

Article 5**DANCING DISEASES: AN APPLIED THEATRE RESPONSE TO THE CHALLENGE OF CONVEYING EMOTIONALLY CONTRADICTIONARY MESSAGES IN HIV EDUCATION****By Andrea Baldwin (Australia)****Abstract**

Health educators face an unusual challenge in relation to HIV: the need to convey two emotionally contradictory messages. On the one hand, there is currently no cure for HIV, which eventually leads to death (emotionally negative message). On the other hand, people with HIV can live long, healthy and productive lives (emotionally positive message). In developing countries where HIV prevalence is high, it is imperative that both messages are conveyed effectively. This article reports on a specific form, *Dancing Diseases*, implemented as one component of the Life Drama pilot study on Karkar Island, Papua New Guinea. Life Drama is an applied theatre and performance approach to HIV education. The article discusses *Dancing Diseases* as an example of applied theatre and performance practice, reflects on the participant group's engagement with the form, and offers some ways in which the form could be refined and used in other health education contexts.

Biography

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Emotionally Contradictory Messages in HIV Education

Health educators have long recognised the potential for drama (including community theatre, puppetry, radio drama, television advertising and soap opera) to help engender negative emotional responses to specific diseases. Malaria is an example of a disease that can readily be portrayed in dramatic form, in such a way as to elicit a negative emotional response. In the 1980s, Raun Raun Theatre in Papua New Guinea regularly staged a 'village play' in which a dancer representing a mosquito (using a piece of fabric to represent wings) flew from victim to victim, passing on malaria. The disease symptoms, in all their severity, were then performed by the actors, with the dialogue raising the possibility of death. Health was restored through appropriate treatment by an actor portraying the local health worker, who also provided information about future prevention (Raun Raun Theatre 2010).

Using similar themes in a different medium, Wan Smolbag in Vanuatu has produced an engaging video drama, 'Wan Present Blong Niufala Bebe'. The puppet mosquitoes are anthropomorphised as dangerous and determined antagonists, intent on infecting two vulnerable children. The well-meaning but mistaken actions of the children's parents almost lead to tragedy, but just-in-time treatment and correct information on prevention (again provided through the local health worker) save the day (Wan Smolbag Theatre, 1998).

Early HIV education efforts, such as the 'Grim Reaper' media campaign in Australia, approached HIV in a similar fashion, with the goal of arousing a generalised negative emotional response to HIV (specifically, fear) by emphasising the ultimately fatal consequences of HIV infection (Slavin et al. 2007). Over time, however, health educators have realised that there are important differences between HIV and a disease like malaria. The approach to HIV prevention must be more nuanced, to address the complexities of this particular virus, its effects and its contexts.

HIV poses what may well be a unique problem in health education. On the one hand, there is currently no cure for HIV, and the virus eventually leads to death (emotionally negative message). On the other hand, people with HIV can live healthy and productive lives for up to 20 years following infection (emotionally positive message). HIV 'awareness' that arouses strong negative emotional reactions may help people who do not have HIV, by motivating them to avoid infection, but inevitably harms people who know they do have HIV, through individual psychological impacts and by promoting stigma and discrimination in the community (SCiPNG 2007; Tau 2007). A related problem is that emotionally negative messages about HIV reduce the likelihood that people will seek testing, and this situation increases the population risk of transmission (Lauwo et al. 2008). Health educators are thus faced with the need to convey two emotionally contradictory messages: that HIV is fatal and infection must therefore be avoided; and that HIV need not be immediately fatal and can be lived with successfully.

The need to convey both parts of this two-pronged message is particularly urgent in developing countries where HIV prevalence rates are high and/or rising. In Papua New Guinea, the national prevalence rate is estimated at between 0.8 and 3.2 per cent (Jenkins 2006); the most commonly cited estimate is between 1.2 and 2 per cent (e.g. National Department of Health 2007), but in sub-populations it may be at least as high as 17 per cent (Mgone et al. 2002). 'Awareness' of HIV is high (98 per cent), but correct knowledge about HIV and AIDS transmission, prevention and treatment is very low, especially in rural areas (McPherson 2008). The dilemma for health educators is that HIV education is urgently needed, but may do more harm than good unless it succeeds in conveying both messages.

Additional Challenges to HIV Educators

Adding to the challenges faced by HIV educators in Papua New Guinea are a number of factors that have been much discussed in the literature. First, there is a lack of evidence for the effectiveness of education (as opposed to awareness) conducted through mass media such as radio, television, newspapers and billboards, even in urban centres (McManus 2008). Since rural and remote areas may have none of these media (or, at best, only radio), media campaigns in any case reach only a small percentage of the total population (Hammar 2008).

Second, rural and remote populations are difficult and expensive to reach in more direct ways, being scattered over mountains and islands in small settlements with little transport infrastructure. While many organisations invest in visits by health educators to rural centres, geography and cost pose major barriers to the further dissemination of health education via 'hub and spoke' models based in these centres (Jenkins 2006).

Third, over 860 languages are spoken in Papua New Guinea, and large sections of the population do not speak the lingua franca Tok Pisin, or do so only as their third or fourth language (Levy 2008). Health educators therefore may be forced to work through translators, without a means of ensuring the translation is accurate. Tok Pisin itself has been described as 'a language of command and demand', with a limited vocabulary and little capacity for expressing complex or abstract ideas (McPherson 2008). The conflation of HIV and AIDS into the commonly used term '*sikaIDS*' is an example of the ways in which Tok Pisin may contribute to the obfuscation rather than the clarification of complex health issues. The lack of suitable terms for describing microscopic organisms such as viruses, bacteria and parasites in Tok Pisin also poses a linguistic challenge for health educators (King and Lupiwa 2010).

A related issue relates to literacy. Although much effort has been invested in developing printed materials on HIV (such as pamphlets and fact sheets) in English and Tok Pisin, and sometimes even in *tok ples* (local languages), Papua New Guinea is an oral society with very low literacy levels. Few rural people read or write in any language (Levy 2008). Since English is the official language for education, some younger people may read and write basic English, but may struggle to grasp new and complex concepts from health materials written in that language.

Fourth, levels of medical knowledge and understanding of how the body works are generally low in rural and remote areas of PNG. Traditional knowledge may have been lost, while 'Western' knowledge may not have caught up. The impossibility of 'seeing' the microscopic organisms mentioned above is one reason for the lack of words to describe them in Tok Pisin – or, indeed, in *tok ples*. If disease processes are not understood, it is not surprising that people understand diseases only in terms of their visible symptoms ('*signs*', in Tok Pisin) and not in terms of their underlying causes. Some of the misconceptions that result from this lack of knowledge promote HIV transmission – for example, the belief that it is safe to have sex with someone if they 'don't look sick' (King and Lupiwa 2010).

Fifth, there is a great deal of emotion, fear, superstition, myth and misconception surrounding HIV in Papua New Guinea, often promulgated by authority figures in churches, politics, the media and traditional village hierarchies. Leaders may have the best of intentions, but they are often prejudiced and/or ill-informed themselves, and thus spread misinformation that becomes enshrined in folklore (Jenkins 2006). Examples of such beliefs include the notion that there are 'bad condoms', which spread HIV, and 'good condoms', which prevent it; or the belief that HIV can be cured by having sex with a virgin (Lepani 2008). Traditional belief systems and cultural assumptions tend to support the development of such folklore – for example, the common perception that misfortune results from either transgression on the part of the victim or sorcery on the part of some enemy (Haley, 2008).

The Life Drama Approach: Experiential Learning Through Participatory Drama

Life Drama is a health education initiative currently being developed in Papua New Guinea, which attempts to address some of the challenges outlined above. Life Drama is an intensive intervention based on participatory, improvisational drama as a means of engaging learners cognitively, emotionally and physically. It belongs to the body of practice variously known as applied theatre or applied drama (Nicholson 2005). The Life Drama team identifies its work as a form of 'applied theatre and performance'. Life Drama does not rely on written materials but on the oral and performative traditions of communication in Melanesian society. The Life Drama model is one of training trainers; it is designed to be disseminated through leaders working with their own communities, in their own languages, dealing with the beliefs and realities of HIV in their own contexts.

Life Drama uses a number of 'forms', including games (e.g. name games, circle games), drama exercises (e.g. focus exercises, frozen image exercises), activities drawn from the field of drama-in-education and particularly process drama (e.g. leader-in-role, hot-seat role-play) and activities drawn from indigenous Papua New Guinean performativity (e.g. 'sing sing forms', the use of improvised music on indigenous instruments). The forms are designed to build on one another, to help groups explore and reach a deeper understanding of the major issues involved in HIV and AIDS. The process of developing these forms has so far involved three distinct stages: a pilot project in Tari, Southern Highlands Province; a Theatre

Exchange Workshop bringing together a number of Australian, English and Papua New Guinean theatre practitioners in Madang, Madang Province; and a pilot project in Karkar Island, Madang Province. More details about these three developmental stages, the design of the Life Drama training package and the specific forms that make up the 'Life Drama *bilum* (bag)' will be discussed in another article.

The purpose of the current paper is to outline the process by which the author, as a member of the Life Drama team and with the participation of the Karkar Island pilot group, devised and conducted a new 'form' or learning activity specifically to tackle the problem of the two messages HIV education must convey. The new form, *Dancing Diseases*, focuses on building up an understanding of how the body combats disease, and then explores the HIV disease process and the implications of this process both for preventing transmission and for living successfully with HIV.

Our purpose in presenting our experience with *Dancing Diseases* is not to imply that we have solved the problem of how to address emotionally contradictory messages in health education using applied theatre and performance, or created the definitive tool for helping groups to understand disease processes. Applied theatre practitioners, educators and facilitators in a range of fields are constantly and creatively engaged in addressing real-world problems through imagined constructions designed to advance participants' learning. By sharing and reflecting on this specific example of our practice, we would like to invite further dialogue on 'what works', particularly in relation to culturally specific development contexts and health education.

The Pilot Site: Karkar Island, Madang Province, Papua New Guinea

Karkar Island is an active volcanic island approximately an hour and a half by boat from Madang, on the north-eastern coast of Papua New Guinea. From an estimated population of 5000 in 1947, Karkar Island now has a population of approximately 65,000, the vast majority of whom are aged under 21. Karkar Islanders are Melanesian people who belong to two language groups, Waskia in the north and Takia in the south. The people have a strong sense of culture and custom, although Western influences are becoming stronger (for example, all participants in the Life Drama workshop wore Western-style clothing). Karkar Islanders live in small villages scattered around the coast of the island and up the lower slopes of the central mountains. There is a ring-road around the island, with a limited number of side roads leading to villages in the interior. The government station is at Kinim, on the northern side of the island. There are a number of small shops located around the ring-road. The island produces cocoa, copra and coconuts, though most of the population lives by subsistence agriculture and fishing rather than paid employment in these industries. The island has two health centres, the Lutheran-run Gaubin Hospital (which has a VCT clinic) and the government-run Miak Health Centre.

The participant group for the Life Drama pilot consisted of seventeen men and eight women. Nearly all were members of 'theatre groups' (more accurately, traditional dance troupes), of which there are at least five active on the island. They ranged in age from mid-teens to approximately mid-sixties, though most were in their twenties and thirties. The group included a teacher, a health-care worker, a mothers' representative, and several church and community leaders.

***Dancing Diseases*: Precursors**

In considering the two messages to be conveyed in relation to the HIV disease process, the trainer originally intended to use two separate forms: 'Healthy *Meri*', a form that has been traced to Jo Dorras of Vanuatu's Wan Smolbag Theatre, and 'Two Tribes', a version of the game 'Westside Story', which another member of the team (Professor Brad Haseman) had introduced previously in Tari.

The author first encountered a version of 'Healthy *Meri*' performed by a small group in a workshop in Lae, in November 2006. The form involved a dancing woman, who announced 'I am healthy *meri* (woman)'. A chorus of three men echoed 'she is healthy *meri*', before taking the stage and announcing 'we are her white blood cells'. The men proceeded to dance around the woman, in concert with her. A figure entered the stage space and announced 'I am HIV virus'. This figure then joined the dance, stylistically striking the white blood cells each time their movements brought them into range. After repeated strikes, the white blood cells began to falter in their dance, moving closer and closer to the floor, and eventually falling down 'dead'. As they did so, the dancing woman in their midst was revealed – also weakening in her dance, and eventually collapsing in death. The author believed that this scene was the original work of the group until she encountered similar enactments performed by several small groups in Tari during the first Life Drama phase. In one of the scenes, the HIV virus wore a blindfold. In another, the white blood

cells destroyed by the HIV virus were 'resurrected' as more HIV virus, which continued the work of killing off the white blood cells until HIV outnumbered the white blood cells and finally killed them all off. The author was told that this form had been introduced by Jo Dorras of Wan Smolbag in a workshop in 2006, and that it represented death resulting from the HIV virus replicating and destroying the white blood cells. The group did not enact or volunteer information about how death actually occurs (i.e. through opportunistic infections that the body can no longer fight off).¹

This seemed to be a simple, powerful form for conveying the negative HIV message that HIV is fatal, along with information about how the disease process works (the virus destroys the white blood cells). In order to convey the positive HIV message (that the white blood cells can resist the virus for extended periods of time, enabling a healthy and productive life), the trainer initially planned to use 'Two Tribes'. The group is divided in two, and one half drives the other back across the space by making a sound and gesture while advancing step by step. Having reached the other side of the space, the retreating group turns the tables by advancing, making their own sound and gesture and driving the other group back. This form seemed to provide a metaphor for the HIV virus beating back the white blood cells, and the white blood cells rallying. The author intended to ask the group for information on factors that would strengthen the white blood cells (e.g. good food, rest, treatment for minor infections, good hygiene, family support, etc.) and use the energy from these suggestions to drive the triumph of the white blood cells, then ask for factors that would strengthen HIV (e.g. poor hygiene, not enough nutritious food, minor infections, rejection, isolation, discrimination, etc.) and use that energy to drive the advance of the HIV. In this way, the game could be used to show that a healthy life is possible when there are enough factors strengthening the white blood cells and suppressing the HIV.

Issues

However, on further reflection, there were a number of problems with the idea of using these two forms in this way. First, between them the two forms introduce at least three different platforms of reality. Healthy Meri portrays a life-sized person dancing in the 'real world', plus the invisible conflict going on inside her body between HIV virus particles and white blood cells – what Kamo et al. (2008) call the 'microworld'. Two Tribes would likewise portray the microworld, but would also introduce abstractions like 'family support' and 'discrimination'. The complexity of these multiple platforms of reality seemed likely to impede coherent communication about the disease process.

Second, too little of the experience would be owned by the participants. One of the Life Drama principles is that learning occurs when people engage, and that engagement requires participants to contribute their own creativity and energy to the form. Requiring the participants to 'act out' two predetermined forms and explaining that they symbolise disease processes seemed shallow and didactic.

Third, a major thrust of Life Drama since the Theatre Exchange Workshop has been to deepen engagement and learning by encouraging participants to bring their own cultural performativity to the work. While both forms allow scope for individual expression (in the dancing, in the sounds and gestures), a radical reframing seemed necessary to provide sufficient time and motivation for the group to tap into their cultural knowledge and create something that was really theirs.

What follows is a description of the *Dancing Diseases* form that was enacted on Karkar Island, informed by the concerns outlined above. Further refinement of the form is envisioned, and directions for such refinement are mentioned at the end of this article.

Dancing Diseases: The Form, Step by Step

The group was divided into smaller groups of approximately three to four members. Each small group was asked to find its own space to work, well away from the others. The trainer moved around the groups and gave 'secret instructions'. Each group was asked to create a dance. They were told that they could use *bilas* (body adornment), music, rhythm or anything else they needed to create their dance.

One group was asked to represent red blood cells. Six groups were to represent diseases: the common cold, cholera, malaria, gonorrhoea, HIV and pneumonia. The trainer talked through the symptoms of each of these diseases with each small group, to inform their dance. The disease groups were told that after performing their dance, they would be attacked by white blood cells. The dance would be performed in normal time, but the fight would occur in slow motion. The cold, cholera and malaria were to be defeated by the white blood cells. Gonorrhoea was to pretend to be defeated, but actually remain active – it was suggested that this might be conveyed by dancing lower to the ground. HIV's dance was to represent an

aggressive attack on the white blood cells right from the start; the white blood cells would fight back.

The white blood cells were asked to create their dance, and told about each of the diseases they would encounter and fight in slow motion. The trainer suggested that one way of conveying the fight might be through 'sword arms' (i.e. slashing movements with the forearms), as bush-knives of approximately this length are a common tool and weapon on Karkar.

When all the groups had had time to plan and practise their dances, the trainer called the whole group into a circle and passed round a skein of wool. Each member held the wool, and the trainer explained that the circle represented a body and the wool represented the skin. The person thus represented was both a man and a woman. The trainer explained that the skin is the body's main defence against diseases. However, there are 'holes' in the skin where diseases can enter the body. The trainer asked the group to identify these 'holes', and select the places in the circle where the holes would be. As the group nominated each hole and its location in the circle (two ears, two nostrils, mouth, anus, urethra, vagina, a sore and a tattoo), the trainer cut the wool and marked the place with found objects on the ground (eg. two coconut shells for the mouth, two large blossoms for the vagina, etc.). Thus the body came to be represented by wool and found objects, freeing up the participants to take other roles.

The trainer suggested that since the skin had holes, another line of defence was needed to protect the body from disease. A few group members provided the desired response: 'white blood cells'. The trainer asked 'What colour is blood?', and group members stated that blood is red because of red blood cells. The trainer then invited the red blood cells to perform their dance inside the body. The red blood cells were then asked to retire, on the understanding that in reality blood consists of both red and white blood cells. The white blood cells were invited to perform their dance inside the body.

The trainer then asked the group by which hole the common cold could enter the body. The group was confident that colds come in through the nose and mouth, so after a brief discussion of cold symptoms, members of the cold group were asked to enter the body through the nose and mouth and perform their dance. They were duly dispatched by the white blood cells, as were cholera and malaria in their turn. Gonorrhoea needed reminding that it was not vanquished but remained active in the body; the course of gonorrhoea was then described to the group, with emphasis on the fact that symptoms may appear to go away but the organism continues to damage the body's organs. As with cholera and malaria, the usefulness of medical treatment to support the white blood cells was discussed.

After gonorrhoea, the trainer devoted some time to discussing with the group 'another sexually transmitted illness – HIV'. There was an extended discussion of the 'holes' and modes through which HIV enters the body, and the modes by which it does not enter the body (e.g. it is not possible to contract HIV by sharing food, kissing, hugging, buying vegetables from someone with HIV, etc.). The trainer drew on the knowledge in the group, and also referenced the pre-training interviews where many misconceptions had been expressed. There was a good deal of discussion regarding stigma and discrimination, again driven by discriminatory responses on the pre-training interviews – for example, the idea that if a female teacher had HIV 'it was her own fault'.

The HIV group then entered the body via the vagina, urethra and anus, and engaged the white blood cells in a war dance. The trainer called a freeze while the two groups appeared equally balanced, and asked the group which side was winning? The group suggested that the two sides were in balance, and the trainer drew on the knowledge of the group to discuss how a person can live a long time with HIV if the white blood cells can be kept strong. The trainer asked for suggestions of things that strengthen the white blood cells, and as each suggestion was made (fruits, vegetables, clean water, exercise, etc.), the person making the suggestion was asked to come into the space and join the white blood cells. After a few suggestions, the white blood cells outnumbered HIV and were asked to 'push HIV back'. The trainer prompted the group for suggestions of family and community actions that would help the person's white blood cells (e.g. visiting, bringing food, praying with them, etc.). In several such steps, the white blood cell group became so large that it pushed the three dancers representing HIV to the extreme edge of the 'body'.

The trainer then returned the group to its starting position (HIV and white blood cells facing off), and asked for suggestions about the things that strengthen HIV in its fight against the white blood cells. As people took the roles of other conditions such as diarrhoea, lack of good food, lack of rest, worry and isolation from the community, the HIV team pushed the white blood cells back, and eventually 'killed' them. At this point, with the body occupied by HIV and no white blood cells remaining, the trainer invited pneumonia to enter the body. Pneumonia energetically performed its dance, and encountered no resistance. The trainer explained that

this condition – a serious opportunistic infection making the person sick, with insufficient white blood cells to defeat it – is called AIDS, and it is at this point that the person may die. All remaining participants standing around the circle of wool, and all the HIV and pneumonia inside the body, were asked to ‘die’ by sinking to the ground, and to make sounds associated with sadness and mourning.

To finish the exercise on a positive note, the body was ‘resurrected’ with all participants standing around the circle of wool, and the white blood cells reinstated within the body. The trainer then asked how the person could have prevented HIV from coming inside the body. The group suggested abstaining from sex, being mutually faithful with one partner, caesarean delivery for the baby of a mother with HIV, not sharing razor-blades and using condoms. The trainer represented the use of male or female condoms by using wool of a lighter colour to ‘cover up’ the holes representing the vagina, anus and urethra. The final message of the exercise was that the HIV can be kept out, and the body kept healthy, through these means of prevention.

Group Engagement with *Dancing Diseases*

The group displayed a striking willingness to engage with the form. Each small group devised a complex, energetic dance. Several members took the opportunity to decorate their bodies with paint and leaves. One of the malaria group donned full *bilas* (including shell lap-lap, feather head-dress, face paint, kina-shell necklace and arm-bands bursting with leaves and feathers) and assumed a cocky ‘trickster’ persona. His improvised Tok Pisin dialogue with the ‘audience’ of other participants (‘I bet you don’t know who I am!’) attracted an enthusiastic response.

While there was some confusion regarding how the diseases and the white blood cells were to symbolically interact (more on this later), the way the white blood cells developed their dance over the course of the form was noteworthy. From their first interaction with a disease group, in which they used the trainer’s suggestion of ‘sword arms’ to defeat the common cold, they quickly evolved more aesthetically interesting ways of engaging with the invading diseases. For example, they killed malaria using adapted movements from their introductory dance – an aggressive, tension-building advance and retreat movement that culminated in a spearing action. When locked in combat with HIV, they chose to dance in a rapid running circle around the other group, as if trying to contain the virus.

The group’s impulse towards musical accompaniment was very strong. The first small group, the red blood cells, began their dance in silence. Members of the group watching, however, picked up the rhythm of the dance and began to clap, with the clapping rhythm then gaining in complexity to the end of the dance. As the white blood cells were about to dance, the clapping began again: the trainer intervened to ask the group to allow the dance to start first, so that the dancers would not be constrained by the rhythm provided but the rhythm would follow the dancers. (It had been explained to the trainer previously that in traditional Karkar Island dance, the music follows the dancers rather than the other way around.) By this stage, several members of the group had begun acquiring musical instruments to help with the accompaniment, and the dance of the white blood cells was marked by improvisational percussion that punctuated the dialogue and supported the dance. By the time malaria entered the body, the musical section included didgeridoo, three kinds of flute and various percussive instruments, which were used to accompany and emphasise the action of the dance.

The group’s engagement in the ‘world of objective fact’ represented through the form was also strong. Much has been made of the taboos associated with naming and discussing reproductive organs in Papua New Guinea, and the obstacle these taboos present to sexual health education (King and Lupiwa, 2010). However, this group readily provided the Tok Pisin terms for the vagina, anus and urethra, following on naturally from the ears, nose and mouth, when all these organs were framed as ‘holes in the skin’. The group seemed to accept the trainer’s description of the symptoms of gonorrhoea with no overt signs of embarrassment, and several members provided Tok Pisin words to assist the trainer (e.g. *susu* for pus, in the context of discharge from the penis or vagina).

The trainer strove to gather most of the factual information to be shared in this session from members of the group, rather than imposing the information in the guise of ‘expert’. The group’s willingness to offer suggestions (e.g. ways to strengthen white blood cells; factors that would strengthen HIV; ways to prevent transmission) enabled the trainer to reinforce existing knowledge and ensure it was shared. It also provided the opportunity for correcting misperceptions. For example, when the trainer asked ‘by what road can HIV come inside the body?’, one participant answered ‘through all roads’, expressing the misperception commonly provided in the pre-training interviews that HIV can be contracted just by being

near someone who has the virus. Without causing this participant to lose face, the trainer was able to reinforce the correct answers provided by other members of the group and emphasise that HIV cannot be contracted 'through other holes' or by other means such as sharing food, touching, and so on.

A Springboard to Other Material

The Life Drama team has learned that because Melanesian societies are oral societies, the repetition of messages is expected and required – it is not enough to say something once and expect it to be remembered. This is also a recognised principle in marketing, including the marketing of health messages.

Dancing Diseases was strategically placed within the overall workshop. It followed a half-day of introductory activities, then a day of building the Open Story (of a husband and wife, their child, the husband's girlfriend and the communities to which these people belong) which provides the spine of the Life Drama training. By the third day on Karkar Island, the Open Story had progressed through process drama activities to the point where the husband's infidelity, and the possibility of HIV infection, was raised. *Dancing Diseases* then introduced the participants to the 'world of objective fact' around HIV by providing a back-to-basics exploration of the body's defences and the HIV disease process.

Following *Dancing Diseases*, the workshop went on to explore various issues raised in this form, both through episodes in the Open Story and through complementary exercises and activities. The vagina, anus, penis, testicles and urethra having been openly named and enacted in *Dancing Diseases*, a later exercise called 'Dancing Body Parts' provided a fuller opportunity to challenge the taboos around representing and discussing the reproductive organs. Condoms were explored during a hands-on session designed to demystify male and female condoms and teach participants how to demonstrate their correct use. Other activities addressed myths and facts about HIV transmission and treatment, sexual networks, gender relations, stigma and discrimination, and support. The training also touched on larger social and contextual factors in HIV transmission, such as traditional customs, rapid social change and economic disempowerment – particularly of women.

Critical Reflection

All phases of Life Drama training development have been videoed in full. This has enabled the team to reflect on the process of *Dancing Diseases* as conducted on Karkar Island, and to identify ways in which the form could be refined for future applications. Since the initial trial of the form outlined above, the author has conducted *Dancing Diseases* in four additional settings in the Highlands and Port Moresby, with high school students and teachers, healthcare workers, church and community leaders, and semi-professional performers. The reflections below are drawn from the Karkar Island pilot program and have been reinforced through the subsequent trials.

First, it would be ideal if the form were conducted in the participants' *tok ples*. The trainer's lack of fluency in Tok Pisin necessitated regular translation, which slowed the process down and probably contributed to some misunderstandings. Although the trainer has refined the instructions for the form over subsequent trials, participants continue to reflect that it would be easier to understand such a novel and complex activity if it were explained in their own language.

Second, for learners with initially low levels of understanding concerning disease processes, the form might be more effective broken into two or more parts. The set-up of the body, skin, 'holes', and red and white blood cells could constitute the first part, with time spent exploring the concept of the skin and white blood cells as two lines of defence against disease. A break, with or without intervening activities, would allow time for this information to consolidate. Health educators focusing on specific diseases could then spend time exploring those diseases within the established form. For example, both malaria and cholera are dangerous diseases in developing countries, which are often not well understood; both could be addressed in some detail through the *Dancing Diseases* form. A third section of the form could focus on sexually transmitted illnesses like gonorrhoea, HIV as a special kind of sexually transmitted illness, and pneumonia or TB as an opportunistic infection that can cause death once HIV has destroyed the white blood cells.

Third, with more time given to each separate part of the form, cultural performativity could be harnessed even more effectively to create the emotional experiences required for learning. One assumption underlying *Dancing Diseases* was that people in Papua New Guinea have more readily absorbed the negative emotional message of HIV education (that HIV is fatal and should be feared) than the positive

emotional message (that people with HIV can live healthy, productive lives, and require support from the community). The form thus emphasised the positive message by enlisting cultural performativity to show how the white blood cells can hold the HIV virus in check. The 'death of the body' part of the form, which conveys the conventional negative emotional message, was somewhat hurried, with the result that some participants took it less seriously than the earlier sections. This part does need to elicit a sense of sadness and loss, which could be done by asking participants to tap into the well of cultural performativity associated with mourning (as was done in other sections of the Life Drama training). Similarly, the 'resurrection' of the body and the exploration of prevention methods could be made more performative, and thus more powerful.

Finally, rather than using wool to represent the body and scissors to cut the wool, it would be preferable in rural settings to use bush string and a bush knife when conducting this exercise. Life Drama is based on a train-the-trainer model. It is important that participants feel they have access to appropriate training materials, as well as the requisite knowledge, to use this form with participants in their own communities.

Conclusion

Dancing Diseases is an example of an applied theatre form that enlists participants' cultural performativity, creativity and aesthetics to explore an important issue and achieve an educational goal. The emotionally contradictory messages that must be understood if HIV education is to be effective are just one example of the formidable challenges that face applied theatre practitioners in health education and developmental contexts. It is hoped that this article will stimulate further reports, critique and discussion regarding creative practice that aspires to meet these challenges.

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Note

- 1 Subsequent communication with Wan Smolbag has revealed that this was a much- simplified version of the exercise conducted at the original workshop.

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