and the “Health Centre” is a place PLHA go to for aid and assistance.

Episode 32 scene 3

En route on taking Steve’s mother to the Health Centre, Steve and John have a significant dialogue that sheds light on what people in rural areas think of HIV/AIDS in lines 64-70. The significance of this scene examines the stigma and fear associated with HIV/AIDS as John is scared to wipe the sweat from Steve’s mother because he believes it is “dangerous” since she is “sick” and he may also “fall sick” however Steve assures him that it is “safe” to do so. Due to a lack of knowledge about AIDS and how it is transmitted, John fears that wiping Steve’s mother’s sweat is a form of AIDS transmission. However Steve reassures him that it is not the case and it is “safe” to touch her or wipe her sweat. This dialogue demonstrates the ignorance prevalent in rural areas and villages in Uganda among people who are illiterate and are not educated enough on HIV/AIDS. The activity indicates the fear associated with PLHA and HIV/AIDS. John

represents the ignorant villager who knows very little of AIDS, as well as the rural Ugandan mentality and the social stigma PLHA go through as they are perceived as “dangerous” and a threat. Steve represents an authority figure on AIDS as he assures his friend that people do not get infected with AIDS by wiping away sweat, Steve uses his learned experience to educate John on AIDS. Steve’s family represents poverty since they use foot transportation to get to the Health Centre. The relationships present demonstrate literacy and educational levels. Steve is literate and educated about AIDS through learned experience but John is illiterate, and may have forgone school to become a fisherman. The politics in the language used examines the poverty and the social stigma PLHA face in rural areas and connects people in rural areas such as the fishing and farming community in *RP256* as lacking knowledge about HIV/AIDS and other sexual health matters. The sign systems and knowledge present are the use of societal and cultural markers John and Steve use to talk about HIV/AIDS without articulating the medical term HIV/AIDS, John uses “dangerous” to describe touching a PLHA (lines 65), both John and Steve use “sick” to reference AIDS, and lastly Steve uses “safe” to acknowledge that John will not be infected by merely touching his mother’s sweat. Other societal and cultural markers used to describe the agony of AIDS are “pain” and “die”. The “health centre” is used to signify a place where there is hope for the AIDS patient to improve and get assistance.

Episode 37 Scene 7

The context of this scene is that Steve’s mother has been released from the Health Centre after her near death experience , she is back at home in the village with Steve, and Betty. The significance of the discourse in this scene is that both Steve and Betty are now aware of their mother having AIDS, yet in their interaction they still do not discuss AIDS openly only through

societal and cultural markers in lines 7-9. The family does not discuss the reason as to why Steve's mother is "weak" or needs to be fed by her children and the family goes about their lives as though their mother does not have AIDS. This shows that children and parents maintain a culture of silence when it comes to matters concerning sexual health and diseases such as AIDS. It is also in this scene (line 23) that Stella comes to Steve's home. Steve tells Stella: "Look, my mother is very sick and I have just brought her back from the hospital".

Steve still uses the cultural marker of "sick" and "hospital" to describe his mother's health status to Stella but does not disclose that his mother has AIDS, in fear that Stella will assume he has AIDS and their transactional relationship will come to an end. The activity taking place in the dialogue recognizes how the family is trying to avoid talking about their mother having AIDS and continuing with their day to day activities in denial. Steve's mother as a PLHA is represented as weak, and unable to care for herself, as well as in denial of having AIDS as she does not discuss the topic openly with her children to whom she had told of her status in Episode 32, Scene 1. Steve is represented as knowledgeable that his mother is a PLHA yet scared of disclosing it to others. The relationship present is Steve's relationship with Stella. Steve is still seeing Stella even after he was warned by his mother that she would soon start 'showing sickness like me' in Episode 5, Scene 7 (Line 32). Steve even tells Stella that his mother is "sick" but she ignores Steve's comments. The perspective is that there is a culture of silence present in Uganda whereby AIDS is not talked about openly however it is discussed through societal and cultural markers such as "sick", "weak" that allow for discussion of AIDS to remain unnamed but yet assumed. This Discourse makes the connection of a culture of silence when the family does not discuss their mothers' diagnosed condition with each other even after Steve's mother disclosed of it in Episode 32 scene 1 lines 29-31. The sign systems and knowledge in this Discourse is the

use of the cultural marker of AIDS used by Steve “weak”, “sick” that signify symptoms of HIV/AIDS and “hospital” that signifies the location where PLHA are treated.

Category 1 (B): Steve, Doctor, Sister Aisha and Betty
(Episode 32 Scene 8)

The context of the scene takes place when Steve’s mother is at the Health Centre, Steve is with the visiting Doctor who is treating their mother. The significance of the language used is that the Doctor is educating Steve on AIDS; he defines it, its symptoms and its medication in lines 99-119. This scene is significant because towards the end Steve has a brief dialogue with Pastor Paul and uses the learned knowledge from his talk with the Doctor to explain to Pastor Paul about his mother’s condition in lines 128-139. The scene illustrates how diseases such as HIV/AIDS are treated and discussed openly at medical or Health Centres yet in other public spaces HIV/AIDS is discussed using societal and cultural markers. It also shows religion playing a vital role as Pastor Paul is the first person Steve confides to about his mother having AIDS. The two activities taking place is that the visiting Doctor has medical authority over naming, explaining and prescribing HIV/AIDS to Steve, and Steve trusts the doctor that is why Steve asks the doctor all the questions about HIV/AIDS in order to be further educated in lines 106-119. Steve trusts the doctor’s knowledge and asks questions freely and openly in order to learn more about it. Steve’s understanding of AIDS allows him to openly discuss the matter with Pastor Paul. The identities represented in this scene are how doctors and medical practitioners have the knowledge to fully explain what AIDS is, how it is transmitted and its treatment. The Doctor does not use societal or cultural markers when telling Steve about his mother’s condition, rather he uses medical terms and information in the scene when explaining HIV/AIDS to Steve and the audience members. Steve represents the Ugandan youth who lack knowledge of AIDS and are in

need of this information. Steve's mother represents impoverished widows in Uganda living with HIV/AIDS as the doctor explains, "In fact, since your mother is a widow she can get AIDS treatment free of charge" (lines 115). Pastor Paul represents the reliance of Ugandans on religion as the pillar of wisdom and guidance for matters like AIDS.

The social relationship examined demonstrates Steve learning about his mother's condition alone from the doctor, since he is the oldest son and patriarch of the family. The Discourse connects the societal and cultural markers of "sick", "weak", and "pain" to the real symptoms of AIDS that the Doctor discusses. The doctor also connects the truth and facts about "AIDS", "HIV virus" and "Antiretroviral Therapy" while at the same dispelling myths about AIDS. This Discourse disconnects Steve's mothers' belief in episode 32, Scene 1 that she was going to die, as the Doctor tells Steve in lines 111, she will live.

The sign systems and knowledge are illustrated by the medical facts spoken about AIDS. The Doctor uses medical and factual terms: "AIDS", "pneumonia", "HIV virus", "HIV", "AIDS treatment", "Antiretroviral Therapy", "medicine", "ill", "widow" and "diseases". It should be noted that the context in which "pneumonia", "widow" "medicine", "ill" and diseases" is used varies with the situated meaning, that is to say the Doctor using these words as medical facts shows that the Doctor is trying to explain to Steve about his mother's condition. However "ill", "medicine", "diseases", "widow" and "pneumonia" can also be used as societal and cultural markers to describe HIV/AIDS because they do not directly identify AIDS but identify its associated symptoms and results.

Steve uses societal and cultural terms "sick", "weak", "tired" and "diseases" that identify symptoms of HIV/AIDS but do not directly articulate it. Steve has been socialized to use such societal and cultural markers.

Episode 33 Scene 2

Steve, Betty and Sister Aisha are at the Health Centre discussing Steve's mother's condition. The significance of this scene is that Betty is inquiring about her mother's illness and Sister Aisha educates her about AIDS in lines 164-173. Betty is receiving facts and information about HIV/AIDS that she otherwise may not have known or have found out at home or at school. She is receiving the information from a medical authority figure, Sister Aisha. However, Steve interjects this conversation stating that he does not want Betty to know too much as she is "too young". Steve is able to learn about HIV/AIDS from a doctor without interference in episode 32 scene 8, yet his sister cannot learn more from Sister Aisha because Steve, the male authority, interrupts them: "Sister Aisha, Betty has so many questions you won't..." (lines 172) and Sister Aisha ends her conversation with Betty by advising her that "Betty I will answer you as you keep coming back to visit your mother" (lines 173). Steve, however, is able to ask Sister Aisha more questions in lines 174-183.

The activities taking place in this Discourse illustrate Sister Aisha educating Betty about HIV/AIDS. For instance Sister Aisha tells Betty that, "Your mother is infected with HIV the virus that causes AIDS. This weakens her body and allows other diseases to infect her easily" (lines 165).

Sister Aisha represents a medical expert who has authority in educating Betty about HIV/AIDS as well as a female role model for Betty to gain wisdom from. Betty represents young girls in rural or village areas who are unaware of this information but are not afraid to ask questions. Sister Aisha also represents a religious female figure, that is to say "Sister" can be associated with religious missionary work or affiliated with a Church. Steve represents the traditional male figure that wants to observe a culture of silence on discussing sexual health

matters with youth as he interrupts Sister Aisha's talk with Betty because she had started to answer Betty's question "how mummy got it?" (line 169), "it" being AIDS and Sister Aisha replies: "there are many ways she could have; blood transfusion, unprotected sex" (line 171). Steve prefers Betty remaining ignorant on certain issues, and gender inequality persists in Uganda whereby the knowledge that a boy is allowed to have on certain matters is significantly different from that which a girl is able to have.

The relationship witnessed is that of Sister Aisha and Betty. As a girl Betty feels more comfortable talking and asking Sister Aisha questions about her mother being "sick" and Sister Aisha speaks openly, educating Betty on sex and sexual health matters that are normally silenced by religious institutions. The other relationship is Steve's authority that hinders the amount of knowledge Betty receives about their mother's condition and HIV/AIDS.

The scene connects medical specialists like the visiting doctor who talked to Steve in Episode 32 scene 8 and Sister Aisha as having authority and power to educate *RP256* characters and the audience about HIV/AIDS. Steve's mother, is a PLHA, she seldom speaks about her condition and does not educate her children about it therefore having HIV/AIDS still does not give her the authority to articulate it to others. This authority is given to the medical specialists. The sign systems and knowledge present in this scene are the societal and cultural markers of HIV/AIDS used by Betty: "sick", "flu", "die". The medical and factual terms used by Sister Aisha: "AIDS", "HIV virus", "infect", "diseases", "blood transfusion", "unprotected sex", "AIDS treatment", "Antiretroviral", "widow", "weak" and "tired". As noted earlier, some of the medical and factual terms used by Sister Aisha such as: "widow", "weak", "tired", "disease" could also be used as societal and cultural markers to describe AIDS since they do not directly identify AIDS but its symptoms and results.

Category 1 (C): Steve, Matata, Coach Tito and Traditional Healer

Episode 16, Scene 6

The context of this scene is significant as it demonstrates Steve's openness in discussing issues pertaining to HIV/AIDS with a male peer in a setting that is more relaxed such as the Rock Point Bar. Steven speaks freely about his sexual encounters and AIDS with Matata, his good friend. The significance of the Discourse is that Steve worries that he is "sick" after having unprotected sex with Vicky, a love interest from his high school (lines 10-16). Steve labels Vicky when he calls her "dangerous" and a "prostitute" due to the fact that she does not want to practice safe sex, lines 10 & 32. Steven goes on to tell Matata that, "I wonder what her motive is. I could get sick" line 16. In this context, Steve is referring to his fear of contracting HIV/AIDS from Vicky after having unsafe sex. Steven understands that risky sexual behaviour results in getting STDs or HIV/AIDS. Steven is educated enough to tell Matata that: "AIDS does not pick on age. That is why for me condoms are a must" line 22, Steve confides in Matata that : "I have seen people die of AIDS, people close to me" lines 20. This further shows that Steve knows of his mother's "sickness" but chooses to discuss this with Matata rather than his mother or his sister Betty. The activity taking place is that Steve is discussing his fears of getting "sick" from his sexual relationship with Vicky.

Steve is represented as a womanizer as he has two sexual relationships – one with Vicky, a high school student, and Stella, his 'sugar mummy'. His actions show a double standard in Uganda, whereby Steve is able to have more than one sexual relationship with a woman, yet labels Vicky a "prostitute" for not wanting to use protection and always wanting money or gifts. Steve does not think of himself as a philanderer or womanizer in the Discourse. In this narrative Matata represents a young adult who is carefree about life, does not practice safe sex and is very

ignorant of HIV/AIDS. This is observed when he states in line 19: “If a girl doesn’t ask for a condom like they always do then why bother? That means she is in her safe days”. Matata takes HIV/AIDS as a joke and believes he is immune to it.

The relationship between Steve and Matata shows one that is open since they talk freely about “AIDS”, “use of protection”, “sex”, “pregnancy” and “condoms”. The relationship between Steve and Vicky examines Steve’s association with HIV/AIDS or getting “sick” with the use of protection or practicing safe sex for instance using condoms. Steve’s relationship with Vicky is of a sexual nature and her not wanting to “use protection” is deemed a “dangerous” behaviour that Steve would like to distance himself from. In this Discourse, the connection to HIV/AIDS relates to Vicky being labelled “dangerous”, a “prostitute” and not wanting to use protection and condoms. Steve connects Vicky’s risky sexual behaviour to someone who may be “sick” and wants to infect him. Matata, meanwhile, makes the connection that Vicky’s behaviour is no different from Steve’s relationship with Stella (lines 14-47) both relationships are for monetary and sexual benefits. The sign systems and knowledge present are the societal and cultural markers that identify HIV/AIDS or symptoms of HIV/AIDS or the behaviour that leads to HIV/AIDS and they are as follows: “dangerous”, “use protection”, “pregnancy”, “sick”, “sexuality”, “condom”, “AIDS”, “sex”, “prostitute”, and “play sex”.

Episode 23 scene 1

The significance of this scene demonstrates Steve’s relationship with a father figure, Coach Tito. Steve feels free to confide in Coach Tito about his “sickness”. Steve informs Coach Tito that he is feeling “sick” and has a “bad sore” (lines 8-18). Coach Tito advises Steve to go to

the Health Centre to get medication since it is free, yet Steve believes that a witch doctor or traditional healer can solve his problems (lines 23-26). The significance of this Discourse reveals the mentality of Ugandans in rural areas, specifically fishermen, who believe in myths and spells. Steve's fishing partners advised him to go to a traditional doctor to get medicine instead of going to the Health Centre to get proper medication. The activity taking place in this scene is that Coach Tito is advising Steve to go to the Health Centre where he will be treated for the STD he contracted from not using a condom. In line 40, Coach Tito tells Steve that he should seek treatment with "real medicine": "Steve, go to the health centre-not a witch doctor. You need treatment with real medicine. It will not cost you more than you can pay."

Coach Tito's relationship with Steve is that of a father and son. Coach Tito is Steve's Football coach and is able to advise Steve about the dangers of not practising safe sex. Steve easily and freely confides in Coach Tito because he knows he will be able to get honest counsel. The politics of the Discourse displays the rural mentality versus the urban mentality where by Steve and his fellow villagers believe that going to see a traditional healer or witch doctor is more effective than going to get treated at the Health Centre.

The connection of this Discourse shows the cultural and societal notions still exist in the younger generation towards modern medication and seeking treatment from the Health Centre because as Steve refers to it as being: "too embarrassing am sure it's just a small thing. It will go away by itself as well as he believes that the girls he has had sexual encounters with are safe" (line 25). Steve is biased about being treated by health practitioners as opposed to a witch doctor, signifying the rural mentality of the myths that HIV/AIDS and STDs are brought about by someone casting a spell upon them (Episode 23 Scene 2, lines 47-51). This is reinforced when

Steve goes to the witchdoctor's or traditional healer's place to ask for some medicine instead of going to the Health Clinic as Coach Tito had advised in Episode 23 scene 3.

The sign systems and knowledge in this Discourse refer to the cultural and societal markers, symptoms, results, and treatment of HIV/AIDS or STDs including: "sick", "sore", "STD", "Health Centre", "medicine", "condoms", "sexual partner" and "treatment".

Episode 23 scene 3

The significance of the Discourse in this scene confirms Steve's rural mentality as he goes to the traditional healer/witch doctor for medicine for his STD. Steve is turned down as the traditional healer or witch doctor can only give Steve a temporary solution and that he is better off seeking proper medicine at the Health Centre. The activity taking place in this Discourse is Steve wanting to get a quick resolution for his infection without others finding out as Steve says: "Then just give me medicine and I get out of here"(line 66). However the Traditional Healer advises him: "to go to the health centre for thorough check up" (line 75). The Traditional Healer represents the identity of a modern Healer who gives the right advice and does not waste Steve's time and money, instead refers him to the Health Centre. Steve is representation of the rural mentality in Uganda, as well as someone prone to getting HIV/AIDS, as he contracts an STD from unprotected sex. Steve is in denial of contracting an STD from having unprotected sex but is told that: "any girl can have one of these diseases and not know about it. Men get signs, but girls don't always. You need to get your girlfriend treated as well" (line 71).

The relationship that the Discourse illustrates is that having unprotected sex results in contracting an STD, specifically syphilis in Steve's case. The Discourse is informing the

audience to opt out of going to traditional healers but and instead seek medical attention from their local Health Centres (lines 74-78). The politics of the Discourse emphasize the use of traditional medicine versus modern medicine. Steve's friends believe that his STD is a spell and needs to be reversed by a traditional healer, which is based on a traditional and rural belief system while Coach Tito and the traditional healer advise Steve to go to the Health Centre to get treatment which is both a modern belief system. The language used in the scene disconnects the myths surrounding the traditional beliefs that STDs are results of spells and magic. The language used connects the audience to the medical facts that STDs such as syphilis are transmitted through unsafe sex and not using condoms. For instance, the traditional healer tells Steve that: "If it's a STD, then you got it from playing sex... that's the only way" (lines 69).

The sign systems and knowledge in this Discourse outline the cultural and societal markers of STDs and HIV/AIDS: "medicine", "sore", "STD", "syphilis", "condom", "sex", "playing sex", "sleep", "diseases", "use protection", and "Health Centre". These words either identify a symptom of HIV/AIDS or STDs, a result of HIV/AIDS or STDs and medical terms and facts that make the audience aware of risky behaviours that lead to PLHA or having STDs.

Category 1 (D): Steve, Vicky, Rebecca, and Stella

Steve has three relationships, two of which are of a sexual nature: with Stella his "sugar mummy", Vicky, his high school peer, and Rebecca who is Steve's budding love interest. The following episodes will highlight Steve's Discourse with Stella, Vicky and Rebecca where issues of sexual health matters are discussed.

Episode 8 Scene 6(b)

The significance of this scene illustrates Steve's awareness of his mother having HIV/AIDS. Steve in this scene seeks Stella for financial help in buying painkillers for his mother who is ill, lines 32-38. This scene shows the transactional relationship between Steve and Stella. Stella provides Steve with money and in return Steve provides sexual favours. Stella is Steve's "sugar mummy". The activity present in this scene is Steve asking Stella for money, "I cannot stay. I need to rush back to my mother quickly" (lines 32), words which signify the urgency of getting his mother to the Health Centre.

Steve's financial situation represents poverty. Steve is a poor village boy who makes a living from fishing and his "sugar mummy". Stella represents an adult who takes advantage of teenage boys for her own sexual gratification. The politics of this Discourse illustrate the poverty in rural areas in Uganda and how teenage boys and girls have to engage in sexual relationships with older men and women in order to obtain the daily necessities of life. Steve's family is of a low social status due to the poverty that has plagued them since their father died unexpectedly and their mother's inability to provide since she is too weak and has no medication.

The connections inherent in this Discourse illustrate that Steve and Stella's relationship may result in Steve contracting HIV/AIDS as he was warned by his mother that Stella would soon start "showing sickness". As well as Stella provides Steve with her own painkillers to give to his mother, this is an indication that both Steve's mother and Stella have HIV/AIDS and share the same type of medication.

The sign systems and knowledge are the societal and cultural markers of HIV/AIDS and PLHA. Steve uses "sick" to connote his mother's having HIV/AIDS, and "painkillers" and

“Health Centre” are used to stand for the medical attention that is needed to help Steve’s ailing mother. “condition” is used by Steve to describe his mother’s HIV/AIDS status. Stella knows Steve’s mother has AIDS yet Steve still does not use the medical term choosing instead to use “sick”, and “condition” to signify his mother having HIV/AIDS despite the fact that her condition is common knowledge to Stella.

Episode 18 Scene 3

This scene takes place in the fishing village in a public place where Stella confronts Steve about his relationship with Vicky. Steve denies all of Stella’s accusations and manages to convince her that he is not cheating on her with Vicky or anyone else at his high school. The significance of this scene is when Stella wants Steve to spend the night with her, in lines 30-35. Steve gives in to Stella’s demands because his relationship with Stella is controlled by power and financial struggles. Despite the fact that Steve discloses that his mother is “sick” (lines 33), Stella ignores him, and instead lures him to her place. The activity taking place is Stella manipulation of Steve’s youthful vulnerability and naivety. Stella represents older women who prey on teenage boys and her sexual relationship with Steve’s father also indicates that she may have contracted HIV/AIDS and Steve might also. Steve in this Discourse represents a struggling village boy who, as a means of providing for his family, has to continue having a sexual relationship with Stella. The relationship in this interaction indicates Stella and Steve’s relationship as a being that of a sexual nature. In line 28, for instance, Stella tells Steve: “Steve, darling, what do you want from those young girls? Am I not enough for you?”

The politics in this Discourse illustrates the pervasive nature of transactional sexual relationships in Uganda whereby sugar mummies and sugar daddies take advantage of teenagers in the village and rural areas. This Discourse connects Steve and Stella's multiple sexual relationships to HIV/AIDS, because Stella was once Steve's father's mistress, and although it is not mentioned that Steve's father died of AIDS, in Episode 1 Scene 2, lines 20, Steve's mother tells Steve that: "Your father's death and my...illness have..." Steve's mother does not openly say the words but connects her "illness" to her husband's passing.

The sign system and knowledge is Steve's use of "sick", a societal and cultural indicator of HIV/AIDS, when he is telling Stella of his mother's health condition.

Episode 15 Scene 3

The scene takes place by a road side in Rock Point, and Steve is talking to Vicky about his worries of not using protection. The Discourse in this scene observes how teenage boys and girls freely discuss issues of sexual health matters such as protection and condoms. Steve is trying to tell Vicky the importance of practicing safe sex by using condoms (lines 33-52). Vicky however, becomes insulted and believes that Steve is calling her a prostitute line 36. Steve makes it clear that he does not want her to get pregnant (line 47). The activity in this Discourse shows that Ugandan teenagers have sex and, even if sexual health matters are not discussed openly at home, teenagers discuss them freely with each other. Both Steve and Vicky represent Ugandan youth who are sexually active and do not practice safe sex. The relationship also reveals the societal assumption that Ugandan youth all abstain from sex while Vicky and Steve's relationship demonstrates that Ugandan youth are sexually active. The sign system and

knowledge in this Discourse examines the use of cultural and societal markers of HIV/AIDS that are results of youth practicing risky sexual behaviour that results in one contracting HIV/AIDS and deemed negative: “condoms”, “use protection”, “pregnant”, “live sex”, “prostitute”, and “safe”.

Episode 30 Scene 7

Steve is with his third love interest, Rebecca, at Foundation High School. Rebecca has heard rumours that Steve has an STD and she confronts him about it: “Do you have syphilis? (...) How can I believe you? What about HIV?” (lines 300-314). Steve lies to Rebecca and deflects the question by answering: “Look at me Sweetheart, would I lie to you?” (line 315). This Discourse is significant because Rebecca uses the medical terms AIDS and syphilis whereas Steve, for fear of being rejected and stigmatized, lies that he does not have syphilis and encourages Rebecca allow their relationship to become a sexual one. The activity in this Discourse is that Rebecca is articulating AIDS and syphilis but Steve prefers not to discuss such issues with Rebecca and he does not want to disclose that he has an STD. Steve represents a traditional womanizer who does not want his female partners to know of his sexual health condition. Meanwhile, Rebecca represents a modern teenage girl who is bold enough to discuss such pertinent issues with a soon-to-be sexual partner. The relationship Steve has with Rebecca in this Discourse seeks to illuminate Ugandan youth as being sexually active with peers at school. The perspective of the language used is centered on urban versus rural mentality. Rebecca’s inquiry into Steve’s health is a modern way for teenage girls to interact with their boyfriends or partners whereas Steve’s constant denial is a traditional way for teenage boys to

react. The Discourse disconnects the societal beliefs that Ugandan youth all practice abstinence and do not engage in sexual relationships (or get infected with STDs or HIV/AIDS). The sign systems and knowledge is the way that Rebecca uses “syphilis” or “HIV” as a medical term to ask about Steve’s health status.

Episode 33 Scene 4

Steve, Rebecca and Betty are at the Health Centre. Steve and Betty are there because their mother was admitted and Rebecca is there because her brother Robert is in a coma following an accident. The Discourse in this scene is significant because Steve tries to tell Rebecca about his mother’s condition (lines 194-222). Steve uses societal and cultural markers to discuss his mother having HIV/AIDS such as “sick”, “pneumonia” and “suffering”. The activity of this Discourse is that Steve is trying to tell the truth about his mother having HIV/AIDS but is unable to do so, instead uses societal and cultural markers to explain without directly stating that his mother has AIDS. Steve’s actions represent a culture of silence and he has been taught to discuss particular issues, at particular times, with particular people. The process of keeping his mother’s HIV/AIDS status private is a result of a fear of being rejected. The relationship between Steve and Rebecca is a platonic one, and while he continues having sexual relationships with Vicky and Stella, his relationship with Rebecca indicates that he truly cares for her, in one instance telling her, “Becky, look, I usually keep certain things to myself but I trust you enough...” (line 220). Steve acknowledges that his mother having AIDS is a private matter but he is willing to tell Rebecca because he trusts her. The Discourse in this scene connects AIDS as a private matter to PLHA and their relatives. The sign systems and knowledge of HIV/AIDS is

illustrated through Steve's use of the societal and cultural markers: "sick", "suffering", and "pneumonia" which are all symptoms of HIV/AIDS.

Category 2: Debra, Lisa, Judith

Debra is the second PLHA on *RP256* and this category will examine the interactions between Lisa, Debra and Judith and how they discuss matters pertaining to HIV/AIDS, PLHA and other sexual and health matters.

Episode 1 Scene 8

This scene introduces us to Lisa and Judith the scene takes place at Lisa's home. The significance of the Discourse in this scene is that Lisa is asking Judith, a teacher and counsellor at Foundation High, for money: "I hate to ask you again, Judith, but I need to borrow some money to buy my daughter a mosquito net...It is difficult to make ends meet these days" (lines 36-40).

The Discourse indicates that Lisa is a struggling parent who is unable to financially care for her family and borrows money from her friend Judith. We are not given any sign as to whether Lisa works for a living or not. We observe that Lisa and Judith confide in each other about their marital and personal lives as evidenced by their discussion about their daughters in lines 70-72. Lisa encourages Judith to discuss matters openly with her daughter Rebecca and instead of the closed relationship Lisa had with her daughter Debra as Judith asks Lisa "How is your daughter?" (line 71) and Lisa replies "...she's fine (...) for the time being anyway..." (line 72). The activity taking place is Lisa warning Judith to discuss issues with her daughter as she

says: “talk with Rebecca... you don’t want to find yourself in my shoes, with a daughter in the situation that mine is” (line 70). The other activity that is taking place is Lisa borrowing money from Judith to buy a mosquito net for her daughter (line 36-40). The identities represented in this scene identify Lisa as a person living in poverty, as well as a wise person who counsels to Judith about her dilemmas with her daughter. Judith is represented as a married educated woman who works as a teacher and school counsellor therefore having a higher standard of living than that of her friend Lisa. The relationships present in this Discourse are that of Lisa and Judith’s friendship, as Lisa indicates: “Oh thank you Judith. You are such a friend” (line 38) and Judith replies: “What are friends for?” (line 39).

The other relationship is Lisa and Debra’s lived experiences helping Judith to communicate more with her daughter Rebecca: “You don’t want to find yourself in my shoes, with a daughter in the situation that mine is” (line 70). The politics of the Discourse communicate societal issues faced by women living in Uganda such as poverty, low incomes, and polygamous marital woes. The Discourse connects Lisa’s life of poverty with Debra’s situation (which is not disclosed in this scene). The sign systems and knowledge examine Lisa’s situation versus Judith. Judith is a working mother who is married with two children and a co-wife, Millie. Lisa does not mention working or being married and only mentions her inability to make *ends meet these days* and her daughter’s situation. This narrative forebodes what we are to learn in future episodes, that Debra is a PLHA. Lisa does not freely disclose this information to Judith (who already knows that Debra has HIV/AIDS) because in societal and cultural terms when someone is known to have HIV/AIDS the culture of silence dictates that it is not to be directly spoken of. The culture of silence reinforces stigma and HIV/AIDS is seen as a taboo

subject. Discussions among peers and the acknowledgment that one of your loved ones has HIV/AIDS will result in being ostracised from the community, both socially and economically.

Episode 5 Scene 4

Lisa and Judith are conversing at Lisa's home about Judith's marital woes with her husband, Monday, and her children Robert and Rebecca who are misbehaving. The significance of the Discourse in this scene is observed when Lisa advises Judith to discuss matters openly with her children who are misbehaving (lines 66-68). In this scene Lisa discloses to Judith that Debra has HIV/AIDS (line 68). Lisa freely admits this to Judith as she tries to convince her to speak openly about love, sex and AIDS with Robert and Rebecca so that they do not end up like Debra who was uninformed about sexual health matters as Lisa did not discuss them. The activity and context taking place in the Discourse is Lisa using words such as AIDS, love and sex in her conversation with Judith in order to warn Judith against being silent about such matters with her kids. Lisa represents a woman who is educated about sex and sexual health matters. When Lisa opens up about Debra having AIDS, she does not use cultural or societal markers but rather the medical term in order to show how important it is for Judith to discuss sexual matters with her children. Lisa regrets the decisions of her past and blames herself for not discussing matters like HIV/AIDS with her daughter. By failing to do so Lisa reinforced the culture of silence whereby certain topics were not discussed for fear of embarrassment and the misconception that if a child knows issues of HIV/AIDS, safe sex, STDs, they will become promiscuous. Lisa has the power to speak about AIDS with Judith because she has experienced the ramifications of keeping silent. Had her daughter not been so naïve in her personal and sexual relationships, if those issues had been discussed at home, she may not have suffered the same fate. Judith still practices the culture of silence and this is observed when she tells Lisa: "But how could I ever discuss such things with my own children, Lisa?" (line 67). The culture of silence is so socialized and naturalized in Ugandan society that breaking the cultural practice

is viewed as taboo. The relationship present in this Discourse examines Lisa's knowledge and awareness of AIDS through her own lived experiences with Debra and her authority to speak about love, sex and AIDS openly with Judith. The perspective of the language used examines the difference of beliefs in speaking about sexual health matters with children. Judith is pro culture of silence whereas Lisa is pro free speech. The Discourse connects Ugandan societal beliefs whether in the rural areas about the culture of silence where parents find it hard to talk about matters concerning sex, love and HIV/AIDS. Judith does not want to talk about those issues with her *own* children and is in denial, stating that they are too young to know about sexual health matters. The sign systems and knowledge in the Discourse are the words that Lisa uses to warn Judith to talk about sexual and health matters: "sex", "love", "infected" and "AIDS". Sex, love and infected are markers that speak to sexual behavior and AIDS is used as a medical term.

Episode 10 Scene 4

Lisa is at Judith's house comforting Judith who is upset that her daughter Rebecca was caught at school with pornography. In this scene Lisa informs Judith about the dangers of keeping quiet and not discussing matters with her children. This scene is significant because Lisa is trying to convince Judith to discuss matters pertaining to sex, AIDS, pregnancy, playing sex, protection and sexuality. The activity taking place is that Judith is explaining her worry to Lisa that her children will start having "sex" or "playing sex" with friends at school but she still does not want to talk about these matters with her kids, as evidenced in line 25: "How can you talk like that? I am sure they learn about such things in school...". Lisa boldly and openly counsels Judith that: "And do you think they will never play sex? Would they rather played sex without

having proper information about how to protect themselves?” (line 24). Lisa informs Judith that keeping quiet about sexual matters and failing to inform her children will only hurt them in the short term and harm them in the long term. Lisa represents authority and knowledge of sexual health matters when she is encouraging Judith to speak to her children sex and health issues. Judith represents the status quo and old tradition of not informing or educating children and instead leaving them to figure out their sexuality by themselves or at school. The relationship shows that Lisa has become a modern parent, in terms of discussing sexual health matters openly, and Judith the traditional parent, in terms of not wanting to discuss sexual health matters with her children. The perspective of this scene communicates the importance of parents talking to their children about sex, AIDS, playing sex, protection, and pregnancy. The Discourse connects how the culture of silence is pervasive in Uganda. The sign systems and knowledge are the cultural and societal markers that Lisa and Judith use to describe sexual behavior such as “sex”, “playing sex”, “protection”, “pregnancy” and “sexuality”. The use of AIDS is used as a medical term as well as a cultural marker.

Episode 13 Scene 7

In this scene Judith takes Lisa’s advice and goes to talk with Debra about the best way to approach Rebecca when talking about sex and love. Judith talks to Debra at the Health Centre. The significance of the Discourse in this scene examines Judith seeking Debra’s counsel because Debra would have first-hand information about youth’s misunderstanding of sex and love since she is a PLHA. Debra acknowledges that just because she is a PLHA does not mean Rebecca will heed her advice (lines 25-39) and Debra believes that more would be accomplished by Judith speaking to Rebecca herself. The activity taking place with Judith and Debra’s interaction

engages the audience to understand the importance of parents specifically mothers talking to their daughters about sex and HIV/AIDS as Debra admits to Judith that: "...my mother never talked with me about pregnancy...or anything..." (line 33). The Discourse studies the ramifications of the culture of silence on young women who get pregnant or contract HIV/AIDS at a young age as a result of not discussing matters of sexual health openly with their parents, elders or guardians.

The representation of PLHA is illustrated through Debra's positive character traits. She works and earns a living as a counsellor helping and educating other families and young women about sexual health matters. Debra is confident and openly discusses her HIV/AIDS status with others. In contrast, Judith represents the traditional parent who is unable to discuss matters about sex with her children and has to ask a third party to help carry out her duty. The representation of youth illustrated through Debra and Rebecca is that they are naïve, innocent and uneducated about sex and HIV/AIDS.

The relationships in the Discourse demonstrate that being young plays a vital role with the transmission of HIV/AIDS in Uganda. Being young is equated to being innocent, uneducated on sex, use of protection, HIV/AIDS and STDs. The other relationship the Discourse enacts is that by being older one is assumed to be wiser and more informed. Debra suggests that her mother had more knowledge and understanding of sexual health matters but never carried out her duty in informing her. The Discourse engages and communicates the notion of Ugandan parents not being able to talk freely about sexual health matters with their children. The sign systems and knowledge in the Discourse elucidate the cultural and societal markers of HIV/AIDS that is to say: "HIV positive" and "HIV" are used as medical terms, "sexually active", "pregnant", are

markers used to signify sexual behaviour and infected while “young” is marker used to portray a PLHA.

Episode 20 Scene 2

Lisa goes to Judith to ask for financial help because Debra was involved in an accident and is at the hospital. The significance of the scene indicates the social stigma and fear people in rural Uganda still have about HIV/AIDS. Debra was in an accident and badly hurt and since she has AIDS, people at the location of the accident were afraid to help her in fear of also contracting AIDS (lines 5-11). The activity taking place in this Discourse illustrates how PLHA in Uganda are discriminated against and ostracized due to the public’s ignorance and fear of becoming infected which is highlighted by both Lisa and Judith in lines 18-20: “Nobody should be made to suffer like that just because they have HIV ...People can be so cruel when they know that someone is HIV+... We all have prejudices and many of us are ignorant about HIV and AIDS.”

The representation of PLHA is illustrated through Debra. PLHA are depicted as a bad omen and therefore ostracized in their communities, feared and are avoided and unattended to in public places. Lisa represents a person who faces associated social stigma since she is Debra’s relative and caregiver and she lives in poverty due to the financial costs of taking care of Debra. Lisa is also saddled with the guilt and shame with her daughter having HIV/AIDS. Women are represented as more open and willing to give a helping hand to PLHA. Topi, the hair dresser, helped transport Debra to the hospital after her accident, Sister Aisha attended to Debra and provided medical aid at the hospital and Judith helped Lisa financially throughout Debra’s predicament. The relationship the Discourse shows is how people living in rural areas still

believe in false myths about HIV/AIDS. The perspective communicated is that discrimination against PLHA still exists in Uganda and has been naturalized into societal beliefs. PLHA are negatively depicted in the Discourse through Debra's experiences where she is depicted as weak and helpless. This Discourse also connects the fact there is still a lack of not knowledge about sex and sexual health matters like HIV/AIDS as illustrated through Debra's lived experience. The sign systems and knowledge in this Discourse are the cultural and societal markers of HIV/AIDS in identifying HIV/AIDS: "AIDS", "HIV positive" are used as medical terms while "pain" is used to reference HIV/AIDS symptom and institutions associated with HIV/AIDS treatment are: "hospital", "treatment" and "condition".

Episode 20 Scene 5

Lisa and Judith are still at the hospital by Debra's bed side and are conversing about how Debra got HIV/AIDS. The Discourse in this scene is significant because we learn from Lisa how Debra got infected with HIV/AIDS: "Debra had been in love like any other young woman. But the man had a secret"(line 54). The secret that Debra's boyfriend did not disclose was that he had AIDS. Debra, who was young and naïve, had no idea of the ramifications of a sexual relationship and Lisa tells Judith in line 46: "She never even had a boyfriend when she was growing up and I never saw her running around with anyone". The Discourse illustrates how teenage girls are uneducated about sex, HIV/AIDS and love and due to their innocence often end up choosing the wrong partners as Lisa tells Judith in line 60.

The activity in the Discourse engages parents to have discussions of sexual health matters with their children and the attempt to encourage youth to discuss sexual health inquires with their

parents. Lisa advises Judith in line 60: “But if there is one lesson I could pass on to you, my dear Judith, it is this: help your own daughter by talking to her openly –so that she does not put herself at risk”.

There are two types of representations of PLHA in the Discourse. The first is the negative representation of the man Debra fell in love with. While he is not named he is described as having “had a secret”, implying that PLHA are mysterious and dishonest. PLHA are also viewed as promiscuous as Lisa defends Debra saying: “She was not what you would call a promiscuous girl. She was just a normal girl like any other” (line 44). Therefore if she were promiscuous it would make sense for her to have HIV/AIDS. The second is the positive representation of PLHA illustrated in Lisa comments about the Debra who is HIV positive, “... She lives life to the fullest! She is strong and brave. She could teach us all a lesson, I tell you” (line 60).

HIV/AIDS is represented negatively this is illustrated with Lisa when she tells Judith that: “The world has dealt her a cruel blow, Judith... No, if there is a God and he is just, I do not know how it works” (line 50-52). Debra having HIV/AIDS is viewed as a curse from God or bad omen religiously. It is Judith who reminds Lisa that “...HIV does not discriminate between good and bad” (line 53). Judith reminds the audience that HIV depends on a person’s choice of behavior. The relationship enacted in this scene demonstrates that HIV/AIDS does not discriminate because Lisa describes Debra as having been an example to other girls in Rock Point, a good girl with good judgement who got infected with HIV/AIDS because she was a young woman in love and was naïve, gullible and innocent. The Discourse is trying to communicate the need for parents and guardians to talk openly with youth about sex and HIV/AIDS. This scene connects Lisa’s reluctance of discussing sex, and HIV/AIDS resulting in with Debra contracting HIV/AIDS as Lisa says: “Debra did not bring HIV upon herself, you

know” (line 42). Lisa blames herself for not taking responsibility and teaching Debra about sexual health matters and hopes that her experience will help Judith talk to Rebecca about these issues.

The sign systems and knowledge also indicate societal and cultural markers that identify with PLHA and identify behaviors associated with HIV/AIDS and sexual behavior:

“promiscuous” and “protect”. The societal and cultural markers also portray PLHA as “young. “HIV positive” is used as a medical term.

Episode 21 Scene 3

Debra and Judith are talking while Debra is recovering from her accident at home. The significance of the Discourse is that Debra is once again encouraging Judith to speak to Rebecca and Robert about sex and HIV/AIDS.

Debra blames herself for being a burden financially and socially to her mother “...I feel like I am a burden to her-all the money she has to spend on me like this... I understand, Judith, but if it was not that I was HIV+... No Judith, each time anything small happens, my mother worries so much. It’s too much for her...” (lines 9-15). Debra feels guilty and ashamed about having HIV/AIDS because it has had a negative impact on her mother and family is very important to her. The activity taking place is that of Debra advocating for Judith to talk openly with her children and learn from her own experiences: “I do not blame my mother, but I do feel I could have used a lot more advice and guidance when I was growing up... Maybe then I would have understood the significance of abstinence and the use of condoms” (line 33-35). Debra speaks about meeting Michael in college, beginning her first sexual relationship, becoming

pregnant and losing the baby, and finding out that he had other girlfriends and had died of AIDS (lines 19-31).

The representation of PLHA and HIV/AIDS through Debra's experiences is as follows; HIV/AIDS is associated with internal social stigma that negatively depicts PLHA as full of shame, regret, and under condemnation for having contracted it which is observed in Debra's life story. However, PLHA also have the authority to speak about their experiences in order to prevent others from making the same mistakes as they did because they are informed and knowledgeable about sexual health matters.

Parents in rural Uganda are represented as uninformed and unaware of their children's sexual activities by not having close relationships with their children as noted by Judith "at the times, parents take it for granted that you just ...educate yourself about sex"(line 36).

The relationship this Discourse seeks to enact is that Debra being a PLHA gives her the authority to educate and advise Judith to start to talk to her children about HIV/AIDS because she is an example of what could happen to girls when they do not receive information about sex, abstinence, condoms, and HIV/AIDS. The relationship also depicts a new era of youth educating and passing on wisdom to the old era of parents who do not discuss matters openly due to the socialized and naturalized culture of silence present in Uganda. The perspective of the scene shows that Ugandan parents failing to discuss sexual health matters with their children is a normal social practice that has negative consequences. The Discourse connects Debra's youthful experience to young girls like Rebecca who are in need of guidance from their parents, specifically mothers, on matters concerning AIDS, sex, and HIV/AIDS.

The sign systems and knowledge are the cultural and societal markers used that represent HIV/AIDS. Debra and Judith use "sick" to reference HIV/AIDS, Debra uses "HIV positive" and

“AIDS” (medical terms) interchangeably with “sick”. Debra uses “sex”, “abstinence”, “condoms” and “pregnant” to reference the behaviors through which one can contract HIV/AIDS.

Episode 22 scene 4

Judith in this scene is at home with her children Rebecca and Robert and discussing what she has learnt from Lisa and Debra’s experiences. The significance of the scene is that Judith is now talking to her children about sex, STIs, pregnancy and AIDS, something she was unable to do at the beginning of her interactions with Lisa and Debra in episode 1 scene 2. Judith has transitioned from a timid parent to a bold parent who is able to discuss all types of issues with her children. Therefore the activity taking place is Judith’s articulation of sexual health matters with her children, as she informs them of sex, STIs, pregnancy and AIDS in lines 16-42.

The old Judith represented the identity of most parents in Uganda who are timid and do not know how to broach such sensitive matters. The newly transitioned Judith is now able to speak about AIDS, STIs and others to her children since she has been educated on these issues and now knows the disadvantage of reinforcing the culture of silence. The relationships in this Discourse illustrate the relationships that few Ugandan parents are able to openly discuss sexual matters with their children. Most parents maintain a culture of silence, which is illustrated with Steve’s mother, Steve and Betty. The Discourse disconnects the notion that all youth want to discuss sexual matters with their parents as Judith meets some resistance from her kids as they believe it is embarrassing to have their mother discuss such topics openly as displayed in lines 17- 26: “Mother, what has gotten into you? (...) We know that, Mom. (...) This is embarrassing, mother. (...) Do we have to talk about this? We know already”.

The sign systems and knowledge are found in Judith's referencing of societal and cultural markers of HIV/AIDS that identify behavior related to HIV/AIDS such as sex. However Judith uses medical and factual terms that are also societal and cultural markers of HIV/AIDS such as "STIs", "AIDS", and "pregnancy". Judith uses these terms because she is educating her children on sexual health matters and wants to be clear, coherent and precise.

Category 3: Rock Point youths: Rebecca, Lillian, Flower, and Akonyo

The episodes and scenes that will be analyzed in this category are premised around Rock Point youth; Rebecca, Akonyo, Flower, and Lillian discussing matters of sex, HIV/AIDS, and STDs.

Episode 7 Scene 5

The scene takes place at Foundation High, the significance of the scene is that the girls; Rebecca, Akonyo and Flower are discussing Rebecca's recent trip from the village where she found out her cousin Tina has fistula. The language used shows that teenage girls freely and openly talk about sex and sexual health matters with each other. For instance this is observed when Rebecca informs Flower and Akonyo that during her trip in the village she found that cousin Tina had fistula in lines 8-20. Tina's condition was referred to as death or worse than death referencing HIV/AIDS by Rebecca in line 12 and Akonyo in line 13, in this case death or to die is a societal and cultural marker that refers to AIDS. Being "sick" and the "village" are referenced negatively. Flower assumes the only reason Rebecca went to the village was for a

burial and Rebecca reinforces the notion of village life as negative when she associates her cousin from the village suffering from a fatal sickness worse than death . Akonyo assumes the cultural and societal marker Rebecca uses “sick” is AIDS but is corrected by Rebecca that Tina has fistula not AIDS in line 13. The activity examines how teenage girls educate and discuss sexual health matters and the effects of having sex at a young age. For instance, Akonyo references a BCC campaign *Straight Talk* as a source where she gets her information on sexual health matters “Rebecca’s friend has a serious problem caused by having a baby when she was too young. I’ve read about it in Straight Talk” (line 24).

Flower informs the audience that she trusts the advice given to young adults by their Ssengas, the paternal aunts who give girls advice about sex and sexual health matters before they get married asking “Can’t you tell us about the interesting advice your Ssenga gave you on how to have glorious sex!” (line 21).

The representation of youth is that they are more aware of AIDS and fistula because they learn about these matters and issues from BCCs such as *Straight Talk*, from each other and from their Ssengas. The representation of the village life is associated with strife and sicknesses, such as AIDS, fistula and death. The relationship in the Discourse is that death or the process of dying is associated with AIDS and village life. Another relationship is the freedom the girls have in discussing sex and sexual health matters openly with each other whereas they are unable to do so at home. For instance, Akonyo advises Rebecca to tell her mother about what she witnessed in the village but Rebecca firmly replies “Humph you are joking? I don’t even know how that woman managed to conceive us” (line 29). Rebecca is stressing the culture of silence on such issues in her home where they do not discuss such matters with her mother (prior to discussing them with Judith in episode 22 scene 4). The perspective communicated is that village life is bad

and urban life is good and discussing matters about sex with parents is abnormal but discussing these matters with your peers is normal . The Discourse connects Ugandan youth as informed about sexual health matters and free to discuss these issues amongst themselves and in public places such as school. The sign systems and knowledge are found in the societal and cultural markers used by the girls to identify HIV/AIDS or fistula including “sick”, “village” and “death” . “AIDS” is used as a marker in order to clarify whether the cultural markers of being “sick” and “death” were indeed symptoms of AIDS or fistula. Sex and Straight Talk are cultural and societal markers of sexual health matters and behavior.

Episode 30 Scene 3

This scene takes place at Foundation High School with Vicky and Rebecca. Vicky is Steve’s ex-girlfriend and Rebecca is Steve’s new love interest. The significance of the language in the Discourse highlights Vicky mocking Rebecca for being with Steve because he has an STI. Vicky is aware that Steve has an STI but this is the first time Rebecca is hearing of Steve’s risky sexual behavior. This conversation demonstrates the freedom that youth have in discussing STIs and sexual behavior amongst themselves at school. The activity of the Discourse stresses the point that Ugandan youth are sexually active and if careless contract STIs. The Discourse represents Ugandan youth as sexually active yet careless and irresponsible as they do not practice safe sex. This is illustrated by Steve’s STI that he sought help for in Episode 23 Scene 1 and 3. Vicky represents someone who is promiscuous as demonstrated by Rebecca calling Vicky a prostitute “you are Teacher Mark’s prostitute. Why are you carrying his books?” (line 116). This is not the first time Vicky has been referred to as a prostitute. In Episode 16 scene 6 Steve and

Matata call her “a prostitute” and she labels herself as such in Episode 15 scene 3. The relationship here is Steve’s relationships with Vicky, Rebecca and Stella. The Discourse examines the negative impacts of youth being involved in sexual relationships at a young age. Steve is 19 (episode 1 scene 2), Rebecca is 17 (episode 13 scene 7) and Vicky is somewhere between 17-19 years of age . The Discourse connects Rock Point youth’s sexual activity and the negative impacts of their risky sexual behavior as indicated by Vicky in the scene notifying Rebecca that Steve contracted an STI. The sign systems and knowledge of the Discourse is that Vicky’s use of referring to Steve as “sexually infected” and “infected” which is a societal and cultural marker of HIV/AIDS or an STI. We also observe Rebecca referring to Vicky as a “prostitute” which is a societal and cultural marker of a trait of a promiscuous person and a PLHA.

Episode 36 Scene 5

In this scene Rebecca and Flower are at school talking about Steve. The significance of the language in the scene highlights Steve’s sexual behaviour as mysterious, and careless (line 17- 42). Rebecca is able to confide in Flower about Steve’s mysterious sexual behavior, indicating that having a sexual relationship with Steve is not possible because he have HIV or an STI (line 28 & 42). The activity that is taking place in this scene indicates that Rebecca is aware that Steve’s mother is “sick” and comes to the conclusion that if his mother is “sick” then Steve may have HIV or something else. Steve represents the identity of a PLHA as he is described as “sleeping around”, having an STI, that practices unsafe sex, and Steve is always at the Health Centre indicating he is sick. Steve is also described by Flower as “fisherman” and this is

correlated to a man who is of a low status, a villager and promiscuous. Steve's mother being sick and having a fever also represents a PLHA although it is hinted in the Discourse and not fully disclosed. The relationship in the Discourse illustrates that Rebecca and Steve are developing an intimate relationship; however, Steve's sexual behavior and his mother falling sick have led Rebecca to believe that he has HIV. Flower also suspects Steve's health as she assumes the worst when she says "I hear that he is always at the health centre also" (line 21).

The perspective is that Steve's sleeping around is deemed as risky behavior and indicates HIV or an STI. The Health Centre is communicated negatively, spreading the belief that people who go to the centre have an STI, or HIV/AIDS. The Discourse connects Steve's multiple sexual relationship with Vicky, Stella and his new relationship with Rebecca as a factor that contributed to Steve contracting an STI from unprotected sex. The Discourse uses sign systems and knowledge to examine the societal and cultural markers used: "sick" and "fever" that indicate symptoms of HIV/AIDS. The Health Centre implies a place PLHA, or those who have STIs go for medical aid. "Sleeping around" means the risky sexual behavior associated with HIV/AIDS. "HIV" and "STI" signify the medical term and societal marker of sexually transmitted diseases. "Fisherman" is used once to describe Steve as young adult that is of low status, a villager and promiscuous.

Episode 14 Scene 5

In this scene we are introduced to Lillian, an orphan living with guardians Solomon and Nana who moved from the North of Uganda before settling in Rock Point where she attends Foundation High. It is revealed that Lillian is having an affair with Solomon and Flower is the

only one of her peers who knows about it. The significance of the Discourse illustrates Lillian's innocence. Lillian is uneducated on sex and sexual health matters and Flower is trying to educate her on the reasons for using condoms in lines 27-31. Lillian believes that she can trust Solomon and loves him, while Flower informs her in lines 19-23 that it is wishful thinking. The activity taking place is that Flower is educating Lillian about sex and sexual health matters as well as the power relation dynamics involved in relationships with older partners, like Solomon, who use their authority to dictate rules in the sexual relationship with their younger partners. Lillian represents the identity of Ugandan teenage girls who are involved in transactional relationships with older men, or "sugar daddies". These relationships are unbalanced and often result in younger partners becoming pregnant or getting infected with HIV/AIDS as Flower warns Lillian. The relationship in the context of the Discourse engages the "sugar mummy" and "sugar daddy" practices in rural areas of Uganda like those of Stella and Steve's or Solomon and Lillian. Both Steve and Lillian come from poverty stricken backgrounds. Steve is trying to make ends meet going to school and working part time as a fisherman to provide for his family whereas Lillian lost her family in the war north of Uganda and is supported and looked after by Solomon and Nana. Steve and Lillian are vulnerable youth who have been manipulated into forming these relationships.

The perspective of the Discourse views Solomon and Lillian's relationship as a bad relationship that will have a negative impact on Lillian. The Discourse connects poverty with transactional relationships meaning that since Lillian depends on Solomon for everything and she is inclined to participate in such a relationship. This draws attention and connection to how gullible and innocent youth from the village are as illustrated with Lillian's dilemma. The sign systems and knowledge in the Discourse are the societal and cultural terms Flower uses to

educate Lillian about sex and sexual health matters. Flower uses factual terms: “sex”, “condoms”, “pregnant”, “protection” to indicate the practice of safe sex. Flower uses “HIV” and “syphilis” to indicate the medical facts and societal and cultural marker of HIV/AIDS or STDs. Lastly, Flower uses “young” which is a societal and cultural marker of ignorance.

Episode 20 Scene 8

Lillian goes to the Health Centre for the first time to find out whether she is pregnant and Sister Aisha informs and educates Lillian during her visit. The significance of the Discourse examines Lillian’s lack of knowledge about sexual health matters such as using “protection”, “condoms” and “pregnancy” as Sister Aisha explains in lines 76-100. The activity taking place encourages Lillian to seek advice and help about sexual health matters from a health practitioner. The Discourse represents health experts like Sister Aisha as a source of knowledge about issues relating to pregnancy, safe sex and HIV/AIDS. Sister Aisha represents an elder who young girls are able to talk freely with about their sexual relationships. These interactions occur in a public place, the Health Centre where matters are kept confidential as Sister Aisha tells Lillian “our talk will be confidential and I will not tell anyone else what we say to each other” (line 76).

Lillian is referred to as young and this represents youth as vulnerable, inexperienced and uneducated. The relationship in the Discourse speaks to Sister Aisha’s relationship with the youth in Rock Point - she is the adult that youth are able to disclose information to that otherwise would not have been able to tell their parents. The Health Centre is viewed from a positive perspective as the source of all medical information for youth in Uganda and the Discourse connects the Health Centre as an open space where youth can talk about sex and sexual health

matters without judgement. The sign systems and knowledge present in the Discourse are demonstrated through Sister Aisha's use of factual and medical terms: "protection", "condoms", "pregnancy" to refer to the safe sex practices to prevent HIV/AIDS or pregnancy. "Sleeping" and "sexual relationship" to refer to sexual behavior and HIV refers to HIV/AIDS.

Episode 24 Scene 6

This scene takes place at the Health Centre with Sister Aisha informing Lillian that she is not pregnant; the significance of the language in use is that Sister Aisha once again is educating Lillian on her relationship with her partner and advising her that unsafe sex could lead to pregnancy as well as HIV/AIDS (lines 30-32). Sister Aisha is giving Lillian information that she would never have received at home with Nana or Solomon. The Discourse in this scene is also significant because it shows that "sugar daddy" relationships have an imbalance of power whereby the younger partner has no control of anything as Lillian confides in Sister Aisha that "I cannot convince my boyfriend to use condoms- and I do not know what else to do." (line 25).

The activities taking place show Sister Aisha providing Lillian, who knew nothing about condoms, HIV, STIs and pregnancy, with information. The identity Lillian represents is that of a naïve and powerless youth, whereas Sister Aisha represents the identity of wisdom in matters of educating youth on sexual relationships. The relationship in the Discourse relates Sister Aisha to a guardian and mother figure that Lillian looks up to as Lillian tells her (line 11).

The perspective of the Discourse demonstrates the dangers of youth who are sexually active and do not practice safe sex. Early sexual relationships are not encouraged as Sister Aisha advises Lillian "You have to ask yourself if this relationship is the right thing for you, if it is

causing you so much stress. Young girls can be misled into sexual relationships when they are not at all ready for them.” (line 20).

The Discourse connects young village girls in Uganda with sexual activity and misunderstanding of the consequences of their sexual behavior due to lack of information and guidance. The sign systems and knowledge present in the Discourse are those cultural and societal markers that discuss sexual behavior: “condoms”, “pregnancy”, “protection”, “contraceptives”, “sexual intercourse”, “sexual relationship” and “sleeping”. As well as language that identifies HIV/AIDS as a medical term: “HIV” or “STIs” and “infected”.

Episode 33 Scene 5

This scene involves Lillian interacting with Sister Aisha at her home. Lillian reveals the identity of the man she has been having the affair with to Sister Aisha. The Discourse is significant because it shows Lillian’s reluctance to leave the relationship she is in with Solomon due to her being scared, however Sister Aisha advises her not to sleep with Solomon because Lillian cannot be sure of his sexual health status (lines 249-253). The activity that the Discourse illustrates is that youth have no rights to voice their opinions in transactional relationships they are controlled and manipulated. Lillian tells Sister Aisha: “That’s why I am avoiding him. I don’t want that but it is like he is putting a lot of pressure on me. All the time” (line 241). The Discourse represents sugar daddies like Solomon as promiscuous partners who most often have HIV because they have unsafe sex with numerous partners. Lillian’s identity represents incompetence and submissive mentality of young villagers. Whereas Solomon’s identity

represents a promiscuous and adulterous man who could HIV/AIDS but this is never indicated in the three quarters.

The Discourse engages the relationship between Lillian and Solomon that is the imbalance of power and sexual rights in the relationship. The Discourse further sheds light on Sister Aisha's role as a mother figure to Lillian because Lillian is able to go visit Sister Aisha after working hours at her home. The perspective of the Discourse discourages youth from engaging in relationships with adults for monetary benefits (lines 259-285). The Discourse makes the connection with the level of poverty orphans in Uganda live in that results in the creation of unhealthy relationships for monetary benefits such as paying school fees in Lillian's case. The sign systems and knowledge of the Discourse are the cultural and societal markers that discuss sexual behavior include: "condoms", "pregnancy", "protection", "safe sex", "unsafe sex" and "sleeping", and "infection". The language used identifies HIV/AIDS as a medical and factual term: "HIV virus" or "STIs". The cultural and societal marker "young" and "village" are used to imply poverty, innocence and disease such as HIV/AIDS.

Category 4: Topi, Nana, Judith and Lisa

The episodes and scenes that will be analyzed in this category will involve the adult women of *RP256* and their discussions of issues pertaining to sex and HIV/AIDS at Topi's salon.

Episode 3 Scene 6

This scene examines the significance of married partners being faithful to one another as Nana, Judith and Topi discuss issues related to young girls in Rock Point having affairs with

older men who are married with children (lines 27-28). The youth of Rock Point are perceived as promiscuous and Topi distinguishes youth that are more dangerous, “My dear. Village girls are more deadly than town girls. Men love that innocence” (line 42). The Discourse indicates that in terms of social status, village girls are more prone to be in relationships with older men because they are “innocent”, uneducated on sexual matters, naïve, gullible and often poor. The activity taking place is how the older women of Rock Point are discussing their marital woes and are allocating the blame of their husband’s adultery on young girls from rural areas or villages. For instance Judith tells her friends, “There are more and more young girls fooling around with other people’s husbands. They even miss school because they want to be with their men” (line 24). The identity of youth represents Ugandan youth as promiscuous, careless and prone to have AIDS or to get pregnant and men are represented as having polygamous relationships, for instance Judith’s husband, Monday, has a second wife, Millie (line 22). The relationship in the Discourse associates young people with the disintegration of marriages and their greed for money as suggested by Topi (line 17). The perspective the Discourse takes is that Ugandan youth are troubled and lack morals, as well as the Discourse is trying to connect youth to AIDS, pregnancy. The sign systems and knowledge associate youth from villages or rural areas with “AIDS” and “pregnancy” as result of their risky sexual behavior. “Young” and “village” is a societal and cultural marker of HIV/AIDS.

Episode 7 Scene 4

Judith is at the salon conversing with Nana and Topi about her marital woes, they also discuss Lisa’s absence from the salon (lines 56-59). The significance of the Discourse signifies

the culture of silence as both Topi and Judith are aware that Debra has HIV/AIDS and understand that Lisa takes care of her and does not have the resources to go to the salon all the time. The activity in this scene demonstrates the denial and fear people in Uganda have about discussing HIV/AIDS openly without fear of being stigmatized. This depicts family members and relatives of PLHA as poor as illustrated by Topi “By the way Judith where is Lisa these days? I haven’t seen her here in ages” (line 56). Lisa is unable to join her friends because she lacks the funds to support her social life. A relationship between poverty and PLHA is demonstrated and this perspective communicates HIV/AIDS as an expensive. The Discourse connects the culture of silence associated with discussion of HIV/AIDS and PLHA. The sign systems and knowledge equates going to the salon as a social status that connotes privilege and wealth.

Episode 21 Scene 7

In this scene the Discourse revolves around Debra’s accident and having HIV/AIDS. Topi is narrating the incident where Debra got into an accident and nobody by the roadside came to help her apart from Topi. The significance of the Discourse shows Topi’s knowledge of Debra having HIV/AIDS, which she did not disclose of in Episode 7 scene 4 and Nana’s lack of knowledge about Debra’s health status. Topi is critical of Debra’s past, lines 42-70. The activity that is taking place shows Topi articulating the problem with youth like Debra who get HIV/AIDS because they are uneducated and ignorant about sex and sexual health matters and allow their partners to dictate the relationships. Topi represents modernity as she openly discusses reasons why Ugandan youth specifically girls contract HIV/AIDS, because of a lack of

knowledge about relationships and sex. PLHA who are women in the Discourse are represented negatively as young, victims, gullible, innocent, careless and irresponsible for instance when Topi describes Debra, line 68: “well, if you willfully stay ignorant it’s like making yourself a victim”. While men who have HIV/AIDS are represented as promiscuous, cunning and manipulative this is observed as Topi tells Nana, line 58: “How can the people of Rock Point be so blind? I knew Michael was up to no good”. The relationship the Discourse communicates is that parents do not discuss issues of sex and relationship openly which results in youth contracting STDs or HIV/AIDS since they are often innocent and gullible about practicing safe sex as Nana explains, line 67: “Maybe she [Debra] just didn’t think. None of us ever think that we could catch AIDS. We feel too smart for it”. The perspective of the Discourse allocates blame on youth’s lack of knowledge about sex and sexual health matters yet the language used does not blame or shift responsibility on parents for not discussing these matters with their children. Debra is blamed for contracting HIV/AIDS yet Lisa is not blamed for not educating Debra on sex and sexual health matters. The sign systems and knowledge are the societal and cultural markers that describe PLHA are: “young”, “innocent”, “victim”. “Playing around” describes sexual behaviour, and “HIV” and “AIDS” is the medical term used in describing Debra’s health status.

Episode 36 Scene 2

In this scene Topi, Nana and Lisa are discussing Steve’s mother’s admission at the Health Centre. The significance of the Discourse is that the ladies are acknowledging that Steve’s mother is sick with HIV/AIDS and informing themselves about the ARV treatment.

ARVs are unknown to Nana but it is Lisa who understands and is informed about them when she clarifies that widows and orphans receive the drugs for free, line 62. Lisa knows this information since her daughter Debra has HIV/AIDS and she financially supports her. The Discourse also illustrates Nana's ignorance about AIDS treatment even though she has knowledge of how HIV/AIDS is transmitted, in lines 56-62 and is educated on ARVs by Topi and Lisa. The other significance of the Discourse is how the ladies analyze Steve's sexual relationships and behavior. The ladies associate Steve's promiscuous ways with HIV/AIDS as well as his relationship with Stella the "fishmonger". The activity of the Discourse communicates PLHA as promiscuous, young, fishmongers and poor. The relationships in the Discourse connect HIV/AIDS with people who are fishermen or fishmongers, as well as people who are young, poor and promiscuous. The perception of the language in use depicts Ugandan youth's promiscuity as a negative; this is illustrated when Topi says, lines 69: "Meanwhile Steve. The way he plays with girls and that woman Stella he will soon go". "Soon go" meaning will soon die of HIV/AIDS. The other perspective that the Discourse shows is that ARVs are costly and therefore a privilege for PLHA who can afford it for instance when Nana wonders, line 61: "But will Steve be able to afford them?" The sign systems and knowledge in the Discourse examines the societal and cultural markers that are used for instance "sick" and "will soon go" suggests AIDS and the results of AIDS is death. "Play" signifies sexual behavior. "Fishmonger and player" connote a promiscuous person likely to contract HIV/AIDS, "widows and orphans" mean poverty and PLHA. "Virus" and "ARVs" imply HIV/AIDS the disease and AIDS treatment.

Gee's seven building tasks examine the context and situated meanings of the Discourse found in *RP256* episodes and scenes that illustrate the societal and cultural markers of PLHA and HIV/AIDS in the four categories. Table 1(a) in **Appendix 2** analyzes the six types of societal and

cultural markers used. These include the markers indicating HIV/AIDS, STI/STDs, the symptoms of HIV/AIDS, the impact of HIV/AIDS, the location of HIV/AIDS and lastly the markers that identify PLHA. Table 1(b) in **Appendix 2** tabulates the number of times these markers were articulated by the characters.

Using a Cultural Studies perspective it is understood that in Uganda knowledge of HIV/AIDS and PLHA is articulated through a matter of positionality; who is doing the speaking, to whom they are speaking and the reasons as to why they are speaking about HIV/AIDS and PLHA (Barker, 2000, 5). In the episodes analyzed above, the characters that have the authority and positionality to speak about HIV/AIDS are Steve, Betty, Steve's mother, Lisa, Debra, Topi, Judith, Sister Aisha, and the Doctor. These characters have the power to speak authoritatively about HIV/AIDS as they are either: PLHA, relatives and friends of PLHA, or medical physicians. The characters above speak about HIV/AIDS and PLHA to educate and inform others about it. Their use of the societal and cultural markers to stand in for HIV/AIDS demonstrates a culture of silence that is reproduced when sex and sexual health matters are not discussed openly between parents and youth or among peers for fear of being stigmatized or rejected in society.

Lisa and Debra speak adamantly against the culture of silence from their learned experience whereby issues pertaining to sex and sexual health matters were not discussed at home resulting in Debra contracting HIV/AIDS from her first sexual relationship. Steve's mother confronts the culture of silence when she tries to tell Steve to be careful in his sexual relationships however she is timid to speak directly with her child about HIV/AIDS therefore uses societal and cultural markers to reference it. Judith struggles to openly discuss matters pertaining to sex, HIV/AIDS and love with Rebecca and Robert. As a transitional character,

Judith is educated on the risks of not talking to her children about sex and HIV/AIDS by Lisa and Debra and manages to discuss these issues eventually in episode 22 scene 4. Sister Aisha uses her medical knowledge to impart information about sex, pregnancy, and HIV/AIDS to the female youth in Rock Point: Betty and Lillian. The Doctor, Coach Tito, and the traditional healer use their medical and learned and lived experiences to inform Steve about HIV/AIDS, STDs, ARVs, and the Health Centre. Topi at her hair salon engages in discussions about HIV/AIDS and PLHA, she creates a space where the adult females of Rock Point educate themselves about HIV/AIDS, who has it and its preventions.

Sister Aisha, the Doctor, Lisa, Debra, and Topi are the characters that use medical and factual terms in their communication of HIV/AIDS and PLHA. Whereas Steve, Steve's mother, and Judith use societal and cultural markers in terms of their communication of HIV/AIDS and PLHA.

The use of the societal and cultural markers in *RP256* is an indication of Ugandans' reactions to HIV/AIDS and PLHA. The fictional community of Rock Point represents that of any other fishing and farming community in rural Uganda and the Discourse used in *RP256* is meant to engage the audience listening to change their behavior or attitudes towards sex, STIs/STDs, HIV/AIDS and PLHA. *RP256*'s message is meant to be reliable and stable and a portrayal of the Ugandan national identity since 256 in the acronym (*RP256*) represents the national area code of the country (YEAH, 2012). However a national identity just as any other type of identity is always in a state of change, and formation and so there is no one definition for an identity let alone a Ugandan national identity (Jones, 1998, 315). Below is a map of Uganda's ethnic and tribal groups.

[illegible]

(Source: The Ritches in Uganda)

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more offensive one that would precisely designate what is intended” (Oxford English Dictionary, 2013). Euphemisms are used to deal with “taboo or sensitive subjects. It is therefore the language of evasion, hypocrisy, prudery, and deceit” (Holder, 2007, 7). In the case of this study, I chose to use the terminology of “societal” and “cultural” markers instead of euphemisms because this study is meant to examine the existence of a particular set of words and phrases present in *RP256* that characterize PLHA and HIV/AIDS. I could not state that the societal and cultural markers were Ugandan euphemisms for HIV/AIDS since there was no scholarly proof but a general belief of mine. By means of Gee’s seven building tasks and analysis of the episodes and scenes, I have found words and phrases that stand in for PLHA and HIV/AIDS. With further study these words and phrases could be classified as Ugandan euphemisms for HIV/AIDS and PLHA, but for the case of this study these words and phrases will be classified as societal and cultural markers.

As observed from Table 1, the findings from the analysis of the episodes and scenes show the following:

1. The societal and cultural markers of HIV are: illness, HIV positive, HIV virus, sick(ness), AIDS, condoms, protection, pneumonia, fever, infection, weak, tired, diseases, ill, ARVs, flu, virus, condition and infected.
2. The societal and cultural markers of STD/STIs are: STI(s), STD(s), sore and burns.
3. The societal and cultural markers of sexual behavior are: play(ing) sex, relating, sex, safe sex, unsafe sex, sexual relationships, sexual partners, condom(s), protection, sleeping, and pregnancy or pregnant.

4. The societal and cultural markers of HIV/AIDS symptoms are: sick(ness), sore, burns, weak, tired, fever, illness, pneumonia, ill, and flu.
5. The societal and cultural markers of the impact of HIV/AIDS are: to die, death, painkillers, medicine/ medication, ARVs, to infect, and treatment.
6. The societal and cultural marker of the location of HIV/AIDS was in the Health Centre, hospital, and the village.

Tables 2 and 3 in **Appendix 2** show the number of times the cultural and societal markers were articulated. By referring to this table we are able to examine that the societal and cultural markers that were used the most were: sick(ness), which was articulated 24 times, HIV positive virus 22 times, AIDS 39 times, and to die/ death 23 times. This proves that in the three quarters that were analyzed, “sick(ness)” is the commonly used cultural marker to reference HIV/AIDS, whereas “HIV positive”, “virus” and “AIDS” are used both as a medical and cultural marker as a result interchangeable in particular contexts.

The societal and cultural markers of PLHA are associated with poverty, someone being young, and naive, someone who is promiscuous, prostitutes, fishermen or fishmongers, and widows. PLHA are labelled as dangerous individuals, victims of their circumstance, sick and infected.

The societal and cultural markers play a pivotal role in reinforcing the culture of silence present in Uganda and this culture of silence originates from the social stigma of HIV/AIDS

where a fear of dread and embarrassment to openly discuss matters such as HIV/AIDS is prevalent in Uganda.

The markers of HIV/AIDS and PLHA are socialized and naturalized as truth and fact that someone being “sick” or “ill” is an indicator that they have HIV/AIDS. The markers in *RP256* take the place of the medical and factual term in order to present or depict the mental image of what the HIV/AIDS is and who PLHA are in rural Uganda (Jhally, 1997). Until a listener tunes into *RP256*, they may not know about HIV/AIDS or may never have had any known interaction with a PLHA, however after tuning in one comes to understand that the representation of HIV/AIDS and PLHA is given meaning through Steve’s mother and Debra’s interactions, the dilemmas they face and how the local Rock Point community treats them. Consequently the true meaning of what HIV/AIDS is and who PLHA are depends on what people take away from *RP256*’s Discourse (Jhally, 1997). The markers are cultural and societal ideologies that aim to fix meaning to what HIV/AIDS is and who PLHA are in Uganda (Jhally, 1997). An ideology has the power to define and represent a people and profess “ideological truths” that are falsehoods of the perceived life of PLHA and HIV/AIDS in Uganda (Hall, 1990, 161). As a result, the societal and cultural markers used in *RP256* represent HIV/AIDS as a disease that is stigmatized, and ostracises people from their communities, it is feared, costly and results in death. Accordingly, PLHA are feared, stigmatized and ostracised in rural areas of Uganda.

For example, in episode 20 scene 2, Debra was ostracised in the Rock Point community when no one came to help her by the roadside or at the Health Centre after the motor accident she was involved in. The people of Rock Point believe Debra is danger to their health condition and they do not help her apart from the exception of Topi and Sister Aisha. In episode 32 scene 2, when Steve, John and Betty are rushing Steve’s mother to the Health Centre, John is afraid to

wipe the sweat from Steve's mother because he fears he will "fall sick" and does not do it (line 67). John believes that Steve's mother is a danger to his own health condition.

To summarize, the societal and cultural markers of HIV/AIDS and PLHA in *RP256* signify the existence of the culture of silence that deviates HIV/AIDS or PLHA in the language used out of fear of what people in society may think, say or do; if people speak directly about HIV/AIDS will that result in betrayal of a cultural code?, if people stop living in denial and speak of their condition will they be welcomed or rejected?, if youth hear messages of sex and sexual health will that make them more sexually active?, if family relatives speak for and about their loved ones' condition, will they be labelled as a PLHA also?

In respect to HIV/AIDS the culture of silence perpetuates the use of societal and cultural markers as a tactic to avoid speaking about HIV/AIDS and PLHA for fear of the negative impact it has.

Question 2: To what extent does the narrative found in *RP256* communicate Ugandan societal beliefs and ideologies toward PLHA and HIV/AIDS?

Fairclough's critical discourse analysis helps to examine the Ugandan societal beliefs and ideologies toward PLHA and HIV/AIDS. This is done using the experiential, relational and expressive values that were discussed in the methodology. The societal beliefs and ideologies about HIV/AIDS and PLHA are demonstrated in the language used on *RP256* specifically the societal and cultural markers that are ideological beliefs that aim to fix meaning and labels of PLHA and HIV/AIDS in Uganda. The societal and cultural markers operate as "common sense assumptions" for example anybody who is "sick" in *RP256* has HIV/AIDS, Rebecca's cousin, Tina is mistaken to have HIV/AIDS in episode 7 scene 5 because she lives in the village and is "sick", however it is later clarified that she has fistula instead of HIV/AIDS. Another example in *RP256* is how fishermen are all assumed to have HIV/AIDS due to their profession; it is low income and through their sexual behaviour as is the case with Steve's characterization in episode 36 scene 5.

The effectiveness of an ideology depends on how that ideology is merged or socialized into society (Fairclough, 1989, 77). The common sense assumptions of the societal and cultural markers of HIV/AIDS and PLHA in *RP256* are a social practice in Uganda and are a natural occurrence in language, and are not questioned. The societal and cultural markers are the dominant discourse type when referring to HIV/AIDS and PLHA. A Dominant Discourse type refers to the "...establishment or maintenance of certain ideological assumptions as commonsensical" (90). The truth and facts of who PLHA are and what HIV/AIDS is, becomes "... ideological common sense to the extent that the Discourse types which embody them

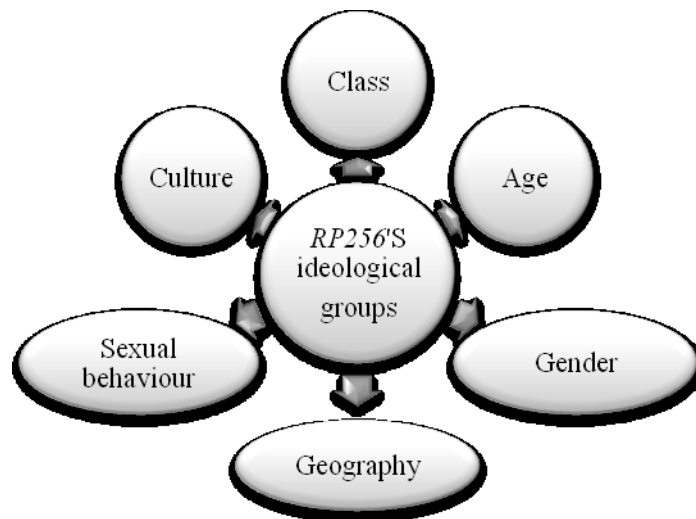
become naturalized” (92). As mentioned earlier, the markers attempt to fix meaning about HIV/AIDS and PLHA; they stand in for the factual term that is avoided due to the sensitivity of HIV/AIDS in Uganda and the social stigma of the disease. Yet problems arise when the naturalization of the societal and cultural markers become the assumed knowledge about HIV/AIDS and PLHA (105). The assumed knowledge is false and is not based on factual or medical information of PLHA and HIV/AIDS (105). For example, in episode 23 scene 3, Steve goes to the traditional healer/ witch doctor to get a magic potion for his STD as his fishing friends believe that when men have STDs, a spell has been cast upon them, line 51. The societal and cultural markers Steve uses to reference the STD are: “sore”, “burn”, and “wound”. Steve is later informed by the traditional healer that he got the STD through unprotected sex, line 69. The Discourse portrays the false “ideological truths” people in rural Uganda have about STDs and the way they are contracted and treated, that is the traditional healer or witch doctor’s potions are preferred to a medical doctor’s diagnosis and treatment.

The experiential value “is a trace of and cue to the way in which the text producer’s experience of the natural or social world is represented” (Fairclough, 1989, 112). Therefore the experiential values of PLHA in *RP256* are represented through the use of the societal and cultural markers that label PLHA as: poor, young, female, promiscuous, prostitutes, fishermen, widows and orphans. PLHA are either dangerous people or victims of their circumstance. For example, Steve’s mother is a PLHA who is poor, a widow, she was once married to a fisherman, she had an adulterous affair therefore is promiscuous and is a victim of her circumstances whereby she cannot take care of her family. Steve’s mother is the ideal PLHA.

In terms of how the natural or social Uganda is represented on *RP256*, there are 6 experiential values termed the ideological groups that categorize PLHA and HIV/AIDS. They

are as follows; the class, age, sexual behaviour, geographic, gender and cultural ideology. Below is a diagram that shows a mapping of the six ideological groups.

The Six Ideological groups



The class ideology has two sub groups, the first is the poor versus rich and the second is educated versus the illiterate.

The poor versus rich ideology in *RP256* represents false “ideological truths” of PLHA as always living in poverty. For instance, Steve’s mother is unable to support her family because she is too weak to do so therefore her son has to become the breadwinner as illustrated in episode 1 scene 2, line 20 when Steve’s mother discusses this issue with Steve: “you’re only 19 and already supporting a family” indicating her inability to support her children.

Debra is the second person in Rock Point that has HIV/AIDS, Debra in episode 21 scene 3, line 9 confides in Judith about the impacts of HIV/AIDS on her mother and their relationship: “Sometimes, I feel like a burden to her- all the money she has to spend on me like this”.

Relatives of PLHA are portrayed as living in poverty whereby Lisa in episode 1 scene 8 and episode 20 scene 2, asks Judith for money. The poor versus rich ideology labels all PLHA in rural Uganda; poor, and women who do not have the means to care for themselves or their families. This is a false truth as HIV/AIDS affects all types of Ugandans from every tribe, religion, class and social status not only poor women in rural areas.

The educated versus the illiterate ideology in *RP256* of PLHA is depicted through Debra's ignorance about sex and sexual health matters that resulted in her getting HIV/AIDS from her boyfriend at the time as narrated in episode 13 scene 6. In episode 21 scene 7, line 64 Topi speaks about Debra's lack of knowledge and gullibility in relation to the way she got HIV/AIDS: "The girl was innocent. In fact, half asleep. You can't shut your eyes and pretend that HIV doesn't exist, Nana. A girl needs to go into relationships with her eyes open". Implying that youth in rural Uganda specifically girls are more susceptible to getting HIV/AIDS because they are not educated on sex and sexual health matters. The false truth presented in this ideology is that HIV/AIDS affects only young ignorant women in rural areas however HIV/AIDS also affects young men and adults who are also oblivious to what HIV/AIDS is and how it is transmitted.

Secondly, the age ideology in *RP256* of PLHA is examined through Debra's relationship with Michael that led to her contracting HIV/AIDS, this was her first sexual relationship and she was young and innocent lacking knowledge about sex and sexual health matters because she was never informed about them. Age also plays a factor with Steve's mother's situation whereby she is older, a mother and a widow. Therefore the age ideological truth fixes meaning that HIV/AIDS in rural Uganda predominantly affects young women who are uninformed or older women who have families.

Third, the sexual behaviour ideology references abstinence versus sexual activity, that is PLHA are deemed promiscuous if females and labelled prostitutes or if males are labelled players. For instance, in episode 16 scene 6, line 32 Steve labels Vicky a prostitute. Although it is not disclosed in the three quarters that were analyzed that Vicky had HIV/AIDS, she is referenced by Steve and Rebecca as a prostitute for being sexually active and as a result may have HIV/AIDS. Steve is labelled a player by Topi in *RP256* in episode 36 scene 2, lines 69- 71. Nana in episode 36 scene 2, line 70 uses the term “fishmonger” to describe Stella. Stella is assumed to have HIV/AIDS by the words Topi and Nana use to describe her risky sexual behavior that will endanger Steve. In episode 33 scene 5, line 253 Sister Aisha assumes that Solomon, Lillian’s sugar daddy has HIV/AIDS due to his promiscuity and adulterous tendencies. In *RP256* it is assumed that when someone has concurrent sexual relationships or is sexually active they have HIV/AIDS. PLHA are single and engage in pre-marital sex in the case of Debra or are married and engage in adulterous affairs in the case of Steve’s mother. *RP256* Discourse represents HIV/AIDS as a disease that is transmitted ONLY through sexual intercourse and this is a false ideological assumption. Since HIV/AIDS is transmitted in various ways such as; blood transfusions, occupational exposure, sharing of used drug injections, pregnancy, childbirth and breastfeeding (Aids.gov, 2012).

Fourth, geography ideology in *RP256* locates and portrays HIV/AIDS as a disease that only affects those who live in rural areas or villages and whose livelihood and trade is fishing. The mental representation of village life is one of death, sickness and anguish. The societal and cultural markers make assumptions that village life can be equated to death, sickness, ignorance and HIV/AIDS. A good example of this ideological assumption is illustrated with Steve’s family that lives in the village area of Rock Point. Steve’s mother is PLHA , unemployed, her husband

was a fisherman that died of HIV/AIDS. Now her son Steve works as a fisherman part time and has multiple sexual relationships with women in Rock Point, he too is assumed to be at risk of contracting HIV/AIDS. HIV/AIDS has no definite location; it affects all types of people in Uganda, that is in Kampala, Gulu, Mbarara, Soroti, in urban or rural areas. HIV/AIDS does not only affect fishermen but all Ugandans of different walks and occupations. HIV/AIDS cannot be pinpointed to a particular sect of people or location, the falsehood in *RP256* represents PLHA in rural areas or villages in Uganda and of a certain trade; fishermen or prostitutes.

Another geographical ideology is the public versus private space. PLHA only have a voice in the parameters of the Health Centre, and their homes. Debra speaks openly and freely about her experience to Judith at the Health Centre or at her home. Steve's mother only speaks to Steve and Betty in her home. Both Steve's mother and Debra's interactions are limited and constrained to private settings such as the home or if they are in public settings the conversations are private. In the three quarters Debra and Steve's mother had no interaction with the general public apart from their immediate family members.

The Health Center is positioned as a place and a space where PLHA are taken care of and youth learn about HIV/AIDS. It is at the Health Centre that Steve's mother is treated after her near death experience and this is where Steve and Betty are informed by medical experts about HIV/AIDS and ARVs. The Health Centre is where Debra counsels Judith. It is at the home where HIV/AIDS, and sex are discussed openly amongst Judith, Lisa and Debra and to an extent with Steve's mother, Steve and Betty. HIV/AIDS Discourse is only permissible in few public spaces in Uganda such as Health Centres or hospitals and the home. Amongst youth HIV/AIDS is discussed in setting where peers hang out for instance at Foundation High School or the Rock Point Bar and soccer pitch. The geography ideology attempts to fix meaning on the boundaries

that HIV/AIDS Discourse should take place, thus it is not a subject to discuss anywhere in Ugandan society. The Discourse also sets boundaries with whom PLHA are able to interact with; Debra mostly interacts with her mother and Judith whereas Steve's mother only interacts with her children.

Fifth, gender ideology in *RP256*, depicts PLHA in rural Uganda as mostly women. Debra and Steve's mother are the only living representations of PLHA and their partners that infected them are dead. These women are unable to function in society without guidance and help from loved ones. Debra is unable to pay for the ARVs and other treatment so Lisa always asks Judith to lend her money to take care of Debra as illustrated in episode 1 scene 8, and episode 20 scene 2. Steve's mother is unable to care for the family and so Steve starts a relationship with Stella for transactional benefits as well as works part time as a fisherman. The false truth is that PLHA in rural areas are only women and are weak and helpless.

Lastly, we examine the cultural ideology in *RP256* whereby PLHA speak about their experience using societal and cultural markers or using medical and factual terms. Debra is a PLHA of a modern era. Debra works as a counselor at the Health Centre and openly speaks about sex, love and HIV/AIDS when given a chance to, to help others. Debra mostly uses medical and factual terms when talking about sex and sexual health issues. Steve's mother seldom discusses HIV/AIDS or sex openly instead uses societal and cultural markers such as "relating" to refer to sex and "sickness" to refer to HIV/AIDS. The way a person is socialized to discuss matters from an early age affects how they discuss matters about a sensitive subject such as HIV/AIDS. Steve's mother's has socialized and naturalized her communication of HIV/AIDS, sex and love culturally and traditionally that it is hard for her to cut ties with the practice. Whereas Debra who is younger has learned to discuss HIV/AIDS and sexual matters directly

using medical and factual terms, through her experience she has been able to cut ties with the culture of silence that is practiced that deviates talking about HIV/AIDS openly.

The relational value “is a trace of and cue to the social relationships which are enacted via the text in the discourse” (Fairclough, 1989, 112). The social relationships of PLHA in *RP256* are as follows: Lisa and Debra’s mother daughter relationship, and Debra’s relationship as Judith’s guidance counselor. Steve’s mother only has two social relationships with her children; Steve and Betty. The social relationships that involve Discourse of HIV/AIDS are carried out by Lisa and Judith who talk about Debra’s condition and past. Sister Aisha who counsels Betty and Lillian about sex and sexual health matters. The Doctor, Coach Tito, and the traditional healer give Steve advice on HIV/AIDS, STDs, ARVs, and the Health Centre. Topi , Nana, Judith and Lisa who discuss Rock Point resident’s social lives as well as sexual health matters.

The expressive value is “a trace of and cue to the producer’s evaluation of the bit of reality [that *RP256*’s Discourse] relates to”, this value focuses on the social identities of the Discourse and how the meaning reflects on the social subjects represented in *RP256*.

Steve’s mother as a subject represents the traditional village widow who practices the culture of silence. She does not discuss sex or sexual health matters directly with her children but prefers the use of societal and cultural markers to discuss issues. She lives in the village and is portrayed as sick, weak, tired, widow, having fever and poor. Steve’s mother is ostracized in the community and is only looked after and aided by Steve and Betty. She is uneducated as we observe in episode 9 scene 6 line 8, she tells Steve ”Soon I will be able to weave my baskets”. Steve’s mother is the example of the negative ramifications of HIV/AIDS, that is mothers are

unable to care of their families and the family morals disintegrate as a result. Steve's mother is depicted as a negative example of a PLHA in rural Uganda.

Debra as a subject educates Judith about her experiences and advocates for Judith to discuss matters pertaining to sex and sexual health matters with her children. She works as a counsellor and is cared for by her mother and the community that is we also observe that Topi and Sister Aisha come to Debra's aid after her accident in episode 20 scene 2. Factors leading to Debra contracting HIV/AIDS were her youthful innocence and lack of knowledge with her first sexual relationship. Debra is portrayed as the positive example of a PLHA in rural Uganda.

The represented stereotypes of PLHA in Uganda are: poor, illiterate, young, widows, women and live in rural areas or villages. HIV/AIDS is naturalized through the use of the cultural and societal markers that are ideological truths that articulate PLHA from one position. This shows the power struggle of knowledge and beliefs of HIV/AIDS and PLHA at the text producers' level. The Discourse found in *RP256* about PLHA and HIV/AIDS is structured in ideologies that reproduce the knowledge and belief systems through the use of societal and cultural markers that are not medical or factual terms. The power struggles are based on the cultural and societal markers as ideological beliefs that are socialized as fact and truth of PLHA and HIV/AIDS. Thus creating an Us versus Them narrative that comes into existence; PLHA versus the rest of Ugandan society (Boudon, 1986, 19). This is illustrated in episode 20 scene 5 when Debra got into an accident, she was left to fend for herself because of the fear people had in contracting HIV/AIDS. It was Debra a PLHA versus the Rock Point society.

When audiences identify with fictional characters there is the development of self-identity "self-identity is related to our perception of others and how they view us" (246). The

Discourse in *RP256* about PLHA and HIV/AIDS requires the audience to situate themselves into the lives of characters that are portrayed and this involves an “us versus them” discourse whereby the audience is meant to “forget [themselves] and became the other-that [they] assure for [themselves] the identity of the target of our identification” (247). Identifying with characters who have HIV/AIDS or who are indirectly affected “means that the knowledge of the audience members is processed from the character’s perspective and is transferred into emphatic emotions” (251). The process of identification takes place when the audience member forms an affection or relation to a character, however identification is halted if there is an interruption with the audience member viewership and they are forced to view circumstances in their real time that is lived experiences (252).

The social practice of societal and cultural markers that are used in *RP256* to communicate information about HIV/AIDS, and the lived experiences of PLHA work to reproduce negative stereotypes and ideologies of HIV/AIDS and PLHA but more so marginalises PLHA to a set category in Ugandan society that are poor, female, living in rural areas or in the village are promiscuous and young. The identity of PLHA is socially constructed in the narrative and can be negotiated or contested with the audience members positioning of the knowledge learned yet the identification of HIV/AIDS is an exact representation of the disease in Uganda and so that knowledge cannot be negotiated or contested when used as societal and cultural markers. *RP256* is essentially tasked to describe and identify the social, economic, sexual and cultural practices of PLHA in order to educate the masses about sex and sexual health matters. As well as to represent the everyday life of rural Ugandans which in turn has led to the examination of the power struggles inherent in the language used as a “social practice” that reinforces false truths about PLHA and HIV/AIDS (Fairclough, 1989, 138).

There are three levels of reading Discourse in *RP256*. The first level is meant to educate *RP256* audience members on HIV/AIDS and PLHA. For instance Barker's (2004) values grid in **Appendix 2** outlines the issues that *RP256* deals with such as HIV/AIDS, youth, gender, misconceptions or rumours, economic issues and dialogue that essentially outline the learning tools *RP256* demonstrates in its narrative.

At the second level reading the ideological assumptions illustrated through the societal and cultural markers of HIV/AIDS and PLHA reinforce the three types of social stigma associated with HIV/AIDS and PLHA. Steve's mother is referred to as sick, weak and tired by her children and community, thus ostracizing her and continuing to naturalize the negative effects of HIV/AIDS. This type of stigma is received stigma. Received stigma is that stigma a PLHA receives from themselves or others in their community and in *RP256* it examines that the community talk of Steve's mother's sickness but do not help her or her children who are living in poverty because they do not want to be associated with a PLHA. Debra has internal stigma and this is observed in episode 21 scene 3 when she expresses her guilt and the shame of her having HIV/AIDS. As the positive PLHA Debra's regret and condemnation makes her a subject and victim thus all PLHA are victims and live unhappy lives. Associated stigma is reinforced with Steve and Lisa. Steve's mother is sick and unable to care for her family, Steve starts to work as a fisherman and uses Stella as a way of providing the basic necessities for his family. Lisa is unemployed and continually asks for money from Judith to support her family and Debra's expenses. The Discourse reinforces the stigma that HIV/AIDS economically drains PLHA and their loved ones subjecting them to poverty.

At the third level reading one finds the power struggles of ideology inherent in the text, different social groupings of age, sexual behavior, gender, geographical, cultural, social status

and class stereotype and frame PLHA as women, poor, living in rural areas or the village, young, and illiterate. Michael and Steve's father are mentioned in passing as having infected Debra and Steve's mother and Stella respectively however, their death omits them from being referred to as PLHA because they are already dead.

To conclude, as a medium of communication, radio has the ability to act as a protagonist, antagonist, or social actor towards a particular cause, ideology, and calamity (Montanari, 2003, 139). Therefore, representation of PLHA and HIV/AIDS in the analyzed episodes and scenes of quarters 1-3 is the process by which language is used to produce meaning about HIV/AIDS and PLHA, and is reproduced through the naturalization of societal and cultural markers that profess false ideological truths.

Chapter 5: Conclusion

This chapter will be divided into six sections: the first section will examine the objective of the study; the second will look at the research that was conducted; third section will analyze the findings of the study; the fourth section will discuss the contribution of the study; the fifth section will list the limitations and challenges of the study; and the sixth section will state the future recommendations.

Objective of the study

The key objective of this study was to examine the use of language and meaning of HIV/AIDS and PLHA present in *RP256*'s narrative. I wanted to understand and learn how media in Uganda specifically radio has been able to communicate and inform Ugandans about HIV/AIDS and PLHA. *RP256* is one of the many media campaigns that the BCC, YEAH has in Uganda that is meant to “simulate dialogue and action among communities, families, schools and health institutions and model positive practice through local and national media” (YEAH, 2012). As an E-E *RP256*'s goal is to communicate better health practices and behaviors to its audience demographic of 15-24 year-olds. In order to have a guideline of how characters evolve or regress the use of language is critical in referencing societal and health matters such as: sex, abstinence, HIV/AIDS, STIs/STDs, transactional relationships, gender equality, and family planning. The words and phrases used to identify PLHA and HIV/AIDS were termed cultural and societal markers. The cultural and societal markers are the ideological or general beliefs of what HIV/AIDS is and who PLHA are.

The Research

The theoretical framework that guided this study was the Cultural Studies perspective. The Cultural Studies approach was used in order to better understand the correlation between the representation of PLHA and HIV/AIDS and the ideologies communicated through the use of the cultural and societal markers that attempt to fix meaning to what HIV/AIDS is and who PLHA are in rural Uganda (Jhally, 1997). In order to find meaning of *RP256*'s representation of PLHA and HIV/AIDS three quarters of the E-E were analyzed that comprised a total of 37 episodes. The following were the questions posed to guide this study:

1. What are the cultural and societal markers that are used in *RP256* to represent the life and experiences of PLHA and HIV/AIDS?
2. To what extent does the narrative found in *RP256* communicate Ugandan societal beliefs and ideologies toward PLHA and HIV/AIDS?

The methodological framework used was Discourse Analysis. I used two types of Discourse analysis; Gee's(1999) Discourse Analysis and Fairclough's (1989) Critical Discourse Analysis (CDA). Using Gee's Discourse Analysis, the seven building tasks were employed to identify the societal and cultural markers used in *RP256* that represent PLHA and HIV/AIDS. The seven building tasks critically analyzed each episode and scene that involved Discourse on HIV/AIDS and PLHA to categorize the existing societal and cultural markers.

Fairclough's (1989) Critical Discourse analysis was used to examine the experiential, relational and expressive values of the societal beliefs and ideologies toward PLHA and HIV/AIDS in *RP256*. Fairclough's analysis examined the power struggles in the Discourse of *RP256* that is the ideology that articulated and naturalized the way HIV/AIDS and PLHA were spoken about, spoken to and who was doing the speaking. Naturalization is the process of an

“ideological truth” or common sense assumptions being practiced by a society that it becomes the appropriated truth and status quo (Fairclough, 1989, 91). In this study’s case the societal and cultural markers that reference HIV/AIDS and PLHA in Ugandan society are a good example of the naturalization of people’s fear in discussing sex and sexual health issues openly. The markers show the naturalization of the stigma that is associated with HIV/AIDS which induces feelings of “fear, revulsion, anger, contempt, self-righteousness, sympathy, pity and shame” among a community (Devine et al, 1999, 1212).

The Findings

On the question: What are the cultural and societal markers that are used in *RP256* to represent the life and experiences of PLHA and HIV/AIDS?

The following societal and cultural markers used to identify HIV/AIDS are: illness, HIV positive, HIV virus, sick(ness), AIDS, condoms, protection, pneumonia, fever, infection, weak, tired, diseases, ill, ARVs, flu, virus, condition and infected. The societal and cultural markers of STD/STIs are: STI(s), STD(s), sore and burns. The societal and cultural markers of sexual behavior are: play(ing) sex, relating, sex, safe sex, unsafe sex, sexual relationships, sexual partners, condom(s), protection, sleeping, and pregnancy or pregnant. The societal and cultural markers of HIV/AIDS symptoms are: sick (ness), sore, burns, weak, tired, fever, illness, pneumonia, ill, and flu. The societal and cultural markers of the impact of HIV/AIDS are: to die, death, painkillers, medicine/ medication, ARVs, to infect, and treatment. The societal and cultural marker of the location of HIV/AIDS was in the Health Centre, hospital, and the village. The societal and cultural markers that were used to identify PLHA are: are associated with poverty, someone being young and innocent, someone being promiscuous or player, someone

who is a prostitute, fisherman or fishmonger. PLHA were associated as people who were suffering, widows, and orphans. PLHA are labelled dangerous, victims, sick and infected.

On the question: To what extent does the narrative found in *RP256* communicate Ugandan societal beliefs and ideologies toward PLHA and HIV/AIDS?

The experiential values of PLHA in *RP256* are represented through the use of the societal and cultural markers that label PLHA as: poor, young, female, promiscuous, prostitutes, fishermen, widows and orphans. PLHA are either dangerous people or victims of their circumstance. These labels originate from the 6 ideological groups that categorize PLHA and HIV/AIDS. The ideological groups are; the class, age, sexual behaviour, geography, gender and cultural ideology.

The relational value evolves from the social relationships of PLHA in *RP256*: Lisa and Debra's mother daughter relationship, and Debra's relationship as Judith's guidance counselor. Steve's mother has no social relationships apart from those with her children; Steve and Betty.

The expressive value focuses on the social identities of the Discourse and how the meaning reflects on the social subjects who have HIV/AIDS. Steve's mother as a subject represents the traditional village widow who is unable to care for her family since she is too weak to do anything; as a result she lives in poverty unable to afford daily necessities. Whereas Debra as a social subject works as a counselor at the Health Centre, she is cared for by many in her community; although she contracted HIV/AIDS through ignorance she has learned from her mistake and educates others about it. HIV/AIDS is represented in a different lens with each of the above social subject's experiences of how they contracted the disease and how they continue to live in the community. Debra represents the positive aspects of a PLHA while Steve's mother represents the negative aspect of a PLHA.

RP256 Discourse is understood in three levels of readings. The first level is the information the Discourse uses to educate its audience on sex and sexual health issues. The second level reading is the ideological assumptions illustrated through the societal and cultural markers of HIV/AIDS and PLHA that reinforce three types of social stigma PLHA face in Uganda: received, internal and associated stigma.

The third level reading illustrates the power struggles of ideology inherent in the text of age, sexual behavior, gender, geography, cultural, and class that stereotype and frame PLHA as women, widows, poor, living in rural areas or the village, young, and illiterate.

Contributions of the Study

RP256's objective is meant to entertain and inform Ugandans about HIV/AIDS to incite positive attitudes and behavior among their audience members. However the findings suggest that HIV/AIDS stigma still exists in present day Uganda. The use of the societal and cultural markers conveys a culture of silence that encourages youth and parents to avoid discussing issues of sex and sexual health matters. The culture of silence encourages PLHA to lie about their condition for fear of rejection from their loved ones and the community. The culture of silence is an act of denial and a fear to talk about HIV/AIDS.

The contributions of this study will help improve *RP256*'s technical message and portrayal of HIV/AIDS and PLHA in the long run. This study's findings examined the content that is produced. This is important because the degree of impact an E-E such as *RP256* has depends on Discourse it is communicating or omitting about HIV/AIDS and PLHA. The findings of this study indicate that the material and issues inherent in the first three quarters on HIV/AIDS and PLHA are stereotypical representations of PLHA in rural areas as: poor, women, and low

income, young, uneducated and if educated worked in menial jobs, they lived in the village and were widows or single women. This representation of PLHA is an inaccurate illustration of PLHA in Uganda as “HIV does not discriminate between good or bad” (episode 20 scene 5, line 53). The Discourse in *RP256* at a first level reading educates society and the target audience members about sex and sexual health matter however at a second and third reading reinforces stereotypes about HIV/AIDS and PLHA that continue to stigmatize PLHA socially, economically, and culturally.

The findings of this study may contribute to the study of E-Es worldwide. Indeed, this study examined *RP256*'s representation of PLHA and HIV/AIDS, using the an interdisciplinary theoretical frameworks from Cultural Studies as well Gee's and Fairclough's Discourse analysis methodologically. Most of the studies about E-E's analyze the impacts an E-E may have on a studied population. This study is a nice add-up because it focuses not only on the cultural and social markers, but as well on the ways in which Uganda's ideological, stereotypes, stigmatic, and discriminatory social articulations create “false” representations about HIV/AIDS and PLHA.

Limitations and Challenges

First, the language-context analysis of Gee's and Fairclough's discourse analysis could have gone into more detail and incorporated more of the aural sound effects. As a researcher this was the first time I used a Language-context analysis in hindsight more time was needed to fully utilize my language-context analysis skills to fully use both Gee's and Fairclough's analyses.

Second, due to time duration of the thesis and page limit constraints only three quarters were analyzed and the findings cannot be generalized to all the twenty quarters of the show. It

would have been beneficial to have analyzed the first 10 quarters of *RP256* in order to examine the Discourse of PLHA and HIV/AIDS over the course of *RP256*'s continued success on Ugandan airwaves.

Third, as a Ugandan I have been socialized and naturalized in the culture of silence and I have practiced it and used the societal and cultural markers in communicating issues such as HIV/AIDS myself. Therefore I was able to find the societal and cultural markers, through my own lived experience as well as with the use of Gee's seven building tasks. However as a Ugandan looking into my own people and the way we communicate was not easy to accept and acknowledge the a fear based reaction of dealing with issues openly and directly, for fear of being rejected or losing approval of loved ones and people in society. Owning up to the truth of the findings was a challenge I faced as a researcher.

Future Research

The first action I would undertake is to send the results of this study to YEAH offices in Uganda as well as HCP, a partner organization whose offices are located in the United States. Indeed, we believe that the results of this research may help these actors see how they could improve *RP256*'s message about HIV/AIDS and PLHA.

Another recommendation for future research would be to carry out a longitudinal ethnographic study with listeners of *RP256* who are PLHA and those who do not have HIV/AIDS. Such a research could help scholars better understand how this particular population receives, interprets and understands the messages as well as how what could be the best practices, medium, an articulation to impact this population. Following Creswell definition ethnography as “ a qualitative strategy in which the researcher studies an intact cultural group in

a natural setting over a prolonged period of time by collecting primarily observational and interview data” (2009, p.229), such as could be carried out to effectively measure the social and cultural articulation of a disease such as HIV/AIDS. This would indeed help to get a better understanding of how the targeted audience members receive and reproduce *RP256* messages.

REFERENCES

- Abrams, L.C., & Maibach, E.W. (2008). The Effectiveness of Mass Communication to change Public Behavior. *Annual Review of Health*. 29: 219-234.
- AIDS.gov. (2012, June 6). How do you get HIV or AIDS? Retrieved from <http://aids.gov/>
- Allen, T. and Heald, S. (2004). HIV/AIDS Policy in Africa: What has worked in Uganda and what has failed in Botswana? *Journal of International Development*. 16, 1141-1154.
- Amienyi, O.P. (1996). Sub-Sahara Africa. In *World Broadcasting : A Comparative View*. A. Wells. New Jersey: Ablex Publishing Corporation
- Atkin, C.K. (2001). Theory and Principles of Media Health Campaigns. In R.E. Rice & C.K. Atkin (Eds.) *Public Communication Campaigns*. California: Sage Publications Inc.
- Avert: Averting HIV and AIDS (2011). THE ABC of HIV Prevention. Retrieved from <http://www.avert.org/abc-hiv.htm>
- Baldwin, J.R., Perry, S.D., and Moffitt, MA. (2004). *Communication Theories for Everyday life*. Boston: Pearson Education Inc.
- Baker, K. (2005). Sex, Soap, and Social Change: The Sabido Methodology. In *Global Public Health Communication: Challenges, Perspectives and Strategies*. (Eds). M. Haider. Boston: Jones and Bartlett Publishers.
- Bandura, A. Social Cognitive Theory for personal and Social change by enabling media. *Entertainment-Education and Social change*. N/A: 75-96.
- Bandura, A. (2004). Social Cognitive Theory for Personal and Social Change by enabling Media. In *Entertainment-Educations and Social Change: History, Research, and Practice*. A.Singhal, M.J. Cody., E.M. Rogers & M. Sabido (Eds). Lawrence Erlbaum Associates, New Jersey.
- Barker, C. (2000). *Cultural Studies: Theory and Practice*. London: Sage Publications Limited.
- Barlas, R., & Yong, J.L. (2000). *Cultures of the World ; Uganda*. New York; Tmies Media Private Limited.
- Barry, A.K.(2002). *English Grammar: Language as Human Behavior*. Prentice Hall: New Jersey.
- Bayer, R. (1996). Societal and Political Impact of HIV/AIDS. In *AIDS in the World II*. (Eds). J. Mann and D. Tarantola. New York: Oxford University Press.

- Berkley, S., Namara, W., Okware, S., Downing, R., Lule-Konde, S., Wawer, M., Musagara, M., & Musgrove, S. (1990). AIDS and HIV infection in Uganda-are more women infected than men? *AIDS*. 4, 1237-1242.
- Berland, J. (1990). Radio Space and Industrial Time: Music formats, local Narratives and Technological Mediation. *Popular Music*. 9(2):179-192
- Boardman, J., and Ovuga, E. (1997). Rebuilding Psychiatry in Uganda. *Psychiatric Bulletin*. 21: 649-655.
- Boudon, R. (1986). The Analysis of Ideology. The University of Chicago Press: Chicago.
- Bourgault, L.M. (2009). AIDS messages in three AIDS-themed Indian movies: Eroding AIDS-related stigma in India and beyond. *Journal of South-North Cultural and Media Studies*. 23(2): 171-189.
- Brown, L., Macintyre, K., & Trujillo, L. (2003). Interventions to reduce HIV/AIDS stigma: What have we learned? *AIDS Education and Prevention*. 15(1), 49-69.
- Bruner, J.S. (1986). Actual Minds, Possible words. Cambridge, MA: Harvard University Press.
- Byrnes, R.M. (1992). *Uganda*. Washington: The Division.
- Cassell, M.M., Jackson, C., Cheurant, B. (1998). Health Communication on the Internet: An Effective Channel for Health Behavior Change? *Journal of Health Communication*. 3:71-79.
- Cerulo, K.A. (1997). Identity Construction: New Issues, New Directions. *Annual Review Sociology*. 23, 385-409.
- Cohen, J. (2001). Defining Identification: A theoretical look at the identification of audiences with media characters. *Mass Communication and Society*. 4: 245-264.
- Cohen, J., & Tate, T. (2006). The less they know, the Better: Abstinence-Only HIV/AIDS Progress in Uganda. *Reproductive Health Matters*. 14(28): 174-178
- Colette, A., and Simbay, L.C. (2006). AIDS Advocacy in South Africa. L.R. Sherrod, C.A. Flanagan, R. Kassimir & A.K. Syvertsen (eds). *Youth Activism: An International Encyclopedia Volume 1*. Greenwood Press: Westport, Connecticut. Pg 58-62.
- Colliantes, X.R., Obradors, M., Pujadas, E., Ferré, J., & Perez, O. (2011). Qualitative-Quantitative analysis of narrative structures: The narrative role of immigrants in Spanish Television Series. *Semiotica*. 184 (1/4): 99-121.
- Cormack, M. (1992). *Ideology*. University of Michigan: United States of America.
- Couldry, N. (2000). *Inside Culture: Re-Imagining the method of Cultural Studies*. London: Sage

Publications.

- Creswell, J.W. (2009). *Research Design: Qualitative, Quantitative and Mixed Methods Approaches*. Los Angeles: Sage Publications Inc.
- Currie, G. (2007). Framing Narratives. In *Narrative and Understanding Persons*. D.D Hutto (eds). Cambridge University Press: United Kingdom.
- de B' Beri, B. E. (2006). *Mapping Alternative Expressions of Blackness in Cinema*. Germany: Bayreuth.
- de B' Beri, B.E., & Middlebrook, R. (2009). The Paradox of National Identity: Region, Nation, and Canadian Idol. *Canadian Journal of Communication*. 34:1, 25-40.
- DePolo, J.R.(2010). Discursive Transformation and the construction of identity: A critical discourse analysis of African American Student texts. (Dissertation). Retrieved from ProQuest Dissertations and Theses.
- Devine, P.G., Plant, E.A., Harrison, K. (1999). The Problem of "US" versus "Them" and AIDS stigma. *American Behavioral Scientist*. 42: (7), 1212-1228.
- Duffy, L. (2005). Suffering, Shame, and Silence: The stigma of HIV/AIDS. *Journal of the Association of Nurses in AIDS Care*. 16:1, 13-20.
- Elkamel, F.(1995). The Use of television series in Health education. *Health Education Research*. 10(2): 225-232).
- Fairclough, N. (1989). *Language and Power*. Longman: London.
- Fairclough, N. (1992). *Discourse and Social change*. Cambridge: Polity Press.
- Fife, B.L. & Wright, E.R. (2000). The Dimensionality of Stigma: A comparison of its Impact on the Self of persons with HIV/AIDS and Cancer. *Journal of Health and Social Behavior*. 4:(1), 50-67.
- Finnegan, J.R., & Viswanath, K. (2008). Communication Theory and Health Behavior Change: The Media Studies Framework. In *Health Behavior and Health Education: Theory, Research and Practice*. K. Glanz, B.K. Rimer & K. Viswanath (Eds). Jossey-Bass, California.
- Finn, M., & Sarangi, S. (2009). Humanizing HIV/AIDS and its (re) stigmatizing effects: HIV public 'positive' speaking in India. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness & Medicine*. 13: (1), 47-65.
- Flick, U. (2002). *An Introduction to Qualitative Research*. Sage Publications: London

- Garcia Gomez, A. (2010). Disembodiment and Cyberspace: Gendered discourse in female teenagers' personal information disclosure. *Discourse Society*. 21(2), 135-160.
- Gavin, J. (2001). Television Teen Drama and HIV/AIDS: the role of genre of Safe sex. *Journal of Media and Cultural Studies*. 15(1):77-96.
- Gee, B.P. (1999). *An Introduction to Discourse Analysis: Theory and Method*. New York: Routledge.
- Gee, J.P., Micheals, S., & O'Connor, M.C. (1992). Discourse Analysis. In *The Handbook of Qualitative Research in Education*. M.D. Le Compte, W.L. Millray and J. Preissle (eds). San Diego, California: Academic Press.
- Georgakopolou, A., & Goutsos, D. (1997). *Discourse Analysis: An introduction*. Edinburgh: Edinburgh University Press
- Glapka, E. (2010). Ideology in Media language: Hegemonic Discourse or Multiple Discourses? *At the Interface/ Probing Boundaries*. 73: 47-65.
- Goldstein, S., Usdin, S., Scheepers, E., Anderson, A., & Japhet, G. (2003). The Treatment of AIDS in Soul Buddyz: A Multimedia Campaign for Children's Health in South Africa. In *The Children of Africa: Confront AIDS*. A. Singhal and W.S. Howard. United States of America: Ohio University Press.
- Government of Uganda. (March 2010). UNGASS: United Nations General Assembly Special Session Country Progress Report. <http://data.unaids.org/>
- Government of Uganda. (2012). UNGASS: United Nations General Assembly Special Session Country Progress Report. <http://www.unaids.org/>
- Graesser, A.C., Olde, B., & Klettler, B. (2002). How Does the Mind Construct and Represent Stories? In *Narrative Impact: Social and Cognitive Foundations*. New Jersey: Lawrence Erlbaum Associates, Inc.
- Green, C.E., Halpenin, D.T., Nantulya, V., & Hogle, J.A. (2006). Uganda's HIV Prevention Success: The Role of Sexual Behaviour Change and the National Response. *AIDS and Behavior*. 10(4) :335-346.
- Green, G. (1995). Attitudes towards people with HIV: Are they as stigmatizing as people with HIV perceive them to be? *Social Science Medicine*. 41: (4), 557-568.
- Giroux, H. (1996). Is there a place for cultural studies in colleges of education? In H. Giroux, C. Larkshear, P. McLaren, and M. Peters. *Counter-narratives: Cultural Studies and Critical Pedagogies in Post modern Spaces*. Routledge: New York.
- Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. Prentice-

- Hall Inc: Englewood Cliffs: New Jersey.
- Grossberg, L. (1996). Identity and Cultural Studies: Is that all there is? In S. Hall and P. Du Gay (Eds.), *Questions of Cultural Identity*. Sage Publications: London.
- Grossberg, L. (1996). The Circulation of Cultural Studies. In What is Cultural Studies?: A Reader. J. Storey (Eds). London: Arnold , a member of the Hodder Headline Group.
- Habermas, J. (1967). Erkenntnis und Interesse [Knowledge and Interest]. Frankfurt on Main: Suhrkamp.
- Hall, S.(1990). The Whites of their Eyes: Racist Ideologies and the Media. In M. Alvarado & J.O. Thompson (Eds.), *The Media Reader* (p7-23). London: British Film Institute.
- Hall, S. (1993). Cultural Studies and its Theoretical Legacies. In Cultural Studies Reader, Second Edition. S. During(Eds). London : Routledge.
- Hall, S. (1996). Encoding and Decoding. In Media Studies: A Reader. P. Morris and S. Thornton (Eds). Edinburgh: Edinburgh University Press Limited. pp41-50.
- Hall, S. (1996). Cultural Studies: two paradigms. In *What is Cultural Studies? : A Reader*. J. Storey. St Martin's Press Inc: Great Britain.
- Hall, S. (1996). Who Needs' Identity? In S. Hall and P. Du Gay (Eds.), *Questions of Cultural Identity*. Sage Publications: London.
- Hall, S. (1997). Representations: Cultural representations and signifying practices. Thousand Oaks, CA: Sage Publications.
- Hasaba, S., & Grant, A. (2010). Language Use, Literacy Learning and Cultural Identity: A case study from Uganda. *E-proceedings of the International Online Language Conference (IOLC)*. 286-291.
- Hausman, C., Benoit, P., O'Donnell, L.B. (2000). Modern Radio Production: Production, Programming and Performance. Wadsworth Thomas Learning: Australia.
- Health Communication Partnership (HCP). (2011). Health Communication Partnership. Retrieved from <http://www.jhuccp.org/hcp/enter.html>
- Hebdige, D. (1993). The Function of Subculture. In Cultural Studies Reader, Second Edition. S. During(Eds). London : Routledge.
- Hepburn, A., & Potter, J. (2004). Discourse Analytic. In Qualitative Research Practice. C. Seale, G. Gobo, J.F. Gubrium & D. Silverman (eds). London : Sage Publications.

- Hermanowicz, J.C., and Morgan, H.P. (1999). Ritualizing the Routine: Collective Identity Affirmation. *Sociological Forum*. 14:2, pp 197-214. Retrieved 1st December 2009 from <http://www.jstor.org/stable/684793>.
- Hladik, W., Musinguzi, J., Kirungi, W., Opio, A., Stover, J., Kahauza, F., Bunnell, R., Kafuko, J., & Mermin, J. (2008). *AIDS*. 22, 503-510.
- Hoffman, N.D. and Futterman, D. (1996). Youth and HIV/AIDS. In *AIDS in the World II*. (Eds). J. Mann and D. Tarantola. New York: Oxford University Press.
- Hogle, J.A., Green, E., Nantulya, V., Stoneburner, R., and Stover, J. (2002). What Happened in Uganda? : Declining HIV Prevalance, Behaviour Change and the National Response. Retrieved from http://www.usaid.gov/our_work/global_health/aids/Countries/africa/uganda_report.pdf
- Holder, R.W. (2007). *How to not say what you mean: A dictionary of Euphemisms*. New York: Oxford University Press.
- Holzemer, W.L., Uys, L., Makoe, L., Stewart, A., Phetlhu, R., Dlamini, P.S., Greeff, M., Kohi, T.W., Chirwa, M., Cuca, Y., & Naidoo, J. (2007). A conceptual model of HIV/AIDS stigma from five African countries. *Journal of Advanced Nursing*. 58(6), 541-551.
- Hooks, b. (1990). Choosing the Margin as a Space of Radical Openness. In *Yearning: Race, Gender and Cultural Politics*. Toronto: Between the lines.
- Hutto, D.D. (2007). Narrative and Understanding Persons. In *Narrative and Understanding Persons*. D.D Hutto (eds). Cambridge University Press: United Kingdom.
- Johnson, R., Chambers, D., Raghunan, P. & Tincknell, E. (2004). *The Practice of Cultural Studies*. Sage Publications: London.
- Joint United Nations Programme On HIV/AIDS (UNAIDS). (2008). Facts About HIV. Retrieved from <http://www.unaids.org/>
- Jones, R.H. (1998). Two faces of AIDS in Hong Kong: Culture and the Construction of the AIDS celebrity. *Discourse Society*. 9: 309.
- Jorgensen, J.J. (1981). *Uganda: A Modern History*. London: Croom Helm Limited.
- Jhally, S. (1997). *Stuart Hall: Representation and the media*. Massachusetts Amherst: Media Education Foundation.
- Jupp, V. (1996). Documents and Critical Research. In *Data Collection and Analysis*. R. Sapsford and V. Jupp (eds). London: Sage Publications.

- Karlynn, A.S. (2001). The impact of a targeted Radio Campaign to prevent STIs and HIV/AIDS in Mozambique. *AIDS Education and Prevention*. 13(5): 438-451.
- Kincaid, D.L. (2002). Drama, Emotion and Cultural Convergence. *Communication Theory*. 12(2), 136-152.
- Kisekka, Nakaterregga, M. (1990). AIDS in Uganda as a Gender Issue. *Women and Therapy*. 10:3, 35-53.
- Kiwanuka-Tondo, J. (1990). Educational Broadcasting in Africa: The Case of Uganda. *Africa Media Review*. 4 (2): 48-63.
- Kiwanuka-Tondo, J., & Snyder, L.B. (2002). The Influence of Organizational Characteristics and Campaign Design Elements on Communication Campaign Quality: Evidence from 91 Ugandan AIDS Campaigns. *Journal of Health Communication*. 7:59-77.
- Kiweera, J.M. (2008). Uganda's HIV/AIDS Success Story: Reviewing the Evidence. *Journal of Development & Social Transformation*. 5: 53-61.
- Kuhn, A. (1996). The Power of the Image. In *Media Studies: A Reader*. P. Morris and S. Thornton (Eds). Edinburgh University Press: Edinburgh. (pg157-160)
- Labov, W., & Waletzky, J. (1967). Narrative Analysis : Oral Versions of personal experience. In *Essays on the Verbal & Visual Arts*. J. Helm (ed.) Washington: Washington University Press.
- Lamphey, P., Ruckstuhl, K., Cates, W. (2003). The Evolving Impact of HIV/AIDS on Global Health. In *Dawning Answers: How the HIV/AIDS Epidemic has helped to strengthen Public Health*. R.O. Valdiseri (eds) . New York : Oxford University Press.
- Lamaraque, D. (2007). On the Distance between literary Narratives and Real Life. In *Narrative and Understanding Persons*. D.D Hutto (eds). Cambridge University Press: United Kingdom.
- Leclerc-Madlala, S. (2008). Transactional Sex and the Pursuit of Modernity. *Social Progress: A Journal of African Studies*. 29:2. 213-233.
- Letamo, G. (2003). Prevalence of, and Factors associated with HIV/AIDS- related stigma and Discriminatory Attitudes in Botswana. *Journal of Health Population Nutrition*. 21(4): 347-357.
- Liu, S., Chen, G-M. (2010). Communicating Health: People, Culture and Context. *China Media Research*. 6(4):1-2.
- Low-Beer, D., & Stoneburner, R. (2003). Behaviour and Communication change in reducing HIV: Is Uganda Unique? *African Journal of AIDS Research*. 2(1): 9-21.

- Low-Beer, D., & Stoneburner, R. (2004). Uganda and the Challenge of HIV/AIDS. In N.K. Poku & A. Whiteside (Eds.), *The Political Economy of AIDS in Africa*. Burlington: Ashgate Publishing Limited.
- Mayer-Guse', E. (2008). Toward a theory of Entertainment Persuasion: Explaining the Persuasive Effects of Entertainment-Education messages. *Communication Theory*.18: 407-425.
- McAlister, A.L., Denny, C.L., & Parcel, G.S. (2008). How Individuals, Environments, and Health Behaviors Interact: Social Cognitive Theory. In *Health Behavior and Health Education: Theory, Research and Practice*. K. Glanz, B.K. Rimer & K. Viswanath (Eds). Jossey-Bass, California.
- McCombie, S., & Eshel, A. (2008). Tugende Uganda: Issues in Defining “Sex” and “Sexual Partners” in Africa. In D.A. Feldman (Ed.), *AIDS, Culture and Africa*. Florida: University Press of Florida.
- McCormack, C. (2010). *Constructing Danger: Emotions and the Misrepresentation of Crime in the News*. Fernwood Publishing: Manitoba.
- McLuhan, M. (2001). *The Medium is the Message*. In *Media and Cultural Studies: Keyworks*. D.M. Kellner & M.G. Durham. United States of America: Blackwell Publishers Limited.
- Merriam, S.B. (2006). Transformational learning and HIV- Positive Young Adults. IN *Theoretical Frameworks in Qualitative Research*. V.A. Anfara Jr.,& N.T. Merts. Sage Publications: Thousand Oaks.
- Miller, A.N., & Rubin, D.L. (2007). Factors leading to Self Disclosure of a Positive HIV Diagnosis in Nairobi, Kenya: People living with HIV/AIDS in the Sub-Sahara. *Qualitative Health Research*. 17(5):586-597. Retrieved 19/10/10 from <http://www.sage.pub.com/>
- Montanari, F. (2003). Crisis of representation in Journalistic communication during the War in Kosovo. *Semiotica*. 143(1/4) : 135-141.
- Mugambi Nabasuta, H. (1994). Intersections: Gender, Orality, text and Female Space in Contemporary Kiganda Radio Songs. *Research in African Literature*. 25(2): 47-70.
- Mulwo, A.K. (2008). *An Analysis of Student's Responses to ABC & VCT Messages at Three Universities in KwaZulu-Natal Province, South Africa*. (Doctoral Dissertation). Retrieved from ProQuest Dissertations and Theses.
- Muyinda, H., Seeley, J., Pickering, H., & Barton, T. (1997). Social Aspects of AIDS-related stigma in rural Uganda. *Health and Place*. 3(3): 143-147.
- Mwesige, P.G. (2009). *The Democratic Functions and dysfunctions of political talk*

- radio: the case of Uganda. *Journal of African Media Studies*. 1(2): 221-245.
- Myhre, S.L., & Flora, J.A. (2000). HIV/AIDS Communication Campaigns: Progress and Prospects. *Journal of Health Communication*. 5: 29-45.
- Nassanga, G.L. (2000). The Coverage of HIV/AIDS in Ugandan Media: A Content Analysis. In *Media and HIV/AIDS in East and Southern Africa: A Resource Book*. UNESCO. Paris.
- Nombuso. (2006). Communication For Development Uganda. Retrieved from <http://www.comminit.com/africa/node/133260>
- Noor, S.M., Palmgreen,P., Chabot, M., Dobrasky, N., Zimmerman, R.S. (2009). A 10- Year Systematic Review of HIV/AIDS Mass Communication Campaigns: Have We Made Progress? *Journal of Health Communication*. 14:15-42.
- Norton, B., & Mutonyi, H. (2010). Languageing for life: African Youth talk back to HIV/AIDS research. *Language Policy*. 9 (1): 45-63.
- Oatley, K. (2002). Emotions and the story Worlds of fiction. In *Narrative Impact: Social and Cognitive Foundations*. New Jersey: Lawrence Erlbaum Associates, Inc.
- Ofcansky, T.P. (1996). Uganda: Tarnished pearl of Africa. United States of America: Westview Press Inc.
- Okuanzi, S.A., & MaCrae, J. (1995). Whose policy is it anyway? International and national influences on health policy development in Uganda. *Health Policy and Planning*. 10(2) :122-132.
- Otiso, K.M. (2006). Culture and Customs of Uganda. Connecticut: Greenwood Press.
- Otolok-Tanga, E., Atuyambe, L., Murphy, C.K., Ringheim, K.E., & Woldehanna,S. (2007). Examining the actions of Faith-Based Organisations and their influence on HIV/AIDS- related stigma: A Case Study of Uganda. *African Health Sciences*. 7(1): 55-60.
- Oxford English Dictionary Online. (2013).
- Papa, M.J., Singhal, A., Law, S., Port, S., Sood, S., Rogers, E.M., and Shefner-Rogers, C.L. (2000). Entertainment-Education and Social Change: An analysis of Parasocial Interaction, Social learning, Collective Efficacy, and Paradoxical Communication. *Journal of Communication*. 50(4) :31-55.
- Parkhurst, J.O. (2002). The Ugandan Success Story? Evidence and claims of HIV-1 prevention. *The Lancet*. 360: 78-80.
- Parkhurst, J.O. (2011). Evidence, Politics and Uganda's HIV success: Moving Forward with

- ABC and HIV Prevention. *Journal of International Development*. 23: 240-253.
- Patnode, R. (2011). The Missing Signifier: Representing Radio Broadcasting in New Yorker Cartoons, 1925-45. *American Periodicals*. 21(2): 164-179.
- Paxton, S. (2001). Breaking the Silence: The Role of HIV-positive speakers .In AIDS Education and Information. M. De Bruyn (Ed). Informa Healthcare: New York. 67-87.
- Peshkin, A. (1988). Understanding complexity: A gift of qualitative inquiry. *Anthropology and Education Quarterly*, 19, 416-424.
- Piot, P., Bartos, M., Ghys,D.D., Walker, N, and Schwartlander, B. (2001). The Global Impact of HIV/AIDS. *Nature*, 410: 965-973.
- Piotrow, P.T., & De Fossard, E. (2004). Entertainment-Education as a Public Health Intervention. In Entertainment-Educations and Social Change: History, Research, and Practice. A.Singhal, M.J. Cody., E.M. Rogers & M. Sabido (Eds). Lawrence Erlbaum Associates, New Jersey.
- Piotrow, P.T., Kincaid, D.L., Rimon, II, J.G., & Rinehart, W.E. (1997). Health Communication: Lessons from Family Planning and Reproductive Health. Westport: Praeger.
- Polichak, J.W., & Gerning, R.J. (2002). “Get Up and Win!”: Participatory Responses to Narrative. In Narrative Impact: Social and Cognitive Foundations. New Jersey: Lawrence Erlbaum Associates, Inc.
- Posetti, J. (2008). Unveiling radio coverage of Muslim women. *The Radio Journal-International Studies in Broadcast and Audio Media*. 6(2/3): 161-177.
- Potter, J. and Wetherell, M. (1987). Discourse and Social Psychology. London: Sage.
- Potter, J., & Wetherell, M. (1994). Analyzing Discourse. In Analyzing Qualitative Data. A. Bryman and R.G. Burgess (eds). London: Routledge.
- Prinsloo, J. (2007). Media, Youth, and Sex in the time of HIV: A South African Story. *Journal of Children and Media*. 1(1):25-34.
- Punch, K.F. (1998). Introduction to Social Research: Quantitative and Qualitative Approaches. Sage Publications: London.
- Quinn, T.C. (1996). Global burden of HIV pandemic. *The Lancet*. 348: 99-106.
- Reddy, S., & Dunne, M. (2007). Risking it: Young Heterosexual Feminities in South African Context of HIV/AIDS. *Sexualities*. 10, 159.
- Riffe, D., Lacy, S. and Fico, F.G. (2005). Analyzing Media Messages. (2nd Edition). New Jersey: Lawrence Erlbaum.

- Ritchie, E. (2011, February 19). Let the people Speak. (Web log comment). Retrieved from <http://ritchiesinuganda.blogspot.ca/>
- Rogers, E.M. (1995). When the mass media have strong effects: Intermedia processes. In *Communication: Views from the Helm for the Twenty-First Century*. ED. J.Trent. Boston: Allyn and Bacon. Pg 276-285.
- Rogers, E.M., Vaughn, D.W., Swalehe, R.M.A., Rao, N., Svenkenud, P., and Sood, S. (1999). Effects of an Entertainment-Education Radio Soap Opera on Family Planning Behaviour in Tanzania. *Studies in Family Planning*. 30(3): 193-211.
- Schank, R.C., & Berman, T.R. (2002). The Pervasive Role of Stories in Knowledge and Action. In *Narrative Impact: Social and Cognitive Foundations*. New Jersey: Lawrence Erlbaum Associates, Inc.
- Schopper, D., Doussantousse, S., Ayiga, N., Ezatirale, G., Idro, W.J., & Homsy, J. (1995). Village-based AIDS prevention in a rural district in Uganda. *Health Policy and Planning*. 10(2): 171-180.
- Singhal, A., and Rogers, E.M. (1999). Entertainment-Education: A Communication strategy for Social Change. New Jersey: Lawrence Erlbawn Associates.
- Singhal, A. (2003). Communication Strategies For confronting AIDS: Empowering the children of Africa. In *The Children of Africa: Confront AIDS*. A. Singhal and W.S. Howard. United States of America: Ohio University Press.
- Singhal, A. , & Rogers, E.M. (2004). The Status of Entertainment-Education Worldwide. In *Entertainment-Educations and Social Change: History, Research, and Practice*. A.Singhal, M.J. Cody., E.M. Rogers & M. Sabido (Eds). Lawrence Erlbaum Associates, New Jersey.
- Slutkin, G., Okware, S., Namara, W., Sutherland, D., Flanagan, D., Carael,M, Blas, E., Delay, P., & Tarantola, D. (2006). How Uganda Reversed its HIV Epidemic. *AIDS Behaviour*. 10:351-361.
- Smith, R.A., Witte, K., Lazell, C.K. (2005). Social Change Interventions in Public Health Communications. In *Global Public Health Communication: Challenges, Perspectives and Strategies*. (Eds). M. Haider. Boston: Jones and Bartlett Publishers.
- Sood,S., Menard, T., & Witte, K. (2004). The theory behind Entertainment- Education. In *Entertainment-Educations and Social Change: History, Research, and Practice*. A.Singhal, M.J. Cody., E.M. Rogers & M. Sabido (Eds). Lawrence Erlbaum Associates, New Jersey.
- Sood, S., & Nambiar, D. (2006). Comparative Cost-Effectiveness of the Components of a Behaviour Change communication Campaign on HIV/AIDS in North India. *Journal of Health Communication*. 11:143-162.
- Stanecki, K.A., and Way, P.O. (1996). The Dynamic HIV/AIDS Pandemic. In *AIDS in*

- the World II. (Eds). J. Mann and D. Tarantola. New York: Oxford University Press.
- Steedman, C. (1993). Culture, Cultural Studies and the Historians. In Cultural Studies Reader, Second Edition. S. During(Eds). London: Routledge.
- Storey, J. (1996). Cultural Studies : An introduction. In What is Cultural Studies?: A Reader. J. Storey (Eds). London: Arnold , a member of the Hodder Headline Group.
- Straight Talk Foundation. (2006). Retrieved March 12, 2010 from <http://www.straight-talk.or.ug/>
- Temin, M.J., Okonofua, F.E., Omorodian, F.O., Renne, E.P., Caplan, P., Heggenhougen, H.K., and Kaufman, J. (1999). Perceptions of sexual behaviour and knowledge about sexually transmitted diseases among adolescents in Benin City, Nigeria. *International Family Planning Perspectives*. 25(4):186-190.
- Tewksbury, R. (1994). "Speaking of Someone with AIDS...": Identity constructions of persons with HIV disease. *Deviant Behavior*. 15:4, 337-355.
- The Henry L. Kaiser Family Foundation. HIV/AIDS Policy Factsheet (Oct 2005). Retrieved from <http://www.kkf.org/hivaids/>
- The Johns Hopkins University. (2011). Center for Communication Programs. Retrieved from <http://www.jhuccp.org/>
- The World Bank. (2004). Education and HIV/AIDS. Washington: The World Bank Publications.
- Tripp, A.M. (2004). The Changing Face of Authoritarianism in Africa : The Case of Uganda. *Africa Today*. 50(3):3-26.
- Tuffe, T. (2004). Soap Operas and Sense Making: Mediations and Audience Ethnography. In Entertainment-Educations and Social Change: History, Research, and Practice. A.Singhal, M.J. Cody., E.M. Rogers & M. Sabido (Eds). Lawrence Erlbaum Associates, New Jersey.
- Uganda AIDS Commission. (April 2010). Special Focus: The Yeah Campaign. Retrieved <http://www.aidsuganda.org/>
- Uganda AIDS Control Programme. (1989). Uganda AIDS Control Programme 1989-1990. Entebbe, Uganda: Ministry of Health.
- UNAIDS. (2009). Global Facts and Figures. Retrieved March 12, 2010 from http://data.unaids.org/pub/FactSheet/2009/20091124_FS_global_en.pdf
- U.S. Agency for International Development (USAID). (2011). The U.S. Agency for International Development. Retrieved from <http://www.usaid.gov/>
- Valdiseri, R. O. (2003). HIV/AIDS in Historical Profile. In Dawning Answers: How the

- HIV/AIDS Epidemic has helped to strengthen Public Health. (Eds). R.O. Valdiseri. New York : Oxford University Press.
- Van Dijk, T.A. (1998). Ideology: A multidisciplinary approach. Sage Publications Limited: London.
- Veenapani, S., & Gupta, M. (2001). How safe are People's Interpretations of Safer Sex? Health Education messages in the context of HIV/AIDS. T. Stanton (eds). HIV/AIDS and Information. New York : Informa Healthcare.
- Vivian, J., & Maurin, P.J. (2009). The Media of Mass Communication. Toronto: Pearson Canada Inc.
- Ward, K. (2001). 'The Armies of the Lord': Christianity, Rebels and the State in Northern Uganda, 1986-1999. *Journal of Religion in Africa*. 31(2): 187-221.
- Wellings, K. (2002). Evaluating AIDS Public Education in Europe: A Cross National Comparison. In Public Health Communication: Evidence For Behavior Change. R.C. Hornik (Eds). Lawrence Erlbaum Associates, Inc: New Jersey.
- Williams, R. (1986b)[1958]. Culture is ordinary. In *Resource of Hope: Culture, Democracy, Socialism*. Versa: London.
- Wheeler, K.S. (2010). Making the significant: A Discourse Analysis examining the teacher's role in negotiating meaning of text with Culturally and Linguistically diverse students. (Dissertation). Retrieved from ProQuest Dissertations and Theses.
- Whooley, O. (2006). The Political work of narratives: A Dialogic analysis of two Slave narratives. *Narrative Inquiry*. 16 (2): 295-318.
- Wodak, R. (2001). What Critical Discourse is about- a summary of its history, important concepts and its Development. In R. Wodak and M. Meyer (Eds.) London: Sage Publications Inc.
- Wodak, R. (2004). Critical Discourse Analysis. In Qualitative Research Practice. C. Seale, G. Gobo, J.F. Gubrium & D. Silverman (eds). London : Sage Publications.
- Wood, L.A., and Kroger, R.O. (2000). Doing Discourse Analysis: Methods for studying Action in talk and text. Thousand Oaks: Sage Publications Inc.
- Woral, P.H. (1990). Offending Women. London: Routledge.
- Ybema, S., Keenay, T., Oswick, C., Beverunger, A., Ellis, N., and Sabelis, I. (2009). Articulating Identities. *Human Relations*. 63 (3), 299-322.
- Yoder, P.S., Hannik, R., and Chirwa, B.C. (1996). Evaluating the Program Effects of a Radio Drama about AIDS in Zambia. *Studies in Family Planning*. 27(4): 188-203.

Young Empowered and Healthy. (2012). Rock Point 256. Retrieved from
<http://www.yeahuganda.org/campaigns/rock256/index/php> .

Zahavi, D. (2007). Self and other: The limits of Narrative Understanding. In Narrative and Understanding Persons. D.D Hutto (eds). Cambridge University Press: United Kingdom.

APPENDIX 1: RP256 Quarter 1-3 episodes

CATEGORY 1: Steve, Steve's mother, Betty

EPISODE 1, SCENE 2

Abstract:

This is the first episode that we are introduced to Steve, his mother and sister. In this narrative we find out Steve goes to school and works part time, and he is the breadwinner of the family at the age of 19.

1. Int. /Ext. Steve's House. Morning
2. B/G SFX: Cock crowing.
3. SFX: Washing in a wash basin, sweeping, whistling.
4. STEVE, MOTHER, BETTY.
5. SFX: STEVE WHISTLING, B/G – ROOSTER CROWING, WASHING CLOTHES, SWEEPING
6. MOTHER: Steven, what time did you get back last night? I heard you but **I was very tired.**
7. STEVE: It was quite late (PROUDLY) but we hit big, real fat fish this time round, Mother.
8. MOTHER: What happened? Did Jesus cast your nets out for you?
9. STEVE: (EXCITED) I tell you, it was that close. We had to hire a pick-up and take our lot to Rock Point. Business was full blast. I tell you.
10. MOTHER: How did you come back? I can't believe this time you went that far to sell. Did you walk?
11. STEVE: On foot. In fact I jogged back. Fit as any two-wheel drive. It is good for my system. Soccer season is about to start. I have to out do everyone on that team via speed...
12. SFX: STOOL KNOCKED OVER
13. MOTHER: (TIRED ALMOST OUT OF BREATH) **Wee – Jesus me!**
14. STEVE: (RUSHINGLY) Sorry, Sorry, Sorry, Are you okay mother?
15. SFX: PANTING
16. MOTHER: (SLIGHTLY OUT OF BREATH): Yes, Sure. **Help me up.** /It's just that I've been **feeling dizzy lately.** / **It will pass.**

17. STEVE: **Maybe you are not taking enough water.**
18. MOTHER: **Water is not the problem all the time but I will keep that in mind.** / Maybe **I am also bothered.** / You know its good that you are doing well in the fishing but your studies are quite, in fact more important. Too much time on that lake and your studies will suffer.
19. STEVE: (ATTENTIVELY) What matters most is that we earn the money to get by. (EXCITED) Aha, by the way, I have left a good amount of cash in your tin bank.
20. MOTHER: Oh, thank you dear. (PAUSE) It is just not right. / **You're only 19 and already supporting a family.** / **You father's death and my (SLIGHT PAUSE) illness have...**
21. STEVE: (INTERUPTING) **Stop worrvng,** mother.... / **The fishing is supporting us and I am doing well in school.**
22. MOTHER: **I suppose there is no point crying over spilt milk.** / I wonder if that little sister of yours is ready for school? (CRYING OUT) Betty!
23. STEVE: (AFFECTIONATE) Mother, you don't worry. I always watch out for her. (CALLING OUT) Betty is the water ready?
24. BETTY: (COMING IN) Tea is ready and I have already dressed up for school.
25. MOTHER: Great my dear. That's my girl. Now both of you have your breakfast. You have a long day at school.
26. STEVE: **You also have to eat something mother. /You have been making it a bad habit...**
27. MOTHER: **I have eaten enough;** it's your young bodies that still need food. Don't forget you are a semi-candidate, Steven.
28. BETTY: I have packed some maize; I will eat on the way.
29. STEVE: You see, don't worry, even Betty can take care of herself. I have managed to come this far. I will make it.
30. MOTHER: (PRIDE AND ADMIRATION) You had better. Okay?
31. STEVE: (CALLING OUT) Betty, can we get moving? (GOING OUT) Have a good day mother.

EPISODE 5, SCENE 7

Abstract:

Steve and his mother are alone at home having a heart to heart conversation about Steve's education and the life choices he should make. Steve's mother indicates to her son that she will not be with them for long, as she is dying.

1. **Int. Steve's hut. Evening.**

2. **B/G SFX: Night Sounds.**

3. **STEVEN, STEVEN'S MOTHER.**

4. **SFX: WATER POURING INTO MUG**

5. STEPHEN: Mama, I told you that you should drink some water every once in a while or you will end up in trouble.

6. MOTHER: Thank you dear. /I know what you mean but it does not come as easy as you say it. It requires some effort /

7. SFX: PAUSE, SWALLOWS WATER

8. MOTHER: /Ah, that was good./ I was dying of thirst.

9. STEPHEN: Please take some more.

10. MOTHER: Not now my dear. Maybe later!

11. STEPHEN: Okay but make sure you drink enough for your own good. /Is there anything else I should get you?

12. MOTHER: No my dear am (COUGHS) am ok. /I just need to rest for a little while.

13. STEPHEN: I think what you need is to get to a hospital.

14. MOTHER: Steven, dear, there is no need to worry./ I will be fine. /It is just my chest. /Maybe if it does not clear up...

15. STEPHEN: I know it will clear.

16. MOTHER: I can lie in the sun in the morning./ It energises me and/ discards the early morning chill out of my chest.

17. STEPHEN: Don't worry mama, I am here and I can take good care of you.

18. MOTHER: No, you won't. You will go to school and I will be just fine. Just promise to make me proud like you did last year when you came out the best in Math. That will also give me some energy.

19. STEPHEN: Don't worry mama; you know I will make you proud again. Math is my greatest love in school. One day I'll be an engineer and my name will appear all over those modern buildings in the city. You wait...
20. MOTHER: I know you can do it my dear. I have trust in you. But please promise me that you shall not neglect your school in order to fish.
21. STEPHEN: Ha, mommy, please stop worrying. You know I can handle my life. Maybe I could be designing those fishing boats when I become an engineer. What do you think eh?
22. MOTHER: I wish you the best my child but...
23. STEPHEN: (DREAMILY) I will be selling boats all over this lake I tell you. I will make a lot of money; buy you a very big house...
24. MOTHER: Stop, stop, stop, I am not likely to live long enough to see the day. /I can only pray that you will look after your sister, Betty./ At least promise me that.
25. STEPHEN: Mama, I don't like it when you talk that way. Nothing is going to happen to you. /I know that.
26. MOTHER: You know this world is not at all predictable. /Your father died unexpectedly, remember? /And ever since things have never been the same. So you have to promise me to love and care for that little girl Steven, even when I am still alive.
27. STEPHEN: Of course mama, you know how I love Betty. As long as I am around, I will be the father she almost never had.
28. MOTHER: Steven, my dear, you must take care of yourself too. I was wondering also when to bring this up but I have been hearing some stories around here about you running around with women and spending your money foolishly.
29. STEPHEN: Mummy, how can you say or even believe in such a thing?
30. MOTHER: What about Stella, are you still seeing her?
31. SFX: PAUSE - NO RESPONSE
32. MOTHER: You know that lady (PAUSE) at one point we used to be close. /In fact she used to work for your father in the fish market. /She might soon start showing sickness like me if I know her well enough. Look after yourself.

END

EPISODE 8, SCENE 6(a)

Abstract:

Steve and Betty are frantic as their mother is weak and in pain and her medication is over and she needs to be rushed to the Health Centre immediately.

1. Int. Steve's Hut. Afternoon.

2. B/G SFX: Peaceful, lake lapping, breeze in trees

3. STEVEN, MOTHER, BETTY

4. SFX: WHEEZING, OCCASIONAL COUGHING

5. BETTY: Mama please, try to sit up.

6. MOTHER: (SLIGHTLY WINCING) Oh, ah, give me a hand my child. Oh, thank you Betty, where is your brother? This is much simpler for him to do?

7. BETTY: Steven is outside. He is trying to fix his old fishing nets. (CALLING OUT) Steve.

8. STEVEN: (COMING IN, CONCERNED) What is it mother?

9. BETTY: (WORRIED) When Mama tries to move she feels pain.

10. STEVEN: (CONCERNED) How long have you been feeling this way?

11. MOTHER: (GASPING PAINFULLY) I am not sure, I woke up...

12. STEVEN: (CONCERNED, TAKING CHARGE) Have you been taking your medication? Is that the bottle by the bed? Look, its has run out!

13. MOTHER: (STILL GASPING, PUTTING ON A FACE) No I will be fine.

14. STEVEN: (INTERROGATINGLY) When did your medicine get finished?

15. MOTHER: (RESIGNING) A few days ago.

16. STEVEN: (ANGRY) But you know how it is Mama, when were you going to tell me?

17. MOTHER: Son, I did not want you to worry.

18. STEVEN: Mama I cannot worry over something that just has to be done. /Now I need to get you to the Health Centre. How to transport you is the problem.

19. MOTHER: I will be okay.
20. STEVEN: No, you will not. Betty, take care of her. Cover her, make sure she is warm. (GOING OUT) Let me see what I can find at that drug store next to the fish landing site.

SCENE 6b

Abstract:

Steve goes to his sugar mummy Stella for aid with transportation money to help him transport his mother to the clinic as well as to get some medication from Stella.

21. Int. Stella's Place. Evening.

22. B/G SFX: Romantic Urban Ugandan Music. (Doctor)

23. STELLA, STEVE.

- 24. SFX: KNOCK ON THE DOOR (TWICE)**
25. STELLA: (CALLING IN) Who is that?
26. STEVEN: (LOUD WHISPER) Stella it's me, Stevo
27. STELLA: (COMING IN) Who?
28. STEVEN: (LOUD WHISPER) Steven.
29. SFX: DOOR OPENS, B/G-ROMANTIC URBAN UGANDAN MUSIC. (DOCTOR)
30. STELLA: (LOW VOICE SEXUALLY CHARGED) Hey boy, I can see you are learning fast. Come in, come in. Wait, your shoes are muddy.
31. SFX: SHOES DROP OFF, DOOR CLOSSES.
32. STEVEN: Look, I cannot stay. I need to rush back to my mother quickly. She is very sick.
33. STELLA: Oh dear, Sorry about that. Do you want me to help you darling?
34. STEVEN: Yes, yes. I need some money to get her some pain killers and to take her to the Health Centre straight away.
35. STELLA: That is okay. Have something to eat first. I know you like it when I cook.
36. STEVEN: Not now, let me first sort out my mother's condition.
37. STELLA: Okay then. Take those pain killers by my bed. Here is the money. Oh and use this one for a boda-boda.

38. STEVEN: Thank you so much Stella. Gosh you have really saved my life.
39. STELLA: (KINDLY) It's nothing really. For the money, it's okay. (SEXUALLY CHARGED) I know we help each other.
40. STEVEN: I know exactly how to pay you back.
41. STELLA: (SEXUALLY CHARGED) Come soon.

EPISODE 9, SCENE 6

Abstract:

While at home Steve, Steve's mother and Betty are looking after their mother who is concerned about their standard of living and education. Betty confronts her mother about the rumours of her having AIDS.

1. **Int. Steve's hut. Early Evening.**
2. **SFX: Dusk sounds; crickets, water bay breeze, evening birds chirping.**
3. **STEVEN, MOTHER, BETTY**
4. **SFX: DUSK SOUNDS**
5. STEVEN: Mama, have you eaten?
6. MOTHER: I tried. /The food you prepared was nice but I really don't have an appetite./ Just leave it here. I will eat little by little.
7. STEVEN: Good. Keep trying. You remember what the doctor told you about keeping your energy up?
8. MOTHER: I tell you Steven, I haven't seen any mother with a Son like you. It's because of your efforts that I am feeling so much better. /Soon I will be able to weave my baskets...
9. STEVEN: Mama you don't have to worry. There is nothing wrong with me looking after you. Take it easy.
10. BETTY: Mummy, I have squeezed for you some fresh juice.
11. STEVEN: Oh, thank you dear.
12. MOTHER: Well done Betty. Do you have some for me too? I am thirsty?
13. BETTY: (CURIOUSLY, CONCERNED) Mummy what exactly is **paining** you?/ You get **sick** a lot these days. / The girls at school say you have **AIDS**....

14. MOTHER: Don't worry dear./ I am getting better and you have been so helpful to your brother. Have you finished your homework?
15. BETTY: Yes Mummy, Steven helped me.
16. MOTHER: Steven what about you own homework?
17. STEVEN: I managed to complete it from school before I went off for soccer.
18. MOTHER: Well, make sure that you concentrate on your studies.
19. STEVEN: (HESITANT) Mama, I had better prepare. I have to go out to the lake tonight.
20. MOTHER: Steven, not tonight. It is very cool, I feel the wind coming.
21. STEVEN: But, Mama, this is when it's perfect for fishing. Am sure John and Andrew are already cursing over the moon that I am late. Besides, we need the money.
22. MOTHER: Steven, you are fishing too much these days. I worry about your school work. Andrew and John will be fine without you for one night.
23. STEVEN: But, Mama, I already promised them. You know they have a hard time fishing with just two. They need me to help pull in the nets.
24. MOTHER: I suppose, if you have to. But, I just don't see the need for you to fish every night...
25. STEVEN: I will stay home tomorrow night, Mama.
26. MOTHER: All right, then. Betty will look after me tonight. Won't you my dear?
27. BETTY: Yes, very well.
28. STEVEN: Okay then. I am off.
29. MOTHER: Aren't you taking something warm?
30. STEVEN: No I am just fine
31. BETTY: Steven, you are dressed like you are going to a wedding.
32. STEVEN: Never mind Betty. My fishing gear is in John's boat. I will change there.

EPISODE 15, SCENE 3

Abstract:

Steve is talking to Vicky about a fight she was involved in at school and their sexual relationship.

1. SCENE 3

2. EXT. ROAD SIDE, ROCK POINT TOWN

3. SFX: B/G-USUAL TOWN SOUNDS

4. STEVE, VICKY

5. VICKY: You VICKY: (CALLING IN) Steve, Steve! (COMING IN) Steven, why are you avoiding me? I have waited for you for almost an hour.

6. STEVE: Vicky, I didn't know you would be here. No big deal. I heard you fought, why?

7. VICKY: That Rebecca brat attacked me. I had to defend myself. And it's because of you. What is going on with the two of you?

8. STEVE: Don't expect me to answer silly questions.

9. VICKY: (EXPLODING) You are so cheap. How can you go for a girl in a lower class?!

10. STEVE: You are the cheap one. How can you fight with a younger girl?

11. VICKY: (CALM) And is that going to change things between us? Does it mean that you no longer love me?

12. STEVE: No. That is not the case.

13. VICKY: So then can I see you tomorrow after school?

14. STEVE: I have soccer practice.

15. VICKY: So soccer is more important to you than I am?

16. STEVE: Vicky, I still like you.

17. VICK: You are lying Steven, you are making excuses to meet Rebecca instead.

18. STEVE: I told you there is nothing going on with Rebecca. She is not even really my friend. I mean the girl just admires me.

19. VICKY: (LAUGHING, TEASING) Sure, you are like a flower that attracts all the bees.

20. STEVE: Now that is my girl, glad to see you laugh my queen bee.

21. VICKY: My parents were really angry about the fight and I got beaten.

22. STEVE: Sorry, is there anything I can do to help take the pain away?

23. VICKY: Rebecca tore my dress. My mother is mad at me. She expects me to replace it.

24. STEVE: Hell, no.

25. VICKY: How am I supposed to pay for another one, eh? Was it my fault she ripped my dress? I don't know. Somebody has to pay.

26. STEVE: I'll pay for one. Don't worry.

27. VICKY: That would be good. That's nice of you, Steve. I always knew I could count on you. You are so sweet, you know? You always look after me.

28. STEVE: Well...

29. VICKY: Have you got cash now? I'll just replace the dress.

30. SFX: (FUMBLING FOR MONEY)

31. STEVE: Sure thing.

32. VICKY: You are a sweetheart, you know. Thanks. Maybe we can meet later and have another party.

33. STEVE: I'd like that. But, this time, we have to use protection.

34. VICKY: What do you mean protection?

35. STEVE: You know...a CD...

36. VICKY: A condom!? What do you think I am? A prostitute?

37. STEVE: No, no! of course not.

38. VICKY: Then why are you bringing it up?

39. STEVE: We didn't use protection when we did it on your birthday, did we?

40. VICKY: Of course not.

41. STEVE: I thought so...

42. VICKY: Why?

43. STEVE: **Its just that I have been worried, you know.**
44. VICKY: (INSULTED) Worried about what?
45. STEVE: You know, I never have live sex... but on your birthday with all that beer...things happened so fast...
46. VICKY: What are you saying exactly, Steve?
47. STEVE: Hey, Vicky, don't get so up tight...it's just that I thought you might get pregnant or something.
48. VICKY: (RELIEVED) No need to worry darling. I always count my days and I was safe.
49. STEVE: Are you sure?
50. VICKY: (POINTED) Are you calling me a liar?
51. STEVE: All I am saying is that if we are going to party together again, we use condoms.
52. VICKY: (COY) We'll see about that.

EPISODE 16: SCENE 6

Abstract :

Steve and Matata are having a man to man talking about sex, Vicky(Steve's ex-girlfriend),and pregnancy.

1. SCENE 6

2. INT. ROCK BAR. EARLY EVENING.

3. SFX: B/G-MUSIC

4. STEVE, MATATA

5. MATATA: How is Vicky? How are you guys doing? Its been a while since you two lovebirds came to use my room. Steven what's up eh?
6. STEVE: (UNMOVED) Matata, I don't know how she is. And I don't think we will ever use your room again.
7. MATATA: Have your goal scoring skills failed you with Vicky?
8. STEVE: Ah, lets drop the topic of Vicky.

9. MATATA: Man, you could never stop talking about that girl even if you wanted. Don't tell me you are losing your addiction!
10. STEVE: **Vicky is too dangerous for me.**
11. MATATA: Dangerous?! How?
12. STEVE: **I told you, man, she doesn't want to use protection.**
13. MATATA: Man, what are you talking about ? Protection from what...
14. STEVE: **Protection from pregnancy...and AIDS. She doesn't want to use condoms.**
15. MATATA: **That is my kind of girl.**
16. STEVE: That to me is a problem Matata. I wonder what her motive is. **I could get sick**
17. MATATA: I don't see any motive. The girl is right man, she just wants to explore her sexuality and I say that is the way it should be.
18. STEVE: Ah-ah-ah, **she could trick me and fall pregnant.**
19. MATATA: A girl like that one! Vicky seems to know her body. **If a girl doesn't ask for a condom like they always do then why bother? That means she is in her safe days.**
20. STEVE: **Matata you are with life. I have seen people die of AIDS, people close to me.**
21. MATATA: **There is no way a young girl like Vicky could have AIDS.**
22. STEVE: **Matata, AIDS does not pick an age. That is why for me condoms are a must.** Besides Vicky is too demanding.
23. MATATA: (LAUGHING) I would like a woman who demands sex like Vicky.
24. STEVE: No, she doesn't demand for sex. She always wants extras, cash - the like.
25. MATATA: But that should not be a problem, you can afford.
26. STEVE: Not what Vicky asks for.

27. MATATA: But Steven, the important thing is that what you get in the end is more profitable. **Give a little and get it all.** Now that is what I call investment.
28. STEVE: Matata you are missing the point.
29. MATATA: Surely you are getting used to free goods from Stella. Vicky should get something from you in return.
30. STEVE: You know, I don't feel anything for Vicky any more. And, she surely doesn't feel anything for me. Before, I thought she was really hot... But, now...I don't know.
31. MATATA: Ah, you are going soft in the head Steven. Take some loving when you need it and simply enjoy the sex.
32. STEVE: You know, Vicky says I think she's a prostitute when I want to use condoms. And, you know, the more I think about it, the more I think she is no more than a prostitute.
33. MATATA: (Surprised) What are you talking about? Vicky's a fine lady. She's no prostitute.
34. STEVE: But, really, what's the difference between Vicky, who will only play sex if I buy her things??
35. MATATA: Yeah, man, but she doesn't ask you for money...
36. STEVE: Maybe it would be easier if I just gave her money instead of spending my time buying her things all the time. She could just buy the things for herself.
37. MATATA: You're being a little harsh, Steve.
38. STEVE: It's just that, if I wanted to buy some love, I could go to the Lodge and get one of those girls. It's about the same thing as Vicky...
39. MATATA: And, what about Stella?
40. STEVE: What about her?
41. MATATA: Are you her prostitute, man?
42. STEVE: (Angry) Hey!! That's completely different. Stella has been helping my family out/

43. MATATA: In exchange for what?
44. STEVE: I give her some of my fish/
45. MATATA: /and what else?
46. STEVE: Okay, but it's different...
47. MATATA: Is it?

EPISODE 18, SCENE 3

Abstract:

In the fishing village, Stella and Steve have an argument about their relationship, Stella wanting more of Steve and jealous of his other girlfriends. Steve however is more concerned with his mother's condition, than Stella.

1. EXT. FISHING VILLAGE. AFTERNOON.

2. SFX: B/G-WATER WAVE SOUNDS, CHATTERING, USUAL SOUNDS

3. STELLA, STEVE

4. STELLA: (FURIOUS) Steven, I don't like it when you play games with me.
5. STEVE: What do you mean, games?!
6. STELLA: Where have you been since I was confronted by that silly girl?
7. STEVE: (PLEADINGLY) Stella...
8. STELLA: Don't Stella me!
9. STEVE: Honey, I have just been busy!
10. STELLA: Even that won't work. You are running around with young cheap girls!
11. STEVEN: Which girls?
12. STELLA: Don't pretend. Of course those silly school girls.
13. STEVE: (FEIGNING CONFUSION) I don't know what you are talking about?
14. STELLA: (SARCASM) Tell me, what do they have to offer you?
15. STEVE: Me, you must be mistaking me with someone else. That is not the case/

16. STELLA: (FURIOUSLY) What is the case then?
17. STEVE: (MUMBLING) I have nothing to do with...
18. STELLA: You left me by the road to sort that girl out for you?! How dare?!
19. STEVE: But I told you to just ignore that girl!
20. STELLA: I am tired of your messes! I did you a favour not to kill that girl of yours.
21. STEVE: That girl Vicky is just super gluing on me. I do not love her at all.
22. STELLA: How come I heard that there are girls busy fighting for you at school.
23. STEVE: (TAKEN ABACK) Who told you that?
24. STELLA: That means I'm right. Isn't that Vicky one of the two girls that were suspended?!
25. STEVE: But what do I.../
26. STELLA: / Is that not where you took the necklace I found you buying in the market?
27. STEVE: **You are very mistaken Stella. Those are cheap rumors! Can I help it if girls are fighting for me anyway? I am not the one fighting.**
28. STELLA: (COYLY) Steve darling, what do you want from those young girls? Am I not enough for you?
29. STEVE: (COYLY) Of course Stella, you are the winner!
30. STELLA: Then come home with me tonight darling. I don't want that firm body of yours to go to waste!
31. STEVE: I have to go home and see if my mother needs help.
32. STELLA: (IMPATIENTLY) Excuses, excuses, Mummy's boy!
33. STEVE: I cannot ignore my mother. **She is sick.** You know that.
34. STELLA: Steven, darling you need to grow up. I want to make you a man. Prove me wrong tonight?
35. STEVE: (TAKING CHARGE) I am a man. **I will prove that I love you.**

EPISODE 19, SCENE 2

Abstract:

Steve and his mother have a heart to heart conversation about Steve's relationships with girls and Stella. Steve's mother warns him of the dangers associated with having sexual relationships such as falling "sick".

1.INT. STEVE'S HOUSE. NIGHT.

2.USUAL NIGHT SOUNDS.

3.STEVE, MOTHER.

4.MOTHER: Steven, I want to talk to you.

5.STEVEN: What is it, mama, are you feeling okay?

6.MOTHER: Sure my dear. I just want to talk.

7.STEVEN: Okay, let me first hang those nets then...

8.MOTHER: No the nets can wait.

9.STEVEN: (WORRIED) Is there something wrong?

10. MOTHER: Don't worry. I just want to know how you are doing in school.

11. STEVEN: Fine.

12. MOTHER: I have heard from the women here in the village that you are playing with girls at school.

13. STEVEN: (AGITATED) I do not play with girls! Those village women have nothing to talk about.

14. MOTHER: You mean it is not true?

15. STEVEN: I am tired of gossip and rumours. It's not true,

16. MOTHER: That makes me glad. You know I want you to settle down in life and make something out of yourself.

17. STEVEN: I am working on it.

18. MOTHER: Good. Take time to sit down for a while and think your life through. See whether you are doing what is really best for you at the moment.

19. STEVEN: You are getting me very confused mama. Am still in school and **I can always make such decisions later.**

20. MOTHER: My son, take it from me, the earlier you sort yourself out the better.
21. STEVEN: I am doing fine Mama.
22. MOTHER: You know these days it's better to settle down and carefully find the right partner.
23. STEVEN: (CARELESSLY) Yes, yes, I intend to do that.
24. MOTHER: Do you know Stella?
25. STEVEN: (TAKEN ABACK) What about her?
26. (GRAVELY) She is not right for you, my child.
27. STEVEN: (CONCEDINGLY) I know that.
28. MOTHER: Women like Stella are only after satisfying their lust. They will take you nowhere.
29. STEVEN: (AGITATED) Stella is a thing of the past.
30. MOTHER: And it should remain that way. **Look out for a nice girl you can be with the rest of your life.** Have you found anyone?
31. STEVEN: Mama, I am not sure but I know what you mean.
32. MOTHER: Even if you find her now you are still young. /You have to be careful while 'relating' with her.
33. STEVEN: (LAUGHING) Oh mother there is nothing wrong in using that magic word.
34. SFX: LAUGHTER/
35. MOTHER: I am glad you have got the message. /I don't want you to fall sick, my child.

EPISODE 23, SCENE 1

Abstract:

Steve confides in Coach Tito that he is not feeling well and Coach Tito advises him to go to the Health Centre to get himself checked out, his illness maybe due to an STD.

1. INT. FOOTBALL FIELD.DAY

2. SFX: B/G-BOYS CHATTERING IN THE FIELD.

3. STEVE, COACH TITO.

4. STEVE: Coach, can I be excused for today's training? I have a problem.
5. COACH TITO: What is it?
6. STEVE: I cannot run well. I am finding it hard right now.
7. COACH TITO: Steven, with a sportsman as good as you shouldn't find trouble running at all!
8. STEVE: I am kind of sick.
9. COACH TITO: This has been the second week in a row. What's going on?
10. STEVE: (HESITANT) I don't know....
11. COACH TITO: There's a bug going round.
12. STEVE: I don't think it's that, coach.
13. COACH TITO: Well, I need my players, Steve. So we must get this thing sorted out – or get on the field. Come on!
14. STEVE GROANS AND YELPS.
15. COACH TITO: I can see, this is bad. Your groin area?
16. STEVE: Yes. There.
17. COACH TITO: Pull a muscle?
18. STEVE: No. I have a bad sore...where it shouldn't be.
19. COACH TITO: Where?
20. STEVE: (Embarrassed) In my private parts, coach.
21. COACH TITO: Steven, you need to get checked at the health centre. It could be a sexually transmitted disease.
22. STEVE: (DENYING) **Ah, coach, that is impossible!**
23. COACH TITO: Have you seen a doctor?
- STEVE: I am waiting to see the witch doctor.

24. COACH TITO: Nonsense! Go to the health center.
25. STEVE: But I don't know what to say to the nurse! It's too embarrassing! I am sure it's just a small thing. It will go away by itself.
26. COACH TITO: You are mistaken! Most witchdoctors will eat your money and, in the end, you'll still have to get treatment at the health center.
27. STEVE: You think?...
28. COACH TITO: Sure. What you need is medicine. At the health center. This isn't something to fool around with.
29. STEVE: But I could not have got a disease from any of the girls I know. They are safe!
30. COACH TITO: **No one is safe my boy, especially if you don't use condoms and have more than one sexual partner.**
31. SILENCE
32. COACH TITO: Son, we used to think that STDs were a sign of strength...but now we know differently. STDs can cause serious problems. They can even make a man impotent.
33. STEVE: But...I/
34. COACH TITO: /Now, just listen to me, Steven. I want my boys to be perfect in all ways. **Not just on the football field but in your own lives as well.**
35. STEVE: I am working on that!
36. COACH TITO: Get yourself treated in the meantime!
37. STEVE: Right now I cannot afford the health centre.
38. COACH TITO: **Steve, the health centre is free...**
39. STEVE: But, I'll have to pay for the drugs...
40. COACH TITO: Steve, go to the health centre – not a witchdoctor. You need treatment with real medicine. It will not cost you more than you can pay.
41. STEVE: Thank you, coach, I will.
42. COACH TITO: Take care! Watch it! Your girlfriend needs to get treated too or she will just give it to you again, even if you treat yourself...

EPISODE 23, SCENE3

Abstract:

Steve goes to the Traditional Healer's place to get medication for his STD.

43. INT. TRADITIONAL HEALERS PLACE.

44. STEVE, TRADITIONAL HEALER (T.H).

45. STEVE: (IGNORANTLY) I didn't know traditional healers wore clothes like a normal person!
46. T.H: (LAUGHING) But I AM an ordinary person! I am not a witchdoctor.
47. STEVE: Oh? All my friends said you could help me... in case somebody does something bad to somebody.
48. T.H. Meaning?
49. STEVE: When a woman puts a spell on a guy, or something.
50. T.H: Is this your problem?
51. STEVE: Maybe. I don't know. My fishing friends John and Andrew said maybe you could tell - if there is a spell.
52. T.H. WHERE? Where is the problem?
53. STEVE: There. (PAUSE) I have a problem with my - you know – in my privates.
54. T.H: What exactly is wrong?
55. STEVE: (EMBARRASSED) Can't you guess?
56. T.H: I can't just tell by looking at your face, young man. If I did, I might be wrong and give you wrong medicine.
57. STEVE: I have a wound...a sore. It burns a lot. And when I urinate....phew.
58. T.H: I need to see the actual area. Can I see? Feel free, feel free.
59. SFX: FLY OPENS, WINCING IN PAIN. MUMBLING, BLOWING, WHISTLING – A REAL PERFORMANCE
60. STEVE: What is it?
61. T.H: It looks like you have a STD. It could be syphilis.

62. STEVE: A friend said. But how?
63. T.H: Did he also tell you to use a condom next time?
64. STEVE: I don't think I got it through sex! It must have been from a public toilet.
65. T.H: I am not judging you. Just trying to help out.
66. STEVE: (AGITATED) Then just give me medicine and I get out of here.
67. T.H: Calm down.
68. STEVE: Sorry but do you really think this was from a girl?
69. T.H: Yes. If it's a STD, then you got it from playing sex...that's the only way.
70. STEVE: But, I don't sleep with girls like that....
71. T.H.: Listen, any girl can have one of these diseases and not know about it. Men get signs, but girls don't always. You need to get your girlfriend treated as well.
72. STEVE: How can I do that?
73. T.H.: I don't know...just tell her. Also, you could easily spread it to others if you don't get this treated before you start playing around again.
74. STEVE: **I always use protection - except once and it was a mistake.**
75. T.H: Once is all it takes...**You should go to the health centre for a thorough check up.**
76. STEVE: **I thought the medicine you are giving me is enough!**
77. T.H: This ointment will only sooth the burning feeling. But you have to get the proper medicine from the health centre to cure it completely.
78. STEVE: This will do for now. **Imagine if they see me going to the health centre!**

EPISODE 30, SCENE 7

Abstract:

Steve and Rebecca are having a talk about their relationship, Rebecca confronts Steve about the rumours she has been hearing concerning his sexual health.

274. **Location:** On the way from School. Day
275. **B/G SFX:** Quiet section of town outside business centre.

276. **STEVE, REBECCA**

279. SFX: (ON MIC) PACE WALKING/ (OFF MIC) RUNNING AND PANTING.

280. STEVE: / (OFF MIC, OUT OF BREATH) Becky! /

281. SFX: (QUICKER PACE, COMING IN) RUNNING AND PANTING.

282. STEVE: (ON MIC) Becky wait/

283. SFX: WALKING AND RUNNING STOP. PANTING CONTINUES

284. REBECCA: Hi Steven, I am so glad to see you.

285. STEVE: Hello Sweet heart, how is Robert doing?

286. REBECCA: There is no real change.

287. STEVE: And you my dear; how are you?

288. REBECCA: I am doing okay. I just feel bad about what has happened to Robert.

289. STEVE: I want you to know I sympathize and I am praying for him.

290. REBECCA: Is that what you really wanted to talk to me about?

291. STEVE: Actually I also want to thank you.

292. REBECCA: For what?

293. STEVE: The letter... it was so touching. Thanks

294. REBECCA: (LIGHTENING UP, BLUSHING) Oh that! You really liked it?

295. STEVE: (COYLY) Becky, how couldn't I? Especially when you showed how much you cared about me.

296. REBECCA: I do care about you Steven but.../

297. STEVE: /but what Becky. You know that I care for you too.

298. REBECCA: Then there is something I want to ask you.

299. STEVE: (SENSING DANGER) What is it Rebecca?

300. REBECCA: Do you have syphilis?

301. STEVE: (OFF GUARD) I ... who... well/

302. REBECCA: /Is that how you show care?

303. STEVE: (HASTILY) What are you talking about?

304. REBECCA: Stop playing the fool with me Steven.

305. STEVE: No really Rebecca, who told you?

306. REBECCA: **(HURT) Of all people Steven, I had to hear this from Vicky. I never thought you are that kind of guy. I feel like a fool.**

307. STEVE: (TOUCHED) Rebecca please don't say that/

308. REBECCA: No Steven/

309. STEVE: Rebecca, Vicky is just lying.

310. REBECCA: What?

311. STEVE: Yes, she is only doing that to hurt you.

312. REBECCA: So you are saying that it is not true.

313. STEVE: Of course it is not. Rebecca, you are special to me. I would never do anything to hurt you.

314. REBECCA: How can I believe you? **What about HIV?**

315. STEVE: Look at me Sweetheart, would I lie to you?

316. REBECCA: (LAUGHS LIGHTLY) You look so sweet I could never doubt you.

317. STEVE: I really care about you Becky, you know that!

318. REBECCA: Now I know. I am sorry I accused you.

319. STEVE: It is okay. I would have done the same thing.

320. REBECCA: (SHYLY) So you said you liked my letter?

321. STEVE: Did you mean all those things you said?

322. REBECCA: Give me a chance and I will show you.

323. STEVE: Woooo! Hot eh? Can't wait. (ROMANTICALLY) In the mean time honey no more dark secrets between us.

EPISODE 32, SCENE 1

Abstract:

Steve's mother is in need of medical attention as she is weaker than before and Steve and Betty hurry to get help to transport her to the Health Centre.

1. Location: Steve's home, Fishing Village. Evening.

2. B/G SFX: Afternoon fishing bay sounds.

3. STEVE, MUM, BETTY

4. SFX: SCRAMBLING, A SAUCEPAN OR TWO KNOCKED, CHAIR BEING PUSHED ASIDE ON MUD FLOOR. HEAVY PANTINGS, GASPING FOR AIR FROM STEVE'S MOTHER.

5. STEVE: (FRANTIC, PANIC) Betty, please hurry. Have you found the candles?

6. BETTY: (DESPAIR, PANIC) I cannot see them, Steve.

7. STEVE: Can you feel the stool next to bed, next to where you keep that bangle Betty gave you?

8. SFX: SCRAMBLING.

9. BETTY: (GREATFULLY) Oh yes! I have got one.

10. STEVE: Good, you know where the matchbox is, light it up quickly.

11. MOTHER: (HYSTERICAL, PAINFULLY) Steven my son...

12. STEVE: Yes mother I am here/

13. MOTHER: (MOANING) I cannot see./ I have gone blind! /What will I do?

14. STEVE: No mother you can still see. Betty is lighting a candle/

15. SFX: MATCHSTICK IS LIT/

16. STEVE: There, you see?

17. MOTHER: Oh my, I can see light; I do not want to die.

18. STEVE: No you are not going to die mother. I am taking you to the health centre now.
19. MOTHER: That is because you know that I am going to die.
20. STEVE: No you are just not breathing well.
21. MOTHER: Steven. Let me just die here. /At least use the money for my funeral.
22. STEVE: (PLEADING) Please stop talking like that mother/
23. BETTY: /STARTING TO CRY/
24. STEVE: Mama, John and some guys from the bay are waiting outside/
25. MOTHER: /Say goodbye to them for me/
26. BETTY: /CRYING EVEN LOUDER/mama please don't leave us.
27. MOTHER: /Steven my son, I want you to take care of your sister and look after your father's house. It is now yours/
28. STEVE: /Betty, don't cry... mama doesn't mean what she is saying/
29. MOTHER: /You see how I'm dying... in my time I have seen diseases come and go, but then...
30. STEVE: (FRANTIC) But what then mother?
31. MOTHER: (GRAVELY) But AIDS really came. AIDS has wiped out villages. I have kept something from you for long /
32. STEVE: /(ALMOST WHISPERING, STAMMERING) Mama you don't deserve to suffer like this/
33. MOTHER: /You and Betty have different fathers...
34. SFX: PAUSE
35. STEVE: (MIXED FEELINGS, CLOSER TO ANGER) Why mother? How could you keep this from us all this time?
36. MOTHER: (HYSTERICAL FITS OF PAIN, ALMOST POSSESSED AND DELUDED) I want to die... my feet are cold... fire... I'm burning... light... oh, oh...

37. STEVE: (DETERMINED ANGER) I won't let you die. Betty has to know who her father is...
38. BETTY: (SOBBING LOUDLY)
39. MOTHER: It is too late Steven, forgive... (SPASMS)
40. BETTY: (CRYING) (CALLING OUT) mama, please don't die.
41. STEVE: (CALLING OUT) John, John, hurry in here. Help me...Health center right now.

EPISODE 32, SCENE 3

Abstract:

Steve, Betty and John (Steve's friend and fellow fisherman) are en route and transporting Steve's mother by foot to the Health Centre.

42. Ext. On the Bumpy road. Evening.

43. B/G SFX: Wheel barrow moving over bumpy track

44. STEVE, JOHN, BETTY, MOTHER

45. SFX: WHEEL BARROW SQUEAKING, HUFFING AND PANTING
46. MOTHER: HYSTERICAL MOANING AND GROANING
47. STEVE: (DETERMINED BUT EXHAUSTED) John, thank you... we are about to... pull that rope harder /
48. MOTHER: (PANTING) Also you push harder... the slope is just a few... meters.
49. STEVE: (CALLING BACK) Betty, hurry up we are leaving you behind.
50. MOTHER: (HYSTERICAL) Betty where are you? I can't see you?
51. STEVE: (CALLING BACK) Betty hurry up, Mama wants you to hold your hand.
52. SFX: RUNNING FOOT STEPS COMING IN
53. BETTY: (OUT OF BREATH) I am here mummy...
54. MOTHER: (GROANING) Banange I am dying. The bumps... ayi...
55. BETTY: (INNOCENTLY) Mummy you won't die. You are still young. Dying is for old people.
56. MOTHER: (MOANING IN PAIN) Oh...Oh... woo...Oh...God...

57. BETTY: (SUDDEN PANIC) Mummy if you die who will pound the g-nuts and cook for me /

58. STEVE: Betty, stop it. Just hold Mama's hand/

59. JOHN: (EXHAUSTED BUT TRIUMPHANTLY) Oh. Finally, we have reached the ka-slope.

60. SFX: WHEEL BARROW SQUEAKING AT A FASTER PACE.

61. MOTHER: (MOANING) Oh. So much pain. Please stop.

62. STEVE: We are almost there Mother. Just hang on.

63. MOTHER: (MOAN) Hurry, please hurry.

64. STEVE: (MORE DETERMINATION) I will take it from here. John, come round... help me. Mama is sweating... wipe it off.

65. JOHN: (ALMOST WHISPERING) Steve, but isn't that dangerous... what if...

66. STEVE: What do you mean?

67. JOHN: What if I also fall sick?

68. STEVE: John, you cannot get sick just by touching her. I do it always, am I sick?

69. JOHN: (HESITANT) Well...

70. STEVE: Believe me, you are safe.

71. JOHN: Okay. (SUDDENLY) Ha, here it is. This short cut here... yes it's the one. It will get us to the health centre quickly.

72. SFX: WHEEL BARROW SQUEAKING STOPS.

73. STEVE: Won't the wheelbarrow be too heavy to go across that small bridge?

74. JOHN: Come on, people push wheelbarrows of fish on that bridge to the market all the time.

75. STEVE: And the fish ends up in the lake where it came from.

76. JOHN: Let me pull the rope again.

77. SFX: SLOW WHEEL BARROW SQUEAKING.
78. STEVE: Careful... to the left /
79. SFX: FOOTSTEPS ON WOODEN BRIDGE, WHEEL BARROW CROSSING WOODEN BRIDGE.
80. MOTHER: (HYSTERICAL, DELIRIUM) I see... light... what... what is that voice? I don't want to go... not yet... no... quick they are following us... they are walking... on the lake
81. JOHN: (PANIC) Steven what is wrong with her?
82. STEVE: Nothing she is in pain.
83. JOHN: Man the way she is talking.../
84. STEVE: /Hurry let us.../
85. MOTHER: /Quick, give me... meat... a lot... Steven (STOPS SUDDENLY)
86. SFX: SILENCE, PAUSE
87. BETTY LET'S OUT A SCREAM
88. STEVE: (PANIC) She has stopped moving!
89. JOHN: Is she... dead?

EPISODE 32, SCENE 8

Abstract:

Steve meets with the visiting Doctor and the doctor educates Steve about his mother's HIV/AIDS condition and the needed steps to be taken to get her back to a healthier state. Pastor Paul consoles an emotional Steve about his mother's condition.

90. Location: Int. Health Center. Day.

91. B/G SFX: Usual Day Health Centre sounds

92. STEVE, PASTOR PAUL, VISITING DOCTOR

93. DOCTOR: Things do not look so good.
94. STEVE: (CRESTFALLEN) Doctor, isn't there anything you can do? Please.
95. DOCTOR: I cannot do much until I see an improvement.
96. STEVE: Do you think she can make it?

97. DOCTOR: She is very ill. We will need to look after her for a while until she starts getting better.
98. STEVE: (ANXIOUSLY) Yes doctor?
99. DOCTOR: She has pneumonia.
100. STEVE: I thought it's because of AIDS.
101. DOCTOR: Yes, the HIV virus has weakened her body, so she cannot fight diseases as she used to which has caused the pneumonia to attack her.
102. STEVE: But how.../?
103. DOCTOR: Has she been eating well?
104. STEVE: She does not eat much but cassava and tea these days...
105. DOCTOR: That could explain it. You know, even with HIV, a person can stay strong if she eats a variety of foods, including fruit and vegetables, three times each day.
106. STEVE: Could she get worse?
107. DOCTOR: If she is to improve then we have seen the worst. She has been hallucinating, not so?
108. STEVE: Yes we brought her like that.
109. DOCTOR: Well, we need to check her blood. That will help us to know how badly the HIV virus has affected her body's ability to fight disease. Meanwhile, we'll give her medicine to fight the pneumonia. We are going to try our best. Steven ... that's your name?
110. STEVE: Yes, thanks doctor. But, what if her body is too weak to fight diseases?
111. DOCTOR: Well, when we test her blood, we will look at her white blood cells. These are the cells in her blood that fight infection. If they are very low, then your mother can start taking Antiretroviral Therapy once we clear up this pneumonia
112. STEVE: What is that?
113. DOCTOR: Anti Retro-viral Therapy means that your mother will start to take AIDS medicine every day, and will visit the clinic regularly to get her blood

- checked. She will have to take the medicine every day for the rest of her life.
114. STEVE: But, won't that be expensive, Doctor.
115. DOCTOR: No, not so expensive. In fact, since your mother is a widow, she can get AIDS Treatment free of charge. But, first, we have to treat the pneumonia...
116. STEVE: Yes, Doctor. And, if mother takes this AIDS medicine, will she be cured of AIDS?
117. DOCTOR: No, Steven. AIDS has no cure. But, with AIDS Treatment, a person with AIDS can stay healthy and productive for many years.
118. STEVE: So, if mother gets better from this pneumonia and starts on AIDS Treatment, she will stop getting sick all the time.
119. DOCTOR: Usually that is the case. But, your mother waited long to come see us. AIDS Treatment works best when a person starts taking medicine as soon as their body begins to weaken. Unfortunately, your mother is seriously ill—she may have waited too long.
120. STEVE: Yes, Doctor.
121. DOCTOR: Let us hope for the best, Steven. (PAUSE) Okay, then. Let me check on my other patients.
122. STEVE: Thank you doctor.
123. SHORT MUSICAL INTERLUDE/
124. STEVE: I hadn't seen you come in Pastor.
125. P. PAUL: (PASTORAL) I came to check in on Robert. He is also here, you know.
126. STEVE: How is he by the way?
127. P. PAUL: He is still in a coma, I am afraid. How is your mother doing my son?
128. STEVE: You can see for yourself Pastor; she looks so tired doesn't she?
129. P. PAUL: I see peace. That means that God is holding her hand.
130. STEVE: I hope you are right. The Doctor says she can get treated for AIDS if she can overcome this pneumonia. She needs God's hand...

131. P. PAUL: God is the doctor of all doctors and by his stripes we are all healed.
132. STEVE: (MEANINGFULLY) Amen to that Pastor.
133. P. PAUL: Let us pray for her... Oh, Father, doctor of doctors, in your hands we place Mama Steven. Give her the strength. Heal her I pray /
134. STEVE: BURSTING INTO TEARS /
135. P. PAUL: /Steven my son; be strong. Your mother and sister need you.
136. STEVE: (SWALLOWING THE TEARS) I am sorry /
137. P. PAUL: Its okay my boy. It is good to cry occasionally.
138. STEVE: This is the first time I am breaking down before anyone other than Mama or Betty.
139. P. PAUL: Don't worry. That is why I am here.

EPISODE 33, SCENE 2

Abstract:

Sister Aisha educates both Betty and Steve about HIV/AIDS, and ARVs.

140. SCENE 2

141. Location: Int. Health Center. Counseling room. Day.

142. B/G SFX: Usual Health Center sounds, Day. Calm in the counseling room

143. STEVE, BETTY, SISTER AISHA

144. SIS. AISHA: Steven, can I have a word with you about your mother?
145. STEVE: (WORRIED) Why? Is there something wrong?
146. SIS AISHA: Betty, perhaps you can wait here a little? Okay Betty?
147. BETTY: (SCARED) Okay. Steven, will you come back quickly?
148. SIS. AISHA: Don't worry Betty; I just want to talk to your brother about your mother...
149. SFX: DOOR OPENS, CLOSES
150. SIS AISHA: Steve, because your mother is so weak, we are feeding her through a tube.
151. STEVE: That will give her strength more quickly?

152. SIS. AISHA: Yes Steve.
153. STEVE: (CONCERNED) Will that be a good sign?
154. SIS. AISHA: For now, she is stable and we are monitoring her.
155. STEVE: How long will it be before we can see a change?
156. SIS. AISHA: Well, your mother is very weak. It may take time before she gets strong again. But she is going to have to stay here a while until she gets better.
157. STEVE: (HESITANT) I will stay and wait.
158. SIS. AISHA: Steven there is nothing you can do right now. She needs the rest... she is very tired...
159. STEVE: Well...
160. SIS AISHA: You must be tired too. Why don't you go home and get some rest. We are looking after her the best we can.
161. STEVE: I am too worried to sleep now.../
162. SIS. AISHA: /Well at least Betty has to get some sleep so you have to take her home.
163. SFX: DOOR OPENS, CLOSES, FOOTSTEPS
164. BETTY: Sister Aisha, what is making mummy so sick?
165. SIS. AISHA: Your mother is infected with HIV the virus that causes AIDS. This weakens her body and allows other diseases to infect her easily/
166. BETTY: (PANIC) /AIDS! Mummy has been having a flu. Does that mean she could have infected me with AIDS? Am I going to die?
167. STEVE: (SHARPLY) Betty!
168. SIS. AISHA: (CALMLY) No Betty you don't get AIDS that way and that doesn't mean you are going to die.
169. BETTY: How did mummy get it?
170. STEVE: Betty!
171. SIS. AISHA: There many ways she could have; blood transfusion, unprotected sex, /

172. STEVE: /Sister Aisha, Betty has so many questions you won't.../
173. SIS. AISHA: /Betty I will answer you as you keep coming back to visit your mother.
174. STEVE: Thank you Sister Aisha.
175. SIS. AISHA: That is why I am here. Now before I forget...
176. STEVE: Yes Sister?
177. SIS. AISHA: We are going to test your mother's blood to see if we can start giving her AIDS treatment.
178. STEVE: Are those the ARVs the doctor told me?
179. SIS. AISHA: Yes Anti Retro-Virals.
180. SFX: PAUSE
181. STEVE: (ALMOST WHISPERING) Ah, you see sister... I don't have that sort of money.
182. SIS. AISHA: I understand Steven. Your mother is able to access those ARVs that are free because she is a widow.
183. STEVE: (SIGHS) Finally, a piece of Good News.

EPISODE 33, SCENE 4

Abstract:

Rebecca while at the Health Centre bumps into Steve and Betty. Steve indirectly tells her why he is at the Health Centre and what his mother is sick of.

184. **Location:** Int. Health Center. Day.
185. **B/G SFX:** Usual Health Center sounds
186. **REBECCA, STEVE, BETTY**
187. SFX: FOOTSTEPS /
188. STEVE: /Am taking you home to get some rest like Sister Aisha has said.
189. BETTY: Will we come back to see mummy tomorrow? /
190. REBECCA: (SURPRISE) Steven?
191. SFX: FOOTSTEPS STOP

192. STEVE: (ABSENT MINDED) Hi Becky,

193. REBECCA: (SURPRISED) Steve...what are you...

194. STEVE: My mother...she is sick...

195. REBECCA: (CONCERNED) Goodness, I am sorry.

196. SFX: PAUSE/SILENCE

197. REBECCA: What is wrong with her?

198. STEVE: She...she has been admitted. She blacked out yesterday.

199. SFX: PAUSE/SILENCE

200. REBECCA: (EMPATHISING) Gosh, Steven... I'm sorry... I didn't know /

201. STEVE: / Its okay Rebecca /

202. REBECCA: / How are you coping? You look like you have not slept in a week.

203. STEVE: (MASTERING A LITTLE LAUGH) Just one day... (REMEMBERING)
This is my little Sister Betty.

204. REBECCA: Hi Betty! How are you?

205. BETTY: Fine.

206. REBECCA: Sorry about your mother.

207. STEVE: (PUTTING UP A FACE) She'll be okay. And how is my gango Robert?

208. REBECCA: Still unconscious ...

209. STEVE: Betty, please wait for me over there.

210. SFX: FADING FOOTSTEPS

211. REBECCA: (CONCERNED) Steven, you seem dead.

212. STEVE: (TEARY) Becky, I just want you to know... I...

213. REBECCA: Steven what is it?

214. STEVE: I really care about you.
215. REBECCA: I know that... but your Mom needs you now.
216. STEVE: Sometimes I wish we had not wasted so much time...
217. REBECCA: Steven don't talk like that/
218. STEVE: / **Epecially with what my mother is going through... I have learnt my lesson.**
219. REBECCA: Steven this must be very bad for you.
220. STEVE: Becky, look, I usually keep certain things to myself but I trust you enough...
221. REBECCA: You can trust me Steven.
222. STEVE: My mother is suffering from...she is...she has pneumonia...she is not breathing well.
223. REBECCA: (BITTERLY) Oh dear, that must be so painful...
224. STEVE: I know Rebecca but that is what life is.
225. REBECCA: Oh Steve...
226. STEVE: At least you know why I seem so lost.
227. REBECCA: Steven, I am tired of all this suffering. Robert has also gone through enough.
228. STEVE: You know what? Just be thankful for the life you have.
229. REBECCA: **I just want to be in control of my life.**
230. STEVE: Becky I am so glad to hear you say that.

EPISODE 37, SCENE 7

Abstract:

Steve's mother is released from the Health Centre and is at home with Steve and Betty recuperating. Stella decides to drop by for a late night rendezvous with Steve. Steve's mother cautions Steve about Stella.

1. **Location:** Steve's house. Afternoon
2. **B/G SFX:** Distant lake sounds, afternoon.
3. **STEVE, STELLA, MOTHER, BETTY**

4. SFX: JUICE/WATER BEING POURED INTO A GLASS.
5. STEVE: Betty help mama drink her juice.
6. MOTHER: (SPEAKS WITH A WEAK BUT DETERMINED TONE ALL THROUGH THIS DIALOGUE AS IF THE PINNACLE OF WISDOM ITSELF) I think I can hold the glass.
7. STEVE: Mama, you are still so weak and Sister Aisha says we have to feed you.
8. BETTY: Yes mummy here let me help you.
9. STEVE: Thank you Betty. You are good children. Thank you for taking care of me.
10. SFX: KNOCK ON THE DOOR.
11. STELLA: (OFF MIC, BEHIND THE DOOR) Hodi... Steven, Steven are you there? I want to talk to you.
12. MOTHER: Isn't that Stella's voice?
13. STEVE: I wonder what she wants.
14. MOTHER: Go and check my dear.
15. STELLA: (STILL OFF MIC, BEHIND THE DOOR) Steven it's me Stella. Is anyone there?
16. STEVE: Me I have nothing to say to that woman.
17. MOTHER: Steven I taught you to be polite to people. What has she done to you?
18. STEVE: (QUICKLY) Nothing Mama, why do you ask?
19. MOTHER: Then go and see what she wants.
20. SFX: DOOR OPENS AND CLOSES HALF WAY. (WIND BREEZING THROUGH TREES CAN BE HEARD IN THE BACKGROUND MORE DISTINCTLY)
21. STEVE: (UNDER HIS BREATH) Stella, now is not a good time to come around. What do you want?
22. STELLA: (SLYLY, UNDER HER BREATH) I want to see you /

23. STEVE: / Look, my mother is very sick and I have just brought her back from the hospital /

24. STELLA: / About the other day /

25. STEVE: / I don't want to talk about it.

26. STELLA: I have brought you some of the money.

27. STEVE: Money for what?

28. STELLA: The boat.

29. STEVE: (RECALLING) Oh, the boat...

30. STELLA: Well? Here take it! You can make a deposit.

31. STEVE: (HESITANTLY) Look Stella, am not so sure... now is not the time.

32. STELLA: (COERCIVELY) Come on Steven darling.

33. STEVE: I have to attend to my mother right now. We can talk about this later.

34. STELLA: Okay darling. When you are ready to talk, you know where to find me. All right?

35. STEVE: Okay, see you.

36. SFX: HALF-CLOSED DOOR OPENS, THEN SWINGS SHUT (EXTERNAL BACKGROUND FADES).

37. MOTHER: Steven?

38. STEVE: Yes mama?

39. MOTHER: Does Stella owe you some money?

40. SFX: PAUSE.

41. STEVE: Mama, you mean... you heard... what we were talking about?

42. MOTHER: Sorry but you left the door slightly open.

43. STEVE: Eh! Your ears are still as sharp as those of a fox.

44. MOTHER: Well, why is she giving you money?

45. STEVE: You see... she is my good customer. And she is willing to give me a loan to buy a boat of my own.
46. MOTHER: Steven I am so proud of you. You have become a good young and ambitious person /
47. STEVE: / Oh, thank you mama /
48. MOTHER: But... I also don't want you to strain your self. Do not stop concentrating on your education.
49. STEVE: Of course mama, am also reading very hard. I can't forget.
50. MOTHER: And besides that my son, do you want to be in debt with that woman forever?

CATEGORY 2: Debra, Lisa, Judith

EPISODE 1, SCENE 8

Abstract:

Judith and Lisa are discussing amongst themselves their dilemmas in their personal lives.

32. Ext: Under a tree Lisa's home. Day.

33. B/G SFX Birds chirping, chickens, goats

34. JUDITH, LISA.

35. SFX: B/G-COMPOUND/HOMESTEAD SOUNDS, F/G-RUNNING WATER, CLOTHES BEING WASHED.
36. LISA: I hate to ask you again, Judith, but I need to borrow some money to buy my daughter a mosquito net.
37. JUDITH: I do not have any money on me at the moment but I will give you some when my salary comes through at the end of the month.
38. LISA: (WITH GLEE) Oh thank you Judith. You are such a friend.
39. JUDITH: What are friends for?
40. LISA: It is difficult to make ends meet these days.
41. JUDITH: I know. It's hard for me too. My salary hardly pays for our food, and Monday drops a coin once in a blue moon these days.

42. LISA: Do I sense a problem brewing with Monday?
43. JUDITH: You know me too well, Lisa.
44. LISA: So what has he done this time?
45. JUDITH: I asked him for money to buy new shoes for Rebecca and you should have seen him. He screamed at me in front of the children and down right refused to give me any money.
46. LISA: Have you told him that his behavior displeases you?
47. JUDITH: Tell who? He would wring my neck off of my head. I cannot dare tell him anything. I know that all this stems up from him staying with that other woman.
48. LISA: You mean Millie?
49. JUDITH: (IRRITATED) Yes Millie. I thought at the beginning that I would be able to live with her as a co-wife but things get worse with Monday every passing visit. He comes and goes as he pleases and does not appreciate anything I do for him. What hurts most is that he constantly compares me to Millie...
50. LISA: It's sad. The two of you used to be inseparable. In fact sometimes it was embarrassing to be around you two. You just couldn't keep your hands off each other.
51. JUDITH: (WITH REGRET) Yes, I remember those days and I miss them.
52. LISA: You used to say that Monday was the heavy weight champion of your bedroom.
53. JUDITH: (LAUGHS) those were the days.
54. LISA: You could still make those days come back, you know
55. JUDITH: (DOUBTFULLY) Ha! how Lisa? The man hardly talks to me. He just screams
56. LISA: That's the problem. You two have got to learn to sit down and talk about things.
57. JUDITH: It is quite hard to know what he is thinking. He has really changed...
58. LISA: You have got to initiate this.

59. JUDITH: We are always arguing. Any little thing I say...Lisa, what can I do? Even my work at school is suffering.
60. LISA: You should not carry your personal problems to school.
61. JUDITH: It's more like I am carrying school to home. I am so busy at school these days, I hardly have time for my own children.
62. LISA: Ah-ah! Now that is bad. You should learn to separate time enough for your family and for your school work.
63. JUDITH: I am thinking about giving up on being school counselor.
64. LISA: (FIRMLY) No, Judith that is not a solution. I think you make a good counselor.
65. JUDITH: I wish you knew. There was an incident with one of my students. She is spending time with the truck drivers and drinking beer with them! Headmaster asked me to have a word with her and I did. But, I know I did not do a good job.
66. LISA: Oh, Judith, you expect too much of yourself. I'm sure you did fine...
67. JUDITH: (INTERUPTING) When she asked me how her behaviour puts her in danger, I was too embarrassed to explain...
68. LISA: Don't be so hard on yourself...How would you know how to counsel if you have never had training?
69. JUDITH: I'll never be able to counsel. I mean, I don't even have the nerve to talk with my own daughter, Rebecca, about such things...
70. LISA: It is so important that you do find the courage to talk with her. Rebecca is 17 years old now, not so? You don't want to find yourself in my shoes, with a daughter in the situation that mine is.
71. JUDITH: (CONCERNED) How is your daughter Debra?
72. LISA: Well, she's fine (SHORT PAUSE) for the time being anyway...

EPISODE 5, SCENE 4

Abstract:

Judith confides in Lisa about her marital woes with Monday and her children's misbehaviour. Lisa counsels Judith and gives her advice on talking to Monday and her children.

33. **Ext. Under the tree. Lisa's house. Day**
34. **B/G SFX: Chicken's, goats**
35. **JUDITH, LISA**
36. **SFX: B/G-HOMESTEAD SOUNDS; FREE RANGE CHICKEN, GOATS TREES BREAKING WIND.**
37. JUDITH: (DULLY) Hello Lisa
38. LISA: (WITH CONCERN) Whenever I see you carrying around that sad face, Judith, I know that there is trouble at home. Is it Monday again?
39. JUDITH: It is worse than that. Haven't you yet heard from the rest of the town?
40. LISA: You know I am not one for Rock Point gossip. Is it gossip that is making you look so dull? Judith, you know people will always talk.
41. JUDITH: Robert and Rebecca were involved in a bar fight last week and came home drunk. (SADLY) Now their father is threatening to take them away and throw me out of the house. Lisa, I do not know what to do.
42. LISA: (CONCERNED) Calm down Judith
43. JUDITH: (DESPERATELY) How can I calm down? EH? If Monday takes the children away, I might as well just die.
44. LISA: (REPRIMANDING) Now Judith, do not talk like that. You have a lot to live for.
45. JUDITH: Like what?
46. LISA: Like the other people in your life that depend on you. It is not like you will never see your children if Monday takes them.
47. JUDITH: So tell me Lisa, what should I do to stop this from happening?
48. LISA: You and Monday need to come to an understanding.
49. JUDITH: Me and Monday talk? He never listens to me. Besides, what would we talk about?
50. LISA: Talk about the way you are both dealing with the children. If the children see that you are divided, they will end up defying you both.
51. JUDITH: I do not understand.

52. LISA: (IMPATIENTLY) Come on Judith. What I am trying to say is that when Monday blames you for the kids' misbehavior, he's giving them an excuse to continue misbehaving.
53. JUDITH: I see what you mean. It is already happening as far as I can see. The problem is that Monday and cannot have a civil conversation.
54. LISA: You have to sit him down and try.
55. JUDITH: Lisa, you know Monday. He hates the fact that I am educated. If I had no need for his money, I bet he would treat me differently.
56. LISA: That's true. He thinks because he supports you it is his license to bully you.
57. JUDITH: So you do understand?
58. LISA: Money is not the only problem. It would help yes, but the real solution lies in you speaking to Monday and agreeing on how to raise the children.
59. JUDITH: But how can I do when he's threatening to throw me out of the house?
60. LISA: You know that he would do that just to hurt you. You have got to make him see that it would not be good for the children.
61. JUDITH: (DOUBTFULLY) I do not think we would agree. I'm not sure he really cares about what's good for the children.
62. LISA: At this rate, I hope that it will not end up as a marriage split. Whatever happens, you are welcome to stay with me.
63. JUDITH: (RELIEF) Thank you Lisa. What would I do without you? But I know it is all Millie's fault. She would like to take me out of the picture completely so that she can have Monday to herself.
64. LISA: Try to forget about Millie and concentrate on your children and yourself.
65. JUDITH: I worry about the children. First Rebecca packs a party dress in her school bag then a week later, they both come home drunk. Whatever will happen next?
66. LISA: You have to find the strength and confidence to be open with your children about their behavior. These are difficult days for young people; we have to talk with them about sex and love and AIDS...
67. JUDITH: But how could I ever discuss such things with my own children, Lisa?

68. LISA: You have to find a way, or you could wind up like me—with a daughter who's infected with AIDS. Oh, how I wish I had warned my Debra, and now it is too late...

END

EPISODE 10, SCENE 4

Abstract:

Lisa and Judith are discussing issues of sex AIDS and pregnancy. Lisa is advising Judith to openly communicate with her children about these issues.

1. Ext. Compound Judith's House. Day

2. B/G SFX: Sweeping

3. JUDITH, LISA

4. SFX: SWEEPING COMPOUND, QUICK STROKES

5. JUDITH: Lisa, I don't know what to do about my children. Rebecca was the last person I thought would do such a thing

6. LISA: Looking at books with naked men and women is not nice but it is a reality and these kids are exposed to them. They are on the streets in the city and nobody looks the other way when they are displayed openly.

7. JUDITH: (DEFEATED) After all my efforts to bring them up right, and it comes to this? I wonder what else she has been up to....

8. LISA: Don't beat yourself up, Judith.

9. JUDITH: I have tried so hard to impress upon them good values and a decent education. But is this what they are learning?

10. LISA: (EXPLAINING) Teenagers are curious and if they are given opportunities, even if the wrong ones, they will take them. You cannot control everything your children do, Judith.

11. JUDITH: (LAMENTING) Just one week Lisa, one week and everything has fallen apart.

12. LISA: It is not the end of the road. Communicating with your children does not stop with telling them what to do. You should start explaining some of the facts of life. So they can make their own decision wisely.

13. JUDITH: You sound like the instructor during our training last week.

14. LISA: Training as a guidance counselor should have helped you talk more openly with your children....

15. JUDITH: (SIGHS) Obviously, the training was not very effective. I ended up yelling and scolding them instead of talking with them like the young adults they are. I feel like a failure as a mother considering I have already failed as a wife.
16. LISA: (REPRIMANDING) Don't speak such rubbish. You are an intelligent, compassionate and loving mother.
17. JUDITH: (EMOTIONALLY) oh Lisa
18. LISA: (EMPHASISING) What's more, you are a great teacher. The school and ministry would not have chosen you if it was not so. Your biggest problem Judith is yourself. (FIRMLY). It is time you started believing in yourself, then others will believe in you.
19. JUDITH: (EMOTIONALLY) That is the best thing anyone has ever said to me.
20. LISA: (FIRMLY) You know that you are my best friend Judith and I want the best for my friend.
21. JUDITH: (FIGHTING BACK TEARS) Thank you, Lisa
22. LISA: (FIRMLY) I don't want thanks this time round Judith; I want to see you change. Talk with your children about **AIDS, and sex, and pregnancy**...
23. JUDITH: (DEFEATED) I don't think so, Lisa. Robert and Rebecca would never listen to me. Worse yet, they may decide to go out and try **playing sex with their friends**. I don't want to give them ideas...
24. LISA: And do you think they will never **play sex**??? Would you rather they **played sex** without having proper information about how to **protect themselves**?
25. JUDITH: (SHOCKED) Lisa!! How can you talk like that? I am sure they learn about such things in school...
26. LISA: (INTERRUPTS) are you sure? Do you know what they have learned about **protecting** themselves? Wouldn't it be better to talk with them yourself so you know they get correct information?
27. JUDITH: (HESITANT) I don't know, Lisa. What you say makes a lot of sense. But, how can I talk about such things with my own children?
28. LISA: You are strong. You can talk to your children about their **sexuality**. You can do it at school and you can do it at home.

EPISODE 13, SCENE 7

Abstract:

Judith and Debra have a heart to heart conversation on the importance of parents discussing sexual health matters with their kids.

1. Int. Health Center. Day.

2. B/G SFX: crying babies, coughing.

3. JUDITH, DEBRA

4. JUDITH: Hello Debra, how are you?

5. DEBRA; (CHEERFUL) Hello, Judith. I'm okay.

6. JUDITH: Your mother told me I could find you here at the clinic...

7. DEBRA: Yeah. I've started working here as a counselor....We're really busy today...

8. JUDITH: I don't want to bother you....I can come back another time, if you are too busy to talk.

9. DEBRA: No, no. Judith, let's go into the counseling room here where it's more private.

10. SFX: WALKING TO ROOM, DOOR OPENING AND CLOSING, SOUNDS OF CHAIRS SCRAPING AS THEY SIT DOWN.

11. DEBRA: Now, that's better... So, how can I help you?

12. JUDITH: Well, your mother suggested that I come talk with you about my daughter, Rebecca.

13. DEBRA: (CONCERNED) I know little Rebecca. She must be, what? 16 now?

14. JUDITH: 17...

15. DEBRA: So, is she having a problem?

16. JUDITH: (CHOKING WITH EMBARRASSMENT) Rebecca was involved in a fight at school today...with another girl...over a boy!

17. DEBRA: (SHOCKED) Oh no, Judith. I am sorry to hear that.

18. JUDITH: I don't know what to do with that girl...

19. DEBRA: It sounds as if this is not the first thing she's done to upset you.

20. JUDITH: A few months ago, she and her brother went to a bar in the fishing village and got into a fight...
21. DEBRA: Oh, no!
22. JUDITH: I don't know what is happening in the mind of that girl... I am so worried.
23. DEBRA: So, that is why you came to me?
24. JUDITH: Yes...well...I thought that since you...
25. DEBRA: (FINISHING HER SENTENCE) Since **I am HIV positive**, I can help you talk with your daughter?
26. JUDITH: Well, yes...I thought that maybe you could help her see the danger in the way she is behaving...
27. DEBRA: Have you discussed this with her?
28. JUDITH: (EMBARRASSED) Well...no...not exactly...
29. DEBRA: Judith, you need to talk with your daughter about this. Do you think she is **sexually active**?
30. JUDITH: Oh, my goodness! I don't know...I don't think so...
31. DEBRA: You know, I met Michael when I was Rebecca's age...and ...well he seemed perfect...and then, when I got **pregnant**, he left me...
32. JUDITH: I'm so sorry, Debra...
33. DEBRA: No, don't be sorry...it was long ago now. But, my mother never talked with me about **pregnancy**...or anything...
34. JUDITH: But, do you think it would have helped you...
35. DEBRA: (INTERRUPTING) Yes! Definitely...I thought nothing bad could happen to me...I was in love and I thought Michael was in love with me...Then, when my baby died...**I learned I was also infected with HIV...**
36. JUDITH: But, I just can't seem to talk to Rebecca about these things.
37. DEBRA: I think it would mean a lot if her mother talked with her.

38. JUDITH: Can't you talk to her for me?
39. DEBRA: It would mean a lot more to Rebecca if you talked with her.
40. JUDITH: I just don't know how to begin...
41. DEBRA: Begin by telling her that you love her and that you are worried...
42. JUDITH: And then?
43. DEBRA: And then tell her that she's too **young** to get involved **sexually**.
44. JUDITH: I don't know if she'll listen to me...
45. DEBRA: You may be surprised...

EPISODE 20, SCENE 2

Abstract:

Lisa is talking to Judith about Debra's accident and the social stigma she faced.

1. **Location:** Judith's school
2. **B/G SFX:** Usual school sounds
3. **LISA, JUDITH**

4. JUDITH: (SURPRISE) Lisa. What brings you here to the school? You are in such a state. (PANICKED) What's happened?
5. LISA: Judith, Debra has been in an accident.
6. JUDITH: (ALARMED) Where? Is she okay?
7. LISA: She will be fine. She had to see the doctor... Judith, I am sorry for asking you this... but I need help to pay the bill.
8. JUDITH: I understand. What exactly happened?
9. LISA: (UPSET) Debra fell off a boda boda and hurt her knee.
10. JUDITH: How is she doing now?
11. LISA: She was bleeding a lot and, apparently, just as someone was about to help her, a person in the crowd yelled out that **she had AIDS**. They all backed off. Every single one... nobody came forward to help.
12. JUDITH: (SYMPATHISING) Oh Lisa..
13. LISA: Debra lay there in pain. She could not move.

14. JUDITH: (GASPS) Oh my!
15. LISA: She just had to wait until help arrived. Can you imagine?
16. JUDITH: But surely, couldn't anyone there help out?
17. LISA: Everybody stood there whispering to each other and not wanting to touch her.
18. JUDITH: **Nobody should be made to suffer like that just because they have HIV.**
19. LISA: **People can be so cruel when they know that someone is HIV+.**
20. JUDITH: **We all have prejudices and many of us are ignorant about HIV and AIDS.**
21. LISA: (STIFFLING A CRY) Oh. You know, Debra told me she cried out in pain. She couldn't help it, my poor daughter! It was only when Topi the salon woman came and stopped a car that she was taken to the hospital.
22. JUDITH: I am glad at least Topi was there to help.
23. LISA: You have not heard the worst yet, my Dear.
24. JUDITH: There is more?
25. LISA: (TEARFULLY) **By the time I got to the hospital**, she was still lying there unattended. **No one** wanted to touch Debra because of **her condition** and I had to massage her until Sister Aisha came and helped me.
26. JUDITH: (SHOCKED) Goodness. Even the hospital?
27. LISA: By the time Sister Aisha came, Debra was weak from so much blood loss.
28. JUDITH: Thank God for people like Sister Aisha. Is Debra better now?
29. LISA: Right now she is doing much better but **I need money to pay for her treatment**.
30. JUDITH: I am more than willing to help out. I have just been paid. I will come to the hospital with you.

EPISODE 20, SCENE 5

Abstract:

Judith goes over to the Health Centre to see how Debra and Lisa are faring and they discuss Debra's life experiences.

31. **Location:** **The hospital. Debra's bedside.**

32. **B/G SFX:** **Child crying, clanking of hospital metals, a doctor talking in the back ground**

33. **JUDITH, DEBRA, LISA**

34. JUDITH: (LOW TONES) I am glad Debra is finally asleep, Lisa.

35. LISA: (TIRED) Yes. Me too.

36. JUDITH: (CONCERNED) I can only imagine what you must be feeling.

37. LISA: (BRAVELY) I am holding up, Judith.

38. JUDITH: I wonder where you get the strength. How can you go through all this and still remain strong?

39. LISA: Sometimes, Judith, problems make people stronger.

40. JUDITH: I wonder whether I would have maintained the strength you have, Lisa.

41. LISA: (CONFIDENTLY) You would have found the strength.

42. JUDITH: (COMFORTINGLY) Thanks, Lisa. Somehow I know that.

LISA: Debra did not bring **HIV** upon herself, you know.

43. JUDITH: (AGREEING) Mmmmh.

44. LISA: She was not what you would call a **promiscuous** girl. She was just a normal girl like any other.

45. JUDITH: I know, Lisa.

46. LISA: She never even had a boyfriend when she was growing up and I never saw her running around with anyone.

47. JUDITH: I remember that she always came back straight home after school.

48. LISA: You remember, eh?

49. JUDITH: The whole of Rock Point looked at her as a good example to other **young girls**.

50. LISA: The world has dealt her a cruel blow, Judith.

51. JUDITH: Don't say that, Lisa.
52. LISA: No, if there is a God and he is just, I do not know how it works.
53. JUDITH: Lisa, **HIV does not discriminate between good and bad.**
54. LISA: Debra had been in love like any other young woman. But the man had a secret. (STIFLING A CRY)
55. JUDITH: **I am more confused than you, Lisa. I do not know how to make Rebecca see that she could be in danger also, if she is not careful.**
56. LISA: Mmmmm.
57. JUDITH: **With her fighting for boys and running around in the wrong company, I can only dread what would happen to her.**
58. LISA: **You have to make her see.**
59. JUDITH: **I wish there was a way I could apply yours and Debra's example in my own circumstances with Rebecca.** I am sorry to be so blunt, Lisa.
60. LISA: No, you are right to want to protect your own daughter. I would have done anything to prevent Deborah from becoming HIV positive. But I can't. And it's no use feeling sorry for myself, because Deborah certainly doesn't. **She lives life to the fullest! She is strong and brave. She could teach us all a lesson, I tell you.** But if there is one lesson I could pass on to you, my dear Judith, it is this: **help your own daughter by talking to her openly – so that she does not put herself at risk.**
61. JUDITH: **Lisa, I feel terrified.**
62. LISA: Don't be.
63. JUDITH: (DEFEATED) I can't seem to help it.
64. LISA: **At this critical moment with Rebecca, be brave, be clear, be strong in your guidance. Show her the way!**

EPISODE 21, SCENE 3

Abstract:

Judith and Debra have a heart to heart about how she got infected with HIV/AIDS and the importance of freely discussing issues pertaining to sex.

1. Location: Lisa's house. Day.

2. B/G SFX: Usual sounds

3. JUDITH, DEBRA

4. JUDITH: Before you know it, you will be back on your feet and going back to your job at the health center.
5. DEBRA: I am looking forward to going back to work. Thanks again for standing by my mother.
6. JUDITH: She would do the same for me, Debra. You are lucky to have a mother like Lisa.
7. DEBRA: I know. I thank God for her everyday. Without her, I would not be here today.
8. JUDITH: (UNDERSTANDING) Mmmh.
9. DEBRA: Sometimes though, I feel like **I am a burden** to her - all the money **she has to spend on me like this.**
10. JUDITH: Debra, you mustn't feel like that.
11. DEBRA: But/
12. JUDITH: (FIRMLY) No Debra. This was not your fault. It was an accident.
13. DEBRA: I understand, Judith, **but if it was not that I was HIV+...**
14. JUDITH: Debra...
15. DEBRA: No Judith, each time anything small happens, my mother worries so much. It's too much for her.
16. JUDITH: Your mother does not blame you **for being sick.** We all know that **you were a good girl**
17. DEBRA: (EMOTIONAL) I feel so cheated.
18. JUDITH: (COMFORTING) Oh Debra.
19. DEBRA: I had only Michael and **he got me sick.** Only that one man.
20. JUDITH: And you did not know **he was sick?**
21. DEBRA: He looked normal. We met in college, we just clicked from the very first, Judith.
22. JUDITH: (IDENTIFYING) Yes.

23. DEBRA: I thought he would marry me - but he disappeared at the end of one term and I never saw him again. It was such a shock because, well, we had made vows to each other, forever. And then I found I was pregnant,
24. JUDITH: Oh.
25. DEBRA: No, I suppose I should not have been so much in love. It was even affecting my studies. And then, my baby died.
26. JUDITH: Poor girl. And you never saw him.
27. DEBRA: At his funeral. That was the biggest shock of all. .
28. JUDITH: (SHOCKED) Oh dear me.
29. DEBRA: There were so many girls at his funeral but it was only later that the full impact hit me.
30. JUDITH: You think he had lots of other girlfriends.
31. JUDITH: It didn't strike me at the time – because it was only much later that I started hearing rumors about him having AIDS.
32. JUDITH: **When you are young you think love conquers all. But in reality it does not!**
33. DEBRA: **I do not blame my mother, but I do feel I could have used a lot more advice and guidance when I was growing up.**
34. JUDITH: (UNDERSTANDING) Mmmmh!
35. DEBRA: **Maybe then I would have understood the significance of abstinence and the use of condoms.**
36. JUDITH: At the time, parents take it for granted that you just ... educate yourself about sex.
37. DEBRA: (IMPASSIONED) I hope you are not taking things for granted with your children.
38. END

EPISODE 22, SCENE 4

Abstract:

Judith is having a talk with Robert and Rebecca about sex, AIDS, STIs and pregnancy.

1. **Location:** **Judith's house. Night.**
2. **B/G SFX:** **Usual night sounds**
3. **JUDITH, REBECCA, ROBERT**
4. **SFX:** ROBERT'S RADIO BLARING
5. JUDITH: Robert, please switch off the radio. Rebecca, come, I want to talk to you both.
6. REBECCA: (SCARED) Have I done something wrong?
7. ROBERT: (DEFENSIVE) Whatever it is Mom, I did not do it.
8. JUDITH: It is nothing of the sort.
9. REBECCA: (CONCERNED) Is something wrong?
10. JUDITH: No, I want to talk. To both of you.
11. REBECCA: (WORRIED) Oh oh, I hope it is not about my marriage. Has Ssenga managed to convince you as well?
12. JUDITH: It is more important than that, my dear.
13. ROBERT: May I be excused then? It seems that this is a woman thing.
14. JUDITH: (FIRMLY) Sit down, both of you. Robert, this concerns you as well.
15. SFX: SHORT PAUSE
16. JUDITH: It is important to discuss sex, STI's, pregnancy and AIDS.
17. ROBERT: (SURPRISED) Mother, what has gotten into you?
18. JUDITH: **I love you both and I do not want to see you end up in a life of heartache because of a moment's foolishness. We are all foolish sometimes, but it can cost you dearly.**
19. ROBERT: I have not been involved with any girls at school.
20. REBECCA: I don't have a boyfriend, either.
21. JUDITH: (MOTHERLY) I am not accusing you of having any boyfriends or girlfriends. I just need you to understand that these days are harsh and it is important to be extremely careful.

22. REBECCA: We know that, Mom.
23. JUDITH: A little reminder doesn't hurt. **I understand that you are growing up and I know, well, that this comes with challenges.**
24. ROBERT: 10 out of 10 on that, Mom.
25. JUDITH: It is not bad to have a boyfriend or girlfriend but one has to be extra careful.
26. REBECCA: This is embarrassing, mother.
27. JUDITH: You cannot be sure of anybody's intentions anymore. **AIDS** lurks everywhere, and not only **AIDS**. There are also those **STIs**.
28. REBECCA: Do we have to talk about this? We know already.
29. JUDITH: I want you to hear me say it: Rebecca, some men want **sex** with you no matter what. They don't mind if they use you and ruin you.
30. REBECCA: Mummy.
31. JUDITH: They get you **pregnant**, and dump you.
32. REBECCA: I do not go out with men, Mummy. All my friends are girls.
33. ROBERT: What a terrible picture of men you paint! Am I going to be one of those 'men'?
34. JUDITH: That's exactly why I am talking to you as well, Robert, because I'll be damned if you are going to turn into one of those kinds of men.
35. REBECCA: I agree. I'll report you if you behave like one of those men!
36. ROBERT: (JOKING) And - If SHE gets a man, I will be sure to tell you, Mom.
37. THEY LAUGH.
38. JUDITH: You are both still have a lot of time for relationships. A whole lifetime, for that matter.
39. ROBERT: (DISSAPPOINTED) A whole lifetime?
40. JUDITH: Learn from my experience.

41. REBECCA: I think you are doing okay, Mom.
42. JUDITH: If I had not rushed into marriage early, I would have gone to University. My life would have been a lot better than it is now.
43. REBECCA: **Don't worry, Mother, when I decide to find a man, it will only be after my education - and he will be the richest man in the world.**
44. SFX: ALL BURST INTO LAUGHTER.

CATEGORY 3: Youth of RP256: Rebecca, Flower, Lillian, Akonyo

EPISODE 7, SCENE 5

Abstract:

Rebecca, Akonyo and Flower are discussing Rebecca's recent trip to the village and the issues of marriage, sex and AIDS.

1. Ext. Playing field, Foundation School. Day.

2. B/G SFX: Far-off pupils' voices

3. REBECCA, AKONYO, FLOWER

4. SFX: B/G-SCHOOL PLAY GROUND SOUNDS
5. AKONYO: Hey Rebecca, what's up? You're kind of lost, very quiet these days.
6. REBECCA: Hi Akonyo, what's up? Hi Flower.
7. AKONYO: Is there a problem at home? You can tell me Rebecca.
8. REBECCA: No, not really. It's just that something happened when I was in the village.
9. FLOWER: Oh, I heard you were in the **village**. What happened? Did someone die?
10. REBECCA: Much worse.
11. FLOWER: What could be worse than death? It cannot be that bad really.
12. REBECCA: (sadly) I have a cousin, Tina, she is so sick. She's as good as dead, Akonyo.
13. AKONYO: Now that is worse than death. Does she have...you know...AIDS?
14. REBECCA: No, no. Worse. I found her living in a hut alone, smelling horribly, like a dead rat. Akonyo, this girl is cut off from the rest of the family, and her husband has left her.
15. FLOWER: Oooh, she must be very dirty. Tell us no more.

16. AKONYO: Shut up Flower. No girl is that dirty. Rebecca what was wrong with her?
17. REBECCA: First, her mother told me she was bewitched. When I talked to her she said she was injured while trying to give birth.
18. FLOWER: (Rudely) How old is she and how did that lead to her **sickness**?
19. AKONYO: Flower, you deserve to be in that girl's shoes. Rebecca, go on.
20. REBECCA: Well, her body system got damaged. She couldn't deliver her baby easily at 15. She was in labour for four days. The baby was dead by the time it came out. Now she keeps urinating all the time without being able to control herself.
21. FLOWER: Oooh! Very disgusting! Can't you tell us about the interesting advice your Ssenga gave you on how to have (SEXUALLY CHARGED) **glorious sex**!
22. REBECCA: Dream on, I don't need advice from a woman who'd like to see me married off to some old man.
23. FLOWER: Why not? If he is rich?!
24. AKONYO: Flower, you don't have any sense of feeling in that skull of yours, do you? Rebecca's friend has a serious problem caused by having a baby when she was too young. I've read about it in Straight Talk.
25. FLOWER: Me I can't be that stupid. Babies are out. I want to stay tight.
26. AKONYO: Then shut up and go away.
27. FLOWER: Fine, these are problems of **village girls**, not me. Bye.
28. AKONYO: Good riddance. Rebecca, you ignore that one. Have you spoken to your mother about it?
29. REBECCA: Humph, you are joking? I don't even know how that woman managed to conceive us. I just don't want to end up in Tina's situation. What I saw was enough.
30. AKONYO: But, that cannot happen to you as long as you continue in school and wait until you are at least 20 before getting a baby.
31. REBECCA: That's the problem. It could happen to me. Ssenga wants to marry me off to an old man in the **village**...

EPISODE14, SCENE 5

Abstract:

Lillian and Flower are talking about Lillian's affair with Solomon and Flower is advising Lillian to practice safe sex with Solomon.

1. **Location:** **School playground. Day.**
2. **SFX B/G:** **Children playing, ball sounds**
3. FLOWER, LILLIAN
4. LILLIAN: (CAUTIOUSLY) Flower, you have to promise you won't tell anyone about me and Solomon.
5. FLOWER: (NAUGHTILY) And who is Solomon? Look what happened to Rebecca just for thinking about Steve. But you are not just thinking, are you?
6. LILLIAN: Flower, this is serious.
7. FLOWER: I know, Lillian. (TEASING) You went for the real thing eh? That is why I like you girl. You are so brave.
8. LILLIAN: Hush now. Some one might hear you.
9. FLOWER: (QUIETLY/TEASING) While the whole school was in an uproar about Vicky and Rebecca, you walk away with first prize.
10. LILLIAN: Shhhhhh!
11. FLOWER: (SURPRISED) Why? Are you having second thoughts about/
12. LILLIAN: (TIMID) It is not like that really.
13. FLOWER: (ENTHUSIASTIC) I can take him on for you if he is becoming too hot to handle.
14. LILLIAN: (FIRMLY) No, Flower.
15. FLOWER: (TEASING) Mmmh. You can't have enough of him eh? So you want him all to your selfish self?
16. LILLIAN: He treats me well, but it is not about the sex.
17. FLOWER: (SHOCK) Are you falling in love with him? (STERNLY) Don't even think about it.
18. LILLIAN: Well...../
19. FLOWER: He only wants you because you are young and pretty. Just keep him happy so he keeps giving you things.

20. LILLIAN: Flower, don't be so rude.
21. FLOWER: (EXASPERATED) Oh please, do you think **he is sleeping** with you because he loves you?
22. LILLIAN: (ANGRY) You don't know what you are talking about.
23. FLOWER: It is a reality my dear, so enjoy it while you can. By the way, if you entertain such notions like love, **you will end up pregnant**.
24. SFX: LOUD GASP
25. FLOWER: (STUNNED) **Don't tell me you are not using condoms!**
26. LILLIAN: (SHEEPISHLY) Ah.../
27. FLOWER: **You should always go prepared to use protection. Be like me. Do not let a man dictate to you my dear. Never go to battle without a shield! (A)**
28. LILLIAN: (QUIETLY) What if he does not accept?
29. FLOWER: Lillian. **You know nothing about Solomon's past. He could have HIV or syphilis.**
30. LILLIAN: (DEFENSIVE) Solomon is a good man.
31. FLOWER: (SARCASTIC) **Good men also get young girls pregnant and good men also die of AIDS. (D)**
32. LILLIAN: (UPSET) That is not a very nice thing to say Flower.
33. FLOWER: Sometimes I have a lot of nonsense, but this time Lillian; it is for your own good.
34. LILLIAN: I understand, but please keep my relationship with Solomon a secret.
35. FLOWER: (LIGHTING UP) I reckon you are really smitten by Solomon. I am really going to have to look out for you.
36. SFX: LIGHT LAUGHTER.

EPISODE 20, SCENE 8

Abstract:

Lillian goes to the Health Centre for the first time to discuss with Sister Aisha about her fears of being pregnant and not practicing safe sex.

65. **Location:** Int. Health Center. Day.
66. **SFX:** Medical ambience
67. **SISTER AISHA, LILLIAN**
68. SIS AISHA: (FRIENDLY) Welcome to the health centre, Lillian. My name is Sister Aisha. Please be seated.
69. SFX: CHAIR SCRAPING FLOOR
70. SIS AISHA: Now, what can I do for you?
71. LILLIAN: (NERVOUS) I **was so worried about coming to the Health center** and I did not know who to talk to, Sister.
72. SIS AISHA: Calm down. Now tell me, what is troubling you?
73. LILLIAN: I think I may be pregnant. (BURSTS INTO TEARS)
74. SIS AISHA: (COMFORTING) **You can talk freely here. Nobody can come into this counseling room.**
75. LILLIAN; (SOBBING) But...but.../
76. SIS AISHA: **Our talk will be confidential and I will not tell anyone else what we say to each other.**
77. LILLIAN; Are you sure?
78. SIS AISHA: Yes. Now tell me, what makes you feel you are pregnant?
79. LILLIAN: I missed my period, Sister Aisha.
80. SIS AISHA: Mmmh. When was your last period?
81. LILLIAN: I was expecting it two weeks ago.
82. SIS AISHA: Lillian, are you in a steady sexual relationship?
83. LILLIAN: (FALTERING) Ah, ah...
84. SIS AISHA: It's okay, Lillian, you can tell me.
85. LILLIAN: I am sleeping with somebody.
86. SIS AISHA: You do not have to give me details of the person.

87. LILLIAN: (BREATHES A SIGH OF RELIEF)
88. SIS AISHA: And are you and your friend using protection?
89. LILLIAN: (Shyly) No, Sister.
90. SIS AISHA: (LECTURING) But do you know that there are dangers and consequences of having unprotected sex especially at a young age?
91. LILLIAN: **I do not know what to do. He will not use a condom...and...and/**
92. SIS AISHA: (GENTLY) There are other methods of contraception that you can use to prevent pregnancy...but they will not protect you from HIV... Let me advise you.
93. LILLIAN: Thank you, Sister Aisha.
94. SIS AISHA: Missing one period may not mean you are pregnant.
95. LILLIAN: (SURPRISED) Oh?
96. SIS AISHA: There are other reasons for a missed period. Stress is one of them.
97. LILLIAN: So, you think I am not pregnant?
98. SIS AISHA: It's possible. A pregnancy test would reveal for certain whether you are pregnant...but it is too early yet for that.
99. LILLIAN: So what would you suggest, Sister Aisha?
100. SIS AISHA: I could do an examination, which could help determine if you are pregnant, but it is by no means conclusive. Once you are two or more months pregnant, we can do a more conclusive test
101. LILLIAN: But...(STARTS CRYING)
102. SIS AISHA: (CONCERNED) Is something else troubling you Lillian?
103. LILLIAN: (STAMMERING) The man concerned wants me to have an abortion.
104. SIS AISHA: (OBJECTING) Oh, no! Abortion is illegal and it is dangerous to you.
105. LILLIAN: But he is insisting on it.
106. SIS AISHA: Because abortions are illegal, they are often conducted without medical care and procedures. Many women die from them...

107. LILLIAN: He says he has a doctor coming from the city.
108. SIS AISHA: Lillian, you could face severe damage, internal injury or even death, not to mention the life of the child that you are ending. (FIRMLY) Abortion is not an option!
109. LILLIAN: (DESPERATELY) Now what can I do?
- SIS AISHA: First let's find out whether you are pregnant. Let us start with an examination. Then we can find a solution to your predicament.

EPISODE 24, SCENE 6

Abstract

Sister Aisha and Lillian have another discussion and Lillian finds out that she is not pregnant.

1. **Location: Health Center. Day.**
2. **SFX: Health center ambience**
3. **LILLIAN, SISTER AISHA**
4. SIS AISHA: Lillian, it must be the stress and worry that made you miss your period.
5. LILLIAN: (OVER JOYED) Oh, Sister Aisha, that is good news.
6. SIS AISHA: As you can see, your body is telling you that you are NOT pregnant, because your period has come.
7. LILLIAN: (LAUGHS OUT) Great!
8. SIS AISHA: In fact, your pregnancy results are saying exactly the same thing. You are not pregnant.
9. LILLIAN: I have been so sick with worry.
10. SIS AISHA: I am pleased that you had the courage to come back and let me know what is going on.
11. LILLIAN: I had to come back because you were so kind to me, Sister Aisha, and you are so easy to talk to - and **nobody else gives me the same good advice.** (EMOTIONAL) Thank you. **It put my mind at rest to understand the facts.**
12. SIS AISHA: I am glad you think of me that way. You should not be afraid to come and use these services.
13. LILLIAN: Really?
14. SIS AISHA: You know many girls come to me with the same situation?

15. LILLIAN: (SURPRISED) What?
16. SIS AISHA: **There are more like you. Some are afraid, others have pressure from husbands and partners not to come to the health center. But some, like you, learn that we CAN help you stay healthy.**
17. LILLIAN: I am grateful for that.
18. SIS AISHA: **We can always provide you with information about your health so that you can make wise decisions**
19. LILLIAN: I wish I had known where to come much earlier, then I would not have worried so much.
20. SIS AISHA: You have to ask yourself if this relationship is the right thing for you, if it is causing you so much stress. Young girls can be misled into sexual relationships when they are not at all ready for them.
21. LILLIAN: (DESPERATELY) **I do not know what to do.**
22. SIS AISHA: You should learn from this experience. Do you like the man you are sleeping with? Has he proposed marriage?
23. LILLIAN: (AVOIDING) What do you mean?
24. SIS AISHA: **You should think about your situation and decide if this sexual relationship is the best for you.** How do you plan to avoid **pregnancies** in the future?
25. LILLIAN: I cannot convince my boyfriend to use condoms - and I do not know what else to do.
26. SIS AISHA: There are other contraceptive methods you could use. Like pills, that you will have to take everyday, or an injection every three months.
27. LILLIAN: Ouch. I hate injections.
28. SIS AISHA: There are also Norplant implants that you can have inserted just under the skin of your arm. Perhaps you can bring in your boyfriend so that I can talk to him.
29. LILLIAN: Impossible.
30. SIS AISHA: You need to be aware that all the contraceptives will prevent pregnancy but they will not protect you from HIV or other STI's.
31. SFX; UNCOMFORTABLE SILENCE

32. SIS AISHA: It would be best if you and your boyfriend took an **HIV test** to be sure that neither of you is **infected**, before you have **sexual intercourse** again.

33. LILLIAN: That is also hard.

34. SIS AISHA: Lillian, do you know if your boyfriend is being faithful to you?

35. LILLIAN: (UNCOMFORTABLE) Well.../

36. SIS AISHA: (KINDLY) There are many things you have to consider, my dear. If you have anything on your mind about your relationship, feel free to talk with me anytime.

EPISODE 30, SCENE 3

Abstract:

Rebecca have a spat and during this conversation Vicky discloses that Steve has an STD.

92. **SCENE 3**

93. **Location:** In the classroom. Day.

94. **B/G SFX:** Kids moving out of class, a lot of shuffling

95. **VICKY, REBECCA, TEACHER MARK.**

96. T/MARK: You have five seconds to go.

97. SFX: QUIET TENSE CLASSROOM, (OFF MIC) COUGHING FROM A STUDENT.

98. T/MARK: Hurry up, I want those books collected. The bell will be ringing any second.

99. SFX: QUICK BUT QUIET SHUFFLING OF DESKS, CHAIRS, BOOKS AND PAPERS FLAPPING. SOME STUDENTS (OFF MIC) SHOUTING 'WAIT'.

100. VICKY: Sir/

101. T/MARK: /Yes, Vicky what is it?

102. VICKY: Can I help you carry the books?

103. SCHOOL BELL RINGS

104. T/MARK: If your book is not among these... Vicky follow me with those books to the staff room.

105. SFX: (OFF MIC) CLASSROOM CHAOS BEGINS. BUMP, STUMBLES, BOOKS DROPPING TO THE FLOOR.

106. REBECCA: (ATTITUDE) Can't you see where you are going you goat?
107. VICKY: (ATTITUDE) Silly, you are standing in the way.
108. REBECCA: Couldn't you pass there?
109. VICKY: Look what you have made me do with other peoples' books.
110. REBECCA: You intended it.
111. VICKY: (THREATENING) Gwe Rebecca, do you think I have forgotten you?
112. REBECCA: You think I fear you?
113. VICKY: I remember very well how you put me in trouble.
114. REBECCA: Nyabo, you shall not scare me.
115. VICKY: Mark you I am not a teacher's pet. Mbu just because you are Madam Judith's daughter.
116. REBECCA: At least I am a pet, for you – **you are Teacher Mark's prostitute.**
Why are you carrying his books?
117. VICKY: (GRITTY, BITTER) Rebecca, I will beat you again.
118. REBECCA: Sha/
119. VICKY: /And this time there won't be anyone to save you.
120. REBECCA: (MOCKING) You are just looking for trouble.
121. VICKY: Rebecca I am trouble itself.
122. REBECCA: Vicky you just have other things disturbing you. Let me not waste my time with you.
123. VICKY: This is a warning; do not cross my path again.
124. REBECCA: (WITH SATISFACTION) Oh, I see, you are just jealous.
125. VICKY: (MOCKING) You think I am interested in that ka-boy of yours Steven?
126. REBECCA: Then why are you wasting my time?

127. VICKY: What would I want with that **useless sexually infected** Steven?
128. REBECCA: (ENRAGED) How dare you say such a thing?
129. VICKY: (ENJOYING HERSELF) They say that **sexual infections** can make you go mad. Maybe he has also **infected** you.
130. REBECCA: (CONTROLLING HERSELF) You know what Vicky? I am not even going to waste my time on you... (MIC FADES OFF).

EPISODE 33, SCENE 5

Abstract

Lillian and Sister Aisha discuss Lillian's sexual relationship and Lillian confides in Sister Aisha that Solomon is the man she is having an affair with.

231. SCENE 5

232. Location: Sister Aisha's house. Interior. Day

233. B/G SFX: Usual Health Center day sounds

234. LILLIAN, SISTER AISHA

- 235.** LILLIAN: Wow, Sister Aisha, this is a nice house...
- 236.** SIS AISHA: Thank you Lillian...um this man, are you still seeing him?
- 237.** LILLIAN: I have been trying to avoid him, Sister...
- 238.** SIS AISHA: Why?
- 239.** LILLIAN: I want to get out of the relationship Sister Aisha but I don't know how.
- 240.** SIS AISHA: Are you still **sleeping** with him?
- 241.** LILLIAN: That's why I am avoiding him. I don't want that but it is like he is putting a lot of pressure on me. All the time.
- 242.** SIS AISHA: Have you told him you want out of the relationship?
- 243.** LILLIAN: he doesn't listen. And since I am not pregnant, he doesn't see a problem anymore.
- 244.** SIS AISHA: Are you prepared in your mind, are you ready for **safe sex**? What about using **condoms**?
- 245.** LILLIAN: I don't know

246. LILLIAN: You see, he is making my life really hard and I have also met someone else and I cannot stop thinking about him.
247. SIS AISHA: Now you are making it more difficult for yourself.
248. LILLIAN: No, it's not like that Sister Aisha.
249. SIS AISHA: if you carry on the relationship, whether you want to or not and you continue to have **unsafe sex**, you put yourself at a great risk – of **pregnancy**.
250. LILLIAN: But Sister Aisha...
251. SIS AISHA: There are other risks. You know that don't you?
252. LILLIAN: Yes.
253. SIS AISHA: Until he has tested you do not know his status. You don't know who his partners have been. He could be carrying the **HIV virus** or **have an infection** that he could pass on to you.
254. LILLIAN: I know.
255. SIS.AISHA: So what is stopping you from taking care of yourself?
256. LILLIAN: (HESITANT) I am scared.
257. SIS AISHA: Of what?
258. LILLIAN: I don't know.
259. SIS AISHA: Does he make you scared?
260. LILLIAN: Well...yes...sort of...
261. SIS AISHA: Do you want to tell me why?
262. LILLIAN: I am afraid he might stop me from going to school.
263. SIS AISHA: He can't do that. You have a right to go to school. Every child has that right.
264. LILLIAN: He is the one paying my fees.
265. SIS AISHA: He is paying your fees?

266. LILLIAN: (SHY) Yes.
267. SIS AISHA: May I ask you Lillian; is this person a relative of yours?
268. LILLIAN: No...but I stay with him...
269. SIS AISHA: (SHOCKED) You stay with him? I don't understand.
270. LILLIAN: (TEARFULLY) it is Mr. Solomon.
271. SIS AISHA: (SHOCKED) I see. (COMFORTING) He cannot ask you to give him sex in exchange for giving you school fees.
272. LILLIAN: It is not quite like that...
273. SIS AISHA: How is it then?
274. LILLIAN: It started differently. He was nice to me. He took care of me.
275. SIS AISHA: Yes?
276. LILLIAN: He gave me nice things. He was kind.
277. SIS AISHA: Did he expect you to repay his kindness with sex?
278. LILLIAN: At first I wanted...to show my appreciation (LAUGH NERVOUSLY)
279. SIS AISHA: (LIGHTER) There are other ways of saying thank you!
280. LILLIAN: I know, but it is as though he expected it. And then when I realized I had been foolish, he begun getting mean, threatening to send me back to my village.
281. SIS AISHA: My dear, there are many young girls in this situation, Many who think that they have to give their bodies to repay kindness.
282. LILLIAN: I know...I regret it...I want to change.
283. SIS AISHA: The first thing you need to do is think about how you are going to support yourself independently.
284. LILLIAN: How can I do that? He has done everything for me.
285. SIS AISHA: Then I suggest you find about school bursaries and see if you qualify for one. When you do small things for yourself, they make big changes in your life.

EPISODE 36, SCENE 5

Abstract:

Rebecca and Flower are talking about Steve's sexual health and discussing his mother's illness.

1. **Location:** **School farm gardens. Day**
2. **B/G SFX:** **Students hoeing, girls chatting, a teacher/student shouts instructions; make sure you all finish weeding your rows of maize**
3. **REBECCA, FLOWER**
4. SFX: (OFF MIC) HOES HITTING GROUND, SLASHERS AT WORK
5. FLOWER: I swear this is forced labor.
6. REBECCA: There you go. I knew it would take you less than a minute before you start complaining.
7. FLOWER: Rebecca, me my skin is sensitive.
8. REBECCA: Eh, Kati what do you want us to say?
9. FLOWER: And these chemicals they give us to put in the soil make me itch.
10. REBECCA: (AMUSED) But Flower you are so spoilt.
11. FLOWER: No let me ask you a question.
12. REBECCA: What is it?
13. FLOWER: Which man would want a woman with a rough skin?
14. REBECCA: Men these days are more interested in hard working women. Ela if you are complaining...
15. FLOWER: Rebecca, beauty is always the first on the list /
16. REBECCA: Mama, kale you are mistaken.
17. FLOWER: Why do you think **your fisherman** likes you?
18. REBECCA: Let's not talk about Steven.
19. FLOWER: Let me hope you are not ignoring him and giving him excuse because Robert is sick.
20. REBECCA: But Steven also has his own problems.

21. FLOWER: I hear that he is always at **the health center** also.
22. REBECCA: Yes I found him there sometime.
23. FLOWER: (CURIOSLY) Aha? Tell me... what is wrong with him, was Vicky right?
24. REBECCA: (GUILTYLY) It wasn't that this time... actually... I even did something stupid.
25. FLOWER: And you had not told me all this time? Aha...
26. REBECCA: Well I confronted him thinking he was lying to me again and /
27. FLOWER: / What did you say?
28. REBECCA: I thought he was still hiding **his STI** only to realize that his mother was the one who was **sick** instead.
29. FLOWER: **His mother is sick?**
30. REBECCA: Flower please don't tell anyone. He made me promise...
31. FLOWER: What is she **sick** of?
32. REBECCA: Well it's just a **fever** that keeps disturbing her.
33. FLOWER: So have you decided to trust him again?
34. REBECCA: Well I am, its just that at first I thought Steven was a guy who couldn't do anything wrong like **sleeping around**.
35. FLOWER: (AMUSED) You... you are still in those first stages of love... obsession.
36. REBECCA: Don't be jealous.
37. FLOWER: Me... jealous, please! I can't even like a guy who is not on market. That means he is boring.
38. REBECCA: **When I talked to Steven he seemed changed but I don't know yet if I can trust him.**
39. FLOWER: Did he say he loved you?

40. REBECCA: Well... but I am not so sure because it seems there is a whole side of him that I don't know about.
41. FLOWER: What makes you think so?
42. REBECCA: Nothing really but... what if he has something else he is hiding... like HIV?

CATEGORY 4: Topi's Salon: Topi, Nana, Judith and Lisa
EPISODE 3, SCENE 6

Abstract:

At Topi's salon the ladies are discussing marital issues, sex, AIDS and the latest town gossip.

1. **Int. Topi's hair salon. Day.**
2. **B/G SFX: Blow dryer, women chatter, tap running.**
3. **HAIR DRESSER TOPI, JUDITH, NANA, LISA.**
4. **SFX: AFRIGO MUSIC, SALOON SOUNDS, DRYER**
5. LISA: Eh Topi. Come and reduce this dryer. It is burning my scalp.
6. TOPI: It is already low, Lisa. If I reduce it any further, your hair will not dry. It is so long you know.
7. LISA: I would rather endure the time and stay longer for it to dry than enduring this heat.
8. TOPI: (ENVIOUSLY) But your hair has grown so much since the last retouch. It is going to be the winner.
9. NANA: You know what they say about a woman's nails and hair. When they are growing faster than usual, they are in love.
10. JUDITH: (TEASING) Lisa, who is the lucky guy?
11. NANA: (JOKING) Unlucky I would say.(LAUGHTER FROM ALL THE WOMEN)
12. LISA: No, same old husband teaching down at the school. It is probably the vitamins I have been taking of late.
13. TOPI: Good for you. These days, you have got to do anything that will make you look pretty. Those young girls hover about in search of prey.
14. LISA/ NANA: Prey?
15. TOPI: Your husbands of course. They are competition to reckon with.

16. JUDITH: (RETORTING) Those silly girls! Why can't they go in for their age mates?
17. TOPI: Judith, dear, their age mates do not have the kind of money they want to spend. You should see them when they come into the salon to do treatment. They ask for the most expensive ones.
18. NANA: The most expensive ones? Where on earth do they get that kind of money?
19. TOPI: (RETORTING) From your men, Nana! That is why you need to style up.
20. NANA: (PROUDLY) I do not think that my Solomon would do such a thing.
21. TOPI: Mmmh. A man is only yours when he is with you. When he walks out the door, he becomes somebody else's.
22. JUDITH: She is right. Don't you see what happened to me? That Millie came Monday's way and before I got to know about it, she was expecting their first child.
23. LISA: I think that the worst part about it all is the fact that you are the last to know. The whole town talks about it behind your back and you have no clue.
24. JUDITH: There are more and more young girls fooling around with other people's husbands. They even miss school because they want to be with their men.
25. NANA: Can't you counsel them Judith? You are the school counselor are you not? And you have the best experience considering your husband was snatched by a school girl at the time.
26. JUDITH: **A hubby snatcher is quite different from a young girl who just wants to have fun.**
27. NANA: It's all the same to me. And it is widespread as well. **Don't they fear AIDS and pregnancy?**
28. JUDITH: I doubt that they do. They seem to imagine those things can't happen to them. I find it so difficult to counsel these **young people**. There is this one girl Flower. That one, I don't know. No amount of counseling could help her.
29. LISA: I hope she is not eying my hubby.
30. JUDITH: Your husband is not her type, Lisa.

31. LISA: (OFFENDED) What do you mean by that?
32. JUDITH: (APOLOGETIC) No offense Lisa. Like you know, teachers do not get much money to spend. She's only interested in heavy spenders.
33. TOPI: You would be surprised, Judith, my dear. Some would do it even for a plate of chips. That Flower is the queen of them all. She comes in here often to do her hair and nails.
34. JUDITH: But her father works for the bank. Why would she need to use her body to get things?
35. TOPI: All those girls you think are **innocent** have boyfriends. In fact they change them like they change their under wear.
36. NANA: But Topi, you sound like you are one of them.
37. SFX: THE REST AGREE
38. TOPI: (DEFENSIVELY) Ahh-ahh. I see them on their way to happy hours lodge. And their parents do not know what they are doing.
39. JUDITH: (WORRIEDLY) You don't think.... (SHORT PAUSE) My daughter Rebecca the other day packed a party dress in her school bag.(OOHS AND AHHS FROM THE REST) It was probably for Flower....
40. TOPI: Watch Rebecca closely. Flower can easily spoil her. And Nana, doesn't Lillian worry you? She is a pretty girl.
41. NANA: She is just an **innocent village girl**. Solomon would never look at her that way.
42. TOPI: My dear. **Village girls are more deadly than town girls**. Men love that innocence.
43. NANA: (CONFIDENTLY) Don't think so. She is even a distant relative and the kids love her. She would never do anything like that.
44. JUDITH: We should not think that all girls are bad. Even girls like Flower can change.
45. TOPI: Not Flower, Judith! (LAUGHING) Once rotten, always rotten

EPISODE 7, SCENE 4

Abstract

Topi, Judith and Nana are at the Salon discussing the latest Rock Point gossip

32. . Topi's Salon. Day

33. TOPI, JUDITH, NANA

**34. SFX: AFRIGO BAND MUSIC IN BACKGROUND, HAIR DRYER,
WATER TAPS-RUNNING WATER.**

35. JUDITH: (EXPLODING) That witch!

36. TOPI: (LIGHT HEARTED) Did she ruin your hair? That's why Topi is here.

37. NANA: (SERIOUSLY) I do not think this is the right time for a joke Topi.
(CONCERNED) What's the matter Judith?

38. JUDITH: It is that Millie. I went to her home to ask after my children and instead of
answering basic questions, she just insulted me. Yet all the while she
knew that they had gone to the village with their father.

39. NANA: But why would Monday take the children that far without telling you?

40. TOPI: (DISGUSTED) That is how men are!

41. JUDITH: Be more specific Topi, that's how Monday is! He thinks he can just do
that and it is okay.

42. TOPI: Men think that they can act stupidly and get away with it. That is why I
thank God that I do not have to deal with a full time man. (PROUDLY) I
value my independence.

43. NANA: (WARNING) That independence also has its problems. At least with a full
time man, most of your worries are taken care of.

44. TOPI: You mean your finances eh? No way, I can take care of myself there! In
my house, I call all the shots!

45. NANA: Topi, it is so easy to talk like that when you are young. But when you have
got children it is a different story.

46. TOPI: Nana, people like you bring those responsibilities upon yourself.

47. NANA: It is a wonderful experience my dear. You will get married one day and
have children. Then we will talk about men!

48. TOPI: And invite problems to myself? No such thing. Do you think that your
husbands feel for their families the way you do?

49. NANA: (DEFENSIVE) But they do think about their families.
50. TOPI: Speak for yourself Nana. By the way, you think that it is only married men who are a problem? I tell you, it starts when they are still young and only gets worse when they get a bit of cash in their pockets.
51. NANA: I do not think we have such problems in Rock Point. It is not as bad as elsewhere.
52. TOPI: Nana, do not be deceived. Rock Point is just like anywhere else in the world.
53. JUDITH: (WORRIEDLY) Robert is coming of age and has started working at his father's garage. I must say that ever since then, he has an air about himself. You do not think he is a player, do you Topi.
54. TOPI: (LAUGHS) Of course he is. It is a good thing he is earning some money. That's what I used to do from the time I was 16. I started braiding hair in the village just to make ends meet.
55. JUDITH: I worry about his education. He is spending more and more time at the garage now. I am afraid he may not graduate.
56. TOPI: I think he is intelligent enough to divide his time between work and school. By the way Judith, where is Lisa these days? I haven't seen her in here for ages.
57. JUDITH: Lisa has her **own problems** these days. **With her daughter Debra and all...**
58. TOPI: You tell her to come in and get her hair done. That'll raise her spirits.
59. JUDITH: I will. It sure works for me. I was so angry when I came in today. Now I feel much better...
60. TOPI: You've become a very regular customer these days, Judith. Any reason for that?
61. JUDITH: What do you mean, Topi.
62. TOPI: I don't know. You just seem to be coming in more regularly ever since Don Guma came back...
63. JUDITH: (EMBARRASSED) Don't be silly...

64. NANA: Have you seen him yet, Judith? I remember the two of you used to be quite an item at Foundation High School.
65. JUDITH: That was years ago, Nana. Before I married Monday...
66. TOPI: Once in love, always in love....

EPISODE 21, SCENE 7

Abstract:

Topi, Nana are at the salon and they are discussing Debra's accident and how Debra contracted HIV/AIDS.

39. Location: Topi's salon. Day.

40. B/G SFX: Usual salon sounds

41. TOPI, NANA

42. TOPI: (EXAGGERATING) Honest. If I had not rescued her, Debra would have lost her leg.
43. NANA: (HORRIFIED) What!
44. TOPI: Seriously, Nana. Everyone there was standing around like they had seen a ghost. I had to help the poor girl. No one else was going to.
45. NANA: I am shocked.
46. TOPI: They were scared – you know.../
47. NANA: Is the rumor true...about Debra having AIDS?
48. TOPI: Yes it is.
49. NANA: (SADLY) That's a pity. **Debra used to be a top student. She never straved.**
50. TOPI: (UNFEELING) AIDS does not care if you are a top student or not. You mess up, you pay for it!
51. NANA: (DEFENDING) Debra never messed up. She was a good girl.
52. TOPI: (BORED) Oh?
53. NANA: Yes. She had one boyfriend... the way she used to talk about him...
54. TOPI: Probably drove him away.

55. NANA: She couldn't help it if she was in love.
56. TOPI: **But you know it was no shock to me when Michael died.**
57. NANA: (SHARPLY) Topi!
58. TOPI: How can the people of Rock Point be so blind? **I knew Michael was up to no good.**
59. NANA: Now how did you know Topi?
60. TOPI: Nana, the man tried getting me to bed but I turned him down. I knew better.
61. NANA: No!
62. TOPI: Yes!
63. NANA: Did Debra know he **was playing around**?
64. TOPI: The girl was **innocent**. In fact, half asleep. You can't shut your eyes and pretend that **HIV** doesn't exist, Nana. A girl needs to go into relationships with her eyes open.
65. NANA: But **she was young – and innocent**. She had no idea he would **infect** her.
66. TOPI: That's no excuse. Maybe Debra knew about **HIV** but she still thought it would not happen to her.
67. NANA: Maybe she just didn't THINK. None of us ever think that we could catch **AIDS**. **We feel too smart for it.**
68. TOPI: Well, if you willfully stay **ignorant** it's like making yourself a **victim**.
69. NANA: That's not fair.
70. TOPI: True, it's NOT fair. But girls have to wake up. Get informed. The problem with these girls who trust men? **THEY** end up being faithful and their **PARTNERS** run around picking up problems. (NAUGHTILY) That's why I always insist on having a part time man.
71. NANA: Now Topi, that is worse than settling down with one and being faithful.
72. TOPI: Husbands are the worst. I would rather control one man when I want to, than *trust* a husband and he cheats on me.

73. NANA: That sounds like hard work!
74. TOPI: No, it's simple. If they don't want to use **condoms** I kick them out. You cannot reach into a well without a bucket.
75. NANA: Otherwise you risk falling in eh?
76. SFX: LAUGHTER
77. NANA: Oh dear, Topi. Look at the time. I had better go. I have a ton of things to do. And, by the way, I want to bring young Lillian in next time.... she needs cheering up.
78. TOPI: Good. We'll put a smile on her face. So don't you even have time for a blow dry today?
79. NANA: No. Solomon hardly ever notices these days anyway.
80. TOPI: (LAUGHING WICKEDLY) Well, Sweetheart, others are looking.
81. NANA: (AMUSED) Don't start.
82. SFX: LIGHT LAUGHTER

EPISODE 36, SCENE 2

Abstract:

Lisa, Nana and Topi are at the salon and they are discussing Steve's mother being admitted to the Heath Centre and Steve's promiscuity.

43. **Location:** Salon. Day.
44. **B/G SFX:** Usual salon sounds, dryers, running water, radio
45. **TOPI, NANA, LISA**
46. LISA: Robert woke up from his coma!
47. TOPI: That's fantastic news!
48. NANA: (AMUSED) But Topi. You are so dramatic.
49. TOPI: Can't help it. Is the dryer hot enough?
50. NANA: Yes thanks. Lisa, did the doctors confirm that he had alcohol in his blood?
51. TOPI: That is where his problems will start.

52. NANA: I think his accident was God's way to stop his bad habits.
53. LISA: Eh Nana, that is a bit harsh.
54. TOPI: But that Robert was also becoming a drunkard.
55. LISA: It is not that but the main cause of this was someone who is a bad driver.
56. TOPI: Meanwhile, did you hear that Steve's mother is very sick?
57. NANA: I heard that she might not make it.
58. TOPI: She s doing very badly but she is going to be put on ARV's.
59. NANA: What is that?
60. TOPI: You know, those drugs that treat AIDS..
61. NANA: But will Steve be able to afford them?
62. LISA: I guess so. I heard that for widows and orphans, ARVs are free of charge.
63. TOPI: That is good for her. Poor woman must be suffering.
64. NANA: But Topi, how did you know all this? But do those drugs really work?
65. TOPI: I heard that they do.
66. .
67. NANA: But it also seems too good to be true.
68. LISA: Eh Topi, maybe you should stick to doing hair.
69. TOPI: (LAUGHS) Meanwhile Steve, The way he plays with girls and that woman Stella he will soon go.
70. NANA: Stella the fish monger? But she is too old for him.
71. TOPI: Those players do not care about age. They just play.
72. LISA: I hope he learns from what his mother is going through

73. NANA: That boy Steve is just so notorious; he may not even see what is happening around him.
74. TOPI: I agree with you Nana.
75. NANA: There are people who think that they are **immune** to the **virus**.
76. TOPI: Eh they think that it can never catch them.

APPENDIX 2: Tables

Table 1

List episodes, scenes and characters in Quarters 1-3

QUARTER	EPISODE	SCENE	CHARACTER(S)
1	1	2	Steve & Mother
1	1	8	Judith & Lisa
1	3	6	Topi, Judith, Nana & Lisa
1	5	4	Judith & Lisa
1	5	7	Steven & Mother
1	7	4	Topi, Judith, & Nana
1	7	5	Rebecca, Akonyo and Flower
1	8	6 a & b	A) Steven, Mother & Betty b) Steven & Stella
1	9	6	Steven, Mother & Betty
1	10	4	Judith & Lisa
1	13	7	Judith & Debra
2	14	5	Flower & Lillian
2	15	3	Steven & Vicky
2	16	6	Steven & Matata
2	18	3	Steven & Stella
2	19	2	Steven & Mother
2	20	2	Lisa & Judith
2	20	5	Judith, Debra & Lisa
2	20	8	Sister Aisha & Lillian

2	21	3	Judith & Debra
2	21	7	Topi & Nana
2	22	4	Judith, Rebecca & Robert
2	23	1	Steven & Coach Tito
2	23	3	Steven & Traditional Healer
2	24	6	Sister Aisha & Lillian
3	30	3	Vicky, Rebecca & Teacher Mark
3	30	7	Steven & Rebecca
3	32	1	Steven, Mother & Betty
3	32	3	Steven, John, Betty & Mother
3	32	8	Steven, Pastor Paul & Doctor
3	33	2	Steven, Betty & Sister Aisha
3	33	4	Steven, Betty & Rebecca
3	33	5	Lillian Sister Aisha
3	36	2	Topi, Nana & Lisa
3	36	5	Rebecca & Flower
3	37	7	Steven, Stella, Mother & Betty

Table 2

The Differential modelling of the characters in *RP256*

Positive Characters	Negative Characters	Transitional Characters
Lisa	Matata	Steve
Debra	Stella	Judith
Akonyo	Flower	Lillian
Pastor Paul	Solomon	Rebecca
Doctor	Michael (Debra's deceased boyfriend)	Steve's mother
Sister Aisha	Petero	Robert
Coach Tito	Jackson	
Traditional Healer	Monday	
Betty	Millie	
Nana	Vicky	
Guma	Teacher Mark	
Headmaster		

Table 3

The Societal and Cultural Markers of HIV/AIDS in Quarters 1-3

Table 4

The frequency of the Societal and Cultural Markers of HIV/AIDS in Quarters 1-3

REEL CODE	SCENE	LOCATION	CHARACTER	MARKER OF HIV/AIDS AND PLHA
1	2	Steve's hut	Steve's mother	ILLNESS, DEATH
3	6	Topi's Salon	Topi	village, town, innocent
3	6	Topi's Salon	Nana	AIDS, pregnancy
3	6	Topi's Salon	Judith	young
5	4	Lisa's home	Lisa	AIDS, infected, sex
5	7	Steve's hut	Steve	HOSPITAL
5	7	Steve's hut	Steve's mother	SICKNESS
7	4	Topi's Salon	Topi	young
7	4	Topi's Salon	Judith	player,
7	5	Foundation High	Rebecca	village, sick,
7	5	Foundation High	Flower	village, death, sickness, sex
7	5	Foundation High	Akoryo	AIDS, Straight Talk
8/6a		Steve's hut	Steve	in education, medicine, Health Centre
8/6b		Stella's Place	Steve	sick, health centre, condition, pain killers
8/6b		Stella's Place	Stella	pain killers
9	6	Steve's hut	Betty	AIDS, sick
10	4	Judith's House	Lisa	AIDS, sex, pregnancy, play sex, protect, sexuality
11	7	Health Centre	Debra	HIV +, sexually, pregnant, infected, died,
14	5	Foundation High	Flower	young, sleeping, pregnant, condoms, protection, HIV, syphilis, AIDS
14	5	Foundation High	Lillian	sex,
15	3	Road Side	Steve	protection, CD (condom) free sex, pregnant
15	3	Road Side	Vicky	protection, prostitute, condoms, safe
16	6	Rock Bar	Steve	protection, pregnant, AIDS, play sex, prostitute, sick, condoms
16	6	Rock Bar	Mataia	protection, pregnant, AIDS, play sex, prostitute, sick, condoms
18	3	Fishing Village	Steve	sick
19	2	Steve's hut	Steve	play
19	2	Steve's hut	Steve's mother	playing, young, sick, relating
20	2	Foundation High	Lisa	AIDS, HIV+, hospital
20	2	Foundation High	Judith	HIV, AIDS,
20	5	Hospital	Lisa	HIV, promiscuous,
20	5	Hospital	Judith	HIV
20	8	Health Centre	Sister Aisha	health centre, pregnant, sexual, protection, young, unprotected sex, HIV
20	8	Health Centre	Lillian	health centre, pregnant, sleeping, condoms,
21	3	Lisa's home	Debra	HIV +, sick, condoms, abstinence, died
21	3	Lisa's home	Judith	sick, AIDS, sex
21	7	Topi's Salon	Topi	AIDS, innocent, HIV, victim, condoms
21	7	Topi's Salon	Nana	AIDS, playing, young, innocent
22	4	Judith's House	Judith	sex, STIs, pregnancy, AIDS
23	1	Football Pitch	Steve	sick, sore, disease, safe
23	1	Football Pitch	Coach Tito	STD, Health Centre, sexual, condoms
23	3	Traditional Healer's Place	Steve	sore, sex, medicine, sleep, protection
23	3	Traditional Healer's Place	Traditional Healer	in medicine, STD, syphilis, condom, playing sex, diseases, health centre
24	6	Health Centre	Sister Aisha	pregnant, health centre, sexual relationships, young, sleeping, HIV, STIs, protect, infected
24	6	Health Centre	Lillian	sick, condom
30	7	School Day	Rebecca	Syphilis, HIV
30	3	Classroom	Rebecca	prostitute
30	3	Classroom	Vicky	sexually, infected
32	1	Steve's hut	Steve	die, health centre
32	1	Steve's hut	Steve's mother	AIDS, dying, diseases, die
32	1	Steve's hut	Betty	die
32	1	Road	Steve	sick, safe
32	1	Road	John	dangerous, sick, health centre, dead
32	1	Road	Betty	die
32	8	Health Centre	Steve	AIDS, weak, medicine, sick, treatment, died
32	8	Health Centre	Doctor	pneumonia, HIV virus, diseases, ARVs, blood, AIDS, medicine, widow, ill
33	4	Health Centre	Steve	sick, suffering, pneumonia
33	2	Health Centre	Sister Aisha	weak, tired, HIV, virus, AIDS, diseases, infect, die, unprotected sex, ARVs, widow
33	2	Health Centre	Betty	sick, AIDS, ill
33	2	Health Centre	Steve	ARVs
33	5	Sister Aisha's house	Sister Aisha	sleeping, condoms, safe sex, unsafe sex, pregnancy, HIV virus, infection, sex, young
33	5	Sister Aisha's house	Lillian	pregnant, village
35	5	School Farm	Rebecca	STI, sick, fever, sleeping, HIV
35	5	School Farm	Flower	fisherman, health centre, sick,
36	2	Topi's Salon	Topi	sick, HIV's, AIDS, suffering, poor, plays, playsex,
36	2	Topi's Salon	Nana	fishmonger, virus
36	2	Topi's Salon	Lisa	widows, orphans, ARVs
37	7	Steve's hut	Steve	sick

	STEVE	STEVE'S MOTHER	BETTY	DEBRA	LISA	SISTER AISHA	DOCTOR	JUDITH	TOPI	NANA	REBECCA	FLOWER	LILLIAN	COACH TITO	MATATA	STELLA	AKONYO	VICKY	TRADITIONAL HEALER	JOHN
Markers for HIV/AIDS and PLHA																				
SICK(ness)	9	2	2	1				2	1			2	4							1
TIRED	1	1					2													
WEAK	2						2													
HIV+ virus				3	3		5	3	3	2		2	1							
STIs/STDs										1	1									
AIDS	9	2	3	1	4		2	6	4	2	3	1			1		1			
CONDOMS	4			1			1		1			1	2	1	1			1		1
SEX	2				1		2		3			1	1		2					
PLAYER									1											
PLAY (ING) SEX	2	1			2			1	2	1						1				2
SLEEPING	1						2					1	1	1						
RELATING		1																		
LIVE SEX	1																			
SAFE SEX							1													
UNSAFE SEX							1													
UNPROTECTED SEX							2													
SEXUAL PARTNER		1												1						
SEXUAL INTERCOURSE							1													
SEXUALLY INFECTED																		2		
ARVs	1				1		2	2	1											
ILL								2												
ILLNESS		1																		
SUFFERING	2								1											
PAIN	1																			
HOSPITAL	2				1			2												
HEALTH CENTRE	6						2					1	1	6					2	1
PROSTITUTE	2										1				2			1		
SAFE	2													1	1			1		
STDs/STIs							1	2						3						2
SORE	2																			
SYPHILLIS											1	1								1
PNEUMONIA	3							5				1								
FEVER											1									
DISEASE(S)	2	1					1	2												1
BLOOD								4												
FLU				1																
PAIN		1	2		1															
DIE(D)/ DEATH	3	8	5	1			1		1			3					1			
WIDOW					1		1	1												
ORPHAN					1															
FISHMONGER										1										
FISHERMAN												1								
INFECT (ED/ TION)				1	1		3	1										1		
PROTECT (ED/ TION)	5				3		3					1			1			1		
SEXUAL/ SEXUALITY				2	1		3								1					
PROMISCUOUS					1															
ABSTIENCE				1																
PREGNANT	3			3	1		14		2			2	3							
STRAIGHT TALK										1								1		
VILLAGE	1	1										2	2	1						
TOWN									1											
POOR									1											
VICTIM									2											
INNOCENT									1											
CONDITION	1				1				2	1					1					
YOUNG			1	1	1		3		1		1		2							
MEDICINE	4							4	1	1					2					2
MEDICATION	1																			
AIDS /TREATMENT	1				1		1	3							2					
PAIN KILLERS	1																1			
DANGEROUS	1															1				1

Table 5

The values grid for HIV/AIDS, GENDER, MISCONCEPTIONS/RUMORS AND DIALOGUE

HEALTH	
A) Maternal Mortality	
It is good that...	It is bad that...
1. It is good that individuals in the community strive to reduce maternal mortality during pregnancy and delivery.	It is bad that individuals in the community do not strive to reduce maternal mortality during pregnancy and delivery.
2. It is good that individuals strive to improve the quality of services provided that will increase awareness of the high prevalence of maternal mortality rate in the society.	It is bad that individuals do not strive to improve the quality that would increase awareness of the high prevalence of maternal mortality rate in the society.
3. It is good that service providers take measures to improve the general health status of the people.	It is bad that service providers do not take measures to improve the general health status of the people.
4. It is good that individual members of the community know and understand the best practices in nutrition that include a balanced diet.	It is bad that individual members of the community do not understand the best practices in nutrition that include a balanced diet.
B) HIV/AIDS	
It is good that...	It is bad that...
1. It is good that individuals within the community recognize that HIV/AIDS exists and is a threat to society.	It is bad that individuals within the community do not recognize that HIV/AIDS exists and is a threat to society.
2. It is good that individuals within society know that everyone who is sexually active stands a risk of contracting HIV/AIDS.	It is bad that individuals within society do not know that everyone who is sexually active stands a risk of contracting HIV/AIDS.
3. It is good that individuals know the various modes of HIV/AIDS transmission.	It is bad that individuals do not know the various modes of HIV/AIDS transmission.
4. It is good that individuals go for counselling and testing in order that they know their HIV/AIDS status.	It is bad that individuals do not go for counselling and testing in order that they know their HIV/AIDS transmission

5. It is good that people practice safe sex.	It is bad that people do not practice safe sex.
6. It is good that people are aware of the link between STI and HIV/AIDS.	It is bad that people are not aware of the link between STI and HIV/AIDS.
7. It is good that people go for treatment as soon as they get infected with STIs.	It is bad that people do not go for treatment as soon as they get infected with STIs.
8. It is good that people accept and give care to victims of HIV/AIDS.	It is bad that people do not accept and do not give care to victims of HIV/AIDS.
9. It is good that society accepts and give care of AIDS orphans.	It is bad that society does not accept and does not take care of AIDS orphans.
10. It is good that HIV positive people do not lose their jobs because of their status.	It is bad that HIV positive people lose their jobs because of their health status.
11. It is good that society understands the basic needs of HIV/AIDS sufferers.	It is bad that society does not understand the basic needs of HIV/AIDS sufferers.
12. It is good that HIV positive pregnant women are provided with anti-retroviral therapy.	It is bad that HIV-positive pregnant women are not provided with antiretroviral therapy.
13. It is good that people know that HIV-positive mothers can transmit HIV to their children during pregnancy, delivery, and breastfeeding.	It is bad that people do not know that HIV-positive mothers can transmit HIV to their children during pregnancy, delivery, and breastfeeding.
C) Family Planning	
It is good that...	It is bad that...
1. It is good that individuals in society have enough correct information about family planning.	It is bad that individuals in society do not have enough correct information about family planning.
2. It is good that individuals know the different modern methods of family planning.	It is bad that individuals do not know the different modern methods of family planning.
3. It is good that people are informed that they should bear children they can afford to provide with basic necessities including food, clothing, shelter and education.	It is bad that people are not informed that they should bear children they can afford to provide with basic necessities including food, clothing, shelter, and education.
4. It is good that parents understand that a good parent is one who, besides	It is bad that parents do not understand that a good parent is one who, besides

providing basic necessities, will treat his/her children equally.	providing basic necessities, will treat his/her children equally.
5. It is good that pregnant women attend ante- pre-natal clinics.	It is bad that pregnant women do not attend ante- and pre-natal clinics.
6. It is good that HIV negative mothers breastfeed their babies for at least two years.	It is bad that HIV negative mothers do not breastfeed their babies for at least two years.
7. It is good that children are immunized against childhood diseases such as tetanus, whooping cough, measles, diphtheria, polio, e.t.c.	It is bad that children are not immunized against childhood diseases such as tetanus, whooping cough, measles, diphtheria, polio e.t.c
8. It is good that couples who cannot have children are examined and given appropriate treatment.	It is bad that couples who cannot have children are not examined and are not given appropriate treatment.
9. It is good that pregnant women understand that malaria can affect their unborn babies.	It is bad that pregnant women do not understand that malaria can affect their unborn babies.
10. It is good that women who are planning to get married get immunized against tetanus before marriage and pregnancy.	It is not good that women who are planning to get married do not get immunized against tetanus before marriage and pregnancy.
11. It is good that traditional birth attendants (TBAs) refer complicated maternal cases to maternal and child health (MCH) clinics.	It is bad that traditional birth attendants (TBAs) do not refer complicated maternal cases to maternal and child health (MCH) clinics.
SOCIOCULTURAL ISSUES/ RELIGION	
It is good that...	It is bad that...
1. It is good that parents take their children to school instead of encouraging them to go out to work	It is bad that parents do not take their children to school and encourage them to go to work.
2. It is good that parents and individuals create an enabling environment at home in order to discourage children from seeking employment.	It is bad that parents do not create an enabling environment at home in order to discourage children from seeking employment.
3. It is good that parents understand the hazards of child labour.	It is bad that parents do not understand the hazards of child labour.
4. It is good that people understand the importance of hard work.	It is bad that people do not understand the importance of hard work.

5. It is good that parents recognize the importance that their children stay in school until the child reaches the highest level instead of dropping out midway.	It is bad that parents do not recognize the importance that their children stay in school until the child reaches the highest level instead of dropping out midway.
6. It is good that parents and guardians understand the negative effects of early marriage by children.	It is bad that parents and guardians do not understand the negative effects of early marriage by children.
7. It is good that men respect women and vice versa.	It is bad that men do not respect women and vice versa.
8. It is good that men and women are allowed (responsibly) to marry spouses of their own choice.	It is bad that men and women are not allowed (responsibly) to marry spouses of their own choice.
9. It is good that individuals understand the negative consequences of early marriage.	It is bad that individuals do not understand the negative consequences of early marriage.
10. It is good that parents realize that poor social upbringing of children results in negative consequences.	It is bad that parents do not realize that poor social upbringing of children results in negative consequences.
11. It is good that parents understand that marrying off young girls to older men brings about social problems to girls.	It is bad that parents do not understand that marrying off young girls to older men brings about social problems to girls.
a) Violence	
It is good that...	It is bad that...
1. It is good that husbands refrain from physical and psychological violence against their wives	It is bad that that husbands engage in physical and psychological violence against their wives
2. It is good that spouses create a harmonious environment in the home.	It is bad that spouses do not create a harmonious environment in the home.
b) Gender	
It is good that...	It is bad that...
1. It is good that individuals are aware of important gender issues.	It is bad that individuals are not aware of important gender issues.
2. It is good that parents provide education equally to both girls and boys.	It is bad that parents do not provide education equally to both girls and boys.

3. It is good a parent values a son and daughter equally.	It is bad a parent does not value a son and a daughter equally.
4. It is good that men understand that women deserve equal job opportunities and equal pay.	It is bad that men do not understand that women deserve equal job opportunities and equal pay.
5. It is good that women have a bigger role in all aspects of life.	It is bad that women do not have a bigger role in all aspects of life.
MISCONCEPTIONS/RUMOURS	
It is Good that...	It is bad that...
1. It is good that individuals understand that mosquitoes do not spread HIV/AIDS.	It is bad that individuals do not understand that mosquitoes do not spread HIV/AIDS.
2. It is good that individuals understand that getting infected with HIV/AIDS is not a curse from God-it is a disease like any other.	It is bad that individuals do not understand that getting infected with HIV/AIDS is not a curse from God- it is a disease like any other.
3. It is good that men understand that female human beings are as intelligent as their male counterparts.	It is bad that men do not understand that female human beings are as intelligent as their male counterparts.
A) Harmful Traditional Practises	
It is good that...	It is bad that...
1. It is good that individuals understand the harmful effects of female genital mutilation (FGM).	It is bad that individuals do not understand the harmful effects of female genital mutilation (FGM).
2. It is good that people understand the medical complications brought about by FGM	It is bad that people do not understand the medical complications brought about by FGM.
3. It is good that men understand the physical pain, agony, and mental anguish women undergo during and after circumcision.	It is bad that men do not understand the physical pain, agony, and mental anguish women undergo during and after circumcision.
4. It is good that men understand the lifelong complications that accompany female circumcision.	It is bad that men do not understand the lifelong complications that accompany female circumcision.
ECONOMIC ISSUES	
It is good that...	It is bad that...
1. It is good that every citizen plays a role in development of the national	It is bad that some citizens do not play a role in development of the national

economy.	economy.
2. It is good that women have an opportunity to engage in viable income-generating activities.	It is bad that women do not have an opportunity to engage in viable income-generating activities
3. It is good that men realize that if you can educate a man you educate an individual, but if you educate a woman you educate the entire nation.	It is bad that men do not realize that if you can educate a man you educate an individual, but if you educate a woman you educate the entire nation
4. It is good that individuals understand the root causes of poverty.	It is bad that individuals do not understand the root causes of poverty.
PEOPLE WITH SPECIAL NEEDS	
a) Youth	
It is good that...	It is bad that...
1. It is good that society understands that the future of any nation lies in its youth.	It is bad that society does not understand that the future of any nation lies in its youth.
2. It is good that individuals understand the importance of youth participation in sporting activities during their leisure time.	It is bad that individuals do not understand the importance of youth participation in sporting activities during their leisure time.
b) People/ Children with disabilities	
It is good that...	It is bad that...
1. It is good that guardians of orphaned children encourage them to make use of their exemption from paying school fees.	It is bad that guardians of orphaned children do not encourage them to make use of their exemption from paying school fees.
2. It is good that disabled people are given an opportunity in economic activities in the country.	It is bad that disabled people are not given an opportunity in economic activities in the country.
3. It is good that children with disabilities are given an opportunity to acquire education.	It is bad that children with disabilities are not given an opportunity to acquire education.
DIALOGUE	
It is good that ...	It is bad that...
1. It is good that there is a quality dialogue between wives and husbands.	It is bad that there is no quality dialogue between wives and husbands.
2. It is good that parents open channels of communication between themselves	It is bad that parents do not open channels of communication between

and their children.	themselves and their children.
3. It is good that siblings learn how to communicate among themselves.	It is bad that siblings do not learn how to communicate among themselves.
4. It is good that parents communicate with their teachers about their children.	It is bad that parents do not communicate with teachers about their children.

Frequency of Societal and Cultural Markers in Quarters 1-3

